Alameda CalAIM PATH Collaborative

July 24, 2026

BluePath HEALTH

DHCS | PATH
Providing Access & Transforming Health

DHCS | PATH
Providing Access & Transforming Health

Please introduce yourself in the chat!

BluePath HEALTH

Housekeeping

Please ensure you are **muted**

Use the chat to ask questions relevant to the topic(s) at hand

Unmute and share your questions or comments during **Q&A**

Add your organization to your Zoom Name

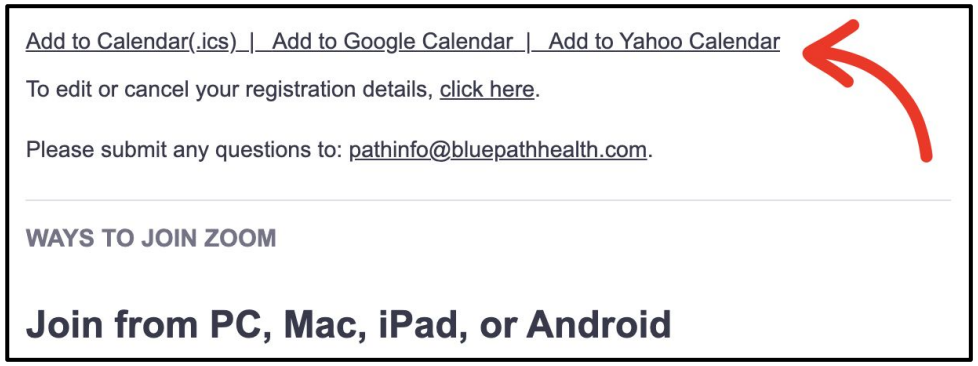
- Click **Participants**, hover over your name in the list and click **More**, select **Rename** from the drop-down menu, and enter your name and organization as you would like it to appear

Meeting slides will be shared with participants and posted to our resource center

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*

Join us in person next month!

Please join us in Oakland
on Friday, August 28th!

Our meeting focus is Preparing for Change: Understanding Medi-Cal Policy Changes!

Participants can expect to:

- Learn about relevant federal and state policy updates
- Foster connections with fellow providers
- Document provider success stories

Lunch provided!

Register Here!

Alameda 2026 Aim Statement and Drivers

By December 2026, the Collaborative will strengthen provider capacity through sustainable provider partnerships and readiness for future Medi-Cal policy changes.

1. **Transform networking into formal and informal partnerships through quarterly in-person meetings**

2. **Prepare for implementation changes through regular policy updates and summaries**

3. **Strengthen capacity through trainings and co-development of tools and resources**

Thank you for joining us in June!

- We heard a provider spotlight from **Bay Area Community Health**, highlighting their whole-person care model and sharing a success story of an ECM member achieving housing, food security, and re-engagement in care.
- We were grateful to have **the Alameda County Sheriff's Office** and **Kaiser Permanente** discuss implementation of the Justice-Involved Initiative in Alameda County.

- **Meeting Materials**
  - Meeting Slides
  - Meeting Recording
- **Additional JI Resources**
  - Alameda County Probation Center of Reentry Excellence
  - Alameda County Probation Programs and Services for AB 109 Adult Clients

Today's Agenda

Time	Agenda Item	Presenter
10:00-10:05 am	Welcome and Introductions	BluePath Health
10:05-10:15 am	Local CalAIM Success Story	Project Open Hand
10:15-10:45 am	Community Support Eligibility and Referral Best Practices	Alameda Alliance for Health
10:45-11:00 am	Announcements and Closing	BluePath Health

BluePath HEALTH

DHCS | PATH
Providing Access & Transforming Health

Local CalAIM Success Story

Will Cooke, Healthcare and Community Partnership Liaison

Meals with love!

We provide a medically tailored nutrition intervention – medically tailored meals, groceries and Medical Nutrition Therapy by a Registered Dietitian – delivered with dignity and care that considers cultural and other preferences of those living with critical and/or chronic illness.

Project Open Hand
meals with love

1) Medical Nutrition Therapy

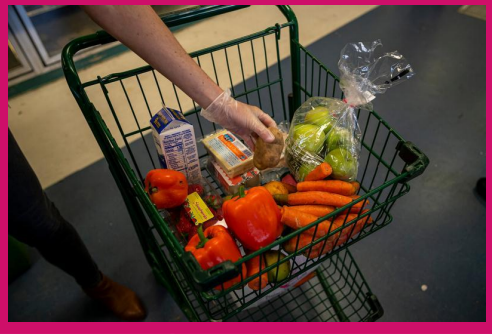
Support from a dedicated team
of Registered Dietitians (RDNs)

- Nutrition assessment when services start
- Plan to address nutrition challenges
- Follow-up counseling and assessments based on care plan
- Monthly group nutrition classes

Project Open Hand
meals with love

2) Medically-Supportive Groceries

- Each box contains food to prepare 7 meals/week.
- Adheres to nutrition standards, with RD oversight
- "No cook" option for people without kitchen access



Protein	Dairy/Alternate	Legumes	Grains	Produce
Chicken Fish Pork Eggs Tofu Tempeh Tempeh cauli patty	Milk Soymilk Yogurt Cheese	Black beans Garbanzos beans Pinto beans Kidney beans Split peas Lentils	Oatmeal Brown rice Barley Corn tortillas Whole wheat pasta Whole wheat bread	Rotating selection from area food banks

Project Open Hand
meals with love

3) Medically-Tailored Meals (MTMs)

- Menus developed by Registered Dietitian Nutritionists
- Made in-house by our culinary team in San Francisco

Tofu Stroganoff:

Vegetarian

Beef Tofu Fricassee:

