Town Hall

CalAIM Changes for Drug Medi-Cal Organized Delivery System (DMC-ODS)

Presenters:
Karen Capece, LCSW, Quality Management (QM) Program Director
Brion Phipps, LCSW, Quality Assurance Clinical Review Specialist Supervisor

June 2022

CalAIM Goals and Timeline

- CalAIM is a California initiative led by the Department of Health Care Services (DHCS) that aims to provide broad delivery system, program and payment reform across the Medi-Cal system.
- The goal of the initiative is to transform the Medi-Cal delivery system, moving it towards a population health approach that prioritizes prevention and whole person care.
- It shifts the focus from **compliance to quality** and performance metrics.
- Goal of Optimized Outcomes: Increased life expectancy and Reduced Suffering in response to Early Detection and Treatment, Recovery, People, Place, Purpose.

Policy	Go-Live Date
Criteria for Specialty Mental Health Services	January 2022
Drug Medi-Cal Organized Delivery System 2022-2026	January 2022
Drug Medi-Cal ASAM Level of Care Determination	January 2022
Updated Annual Review Protocol and Reasons for Recoupment FY 2021-2022	January 2022
Documentation Redesign for Substance Use Disorder & Specialty Mental Health Services	July 2022
Co-Occurring Treatment	July 2022
No Wrong Door	July 2022
Updated Annual Review Protocol and Reasons for Recoupment FY 2022-2023	October 2022
Standardized Screening & Transition Tools	January 2023
Behavioral Health CPT Coding Transition	July 2023
County Behavioral Health Plans Transition to Fee-for-Service and Intergovernmental Transfers	July 2023
Administrative Behavioral Health Integration	January 2027

CalAIM Goals

- The CalAIM changes are significant.
- They involve a major a paradigm shift.
- With these changes, the focus moves away from Compliance to Quality.
- Recoupment efforts shift to specific issues of fraud, waste, and abuse rather than simple documentation compliance.
- They empower providers to focus on providing quality care by reducing administrative burden.
- They benefit beneficiaries by removing barriers to accessing care.

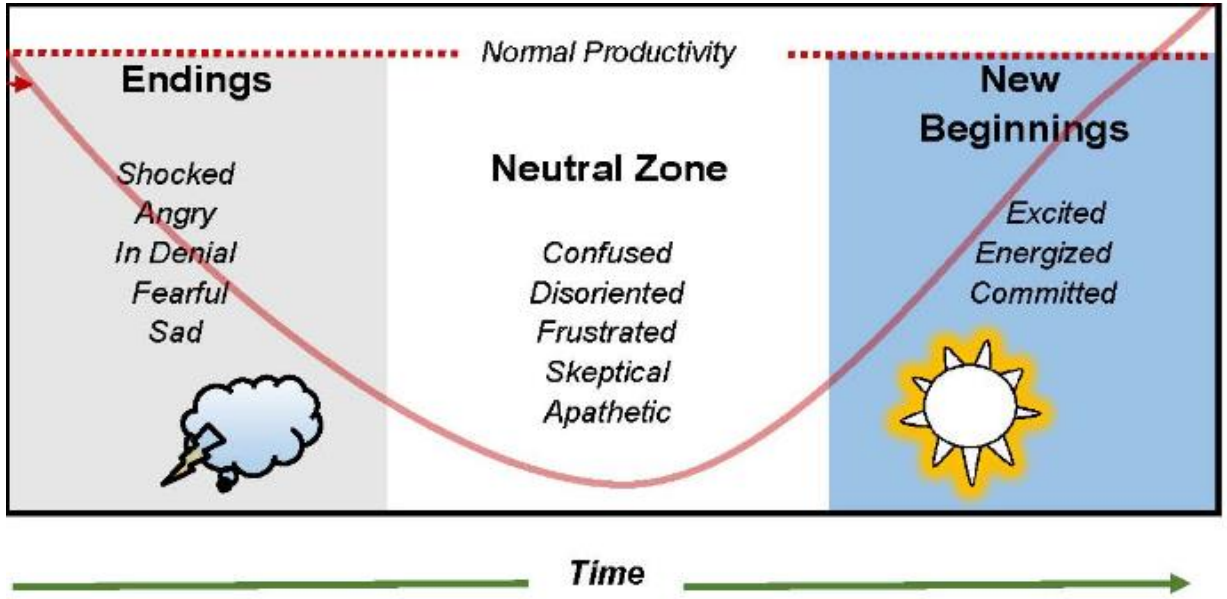
Change can be hard and this one is a heavy lift!

But we can do it if we work together…

We are in this together!

- There are many moving parts.
- We are still learning and determining how to implement requirements.
- Things won't always go perfectly as we roll these changes out but no one expects perfection.
- We will figure it out together.

