LESSONS FROM THE FIELD: DELIVERING ECM FOR CCS POPULATIONS

About this Resource

California Children's Services (CCS) Whole Child Model (WCM)[1] is a critical program for over 180,000 children up to age 21 with certain diseases or health conditions enrolled in Medi-Cal. CCS serves some of Medi-Cal's most vulnerable children. In addition to their physical health condition qualifying them for CCS, these children often experience a high co-occurrence of social and behavioral health challenges. Many children in CCS interact with multiple care or case managers to navigate various delivery systems. This creates a need for the child's caretaker to manage fragmented delivery systems and different care plans. For children in CCS, offering comprehensive medical care and navigation support across care delivery systems is essential for their well-being.

Enhanced Care Management (ECM) launched in Medi-Cal Managed Care Plans (MCPs) in July 2023 as a complementary service that enhances and/or coordinates across the case management available in CCS.[2] Since the launch, the California Department of Health Care Services (DHCS) has received stakeholder questions about which children are a best fit for ECM, how ECM and CCS care management models can work together to meet the needs of families, and strategies for strengthening the capacity of ECM Providers to meet the unique and varied needs of children in CCS.

To support addressing these questions from stakeholders, DHCS conducted interviews with nine CCS and ECM Providers in Spring 2025. CCS and ECM Providers shared that ECM consistently allows ECM Lead Care Managers (LCMs) to provide complementary supports to CCS services, including health system navigation, health literacy support, and social determinants of health (SDOH) access.

Based on the experience of ECM providers serving the CCS Population of Focus detailed within this Lessons from the Field resource, there are substantial opportunities for CCS and ECM team members to work together to address the clinical and non-clinical needs of children and families.

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[1] Throughout this resource, "CCS" refers to Classic CCS and WCM.
[2] MCPs are responsible for ensuring ECM services do not duplicate the services a child is already receiving through CCS.

This resource is not intended as policy guidance; instead, it offers promising practices and lessons from the field to assist CCS Providers, ECM Providers, MCPs, and referral partners in strengthening the delivery of ECM for CCS populations.

This resource is intended to be a **supplement to DHCS' existing guidance on implementation** of ECM for CCS populations available in the ECM Policy Guide and the ECM for Children and Youth Populations of Focus Spotlight, which includes detailed vignettes on delivering ECM for children and youth populations, including CCS.

Lessons from the Field

Opportunities for ECM to Support Children in CCS

- **Identifying Children in CCS Who Would Benefit from ECM:** ECM and CCS Providers regularly prioritize children for ECM whose family/caregivers need more intensive, longer-term support navigating complex health systems and/or assistance accessing social supports such as Medi-Cal transportation, food, and In-Home Support Services (IHSS).
- **Cultivating Referrals for the ECM CCS POF:** ECM and CCS Providers recommend keeping key referral partners updated on ECM services, successes, and progress to build trust and create strong referral pipelines. Providers can also collect informal ECM referrals via phone, electronic health records (EHRs), or abbreviated forms and then submit the formal ECM referral to the MCP.
- **ECM Supports for Children in CCS:** ECM can address a child or family's needs beyond the child's CCS condition, including supports for health system navigation, supporting family/caregivers' health literacy, and connecting children and families to SDOH supports.
- **Roles Within the Care Team:** Within a child's care team, CCS Nurse Care Managers (NCMs) coordinate care focused on a child's medical and therapy-related needs for their CCS eligible condition(s). ECM LCMs provide in-depth, in-person support and conduct home or community visits to complement CCS medical case management.
- **ECM Provider Competencies:** ECM Providers for children in CCS should receive training on key skills such as working with children and youth with special health care needs, Motivational Interviewing, home visiting safety, ACEs and trauma-informed care, SMART goals and co-creating care plans with families, community resource navigation, and how to communicate with health care providers and care teams.

Section I: Overview of ECM for Children in CCS

Background on CCS

CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with eligible medical conditions, including cystic fibrosis, cancer, organ transplant, kidney disease, and others.

Families with children engaged in CCS often have to navigate complex health systems and many different providers on behalf of their children in addition to supporting their family's social and behavioral health needs, such as transportation, food and nutrition, accessible housing, school supports, and behavioral health care for children and caregivers themselves.