Bland

Chicken Fajita Stew:

Wellness

Cod Patty & Tofu Cashew Curry:

ESRD

Pork & Bean Mole:

CKD

Project Open Hand
meals with love

Project Open Hand
meals with love

ALAMEDA Alliance FOR HEALTH

The Community Supports Program

Eligible Diagnoses

- Cancer
- Diabetes
- Hypertension
- Pre-diabetes (A1C ≥ 5.6)
- High-risk perinatal conditions
- Elevated lead levels
- High cholesterol
- HIV/AIDS
- Chronic Kidney Disease
- Liver Disease
- ESRD (dialysis)
- Fatty Liver
- COPD
- Obesity
- Congestive Heart Failure
- Coronary Artery Disease
- Asthma
- Stroke

- Nutrition-sensitive GI conditions (E.g. IBS)
- Pancreatitis
- Malnutrition

Project Open Hand
meals with love

The Community Supports Program

- Weekly (12 weeks per service period):
  - 14 meals + 1 grocery box OR
  - 7 meals + 1 grocery box OR
  - 7 meals OR
  - 14 meals OR
  - 1 grocery box
- Alameda Alliance for Health insurance required
- Re-refer every 3 months
- Up to 12 months of services

Oakland Grocery Center

1921 San Pablo Ave, Oakland

Clients can pick up once a week

- Monday, Tuesday, Thursday, Friday:
  - 10 am – 2 pm
- Wednesday:
  - Closed

OR we can deliver!

- Trailers, RVs, street corners included

Project Open Hand
meals with love

Client success story #1

(Obtained from Project Open Hand's Annual Survey, 2025)

Becky

After spending one year in a shelter and nine months in a motel, Becky moved into permanent housing. She shared that remaining at the shelter during the housing process was especially challenging and noted that many people fall out of care during this stage. Becky said "Thank you for sticking with me and for all the hands that have had a part in getting me healthy and strong again… It's been quite a long journey, and I was far from alone. Thank you ALL!"

Project Open Hand
meals with love

Client success story #2

(Obtained from Project Open Hand's Annual Survey, 2025)

Leobardo

When asked about how Project Open Hand services impacted his health, Leobardo said "I have gone through many long periods of wasting, depression, poverty, COVID, and poor health. Open Hand has saved my life. It's always there with food and concerned volunteers and a sense of community that I can count on."

Project Open Hand
meals with love

Client success story #3

(Obtained from Project Open Hand's Annual Survey, 2025)

Nick

Nick, who had recently been evicted and was living in a tent, came to the Grocery Center following a nearby incident of violence that was extremely traumatizing. He shared that he came because he needed to feel safe, and that Project Open Hand's Grocery Center is the only place where he consistently feels welcomed and secure. He expressed profound gratitude for the support and care he experiences from the staff and volunteers at Project Open Hand.

Project Open Hand
meals with love

Contact us!

Project Open Hand

meals with love

Will Cooke (he/him)

Healthcare and Community Partnership Liaison

730 Polk St. | San Francisco, CA 94109

wcooke@openhand.org

415.991.2540

Client Services

1921 San Pablo Ave. | Oakland, CA 94612

clientservices@openhand.org

510.622.0221

BluePath HEALTH

DHCS | PATH
Providing Access & Transforming Health

Community Support Eligibility and Referral Best Practices

Allison Lam, Executive Director, Health Care Services

ALAMEDA Alliance FOR HEALTH

30 Years OF CARE & IMPACT

Community Supports Referrals & Authorizations

Allison Lam, Executive Director, Health Care Services

07.24.2026

Community Supports Team Members

Leadership

- Dr. Daphne Lo – Medical Director, Long Term Services and Supports
- Allison Lam – Executive Director, Health Care Services
- Corinne Casey-Jones – Manager, Community Supports
- Oscar Macias – Housing Program Manager
- Susan Baca – Community Supports Supervisor

Team Members

- Nurse Reviewers
- Specialists
- Coordinators

Our Mission

Improving the **health and well-being** of our members by **collaborating with our provider and community partners** to deliver **high quality and accessible** services.

Community Supports

Volume 1:

- Respite Services (Caregiver Respite)
- Assisted Living Facility (ALF) Transitions
- Community or Home Transition Services
- Personal Care & Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Tailored Meals (MTM)/Medically Supportive Food (MSF)
- Asthma Remediation

Volume 2:

- Housing Transition Navigation Services
- Housing Tenancy and Sustaining Services
- Housing Deposits
- Recuperative Care (Medical Respite)
- Transitional Rent

The Alliance does not offer:

- *Sobering Centers*
- *Day Habilitation*
- *Short-Term Post-Hospitalization Housing*

Why Referral Criteria? Why Authorizations?

Shared goal across healthcare systems

"right care, right time, right place"

source: https://www.ihi.org/library/topics/quintuple-aim

Why Referral Criteria? Why Authorizations?

❖ **Quintuple Aim**:

- **Improving Experience of Care** – improving quality, safety, and trust
- **Improving Population Health** – health outcomes of groups & communities
- **Lowering Per Capita Cost** – decrease overall healthcare delivery cost/person without compromising quality
- **Improving Workforce Well-Being** – addressing burnout and workplace sustainability
- **Advancing Health Equity** – everyone has opportunity to achieve their highest level of health

source: https://www.ihi.org/library/topics/quintuple-aim

Why Documentation?

❖ **Timely, accurate, & comprehensive documentation helps us all:**

- Understand individuals' **journey throughout their many touchpoints** within our healthcare delivery system
- Understand individuals' **holistic health status** (including physical, mental, social health) and their **existing support systems**
- Determine **personalized, appropriate** and **coordinated supports** across systems
- Reduce **duplication, workforce burnout, and wasted resources** across systems

Quintuple Aim!!!

