Town Hall

CalAIM Changes for Specialty Mental Health Services (SMHS)

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June 2022

Alameda County Behavioral Health Care Services

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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.

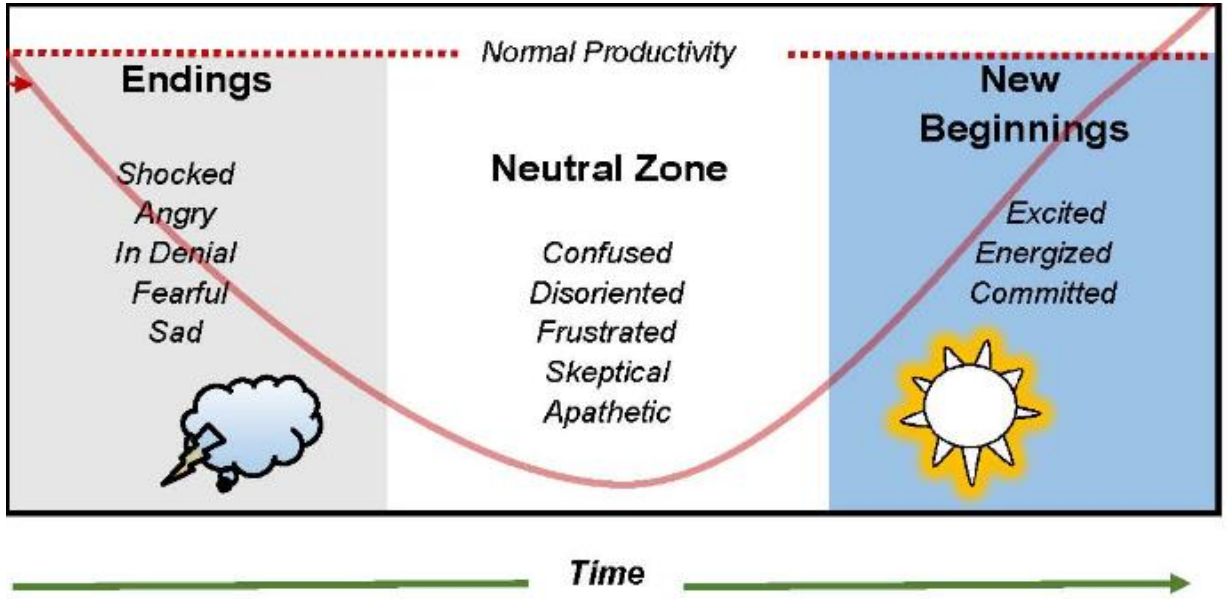
Change can be hard and this one is a heavy lift!

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.

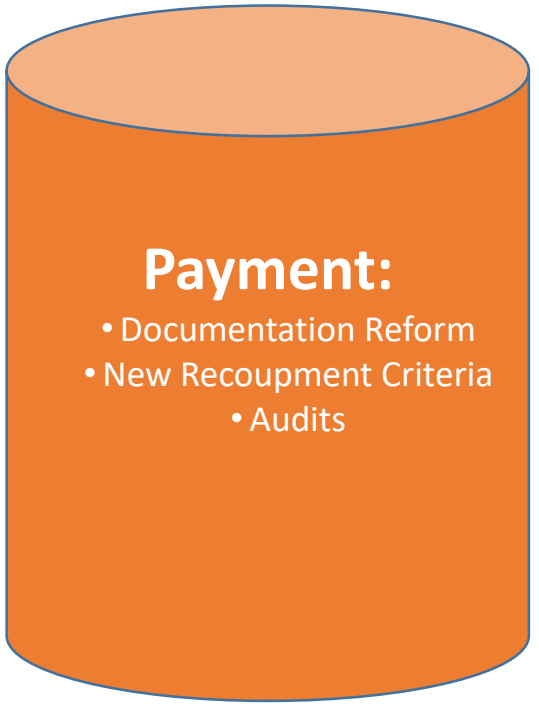
William Bridges- The Transition Model



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:



Access Criteria and Medical Necessity

BHIN-21-073

What Has Changed?

