

Tri Counties CalAIM PATH Collaborative

February 18, 2026



**Please introduce
yourself in the
chat!**

How to Add Your Organization to Your Zoom Name

- Click on the “Participants” icon at the bottom of the window.
- Hover over your name in the “Participants” list on the right side of the Zoom window and click “More.”
- Select “Rename” from the drop-down menu.
- Enter your name and add your organization as you would like it to appear.
 - For example: Elicica Morris – BluePath Health

2026 Scheduling

Join us on Wednesdays in 2026!



Register today to add the meetings to your calendar!

[Add to Calendar\(.ics\)](#) | [Add to Google Calendar](#) | [Add to Yahoo Calendar](#)

To edit or cancel your registration details, [click here](#).

Please submit any questions to: pathinfo@bluepathhealth.com.

WAYS TO JOIN ZOOM

Join from PC, Mac, iPad, or Android



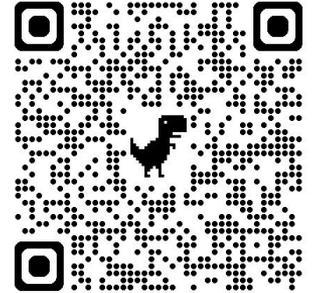
Meeting Calendar
January 21
February 18
March 18
Week of April 13th (in-person)
May 20
June 17
July 15
August 19
Week of September 14th (in-person)
October 21
November 18
December 16

Today's Agenda

Time	Agenda Item	Presenter(s)
10:00-10:05am	Welcome and Introductions	BluePath Health
10:05-10:10am	2026 Aim Statement and Drivers	BluePath Health
10:10-10:20am	Local CalAIM Success Story	Santa Maria Wisdom Center
10:20-10:50am	D-SNP Overview and Discussion	BluePath Health Managed Care Plans
10:50-11:00am	Announcements and Closing	

Thank you for joining us in January!

- We were grateful to have **Gold Coast Health Plan, Kaiser Permanente** and **CenCal Health** share key updates on transitional rent and the referral process including updated referral forms.
- **Transitional Rent Resources**
 - [January 2026 Meeting Slides](#)
 - [January 2026 Meeting Recording](#)
 - [Transitional Rent Flyer](#)
 - [Homebase Transitional Rent Factsheet](#)
 - [Homebase vignettes of Transitional Rent eligibility](#)



All referral forms and resources are available at the [Tri Counties CalAIM Resource Center](#).



2026 Collaborative Aim Statement and Drivers

2026 Collaborative Aim Statement and Drivers

By December 2026, the Collaborative will develop a foundation for ongoing collaboration to support continuity beyond the PATH program.

Transform networking into formal and informal partnerships through in-person meetings

Prepare for implementation changes through regular policy updates and summaries

Strengthen capacity through trainings and co-development of tools and resources

Local CalAIM Success Story

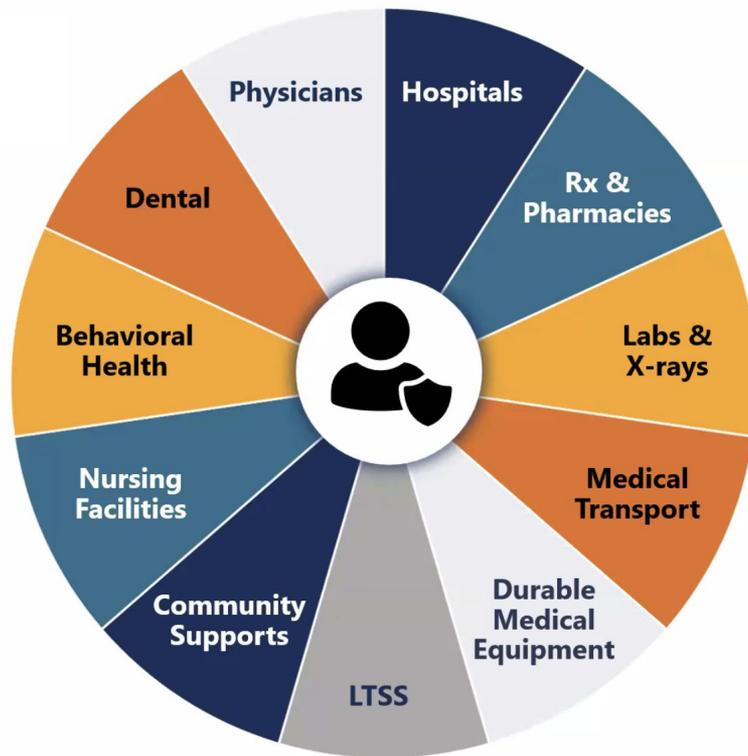


D-SNP Overview and Discussion

Medi-Medi Plans

As part of the CalAIM Initiative, **Medi-Medi Plans (MMPs)**¹ (Exclusively Aligned Enrolled (EAE) D-SNPs) are a type of Medicare Advantage plan in California only available to dual eligible beneficiaries. As of January 1, 2026, they're available in 41 counties².