How to Get Services?

- **Referral Criteria listed on form** *(aligned with DHCS Policy Guide)*
- **Referrals for Housing Community Supports** ***(including Transitional Rent)***

REFERRAL PROCESS

Referral Form Received by Alliance

Referral sent to contracted CS Provider

CS Provider determines ability to accept referral

AUTHORIZATION PROCESS

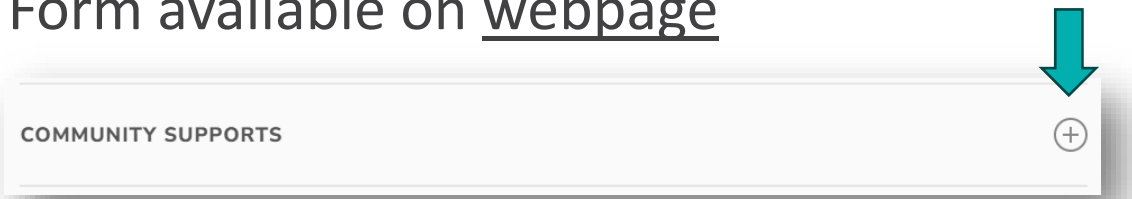
CS Provider submits Auth Request to Alliance (if meets Alliance criteria)

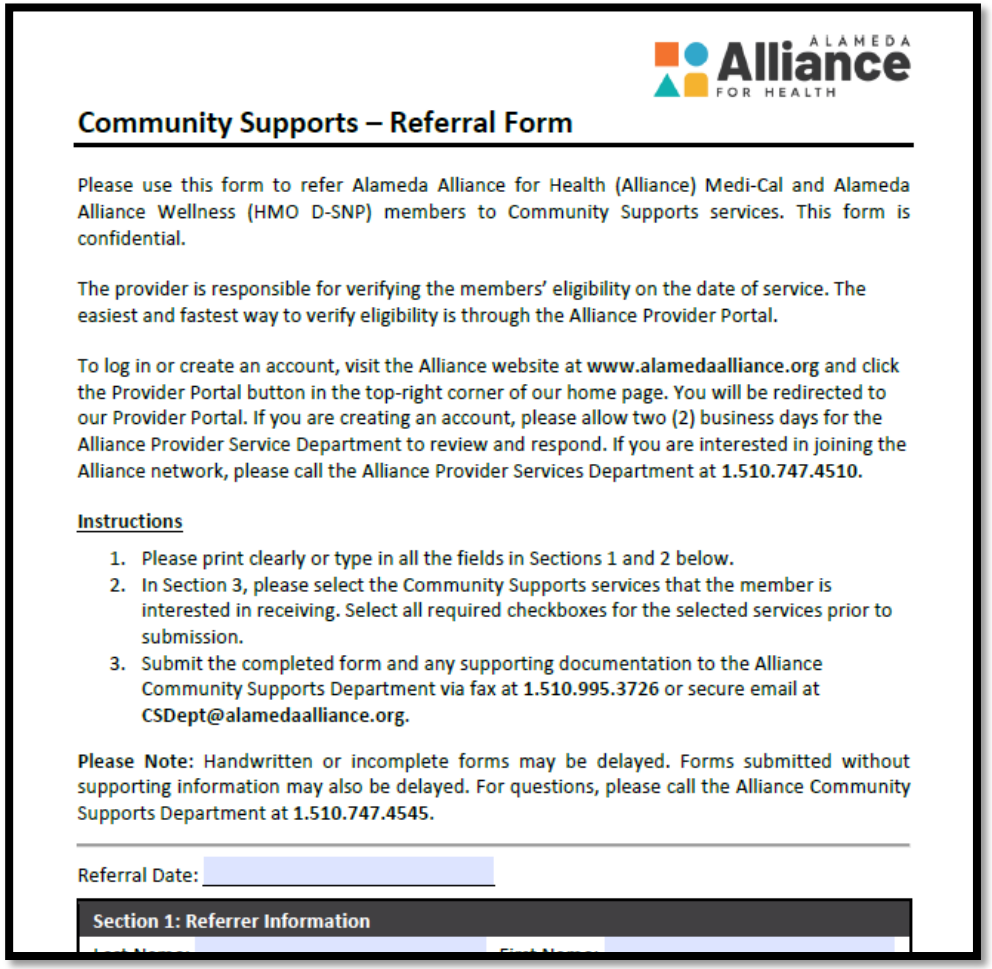
Alliance reviews Auth Request to confirm the request meets criteria

Referral Form – Walk Through

❖ New Referral Form (updated 06/2026)

- Submitted by any provider who identifies a member who **may be** appropriate for a Community Support
- Member self-referrals are accepted, and will need coordination with their treating providers to provide appropriate documentation
- Form available on webpage





Community Supports – Referral Form

Please use this form to refer Alameda Alliance for Health (Alliance) Medi-Cal and Alameda Alliance Wellness (HMO D-SNP) members to Community Supports services. This form is confidential.

The provider is responsible for verifying the members' eligibility on the date of service. The easiest and fastest way to verify eligibility is through the Alliance Provider Portal.

