Lessons from the Field: Delivering ECM for CCS Populations

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Updated June 2025

Section I: Overview of ECM for Children in CCS

Section 1: Key Takeaways

Overview of ECM for Children in CCS

- **Eligibility for ECM:** All children enrolled in CCS or WCM who have **additional needs beyond their CCS condition** are eligible for ECM.
  - Ex: Health system navigation, lack of access to food, lack of access to stable housing, or difficulty accessing transportation
- **ECM's Role in the Care Team:** ECM Lead Care Managers can work alongside a caregiver, often in person, to **coordinate across a child's care team** to best meet the child and family's needs.

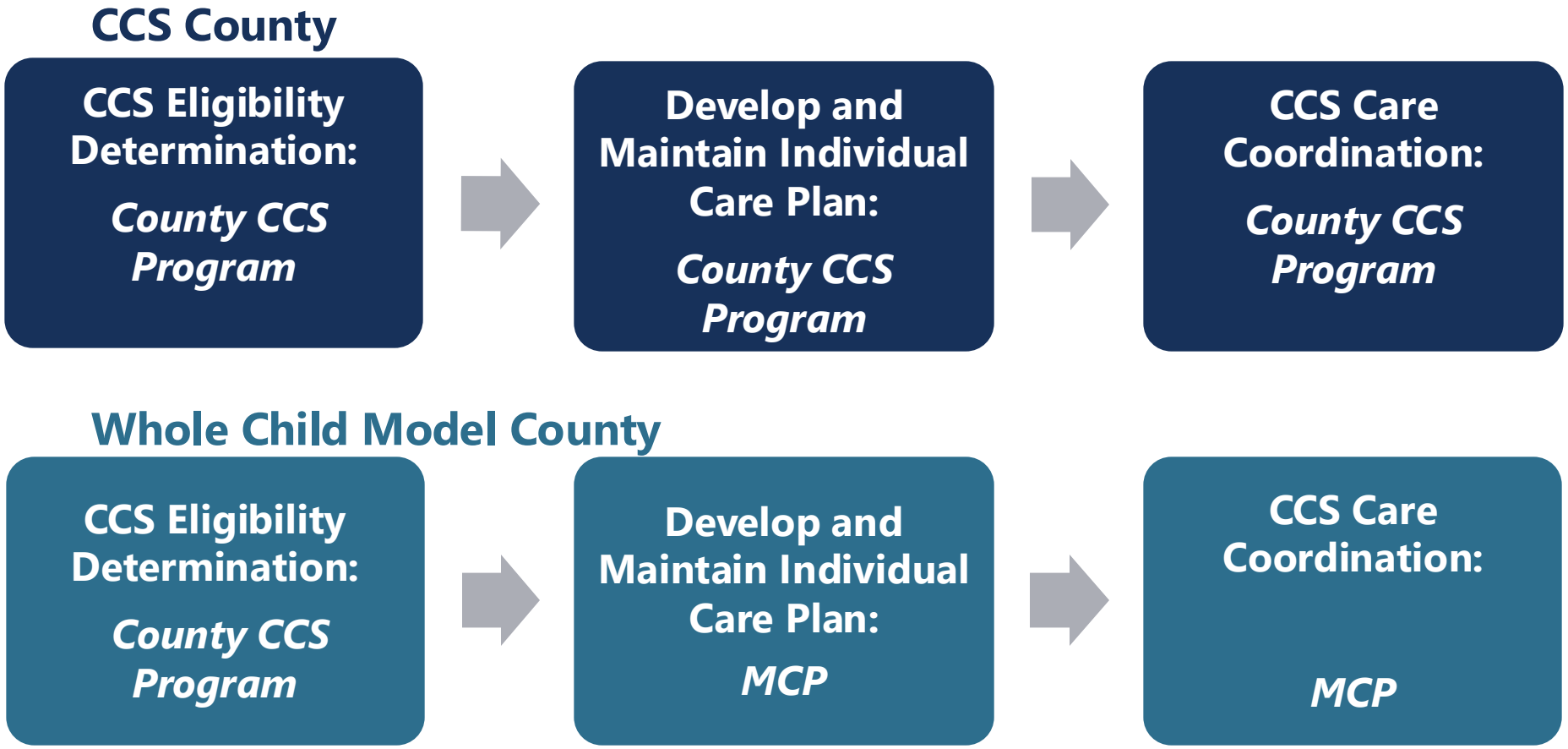
California Children's Services

- California Children's Services (CCS)/Whole Child Model (WCM) is a critical program for over 180,000 children up to age 21 with certain diseases or health conditions enrolled in Medi-Cal.
- **Services:** Diagnostic and treatment services, medical case management, and physical and occupational therapy.
- **Example conditions:** Cystic fibrosis, cancer, organ transplant, kidney disease and others.