CCS teams include a NCM who leads CCS medical case management. CCS NCMs must understand the complex medical conditions of children in CCS, including chronic illnesses and disabilities. They provide medical case management, care coordination, and patient advocacy to ensure children with CCS-eligible conditions receive proper care at the right time and place. Additional details on CCS case management are available at DHCS' CCS webpage.

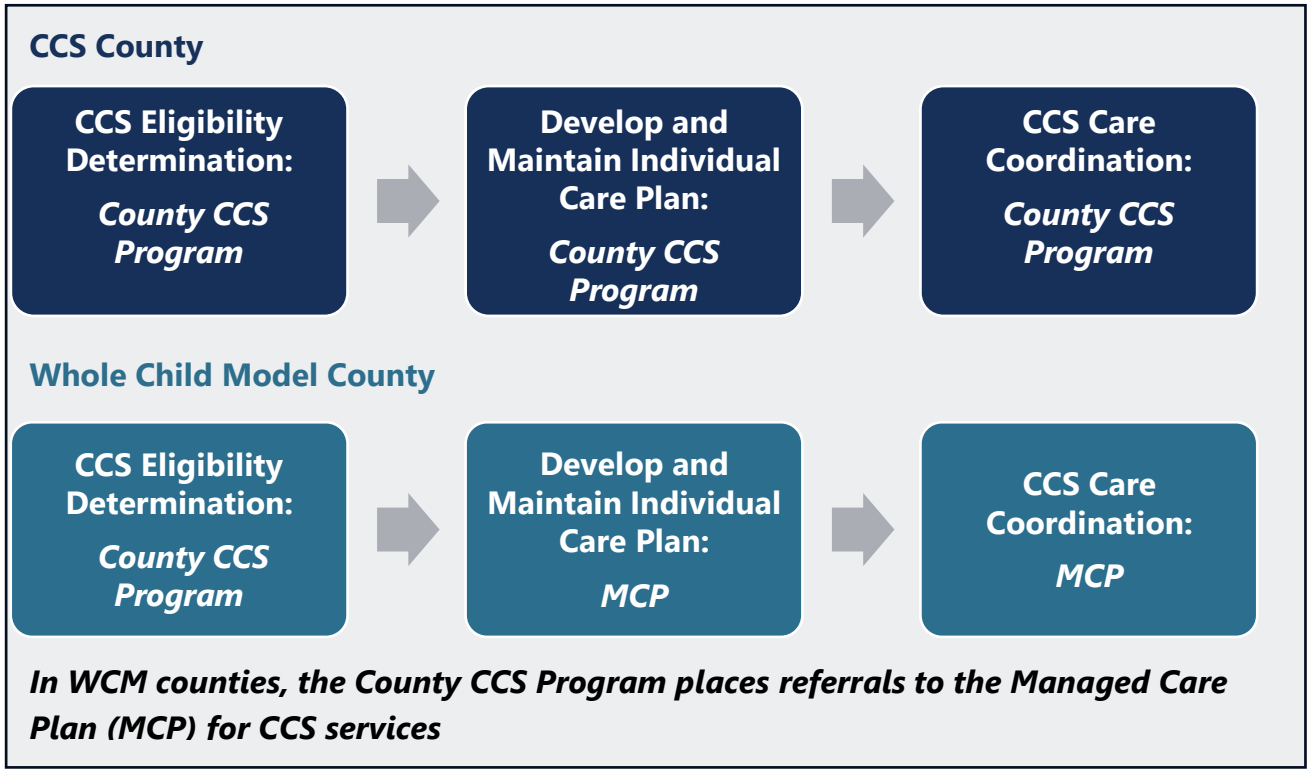
CCS in WCM Counties

In 2018, DHCS established the WCM program, which integrated CCS services into Medi-Cal MCPs in certain counties. Previously, CCS was always operated out of County CCS Programs. As of January 2025, CCS has 33 WCM counties.[3] When WCM Members are eligible for both CCS Case Management and ECM services, the MCP may delegate some CCS Case Manager functions to qualified ECM Providers. Additional details are available

[3]As of January 1, 2025 WCM includes the following counties: San Luis Obispo, Santa Barbara, Merced, Monterey, Santa Cruz, San Mateo, Orange, Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Siskiyou, Shasta, Solano, Sonoma, Trinity, Yolo, Butte, Colusa, Glenn, Mariposa, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, and Yuba.

in APL 24-015. Figure 1 summarizes which entities are responsible for delivering CCS based on whether the county operates under CCS or WCM.