To log in or create an account, visit the Alliance website at **www.alamedaalliance.org** and click the Provider Portal button in the top-right corner of our home page. You will be redirected to our Provider Portal. If you are creating an account, please allow two (2) business days for the Alliance Provider Service Department to review and respond. If you are interested in joining the Alliance network, please call the Alliance Provider Services Department at **1.510.747.4510.**

Instructions

1. Please print clearly or type in all the fields in Sections 1 and 2 below.
2. In Section 3, please select the Community Supports services that the member is interested in receiving. Select all required checkboxes for the selected services prior to submission.
3. Submit the completed form and any supporting documentation to the Alliance Community Supports Department via fax at **1.510.995.3726** or secure email at **CSDept@alamedaalliance.org.**

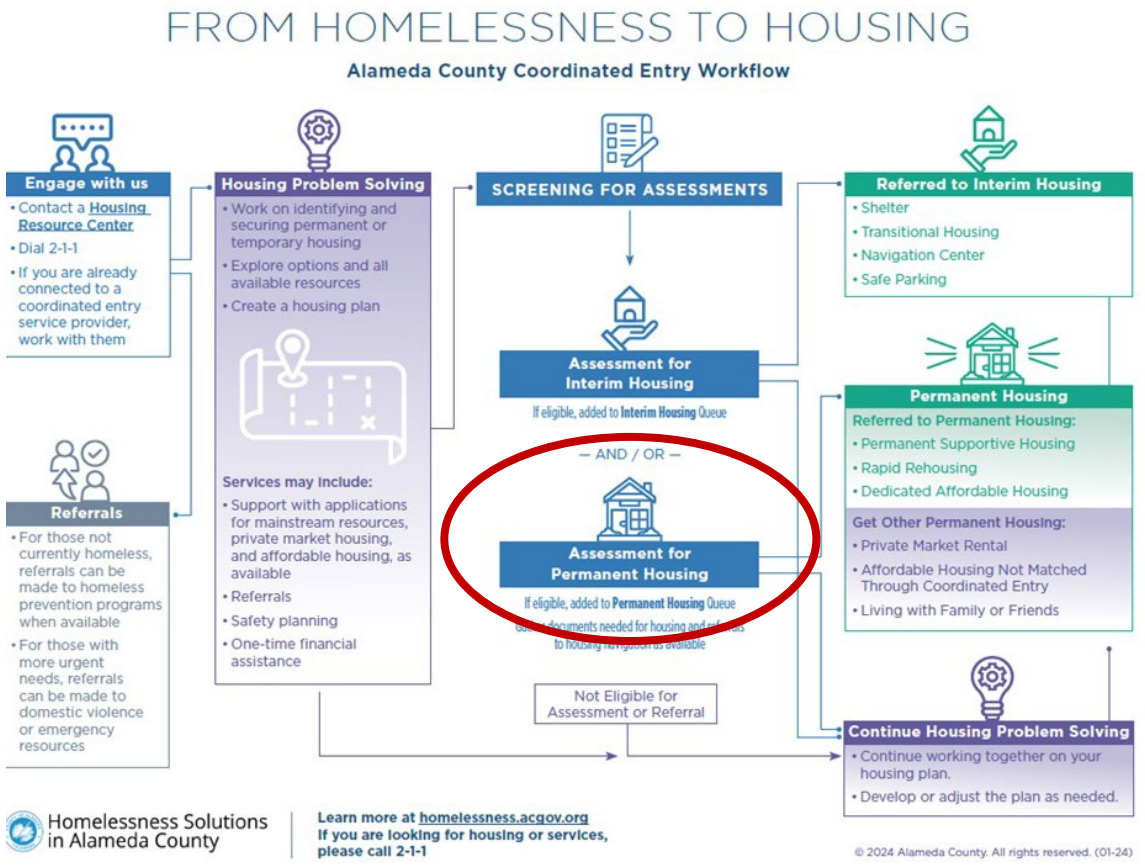
Please Note: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed. For questions, please call the Alliance Community Supports Department at **1.510.747.4545.**

Referral Date: _____

Section 1: Referrer Information

Coordinated Entry Workflow (for Housing CS)

- It serves as a single, countywide process for accessing homelessness services and housing
- Alameda County's CE creates one "front door" and uses shared data in HMIS to match people to the most appropriate and available resource in an equitable and consistent manner



How to Get Services?

- **Referral Criteria listed on form** *(aligned with DHCS Policy Guide)*
- **Referrals for Housing Community Supports** ***(including Transitional Rent)***

REFERRAL PROCESS

AUTHORIZATION PROCESS

Referral Form Received by Alliance

Referral sent to contracted CS Provider

CS Provider determines ability to accept referral

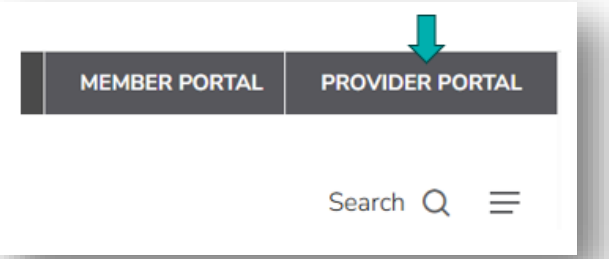
CS Provider submits Auth Request to Alliance (if meets Alliance criteria)

