Family Navigator Handbook

Final

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1.0 Purpose of the Handbook

The Family Navigator Handbook is designed to provide a comprehensive overview of the key components of the North Carolina Integrated Care for Kids (NC InCK) model and support Family Navigators working with families to provide family-centered, integrated care to NC InCK members. Sections point to parallel, in-depth resources and tools that Family Navigators can use to link families to services, convene an integrated care team, complete the NC InCK Consent form with families, and complete the NC InCK Shared Action Plan (SAP). The guide also provides recommendations for how Family Navigators can work with NC InCK Integration Consultants.

The guide will be updated over time to best meet the needs of Family Navigators. If Family Navigators have additional needs not outlined in this guide, please see the NC InCK website or contact the Integration Consultant assigned to you and your NC InCK member.

2.0 NC Integrated Care for Kids (NC InCK) Overview

2.1 Mission, Vision, Key Strategies and Values

2.1.1 Mission

Partnering with communities to support and bridge services where children live, learn, and play

2.1.2 Vision

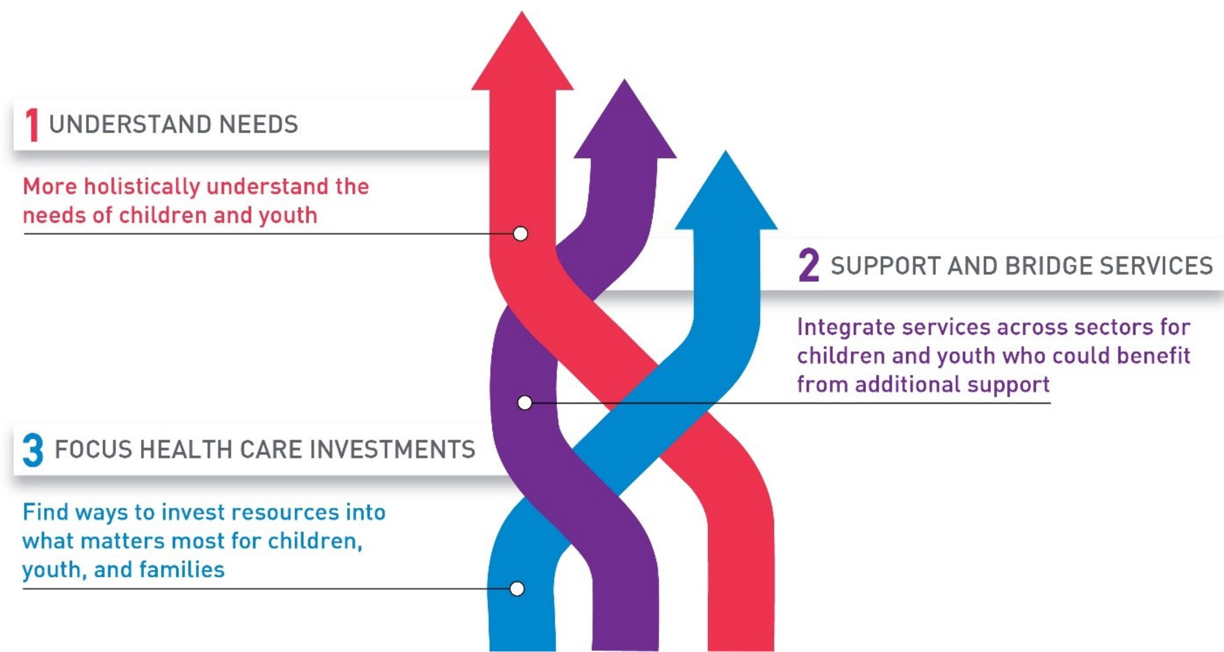
Healthy, thriving children, youth, and families living in a collaborative community

2.1.3 Key Strategies

- Understand the needs of children and families in the communities where they live, learn, and play.
- Support and bridge services that improve a child's well-being.
- Focus health care investments in new ways to improve child health and well-being.

Figure 1 illustrates our three key strategies as the threads in the braid of our NC InCK logo.

Figure 1. NC InCK's Key Strategies



2.1.4 Values

NC InCK Values are that we are Equitable, Strength-Based, Collaborative, Child- and Family-Led and Data Driven, as shown in **Figure 2**.

Figure 2. NC InCK Values

2.2 Timeline

Work on NC InCK launched in January 2020 and will extend through June 2026. The InCK service model and the Family Navigator role will be in effect for InCK members from 2022 through 2026.