Figure 1: Entities Responsible for Delivering CCS in CCS and WCM Counties



ECM for the CCS Population of Focus (POF)

ECM is a Medi-Cal managed care benefit to support comprehensive care management for MCP Members with complex needs. ECM is the highest care management tier in the Medi-Cal Population Health Management continuum and is designed to be delivered by community-based providers. All children enrolled in CCS or WCM who have **additional needs beyond their CCS condition**, such as lack of access to food, lack of access to stable housing, or difficulty accessing transportation, are eligible for ECM.

As of Q3 2024, **4,040 children/youth** enrolled in the ECM CCS Population of Focus (POF). This represents **~2%** of children enrolled in CCS statewide.

Families and caregivers of children in CCS often attend appointments at multiple specialty clinics and need outpatient and inpatient services because of their child's complex medical condition(s). They may need to coordinate with social workers from various specialty clinics along with the CCS program for discrete needs. An ECM LCM

can work alongside the family/caregiver, often in person, to coordinate across the many individuals and providers in a child's care team to best meet the child and family's needs.[4] Members that turn 21 while enrolled in ECM for the CCS POF should not be disenrolled from ECM due to aging out of CCS; Members can remain enrolled in ECM until their care plan goals are achieved.

The following sections offer lessons from the field on how ECM Providers, County CCS Programs, and health care providers serving children in CCS are working together to operationalize ECM.

Section II: Engaging Children and Families in ECM

Identifying children and families in CCS who would benefit from ECM

ECM and CCS Providers regularly **identify children for ECM whose family/caregivers need more intensive, longer-term support** navigating complex health systems and/or need assistance accessing social supports such as transportation[5], food, and In-Home Support Services (IHSS). **For example,** families in CCS often need to schedule multiple specialty clinic appointments. ECM Providers can explain the purpose of each specialist and the importance of the visits and help strategically plan these appointments, potentially consolidating visits into a single day.

[4] For full details on ECM services and eligibility please reference the ECM Policy Guide, including a list of care management programs that are duplicative of ECM on page 83.
[5] Medi-Cal provides transportation services for medical-related appointments, including dental, mental health, and substance use disorder services, as well as for picking up prescriptions and medical supplies.

Key ECM Supports for Children and Families in CCS

Children in CCS may begin ECM to address a specific need, but ECM Providers expand their support across multiple areas as they build trust and develop a child's care plan. ECM can address additional needs of a child or family beyond the child's CCS condition.

Note: The following are examples of ECM supports for children and families in CCS, as described by ECM and CCS Providers during DHCS interviews. This list is not exhaustive.

Health System Navigation	Support Family/ Caregiver Health Literacy	Access to SDOH Supports
ECM supports children/families in CCS with navigating their health care and other services.	**ECM supports children/families in CCS with understanding their care plans and communicating with their providers, especially when a family faces language barriers and/or needs culturally sensitive and linguistically competent support.**	**ECM supports children/families in CCS with connecting to social supports, SDOH resources, and Community Supports.**
Example ECM supports: » Assistance scheduling health care, dental, and social services appointments » Coordinate appointments across various specialty clinics on the same day to minimize the need for families to make multiple trips throughout the week/month » Connect Members and families with mental health services and counseling » Arrange transportation to appointments » Support transitions in care (e.g. discharges from a hospital or long-term care facility) » Bridge communication between Special Care Centers (SCCs) and non-CCS Providers on a child's care team	**Example ECM supports:** » Prepare families for appointments to address key questions/needs with their providers » Attend appointments with families and identify areas where families need more support from providers » Ensure families understand their child's care plan and the roles of the care team » Advocate with families in discharge discussions with hospital teams » Translate or connect families with their MCP's language services	**Example ECM supports:** » Home visits to assess social needs » Address food insecurity by connecting families to CalFresh, WIC, Medically Tailored Meals, and/or community resources (e.g. food banks) » Support applications for IHSS, SSI, and other in-home services » Navigate the conservatorship process[6] » Connect to social services such as CalWORKs » Place referrals to Community Supports (e.g. respite, medically tailored meals, home modifications, housing transition navigation services) » Coordinate support services to address functional needs (e.g. placing referrals for home modifications, assisting families in securing housing that meets their child's physical needs)

[6] Additional details on transitions from the CCS program to adult health care when a Member turns 21 are available here.