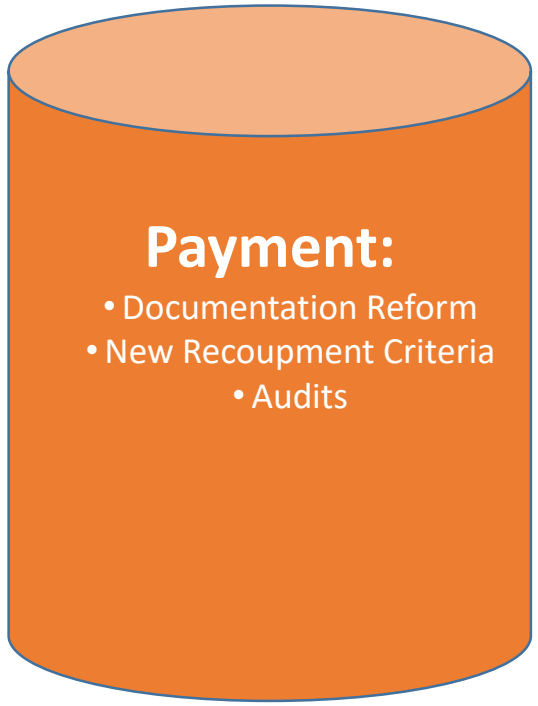
William Bridges- The Transition Model



Adapted by Career Vision from
Managing Transitions: Making the Most of Change (W. Bridges, 1991).

Overview of Changes

The changes fall into these two general buckets:

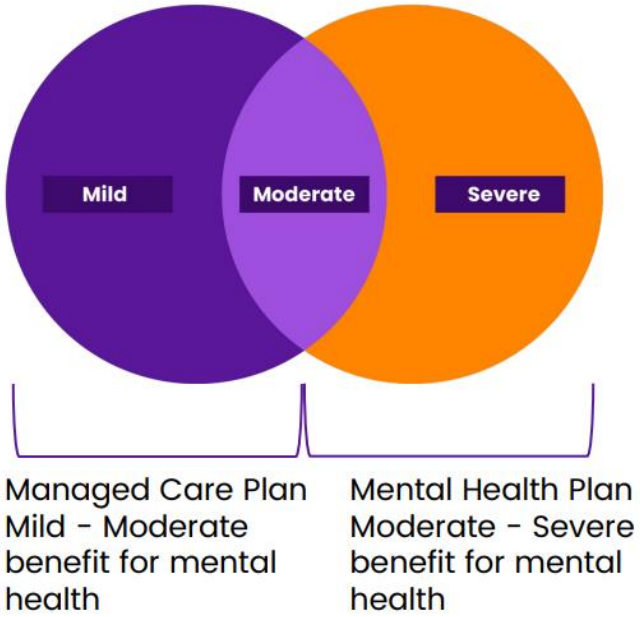


No Wrong Door Policy

BHIN 22-011

No Wrong Door and Co-Occurring Treatment

- The “No Wrong Door” policy allows Medi-Cal beneficiaries to receive timely mental health services regardless of the delivery system in which they seek care.
- Clinically appropriate services can begin “through any door” regardless of a co-occurring diagnosis.
  - Specialty Mental Health Services (SMHS) delivered by MHP (Mental Health Plan) providers are covered whether or not an individual has a co-occurring substance use disorder (SUD).
  - Similarly, clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers are covered whether or not the beneficiary has a co-occurring mental health condition.
- Provider reimbursement even if the individual is ultimately transferred.
- Care Coordination services can be claimed to assist the beneficiary’s in accessing services in a different delivery system. Example: Supporting a referral to a mental health provider while the beneficiary is receiving SUD services.
- Beneficiaries can maintain established therapeutic relationships



No Wrong Door Clarified

- No Wrong Door **does not mean,**
  - Providers are expected to practice outside of their expertise, training and scope of practice.
  - There are changes to the responsibilities and benefit packages of DMC-ODS plans and Managed Care Plans (MCPs) remain unchanged.

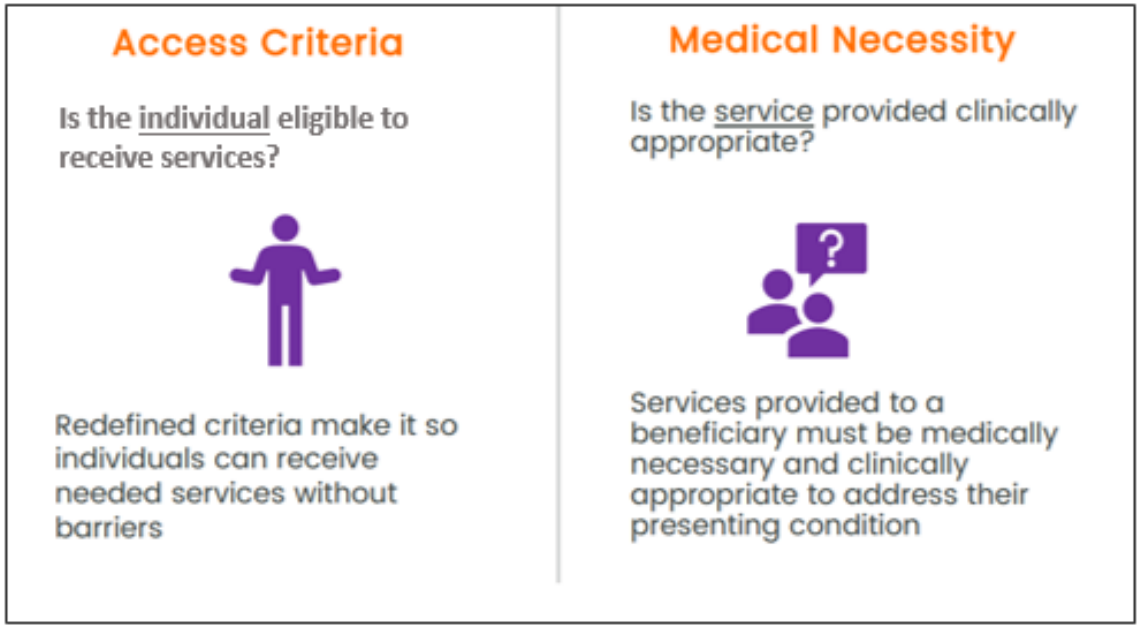
Scenario	Appropriate Action
Adolescent with mental health needs is brought to your SUD program.	Refer to appropriate access point for mental health services.
Client requests services for the first time and comes through door of a county contract provider in the community.	Follow your county's contractual terms regarding how clients initially access services.
An adult beneficiary walks into an adolescent SUD program.	Refer them to Center Point for service requests.