- To remove barriers to accessing care, the criteria to access SMHS has been separated from Medical Necessity.
- A diagnosis is no longer a prerequisite for accessing needed SMHS or DMC/DMC-ODS outpatient services.
- 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.

Access Criteria

Is the individual eligible to receive SMHS?

Redefined criteria make it so individuals can receive needed services without barriers

Medical Necessity

Is the service provided clinically appropriate?

Services provided to a beneficiary must be medically necessary and clinically appropriate to address their presenting condition

*Under CalAIM, SMHS Access Criteria and Medical Necessity are **separated** and **redefined***

SMHS 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+	Youth Under Age 21
A service is "medically necessary" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.	A service is "medically necessary" if it is necessary to correct or ameliorate a mental illness or condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition.
Welfare & Institutions Code sections 14184.402(a) & 14059.5	*Section 1396d(r)(5) of Title 42*

SMHS Access Criteria

Adults Age 21+

Must meet *both* of the following criteria:

Criteria 1:

- The beneficiary has *one or both* of the following:
  - Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

  And/or
  - A reasonable probability of significant deterioration in an important area of life functioning.

and

Criteria 2:

The beneficiary's condition is due to *either* of the following:

- A diagnosed DSM mental health disorder

or

- A suspected mental disorder that has not yet been diagnosed.

14184.402(f)(1)(A), **Except for psychiatric inpatient hospital and psychiatric health facility services** a mental health diagnosis is not a prerequisite for access to covered SMHS.

SMHS Access Criteria

Youth Under Age 21

Must meet *either* of the following criteria:

The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma as evidenced by *any* of the following:

- Scoring in the high-risk range under a trauma screening tool approved by the department
- Involvement in the child welfare system
- Juvenile justice involvement
- Experiencing homelessness

Optional Trauma Screening tools:
- Pediatric ACES and Related Life-Events Screener (PEARLS) tool
- ACE Questionnaire

or

The beneficiary meets *both* of the following requirements

The beneficiary has at least *one* of the following:
- A significant impairment
- A reasonable probability of significant deterioration in an important area of life functioning
- A reasonable probability of not progressing developmentally as appropriate.
- A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

and
- The beneficiary's condition is due to *one* of the following:
- A diagnosed mental health disorder
- A suspected mental health disorder that has not yet been diagnosed.
- Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

Z Codes

During the assessment phase when a diagnosis has yet to be established, the following codes may be used:

ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).

NOTE: Due to system limitations, these codes will not be available for SMHS until the launch of SmartCare, expected in July 2023.

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, options are available for an LPHA or LMPH in the CMS approved ICD-10 diagnosis code list, which may include Z codes. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