Cultivating referrals to ECM for children and families in CCS

Building Awareness of ECM Among Regional Providers and Key Referral Partners

ECM outreach should be a continuous effort. Current ECM and CCS Providers emphasize the importance of **regularly engaging key referral partners** to increase awareness of ECM services, build trust with providers, and create a referral pipeline for their ECM programs. CCS Providers note that additional, intentional effort is needed to build awareness and simplify referrals to ECM when ECM Providers are **not integrated into a CCS Program** to ensure teams know about the resources available under ECM to support children and families in CCS. The strategies below can help.

Strategies for Counties and Health Systems to Build Awareness of ECM

- Presentations at clinic "Lunch and Learns" and staff meetings
- Presentations to CCS Medical Therapy Program (MTP) Occupational Therapists and Physical Therapists
- Assigning key ECM Staff as points of contact for pediatric providers serving children in CCS, including Special Care Centers, Children's Hospitals, and pediatric practices
- Regular huddles with ECM Care Managers, Clinic/Program Nurses and Social Workers
- Conducting a Health System Grand Rounds on ECM
- Sending ECM Frequently Asked Questions (FAQ) mailings to regional providers' offices

ECM and CCS Providers found that regular communication and "huddles" with CCS, ECM and specialty clinic teams were especially helpful to increase ECM referrals from providers in their community. In addition to these knowledge-building strategies, **ECM Providers use various tools in practice to identify Members for ECM**. Providers noted that social needs screenings delivered by providers (e.g. social workers, CCS NCMs, physical therapists, occupational therapists, and primary care physicians (PCPs)), CCS care team meetings, and the CCS team conferences helped them identify Members for ECM.

Strategies for Counties and Health Systems to Engage Families in ECM

- **Member Flyers and Messaging:** Key information about ECM may include background information explaining what ECM is, the key services available to Members in ECM, eligibility for ECM, and how to make an ECM referral.[1]
- **Member FAQs:** Some County CCS Programs develop their own "FAQs" that address common questions about ECM, such as whether there is a cost for ECM, who the ECM Provider staff are (i.e. licensed vs. unlicensed), and where ECM takes place (i.e. preferably in-person at a Member's home or community location).
- **Warm Handoffs:** Providers shared that ECM engagement is the most successful when it is based on a preexisting trusted relationship, which can be established through a warm handoff process.
- **Informational Mailers:** Sending ECM fact sheets and FAQ mailings to regional providers' offices and CCS clients and families.

Additional strategies for building an outreach team for ECM and leveraging community partnerships is available in the ECM Outreach Toolkit.

ECM and CCS Providers found that using a **warm handoff process where the referring provider introduces the ECM Provider to the child and family** can help build trust and improve the referral process. Some ECM LCMs reference a known provider to the family (such as a physical therapist) to establish trust. Other ECM LCMs are available to meet the child/family after an appointment and establish a connection.

Raising Awareness of ECM for CCS Populations Among MCP Provider Networks[7]

MCPs can play a valuable role in coordinating referral partner engagement to streamline messaging and strategies across a county's ECM Providers. MCPs should actively build ECM knowledge and foster referrals within their Provider Networks for the ECM CCS POF. MCPs should coordinate across their ECM Providers within a County to streamline ECM outreach and education efforts. Additionally, MCPs can use similar strategies as ECM Providers to raise awareness of ECM, such as distributing mailers about ECM to families enrolled in CCS and sending ECM fliers and FAQs to referral partners. MCPs are also encouraged to communicate with County CCS Programs to facilitate knowledge-building and referrals to ECM.