Access Criteria and Medical Necessity

BHIN 21-075

What Has Changed?

- To remove barriers to accessing care, the criteria to access services has been separated from Medical Necessity.
- A beneficiary does not need to meet criteria for a diagnosis to access needed SMHS or DMC/DMC-ODS outpatient services during the initial assessment period.
- Outpatient services rendered in good faith are reimbursable prior to determination of an official diagnosis.
- The “Included” diagnosis list is no longer used to determine if an individual can receive services.



With CalAIM, Access Criteria and Medical Necessity are separated and redefined

DMC-ODS Medical Necessity

Definition of Medical Necessity was brought into alignment with Welfare and Institutions Code 1418.402(a) for those 21 and over and with Section 1396(r)(5) of Title 42 of the US Code for Individuals under 21 years of age.

Adults Age 21+

A service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain

Welfare & Institutions Code section 14059.5

Youth Under Age 21

A service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate screened health conditions. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

Section 1396d(r)(5) of Title 42

DMC-ODS
Services Covered During the Assessment Period

Adults Age 21+

Within non-residential settings, covered and clinically appropriate DMC services are reimbursable **for up to 30 days**, following the first visit with a Licensed Practitioner of the Healing Arts (LPHA), or registered/certified counselor, **whether or not a diagnosis for Substance-Related and Addictive Disorders is established**

Or

Up to 60 days if a provider documents that the client is experiencing **homelessness** and requires additional time to complete the assessment.

Youth Under Age 21

Within non-residential settings, covered and clinically appropriate services are reimbursable for **up to 60 days whether or not a SUD diagnosis is established.**

Early and Periodic Screening, Diagnostic and Treatment (**EPSDT**) Medicaid mandate entitles beneficiaries under the age of 21 to any **medically necessary services** coverable under a Medicaid state plan **to correct or ameliorate identified conditions, even if they do not meet criteria for a SUD diagnosis.** This includes treatment for risky substance use and early engagement services. For example, individual and group counseling and educational services.

A brief American Society of Addiction Medicine (ASAM) screening may be used to identify the most appropriate services prior to the completion of a comprehensive assessment.

Z Codes

The flexibility related to diagnosis at initial assessment for non-residential services does not eliminate the requirement that all Medi-Cal claims include a CMS ICD-10 diagnosis code. **The following options may be used during the assessment phase when a diagnosis has yet to be established**:

- **ICD-10 codes Z55-Z65**, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP). **These codes are now available in Clinician Gateway.**
- **ICD-10 code Z03.89**, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.
- In cases where services are provided due to a suspected disorder that has not yet been diagnosed, LPHA and LMPHs may use any clinically appropriate ICD-10 codes. For example, codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

DMC-ODS
Services Provided Following the Assessment Process

Adults Age 21+

Within non-residential settings, within 30 days (60 days if homeless) of first visit with a Licensed Practitioner of the Healing Arts (LPHA), or registered/certified counselor, must meet **one of the following** criteria:

- Have **at least one SUD DSM diagnosis**, with the exception of Tobacco-Related Disorders

Or

- **Have had at least one diagnosis** from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders, **prior to being incarcerated or during incarceration, determined by substance use history.**

Youth Under Age 21

Within non-residential settings, within 60 days of first visit with a LPHA or registered/certified counselor, must meet **one of the following** criteria:

- Have **at least one SUD diagnosis**, with the exception of Tobacco-Related Disorders, ***Or***
- Have **had at least one SUD diagnosis**, with the exception of Tobacco-Related Disorders, **prior to being incarcerated or during incarceration, determined by substance use history.**

- Under the EPSDT mandate, individuals under the age of 21 are eligible to receive appropriate, and medically necessary Early Intervention services, needed to correct and ameliorate health conditions, without a SUD diagnosis.
- **Providers are still expected to complete an ASAM assessment for youth and offer the level of care and services that are clinically appropriate both during and after assessment.**