CCS in Whole Child Model Counties

In 2018, DHCS established the Whole Child Model (WCM) program, which integrated CCS services into Medi-Cal MCPs.

As of January 2025, CCS has 33 WCM counties.



In WCM counties, the County CCS Program places referrals to the Managed Care Plan (MCP) for CCS services

For more information on the WCM Program, please see APL 24-015.

Enhanced Care Management

ECM is a Medi-Cal managed care benefit to support comprehensive care management for Members with complex needs.

- ECM is the **highest care management tier** in the Medi-Cal Population Health Management continuum available for MCP Members.
- Designed to be delivered primarily in-person by community-based providers.
- For children in CCS, ECM Lead Care Managers (LCM) work alongside families/caregivers, often in person, to coordinate across a child's care team to best meet the child and family's needs.
- 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.

Additional details are available in the ECM Policy Guide, including a list of care management programs that are duplicative of ECM on page 83.

Eligibility for ECM CCS POF

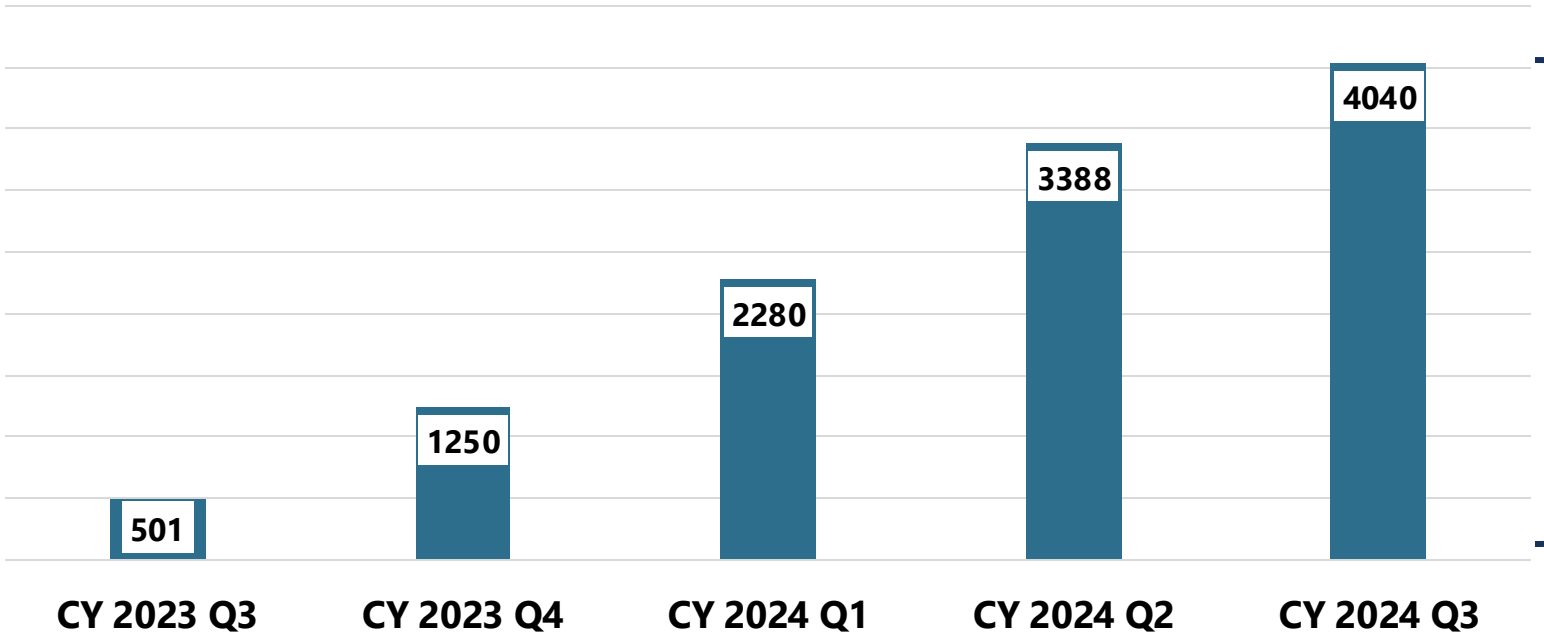
Eligibility:
All children enrolled in CCS or WCM who have additional needs beyond their CCS condition, such as health system navigation needs, lack of access to stable housing, or difficulty accessing transportation are eligible for ECM.