Facilitating the ECM referral process

In addition to identifying eligible Members, MCPs ultimately **receive referrals and approve authorizations** for ECM services. DHCS recently released updated ECM referral standards so that all MCPs collect the same information on their ECM referrals to streamline the process for providers, community-based organizations, and other referral partners. Families, caregivers, legal guardians, and adults or youth may also **self-refer** by contacting their MCP directly. As of July 2025, MCPs are required to implement Closed-Loop Referral requirements for all referrals made for ECM and Community Supports.

[7] MCPs must create policies and procedures for their network providers to refer patients for ECM if they meet eligibility criteria. MCPs are also required to track key performance indicators to monitor and improve the volume of provider referrals to ECM (ECM Policy Guide, pg. 16).

MCPs' Role in Facilitating Referrals

Members can be referred for ECM and Community Supports through community providers, self/family referrals, or by MCPs using data. MCPs must provide the ECM and Community Supports referral forms and signup instructions on their website.

Some ECM and CCS Providers are taking additional steps to **further simplify their internal referral processes** by having a child's care team route the ECM referral to the Provider's ECM team. The ECM team takes on the responsibility of completing and sending the referral to the MCP on behalf of the care team.[8] For example, a County delivering CCS and ECM **created a simplified internal referral form** that CCS and Medical Therapy Unit (MTU) staff use to identify children/families for ECM services. The County's ECM team then completes the MCP's ECM referral. The form includes checkboxes for various referral reasons, making it user-friendly for CCS and MTU staff and centralizing ECM referrals with the County's ECM team.

Placing referrals to ECM looks different based on who your key referral partners are. Below are examples of how Providers and community partners refer children in CCS to ECM.

- Abbreviated internal referral forms (*described above*)
- Secure emails from providers (e.g. social workers, nurse case managers, physical therapists, occupational therapists, PCPs) to a county or hospital ECM team
- EHR functionality that alerts a County or Hospital ECM team when a Member is identified as potentially eligible for ECM
    - For example, providers can document social needs like housing instability or transportation issues in EHR notes to provide a comprehensive view of a child/family's health and social needs.
- Community-based referral to an MCP using ECM referral standards
- Integrate ECM referrals into EHRs

[8] MCPs' ECM referral forms must adhere to DHCS-required ECM referral standards and form templates.

Providers should work with their internal teams to develop effective strategies for promoting referrals of children in CCS to ECM.

Section III: Service Delivery and the Role of ECM and CCS Care Managers

Delivering ECM services to Members in CCS

ECM LCMs and CCS NCMs both play important roles in a child's care team. ECM and CCS Providers described that **CCS NCMs** coordinate care focused on a child's specialty medical needs, therapy-related needs, and other general care needs while **ECM LCMs** provide in-depth, psychosocial support and conduct in-person or telehealth visits to complement CCS NCM medical case management. ECM LCMs are expected to leverage CCS' comprehensive assessment and the care plan developed by the CCS NCM in developing a child's ECM care management plan. ECM LCMs often help families **complete applications for services like IHSS and CalFresh, arrange key medical appointments, attend appointments with families, provide health education, and conduct home visits**. ECM LCMs may also be able to provide **culturally responsive support from community organizations and health care providers, including interpretation and translated materials.** For members enrolled in both CCS and ECM, the ECM Lead Care Manager and CCS Nurse Case Manager can work together to share responsibilities[9] for case management activities that complement CCS services.

[9] Additional details on CCS Case Management core activities are available in DHCS' CCS Case Management Core Activities guidance.

Several ECM and CCS Providers include a nurse clinical supervisor on their ECM teams or have a close relationship with CCS NCMs for instances when there is a need for clinical consultation, especially when ECM Providers are not integrated into a CCS program. ECM and CCS Providers shared that, as a recommended practice, their teams hold regular meetings between ECM and CCS teams for the ECM LCM and CCS NCM to communicate any changes to the child's care plan and for the CCS NCM and ECM LCM to coordinate care management services.[10]

Lessons from the Field

Additional recommendations for communicating across CCS and ECM teams include:

- ECM Providers regularly **share lists of their CCS-enrolled Members** with the county's CCS Program.
- **MCPs provide a monthly eligibility/enrollment list** to the County CCS Program
- **Huddles between ECM LCM and specialty clinics** to discuss case needs and relay updates on care.
- **EMR messages** between embedded ECM LCM and health care providers to elevate key family needs for additional education or medical questions.
- **Monthly meetings between ECM, CCS Providers and partner programs** in their region (e.g. Child and Family Services, Regional Centers) to coordinate services.

