At the Intersection: Child Welfare and Enhanced Care Management

Tapping the potential to support families

Full Circle Health Network

February 2025

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Medi-Cal's introduction of new benefits and services – Enhanced Care Management (ECM), Community Health Workers (CHWs) and Community Supports – represents an enormous opportunity for children, youth and families involved in child welfare. By addressing social determinants of health like food, housing and safety and making connections to services that mitigate the impacts of trauma, ECM, CHW and Community Supports are important new tools to propel system-involved children and families toward stability and healing.

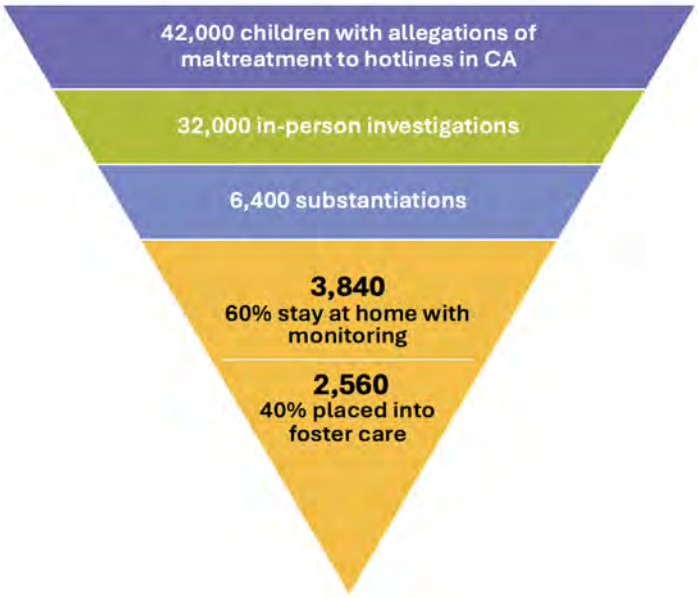
Yet, despite being a targeted population of focus and categorically eligible for ECM, as of June 2024, less than 4% of children involved in child welfare were receiving ECM services.[1]

Major system changes take time to understand and adopt, but children and families involved with child welfare urgently need additional supports and resources. Increasing linkages to these new services for impacted children and families requires new collaboration between county agencies, managed care plans, and providers. In the following pages we recommend specific actions that can be taken now to link more children and families to these important services.

These insights are based on our experience at Full Circle Health Network collaborating alongside our 100-plus provider partners, multiple Medi-Cal managed care plans and dozens of counties to serve thousands of children and youth over the last year and a half. Full Circle was created by and for community-based organizations (CBOs) that have decades of experience providing trauma-informed care to children, youth and families via contracts with county child welfare and behavioral health departments. These provider agencies pioneered complex care models for youth, and their collective experience connecting, collaborating and coordinating among child-serving systems is the foundation for successful ECM delivery.

This document includes three sections that can be read together or separately. First, we aim to succinctly promote a deeper understanding of the child welfare population's needs, next we recommend actions to increase ECM engagement, and finally we provide real-world, case examples to help others envision ways these new CalAIM services can help children, youth and families.

Figure 1: Monthly child welfare allegations and investigations in 2023-24



Source: California Legislative Analyst's Office

The Nation's Largest Child Welfare System: Understanding the Population

Each month nearly 100,000 children and theifamilies interact with California's 58 county child welfare agencies, according to the California Legislative Analyst's Office.[2] The impacted families are disproportionately people of color and low-income.

California's number of children in foster care decreased by 28% over the last decade to 40,165 children in October 2024 – an all-time low.[3] This shift to preventing system involvement and reducing family separation is a national trend. In California, counties have developed comprehensive prevention plans and are implementing community pathways to services that promote prevention and family stability.

About 80% of child welfare cases originate from allegations of neglect – not abuse.[4] Interpersonal violence, mental health disorders and substance use disorders frequently are co-occurring risk factors.[5] Substantial evidence exists that child abuse and neglect can be prevented by helping caregivers meet their families' concrete needs, such as housing, food, transportation, and child care, and help them access services to address their complex risk factors. These concrete needs are also social determinants of health.

Medi-Cal plays an enormous role in promoting family stability. About half of California's youth in foster care come from families with incomes less than $12,000 annually, and most others have household incomes low enough to qualify for Medicaid.[6] Thus, nearly all children, and often their parents and caregivers, qualify for Medi-Cal prior to any child welfare system involvement. About one in three children in foster care are younger than age five, underscoring that support for these children requires supporting parents and natural support systems.[7]

Figure 2: California Foster Care Population by Age Group, Oct, 2024

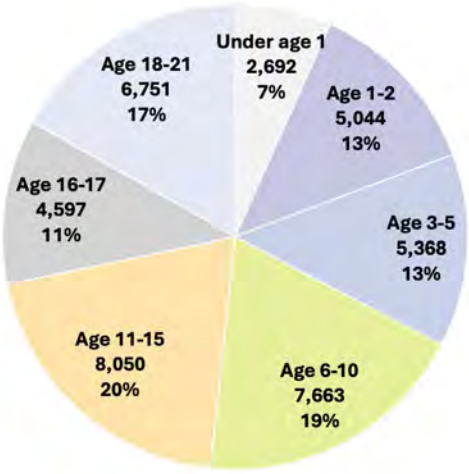
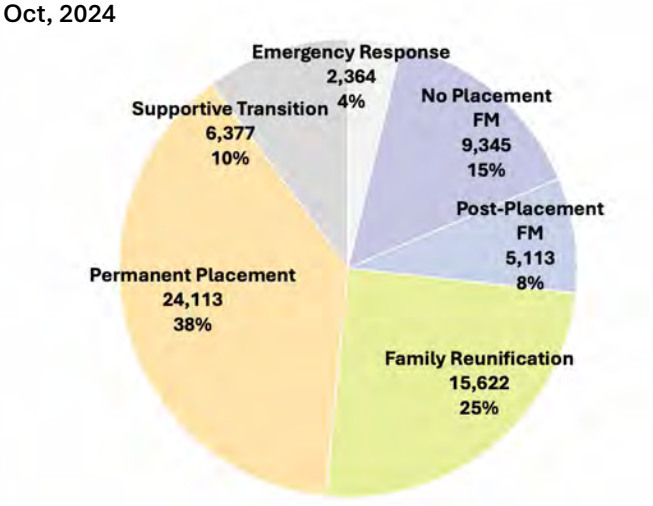


