Alameda CalAIM PATH Collaborative

December 12, 2025

BluePath HEALTH

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Please introduce yourself in the chat!

BluePath HEALTH

Today's Agenda

Time	Agenda Item	Presenter
10:00-10:05am	**Welcome and Introductions**	BluePath Health
10:05-10:20am	**2026 Policy Overview**	BluePath Health
10:20-10:40am	**Alameda Alliance Updates**	Alameda Alliance for Health
10:40-11:00am	**Transitional Rent Updates**	Alameda County Health
11:00-11:20am	**2025 Year-In-Review and 2026 Aim Statement Activity**	BluePath Health
11:20am-12pm	**Office Hours with the Facilitators**	

2025 Collaborative Aims and Drivers

By December 2025, the Collaborative will build provider capacity to deliver high-quality CalAIM services to eligible members, as evidenced by an increased proportion of enrollees with high-quality care plans in place and an increase in care coordination among CalAIM providers.

1. **Ensure delivery of high quality CalAIM services through education and training on CalAIM policies and program design**

2. **Enhance available resources and supports to help providers deliver CalAIM services to underutilizing Populations of Focus, including children and youth**

3. **Strengthen relationships between providers, plans, & referral partners to enable efficient, high-quality referrals and strong care coordination**

Thank you for joining us in November!

We discussed Housing Community Supports, including:

- Overview of Housing Community Supports Referrals
- Overview of the Alameda County Coordinated Entry System
- Spotlight on Lifelong Medical Care's Scattered Site Program
  - Quickly resolved 60-day notice that "Alice" received with no impact to her housing stability
  - "Billy" was successfully relocated to a home and was able to reconnect to behavioral health services

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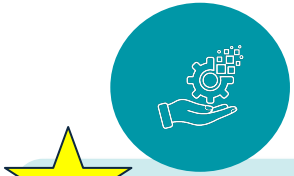
2026 Policy Overview

2026 Policy Overview: Key Focus Areas



CalAIM Program Structure & Sustainability

- CalAIM Programs
- CalAIM Waiver Renewal
- PATH Initiative Sunsets

Behavioral Health Reform

- BH-CONNECT and Transitional Rent
- BHSA

Eligibility & Enrollment

- Federal and state policy changes impacting Medi-Cal access for undocumented adults

Care Coordination & Integration

- Data Sharing (DxF)
- Duals Integration/ D-SNP

CalAIM programs will continue in 2026

- Enhanced Care Management
- Community Supports
- Justice-Involved Re-entry Initiative, including the launch of pre-release services
- And more!

CalAIM Waiver Renewal

- While the Medicaid waiver that created CalAIM expires at the end of 2026, California plans to apply for a renewal to enable CalAIM programs to continue.
- Waiver authority is not needed to continue ECM and 12 of the 14 Community Supports.
- DHCS proposes to continue and strengthen several services in the next waiver, including some Community Supports, the Justice-Involved Reentry Initiative, CBAS, Traditional Healers, and more.

PATH Initiative Sunsets December 2026

- While California plans to continue many CalAIM programs, the CalAIM PATH Initiative will sunset December 31, 2026.
- This includes:
  - PATH Collaboratives
  - Technical Assistance Marketplace
  - CITED Funding

2026 Policy Overview: Key Focus Areas

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Landscape of Behavioral Health Reforms

BH-CONNECT

BH-CONNECT* is a five-year Medicaid demonstration intended to expand access to community-based behavioral health care for Medi-Cal members. It aims to reduce reliance on inpatient and institutional care.

Medi-Cal

BHSA

The Behavioral Health Services Act (BHSA) is a component of Proposition 1, passed by CA voters in 2024. It reforms how BH funding is distributed to counties to prioritize individuals with the most significant mental health and SUD needs.

Statewide

**Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)*

BH CONNECT & BHSA Key 2026 Dates

January 1, 2026

Transitional Rent Go-Live Date

- Medi-Cal Community Support covering short-term housing costs for members experiencing or at risk of homelessness during their transition to stable housing

June 30, 2026

County Integrated Plans Due

- Counties must submit integrated plans that align Medi-Cal, realignment, BHSA, and other behavioral health funding streams

July 1, 2026

BHSA Reforms Go-Live

- Counties operate under the new BHSA rules: funding allocations are recalibrated and new requirements kick in

2026 Policy Overview: Key Focus Areas

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Timeline of Selected Changes to Medi-Cal Eligibility

January 1, 2026

- Adults without Satisfactory Immigration Status can no longer enroll in Medi-Cal.
- Adults who have already enrolled keep their coverage given timely renewal

July 1, 2026

- Adults without Satisfactory Immigration Status are no longer eligible for Medi-Cal dental benefits

October 1, 2026

- Some lawfully present immigrants lose Satisfactory Immigration Status for Medicaid under H.R. 1

January 1, 2027

- Work requirements apply for some adults aged 19-64
- Eligibility redetermination required twice per year instead of once

July 1, 2027

- Adults without Satisfactory Immigration Status who are still enrolled in Medi-Cal are required to pay a $30 monthly premium to keep their coverage

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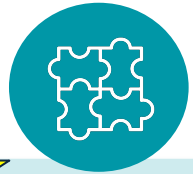

Care Coordination & Integration

- Data Sharing (DxF)
- Duals Integration/ D-SNP

Care Coordination and Integration

Data Sharing

California's Data Exchange Framework (DxF) requires healthcare entities to electronically exchange patient information in real time to support coordinated care across settings.