Frequently Asked Questions

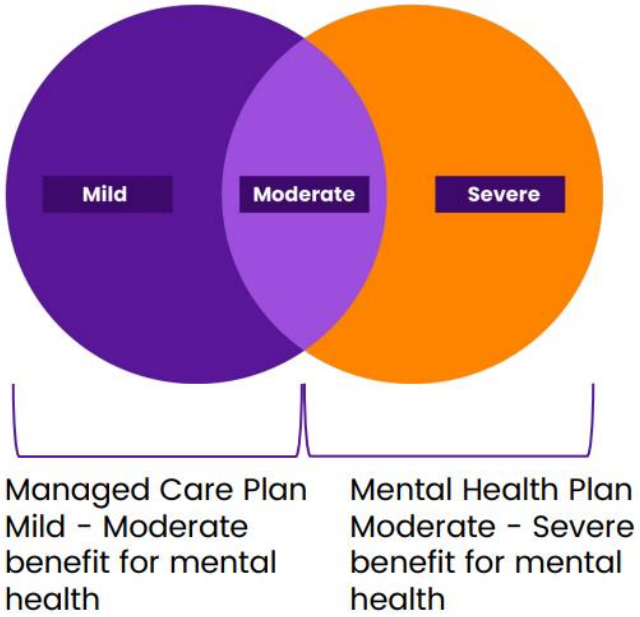
Question	Answer
Can CBOs stop using the Brief Screening Tool given the changes to the access criteria?	• Yes. DHCS is developing a set of statewide tools to facilitate screenings and transitions of care for the specialty mental health, Medi-Cal managed care and fee for service systems. These tools are expected to be available in January 2023. • CBOs need to continue to have screening procedures in place to determine if an individual will be served by the Mental Health Plan (MHP) or if they should be referred to the Managed Care Plan (MCP). • ACBH has created a BH Screening Tool for Outpatient Services that can be used by providers as an optional resource.
Since a diagnosis is no longer required for access to services, how will the assessment be completed with a Z code? Will documentation of functional impairment be sufficient?	• Documentation in the medical record must initially demonstrate that the beneficiary meets the specific access criteria for each delivery system. If a diagnosis cannot be immediately established, specific Z Codes are allowed for billing and to start the Problem List. • DHCS has noted that there is no need for Progress Notes to demonstrate full medical necessity in each note; A comprehensive, up-to-date assessment and problem list are sufficient to meet this requirement. • Clinically assessing a beneficiary's functional impairments is appropriate and should be part of an assessment.

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.
- Beneficiaries can maintain established therapeutic relationships. Non-specialty mental health services (NSMH) and SMHS can be provided concurrently, as long as services are coordinated between Managed Care Plans (MCP) and MHP providers and are not duplicative.
  - Example: An individual may only receive psychiatry or individual therapy services in one network, not both networks.



No Wrong Door Clarified

- No Wrong Door **does not mean,**
  - A client can obtain services from any possible program within the MHP.
  - MHP has to serve every individual who reaches out for services.
  - Responsibilities of MHPs and Managed Care Plans (MCPs) remain unchanged. MHP services are intended for individuals who meet access criteria for specialty mental health services.

Scenario	Appropriate Action
Child without SUD needs is brought to your SUD program.	Refer to appropriate access point for DMC-ODS 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 a children's clinic requesting services.	Refer them to the appropriate access point for service requests.

NO WRONG DOOR - A VISUAL

SCREENING: MHP conducts screening (eventually the Screening Tool) This occurs BEFORE a client "comes through the door"). If the screening suggests the client receive an MHP assessment, they will move on to be assessed by the MHP. If not, a referral is made to the MCP

NO WRONG DOOR: MHP begins assessment and can bill for services rendered prior to determination of an official diagnosis

DETERMINATION: Individual referred for ongoing services with the MHP OR if it is determined that the client does not meet criteria to access SMHS, the MHP will support a coordinated transition/referral to the MCP

Frequently Asked Questions

Question	Answer
Are we at risk of having the service disallowed if we mention SUD treatment in our MH documentation, or MH treatment in our SUD documentation?	No, with the new guidance, co-occurring conditions are covered. The guidance allows for more flexibility for providers, allowing them to treat individuals holistically.
Do SMHS providers now have to treat substance use disorders and SUD providers now have to treat MH disorders?	Providers are not being expected to work outside of their scope and abilities. There is now greater flexibility to support an individual with both co-occurring conditions.

Documentation Redesign

BHIN 22-019

Documentation Redesign: Non-Hospital Services

Changes:

- Lean documentation
- Streamlined standards
- Standardized SMHS Assessment Requirements
- Introduction of a Dynamic Problem List
- DHCS removed client plan requirements from SMHS and treatment plan requirements from DMC and DMC-ODS, for most services. Some care plan requirements remain in effect due to applicable federal regulations or guidance.
- Simplified Client Plans for TCM and Peer Support.
  - Client Plans for these services must be documented in a Progress Note.
- Disallowances for Fraud, Waste and Abuse or clear incidents of a service being incorrectly billed.