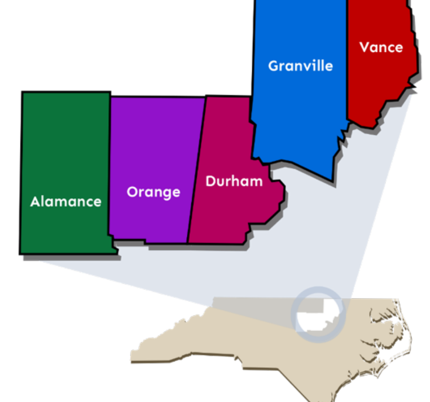
2.3 NC InCK Model Components

2.3.1 What is NC InCK?

NC InCK is a new government-funded model aimed at improving the way children and families receive care and support services.

2.3.2 NC InCK Population and Areas

NC InCK is available to all children, from birth to age 20, who are insured by Medicaid or CHIP in five central NC Counties: Alamance, Orange, Durham, Granville, and Vance. All children who receive insurance through Medicaid or CHIP in these counties are eligible, no matter where they receive medical care or which health plan they participate in. Children in standard plans, tailored plans, and Medicaid Direct are all enrolled in the NC InCK model. We estimate 90,000-100,000 children will be part of the NC InCK model.



2.3.3 Core Child Service Areas

NC InCK works in 10 core child service areas, described in **Table 1**, below:

Table 1. NC InCK Core Child Service Areas

Core Service	Description	Icon
Physical and Behavioral Health	Services that support an individual's physical, emotional, social, and psychological well-being and improve health outcomes. Providers include primary care providers (e.g., pediatricians family medicine practitioners), those who specialize in mental health and substance use needs, and community-based and inpatient treatment programs; social workers; dentists; nutritionists; and other health workers.	
Early Care and Education	Programs that focus on keeping children from birth to 8 years healthy, safe and nurtured, and learning and ready to succeed. For example, programs that provide early childhood education, health, nutrition, and family services for children (e.g., Head Start, Smart Start, Pre-K, home visiting, Reach Out and Read, and public and private early childhood centers).	A B C
Housing	Federally-funded and community-based programs addressing housing instability (e.g., having trouble paying rent, overcrowding, frequently moving, staying with relatives, or spending the bulk of household income on housing, homelessness) for children and families. These include Continuums of Care (funded by the Department of Housing and Urban Development), NC 211, and homeless shelters. Also includes rental and financial assistance programs, such as Public Housing Agencies (PHAs), or eviction	

Core Service	Description	Icon
Food	Federal, state, and community-based programs that address food insecurity and nutrition, as well as mitigating barriers to food access (e.g., transportation, stigma). Food assistance programs provide families the food they need for a nutritionally adequate diet, such as Food and Nutrition Services (Food Stamps), Women, Infants, and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), school lunch programs, and food distribution programs.	
Schools	K-12 public, private, charter, and alternative schools for children and youth. Health services delivered in schools include school-based health centers (SBHCs), food and nutrition supports, and Medicaid-covered services, such as school nursing services, and physical, occupational, and speech therapies. Services also include educational supports, such as for children and youth with an Individualized Education Program (IEP) or 504 Plan.	
Public Health Services-Title V	A federal block grant program that funds state maternal and child health agencies to work collaboratively with local health departments, schools, nutrition services, Early Intervention (EI), and other children's health programs.	
Child Welfare	A continuum of child and family social work services designed to ensure that children are safe and that families have the necessary support to care for their children successfully, including family preservation and support services; child protective and placement services; adoption and foster care; and other community-based programs that prevent abuse, neglect, and exploitation.	
Mobile Crisis Response	Assessment and de-escalation services provided by a team of qualified professionals that aim to reduce acute symptoms related to mental health and/or behavioral health emergencies where they occur.	
Juvenile Justice	Juvenile Justice includes Juvenile Crime Prevention Council programs, non-residential and residential services, and juvenile commitment facilities that operate to prevent and reduce delinquency by children and youth ages 6 to 18 years old. Juvenile Clinical Services and Programs include medical, psychiatric, dental, psychological, substance abuse, recreational, spiritual and case management services.	

Core Service	Description	Icon
Legal Aid	Civil legal aid has historically worked to address access to key health-related services, such as Medicaid and other public benefits like the Supplemental Nutrition Assistance Program (SNAP). Legal Aid of NC provides free legal services to people experiencing lower incomes in cases involving basic human needs, like safety, housing, and income.	

2.4 NC InCK Model Roles

2.4.1 Integration Consultant

Integration Consultants are NC InCK staff who support members of a child's team to meet the child's health, education, and social service needs. Integration Consultants support Family Navigators as they work to meet these needs for children and families across sectors. They can support the completion of Shared Action Plan (Appendix A) s for children and families. The NC InCK Integration Consultant team includes 16 members who are based in child welfare, Head Start, health departments, health plans, Duke, UNC, juvenile justice, and schools nursing. Integration Consultants will focus their efforts on building capacity and support for children who could benefit from additional cross-sector integration support.