Figure 3 California Child Welfare Cases by Service Type, Oct, 2024

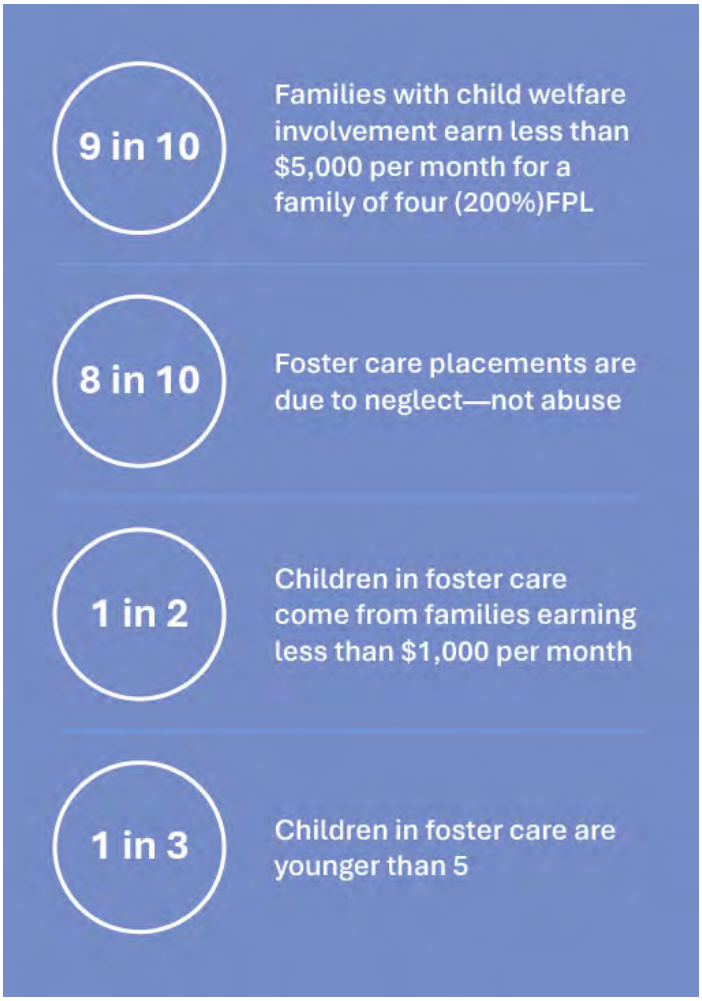


Source: Webster, D., Lee, S., et al. (2024) CCWIP reports. Retrieved Feb 1, 2025, from University of California at Berkeley California Child Welfare Indicators Project website.

At the Intersection: Child Welfare and Enhanced Care Management

As with most social safety-net programs in California, responsibility for child welfare services delivery has been "realigned" to county child welfare agencies. All children in foster care are eligible for Medi-Cal, and eligibility is determined at the county level.

Medi-Cal's new enhanced care management benefit was created to help individuals with complex needs navigate systems, programs and providers. Children and youth in foster care, formerly in foster care or in family maintenance are automatically eligible for ECM. ECM case managers aim to help program enrollees identify and close service gaps and improve coordination across a child's and/or family's medical, behavioral health, and social services delivery systems. ECM services should augment any existing case management efforts and promote effective, timely communication.



ECM Eligibility Definition for Child Welfare Involved[8]

One or more of the following conditions:

- Age 21 and younger and currently receiving foster care in California;
- Age 21 and younger and previously received foster care in California or another state within the last 12 months;
- Aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state;
- Age 18 and younger and eligible for and/or in California's Adoption Assistance Program;
- Age 18 and younger and currently receiving or have received services from California's Family Maintenance program within the last 12 months.

ECM has great potential to bolster capacity of child welfare case workers and public health nurses improving their job satisfaction and promoting their ability to support children and families along the entire service continuum.

Critically, ECM is a sustainable funding source for community-based organizations doing family systems work. We are hopeful that child welfare agencies increasingly view ECM as an additional support tool.

Targeted ECM Goals for Child Welfare

No targeted goals for ECM utilization rates among the child welfare population exist. We believe setting considered targets for subgroups within the child welfare population is useful. In part, because child, youth and family needs are different but also because different referral pathways and connection points likely need to be considered. We summarize the different subgroups, recommend target ECM utilization rates, and offer examples for high-impact ECM. These recommendations are based on our experience and knowledge of what children and families need broadly at various stages. If these utilization rates were achieved, about 45,000 child welfare involved children and youth would be enrolled in ECM. This would require about 1,125 lead care managers (at a ratio of 1:40). This would be a 26-fold increase over the numbers reported in June 2024.

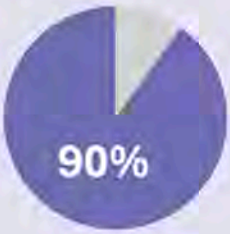
Differential Response – unsubstantiated risk allegations

Statewide population

~76,000

(About 20% of hotline calls that are investigated)

Portion in Medi-Cal Managed Care



Description and Implications for ECM Services

Many families screened out of CW services may benefit from ECM to connect to concrete supports and targeted services. Common risk factors, such as mental illness, SUD or unstable housing, are qualifying factors for ECM. If they don't qualify for ECM, they may qualify for Community Health Worker services. Most system-involved children, and often the parents, have Medi-Cal based on research and interviews.

High Impact ECM Example

Counties could seek consent from families to make community pathway referrals to local agencies contracted for ECM and CHW services. Agencies screen for ECM eligibility and, if authorized, leverage ECM funding to connect child/family to necessary services and supports and coordinate among and across providers. They can use CHW services if not eligible for ECM.

Penetration Rate & ECM Enrollment Targets

33% | 25,000

Family Maintenance

Statewide population

14,800

Portion in Medi-Cal Managed Care

Description and Implications for ECM Services

These children and families receive supportive services to prevent removal or promote stability and prevent re-entry. Most of these children qualify for Medi-Cal, but their Medi-Cal is not linked to foster care and so they do not have a foster care specific aid code. They are eligible for ECM, but MCPs know about these children only if they are told by the individual or the county child welfare agency.

