2014 Gage Awards

Reference #	7493061
Status	Complete
Name of hospital or health system	Maricopa Integrated Health System
Name of project	Maricopa Integrated Health Home Project
CEO name	Steve Purves
CEO approval	Check here to confirm that your CEO approves of this project being submitted for a 2014 Gage Award
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Within which of the two categories does your application best align?	Population Health

1. Provide a brief description of the project. (This section should resemble an abstract for a poster presentation or an abstract for a peer reviewed journal. Include an objective, data sources, study design, findings, and conclusions.)	The Maricopa Integrated Health Home Project in Maricopa County, Arizona, addresses the unique needs of the community's Seriously Mentally Ill population, forges a stronger link between the behavioral and physical health providers, and holistically focuses on the individual with the goal of driving better health outcomes. Individuals with severe mental illness who are served by our public mental health system die 25 years earlier on average than the general population, largely due to treatable, manageable conditions. Conceived in 2009 and launched in 2011, Integrated Health Homes (IHH) today function in 10 of the 20 community based mental health clinics in Maricopa County. The physical and behavioral health needs of individuals challenged with severe mental illness are being effectively managed through a person-centered, population-based, data driven and evidenced-based approach. The IHH model includes more than just co-location of behavioral and physical health care services. The goal is whole-person care and includes Stanford's Chronic Disease Self-Management Program, health and wellness training and mentoring, and providing assertive engagement and support for hospitalized individuals. Individuals with lived experience are trained as Peer Support Specialists and Health Coaches to partner with the individual while assisting in setting wellness goals, navigating the healthcare system, accessing screening and preventive services, even setting up exercise programs and creating peer communities of support and encouragement. The service experience is focused on self-directed recovery — assisting each person to identify strengths and needs in terms of skills, resources and support. Integrated health home programs help by holistically treating the person, not focusing on one specific condition at a time, with the goal of improving the quality of care through prevention, adherence to treatment plans and management of co-morbid conditions. A coordinated approach to care means fewer emergency room and urgent care visits, medical inpatient admissions, behavioral health admissions and long-term care admissions, leading to reduced costs for the state and improved outcomes for the individual. The Maricopa Integrated Health Home Project is a collaboration between Maricopa Integrated Health System, Magellan Health Services of Arizona and community-based mental health clinics managed by Provider Network Organizations (PNOs). The project's mission is based on shared governance and oversight to more closely integrate the overall delivery of care for individuals challenged with SMI to focus on their whole health and wellness.

2. Describe the methods use in this project. Include where, why, and how the project was accomplished.	The Maricopa Integrated Health Home project integrates mental and physical health care for the 14,000 Medicaid-eligible individuals in the central Arizona behavioral health system challenged by serious mental illness. Through the partnership with the PNOs' SMI specialty clinics, MIHS has created health homes for adults with SMI to shape the care coordination of individuals with complex needs. An evolution of the medical home model, health homes are intended for individuals with chronic conditions, with care coordination efforts incorporating all the medical, behavioral health, and social supports and services needed by a beneficiary. Simply co-locating services does not ensure care integration. Health Homes guarantee the sharing and utilization of health information necessary to improve the quality of care and clinical outcomes. These efforts have begun with targeted efforts for adults with serious mental illness with plans to expand to the rest of the population served, including those seeking services for general mental health and/or substance abuse challenges. Success is dependent on adapting the current treatment cultures, adequately training staff, and developing strategies for effective Health Information Exchange (HIE) and other supports for this innovative and long overdue approach to care. MIHS has placed a strong emphasis on ensuring that physical healthcare providers are trained in the behavioral health "Recovery Model" – using person-first language and approaches; understanding how to treat and individual, not an illness; and considering the person's overall life goals, support network, and environment. Future goals of the Maricopa Integrated Health Home project include expanding to bi-directional integration. This means that not only will the community-based mental health clinics be equipped to meet the primary health care needs of persons with serious mental illness, but the 11 FQHC look-alike health centers managed by MIHS will expand their already robust array of healthcare services to include the ability to meet the behavioral healthcare needs of the people they serve. This will include behavioral health assessment, family and peer support services related to wellness and health promotion, assistance enrolling in the behavioral health system, other behavioral health services, and specialized training for all healthcare providers. As MIHS implements true bi-directional integration, individual preference and level of need will determine where and what services are delivered. The Four Quadrant Model (National Council for Community Behavioral Healthcare, 2009) will be used to provide a schema for assigning individuals to quadrants based on physical and behavioral health needs.