2.4.2 Family Navigator

The Family Navigator is the primary contact who coordinates and integrates services for families in the NC InCK model. Family Navigators are based in organizations outside of NC InCK. They may be care coordinators or case managers based in a child's health plan or health care provider. The Family Navigator works directly with the family to meet their health and well-being goals and coordinates with integrated care team members who are working alongside the child and family. For children who could benefit from additional cross-sector care integration and support, the Family Navigator will bring together their family and integrated care team to create a Shared Action Plan.

3.0 Family Navigator Role Overview

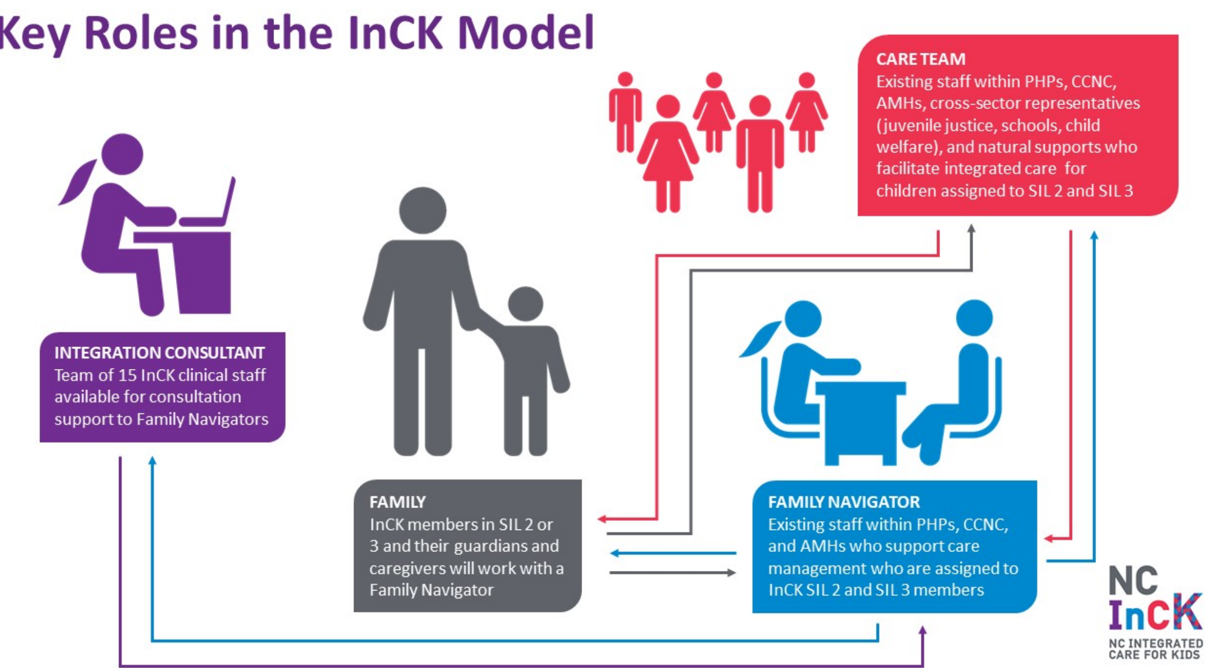
3.1 Purpose

Family Navigators take on the role of single point of contact for a subset of NC InCK members who can benefit from NC InCK's integrated care model. The Family Navigator will often be an existing staff member in a health plan, Advanced Medical Home (AMH), or Community Care of North Carolina (CCNC) who works directly with the family and integrated care team to meet the NC InCK member's health, social, and educational goals.

Family Navigators serve as the trusted support for families as they navigate the services and support needed to strengthen their child's well-being. They also play a critical role in identifying, convening, and collaborating regularly with the NC InCK member's integrated care team.