High Impact ECM Example

In pre-placement FM, ECM may provide a family extra support outside of the child welfare system. The ECM team helps children and parents connect to needed medical, behavioral health and dental services, including coordinating transportation to appointments. They help find support for basic needs like food, hygiene supports and maybe housing. They support child and family development goals.

After reunification, an ECM team may continue working with a family to provide additional support to prevent re-entry. The ECM provider is not part of the CW system, and so the family may be more accepting of their ongoing support.

Penetration Rate & ECM Enrollment Targets

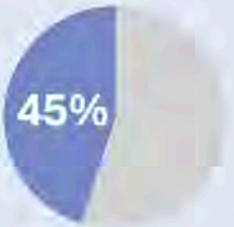
75% | 10,000

Family Reunification

Statewide population

15,800

Portion in Medi-Cal Managed Care



Description and Implications for ECM Services

These children are removed from their home. They have Medi-Cal tied to their foster care status, but they may not be enrolled in managed care. In sibling sets, each child is eligible for ECM.

Impacted parents may also be enrolled in Medi-Cal and be eligible for CHW or ECM services tied to risk factors that led to the child's removal.

High Impact ECM Example

ECM care managers can be an additional resource and work alongside public health nurses to help children and families connect to necessary services. ECM can work with resource families and/or biological parents on case plan goals and help ensure continuity of care, especially if a child changes placements.

Penetration Rate & ECM Enrollment Targets

60% | 4,266

Permanent Placement

Statewide population

25,400

Portion in Medi-Cal Managed Care

Description and Implications for ECM Services

These children are adopted or placed with permanent legal guardians and receive continued financial support, including Medi-Cal enrollment, up to age 18 or 21. Many of these children are in stable situations and may have Medi-Cal as a secondary source of insurance. As a whole, their need for ECM likely is lower, but there may be changes to life circumstances or transitions when extra support can be stabilizing.

High Impact ECM Example

ECM services may be useful at providing extra support, system navigation and coordination in instances when placements are unstable or at-risk or experiencing transitions and changes.

Penetration Rate & ECM Enrollment Targets

25% | 2,857

Medically Fragile Youth

Statewide population

6,000

Portion in Medi-Cal Managed Care

Description and Implications for ECM Services

Medically fragile foster youth require services from multiple providers across multiple systems. They all are enrolled in Medi-Cal but not necessarily managed care. They must be in managed care to receive ECM services.

High Impact ECM Example

ECM services can augment existing case management services provided by public health nurses and/or the California Children's Services (CCS) program. Caregivers for these children must manage numerous health care services and coordinate across multiple providers. Supporting these caregivers in addressing all of a child's complex needs can prevent burnout and promote placement stability.

Penetration Rate & ECM Enrollment Targets

90% | 2,430

Probation Youth

Statewide population

2,700

Portion in Medi-Cal Managed Care

Description and Implications for ECM Services

Wards of the juvenile delinquency court supervised by probation officers and eligible for services similar to those in the child welfare system.

High Impact ECM Example

A large portion of these youth are placed in residential settings. ECM can be part of the transition of care process when youth return to their communities, focusing on connecting them to the full range of Medi-Cal and social services for which they are eligible. ECM teams can be an important tool to augment a probation offer's ability to coordinate all services and motivate a youth to engage in all aspects of their required case plan.

Penetration Rate & ECM Enrollment Targets

25% | 337

Non-minor dependents in Extended Foster Care (EFC)

Statewide population

7,000

Portion in Medi-Cal Managed Care

Description and Implications for ECM Services

Optional program for youth ages 18-21 to receive financial, housing and other supports as they transition to adulthood. Non-minor dependents provide consent for themselves to services and to whom their information may be shared.

High Impact ECM Example

Not all NMD may want additional support as they are asserting their independence, but their case workers should know that ECM /Community Supports (specifically the housing services) could be an additional support in instances of transitioning housing or between levels of care. An ECM team can also support their transition to independent living by teaching them how to navigate a managed care plan and take advantage of all available services.

Penetration Rate & ECM Enrollment Targets

25% | 875

Systemic Drivers behind Low ECM enrollment

Full Circle has observed several factors contributing to slow uptake among child welfare impacted youth and families. We summarize and offer recommendations to address them below.

Driver #1

Most foster children statewide are not enrolled in managed care. ECM and Community Supports can be accessed only via managed care plans. They are not available in "regular" fee-for-service Medi-Cal. More than half of children in foster care in California are not enrolled in managed care, and thus ineligible for ECM and Community Supports.

Recommendation

Keep more children in Medi-Cal managed care.

In counties where managed care enrollment is optional, county child welfare agencies should explore updating policies, procedures and workflows to keep more children enrolled in managed care. More education is needed for social workers and foster parents.

Most children who enter foster care already are enrolled in Medi-Cal and in a managed care plan. Keeping them in their default "status quo" managed care plan may be better than switching to fee-for-service, which has the potential to introduce more change if they also have to switch health care providers. If successfully reunified, the child will return to their parent's Medi-Cal and likely be enrolled in managed care.

Agencies also should develop workflows and procedures to ensure parents and caregivers who are eligible enroll in Medi-Cal and link to all services for which they are eligible.

Driver #2

ECM is relatively new and unknown among child welfare staff. County child welfare staff and social workers need to see evidence of ECM helping children and families.

Recommendation

Use case examples to train social workers and foster parents on how ECM can be an additional, helpful support.

It is not realistic to expect child welfare case workers or foster parents to be experts in Medi-Cal, but a better understanding of how ECM can augment their efforts may increase engagement among children and families. Using vignette examples can illustrate common scenarios to help child welfare staff imagine the possibilities for improved support and collaboration. The resource section of this document includes several case examples that can be used in training curriculum.