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.

A Client Plan is still required for the following:

- Targeted Case Management (TCM) = Case Management
- Intensive Care Coordination (ICC)
- Intensive Home Based Services (IBHS)
- Therapeutic Foster Care (TFC)
- Therapeutic Behavioral Services (TBS)
- Narcotic Treatment Programs (NTP)
- Short-Term Residential Therapeutic Programs (STRTP)
- Psychiatric Health Facilities (PHF)
- Special Treatment Programs with Skilled Nursing Facilities (STP-SNF)
- Mental Health Rehabilitation Centers (MHRC)
- Community Treatment Facilities require a Needs and Services Plan (NSP)
- Youth in Social Rehabilitation Programs
- Peer Support Services
- Discharge Care Plans

Case Management Client Plans

Case Management Client Plans Required Elements:

- Specify the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the beneficiary.
- Include activities such as ensuring the active participation of the beneficiary, and working with the beneficiary (or the beneficiary's authorized health care decision maker) and others to develop those goals.
- Identify a course of action to respond to the assessed needs of the beneficiary
- Include development of a transition plan when a beneficiary has achieved the goals of the care plan.

These required elements shall be provided in a narrative format in the beneficiary's progress notes.

Sample Care Plan within a Progress Note- First Note:

Case Management Care Plan:

Writer met with client today and recommended referral to Case Management to assist with locating permanent housing. Client was in agreement with plan.

Goal: Find stable housing

Actions: 1) Writer will submit referral to Program X today requesting Case Management Services. 2) Writer will follow up with client once an Intake appointment has been scheduled.

Sample Care Plan within a Progress Note- Second Note:

Case Management Care Plan:

Writer contacted client today by phone advising him of intake appointment on (date) at Program X for case management services to assist with locating permanent housing.

Goal: Find stable housing

Actions: 1) Client agreed to contact the program today to confirm the appointment. 2) Client will provide an update regarding the appointment during next week's session.

SMHS Assessment Domains

Domain 1: Presenting Problem/Chief Complaint
- Current and History of Presenting Problem
- Current Mental Status
- Impairments in Functioning

Domain 2: Trauma
- Trauma Exposures
- Trauma Reactions
- Trauma Screening
- Systems Involvement

Domain 3: Behavioral Health History
- Mental Health History
- Substance Use/Abuse
- Previous Treatment Services

See SMHS Documentation Manual for more details

For beneficiaries under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the assessment domain requirements but does not replace the assessment.

Domain 4: Medical History and Medications
- Physical Health Conditions
- Current and past Medications
- Developmental History

Domain 5: Psychosocial Factors
- Family
- Social and Life Circumstances
- Cultural Considerations

Domain 6: Strengths, Risks and Protective Factors
- Strengths and Protective Factors
- Risk Factors and Behaviors
- Safety Planning

Domain 7: Clinical Summary, Treatment Recommendations, Level of Care Determination
- Clinical Impressions
- Diagnostic Impressions
- Treatment Recommendations