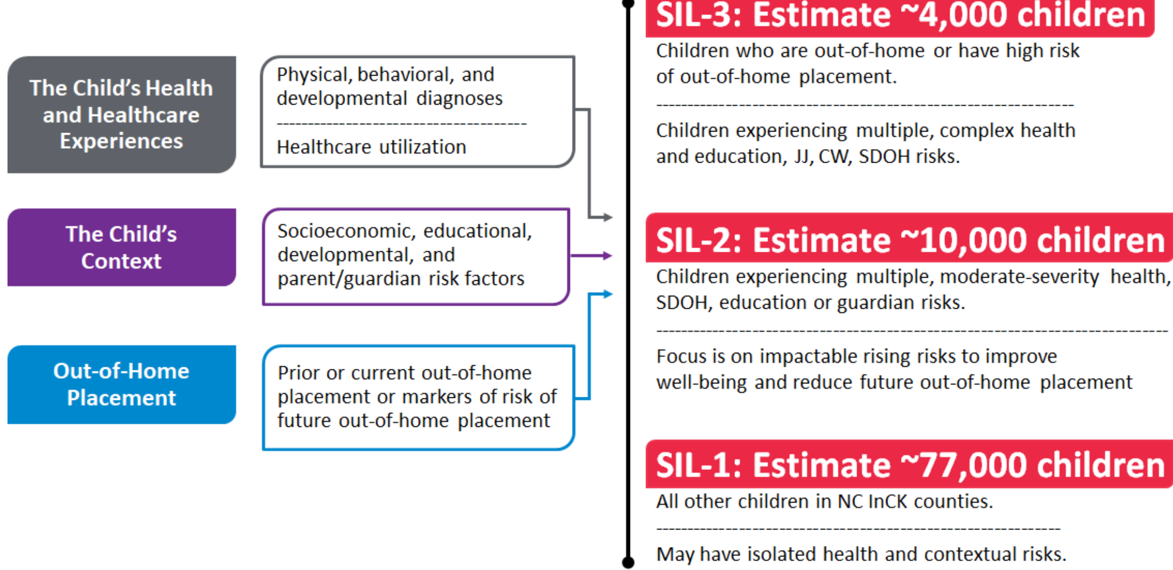
Unlike many other care management roles, the Family Navigator is intended to serve as a long-term support for families. Family Navigators serve in their role for at least 1 year and conduct regular check-

ins with both the NC InCK member's family and the member's integrated care team. These check-ins must occur at least quarterly, and they focus on both the goals and strengths of the NC InCK member and any open service and integrated care team coordination needs of the NC InCK member. **Figure 3** provides an overview of the key roles in NC InCK.



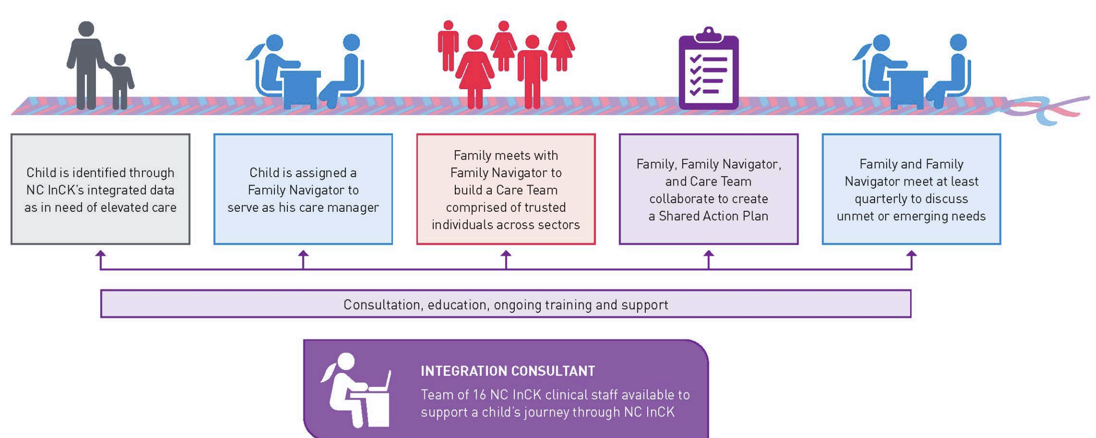
3.2 NC InCK Members Assigned to a Family Navigator

Each NC InCK member has a rich set of experiences, strengths, and needs that are included when assigning the member a Service Integration Level (SIL). Service Integration Levels signal a member's need for integrated care and risk for out of home placement. Health plans, AMH Tier 3's, and CCNC divide the responsibility of assigning a Family Navigator to all NC InCK members with a Service Integration Level of 2 or 3. These entities will receive a monthly list of all NC InCK members from NC Medicaid so they know which members to prioritize for Family Navigator assignment and the portions of the NC InCK integrated care model for each Service Integration Level. Figure 4 provides an overview of the estimated number of NC InCK members assigned to each SIL and the factors that go into SIL assignments.



3.3 Family Navigator Responsibilities

Family Navigators are the backbone of the NC InCK model, supporting NC InCK members in Service Integration Levels 2 and 3. They provide care integration support over a long-term period with touch points for both the family and the integrated care team. **Figure 5** provides an overview of a NC InCK member's path through the service model and how the Family Navigator supports their milestones.