ASAM Criteria should be used to determine best level of care

ASAM Criteria (ALOC) Assessment Requirements

Level of Care	ASAM Requirements at Initial Assessment	ASAM Requirements Ongoing
Level 1 OS (Outpatient Services), OTP (Opioid Treatment Program) Level 2.1 IOS (Intensive Outpatient Services)	Full ASAM within 30 days for adult or within 60 days if under 21 years old or homeless.	When beneficiary's condition changes.
Level 3.1 Residential – Clinically Managed Low-Intensity Residential Services Level 3.3 Residential - Clinically Managed Population – Specific High Intensity Residential Services Level 3.5 Residential - Clinically Managed High Intensity Residential Services	Full ASAM within 5 days ***COUNTY NOTE:*** *Per UM prior authorization policy, a brief ASAM screening will continue to be completed by Portal prior to admission.*	When beneficiary's condition changes ***COUNTY NOTE:*** *As authorization for services is required for Residential level of care, ACBH will continue to require that a full ASAM be completed when requesting authorization after the first 5 days- for up to 30 days and whenever additional authorization is requested.*
Level 3.2 - WM Residential - Clinically Managed Withdrawal Management Level 3.7 – WM Medically Monitored Intensive Withdrawal Management Services	A full ASAM is not required to admit to withdrawal management ***COUNTY NOTE:*** *Complete a brief ASAM (ALOC Portal Screener in CG) within 24 hours of admission. May complete only the clinically relevant ASAM Dimensions. To allow capturing of ASAM and timelines data, a completed brief ASAM is required even if the client leaves within 24 hours of admission.*	May use ASAM or other brief assessment tool to support appropriate transition ***COUNTY NOTE:*** *Complete all ASAM Dimensions (ALOC Portal Screener in CG) for transitions of care prior to discharge.*

See **County Note** sections for ACBH guidance/requirements

OTP/NTP Requirements

- At this time OTP/NTP medical necessity and documentation requirements as specified in 9 CCR, Div. 4, Ch. 4 Narcotic Treatment Programs have not changed.

- OTP/NTP documentation requirements are a complicated combination of requirements specific in 9 CCR, Div. 4, Ch. 4 Narcotic Treatment Programs, the DHCS DMC-ODS Intergovernmental Agreement, applicable DHCS BHINs, and other requirements.

- ACBH is working with DHCS to clarify redundant assessment requirements, as well as other outstanding questions related to OTP/NTP documentation. More information will be forthcoming.

Assessment Requirements

- DMC-ODS providers must use the American Society of Addiction Medicine (ASAM) Criteria assessment for DMC-ODS beneficiaries.
- The assessment shall include
  - A typed or legibly printed name, signature of the service provider and date of signature.
  - The provider's determination of Medical Necessity and recommendation for services.
- Assessments shall be updated as clinically appropriate when the beneficiary's condition changes.
- Additional information on assessment requirements can be found in BHIN 21-075 (DMC-ODS), BHIN 22-019.

Documentation Redesign

BHIN 22-019

Documentation Redesign

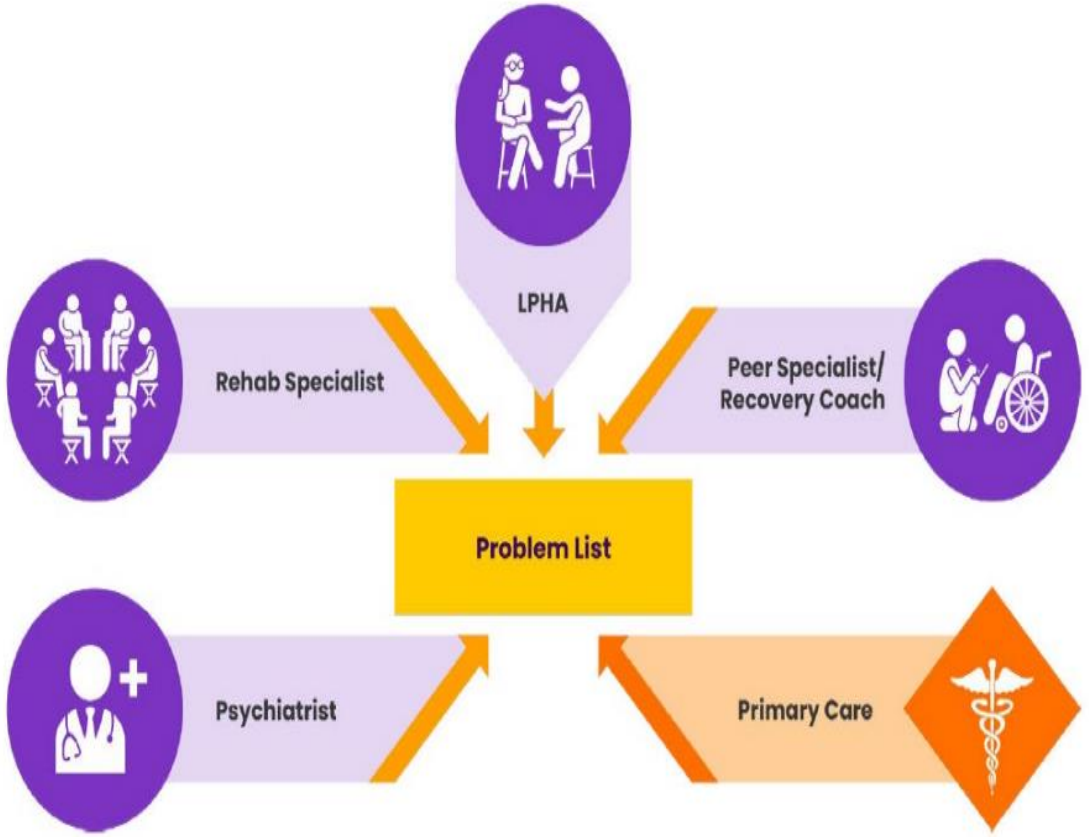
Changes:

BHIN 22-019, Attachment 1, provides links to documents that describe the requirements for the services that continue to require Client Plans, Care Plans or Treatment Plans.