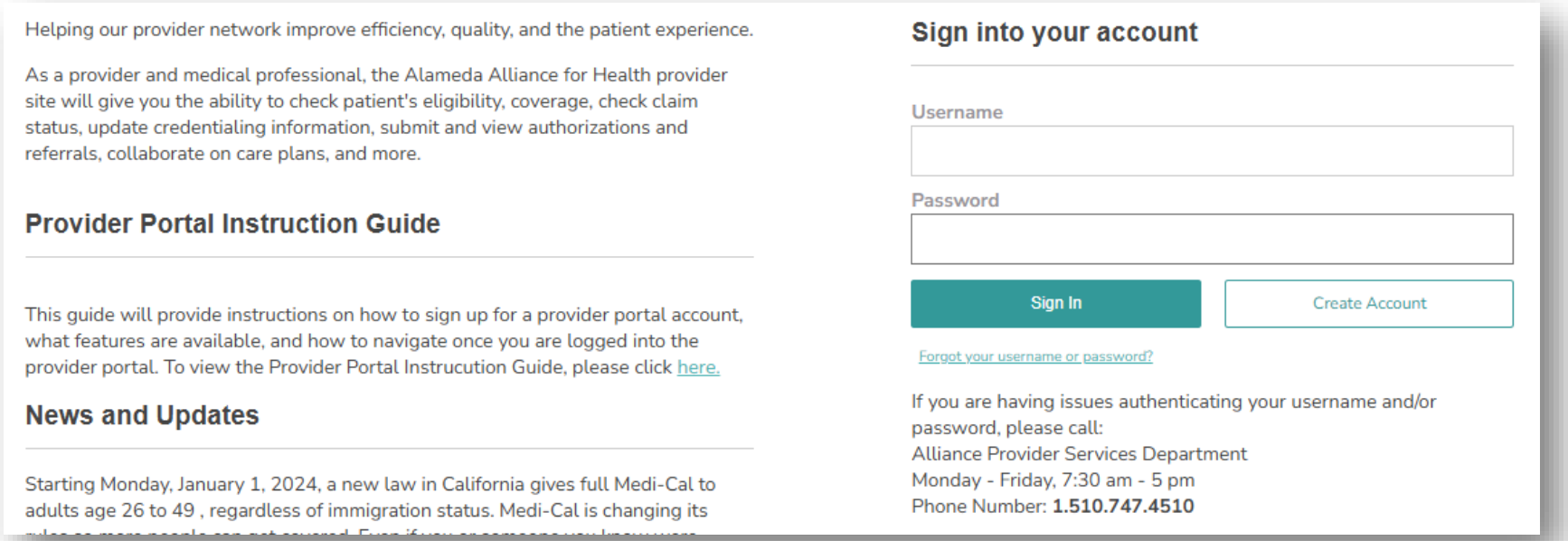
Alliance reviews Auth Request to confirm the request meets criteria

Authorization Request Submission

❖ Authorization Form

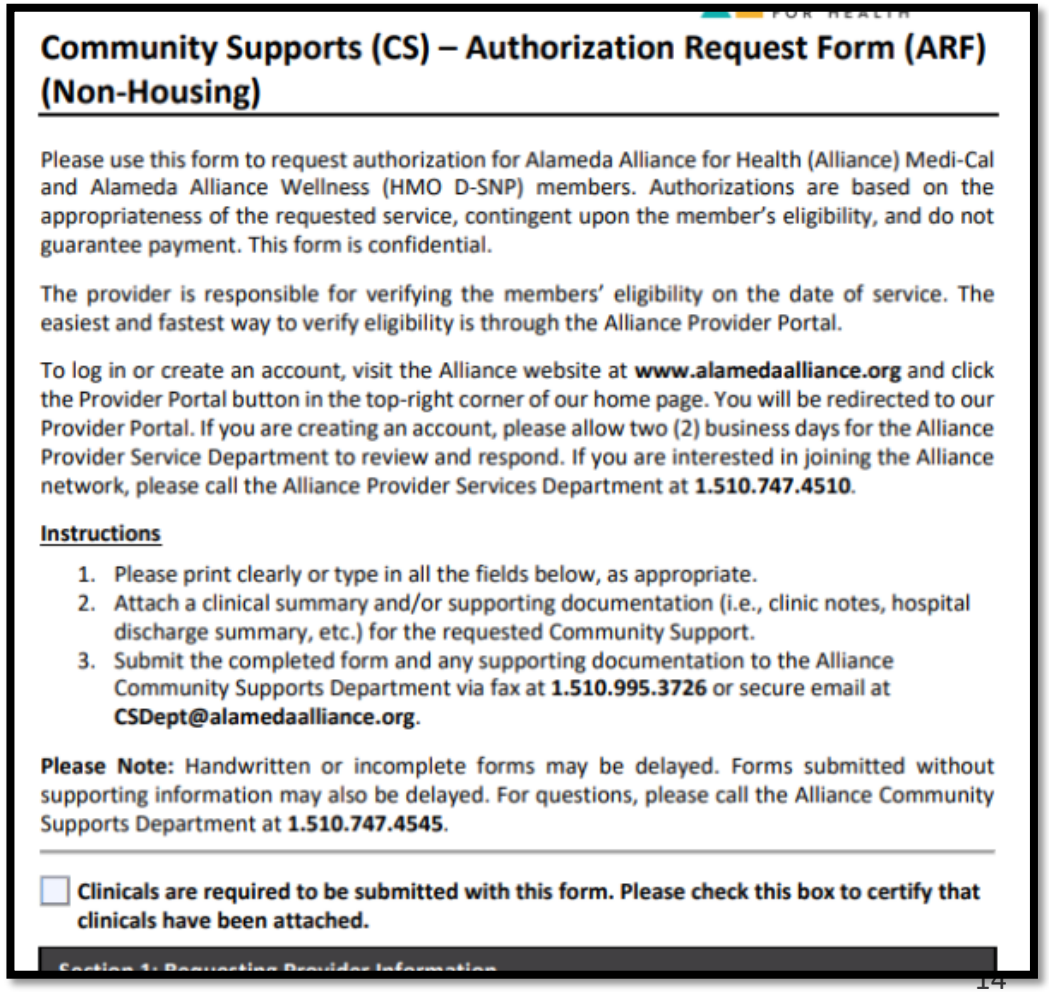
- Provider Portal *(direct link),* or
- Access from Alliance website: https://alamedaalliance.org/
- Must create an account





Authorization Form – Walk-Through

- **Non-Housing Community Supports**
  - Code & Modifier combinations *(always refer to contract)*
  - Turn-around times
- **Supporting Documentation**
- **Rubric pending** *(includes guidance for documentation requirements to assist with authorization submission)*



Community Supports (CS) – Authorization Request Form (ARF) (Non-Housing)

Please use this form to request authorization for Alameda Alliance for Health (Alliance) Medi-Cal and Alameda Alliance Wellness (HMO D-SNP) members. Authorizations are based on the appropriateness of the requested service, contingent upon the member's eligibility, and do not guarantee payment. This form is confidential.