January 31, 2026: DxF compliance deadline for small practices and physician groups; Government agencies and Community-Based Organizations who have signed on are required to begin exchanging data.

Duals Integration/D-SNP

Aims to coordinate Medicare and Medicaid benefits for the 1.3 million Californians eligible for both programs ("dual-eligibles").

Includes integrated ID cards, combined assessments, and unified member materials.

January 1, 2026: Medi-Medi Plan Expansion to Alameda County.

2026 Policy Overview: Key Focus Areas

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2026 ECM Updates: Transitional Rent and D-SNP

ALAMEDA Alliance FOR HEALTH

ECM Updates coming 1/1/2026

ALAMEDA Alliance FOR HEALTH

Agenda

- Transitional Rent's Impact on ECM
- DSNP

Transitional Rent

- Newest addition to Community Supports
- Biggest difference: ALL managed care plans are required to cover Transitional Rent for members meeting the behavioral health PoF within the overall population eligible for Transitional Rent (TR).

https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf

Transitional Rent and ECM

- When the Alliance authorizes for Transitional Rent, it must also authorize the member for ECM and the Housing Trio Community Supports (HTNS, Housing Deposits, and HTSS)

- If a member is authorized for Transitional Rent but not yet receiving ECM, the Alliance is required to authorize a member for ECM, assign an appropriately selected ECM provider, and share all necessary information with the ECM provider to enable the ECM provider to begin conducting in-person outreach visits to the member. The Alliance is required to ensure that the ECM Provider conducts weekly in-person outreach visits to the member as soon as feasible and acceptable to the member, and no later than two weeks after a member begins receiving Transitional Rent, to invite engagement in ECM until a member chooses to participate in ECM or declines participation.

https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf

ECM Providers

- As soon as the Alliance authorizes Transitional Rent, members will be assigned out to appropriately matching ECM providers to conduct this urgent outreach to invite engagement into ECM (or decline).
- Expectations of the ECM providers will include (but not limited to:
  - Quick response/turnaround times (within 24 hours) to respond to the Alliance's ECM team of outreach and engagement efforts.
  - Frequent communication (once a week minimum) with the Alliance ECM team to confirm member engagement (or declination) of ECM.

D-SNP

- What is D-SNP?
  - Dual Special Needs Population – Medicare Advantage Plan
  - DHCS Contract agreement so that Medi/Medi members will be with one plan

- Additional Line of Business for Alameda Alliance
  - Alameda Alliance Wellness
  - Expectation that year 1 will be a small enrollment
    - Goal is to have 1500 members enrolled by 12/31/2026

D-SNP (continued)

What does this mean for ECM?

- For D-SNP – there is no 'ECM' benefit. Instead, there is a level of care management called California Integrated Care Management (CICM)
- Members are identified for CICM if they meet certain criteria for the below populations:
  - Adults Experiencing Homelessness
  - Adults at Risk for Avoidable Hospital or ED Utilization
  - Adults with Serious Mental Health and/or SUD Needs
  - Adults Transitioning from Incarceration
  - Adults Living in the Community and At Risk for Long-Term Care (LTC) Institutionalization
  - Adult Nursing Facility Residents Transitioning to the Community
  - Adults who are Pregnant or Postpartum and Subject to Racial and Ethnic Disparities
  - **Adults with Documented Dementia Needs**
- Additional Information:
  - Members do not need authorization approvals to receive CICM
  - Follow specific requirements depending on the PoF
    - For example for the PoF Adults Experiencing Homelessness, all encounters are required to be in-person

https://www.dhcs.ca.gov/provgovpart/Documents/DHCS-CalAIM-D-SNP-Policy-Guide-26.pdf

D-SNP (continued)

What will the Alliance do?

- The Alliance:
  - Expects to have members carry over ECM in the form of Continuity of Care
  - Is planning to start with CICM primarily in-house (managed by internal ECM team)
  - Is working on agreements with the Street Health teams to discuss CICM for in-person encounters for adults who are experiencing homelessness
  - Is starting slow, with a small goal of members enrolled in D-SNP, leading to the expectation of CICM enrollment for D-SNP members to also be small

https://www.dhcs.ca.gov/provgovpart/Documents/DHCS-CalAIM-D-SNP-Policy-Guide-26.pdf

Thanks!
Questions?