- Lean documentation
- Streamlined standards
- Standardized SMHS and DMC-ODS Assessment Requirements
- Introduction of a dynamic Problem List (excludes OTP/NTP services)
- DHCS is working towards removing all client plan requirements for SMHS and DMC-ODS. Client Plans continue to be required for some services primarily due to licensing and federal regulations.
- A Client Plan is still required for the following services:
  - Residential
  - Narcotic Treatment Programs (NTP)
  - Peer Support Services
  - Discharge Care Plans
- At this time, all DHCS AOD licensed or certified programs are still required to complete treatment plans per requirements set forth in the DHCS AOD Certification Standards. DHCS has indicated they will be removing this requirement when they update the standards.
- DHCS is transitioning to disallowances based on Fraud, Waste and Abuse.

Problem List as Living Document Across Disciplines

- Problem Lists are a common tool in physical healthcare.
- They function as a one stop shop to capture the needs of the people we serve.
- All DMC-ODS programs are required to complete a problem list, including those that are also completing plans of care.
- Each problem on the problem lists must include:
  - Behavioral Health diagnoses (DSM/ICD10 Diagnosis)
  - Physical Health conditions (ICD10/SNOMED Codes)
  - Social Determines of Health Needs, like homelessness



Problem List

The Problem List shall include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice. Include diagnostic specifiers from the DSM if applicable.
- Problems identified by a provider acting within their scope of practice.
- Problems or illnesses identified by the beneficiary and/or significant support person, if any.
- The name and title of the provider that added or removed the problem
- The date the problem was added, or removed.

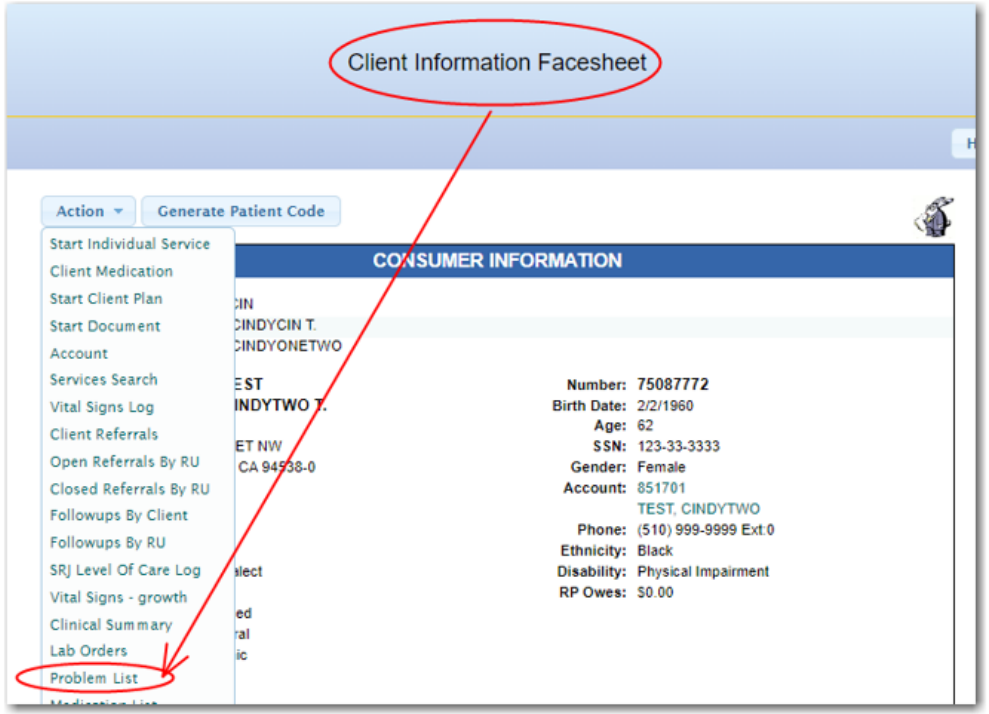
New Clinician Gateway Template Effective 7/1/22