Under the InCK model, Family Navigators meet the following responsibilities for all NC InCK members in Service Integration Levels 2 and 3 who agree to participate in integrated care:

- Serve as consistent point of contact for the family
- Foster long-term support of the NC InCK member and their family: NC InCK members will be paired with a Family Navigator for **1 year** from the initiation of integrated care

- Conduct **regular check-ins** with the NC InCK member and their guardian. These check-ins should be at least quarterly (every 90 days) but can be more frequent.
- Convene and communicate with an **integrated care team** as defined by family (including schools, early childhood education, child welfare, etc.)
- Support the NC InCK member's care needs across NC InCK's **10 core child service areas** (see Table 1 for additional details)
- Support completion of a **Shared Action Plan** and **NC InCK Consent form** (for applicable members)

3.4 Checklist for Family Navigator Support of NC InCK Members and Families

This checklist is also provided as a standalone document in Appendix B.

Family Navigator Checklist for Each InCK Member	**Done**
WEEK 1 – Assignment of InCK Member, Initial Outreach, InCK Consent	-
Once the NC InCK member is assigned, review the NC InCK member's Service Integration Level and conduct chart review in your internal electronic medical record for the member (for more information see Section 12.2)	
Conduct initial outreach (see example template in Appendix) to NC InCK member's guardian or NC InCK member to initiate care management and the NC InCK Model.	
Describe care management and support in the NC InCK model and the Family Navigator role. Confirm willingness to participate in services.	
Assess the NC InCK member's strengths and needs in 10 core child service areas	
Complete NC InCK Consent Form and use it to formulate member's cross sector integrated care team.	
(if applicable) Discuss Shared Action Plan and set up plan for completing with integrated care team.	
Review next steps with the NC InCK member and schedule next conversation.	
WEEK 2 – Service Linkages and Integrated Care Team Contact	-
Provide linkage to services for any needs identified in the 10 core child service areas.	
Initiate outreach to identified integrated care team members listed on NC InCK Consent Form. Share NC InCK Consent form with integrated care team members.	
(if applicable) Schedule time to complete the Shared Action Plan with integrated care team and guardian(s). **TIP:** Use an existing meeting at school or DSS if one already is already occurring and use 30 minutes for the Shared Action Plan.	

Contact NC InCK member's assigned Integration Consultant with participation status and completed NC InCK Consent Form.	
WEEKS 3-6 – Follow Up on Service Linkages and SAP Completion	-
Follow up on linkages to services for any needs identified in the 10 core child service areas.	
Communicate any care coordination needs or service gaps with applicable integrated care team members.	
Convene the integrated care team, including the family, to discuss the NC InCK member's strengths and goals and establish ways of working together over time with the family.	
(if applicable) Complete the Shared Action Plan with integrated care team, including guardian(s) and NC InCK member.	
(if applicable) Send the completed Shared Action Plan to integrated care team, family, and Integration Consultant.	
Continuing	-
Convene with the NC InCK member as necessary to meet open care needs across the 10 NC InCK core child service areas.	
Convene with the integrated care team members as necessary to meet open care needs across the 10 NC InCK core child service areas.	
Update the NC InCK Consent Form and the Shared Action Plan as needed based on changes to the integrated care team or the family's goals.	
Quarterly (every 90 days)	-
(Optional) Send NC InCK Quarterly Check-In Questionnaire to guardian in advance.	
Schedule quarterly check-in at a time convenient for the guardian.	
Convene for regular check-in with NC InCK member.	
Communicate and align with the integrated care team members listed on the NC InCK Consent form if new needs are identified or if needs persist.	
Transitions in NC InCK Enrollment	-
Family Navigator changes: Report changes in Family Navigator staff to Integration Consultant and schedule warm handoff with receiving Family Navigator	
Ending NC InCK enrollment: Confirm that NC InCK member plans to end NC InCK enrollment due to completion of goals, loss of eligibility, or NC InCK member's request to end NC InCK services	

Ending NC InCK enrollment: Inform Integration Consultant of discharge date from NC InCK services and reason for discharge	

4.0 Introducing Yourself to Families

4.1 Family-Centered Outreach

Each Family Navigator may have their own approach to introducing themselves to families and enrolling families in integrated care. NC InCK has supplied Family Talking Points with language to help describe NC InCK and introduce yourself. Family Navigators are encouraged to adapt the language in a way that best matches their style.