The goal is to provide coordinated care for Medi-Medi members to have a streamlined care experience.

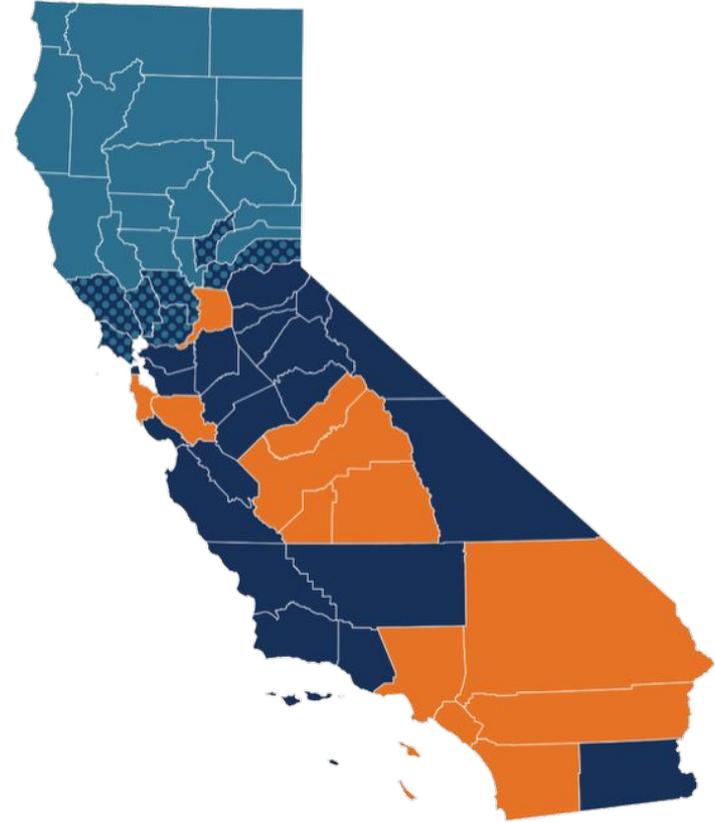


"Dually-eligible," "duals," or "Medi-Medi" describe individuals who have both Medicare and Medi-Cal coverages

⁽¹⁾ [California Department of Health Care Services Medi-Medi Plans](#); ⁽²⁾ [California Department of Health Care Services Medi-Medi Plan Expansion](#)

Medi-Medi Plans in California Counties

-  **Existing counties (launched in 2023 or 2024):** Fresno, Kings, Los Angeles, Madera, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, Santa Clara, Tulare
-  **Newly added as of 2026:** Alameda, Alpine, Amador, Calaveras, Contra Costa, El Dorado, Imperial, Inyo, Kern, Mariposa, Merced, Mono, Monterey, San Benito, San Francisco, San Joaquin, San Luis Obispo, Santa Barbara, Santa Cruz, Stanislaus, Tuolumne, Ventura
-  **One plan newly added as of 2026 (additional option expected after 2026):** Marin, Napa, Placer, Solano, Sonoma, Yolo, Yuba
-  **Will be phased in after 2026:** Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity



Key Features of Medi-Medi Plans (MMPs)

Full coverage of Medicare Part A, B, and D benefits as well as Medi-Cal services, including access to additional benefits such as dental, hearing, or vision care beyond standard Medi-Cal coverage.



One care team to coordinate care



One health plan to coordinate delivery of services, including medical supplies, transportation, and long-term services and supports



One set of benefits and a network of providers, including doctors, hospitals, clinics, labs, pharmacies, and medical equipment suppliers

California Integrated Care Management (CICM) Populations of Focus (PoFs)

Instead of Enhanced Care Management (ECM), Medi-Medi Plans (MMPs) provide California Integrated Care Management (CICM). Members are identified for CICM if they meet certain criteria for ECM PoFs with the inclusion of one new PoF outlined below.

Adults with Documented Dementia Needs

Specific requirements: D-SNPs must have trained dementia care specialists on Interdisciplinary Care Teams (additional criteria: for members who also have 2+ coexisting conditions, moderate to severe behavioral issues, or high utilization, or live alone or lack adequate care support or moderate to severe functional impairment), and dementia-specific training for dementia-care specialists.

Breakout Groups

Join **Room #1** if you work in San Luis Obispo and/or Santa Barbara Counties.

Stay in the **main session** if you work in Ventura County.

Note: Meeting recordings will be available on our [Resource Center](#).



Kaiser Permanente

Gold Coast Health Plan

CenCal Health Plan



**Gold Coast
Health Plan**SM
A Public Entity

Gold Coast Health Plan Total Care Advantage HMO D-SNP

By

Kimberley Marquez-Johnson, Director of DSNP

and

Nathan Norbryhn, Sr. Director Model of Care

Integrity

Accountability

Collaboration

Trust

Respect

Total Care Advantage HMO D-SNP Overview

1. Introduction to Total Care Advantage HMO D-SNP
2. Eligibility
3. Total Care Advantage Benefits
4. Understanding Total Care Advantage Model of Care
 - MOC 1: Understanding Total Care Advantage D-SNP Members
 - MOC 2: Understanding Total Care Advantage Care Coordination

Introduction: Total Care Advantage (HMO D-SNP)

Total Care Advantage is Gold Coast Health's Medicare Advantage Special Needs Plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal.