Problem List

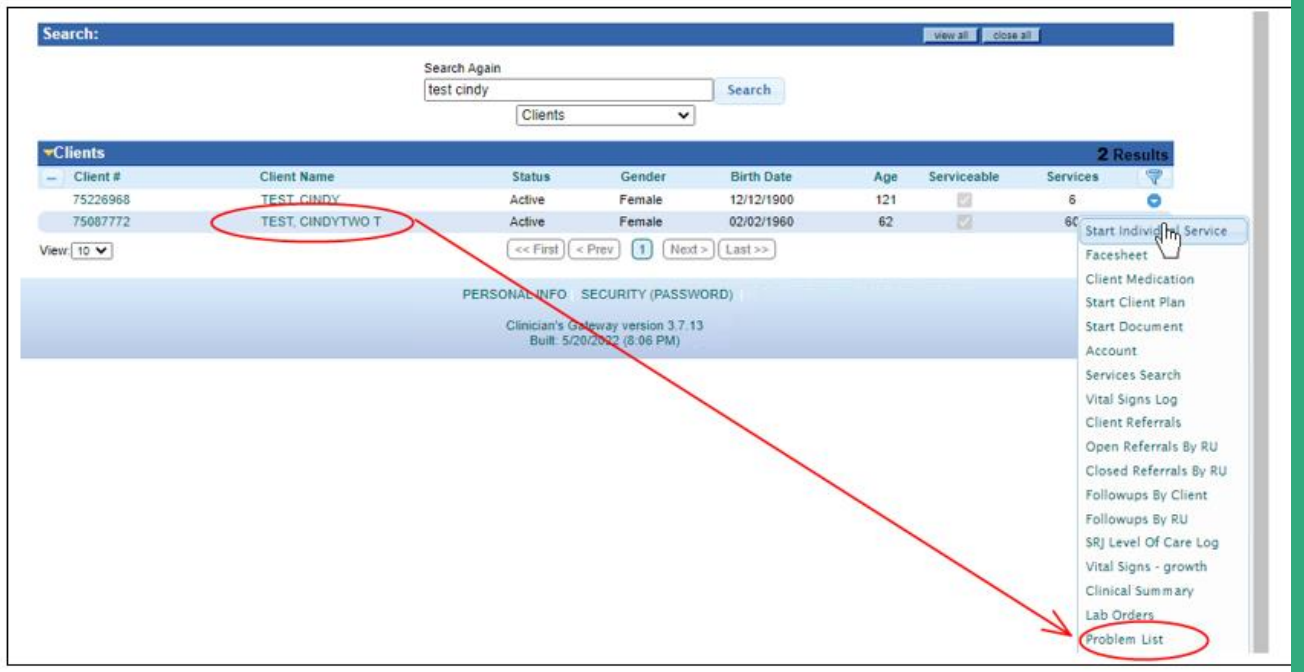
Number	Code	Description	Added By	Job Title/ Credential Level	Begin Date	End Date	Ended By	Job Title/ Credential Level
1	F33.3	Major Depressive Disorder recurrent, severe with psychotic features	Name	Psychiatrist	8/1/2022	Current	Name	Psychiatrist
2	F10.99	Alcohol Use Disorder, unspecified	Name	Clinical Social Worker	7/26/2022	Current	Name	Clinical Social Worker
3	I10.	Hypertension	Name	Primary Care Physician	7/25/2022	Current	Name	Primary Care Physician
4	Z62.819	Personal history of unspecified abuse in childhood	Name	Clinical Social Worker	7/16/2022	Current	Name	Clinical Social Worker
5	Z59.02	Unsheltered homelessness	Name	Peer Support Specialist	7/1/2022	Current	Name	Peer Support Specialist
6	Z65.9	Problem related to unspecified psychosocial circumstances	Name	Mental Health Rehabilitation Specialist	7/1/2022	7/19/2022	Name	Mental Health Rehabilitation Specialist

Non-licensed staff are able to add to the problem list. However, they must utilize the SDOH Z codes (Z55 to Z65)

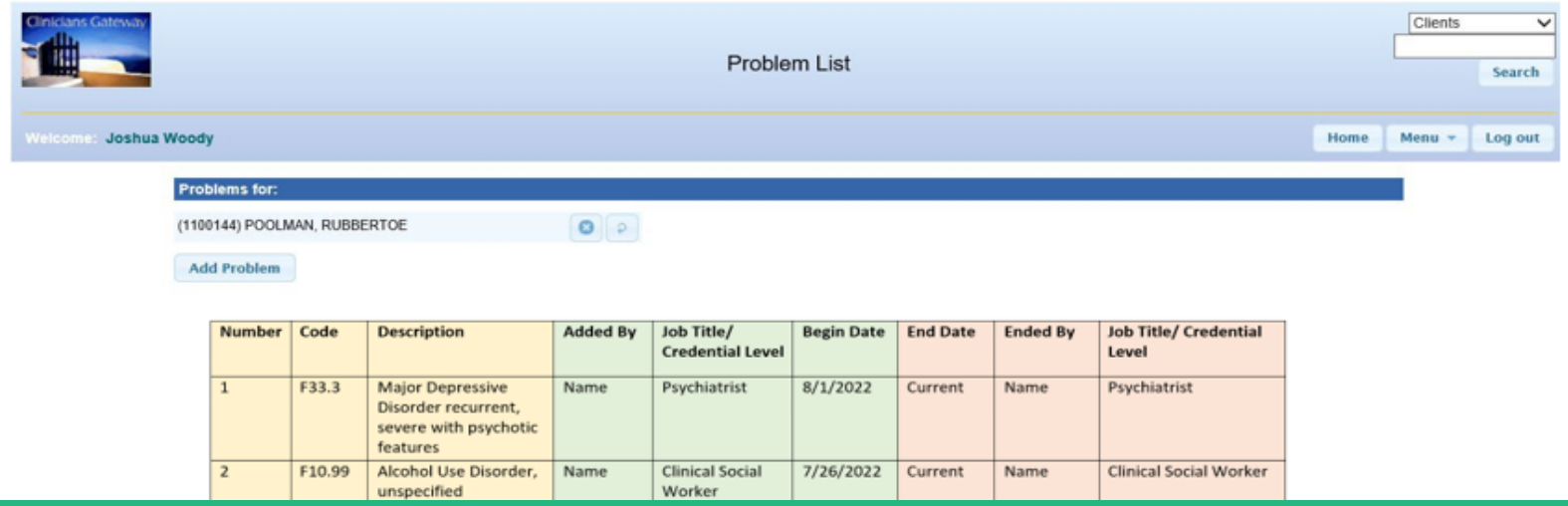
The Problem List may be accessed via the Action menu from the Client Facesheet or the Client Search Results