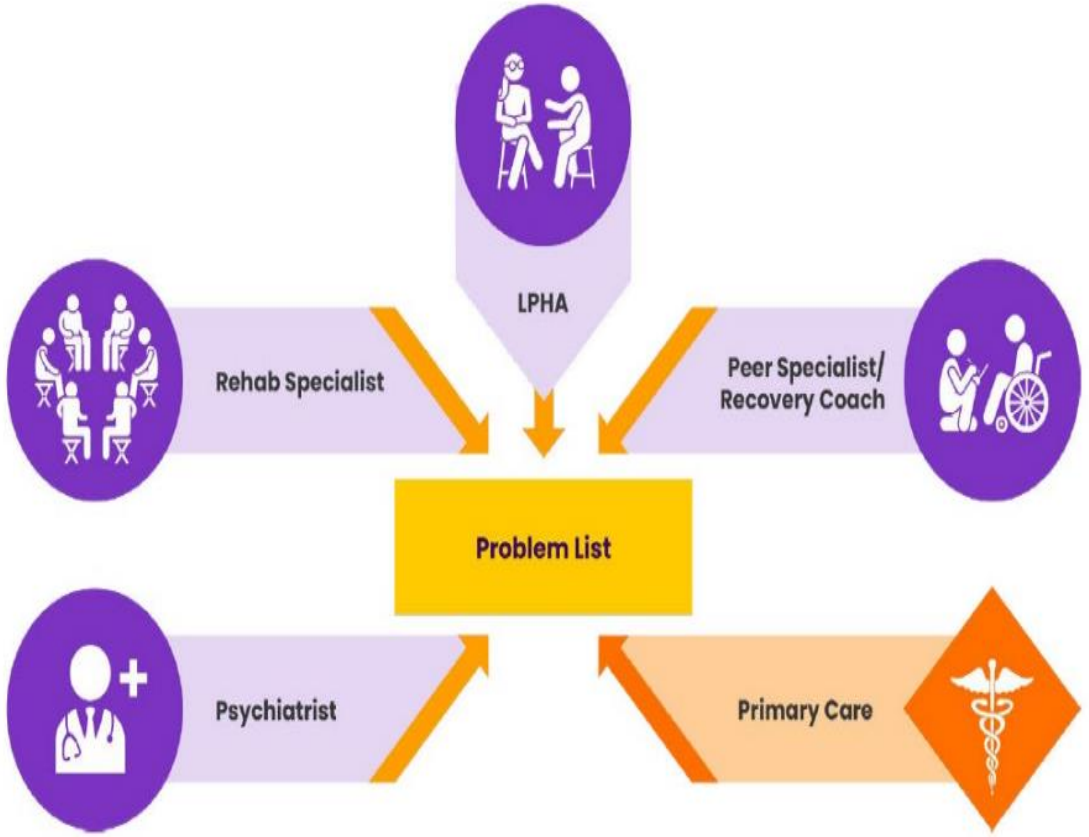
The time period for providers to complete an initial assessment is up to clinical discretion. However, providers shall complete them within a reasonable time and in accordance with generally accepted standards of practice.

Frequently Asked Questions

Question	Answer
The Information Notice does not establish a "reasonable timeframe in accordance with generally accepted standards of practice" for doing an initial assessment. Will ACBH defer to the providers and clinicians' judgment on these standards?	ACBH is following the State's guidance around timeliness requirements and not setting an artificial timeframe for completion of an initial assessment or establishing a formal diagnosis. It is our position that best practice involves completing a thorough assessment and establishing an accurate diagnosis as quickly as possible. If there are barriers to doing so, we would look for those to be documented in the clinical notes. For services where care plans are still required, the assessment due date would logically have to be prior to the plan due date as the assessment is used to develop the plan. Completion of timely assessments no longer result in disallowances.
Must an updated assessment be completed in the "Assessment section" or is a progress note sufficient?	Standardized forms are not required for the assessment domains, problem list or progress notes. Due to complexity of the assessment we highly recommend a form be used so required elements are not missed.
Are the CANS/ANSA and PSC35 still due every 6 months?	Yes. There are no changes to PSC-35 and CANS/ANSA requirements at this time. CANS policy

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.
- Problem lists contain:
  - 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.