Current ECM and CCS Providers shared that **ECM referrals are often prompted by a child's immediate needs**. After addressing immediate needs, ECM Providers build relationships with families to offer a broader set of services and supports.

The following Lessons from the Field summarize examples from interviews with ECM and CCS Providers of how Providers are integrating ECM with CCS services to support children and families.

[10] Note: MCPs are responsible for knowing when all Members are admitted, discharged or transferred and must assign a single point of contact/care manager to ensure transitional care services are completed for all high risk Members. As defined in the PHM Policy Guide, high risk Members includes those eligible for ECM.

Lessons from the Field: ECM Supports for Children in CCS and Their Families

ECM Supports for SDOH Access: Addressing Food Insecurity

Some CCS teams use a social needs screening tool to identify children or families that could benefit from ECM. Food access is often an immediate need that prompts referrals to ECM. For example, after connecting with a family, an ECM LCM visited the family's home to assist with placing referrals for food access. Through this in-person visit, the ECM LCM shared information about local food banks and connects the family with Medically Tailored Meals and their local food bank.

After addressing the family's food access needs, the ECM LCM learned that the family is confused about how to complete the at-home physical therapy exercises from their MTP physical therapist. The ECM LCM helped the family create a plan to clarify the child's at-home exercise instructions during their next visit with the MTP physical therapist.

ECM Supports for Health Literacy: Assisting Children and Families Through the Transplant Process

Supporting health literacy among families of children in CCS is crucial to ensuring families understand their child's care plan and necessary services, empowering families to navigate their child's health care needs. At a Children's Hospital CCS Program, one family's health literacy barriers led to hesitance in consenting to their child's transplant procedure due to language barriers, cultural differences, and unclear communication with providers at the transplant clinic.

The CCS team addressed this barrier by matching the family with a culturally competent ECM LCM who explained the necessity of the transplant in terms that resonated with the family, ultimately gaining their trust and consent for the procedure. The ECM LCM helped the family schedule multiple post-discharge follow-up appointments with specialists at the hospital. After the transplant, the ECM LCM visited the family at home to ensure they understood their post-discharge care instructions.

Lessons from the Field: ECM Supports for Children in CCS and Their Families

ECM Supports for Health System Navigation: Helping Families with Complex Scheduling

Families of children in CCS frequently need to manage appointments across various specialty clinics to address their child's health and social needs. This complex coordination can lead to missed appointments.

For instance, a County CCS Program was notified by their Medical Therapy Program team that a child with cerebral palsy missed their most recent MTP physical therapy appointment. The physical therapist informs the CCS NCM that the family struggles to manage their child's multiple specialty appointments each month because they need to arrange transportation for each visit. To address this issue, the CCS NCM referred the family to ECM for assistance with managing their child's medical appointments. The ECM Lead Care Manager then assisted the family in rescheduling their child's MTP appointments to coincide with another clinic visit on the same day and arranged transportation for both appointments. Additionally, the ECM Lead Care Manager helped the family prepare key questions to ask their providers at their upcoming visits.

ECM Supports for SDOH Access: Transportation to Appointments

Accessing transportation to appointments can be difficult for CCS families, particularly those who require wheelchair assistance. ECM LCMs are available to help families request transportation services and can show families how to use their MCP's website or phone app to schedule rides directly. Additionally, ECM LCMs can help coordinate transportation by confirming appointments and addressing any language or cultural barriers. On appointment days, ECM LCMs can assist families by confirming pickup times to ensure drivers arrive on time and filing complaints if transportation fails to arrive.

Section IV: Preparing ECM Providers to Serve CCS Populations

Recommended competencies of ECM Lead Care Managers

ECM and CCS Providers interviewed emphasized the importance of building the skills of ECM Providers for children in CCS as they prepare to support children and families navigating complex health systems. The competencies and skills detailed below were recommended by ECM and CCS Providers as vital for preparing ECM LCMs to deliver high quality ECM for children in CCS and their families.