Client Search Results – Find the Problem List on the Action Menu



The Problem List would then show as it does below with the option of “Add Problem” & “End Date Problem”



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2	F10.99	Alcohol Use Disorder, unspecified	Name	Clinical Social Worker	7/26/2022	Current	Name	Clinical Social Worker

Progress Notes

Required Components:

- The type of service rendered.
- The date the service was provided to the beneficiary.
- Duration of the service, including travel and documentation time.
- Location
- A typed or legibly printed name, signature of the service provider and date of signature.
- Two narrative sections:
  - A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors).
  - Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.
- Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.

Progress Note timeliness issues do not lead to disallowances.

Progress Note Timeframes

Routine services:

- Documentation should be completed within **3 business days**.
- OTP/NTP: ACBH is checking with the DHCS regarding Progress Note due dates.

Crisis services:

- Documentation should be completed within **24 hours**.

Higher Levels of Care:

- For services that claim using a day rate (e.g. residential), a **daily** note is required.
- Daily progress notes must be signed by a SUD Counselor or LPHA who provided a service that day.
- Administrative staff may be used to enter individual service data into daily progress notes, however only a SUD counselor or LPHA may complete the required narrative portions of the note.
  - Prior to signing the note, the SUD Counselor or LPHA must review service entries for accuracy.
  - ACBH IS Department has provided a process to change ownership of a note in CG for providers who would like to use this option.
- Weekly summaries are no longer required.

Late notes should be identified as “late” entries and the reason for delay documented in the note. Late notes should not be withheld from the claiming process.

SUD Residential Services
3.1, 3.2-WM, 3.3, 3.5

- SUD Residential programs are contracted to provide a specific array of treatment services, bundled and claimed under a single day code.
- As part of the CalAIM updates, DHCS has made several changes to the contracted services bundle for Residential and Residential WM services.
- ACBH is updating the Residential Minimum Services Activities Grid and will publish as soon as it is available.
- **Transportation** has been removed as a separate component of SUD residential services. However, it is still part of Care Coordination services. SUD staff may provide transportation services and/or utilize Medi-Cal Transportation services, when part of a care coordination service.
- **Medication Assisted Treatment** and **Care Coordination** services are now included in the contracted bundle of residential services and may no longer be claimed separately.
- For all residential LOCs, there has been no change to the weekly minimum service requirements
- To reduce access barriers to treatment, WM services do not require prior authorization.

Changes to Clinician Gateway (CG) Templates

- As of July 1, 2022, the following changes are expected in InSyst and CG:
  - Addition of Z55-Z65 codes in CG and INSYST for SUD services
  - Creation and launch of a new Problem List template
  - Addition of Care Coordination option to treatment components in the Service Note Daily RES template.
  - In partnership with the BH Collaborative, ACBH is working to simplify other note templates to reduce administrative burden. Information about these changes will be shared as the templates are developed and prior to launch.

Change to Service Types

Recovery Services

Previously Recovery Services were an after-treatment modality for beneficiaries in remission from a SUD. Other DMC-ODS services were not allowed to be provided in concurrence with recovery services.

- With CalAIM, **Recovery Services are no longer considered an aftercare service**.
- They are now a unique service type, able to be provided concurrently in each SUD level of care (LOC), including residential WM services.
- Services may be provided based on a self-assessment or provider assessment of relapse risk.
- Within OS, IOS levels of care, they can be delivered and claimed as a standalone service using the most appropriate procedure code designations based on the beneficiary's presentation.
- Beneficiaries may receive Recovery Services while receiving MAT, including OTP/NTP services.
- Beneficiaries do not need to be diagnosed as being in remission to access these services.
- Beneficiaries can receive these services immediately after incarceration with a prior diagnosis of SUD.
- For more information on the transformation of Recovery Services, refer to The ASAM Criteria and DHCS BHIN 21-020.

Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level.

Clinician Consultation Service

- Services previously referred to as Physician Consultation are now called Clinician Consultation.
- These are services between a provider's Licensed LPHA and an ACBH designated consultant to assist clinicians with seeking expert advice on treatment needs for specific DMC-ODS beneficiaries.
- ACBH will contract with one or more physicians, clinicians, or pharmacists specializing in addiction in order to provide Consultation services.
- This service is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug interactions, or level of care considerations.
- Clinician Consultation is not for internal agency consultations.
- Consultations can occur in person, by telehealth, by telephone, or by asynchronous telecommunication systems (e.g. encrypted email, secure EHR communications).

Documentation of, and claiming for Clinician Consultation services is completed by the provider's licensed clinician.

Clinician Consultation is available at every Substance Use Disorder (SUD) Level of Care (LOC) using the codes specified below.