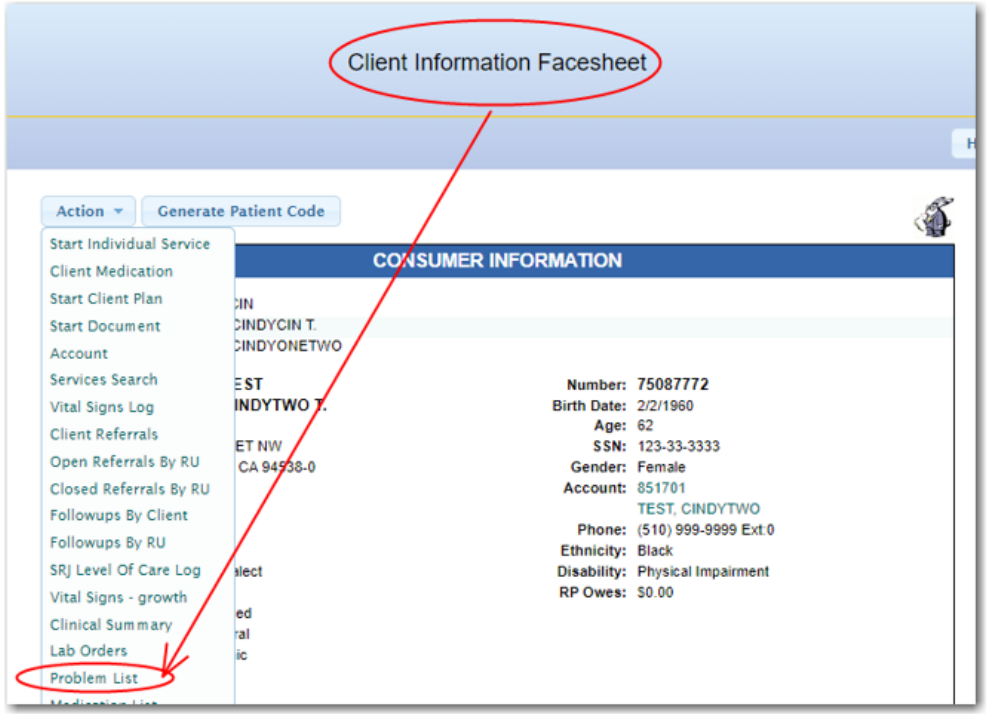
New Clinician Gateway Form Effective 7/1/22

Problem List

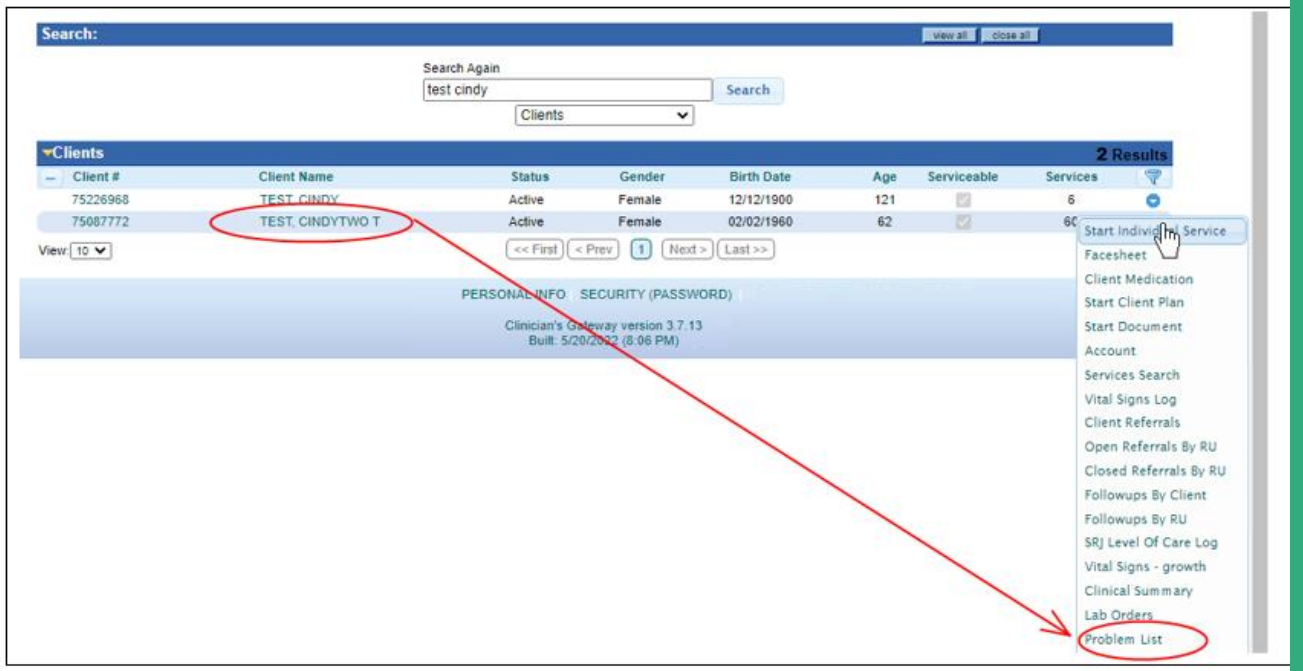
Number	Code	Description	Added By	Job Title/ Credential Level	Begin Date	End Date	Ended By	Job Title/ Credential Level
1	F33.3	Major Depressive Disorder recurrent, severe with psychotic features	Name	Psychiatrist	8/1/2022	Current	Name	Psychiatrist
2	F10.99	Alcohol Use Disorder, unspecified	Name	Clinical 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)