Driver #3

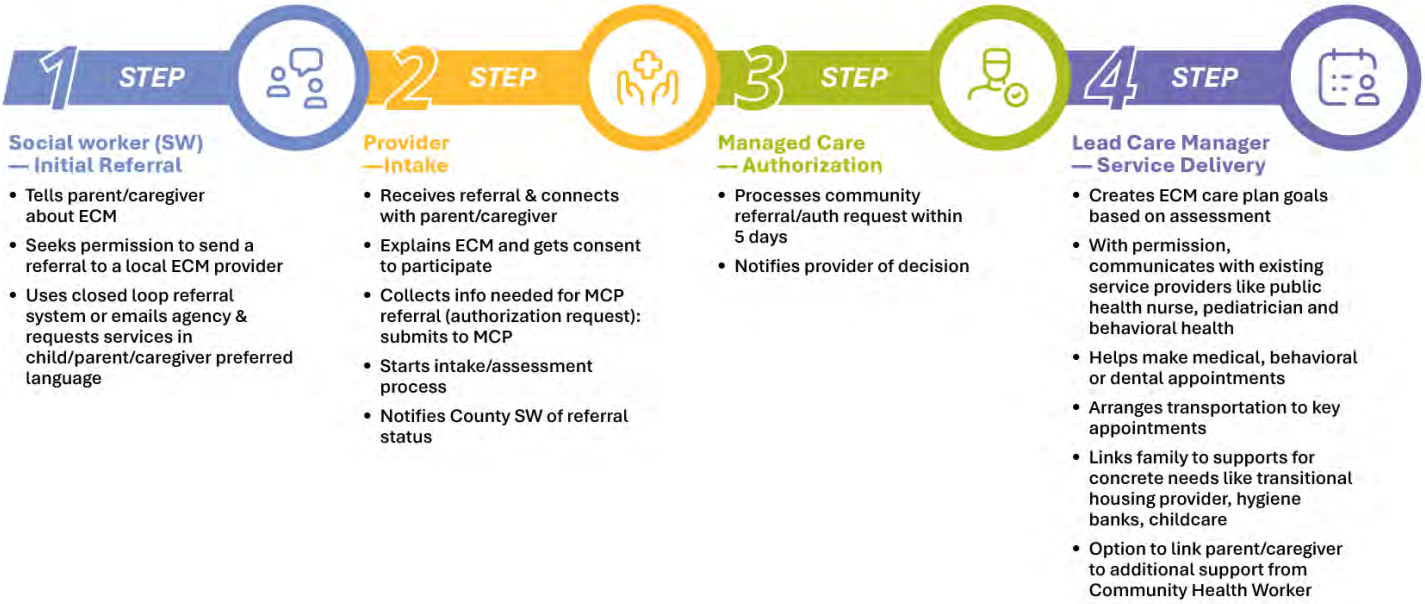
Social workers and public health nurses need simple referral pathways. When social workers know about available Medi-Cal services, systematic, simple referral workflows pathways may not exist, thus preventing connections.

Recommendation

Develop simple referral pathways and train case workers and foster parents.

MCPs and counties should work together to develop straightforward protocols for social workers and/or public health nurses to collect parent/caregiver consent and send referrals for ECM. The easiest pathway for child welfare agencies – at all stages – may be to send referrals directly to a community provider that is contracted for ECM or to Full Circle Health Network. Full Circle and providers can then screen for eligibility and complete all required information for authorizing ECM services. Social workers can give the parent/caregiver a pamphlet or brochure that describes ECM and tell them to expect a phone call. Our experience has shown that "priming" a parent/caregiver/foster parent with the information improves their willingness to engage. Emphasizing that ECM is a Medi-Cal benefit and not part of the child welfare system may also increase engagement.

Figure 4: Leveraging ECM To support Families: Example Referral Pathway



Driver #4

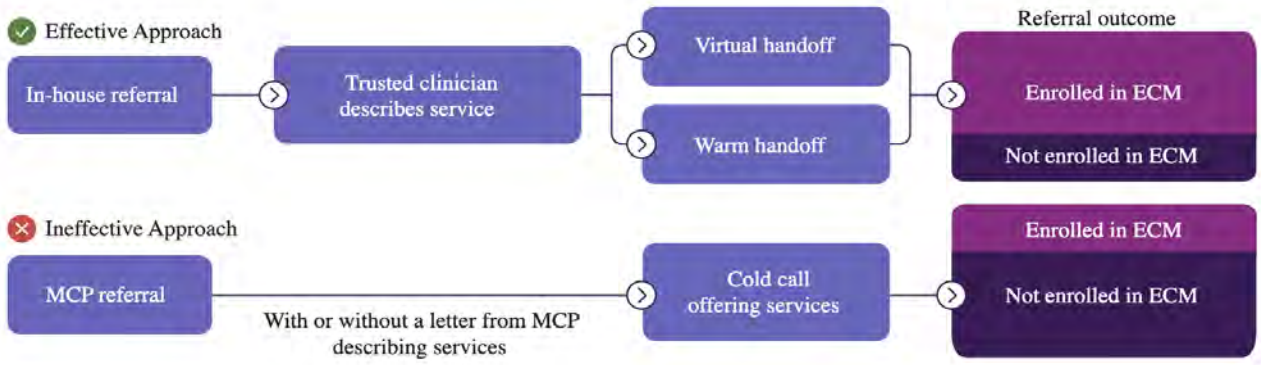
Some MCP ECM networks do not include agencies child welfare agencies recognize.
Previous research by the RAND Corporation found that the most effective method for enrolling patients in ECM is when referrals come from trusted providers that already have a relationship with the patient. MCPs sending eligibility lists of patients who were potentially eligible for ECM services was far less effective because the lists are often inaccurate or patients did not answer cold calls from an unfamiliar person. However, many community-based organizations that child welfare agencies know and trust and are already serving these children and families are not enrolled as managed care ECM providers.

Recommendation

Counties and MCPs should collaborate closely to align their networks.

Counties should share with MCPs the list of family resource centers and other community-based organizations with which they contract to provide support and services to their families. MCPs should make a concerted effort to being these organizations into their networks for ECM, CS and/or CHW services. When these networks are aligned, children and families can receive a full range of services all under one roof, and Medi-Cal funding can be fully leveraged. Full Circle's network includes CBOs that comprise the child and family serving safety net. Full Circle can be a conduit to network alignment.

Figure 5: ECM Referral Approaches



Source: Rand Corporation, Oct. 2024

Driver #5

Inaccurate contact information. Medi-Cal managed care plans can identify children in foster care by their Medi-Cal aid codes. However, the contact information for the foster parent or guardian often is not accurate or the county social services agency is listed. This makes it difficult to contact the adults responsible for the children to let them know about ECM as a new resource. Further, managed care plans may not know the county of jurisdiction for their foster care enrollees.

Recommendation

Counties should increase education and communication materials.

Counties should increase education and communication materials about ECM for foster family agencies and foster parents. Social workers can help connect the children and families to an ECM provider. Managed care plans and counties should develop methods to match their populations, identify them in a registry and provide updated contact information to providers.