You can contact us at:

For ECM:
ECM@AlamedaAlliance.org

510-747-4546

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Overview of Transitional Rent and Flexible Housing Subsidy Pool

Alameda County Health

Flexible Housing Subsidy Pool: Alameda County

Alameda County CalAIM PATH Collaborative

December 12, 2025

Alameda County Health

Agenda

1. Alameda County Housing Goals
2. Flexible Housing Subsidy Pool Overview
3. Transitional Rent Process
4. Questions

Alameda County Health

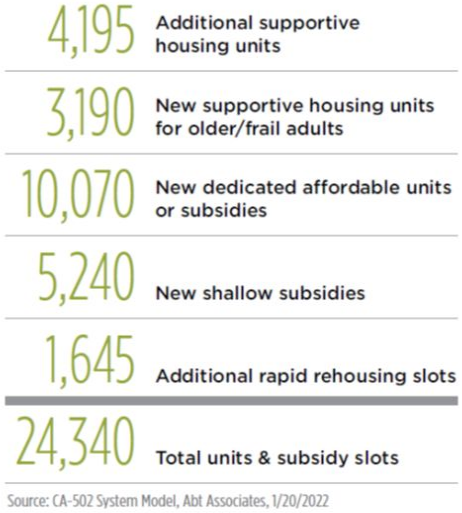
Alameda County Housing Goals

Home Together System Needs

- In order to drastically reduce homelessness and racial inequities, the 5-year Home Together 2026 Community Plan calls for the **addition of more than 24,000 housing resources** in a variety of programs.
- The total estimated **cost of operating this inventory over 5-years is $2.5 billion** (and $731M annually for years 5 and beyond). This cost **does *not* include** capital development or the cost of additional operations such as prevention, street outreach, or administrative activities.

The total cost of scaling up shelter and housing inventory over 5-years to fully meet system needs is **$2.5 billion**.

- $430M for additional shelter
- $1B for permanent supportive housing
- $814M for dedicated affordable housing and shallow subsidies
- $196M for rapid rehousing



Housing Continuum

A Flexible Housing Subsidy Pool is a mechanism to help find **permanent** housing units and administer rental subsidies (referrals will go through coordinated entry)

Target Population

People in Unsheltered situations

People exiting hospital, jail, & other institutions

People living in vehicles

The working homeless

Interim Housing

1 day to 2 years

Many models, but all provide:

- A **safe indoor place** to temporarily live and recover from life on the streets
- High quality **housing search** that is resident centered
- **Case management** and/or direct connection to treatment
- Varying levels of **services**, with intensity depending on program focus

Shelter | Navigation Center | Residential Treatment | Medical Respite | Transitional Housing

Housed

Permanent Supportive Housing (PSH)

Affordable Housing

Scattered-Site Subsidies

Market–rate housing

Shallow rent subsidies

Home-Sharing

Enhanced Problem Solving

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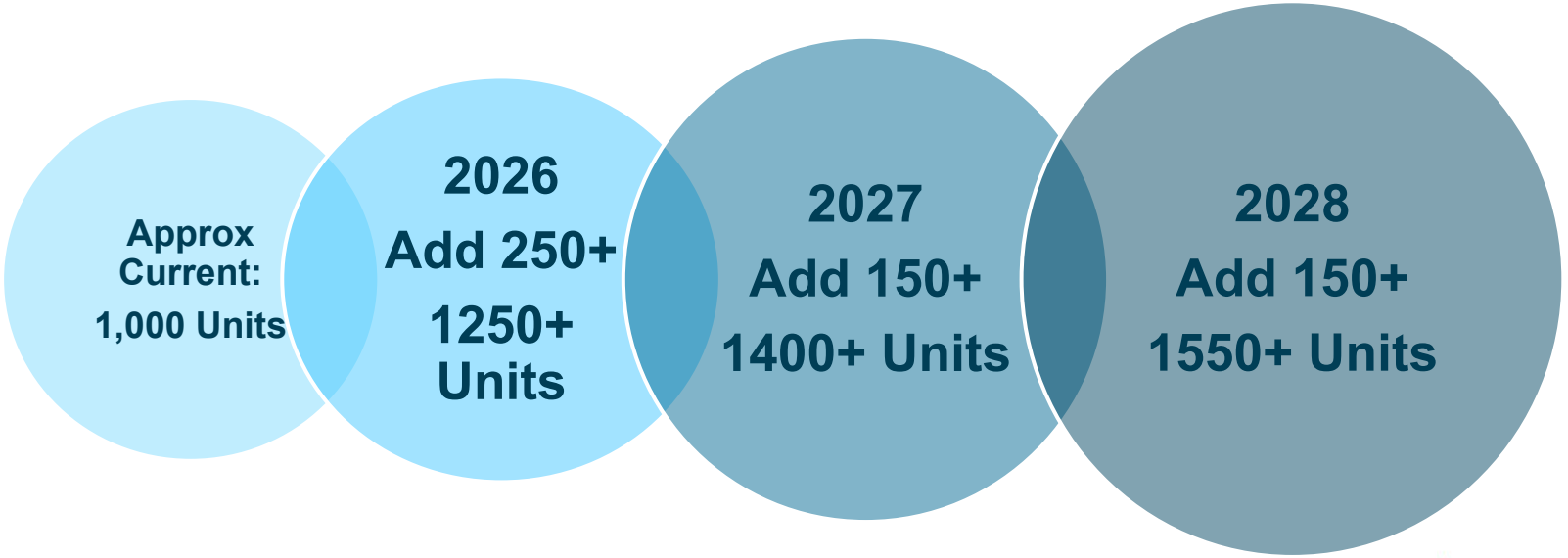
Alameda County Flex Pool Goals

Create a flexible model to do what it takes to get housing

- Identify scattered site units to house more people
- Build from existing infrastructure and help maximize new funding sources (BHSA, transitional rent, local tax measure, etc.)