Total Care Advantage is an Exclusively Aligned Enrollment D-SNP (EAE D-ANP), also called a Medi-Medi Plan.

This allows Total Care Advantage (TCA) to serve our members by integrating their Medicare and Medi-Cal benefits and support them with a Model of Care that coordinates their care.



Eligibility for Total Care Advantage

Eligibility requirements

Members can join if they:

- Have both Medicare Part A and B
- Have full-scope Medi-Cal
- Are 21 years or older
- Live in Ventura County



Enrollment is **voluntary**.

To enroll, people can call Total Care Advantage
at **1-888-808-7879** or
1-800-MEDICARE.

Total Care Advantage Benefits

Total Care Advantage provides Medicare services, such as:

- Hospitals
- Providers
- Prescription drugs
- Supplemental Benefits

Total Care Advantage also provides wrap-around services, such as:

- Medicare cost-sharing
- Long-Term Services and Supports (LTSS)
- Transportation

Total Care Advantage also provides Care Coordination where every member is assigned a Care Navigator or Care Manager who:

- Conducts Health Risk Assessment (HRA) to identify member needs and recommended services/supports/benefits.
- Works w/ the member on an Individualized Care Plan (ICP),
- Facilitates Interdisciplinary Care Team (ICT) and
- Provides Transitional Care Services (TCS)



Total Care Advantage Supplemental Benefits

Supplement Benefits:

- Acupuncture - ASH
- Fitness - Optum One Pass
- Hearing - VSP
- Vision - TruHearing
- Worldwide Emergency



Total Care Advantage members also have supplemental benefits available if they meet criteria such as:

- Readmission Prevention Meals (24 meals/year)
- Readmission prevention Personal Care/Homemaker (64 hours/year)
- SSBCI Social Transportation to Church, Gym, Grocery Store and Senior Center (24 one-way rides/year, 30 miles each ride maximum)

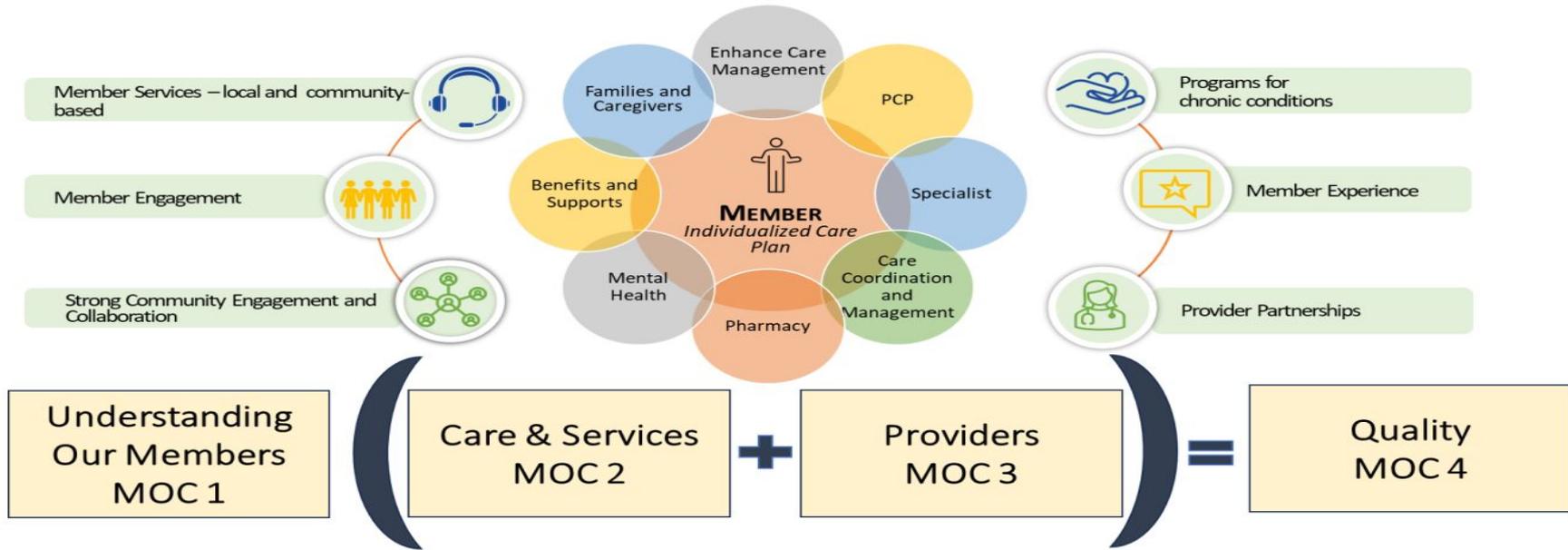
* Community Supports benefits continue to be available to eligible **Total Care Advan**