- CCS and WCM serve some of Medi-Cal's most vulnerable children.
- In addition to their physical health condition qualifying them for CCS/WCM – such as cancer, cerebral palsy, and cystic fibrosis – children often experience a high co-occurrence of social and behavioral health challenges beyond their CCS/WCM qualifying condition.

Full ECM CCS eligibility criteria is available in the ECM Policy Guide.

ECM CCS POF Enrollment Trends

Total Number of Members Who Received ECM for the CCS POF Each Quarter Since Launch



The 4,040 children/youth enrolled in the ECM CCS POF in Q3 2024 represent ~2% of children enrolled in CCS statewide* signaling an opportunity to increase ECM enrollment

**An estimated 91% of CCS-enrolled children/youth are part of the Managed Care delivery system*

Source: ECM and Community Supports Quarterly Implementation Report for Q3 2024; CCS Demographics and Enrollment Dashboard.

Collecting Feedback on ECM/CCS Implementation Challenges

Since 2023, DHCS has received extensive feedback from Providers and stakeholders on areas of ambiguity and the need for improved implementation of ECM for the CCS Population of Focus (POF).

DHCS engaged the following entities to understand implementation challenges:

- County CCS Programs;
- CCS Providers;
- ECM Providers;
- Children's Advocates;
- Children & Youth Advisory Group;
- CCS Advisory Group;
- Collaborative Planning and Implementation (CPI) Facilitators;
- MCPs

TA Overview: Lessons from the Field

Providers Sharing Implementation Lessons

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

DHCS interviewed current Providers to support MCPs, Providers and stakeholders with lessons learned on:

- How to cultivate referrals for the CCS POF;
- How ECM can be delivered to add value in parallel to CCS;
- How to strengthen competencies of ECM Providers of the CCS POF.

Section II: Engaging Children and Families in ECM

Section II: Key Takeaways

Engaging Children and Families in ECM

Identifying Children in CCS Who Would Benefit from ECM:

- 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.

Cultivating Referrals for the ECM CCS POF:

- ECM Providers often collect informal ECM referrals via phone, EHRs, or abbreviated forms and then submit a formal ECM referral to the MCP.
- ECM and CCS Providers recommend keeping key referral partners updated on ECM services to build trust and create strong referral pipelines.

Identifying Children and Families in CCS Who Would Benefit from ECM

- Children in CCS often referred for ECM include:
  - Children/families who need more intensive, longer-term support navigating complex health systems;
  - Children/families who need assistance accessing social supports such as transportation, nutrition assistance, and In-Home Support Services (IHSS).
- For members enrolled in both CCS and ECM, the ECM Lead Care Manager and CCS Nurse Case Manager can work together to share responsibilities for case management activities that complement CCS services.

Additional details on CCS Case Management core activities are available here.

Key ECM Supports for Children and Families in CCS (1/3)

Health System Navigation

Support Family/Caregiver Health Literacy

Access to Social Determinants of Health (SDOH) Supports

ECM supports children/families in CCS with navigating their health care and other services.

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 children and families with mental health services and counseling
- Arrange Medi-Cal funded 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

Key ECM Supports for Children and Families in CCS (2/3)

Health System Navigation

Support Family/Caregiver Health Literacy

Access to Social Determinants of Health (SDOH) Supports

ECM supports children/families in CCS with understanding their care plans and communicating with their providers, especially when a family faces language barriers or needs culturally sensitive support.

