Alameda CalAIM PATH Collaborative Success Stories

BAY AREA COMMUNITY HEALTH

BACS
Bay Area Community Services

FredFinch
Youth & Family Services

ALAMEDA COUNTY RECIPE4HEALTH

NATIVE AMERICAN HEALTH CENTER
Serving the community since 1972
a california health+ center

The Alameda CalAIM PATH Collaborative is facilitated by BluePath Health as part of the California Department of Health Care Services (DHCS) Providing Access and Transforming Health Initiative (PATH)

BluePath HEALTH

Developed by the Alameda CalAIM PATH Collaborative

What is the Alameda CalAIM PATH Collaborative?

The Alameda CalAIM PATH Collaborative, funded by the California Department of Health Care Services (DHCS), brings together Medi-Cal managed care plans, local hospitals and clinics, community-based organizations, county agencies, and their referral partners to support implementation of CalAIM services, including Enhanced Care Management and Community Supports. Enhanced Care Management is a person-centered Medi-Cal benefit that provides comprehensive care coordination for individuals with complex medical and social needs by connecting them with healthcare, behavioral health, and community-based services. Community Supports are optional Medi-Cal services that address health-related social needs, such as housing, nutrition, and recuperative care, to improve health outcomes and reduce unnecessary healthcare utilization.

Where Do These Success Stories Come From?

The stories featured in this project come directly from local ECM and Community Supports providers in Alameda County. They were shared by case managers, housing navigators, community health workers, and administrators who participate in the Alameda CalAIM PATH Collaborative. These narratives capture the experiences of individuals receiving care and highlight the collaborative efforts of providers working across healthcare, housing, and social services to improve outcomes. Names have been anonymized or replaced by initials by the organizations that shared these stories.

Why Do These Stories Matter?

The Success Stories Project showcases the real-world impact of CalAIM by documenting firsthand accounts from community based organizations, county agencies, and healthcare providers. These stories demonstrate how targeted funding, coordinated care, and cross-sector collaboration translate into meaningful improvements in health, housing stability, and quality of life. They illustrate how system-level investments create lasting change for individuals, families, and communities.

CalAIM Success Stories

BluePath HEALTH

Restoring Health Through Food

After losing her job and experiencing homelessness, Tammy was facing several health challenges. Feeling overwhelmed and seeking support, she was referred to the **Recipe4Health Food as Medicine** program by her physician.

Through nutrition education, group visits, and coaching, Tammy received guidance on healthy eating while connecting to behavioral health resources, including a therapist and treatment for post-traumatic stress disorder.

Reflecting on her experience, she shared, **"The first class gave me hope. It literally saved my life. It gave me my spark back."**

Today, Tammy has lost weight and her blood pressure is within a healthy range. She fell so in love with the community and the program that the team invited her to become a peer leader, and now she inspires others on their health journeys.

Exceptional Care Leads to a New Home

This individual was doubled up on a relative's couch while working toward securing an apartment of her own. She was living on a tight budget and found it very difficult to navigate housing and benefits programs alone.

An **ECM manager at Bay Area Community Health** stepped in and immediately performed a whole-person needs assessment and developed a care plan. Her care manager connected her with a primary care physician, housing applications, and CalFresh, while also providing food bank resources and appointment reminders.

Thanks to this support, **the client achieved food security, became actively engaged in her healthcare, and is finishing school. Recently, the client was approved for a housing program and moved into her first apartment.**

Reflecting on the journey, the client shared, **"For the first time, I have my own keys. My case manager didn't just hand me a list—she walked it with me until something actually worked."**

BAY AREA COMMUNITY HEALTH

CalAIM Success Stories

BluePath HEALTH

NATIVE AMERICAN HEALTH CENTER
Serving the community since 1972
a californiahealth+ center

Coordinated Support Strengthens Recovery

Before enrolling in **Native American Health Center's ECM program,** this individual faced significant barriers to navigating the healthcare system. With unmanaged conditions, they struggled to stay consistent with medical and behavioral health appointments and had frequent emergency department visits.

Upon ECM enrollment, a care coordinator worked closely with the member, primary care provider, and social worker to create a coordinated plan of care. The team supported medication management for alcohol use disorder, connected the member with specialists, and provided transportation to appointments.

Now, this individual is **engaging successfully with medication management, regularly attending visits with their primary care provider and therapist, utilizing transportation support to attend appointments, and picking up and taking their medications consistently.**

Accessible Transportation Restores Independence

Limited mobility made it difficult for this member to leave her home, attend medical appointments, and take her son to school. Further, complex transportation systems and proper mobility equipment impacted her ability to live independently.

Native American Health Center's ECM team coordinated wheelchair-accessible transportation that met her needs and helped her obtain a motorized scooter. By removing these barriers, she had reliable transportation and the mobility support necessary to access healthcare and her community.

Now, she can travel independently, attend medical appointments for both herself and her son, and take her son to school. With the right support, she has regained independence and an improved quality of life.

BACS
Bay Area Community Services

Achieving Stability and Employment

This individual was living with schizoaffective disorder, substance use disorder, and frequent homelessness when he enrolled in **Bay Area Community Services' LIFT program,** an FSP that provides support for people with behavioral health needs. This individual came into LIFT with clear goals to maintain sobriety, secure stable housing, and find employment.

Bay Area Community Services provided case management, mental health services, support groups, and connections to residential treatment programs. Although his recovery included periods of relapse, housing instability, and incarceration, the team remained engaged, providing consistent support as he worked toward his goals.

Today, this individual has been sober for 16 months, is employed as a security guard, and has been promoted to assistant supervisor at his sober living environment.

A Second Chance at Recovery

When this individual first connected with **Bay Area Community Services,** he was struggling with substance use disorder, schizoaffective disorder, bipolar disorder, and chronic homelessness. He was discharged from the program due to non-engagement and inability of the treatment team to successfully outreach, but he came back two years later ready to begin his recovery journey.

Bay Area Community Services provided support through psychiatric care, residential services at his sober living environment, Individual Placement and Support employment services, and case management. With consistent care, he remained engaged in treatment and built a strong foundation for long-term recovery.

Today, he has been sober for more than two years, continues to maintain stable housing, is taking classes at Chabot College, and has not experienced a single arrest or hospitalization since re-engaging in services.

Supporting a Child Through Care

As a single mother, Elena was struggling with the emotional toll of caring for her 6-year-old son alone, whose Hirschsprung's disease and autism led to frequent hospitalizations. His medical needs made it difficult for Elena to maintain employment, causing her to lose her income and placing the family at risk of homelessness. They also lost reliable transportation and experienced food insecurity.

After her son enrolled in Fred Finch's ECM program, their family was connected to therapy, support groups, In-Home Supportive Services, food assistance, and transportation resources. Their care manager provided consistent encouragement and even personally delivered food during times of urgent need.

Thanks to this support, Elena and her son are safely housed, stable, and thriving. They are deeply grateful to Fred Finch and are passionate about expanding awareness of Enhanced Care Management and ensuring it is accessible to every family who needs it.