- CBAS and PERS are also available benefits



Total Care Advantage D-SNP Model of Care

Gold Coast Health Plan D-SNP Model of Care



MOC 1: Understanding Total Care Advantage D-SNP Members

Objective:

- Become familiar with characteristics of Total Care Advantage D-SNP membership
- Understand most vulnerable target population within Total Care Advantage D-SNP and possible supports

MOC 1: Understanding Total Care Advantage D-SNP Members



DSNP Daily Member Roster: 2/11/2026

Report Last Refreshed:
2/11/2026 4:10:24 PM

Roster Demographics

Age Group	Members	% Members
00-64	72	15.8%
65-69	172	37.7%
70-74	92	20.2%
75-79	64	14.0%
80-84	33	7.2%
85-89	13	2.9%
90-94	6	1.3%
95-99	3	0.7%
100+	1	0.2%
Total	456	100.0%

Language	Members	% Members
Spanish	247	54.2%
English	197	43.2%
Tagalog	4	0.9%
	2	0.4%
No Valid Data Reported	2	0.4%
American Sign Language	1	0.2%
Mandarin (China)	1	0.2%
Other	1	0.2%
Russian	1	0.2%
Total	456	100.0%

City	Members	% Members
OXNARD	179	39.3%
VENTURA	53	11.6%
SIMI VALLEY	42	9.2%
SANTA PAULA	37	8.1%
CAMARILLO	29	6.4%
OJAI	24	5.3%
FILLMORE	23	5.0%
THOUSAND OAKS	23	5.0%
PORT HUENEME	14	3.1%
MOORPARK	10	2.2%
NEWBURY PARK	9	2.0%
OAK VIEW	7	1.5%
OAK PARK	2	0.4%
PIRU	2	0.4%
SAN BUENAVENTURA	1	0.2%
SOMIS	1	0.2%
Total	456	100.0%

Category of Aid	Members	% Members
SPD	409	89.7%
Adult Expansion	38	8.3%
Adult/Family/OTL IC	6	1.3%
	3	0.7%
Total	456	100.0%

Sex	Members	% Members
F	259	56.8%
M	197	43.2%
Total	456	100.0%

Ethnicity	Members	% Members
Hispanic or Latino	274	60.1%
Not Hispanic or Latino	84	18.4%
Decline to Answer	71	15.6%
Asian	18	3.9%
Unknown	6	1.3%
	3	0.7%
Total	456	100.0%

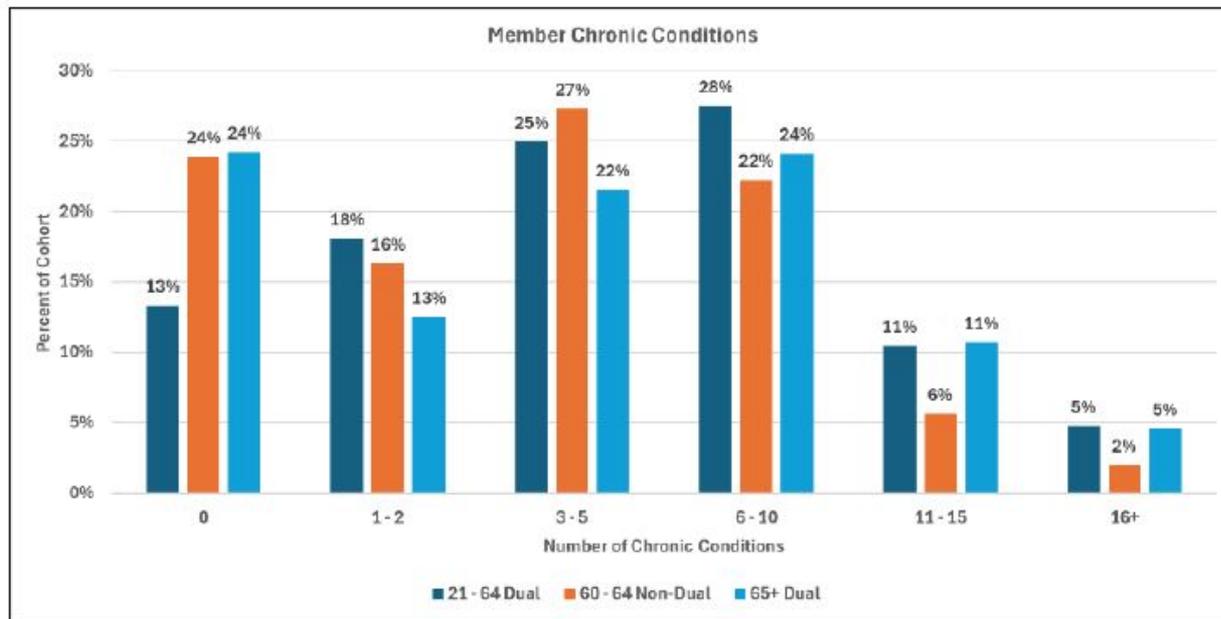
PCP System	Members	% Members
CLINICAS	282	61.8%
VCMC	174	38.2%
Total	456	100.0%