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Flexible Housing Subsidy Pools

What is a Flexible Housing Subsidy Pool (Flex Pool)

A model for centrally administering and coordinating multiple streams of funding for rental subsidies and engaging landlords:

- **Centralized unit acquisition:** Find and contract for affordable and market rate units
- **Rental Administration:** Pay rental subsidies for approved households
- **Administer flexible funding:** incentives, housing deposits, unit holds, etc.

Why :

- Aggregate and braid multiple funding streams
- Standard operating procedures
- Stronger relationships with landlords = more units

Why now:

- DHCS interest
- Transitional Rent
- BHSA
- Measure W

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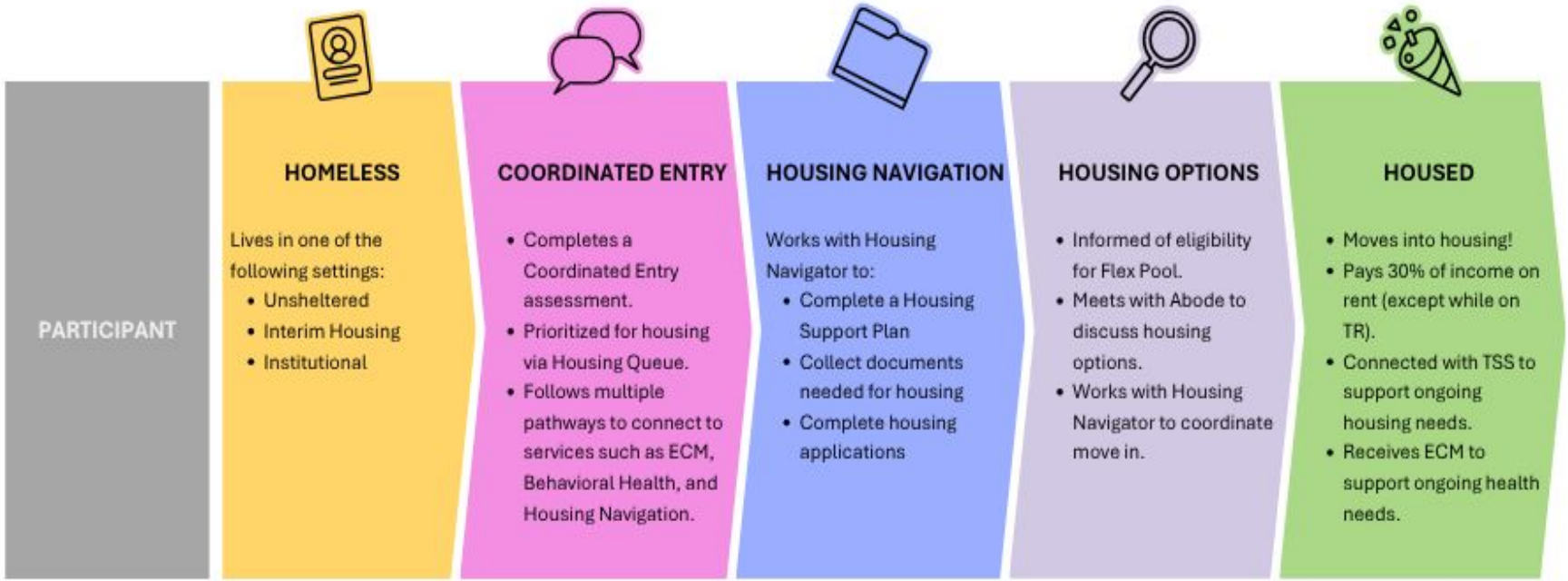
Flex Pool Sample Participant Housing Journey



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Flex Pool Model

Funders

- Funding Source A
- Funding Source B
- Funding Source C

Flex Pool Administration and Operation

Lead Entity: Plays the role of convener and "system driver"—identifies, aggregates, and administers funding sources, likely also a funder, and contracts with the Operator

Operator: Responsible for keeping the day-to-day operations of the Flex Pool running smoothly and delivering excellent customer service to landlords, participants, and the Lead Entity

Housing Supportive Service Providers

Landlords

- Landlord X
- Landlord Y
- Landlord Z

Housing and Supports for Participants

Flex Pool Roles

1. **Lead entity (H&H):** Coordinates, aggregates, and braids funding streams. Provides program planning and direction and referrals (requires multiple staff - program, finance, and data)
2. **Operator (Abode):** Identifies and secures units, administers rental payments and coordinates with providers of housing supportive services (submits a single monthly invoices by funding stream)
3. **Funders:** Designate eligibility criteria for funding. Some or all of the following:
   - *County*: ***BHSA***, ***Measure W***, etc.
   - *State*: HDAP, HHAP, etc
   - *Health Plans* (Community Supports): Housing Navigation, Housing Deposits, ***Transitional Rent***, Tenancy and Sustaining Services
   - *Public Housing Authorities*: Housing Choice Vouchers