4.2 Relaying NC InCK Members' Participation in NC InCK

After your initial conversation with the family or NC InCK member, Family Navigators are asked to relay the NC InCK member's engagement in integrated care to the associated Integration Consultant. Integration Consultant assignments are shared to health plans and Advanced Medical Homes through the monthly Patient Risk List from NC Medicaid. This file includes the Integration Consultant assigned to each member, their name, email, and phone number.

Family Navigators should relay one of the following statuses to the assigned Integration Consultant within 14 days of outreach to the NC InCK member. If a Family Navigator needs more time to make additional attempts to engage the member outside of 14 days, NC InCK supports this. This information helps the NC InCK Integration Consultant confirm the NC InCK member's participation and anticipate which additional support and resources they should share to help the Family Navigator in their responsibilities.

Options for relaying NC InCK member participation to the Integration Consultant include:

- Unable to reach the NC InCK member after multiple attempts
- Guardian of NC InCK member declines integrated care services
- Guardian of NC InCK member confirms participation in integrated care & completed consent
- Guardian of nC InCK member confirms participation in integrated care but does not complete consent

Once a member is engaged in integrated care, Integration Consultants are also available to answer questions about the NC InCK model, provide connection to NC InCK resources, and provide one on one advising to meet a member's needs in NC InCK's core child service areas.

5.0 Establishing an Integrated Care Team

5.1 NC InCK Model Integrated Care Team Overview

An integrated care team is a cross-sector team of professional and natural supports that collaborate to support an NC InCK member and their family in meeting the health and social service needs identified by their family. Family Navigators will work with families to identify, convene, and collaborate with care teams to address goals in the core child service areas. Establishing an integrated care team model provides a mechanism for a child's and family's needs to be comprehensively assessed and supported over time, allows sharing of resources and knowledge, reduces the duplication of services, creates shared accountability among team members, and promotes family voice through a collaborative process.

Here we provide a brief overview of considerations for establishing an integrated care team for NC InCK members. For more detailed guidance and support on identifying and establishing an integrated care team, including tools and meeting agendas, please review NC InCK's Care Team and Shared Action Plan Guides.

5.2 Best Practices in Soliciting Integrated Care Team Members from Families

The most effective integrated care team will have a mix of family members, community supports, and professional supports. Natural supports can also work with the family before the meeting to identify and help remember any priorities they have to elevate to the integrated care team. NC InCK has created a few different tools to support Family Navigators in working with families to identify their integrated care team.

- **NC InCK Consent Form:** Lists entities and preferred contacts for integrated care team communication
- **NC InCK integrated care team roster (pg 2 of the SAP):** Similarly structured to NC InCK Consent form, this component of the SAP lists individuals, their contact information, and their preferred method of contact when sharing the SAP
- **NC InCK supplemental guide to services received (page 4 of the SAP):** A supplemental page to the SAP with a list of potential services and supports for the Family Navigator and family to review for inclusion by the integrated care team

Family Navigators should use a process that they believe works best for the families they work with when identifying and engaging individuals on their integrated care team. Most importantly, the family should decide who is part of their integrated care team and what information is disclosed. The Family Navigator should spend time building a rapport and listening to the family's story to help them identify their integrated care team members.

The Family Navigator may help the family build their integrated care team over time. If a need is identified, a referral may lead to the addition of other integrated care team members.

NOTE: If you add integrated care team members who need to be included in the NC InCK Consent form to share information, be sure to update the Consent and share it with the family, integrated care team and NC InCK Integration Consultant.

Example members of an NC InCK integrated care team (as applicable):

- Guardian and NC InCK member
- Family Navigator
- Natural supports, including: Grandparents, other family members, neighbor, church member, coach
- Primary Care Provider
- Healthcare Specialists
- Behavioral Health Provider
- Speech or Occupational Therapist
- School Nurse, School Social Worker, or School Teacher
- Early Childhood Provider, including: Head Start Family Engagement Specialist, Teacher
- Child Welfare Social Worker
- Juvenile Justice Court Counselor
- In-Home Services Provider
- Other Care Managers or Service Providers, including: Housing, home visiting, Counselors

5.3 Using the NC InCK Care Team Roster

The NC InCK Shared Action Plan includes an integrated care team roster (page 2) and a supplemental services list (page 4) used to help families identify integrated care team members and areas where additional support is needed. The integrated care team roster includes names, roles, and contact information for community-based supports or services. NC InCK members who may be involved in a variety of services benefit from the roster because it identifies all providers in one space and it can be used by the Family Navigator for integrated care team planning.

TIP: Make sure the Shared Action Plan's integrated care team roster (page 2) is highlighted and shared with other integrated care team members along with the consent form to encourage ongoing communication and care coordination for the NC InCK Member.