Key programs ECM Providers should be familiar with to support referrals and applications to services:	**Key skills ECM Providers should receive training on:**
» CCS » Assistance applying for IHSS » Assistance applying for conservatorship » Medi-Cal Transportation services » Food and nutrition services and supports (e.g. CalFresh, WIC, Medically Tailored Meals, and community resources) » Medi-Cal Community Supports	» Motivational Interviewing » Home visiting safety » ACEs and trauma-informed care » Complex Care Management » Documentation and care planning » Health Equity » Communication/soft skills » Administering screenings » Communicating with health care providers and care teams
 Technical assistance on select skills-based training is available on the PATH TA Marketplace, which includes TA Vendors and Off-the-Shelf products cover topics such as ACEs, toxic stress, and Motivational Interviewing.	

ECM Providers emphasized the need for **comprehensive orientation and skills-based training for new ECM LCMs** to adequately prepare them to support children in CCS and their families. They highlighted the importance of preparing ECM LCMs to navigate difficult conversations, collaborate with interdisciplinary teams, and strengthen their communication and interpersonal skills. Providers also noted the importance of hiring ECM LCMs with qualities such as emotional intelligence, various cultural backgrounds

reflective of the communities they serve, and a readiness to assist children and families in navigating health systems.

Strategies for MCPs[11] to Build ECM Provider Capacity for Working with CCS Populations

MCPs' Role in Building ECM Provider Capacity

MCPs must provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars and/or calls. MCPs are well-positioned to offer information and training on accessing essential benefits for the CCS population, including transportation services and how to refer individuals to Community Supports services.

ECM Provider Networks for the ECM CCS POF

Technical assistance is available via the PATH TA Marketplace to support prospective ECM providers with staffing, financial modeling, and information technology infrastructure, especially for community-based providers who do not have the same level of contracting infrastructure as hospitals or health systems. In Summer 2025, DHCS also released an *[ECM Rates TA Resource]* that provides additional information for current and prospective ECM Providers about the considerations and assumptions DHCS uses in establishing ECM rates to MCPs.

[11] MCPs are required to meet the minimum Network Provider training requirements described in Medi-Cal Boilerplate Contract Template (ECM Policy Guide, pg. 125).

Appendix

Key ECM and CCS resources

- **Technical Assistance and Regional Resources for Providers**
  - Regional Collaborative Planning and Implementation (CPI) groups support local information sharing and collaborative implementation among MCPs, providers, counties, and other local stakeholders.
  - TA Marketplace and On-Demand Resource Library: List of PATH TA vendors and resources available to assist organizations in learning more about CalAIM.
- **CCS Resources**
  - DHCS' CCS Family Resources webpage: Detailed information on CCS benefits, program expectations, and grievances/appeals is available in the CCS Family Handbook and the CCS Grievance, Appeal, and State Hearing Fact Sheet.
  - APL 24-015: Updated guidance for MCPs participating in the WCM Program, detailing requirements for integrating CCS-covered services into managed care, ensuring coordinated care, and expanding program implementation to additional counties effective January 1, 2025.
- **ECM Resources**
  - *[ECM Rates TA Resource]*
  - ECM Children & Youth Spotlight: Guidance for ECM Providers on delivering coordinated, whole-person care to Medi-Cal enrolled children and youth with complex needs.
  - ECM Policy Guide: Comprehensive guidance for Medi-Cal MCPs on implementing ECM services, detailing eligibility criteria, core service components, provider requirements, data sharing protocols, and oversight mechanisms to support populations with high needs.
  - ECM Referral Standards and Form Templates: Standardized set of data elements and referral processes that all Medi-Cal MCPs must adopt by January 1, 2025, to streamline and unify ECM referrals across California.

Acknowledgements

The strategies included in this resource are informed in part by a series of informational interviews conducted in March 2025 with the following CCS Providers and ECM Providers in various stages of implementing ECM for the CCS POF.

- Rady Children's Hospital
- Children's Hospital Los Angeles
- Alameda County
- Butte County
- Tulare County
- Ventura County
- Shasta County
- Fresno County
- San Mateo County