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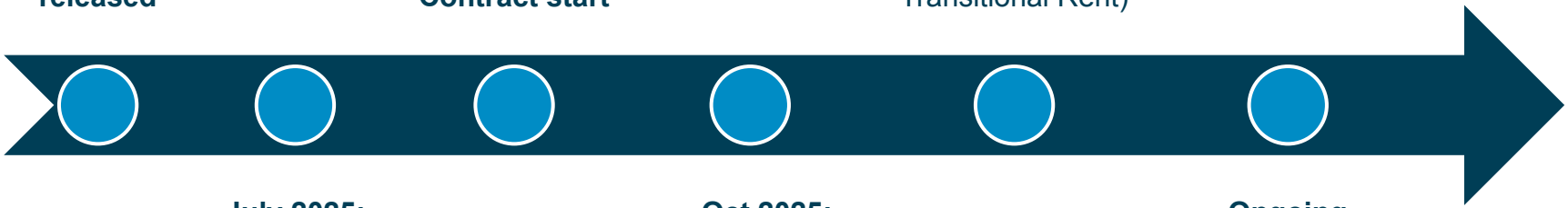
Alameda County Flex Pool: Implementation Timeline



May 2025:
RFP released

July 2025:
Operator review and selection

Sept 2025:
Contract start

Oct 2025:
Consolidation of existing rental assistance contracts

Jan 1, 2026:
Expansion with new funding sources (including County funding and Transitional Rent)

Ongoing opportunity to grow flex pool with additional funding sources

Alameda County Health

Transitional Rent

DHCS Vision for Transitional Rent

California is transforming Medi-Cal through DHCS-led initiatives to improve health care quality, access, and outcomes for Medi-Cal members, recognizing that a member's health and well-being is driven by both clinical and social factors.

Transitional Rent will be a new, fifteenth Community Support under CalAIM.

Under Transitional Rent, Managed Care Plans (MCPs) will cover up to six months of rent for members who are experiencing or at risk of homelessness and meet certain additional eligibility criteria.

This benefit will be available for **up to 6 months per household per demonstration period.**

- Transitional Rent is designed to provide a time-limited *opportunity* to help a member exit homelessness, or no longer be at risk of entering into homelessness, and establish a bridge to permanent housing.
- Transitional Rent will help prevent and address the adverse health outcomes that result from homelessness.
- Transitional Rent will improve overall health outcomes that have been shown to result from stable housing.

Who is Eligible?

1

Meet access criteria for SMH, DMC, DMC-ODS.

AND

Have a long-term subsidy source identified.

3

- Transition from specified settings: institutional care, congregate residential, interim housing
- Transitioning out of child welfare system
- Experiencing unsheltered homelessness
- FSP eligible

2

HUD definition of homelessness or at risk of homelessness with two modifications:

- If exiting an institution or a state prison, county jail, or youth correctional facility individuals are considered homeless if they were homeless immediately prior to entering that institution or carceral stay, regardless of the length of the institutionalization or incarceration
- The timeframe for an individual or family who will imminently lose housing is extended from 14 days for individuals considered homeless and 21 days for individuals considered at risk of homelessness under the current HUD definition to 30 days for both groups of people

Alameda County Transitional Rent Process

1. H&H identifies eligible participants based through **Coordinated Entry System**
2. H&H utilizes **Flex Pool** to identify housing units and long-term subsidies for participants
3. Participant signs a lease, Abode begins rent payment, H&H **requests authorization for Transitional Rent**
4. MCP shares authorization period with H&H, H&H **bills Transitional Rent** for rent payments and admin fee during authorized period
5. H&H **transitions participant rent payments** to long-term funding source

Alameda County Health

Transitional Rent Limitations

- Limited Population of Focus (POF) starting January 1, 2026.
  - The **Behavioral Health POF** is the only mandatory POF
  - Future POF expansions up to MCPs

- Authorizations for Transitional Rent
  - Require participants to be **prioritized for permanent housing via Coordinated Entry** in Alameda County
  - Require completion of a housing support plan that identifies the payment source(s) and mechanism(s) to **maintain ongoing housing** (Flex Pool)
  - Requires coordination and **planning around post-TR options** ahead of TR enrollment

- There is a “global cap” on coverage of room and board services.
  - Members **may not receive more than a combined six months** of Short-term Post Hospitalization Housing, Recuperative Care and Transitional Rent during any rolling 12-month period
  - Transitional Rent has an additional **cap of six months per household** per demonstration period

Alameda County Health

Transitional Rent Changes to Housing Trio

- Housing Deposits under Community Supports are modified in response to Transitional Rent:
  - Coverage of **first/last month's rent is removed** to avoid duplication (security deposits are still eligible)
  - **Housing Navigation** is no longer a prerequisite

- Anyone eligible for Transitional Rent is **automatically eligible for the Housing Trio** (Housing Navigation, Housing Deposits, Tenancy Sustaining Services) and Enhanced Care Management

- Increased **importance of Housing Support Plan** throughout

Questions?