Example ECM supports:

- Prepare families for appointments by mapping key questions/needs they have for their providers
- Provide health education
- 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

Key ECM Supports for Children and Families in CCS (3/3)

Health System Navigation

Support Family/Caregiver Health Literacy

Access to Social Determinants of Health (SDOH) Supports

ECM supports children/families in CCS with connecting to social supports, SDOH resources, and Medi-Cal Community Supports.

Example ECM supports:

- Conduct home visits to assess social needs
- Address food and nutrition needs 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
- 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 DME, Home Modifications, assisting families in securing housing that meets their child's physical needs)

Strategies for Cultivating Referrals to ECM

Provider Tips for Cultivating Referrals

- **Regular, Frequent Engagement:** Outreach to referral partners should be continuous, not a one-time effort.
- **Trust Building:** Keep key referral partners updated on ECM services, successes, and progress to build trust and create a strong referral pipeline.
- **Streamline the Process:** Collect informal ECM referrals via phone, electronic health records (EHRs), or abbreviated forms.
  - ECM Providers can then submit the formal ECM referral to the MCP.

Strategies for Providers and Community Partners to Facilitate Referrals to ECM

ECM Providers shared different approaches to simplifying the process partners use to refer Members.

Lessons from the Field

- Abbreviated internal referral forms that route information to the ECM team that then completes the MCP's ECM referral
- Secure emails from providers (e.g. social workers, nurse case managers, PTs, OTs, PCPs) to a County or Hospital ECM team
- Electronic Health Record (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 form on their website
- Integrating ECM referral forms into EHRs

Cultivating Referrals: County and Health System Strategies

Strategies for Building Awareness of ECM

- ECM orientations at clinic "Lunch and Learns"
- Presentations to CCS Medical Therapy Program (MTP) Occupational Therapists and Physical Therapists
- Conduct a Health System Grand Rounds on ECM
- Assign an ECM lead point of contact for hospital clinics, specialty centers and pediatric practices
- Regular case huddles with ECM CMs, Clinic Nurses and Social Workers
- Distribute ECM FAQs to providers' offices

Lessons from the Field: How ECM Providers Identify Members for 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.

» ECM Providers use various tools and practices to identify Members for ECM, including:

- Social needs screenings delivered by providers (e.g. social workers, CCS NCMs, physical and occupational therapists, PCPs)
- CCS care team meetings
- CCS team conferences
- Clinic nurse/social worker huddles

ECM for Children and Families in CCS: Strategies to Engage Families

Butte County's ECM Flyer

- **Member Flyers and Messaging:** Overview of ECM, the key services available to Members in ECM, eligibility for ECM, and how to make an ECM referral.

- **Member FAQs:** Address common questions, such as whether there is a cost for ECM, who the ECM Provider staff are, and where ECM takes place (i.e., at a Member's home or community location).

- **Warm Handoffs:** Warm handoffs, where the referring provider introduces the ECM Provider to the child and family, help build trust and improve the referral process.
  - Reference a known provider to the family to establish trust
  - Meet the child/family after an appointment to begin establishing rapport

MCPs' Role in Building Awareness and ECM Referrals

MCPs: Raising Awareness of ECM for CCS Populations Among Provider Networks

MCPs should play an active role in coordinating referral partner engagement to streamline messaging and strategies across a county's ECM Providers.

- **Actively build ECM knowledge** and foster referrals within their Provider Networks for the ECM CCS POF.
- **Coordinate across ECM Providers within a County** to streamline ECM outreach and education efforts.
- 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.

Note: 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 in APL 24-015.

MCPs' Role in Facilitating Referrals to ECM

MCPs must provide the ECM and Community Supports referral forms and instructions on their websites.

- **Data-Driven Referral:** MCPs must have a process to use data to proactively identify Members who may benefit from ECM and meet ECM CCS POF criteria. This process should supplement, and not replace, community-based provider referral sources.
- **Self-Referrals:** Families, caregivers, legal guardians, and adults or youth may also self-refer by contacting their MCP directly.
- **Community Referrals:** 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.
- **Closed-Loop Referrals (CLRs):** As of July 2025, MCPs are required to implement CLRs requirements for all referrals made for ECM and Community Supports.

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

Section III: Key Takeaways

Service Delivery and the Role of ECM and CCS Care Managers

- **Roles Within the Care Team:** CCS NCMs coordinate care primarily focused on a child's medical and therapy-related needs for their CCS eligible condition(s). ECM LCMs provide **in-depth support** and **conduct home or community visits** to complement CCS.