The provider is responsible for verifying the members' eligibility on the date of service. The easiest and fastest way to verify eligibility is through the Alliance Provider Portal.

To log in or create an account, visit the Alliance website at **www.alamedaalliance.org** and click the Provider Portal button in the top-right corner of our home page. You will be redirected to our Provider Portal. If you are creating an account, please allow two (2) business days for the Alliance Provider Service Department to review and respond. If you are interested in joining the Alliance network, please call the Alliance Provider Services Department at **1.510.747.4510**.

Instructions

1. Please print clearly or type in all the fields below, as appropriate.
2. Attach a clinical summary and/or supporting documentation (i.e., clinic notes, hospital discharge summary, etc.) for the requested Community Support.
3. Submit the completed form and any supporting documentation to the Alliance Community Supports Department via fax at **1.510.995.3726** or secure email at **CSDept@alamedaalliance.org**.

Please Note: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed. For questions, please call the Alliance Community Supports Department at **1.510.747.4545**.

☐ **Clinicals are required to be submitted with this form. Please check this box to certify that clinicals have been attached.**

Supporting Documentation

- Examples
- Best Practices

Medically Tailored Meals/Medically Supportive Food

Medical History

Past Medical History

H/O stroke with right hemiplegia (per Healow)

Vitals

Name	Date	Value
BP	05/02/2025	135/86
Ht	05/02/2025	68
Wt	05/02/2025	202
BMI	05/02/2025	30.71

When did the stroke occur?
What is the plan of care?
How will the MTM/MSF support the plan of care?
Who's overseeing the plan of care?

Medically Tailored Meals/Medically Supportive Food

Diabetic Medical Nutrition Therapy Initial Note

Start Time: 1045, Stop Time: 1130
Visit completed:1 Allowed hours: as medically needed
Diet from Referral: CHO Consistent, low cholesterol

Assessment

Active Problem List
Patient Active Problem List
Diagnosis
•ASCUS with positive high risk HPV cervical
•Type 2 diabetes mellitus with other specified complication, without long-term current use of insulin (HCC)
•Mixed hyperlipidemia
•Current occasional smoker

PMH	
Past Medical History:	
Diagnosis	Date
•Diabetes mellitus (HCC)	
•Hypertriglyceridemia	
•Infertility, female	
•Irregular menses	
•Non-scarring alopecia	

Medications
atorvastatin (LIPITOR) 40 MG tablet
BIOTIN ORAL
cholecalciferol, vitamin D3, 1,250 mcg (50,000 unit) Tab
empagliflozin (JARDIANCE) 25 mg Tab tablet
metFORMIN (GLUCOPHAGE) 500 MG tablet

Monitoring
- Do you test your blood sugar?: Yes
- If yes, what meter do you use?: manual
- How often do you test?: 1-2 times a day
- What time(s) of the day?: fasting (1-2 hours after meals)
- Symptons of Hyperglycemia: (no symptoms)

Anthropometrics
- Height: 144.8 cm
- Weight: 45 kg
- BMI (Calculated): 21.5

Exercise
- **Have you been advised to limit exercise?: No
- Do you exercise on a regular basis (frequency and type in comment)?: (walking during work shifts (about 24 hrs/week); outside of walks 5x/week for 30-60 min each time)

Nutrition
- **Who cooks?: pt
- **Who shops?: pt/son
- **How often do you eat out and where?: sometimes salad at work (works at italian restaurant); dining out now only 1-2x/week
- What changes have you made in your diet recently, if any?: more mindful of her intake, prior would eat what she wants. staying away from starches and sugary foods. less pork and beef, more chicken.
- **List any food allergies or intolerances:: NKFA
- How would you describe your appetite : (less recently, now 1-2 meals/day. maybe r/t stress.)

Diet
- What food do you usually eat for breakfast?: never has been a breakfast person, even before diabetes
- What food do you usually eat for lunch?: 3p: lot of steamed broccoli and salad + grilled chicken/seafood; lettuce wraps; stir fry veggies with protein. very limited intake of starch, had potatoes last night but that isn't common.
- What food do you usually eat for dinner?: 6-7p: similar to lunch
- What food do you usually eat for a snack?: 2 hours after dinner: plain popcorn she makes on her own or movie theatre style. veggies with hummus. unsalted nuts.
- What beverages do you usually drink?: diet soda, used to have up to 6 cans a day. trying to intake more water now.

Comparative Standards
- Kcal Recommendations: 1500 kcals, Recommended protein intake : 75 gram protein /day
- Method for estimating calories: (MSJ using AF 1.5), (20% of kcal intake)

Nutrition Diagnosis
PES statement
Behavioral Problem: Food and nutrition related knowledge deficit
Related to: Lack of prior exposure to accurate nutrition-related information
As evidenced by: Patient report and diet history
Problem evaluation: New

Intervention
Food/Nutrient
- Kcal Recommendations: 1500 kcals
- Recommended protein intake : 75 gram protein /day (20% of kcal intake)

Caregiver Respite

"Please see the attached referral form for member [redacted]
This member is being referred for Respite Care services. If approved, please refer this member to [redacted]
Please let me know if you have any questions or if any additional information is needed.