3. Describe the results of the project. What data was used to support improvement results?	3.More than 6,000 primary care visits have already been completed at the IHH clinics. Volume has continued to grow each quarter at existing clinics and more clinics will be opening soon. The focus on integrated care has expanded, along with the emphasis on improved health outcomes, though other means: •Conducting Health Risk Assessments for all individuals receiving services at an SMI clinic to identify potential risks and needs, while ensuring that recipients are engaged with a primary care provider and offering care coordination as needed. •Ensuring SMI clinic providers and primary care physicians have real-time access to key healthcare information through use of health information technology. •Educating members about the benefits of integration so that consent is provided to share all behavioral health and physical health information between providers. •Integrating an Arizona Smoker's Helpline referral into the electronic medical health record of all SMI clinic providers to ensure smoking cessation is available to all members. •Promoting thorough screening for chronic physical health conditions. As a result, the IHH clinics have achieved a 96 percent screening rate for obesity and 97 percent screening for heart disease. Health Screening Improvements Among Arizona's SMI Population Screening Obesity High Blood Pressure Diabetes Heart Disease Cholesterol Year one data collection (2011) 59% 64% 54% 30% 5/29/2013 96% 97% 70% 69% Screening rate change from 2011 to 2013 +63% +52% +30% +130%

4. Describe what happened as a result of the project. Was the improvement related to the intervention? Can the project be duplicated by other organizations?	4.The Maricopa Integrated Health Home project predates the Affordable Care Act's patient-centered medical home concept and offers a model for other community mental health centers to function as healthcare homes. As a result of this effort, more than 92 percent of all members diagnosed with serious mental illness — more than 13,000 people — have completed a health risk assessment with a nurse, which helps identify physical health conditions, patterns of seeking (or not seeking) health care, and lifestyle habits that affect overall health and well-being. Based on health risk assessment results, recipients are assigned an IHH, which allows them to receive whole health integrated services in a coordinated approach. At the IHH, case management and care coordination are provided, people with serious mental illnesses have their medical diseases managed, and healthcare providers offer preventive healthcare screening and monitoring. Primary care nurse practitioners play an active role as agents of change at the Integrated Health Homes. To ensure that members do not fall through the cracks, care managers scrutinize data from electronic health records, spot "care gaps," and initiate follow-up. By creating this partnership, we are also able to avoid duplicate health screenings, such as blood tests, thereby reducing costs. Furthermore, behavioral healthcare providers and Peer Support Specialists are learning how to talk to recipients about their healthcare needs and goals, offering new health promotion activities, and creating a supportive and motivating environment for recipients to make positive changes towards a healthier lifestyle. A survey showed that member satisfaction is at 93 percent approval rating. Integrated care is making a difference!

5. Describe how patients, families, and if appropriate, community was included in the work.	The Maricopa IHH project has created a significant opportunity for member and family involvement in recovery goals, wellness plans, services and intervention. The service experience is focused on self-directed recovery — assisting each person to identify strengths and needs in terms of skills, resources and support. Members are given the opportunity to own, direct and define their recovery process. Here are examples of members positively impacted by the IHH: •One man, who had been misdiagnosed with anxiety, learned at his IHH clinic that he had a congenital heart defect — he had been taking anti-anxiety medicine for years for a condition he did not even have. •A woman who was frequently being readmitted to the hospital with breathing problems was helped at her IHH clinic when it was discovered that symptoms of her schizoaffective disorder were preventing her from using her prescribed inhaler properly. •A woman who had been afraid to see her physical doctor because of stigma was escorted by her behavioral health provider to the office across the hall of a physical health provider, at the IHH clinic, when a wound on her face would not heal. She was treated for MRSA — a very serious infection. •Another young woman lost 70 pounds when her IHH nurse practitioner discovered she was pre-diabetic and provided self-care guidance. These are just a few of the numerous stories that have emerged since the IHHs began operating. The experience of integrated health services is working in Maricopa County and providing extraordinary outcomes.
Last Update	2013-12-16 12:13:54
Start Time	2013-12-16 12:04:41
Finish Time	2013-12-16 12:13:54