Case Type	Members	% Members
General	340	74.6%
No Case	80	17.5%
CICM	36	7.9%
Total	456	100.0%

[View Roster \(Restricted\)](#)

MOC 1: Understanding Total Care Advantage D-SNP Members

Chart 1.3: Number of Chronic Conditions by GCHP D-SNP Cohort



Data Source: Johns Hopkins ACG Patient Data
Data Reference Date: November 2024

MOC 1: Understanding Total Care Advantage D-SNP Members

Most Vulnerable Population Sub-Type	Possible Support Provided
Medical Complexity including CICM* populations: <ul style="list-style-type: none"> • Individuals At Risk for Avoidable Hospital or ED Utilization • Birth Equity 	<ul style="list-style-type: none"> • Nurse Care Manager • Pharmacist engagement • Chronic Condition Management Program • Referral to palliative care • Referral to high-risk obstetrics care management
Frailty including CICM* populations: <ul style="list-style-type: none"> • Adults Living in the Community and At Risk for LTC Institutionalization • Adult Nursing Facility Residents Transitioning to the Community 	<ul style="list-style-type: none"> • Social worker engagement • Long Term Services and Support • Referral to palliative Care • Hospice Care
Psychiatric/Behavioral Health Complexity including CICM* population: <ul style="list-style-type: none"> • Individuals with Serious Mental Health and/or SUD Needs 	<ul style="list-style-type: none"> • Intensive Behavioral Health Care Management • Collaboration with County Behavioral Health Services
Access to Care including CICM* populations: <ul style="list-style-type: none"> • Adults Living in the Community and At Risk for LTC Institutionalization • Adult Nursing Facility Residents Transitioning to the Community • Individuals in need of specialty care, community or dental care 	<ul style="list-style-type: none"> • Targeted outreach to support connection to primary care and to access preventive services • Dental Care Navigation • Closed loop referral to Medi-Cal services
High Social Need including CICM* populations: <ul style="list-style-type: none"> • Individuals Experiencing Homelessness • Individuals Transitioning from Incarceration 	<ul style="list-style-type: none"> • Social worker engagement • Long Term Services and Support • Community Supports and Referrals

*In the California D-SNP, the program of ECM-like services is called California Integrated Care Management (CICM).

MOC 1: Understanding Total Care Advantage D-SNP Members

Key Takeaways:

- Majority of likely D-SNP members are 65+
- More than half have 3+ Chronic conditions
- Most common health conditions shared in all 3 cohorts were:
 - Hypertension
 - Disorders of lipid metabolism
 - Type Two Diabetes
- Total Care Advantage D-SNP defines its Most Vulnerable enrollees as those members with complex health and social needs including members who meet California Integrated Care Management (CICM) populations criteria. Vulnerable members will be assigned a nurse care manager or social work care manager.