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2025 Year-In-Review

2025 Collaborative Aims and Drivers

By December 2025, the Collaborative will build provider capacity to deliver high-quality CalAIM services to eligible members, as evidenced by an increased proportion of enrollees with high-quality care plans in place and an increase in care coordination among CalAIM providers.

1. **Ensure delivery of high quality CalAIM services through education and training on CalAIM policies and program design**
2. **Enhance available resources and supports to help providers deliver CalAIM services to underutilizing Populations of Focus, including children and youth**
3. **Strengthen relationships between providers, plans, & referral partners to enable efficient, high-quality referrals and strong care coordination**

2025 Collaborative Aims and Drivers

1 **Ensure delivery of high quality CalAIM services through education and training on CalAIM policies and program design**

Training Relevant to ECM and Community Supports Care Delivery

Ongoing Peer Learning

TRAINING DEVELOPMENT UNIT

Alameda County Health
Healthy Brain Initiative
AND
SAGE DEMENTIA CONSULTING

Peer Learning

2025 Meeting Topics included:

- SMI/SUD Services
- Community Supports & Closed Loop Referrals
- Transitional Rent
- Motivational Interviewing
- Justice-Involved Initiative
- Alameda County Community Health Assessment
- Housing Trio & Housing Navigation
- Statewide CalAIM Policy Updates
- MCP updates

2025 Collaborative Aims and Drivers

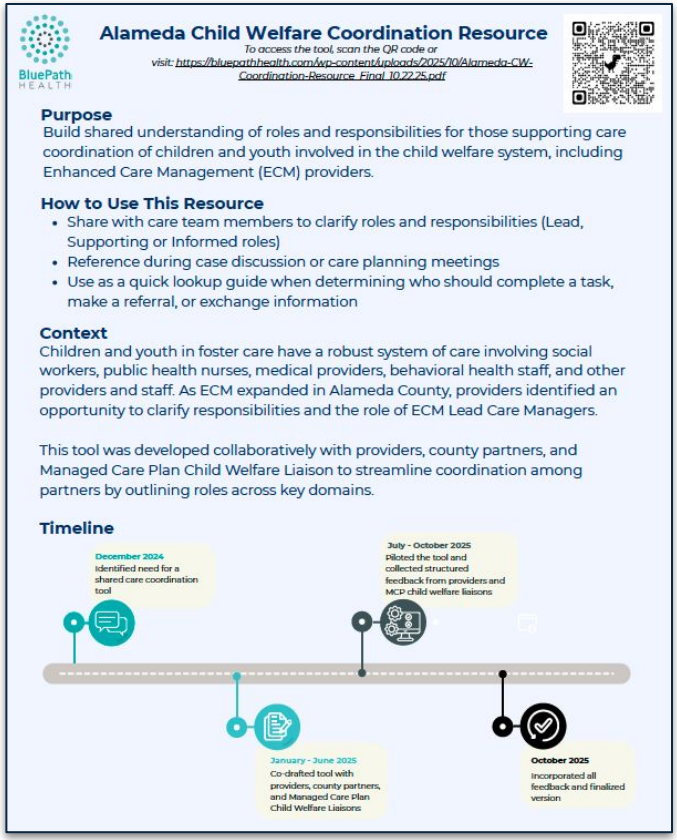
2

Enhance available resources and supports to help providers deliver CalAIM services to underutilizing Populations of Focus, including children and youth

- **Resources for Supporting Immigrant Communities**
- **Child Welfare Care Coordination Handout**
- **Updated ECM and Community Supports Provider List and Spreadsheet**

Alameda Resources for Supporting Immigrant Communities

Child Welfare Care Coordination Handout



Alameda Child Welfare Coordination Resource

To access the tool, scan the QR code or visit: https://bluepathhealth.com/wp-content/uploads/2025/10/Alameda-CW-Coordination-Resource_Final_10.22.25.pdf

Purpose

Build shared understanding of roles and responsibilities for those supporting care coordination of children and youth involved in the child welfare system, including Enhanced Care Management (ECM) providers.