5.4 Holding Integrated Care Team Meetings

Once the NC InCK member and Family Navigator have worked together to identify the integrated care team members, Family Navigators will educate integrated care team participants on the process and begin planning a meeting. NC InCK focuses on two core values that stand out in when convening care team meetings – the process should always be child- and family-led and collaborative. Historically, child and family team meetings were designed to be strengths-based and solution-focused. This makes the NC InCK integrated care team meetings unique because they are not agency-specific and the goals come from the family.

5.4.1 Invitations and Establishing a Common Time

Family Navigators have the option of using an email script (see the Appendix B) to introduce themselves and the integrated care team process to potential integrated care team members. Integrated care team members should be informed of the purpose of the meeting and invited to be a part of the process. Several potential integrated care team meeting times should be presented. Once a common time is established, Family Navigators should send invitations to the team and ensure team members have access to the platform or space used. Reminders should be sent to the family and team the day before the meeting.

5.4.2 Information to Send Before the Meeting

Family Navigators should collaborate with the NC InCK member to create an agenda for the meeting, which should include introductions, review of ground rules, review of the purpose of the meeting, discussion of strengths and concerns, prioritization of concerns, and development of goals for the Shared Action Plan. The agenda should be distributed to the integrated care team and the family prior to the meeting. Additional items to consider are detailed in the NC InCK Care Team and Shared Action Plan Guide (Linked to website and available in Appendix).

5.4.3 Working with Families to Set Meeting Topics

Prior to the integrated care team meeting, the Family Navigator should talk about the integrated care team meeting format with the family, discussing what concerns they would like to bring to the meeting.

Consider exploring the following questions with families prior to the integrated care team meeting:

- What activities does your child do for fun?
- What are your child's strengths?
- What are your dreams for your child?
- If you could change something about how things are going for your child, what would it be?
- What are some difficulties your child and/or your family experience during everyday activities?
- What are some difficulties or challenges your child experiences during rare occasions?
- Are there places or people you find it challenging to communicate with to meet the needs of your child?

Families can also be encouraged to write down a list of issues they would like to prioritize and bring it to the meeting. It may also be helpful for families to bring existing care plans to the integrated care team meeting.

5.4.4 Other Care Team Meetings to Align with the NC InCK Integrated Care Team Meetings

Some NC InCK members may be involved with agencies or services that already use a similar care team process. Family Navigators do not need to facilitate additional meetings but can utilize the existing meeting structure to enhance the NC InCK integrated care team process and complete the Shared Action Plan. For example, if child has a regular meeting convened by Department of Social Services (DSS) or their school, this is a great time to consider bringing everyone together rather than creating another meeting.

6.0 Completing an NC InCK Shared Action Plan (SAP)

6.1 Shared Action Plan Purpose

The Shared Action Plan (SAP) (Appendix A) is a **brief, shareable, living document** created in collaboration between the Family Navigator, family, and the NC InCK member's integrated care team. The SAP encourages coordination and communication among all integrated care team members and trusted, natural supports. Key components of the SAP include preferences and strengths, a list of integrated care team members and their contact information, and the family's personal goals. The SAP serves as a valuable tool in building partnerships with families, and it promotes communication and integrated care coordination among families and integrated care team members.

One of the most valuable aspects of the SAP is that, with the family's permission, it is shareable to all those involved in the care of the NC InCK member. NC InCK has designed page 2 of the SAP as an integrated care team roster, so that all care team members can more easily access everyone's contact information to coordinate support for the NC InCK member.

The SAP went through and intensive design process based on NC InCK's review of over 100 care plans across the health care, child welfare, early childhood, and education sectors. Benefits of the Shared Action Plan include:

- Facilitates innovation and whole person care by using the family's voice to drive decisions, interventions, and goals
- Updates easily and can be shared with the integrated care team and family
- Empowers families to advocate for their child
- Actively engages the integrated care team in supporting goals and regular communication
- Provides a platform where all integrated care team members can be easily identified and accessed
- Creates shared accountability among all members of the integrated care team for cross-sector goals

6.2 Shared Action Plan Page by Page

The Shared Action Plan is a brief, four page plan that creates a platform for the family and Family Navigator to engage in a conversation about their needs, strengths, goals, and supports.

Page 1: Child and Family Background

This section gives a snapshot of the NC InCK member and their family, including their hopes, values, and preferences. This section can also be helpful in building a relationship with the family. The Family Navigator can pre-populate the child and family demographics and verify for accuracy with the caregiver.

Page 2: Integrated Care Team Roster

Children and families with different health, social, and behavioral needs frequently rely on a variety of services, providers, and resources to ensure access to care and support. It is helpful if families understand the system of services and people who may be contacting them as well as how they can contact their service providers. Members listed on the integrated care team roster can also communicate with one another.