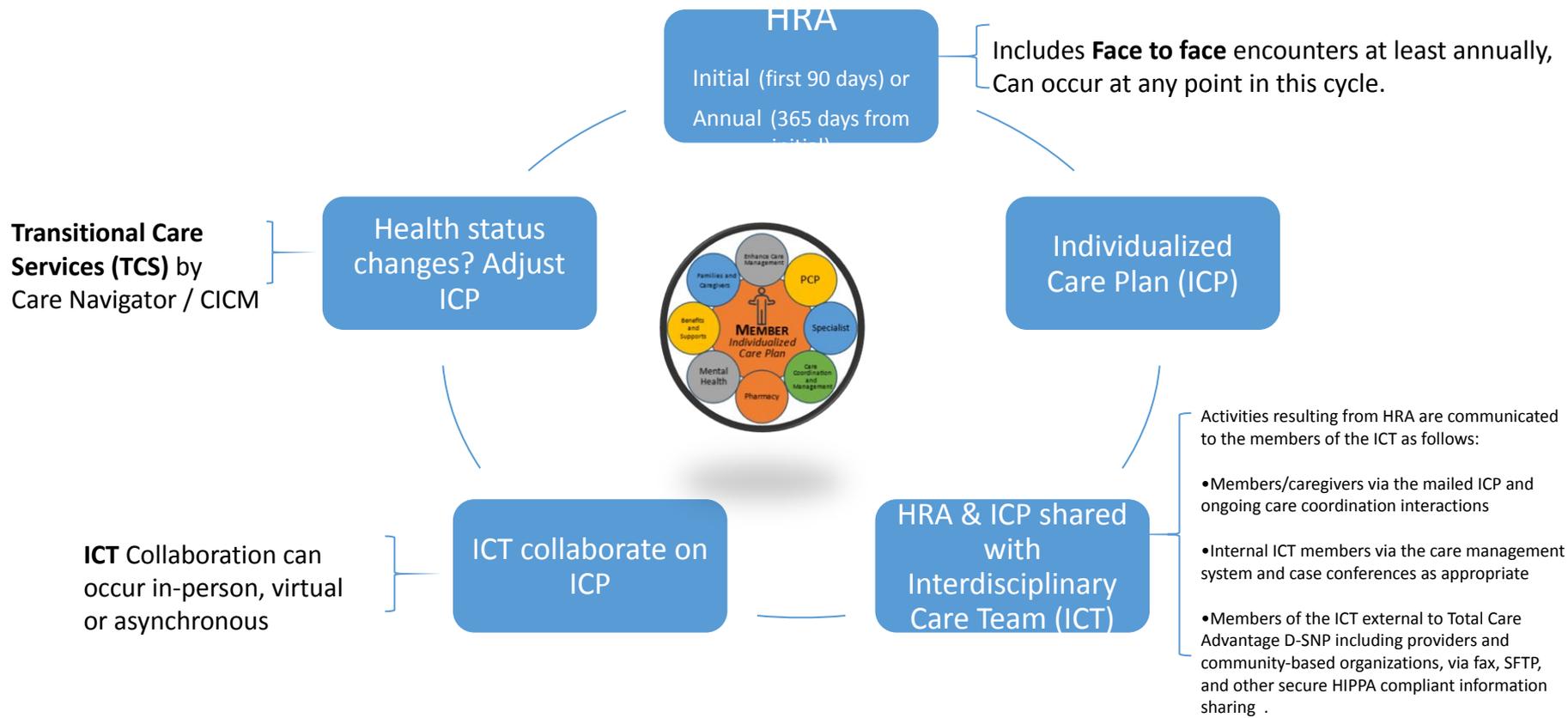
MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

Objectives:

- Understand Total Care Advantage D-SNP Care Coordination including Health Risk Assessment (HRA), Individualized Care Plan (ICP), Interdisciplinary Care Team (ICT), Face-to-Face Encounters, and Care Transitions
- Understanding of each Total Care Advantage D-SNP department's role in the Model of Care (MOC).
- Understanding of D-SNP Enhance Care Management (ECM) / California Integrated Care Management (CICM) processes
- Continuity of Care (COC) process

MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

SNP HRA, Care Plan and Interdisciplinary Care Team Cycle



MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

Health Risk Assessment (HRA)

What: The Health Risk Assessment Tool (HRAT) is an assessment of the medical, functional, cognitive, social, mental and behavioral health needs of D-SNP member.

When: Within 90 days of enrollment and at least annually thereafter. Also conducted with any changes in health status including immediately following hospitalizations.

How & Where:

- All new members are mailed a HRA within 15 days of enrollment to complete and mail back if they are able.
- Care Coordination staff also conduct a phone outreach to members to perform the HRA via telephone or make appointments for an in-person HRA

Who: Total Care Advantage Care Coordination staff, but may engage the support of other plan staff, a provider, community-based organization or third-party vendor to support in the process for members who are hard to reach



MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

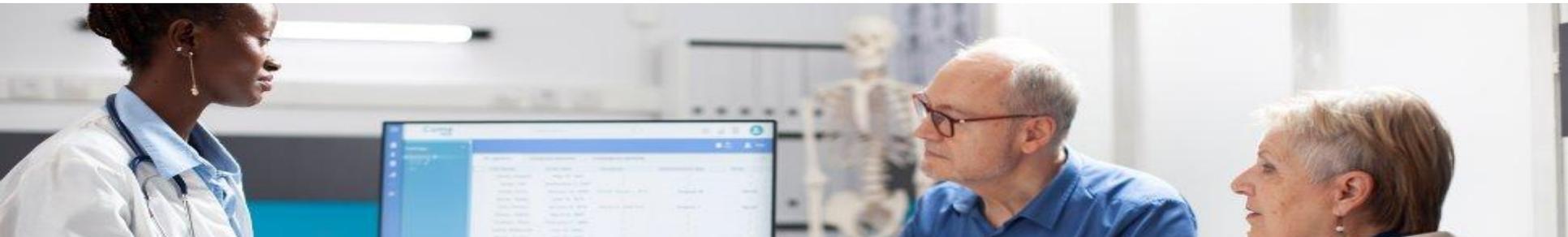
Individualized Care Plan (ICP)

What: The HRA response data is used to develop an individualized care plan (ICP) specific to the member's identified needs.

Who: Care Coordination staff reviews the results of the HRA with the member and/or caregiver and works together to develop an ICP based on needs identified.

When: Within 90 days of enrollment and at least annually thereafter. An ICP is also updated with any changes in health status including immediately following hospitalizations.

Where and How: The members ICP is created and managed in Total Care Advantage D-SNP's care management system. The ICP is sent to the member/caregiver by mail and to the PCP team, with other members of the interdisciplinary care team (ICT) as needed through mail, fax, SFTP or other mechanisms.



MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

Additional Individualized Care Plan points:

- The member's ICP includes the member's personalized goals and objectives, specific services and benefits and measurable outcomes
- Goals and objectives are prioritized by the member's preference
- Records including the ICP must be maintained per HIPAA and professional standards
- The ICP is shared with the PCP with the expectation to review, provide additional feedback if appropriate.



MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

Interdisciplinary Care Team (ICT)

What & Who: The ICT includes D-SNP Care Coordination staff, the member/caregiver, PCP team and other providers and community resources, as necessary to prioritize and coordinate care, prompt additional assessments, identify and resolve care gaps, modify the ICP and connect members with resources and treatments.

When: Following every HRA

Where & How: ICT can occur via Live/Real Time (Phone calls, in-person meetings) or Electronic/Paper (Faxes, letters, EHR, other secure electronic formats).



MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

Interdisciplinary Care Team (cont.)

- The ICP is provided in members preferred language and font size.
- All D-SNP members have an ICT
- Members enrolled in Palliative Care must use the Palliative Care ICT that includes their assigned CICM Care Manager from Total Care Advantage D-SNP.
- The member, caregiver, primary care provider (PCP) and assigned Care Navigator and or CICM Care Manager are core members of the ICT. The following are additional Possible Participants of ICT:

Possible Participant	Member Clinical or Social Need Addressed
Specialist	Complex medical need that cannot be managed by PCP team
Behavioral Health Provider	Complex mental/behavioral or substance use need
Pharmacist	Complex polypharmacy
Medical Director	Complex health system needs
Palliative Care Provider	Member on palliative care
Dementia Care Specialist	Dementia care needs and two or more co-existing conditions, or moderate to severe behavioral issues, or high utilization or live alone or lack adequate caregiver support or moderate to severe functional impairment
Doula	High risk pregnancy
Justice Involved ECM provider	Recent or current incarceration
Independent Living Center care manager	Disability related needs
Disease specific association staff	Complex disease, rare disease focused needs
MSSP Care Manager	Complex home and community-based service needs or transitioning from or to LTC setting
IHSS Social Worker	Member with complex ADL need or transitioning from or to LTC setting
CBAS Provider	Member having difficulty adjusting to adult day services
Housing organization care manager	Member experiencing homelessness
Specific cultural support organization	Members who speak indigenous languages or have cultural needs and preferences that are best supported by organizations that bridge cultural gaps

MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

Face to Face Encounters

What: D-SNP conducts face-to-face encounters with members to promote improved understanding of the member, their needs, and to develop trust with the ICT.

Who: The purpose of the encounter may vary depending on the member of the ICT conducting the encounter.

Where & How: Face-to-face encounters are conducted in-person in the member's home or in their place of preference (e.g., shelter or drop-in center for people experiencing homelessness). Member's may also opt for a virtual encounter with prior written consent.

When: These face-to-face encounters are required within the first 12 months of enrollment and at least annually thereafter.



MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

Care Transitions

What: D-SNP uses Transitional care service (TCS) protocols in partnership with our provider partners (physician organizations and hospitals) and community-based organization partners to support D-SNP members when moving from one care setting to another.

Who: Transitions of care are managed and coordinated through an assigned care navigator, nurse care manager or social work care manager depending on the needs of the member. Partner with providers including hospitals, nursing homes, physicians, discharge planners and home health providers to support seamless transition from one care setting to another.

Where: Transition of care settings may include hospitals, skilled nursing facilities, the home, home health care, rehabilitation facility, outpatient surgery centers, etc.

When: Care Transitions support is offered by their assigned Care navigator or Care manager with every inpatient admission and related transition in that episode of care. Members will be followed for at least 30 days post discharge.



MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

California Integrated Care Management (CICM)

What: In the California D-SNP, the program of Enhanced Care Management ECM-like services is called California Integrated Care Management (CICM). The Total Care Advantage D-SNP Model of Care is designed to incorporate all elements of CICM and ensures that the core CICM services are performed by staff with the appropriate training and expertise.

Who: Care coordination to support members with more complex needs is provided by a Total Care Advantage D-SNP Clinical Care manager that is a Registered Nurse, Social worker, LCSW or other licensed behavioral health professional.

Where: A combination of field/member home visits and telephonic visits

When: Home visits are conducted at a minimum annually for more frequently depending on the members needs and consent.



MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

Community Support (CS) benefits and select Supplemental benefits

What: Community Support benefits including but not limited to Housing Transition, Medically Tailored Meals/Medically Supportive meals, Personal Care and Homemaker Services and others CS benefits continue to be available to eligible members and authorized by the GCHP CalAIM team. Medicare Supplemental benefits like Readmission prevention meals and Personal Care are authorized by the members assigned Care Navigator.

Who: Total Care Advantage assigned Care Navigator coordinates with CalAIM team

When: Authorized based on member need and established benefit criteria.