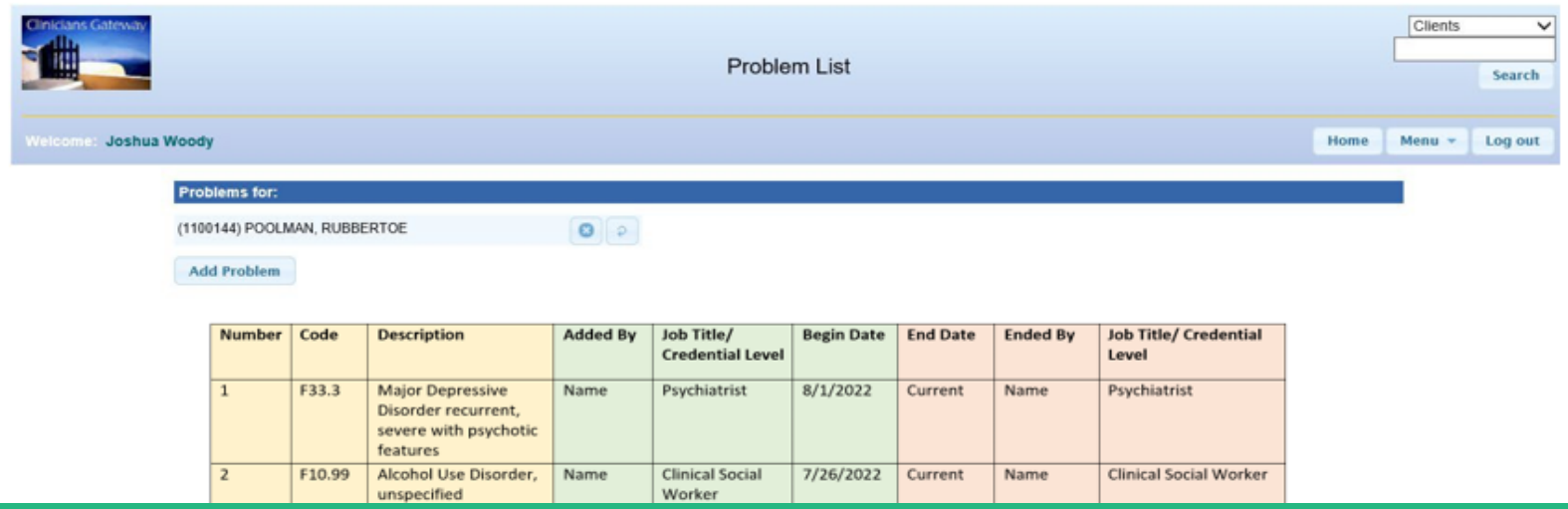
The Problem List may be accessed via the Action menu from the Client Facesheet or the Client Search Results