Name	InSyst Procedure Code	HCPC and Modifier
OS Clinician Consultation	670	G9008 U7
IOS Clinician Consultation	270	G9008 U8
OTP Clinician Consultation	513	G9008 UA HG
3.1 Clinician Consultation	116	G9008 U1
3.3 Clinician Consultation	176	G9008 U2
3.5 Clinician Consultation	397	G9008 U3
WM-3.2 Clinician Consultation	146	G9008 U9

BHIN 21-075

Peer Support Services

- Peer Support services can only be claimed as a standalone service.
- DMC-ODS providers delivering Peer Support Services must use the Peer Support Services procedure codes to claim for these services.
- These services are covered under the DMC-ODS program,
  - While a beneficiary is receiving SUD services OR
  - Even if the beneficiary is not receiving treatment at the DMC-ODS level of care (e.g the “Engagement” service component is designed to support outreach and engagement efforts prior to initiation.

New Recoupment Criteria and Focus

Understanding Fraud, Waste and Abuse

- DHCS is transitioning to recoupment for Fraud, Waste and Abuse.
  - **Fraud** is **knowingly** and **willfully** executing, or attempting to execute, a scheme or artifice to **defraud** any health care benefit program or to obtain any of the money or property owned by, or under the custody or control of, any health care benefit program (18 U.S.C. § 1347). ***Example****: Deliberately claiming for services that were not provided.*
  - **Waste** is the **overutilization of services**, or other practices that, directly or indirectly, result in **unnecessary costs** to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the **misuse of resources**. ***Example****: large scale duplicative services, Providing services/procedures/medications that are not medically necessary*
  - **Abuse** includes actions that may, directly or indirectly, result in: **Unnecessary costs** to the Medicare Program, **improper payment**, payment for **services that fail to meet professionally recognized standards of care**, or **services that are medically unnecessary**. Abuse involves payment for items or services when there is no legal entitlement to that payment and the **provider has not knowingly and/or intentionally misrepresented facts to obtain payment**. ***Examples****: Billing for a non-covered service, Inappropriately allocating costs on a cost report*

Examples of Disallowance Reasons

DHCS is creating Disallowance Reasons for DMC-ODS. They have published SMHS disallowance reasons for FY 2021-2022 for non hospital services in BHIN-21-053.

Until DHCS publishes the DMC-ODS Recoupment reasons, ACBH will be using the SMHS Disallowance Reasons as a guide for the SUD services.

Examples of SMHS Recoupment reasons for FY 2021-2022:

- Mental Health Plan (MHP) did not submit documentation that Medical Necessity Criteria was met and that substantiated the beneficiary's need for Specialty Mental Health Services (SMHS).
- The MHP claimed for a service where the MHP did not submit documentation that a valid service was provided to, or on behalf of, the beneficiary:
  - There was no Progress Note or other clinical documentation to substantiate the service was provided.
  - The Progress Note or other clinical documentation indicated "No show" or "Appointment cancelled" but a service (other than chart review) was still claimed.
  - The documented service provided did not meet the applicable definition of a SMHS.
- The service provided was not within the scope of practice of the person delivering the service.
- The progress note was not signed (or electronic equivalent) by the person(s) providing the service.
- The service claimed did not match the service documented in the progress note. ("Recovery" is limited to mismatches resulting in "overbillings").
- The date of service documented in the progress note does not match the date of service claimed.
- The service provided was a Non-Reimbursable Service

Managing and Communicating about Change

Resources Available to Begin Communication and Training

Resources

- Check the CalMHSA webpage for new references that might be published over time
- Watch the CalAIM training videos by registering on CalMHSA's training page: Learning Management System (LMS)
- Review the appropriate Documentation Manuals published by CalMHSA
  - Documentation Manual for Outpatient Specialty Mental Health Services
  - Documentation Manual for Outpatient Drug Medi-Cal Organized Delivery System (DMC-ODS)
- Check ACBH Provider Website for memos and important updates
- Review the CalAIM Frequently Asked Questions document that is posted on the Provider Website under Quality Assurance/QA Manual/section 19
- Find new policies on the ACBH Policies on Provider website
- Find relevant ACBH Policies on Provider website:
  - 150-2-1 DMC ODS Requirements for Period 2022-2026 P&P.pdf (acbhcs.org)
  - 100-3-1 Criteria for Beneficiary Access to SMHS P&P.pdf (acbhcs.org)

Support

- Attend the ACBH Town Halls Q&A- **6/29/22, 3:00-4:00**
- Attend the ACBH Brown Bags
- Use QA TA email box for questions: QATA@acgov.org

California Mental Health Services Authority (CalMHSA) is a Joint Powers of Authority that provides administrative and fiscal services in support of Behavioral Health Departments.

CalMHSA, on behalf of the counties, has assumed scopes of work to support the statewide implementation of CalAIM behavioral health initiatives.

ACBH has opted to use CalMHSA's resources for the CalAIM roll out.

Managing and Communicating about Change

Change can be hard…

- The old way is familiar, or it is perceived that there is no need for change (the current way is good enough)
- Loss of control
- A desire for recognition of past successes/efforts
- Worried about job security
- Fear of failure or the unknown
- Overwhelm about the need to learn new content and develop new skill

Change is a process

There will be bumps along the road

We will get through it together and create something great!

Questions/Discussion

Contact QATA@acgov.org for more information