- **ECM Provider Competencies:** ECM Providers for children in CCS should **receive training** such as:
  - Working with children and youth with special healthcare needs, Motivational Interviewing, home visiting safety, ACEs and trauma-informed care, SMART goals and co-creating care plans with families, community resource navigation, and communicating with health care providers and care teams.

Delivering ECM Services to Members in CCS

ECM LCMs and CCS Nurse Case Managers (NCMs) both play important roles in a child's care team.

Lessons from the Field:

- **CCS NCMs** coordinate care primarily focused on a child's medical needs, therapy-related needs, and other general care needs.
- **ECM LCMs** provide in-depth, in-person support and conduct home visits to complement CCS NCM medical case management, such as:
  - Helping families apply for IHSS and CalFresh
  - Arranging medical appointments
  - Attending appointments with families
  - Providing culturally responsive support from community organizations and healthcare providers, including interpretation and translated materials

Lessons from the Field: Communication Across CCS and ECM Teams

ECM and CCS Providers recommended regular communication on care plan updates and to coordinate care management services.

- Regularly **share lists of CCS-enrolled Members** with the County CCS Programs.
- **Huddles between ECM LCM and specialty clinics** to discuss case needs and updates on care.
- **EHR messages** between ECM LCMs and health care providers to elevate needs for additional education or medical questions.
- **Monthly meetings between ECM, CCS Providers and local programs** (e.g. Child and Family Services, Regional Centers) to coordinate services.

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

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.

ECM Supports for SDOH Access: Addressing Food and Nutrition Insecurity

Initial Need: Food and Nutrition Access

- A Children's Hospital CCS team uses social needs screening to identify food access and nutrition challenges for a child.

SDOH Support to Address Food Access and Nutrition Needs:

- The ECM LCM visits the family's home to assist with placing referrals for food access and nutrition support. The ECM LCM also refers the child for Medically Tailored Meals.

Health System Navigation Support:

- The ECM LCM learns that the family is uncertain how to complete at-home physical therapy exercises from their Medical Therapy Program (MTP). The ECM LCM helps the family create a plan to clarify the at-home exercises during their next visit with the physical therapist.

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

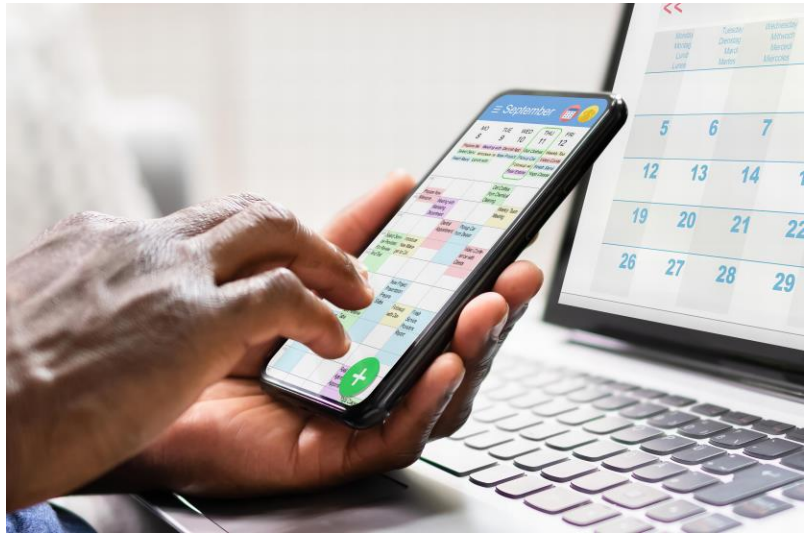
Initial Need: Health Literacy Support

- A Children's Hospital CCS team recognizes that a family is hesitant to consent to their child's transplant due to language barriers, cultural differences, and unclear communication with providers at the transplant clinic.

Health Navigation Support:

- The CCS team connects the family with a culturally responsive ECM LCM who explains the transplant's importance in terms that resonated with the family, ultimately gaining their trust and consent for the procedure.
- The ECM LCM helps the family schedule multiple post-discharge follow-up appointments with specialists at the hospital.
- After the transplant, the ECM LCM visits the family at home to ensure they understand their post-discharge care instructions.