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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Frequently Asked Questions

Question	Answer
Do ALL clients require a Problem List, even those that also have a Treatment Plan and/or Peer Support Care Plan.	Correct. Services that require creation of a Care Plan, now also require Problem Lists.
Will ACBH defer to the provider on the timeframe for the initial problem list creation?	While ACBH has not designated a due date, it is our perspective that a problem list should be started as early as possible in the treatment episode and in most cases can be started after the first session. The Problem List is a living document. Problems should be added and removed from the list in real time so that the list represents an accurate picture of progress and continuing treatment issues.
Should we create Problem Lists for all of our existing cases effective 7/1/22?	While problem lists go into effect 7/1, there is no expectation that all existing cases have Problem lists as of that date. Begin creating Problem Lists for your existing cases as you work the cases.
Is there a new CQRT checklist that we should be using?	ACBH, in partnership with BH Collaborative, will be developing an updated CQRT. Until that is published, providers should continue to use the existing CQRT checklist and mark N/A for requirements that no longer apply.

Progress Notes

Required Information:

- The type of service rendered
- 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).
- The date that the service was provided to the beneficiary.
- Duration of the service, including travel and documentation time.
- Location of the beneficiary at the time of receiving the service.
- A typed or legibly printed name, signature of the service provider and date of signature.
- 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

Notes do not need to follow a specific narrative format.
One facilitator can write a note describing all staff interventions in a group.

Progress Note Timeframes

Routine services:

- Documentation should be completed within **3 business days**.
- If a note is submitted outside of the three business days, it is good practice to document the reason the note is delayed.
- Late notes should not be withheld from the claiming process.
- Based on the program/facility type (e.g., STRTP), stricter note completion timelines may be required by state regulation.

Crisis services:

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

Residential:

- A daily note is required for documentation of some residential services, day treatment, and other similar settings that use a daily rate for billing. In these programs, weekly summaries are no longer required.

Progress Note timeliness issues do not lead to disallowances.

Frequently Asked Questions

Question	Answer
How will the “narrative” requirement of the progress note be defined? Can the narrative be simply a reference to addressing the Problem List or Care plan or will there be county specific length or content requirements?	Progress notes must include sufficient detail to support the service code selected for the service type. The actual length and detail of the note must meet this standard. Individual Progress Notes no longer need to stand on their own to justify medical necessity for all services being provided.
We currently train clinicians to write in the BIRP (Behavior, Intervention, Response, Plan) format. Is a particular format still required?	The new regulations do not require the use of SOAP, SOAIRP, BIRP or PIRP formats in Progress notes.
Will a checklist of interventions be acceptable as part of the narrative? Similarly, if interventions are repeated verbatim across multiple notes will that be interpreted as fraud even if those are accurate to the service being provided?	CMS documentation rules (e.g. copy/paste, cloning, individualization, etc.) of progress notes are still in place and, although likely don’t constitute fraud, they are not good clinical practice.

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 (by means of false or fraudulent pretenses, representations, or promises) 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*

DHCS Disallowance Reasons for FY 2021-2022 Non-Hospital Services

DHCS has published its disallowance reasons for FY 2021-2022 for non hospital services. Examples of Disallowances are noted below. For a full list see: BHIN-21-053

- 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

Frequently Asked Questions

Question	Answer
Will a service be disallowed or billing recouped, if it is not reflected in the Care plan?	No. Per DHCS, clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery services are not excluded for 1) Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process; 2) The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan; 3) The beneficiary has a co-occurring substance use disorder.
Will a service be disallowed if a note is late?	No, the service is not disallowed. However, all late notes should continue to indicate “late” and note the reason for the late note.

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

- ACBH Town Hall Q&A meeting on **Tuesday 6/28/21 from 10-11**
- ACBH Brown Bags
- 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