Detailed summary: [redacted] primary caregiver, and watches over her above and beyond IHSS. She would like a break on Sundays to go to church and run her errands.

Respite schedule: Once a week for 8 hours per shift.

How many hours has IHSS approved for the primary caregiver?
Has an IHSS reassessment been requested?
Who is providing the respite service and for how many weeks?

Caregiver Respite

Patient Name: [redacted]
DOB: [redacted]
Medical Record Number: [redacted]
Date of Admission: 2025-08-01
Date of Discharge: 2025-08-11
Discharging Facility: [redacted]
Attending Physician: [redacted]

Reason for Admission
The patient was admitted due to increased confusion, agitation, and wandering behaviors associated with moderate-stage Alzheimer?s disease. The caregiver reported difficulty managing behavioral symptoms and concerns for safety at home.

Hospital Course
During the stay, the patient was stabilized with adjustments to medication for mood and sleep disturbances. Occupational therapy and nursing staff provided support with ADLs and safety monitoring. No acute medical issues were identified during the admission. The patient responded well to a structured environment and consistent routine.

Discharge Condition
The patient is medically stable but continues to require supervision and assistance with daily activities. Cognitive impairment remains significant, with poor short-term memory and disorientation to time and place.

Discharge Plan
Disposition: Discharged to home with primary caregiver (spouse).
Services Ordered:
- Home health nursing for medication management.
- Respite care services: 15 hours/week for 2 months to support caregiver.
- Follow-up with primary care and neurology within 2 weeks.
- Referral to adult day health program for cognitive stimulation and social engagement.

Medications at Discharge
- Donepezil 10 mg daily
- Memantine 10 mg twice daily
- Trazodone 50 mg at bedtime as needed for sleep
- Lisinopril 10 mg daily

Caregiver Instructions
- Maintain a consistent daily routine.
- Use safety measures (e.g., door alarms, ID bracelet).
- Monitor for changes in behavior or mood.
- Contact provider if symptoms worsen or caregiver stress increases.

Sample Clinical Documentation for Caregiver Respite Referral

Patient Name: [Insert Name]
DOB: [Insert DOB]
Diagnosis: Alzheimer's Disease (Moderate Stage), Osteoarthritis, Hypertension
Provider: [Insert Provider Name, Title, and License Number]
Date: [Insert Date]

Clinical Summary:
The patient is a 76-year-old individual with moderate-stage Alzheimer's disease, resulting in significant cognitive decline, memory loss, and disorientation. They require assistance with most activities of daily living, including toileting, dressing, meal preparation, and medication management. The patient is prone to wandering and has experienced multiple episodes of confusion and agitation.

Caregiver Situation:
The patient is cared for at home by their spouse, who is 74 years old and managing their own chronic health conditions. The caregiver reports increasing stress, fatigue, and difficulty maintaining their own medical appointments and basic self-care. There is no additional family or paid support available.

Clinical Justification for Respite Services:
Due to the patient's high level of dependency and behavioral symptoms, continuous supervision is required. The caregiver's declining physical and emotional health places both the patient and caregiver at risk. Without access to respite services, the caregiver may be unable to continue providing care at home, which would likely result in the patient's placement in a long-term care facility.

Recommendation:
Respite services are medically necessary to support the caregiver's ability to maintain the patient safely at home. I recommend **15 hours per week of respite care for a duration of 2 months** to allow the caregiver time for rest, recovery, and attending to personal health needs. This support is essential to prevent caregiver burnout and avoid premature institutionalization of the patient.

Primary Caregiver: Martha Mae, Spouse of member

Respite Caregiver: Billy Bob, nephew of the member

Applied for IHSS and are awaiting an assessment date to hire an additional caregiver to assist and avoid future burnout.

Member referred to CBAS to allow for daytime relief to primary caregiver and decrease risk for institutionalization.

Referral sent to AAH for CM resources and Transition to ALF.

Quality Assurance

Oversight and Monitoring procedures enable:

- Alignment and Achievement of Shared Goals across systems
- Quality, Safety, and Continuous Improvement
- Person-Centered Care
- Measurable Outcomes *(translate action to value)*

source: https://www.ihi.org/library/topics/quintuple-aim

Thank you.

Questions?

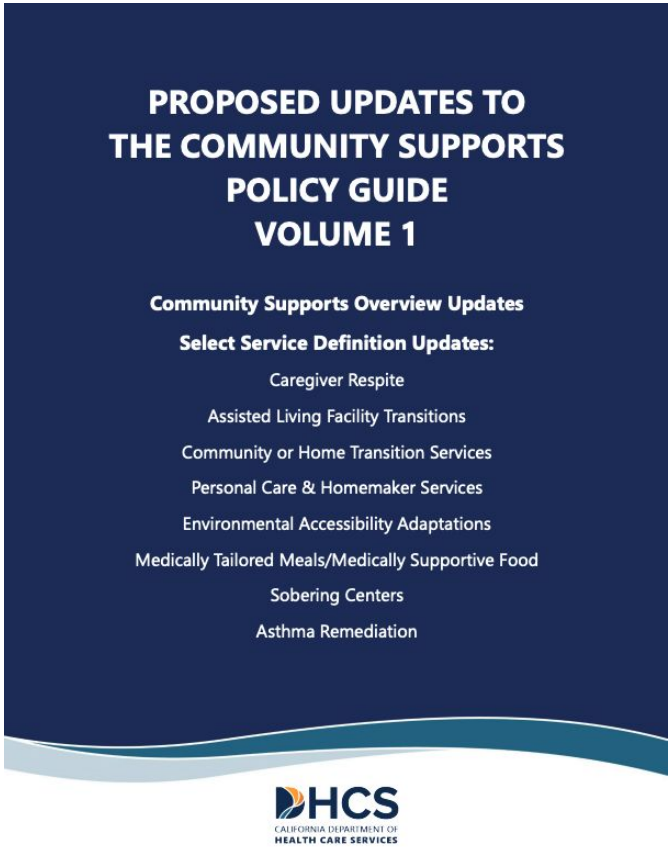
You can contact me at:
Allison Lam
allam@alamedaalliance.org