Driver #6

Lack of clarity around consent. Confusion exists on who has authority to consent to ECM services or with whom ECM services should be coordinated (i.e. public health nurse, foster parent, biological parent, etc), especially for the one in three children younger than age five.

Recommendation

Clarify that consent for ECM is the same as general health care services.

Educate social workers, foster parents and biological parents that consent for ECM should not be any different than referrals and coordination to existing prevention services or basic health care services. It is the responsibility of the county social worker, in consultation with the foster parent, to decide if it is in the child's best interest to enroll in managed care or fee-for-service (if there is an option). Foster parents may consent on behalf of a minor for ordinary health services. In most cases, a youth 12 or older may consent on their own per California's minor consent laws. In short, consent for ECM shouldn't be any different than consent for other types of services.

Using Community Health Workers to Increase Connections

While most of this paper focused on increasing uptake of ECM, we do not want to ignore the significant opportunity that CHW services presents – especially for parents and family members. Uptake of CHW services is even lower than ECM, but the thresholds to provide the service and complexity in delivering the service also are lower (e.g. now customized reporting). Furthermore, CHW services are available in fee-for-service, which is how half of children in foster care access their Medi-Cal benefits today. By building out CHW and ECM services, child welfare providers can provide navigation and advocacy support to most children they serve regardless of managed care or fee-for-service status. CHW services for the parent or caregiver can be paired with ECM for a child/youth.

Conclusion

Any major system change takes time to understand and adopt, but children and families involved with child welfare are at a significant crisis point in their lives and urgently need additional support and resources. Medi-Cal's introduction of Enhanced Care Management, Community Health Workers and Community Supports represents an enormous opportunity for these families. Successful adoption requires new collaboration between county agencies, managed care plans, and providers. Implementing the action steps described above will result in linking more children and families to necessary services and increase their trajectory toward maintaining safe, stable and nurturing relationships which are foundational to mitigating the impacts of trauma and promoting long-term wellbeing.

About Full Circle Health Network

Full Circle Health Network empowers community-based organizations with the tools and knowledge to connect with health plans and public systems working to positively impact the health and wellbeing of vulnerable children, youth adults and families across California. Full Circle is a nonprofit organization built for and by community-based organizations that are the backbone of California's family serving social safety net. Learn more at www.fullcirclehn.org.

Acknowledgements

We want to express our gratitude to the UCAAN ACE's Aware Funding Initiative for financially supporting this work. We are grateful to network providers for their review and contributions to this paper and thought leadership around mitigating the impact of trauma and toxic stress among vulnerable youth and families. We appreciate the foundational support we received from the PATH CITED program at DHCS and from several Medi-Cal health plans that recognized the need to strengthen ties to community-based organizations and partnered with Full Circle. Finally, we appreciate the vision and leadership of the California Alliance of Child and Family Services to create the Full Circle Health Network.

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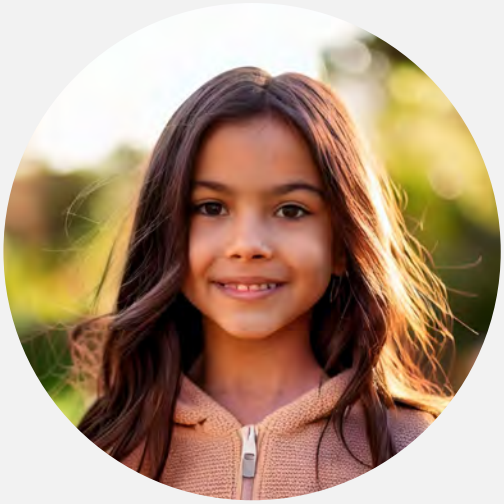
Resources

- **Child welfare ECM case examples**
  Hypothetical but real-world scenarios to show how ECM, CHW and CS can be leveraged to support youth and families in child welfare.

- **Child welfare case summaries**
  Explanations of different parts of the child welfare continuum.

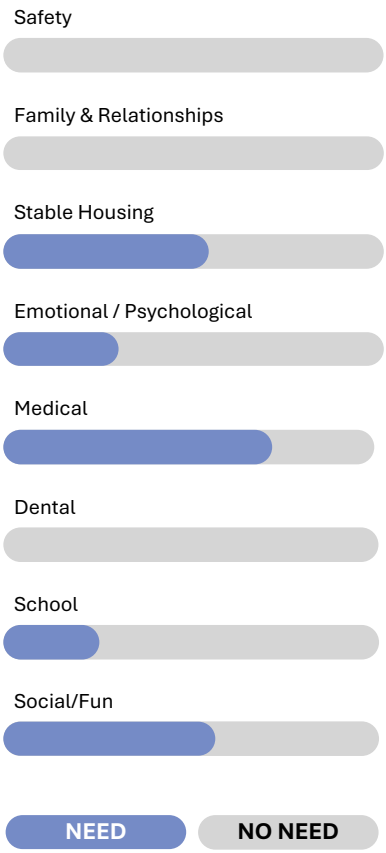
Sonja, 7



Scenario

Sonja, 7, was removed from her mother's care and placed with her father, Carlos, and a family maintenance case was opened. Carlos had not seen her in several years. He was living in his mother's subsidized apartment in violation of the apartment complex' rules. He and Sonja could not stay there long-term. Sonja is enrolled in a Medi-Cal managed care plan. Sonja goes to half-day school due to emotional dysregulation and stays with grandma for other part of day. Grandma has diabetes and may not be able to take care of Sonja if it is not better managed. Grandma is enrolled in the same Medi-Cal managed care plan as Sonja.