How to Use This Resource

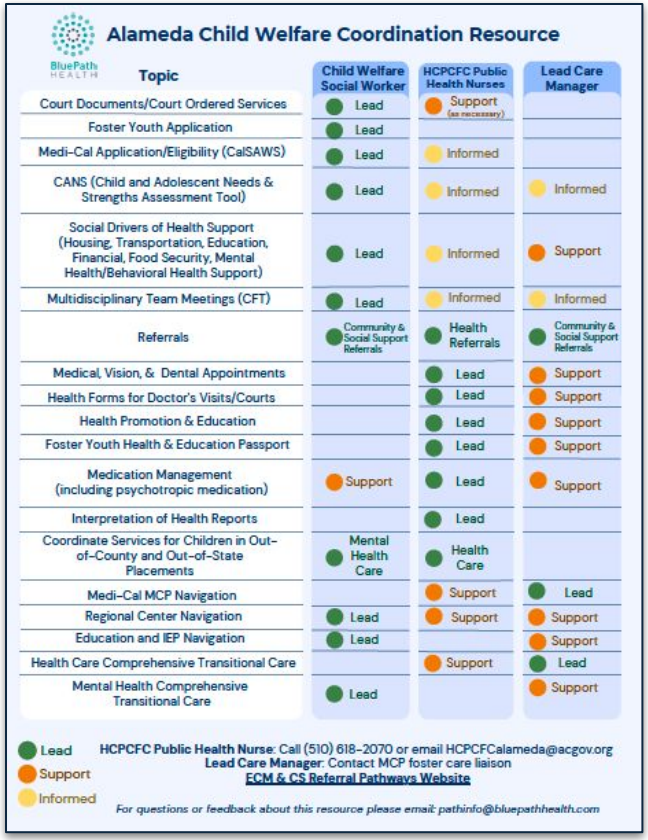
- Share with care team members to clarify roles and responsibilities (Lead, Supporting or Informed roles)
- Reference during case discussion or care planning meetings
- Use as a quick lookup guide when determining who should complete a task, make a referral, or exchange information

Context

Children and youth in foster care have a robust system of care involving social workers, public health nurses, medical providers, behavioral health staff, and other providers and staff. As ECM expanded in Alameda County, providers identified an opportunity to clarify responsibilities and the role of ECM Lead Care Managers.

This tool was developed collaboratively with providers, county partners, and Managed Care Plan Child Welfare Liaison to streamline coordination among partners by outlining roles across key domains.

Timeline



Alameda Child Welfare Coordination Resource

Topic	Child Welfare Social Worker	HCPCFC Public Health Nurses	Lead Care Manager
Court Documents/Court Ordered Services	Lead	Support (as necessary)	
Foster Youth Application	Lead		
Medi-Cal Application/Eligibility (CalSAWS)	Lead	Informed	
CANS (Child and Adolescent Needs & Strengths Assessment Tool)	Lead	Informed	Informed
Social Drivers of Health Support (Housing, Transportation, Education, Financial, Food Security, Mental Health/Behavioral Health Support)	Lead	Informed	Support
Multidisciplinary Team Meetings (CFT)	Lead	Informed	Informed
Referrals	Community & Social Support Referrals	Health Referrals	Community & Social Support Referrals
Medical, Vision, & Dental Appointments		Lead	Support
Health Forms for Doctor's Visits/Courts		Lead	Support
Health Promotion & Education		Lead	Support
Foster Youth Health & Education Passport		Lead	Support
Medication Management (including psychotropic medication)	Support	Lead	Support
Interpretation of Health Reports		Lead	
Coordinate Services for Children in Out-of-County and Out-of-State Placements	Mental Health Care	Health Care	
Medi-Cal MCP Navigation		Support	Lead
Regional Center Navigation	Lead	Support	Support
Education and IEP Navigation	Lead		Support
Health Care Comprehensive Transitional Care		Support	Lead
Mental Health Comprehensive Transitional Care	Lead		Support

Lead
Support
Informed

HCPCFC Public Health Nurse: Call (510) 618-2070 or email HCPCFCalameda@acgov.org
Lead Care Manager: Contact MCP foster care liaison
ECM & CS Referral Pathways Website

For questions or feedback about this resource please email: pathinfo@bluepathhealth.com

Updated ECM and Community Supports Provider List & Spreadsheet

BluePath HEALTH

CalAIM PATH Care Coordination Provider List
ECM and Community Supports Providers
October 2025

	Alameda Alliance	Kaiser
Recuperative Care (Medical Respite)		
• Bay Area Community Services	X	
• Cardea Health/Eddie's Place	X	X
• City Serve		X
Respite Services (Caregiver Respite)		
• Accentcare of California		X
• 24 Hour Home Care	X	
• Aging Assistance LLC		X
• J&M Homecare Services		X
• Maxim Healthcare		X
• O. Community Doulas		X
• Omatochi	X	X
Short-Term Post Hospital Housing		
• Serene Health		X
• City Serve		X

Provider *(See the Provider List on our website for det*	MCP CONTRACT: Is this provider contracted with Alameda Alliance for Health (AAH)?	MCP CONTRACT: Is this provider contracted with Kaiser Permanente (KP)?	ECM: Does this provider offer Enhanced Care Management for Children/Youth?	ECM: Does this provider offer ECM for Adults?
24 Hour Home Care	x			
A Better Way, Inc.		x	x	
AAT Home Placement Agency		x		x
Accentcare of California		x		
Agape Village		x	x	
Aging Assistant LLC		x		
Alameda County Behavioral Health Care Services	x			x
Alameda County Behavioral Health, Eastmont Health Center	x			x
Alameda County Care Alliance (dba AC Care Alliance)		x	x	x
Alameda County Community Food Bank	x			
Alameda County Health Care Services	x			
Alameda County Public Health (Asthma Start)	x		x	
Alameda County Public Health, California Children's Services (CCS)	x		x	
Alameda County Recipe4Health	x			
Alameda Family Services	x	x	x	
Alameda Health System	x			x
Alameda Health System, Eastmont Wellness	x			x
Alameda Health System, Hayward Wellness	x			x
Alameda Health System, Highland Wellness	x			x
Alegrecare		x		
Alternative Family Services	x	x	x	

Check out our Resource Center!