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



Initial Need: Missing Appointments

- A Medical Therapy Program team noticed a child with cerebral palsy was missing their physical therapy appointments.
- The physical therapist informed the CCS NCM that the family struggles to manage their child's multiple specialty appointments each month because of challenges accessing transportation.

Health Navigation Support: The ECM Lead Care Manager:

- Assists the family in rescheduling their child's MTP appointment to coincide with another clinic visit on the same day;
- Arranges Medi-Cal transportation for both appointments;
- Helps the family prepare key questions to ask providers at the upcoming visits.

Spotlight: Transportation to Appointments

Need: Accessing Transportation

- Accessing transportation to appointments can be difficult for CCS families, particularly those whose children require wheelchair assistance.
- ECM LCMs are available to help families request Medi-Cal transportation services and can show families how to use their MCP's website or phone app to schedule rides directly.

Health Navigation Support:

- ECM LCMs can help coordinate transportation by confirming appointments and addressing any language barriers. On appointment days, ECM LCMs can assist families by confirming pickup times with the driver, communicating with provider teams, and filing complaints if transportation fails to arrive.

Section IV: Preparing ECM Providers to Serve CCS Populations

Recommended Competencies of ECM Lead Care Managers for CCS POF

Key programs ECM Providers should be familiar with to support referrals and applications to services:

- CCS
- In-Home Supportive Services
- 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 (e.g. Respite, Asthma Remediation, Home Modifications)

Key skills ECM Providers should receive training on:

- 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

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

MCPs should play an active role in Building ECM Provider Capacity to serve the CCS POF

- 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 Medi-Cal transportation services and how to refer individuals to Community Supports services.

Technical Assistance Marketplace

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.

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 IT 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 an overview of the considerations and assumptions DHCS uses in establishing ECM rates to MCPs.
- Intended audiences: MCPs, ECM Providers, Prospective ECM Providers

Appendix

Supplemental Material: Medi-Cal Connect

DHCS

Medi-Cal Connect Vision

The Medi-Cal Connect vision is to:

- **Improve the health of Medi-Cal members** and **reduce disparities** by providing a data-driven solution that supports whole-person care and population health functions.
- **Integrate information** from diverse sources, enabling multi-party data access and sharing to inform policy and enhance the member care experience.

Medi-Cal Connect Key Features

- Key features will enable users to evaluate population health trends. In Release 3, DHCS users will have access to a Risk Stratification, Segmentation, and Tiering (RSST) dashboard, and MCPs will have access to a Quality Measures Dashboard.

Functionality Available to Users in Release 3

Key Feature	Purpose	DHCS Users	Medi-Cal MCPs
Condition Prevalence Dashboard	Provides insight into the prevalence of clinical conditions and related utilization of services	X	
Quality Measures Dashboard	Analyzes quality performance for a given calendar year and initiative	X	X
Health Equity Dashboard	Analyzes and monitors existing knowledge about disparities	X	
RSST Dashboard	Tracks distribution of the risk tiers within the Medi-Cal program	X	
Care Management Demographics Dashboard	Provides demographic data on members receiving Enhanced Care Management (ECM) and Community Supports	X	
Longitudinal Medical Record	Access to member-level data and health records	X	X
RSST File	Standardized risk tiering to identify members who may benefit from services		X

LMR and Care Management Capabilities (1/2)

Member Summary

- Overview of member's health history

Member Information

- Contact and demographic information
- Health plan enrollment

Diagnoses

- Record of conditions, including chronic conditions
- Provider visits associated with a condition

Care Team Information

- Primary Care Physician (PCP) information
- ECM or Chronic Care Management (CCM) care manager information
- Other frequently seen providers

Key care management features are available in Release 3. Additional features may be included in future releases as prioritized by DHCS.

LMR and Care Management Capabilities (2/2)

Claims

- Inpatient
- Outpatient
- Pharmacy
- Dental
- Behavioral Health

Risk Profile

- Risk domains
- Quality measure outcomes

Programs and Services

- Eligibility
- Enrollment

Key care management features are available in Release 3. Additional features may be included in future releases as prioritized by DHCS.

LMR: Member Summary (dummy data)