Core Needs



Presenting Needs/ Child & Family Goals

- Complete Family Maintenance Case Plan
- Support Sonja's education goals and get her ready to be in full-day school
- Help father find safe, stable housing and other food and employment assistance
- Support Sonja's ability to self-regulate and increase coping skills
- Support Grandma in controlling her diabetes so she can continue being stable child care

Role of ECM Care Manager

- Refer family to transitional housing program for 60 days of housing and help finding employment
- Connect dad and daughter to FQHC for medical, dental and behavioral needs
- Connect Spanish-speaking grandma to community health worker to support managing her diabetes
- Help father apply for food and cash assistance
- Research specialty MH services within the agency or elsewhere & make a "closed loop" referral
- Help father connect with school to ensure assessments have been completed and accommodations made (e.g. IEP/504 plan)
- Help Sonja/Dad explore and enroll in afterschool enrichment youth programs

Expected outcomes

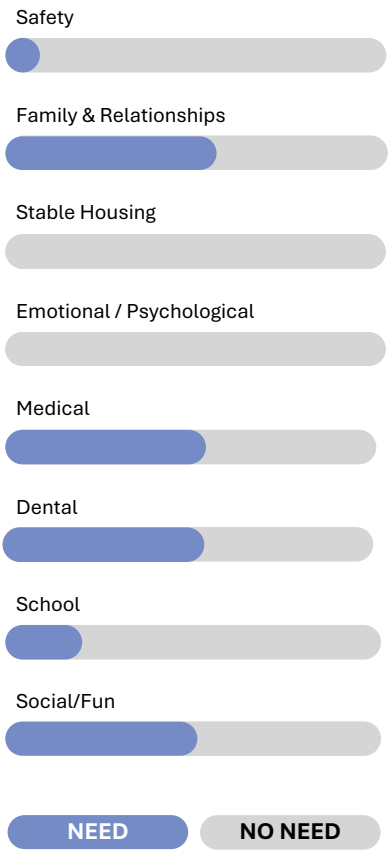
- Safe, stable housing
- Enrolled in school and enrichment programs
- Linkage to MH services

Sisters

Scenario

Two sisters ages 9 and 7 were removed from their home due to sexual abuse by their mother's boyfriend. The mother is an undocumented immigrant and Spanish is her primary language. The mother wants her children back ASAP, but had no family or supports. She needs a place where she and her children could live, but she has never rented an apartment before on her own.

Core Needs



Presenting Needs/ Child & Family Goals

- Help the mother find stable housing so she can reunify with her children
- Ensure family is enrolled in all available social services supports for utility support and food
- Connection to mental health services for the daughters to address trauma
- Connection to mental health services for the mother to address trauma
- Catch up on all physical health and dental appointments
- Afterschool activities and supports

Role of ECM Care Manager

- Community Supports referral to housing services agency to help family find, secure and sustain housing
- Ensure both sisters are linked to a specialty mental health services provider
- Help mom connect to a mental health provider
- Help both sisters update their assigned pediatrician and make appointments
- Help make dental appointments for both girls
- Identify and find resources for transportation if needed for appointment attendance
- Research youth enrichment programs and help girls enroll
- Refer mother to parenting resources

Expected outcomes

- Secure stable housing
- Speed up family reunification timeframe
- Linkage to MH services
- Once the family is reunified, stay with the case for an additional 5 months to maintain family stability

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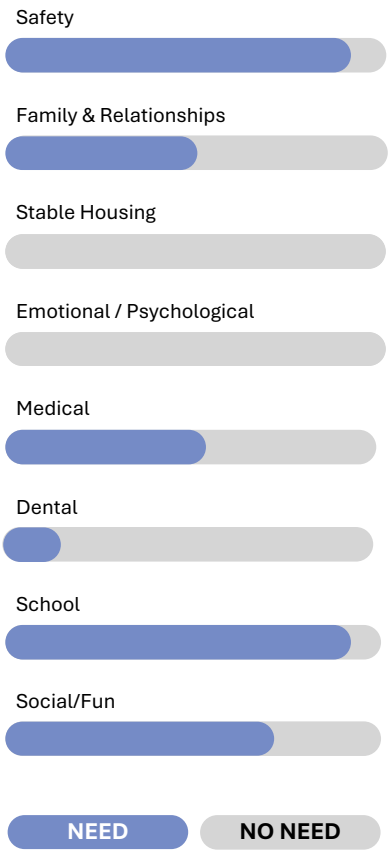
Marcee, 17

Scenario

Marcee, 17, was adopted by her grandparents out of foster care when she 2 years old. Her grandfather died unexpectedly when she was 3. Adoption assistance funds helped the family survive financially. Marcee was diagnosed with bipolar disorder, anxiety and ADHD. She had suicidal ideation in the past but currently was receiving services to help her manage. She was doing well in school. Her 18th birthday was approaching and the family worried that the adoption assistance financial support would end, which would be disastrous for the family. Marcee's grandma needed a plan for after she turned 18. Additionally, Marcee had severe tooth pain but couldn't find a dentist.

Core Needs



Presenting Needs/ Child & Family Goals

- Help grandmother and Marcee make a plan for ongoing financial and other assistance after Marcee's 18th birthday
- Help Marcee find a dentist to address her tooth pain
- Ensure that Marcee remains engaged in mental health services
- Work with Marcee on post-high school planning
- Give grandmother additional training and tools to support Marcee

Role of ECM Care Manager

- Help grandmother advocate for extension of adoption assistance funds.
- Ensure Marcee will continue to quality for all necessary services after turning 18 and educate Macree on how she can maintain her eligibility
- Family already received CalFresh food benefits; help them apply and qualify for reduced utility bill program
- Find a dentist that accepts Medi-Cal and make a appointment for Marcee
- Enroll Grandma in agency's Trust Based Relational Intervention training to give her better skills in dealing with her granddaughter's trauma responses
- Encourage Marcee to engage with her mental health service provider

Expected outcomes

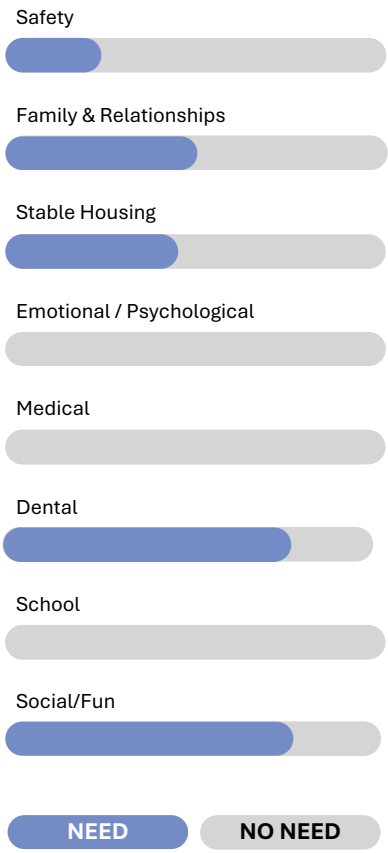
- Extend adoption assistance financial support due to Marcee's mental health needs
- Connection to Medi-Cal dental services
- Marcee stays engaged in mental health services and has a plan for post high school
- Education for grandma in supporting Marcee

Brothers

Scenario

Three brothers, ages 13 and 9 (twins), were removed from their adoptive grandmother for neglect and placed with their great aunt and uncle. Soon after the placement, the grandmother died unexpectedly. The older boy has short gut syndrome requiring a feeding tube and one of the younger boys (twins) has ADHD. The eldest sibling requires frequent medical care and hospital visits due to short gut syndrome. The aunt has learned to care for him. The boys are happy to be together but sad about grandma's death. They did not get to visit or say goodbye. Great aunt and uncle are in their 60's and are mentally and financially overwhelmed raising three young boys.