Our Resource Center has all of our updated resources, including ***immigration resources and policy updates.***

Check out the ***Past Materials Page*** for all recordings and slide decks of collaborative meetings since January 2024!

See past meeting materials

Check it out:

2025 Collaborative Aims and Drivers

3 **Strengthen relationships between providers, plans, & referral partners to enable efficient, high-quality referrals and strong care coordination**

In-Person Peer Networking

- **12** collaborative meetings, including **4** in-person meetings
- Over **150** participating organizations
- Over **345** participating individuals
- Average meeting attendance of over **75** participants

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2026 Collaborative Planning

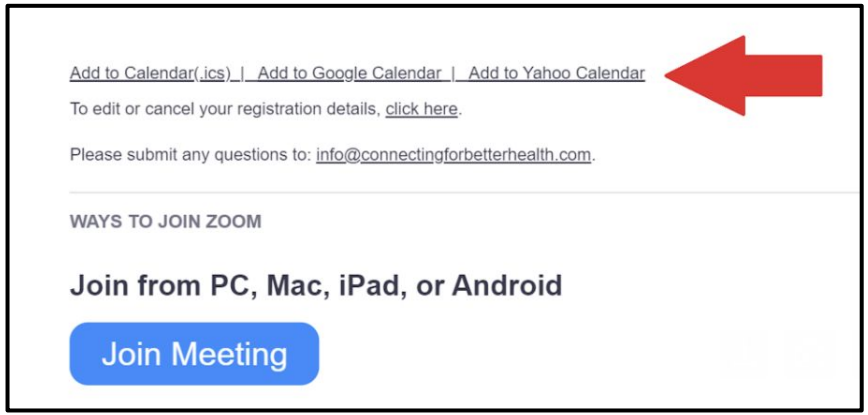
2026 Collaborative Overview

- CalAIM PATH Collaboratives are funded to continue until December 31, 2026
- In 2026, the Alameda CalAIM PATH Collaborative will continue to meet monthly, with one hour meetings
- Meeting topics and structure will rotate between:
  - Policy and Program Updates
  - Managed Care Plan Updates
  - In-Person Networking and Peer Learning Sessions

2026 Scheduling

Join us on Fridays in 2026!

Register to add the 2026 meetings to your calendar!



Meeting Calendar
January 23
February 27 (In-person)
March 27
April 24
May 29 (In-person) *fifth Friday*
June 26
July 24
August 28 (In-person)
September 25
October 24
November 13 (In-person) *second Friday*
December 18 *third Friday*

We would to love to spotlight your organization in 2026!

If you are a contracted ECM or Community Supports provider, we invite you to provide an organizational overview and 1-2 anonymized client success stories based on the services you provide under CalAIM.

Fill out a brief form here:

2026 Collaborative Aim Statement Activity

2025 Aim: By December 2025, the Collaborative will build provider capacity to deliver high-quality CalAIM services to eligible members.

As we reflect on the work we've accomplished to date, we want to take a moment to envision our goals as a Collaborative for 2026 and beyond.

In 2026, I want the Collaborative to accomplish… [fill in the blank].

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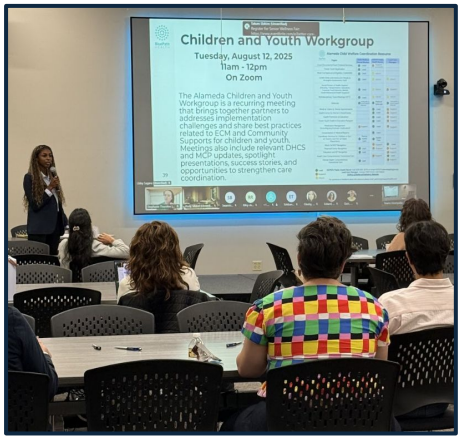
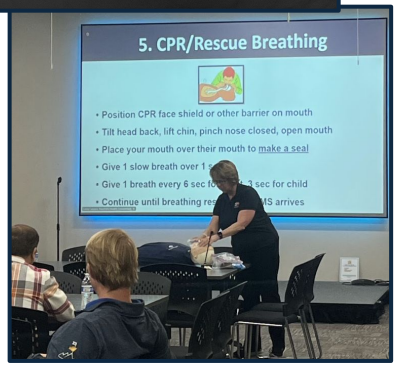
Thank you all for your participation in the Alameda CalAIM PATH Collaborative this year!





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Thank you for joining and see you next year!

Questions? Please email pathinfo@bluepathhealth.com.

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