Continuity of Care Process

Continuity of Care (COC)

What: New enrollees with ongoing care or services used in the past 12 months including but not limited to specialty care/treatment (ex. oncology), physician administered medications, ECM, can continue these treatments or services up to 12 months with approval to avoid disruption.

Who: Total Care Advantage sales representatives, call center staff and assigned Care Navigators submit a Continuity of Care form to the Utilization Management team for review and approval. The member's assigned care navigator or CICM care manager coordinates the COC with member and or caregiver once the approval is received.

When: The COC form is completed at the time of enrollment or immediately thereafter. The COC form asks the member and or their caregiver to list any ongoing care and services which have been used in the past 12 months, these services are reviewed at the member's effective date for necessity and approval.

MOC 2: Understanding Total Care Advantage D-SNP Care Coordination

Key Takeaways:

- Every D-SNP member is assigned a Care Navigator or CICM Care Manager depending on the member's needs.
- Health Risk Assessment (HRA) must be completed in the first 90 days of enrollment, annually and with any change in health status including a hospital
- Individualized Care Plan (ICP) is developed w/ member, patient centered and reviewed/managed w/ Interdisciplinary Care Team (ICT).
- ICT collaboration can occur through same time meetings as well as informal exchanges of information (voice mail, fax, secure email, other).
- Face to Face encounters occur at least annually w/ members care navigator/ Care Manager ideally in member's home or setting of choice. It can also occur in the form of provider visits.

Questions



Announcements and Closing

DHCS requests your feedback

This statewide PATH Collaborative survey measures:

- The impact of participation in the collaborative
- The value of partnerships across organizations
- The sustainability of our progress



CalAIM Renewal Update: DHCS Draft



Strengthen the ability of DHCS, plans, and providers to identify and intervene early to manage member risk and need through whole person care approaches that optimize member experience



Continue to move Medi-Cal to a more consistent and seamless system by further reducing complexity, strengthening accountability, and improving program efficiency



Continue to improve quality outcomes and drive delivery system transformation and innovation through value-based initiatives that allow members to receive the right care, at the right time, in the right place, at the right cost

DHCS Draft 1115 Demonstration Waiver Request Details

- **ECM:** ECM is not covered in the waiver renewal application because they are transitioning the authority to not require federal approval.
- **Community Supports:** This application confirms that 12 Community Supports will be continued as ILOS.
- **Recuperative Care and Short Term Post Hospitalization Housing:** DHCS requests to combine these two services as one continuum of offerings under Recuperative Care. DHCS plans to sunset STPHH. DHCS will transfer Recuperative Care to ILOS.
- **PATH:** The PATH initiative, including CITED, TAM, CPI, and PATH JI will sunset in December 2026.
- **Employment Supports:** DHCS seeks new authority from CMS to provide Employment Supports to assist individuals with meeting work requirements and maintaining Medicaid eligibility.
- **BridgeCare Pilots:** DHCS seeks new authority from CMS to pilot home and community based services and caregiver supports for “near duals,” or traditional Medicare beneficiaries with incomes just above the Medicaid income limits (138-220% of FPL) who require home and community supports in order to remain at home.

CalAIM Renewal: Public Comment

Open for public comment
through March 12, 2026.

Various avenues to share comments:

- 1) Public Hearings
- 2) Written Comments via Mail
- 3) Written Comments via Email
(1115Waiver@dhcs.ca.gov)



CHW Readiness Assessment Opportunity: March 6 Webinar



WEBINAR

What It Takes to Implement the California CHW Benefit: A CBO Readiness Check

Friday, March 6 at 12 PM

[Register Now](#)

With:



Join Pear Suite on March 6 at 12:00pm for a webinar hosted by the CACHW. CBO attendees will learn best practices for delivering services in California including:

- Strategies to strengthen organizational, technological, operational, and workforce readiness
- Real examples of organizations overcoming capacity barriers
- Practical approaches to support sustainability and long-term impact

[Register for the webinar today](#)

March Collaborative Meeting

Financial Planning & Sustainability Tools for CalAIM CBOs March 18, from 10:00 – 11:00 am

Please join a hands-on session offered by BluePath Health and Camden Coalition focused on financial planning and sustainability for CBOs delivering CalAIM services. Participants will explore best practices and practical tools to support their organizations at any stage of CalAIM service delivery. Coastal partners, including Monterey and San Benito, are welcome.



Join us in person in April!

Participants will:

- Foster connections with fellow providers
- Discuss development of high-quality care plans
- Connect and share best practices

Breakfast will be provided!

Santa Barbara and San Luis Obispo Stakeholders: Please join us at the

Santa Maria Inn on

Tuesday, April 14th

**Register
Here!**



Ventura Stakeholders: Please join us at
Ventura County Community Foundation on

Wednesday, April 15th

**Register
Here!**



**Thank you for joining and
see you next month!**

Questions? Please email pathinfo@bluepathhealth.com.

Appendix