Core Needs



Presenting Needs/ Child & Family Goals

- Relative caregivers need additional financial support to supplement the cost of raising the boys.
- Connect brothers to grief counseling to process death of grandmother
- Medical management support/coordination for eldest sibling to maintain condition
- Afterschool and summer programs are needed for all siblings to maintain the adaptive skills needed to live successfully in the community.

Role of ECM Care Manager

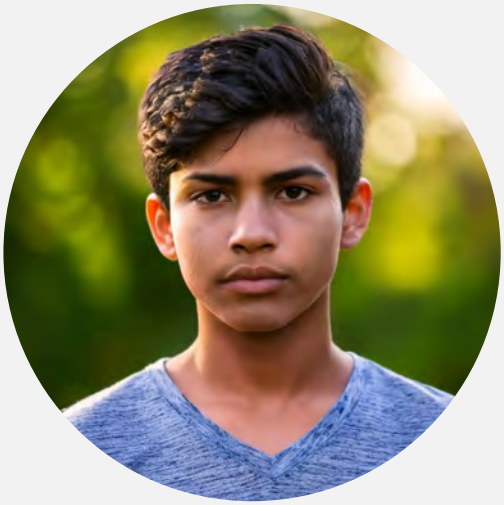
- Help relative caregivers ensure they are receiving all financial and other assistance related to meeting boys' needs
- Provide resource linkage, program enrollment support and care coordination support to family
- Coordinate and centralize services among eldest brother's medical care team, ensure aunt understands who all the providers are and feels confident in working with them
- Identify and apply for local funding scholarships to help pay for extra-curricular activities for the boys
- Identify resources for educational tools for aunt and uncle
- Guide aunt and uncle through the process of getting an IEP for twin with ADHD

Expected outcomes

- Boys have outlets to process feeling about recent changes, including grandmother's death
- Aunt and uncle feel less overwhelmed and better able to manage the boys, including having a financial plan to meet the basic needs of the brothers moving forward
- Enrolled in school and enrichment programs, receive scholarships to help cover costs of extra-curricular activities
- Linkage to MH services

Full Circle Health Network

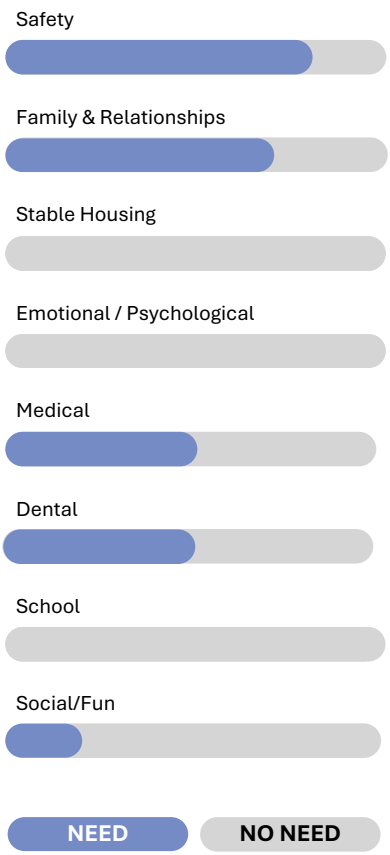
David, 14



Scenario

David was recently released back home from Juvenile Hall with terms and conditions placed upon him from the probation department. He must attend school, meet curfew, not associate with old acquaintances and follow his grandmother's rules in the home. The apartment building doesn't want David to return due to fear of bringing violence at the building, adding to his grandmother's stress. David has a history smoking marijuana on a daily basis. He has asthma. David has not been to the dentist in 3+ years and is complaining of a toothache and is self-conscious about an underbite. Grandma feels stressed about being able to manage her own health issues (hypertension and diabetes) while supporting David.

Core Needs



Presenting Needs/ Child & Family Goals

- Attend school on a daily basis
- Enroll in a tutorial program to catch up in school
- Participate in family counseling and be part of a Child and Family Team process
- See a dentist to address toothache and try to get braces
- Sign up for a club or social activity to make new friends
- Meet terms of probation

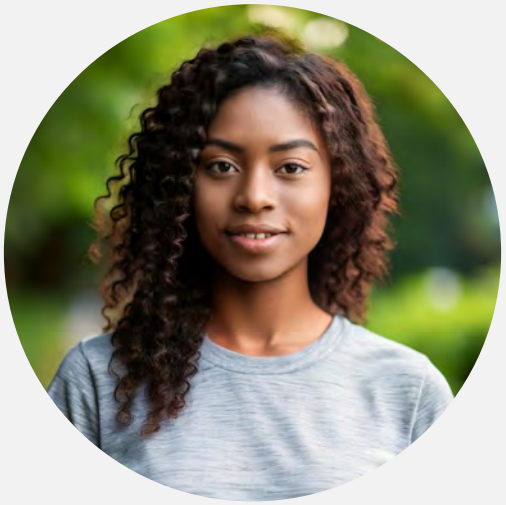
Role of ECM Care Manager

- Research alternative housing options with grandmother
- Make a referral to a mentoring program and ensure school links David to tutoring program
- Participate in the Child and Family Team (CFT) to support coordination of care
- Connect grandmother with a Community Health Worker at her FQHC to talk about how to better manage her own health conditions
- Connect David to pediatrician and help make sure he is caught up on all prevention health (vaccines, etc.), has refills on medications for asthma and gets questions answered on how to best manage his asthma
- Find a dentist taking Medi-Cal get David transportation to the appointment across town (only dentist available)
- Make referral to Community Supports for asthma abatement within apartment