BluePath HEALTH

DHCS | PATH
Providing Access & Transforming Health

Public Comment Open: Community Supports Policy Guides

Proposed Updates To The Community Supports Policy Guide Volume 1

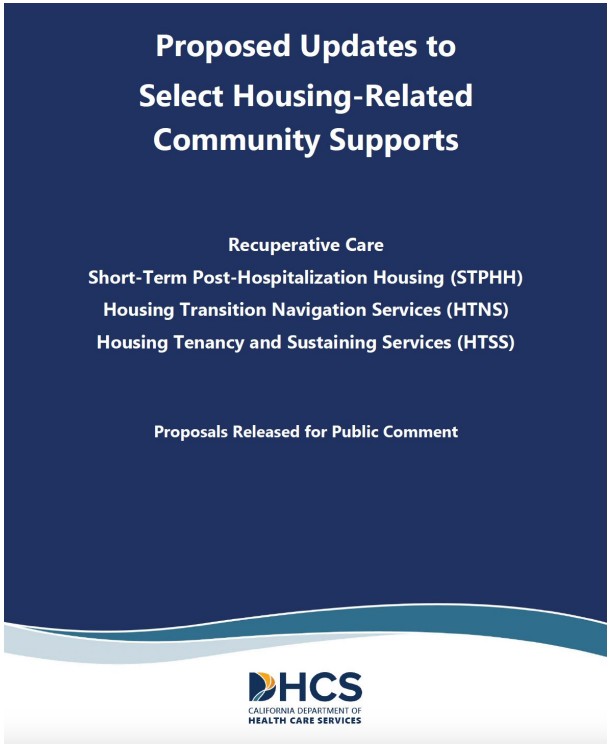


Updates include:

- Provider screening and credentialing requirements
- Eligibility criteria adjustments for certain Community Supports, including Medically Tailored Meals/Medically Supportive Food
- Service time-limits
- Documentation and referral pathway requirements

Proposed Updates to the Community Supports Policy Guide Volume 1

Proposed Updates to Select Housing-Related Community Supports



Updates include:

- Transition of Recuperative Care to In Lieu of Services (ILOS) authority and sunset of Short-Term Post-Hospitalization Housing
- Six-month authorization periods and formalized graduation/discontinuation criteria for Housing Transition Navigation and Housing Tenancy and Sustaining Services
- Updated payment practice recommendations for provision of these housing services

Proposed Updates to Select Housing-Related Community Supports

Public Comment Opportunity

On July 20, DHCS released proposed updates to the Community Supports Policy Guide and requests your feedback.

- Proposed updates to Community Supports Policy Guide: Volume 1 (a summary of proposed changes can be found here)
- Proposed housing-related updates in Community Supports Housing-Related Updates

Submit comments by Friday, July 31.

How to submit your feedback:

Please submit comments directly to DHCS at **CommunitySupports@dhcs.ca.gov**. Please use one of the following subject lines according to the focus of your feedback:

- *"Feedback on the Community Supports Policy Guide: Volume 1 Updates"*
- *"Feedback on the Community Supports Housing-Related Updates"*

BluePath HEALTH

DHCS | PATH
Providing Access & Transforming Health

Announcements and Closing

California Rural Health Transformation (CalRHT)

CalRHT Grant Funding Now Open: Accelerator Partners, EHR Modernization, and Rural Workforce Capacity

The **California Rural Health Transformation (CalRHT) Program** is a $233.6 million CMS-funded initiative to strengthen rural healthcare through care model transformation, workforce development, and technology upgrades.

HCAI has released **grant materials** for three open opportunities:

- **Accelerator Partner Program:** Support for regional care collaboratives for primary and maternity care
- **Expand and Support Rural Workforce Capacity Grant:** The Family Medicine Obstetrics (FM-OB) Fellowship Subaward Program to build rural obstetric workforce capacity through GME sponsoring institutions
- **EHR Modernization Grants:** Funding for EHR adoption or replacement at rural facilities

Join HCAI for the **EHR Modernization Grant Funding Webinar** on Monday, July 27 at 12:30pm.

Coverage Ambassador Webinar

Get and Keep Your Community Covered

Thursday, July 30, 2026
11 a.m. to 12 p.m PDT
Advance registration required

The webinar will:

- Provide an overview of the DHCS Coverage Ambassador Program, which supports Medi-Cal members in maintaining coverage and connecting to available services and resources
- Review the Unsatisfactory Immigration Status (UIS) Managed Care to Fee-for-Service transition

BluePath HEALTH

DHCS | PATH
Providing Access & Transforming Health

End-of-Meeting Poll

BluePath HEALTH

Join us in person next month!

Please join us in Oakland
on Friday, August 28th!

Our meeting focus is Preparing for Change: Understanding Medi-Cal Policy Changes!

Participants can expect to:

- Learn about relevant federal and state policy updates
- Foster connections with fellow providers
- Document provider success stories

Lunch provided!

Register Here!

BluePath HEALTH

DHCS | PATH
Providing Access & Transforming Health

Thank you for joining and see you at our in-person meeting on August 28 focused on *Preparing for Change: Understanding Medi-Cal Policy Changes*!

Questions? Please email pathinfo@bluepathhealth.com.

BluePath HEALTH