BHICCI Vision: Whole health care that results in improved health and wellness, is cost effective, and ensures a seamless, integrated experience of care

BHICCI Road Map to Achieve the Vision: A Summary of Domains & Key Change Areas

Foundations for Improvement

Domain 1. Engage Leaders	• Leaders actively engage in system transformation-supporting BHICCI, sharing progress, learning and outcomes across the organization • Leaders have collaborative relationships with other organizations in region
Domain 2. Engage Teams	• Improve employee experience for better patient and system outcomes • Team leader supports monthly team member measurement, reflection and goal setting to understand and improve team experience
Domain 3. Partner with Patients to Transform to a Truly Person-Centered System of Care	• Partner with patients for wellness and health • Engage in shared decision-making honoring patient goals, strengths, and preferences as critical drivers of treatment, and health/self-care behaviors • Measure and improve patient experience at clinic through team reflection on monthly results, goal setting and tracking impacts and trends
Domain 4. Use Data and Measurement to Guide Practice Change and System Transformation	• Use measurement and data to systematically address population health priorities for patient populations with complex needs including behavioral health, medical and social determinants • Train teams to use client and system level measures for improvement
Domain 5. Adopt a Quality Improvement Method	• Teams consistently use a QI method, including PDSAs to test, implement and spread integrated complex care management practice changes

Building Behavioral Health Integration Complex Care

Domain 6. Define/Identify Population to Receive Integrated Complex Care Management (ICCM)	• Define and identify patients at the clinic/site that are likely to benefit from ICCM • Support patients to use lower levels of care (step-down) based on choice and clinical progress—and engage new patients/clients
Domain 7. Build Multidisciplinary, Complex Care Team	• Provide collaborative, patient-centered, team-based care to improve the experience and outcomes of individuals with complex needs • Improve effectiveness of team communication and care processes
Domain 8. Integrate Behavioral Health Services with Complex Care	• Train/coach BH clinicians and team members in motivational interviewing • BH clinicians within the integrated care team provide evidence-based treatment, including for substance use disorders
Domain 9. Offer Integrated, Complex Care Management *(Note: Core Competency Curriculum provides extensive detail)*	• Develop patient-driven shared care plans to guide care and support • Use registry to track patient and population level measures and outcomes • Use measures to inform clinical care, assess outcomes and prioritize services • Engage in regular Systematic Caseload Reviews to guide patient and population level interventions and accountability • Promote health literacy and support health/wellness self-management • Improve coordination and transitions of care
Domain 10. Sustaining Changes	• Plan for sustaining and spread of ICCM-across health organization and IEHP • IEHP and organization leaders plan for financial sustainability

IEHP Inland Empire Health Plan

Behavioral Health Integration Complex Care Initiative