Expected outcomes

- Stabilize behaviors from David in attending school and meeting curfew
- Build healthy support systems for David and grandmother
- Catch up on all pediatric appointments and good management of asthma resulting in no emergency room visits
- Fix toothache
- Receive asthma management education from a Community Supports provider
- Regular engagement in mental health services

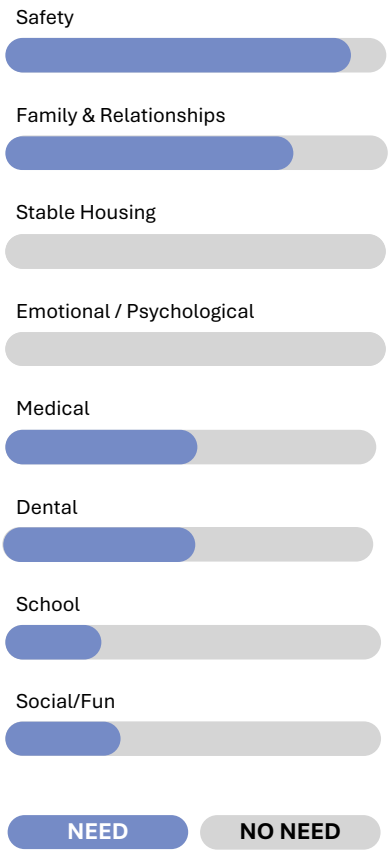
Jo, 20



Scenario

Jo is in extended foster care as a non-minor dependent. She lives in a transitional housing plus program and attends community college, traveling to and from school on the bus. She plans to transfer to a state university to complete a bachelor's degree and wants to be a teacher. She is suffering from frequent panic attacks and reports a constant feeling of anxiety. She acknowledges struggling with healthy eating to cope with her anxiety. She has some contact with her birth family but says she has not fully addressed her prior trauma exposure. After contact with her family, her anxiety increases. Due to her trauma history, Jo also struggles with developing trusting relationships and has few friendships. She does not engage in many clubs or activities outside the classroom.

Core Needs



Presenting Needs/ Child & Family Goals

- Start therapy and learn behavioral techniques to manage anxiety and cope with trauma triggers to reduce panic attacks
- Join social activities on campus and develop connections with peers
- Establish with a primary care provider
- Develop healthy eating and exercise habits
- Develop a plan to transfer to a four-year college with financial support

Role of ECM Care Manager

- Help Jo establish care with a PCP and connect to a mental health therapist contracted with her Medi-Cal MCP
- Teach Jo about the benefits available through her health plan and how to navigate them
- Engage with on connecting with the community college counselor and researching what social programs are available at school
- Help Jo research long-term housing programs to reduce anxiety about where she will live
- Support development of a plan to navigate the transfer to a four-year university

Expected outcomes

- Establish healthier habits and skills to manage her anxiety in coordination with her PCP and MH Provider
- Access Community College resources to develop a clear path to a State School & get involved in a social activity
- Jo understands how to navigate her health plan moving forward

At the Intersection: Child Welfare Definitions

As Medi-Cal Managed care plans focus more on supporting children and families involved with child welfare, it is important they understand more about the system. Below are summaries of key stages in the child welfare continuum. Each MCP can ask their local county about how many children and families are impacted at each stage below and if there are specific ways they can collaborate to mitigate trauma and impact from the system involvement.

- **Emergency Response (ER)** hotline workers receive 420,000 referrals annually and conduct safety assessments for each referral to evaluate risk to the child. ER workers conduct the investigations, may provide short-term ER services, and develop initial case plans.
- **Family Maintenance (FM) cases** are when a child stays at home with the parent, and the family receives support to prevent or remedy any abuse or neglect. FM services may happen voluntarily or on a court-ordered basis and may occur on the front-end to prevent removal or after reunification to prevent re-entry. FM status does not trigger Medi-Cal enrollment so there is no Medi-Cal aid code to identify these children.
- **Family Reunification (FR)** cases occur when abuse and neglect are substantiated, and children are removed from their parents. Counties must offer FR services to the parents of foster children with limited exceptions for up to 24 months. FR services are guided by case plans developed by the social worker with input from child and family teams and approved by the juvenile court. Case plans may require parents to participate in services for parenting-skills, mental health and substance use disorders. All children in FR cases are enrolled in Medi-Cal. About one in three children in foster care are younger than five.
- **Permanent Placement** occurs when children cannot live safely with their parents. Child welfare agencies must pursue concurrent planning as a two-track process that involves making reasonable efforts to reunify children with parents while simultaneously developing alternatives for a legally permanent family, which is either adoption or legal guardianship. When adoption or legal guardianship are not available, child welfare agencies must continue to seek permanent families for foster children while providing foster children and youth with services and supports, including mental health, educational and developmental services. All children in permanent placement cases are enrolled in Medi-Cal.
- **Post-permanency** services are provided by community agencies to ensure the continuing stability, safety, and well-being for children and youth who have moved from the temporary custody of the child welfare system into a permanent legal arrangement with committed caregivers. Medi-Cal may be the secondary insurance coverage to the legal guardian's primary insurance. Former foster youth are eligible for Medi-Cal up to age 26.
- **Resource Parents** is an additional term for **Foster Parents**. About 43% of foster youth are placed with relative caregivers in "kinship" placements and 33% are placed with non-relative resource parents. About 3% of youth are in placement settings called **Short-Term Residential Therapeutic Programs (STRTPs)**, which are intended to be temporary settings of intensive care and Specialty Mental health Services. About 9% are living independently in transitional housing and 11% are in other types of placement settings.[1]
- **Extended Foster Care (EFC) for Non-Minor Dependents (NMD)** is a program that allows foster youth to remain in foster care and receive services between ages 18 and 21. Youth may choose to live independently with financial support and other age-appropriate services to support their transition to adulthood provided by the county. These youth can be enrolled in Medi-Cal up to age 26.
- **Probation Youth.** County probation departments service foster youth who have been made wards of the juvenile delinquency courts. These youth receive supervision by probation officers and services similar to those provided to children in the child welfare system. These children are enrolled in Medi-Cal.

[1]California Legislative Analyst's Office. April 24, 2024. California's Child Welfare System: Addressing Disproportionalities and Disparities. Accessed Nov. 8, 2024.