Use this page to identify and list names, roles, and contact information of profession and natural supports that, combined, will be the integrated care team for the NC InCK member. Natural supports can include trusted family, friends, coaches, etc. Professional service providers can include specialists, clinicians, coordinators of care, educational supports, etc. The "additional info" column can be used to document tips such as the best times and methods to reach the identified person or important dates.

Page 3: Shared Action Plan

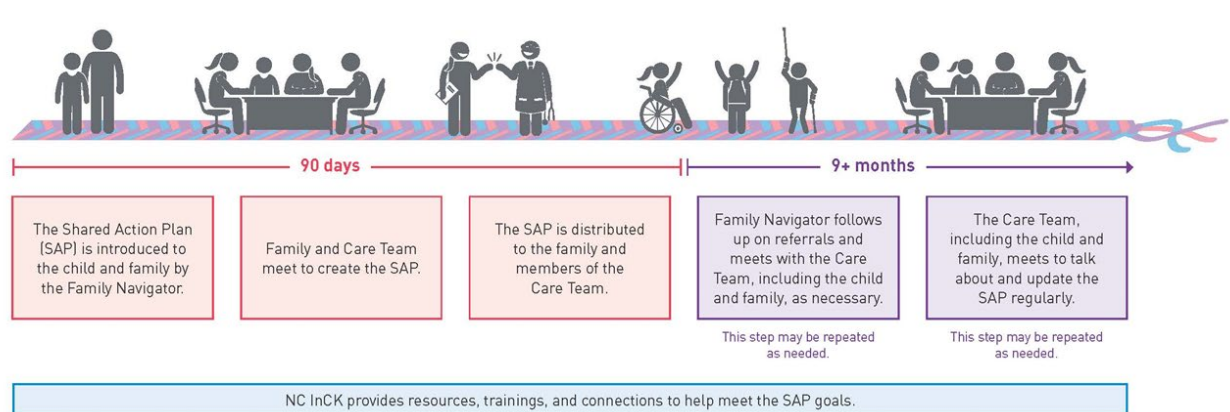
Families know their children best, and the SAP gives precedence to the family's goals and strives to empower the family to be involved in all aspects of their child's care. The SAP is also intentionally

designed to lift up cross-cutting goals that span health, education, social service, and other prioritized goals of families. The family and integrated care team can create up to five goals; however, NC InCK recommends starting with three. The SAP will be updated on a continual basis, and it is set up so that it is easy to add goals as needed. Each goal will be assigned an integrated care team member with concrete steps that they will take to support the goal. For additional details on updating the Shared Action Plan, including reasons to update, please see NC InCK's Care Team and Shared Action Plan Guide.

Page 4: (Supplemental) Current Services Received and/or Completed in the Last Year

This supplemental and optional page can be used in a few ways. During their first call with the caregiver, the Family Navigator can use this page to help the family determine which services they have received in the last year, including their current providers. The caregiver can determine which of these providers they would like to be part of their child's Shared Action Plan.

6.3 Preparing to Complete a Shared Action Plan



The Family Navigator will advocate for and advise families on how to fully participate as partners in the process. For the Shared Action Plan to be effective, the family will identify personal goals and be included in the creation of team strategies. Therefore, the Shared Action Plan should be developed with the caregiver's and NC InCK member's input.

The Family Navigator will lead the convening of the family and integrated care team for the development of the Shared Action Plan. The Shared Action Plan will be developed by the Family Navigator with the family with input from the NC InCK member's integrated care team members. The Integration Consultant will provide initial training to the Family Navigator and ongoing consultation as needed, such as developing obtainable goals, maintaining and updating the Shared Action Plan, and the central role of the family in the creation and ongoing use of the Shared Action Plan.

A convening for the SAP could be held in person, virtual, or by phone. NC InCK recommends convening in person or through a virtual platform to promote a sense of team buy-in and support of the family.

6.4 Supplemental Materials for Families Completing the Shared Action Plan

NC InCK has developed materials to help the Family Navigator, integrated care team, and family in the development of the Shared Action Plan. The following materials are available on the Family Navigator page on the NC InCK website:

- Guide to Integrated Care Teams and the NC InCK Shared Action Plan
- Shared Action Plan Template (also in Appendix A)
- Example of completed Shared Action Plan (also in Appendix A)

6.5 Sharing the Shared Action Plan with the NC InCK Integration Consultant and the Integrated Care Team

Sharing and using the Shared Action Plan after completion are critical to increasing the impact of the document for improving an NC InCK member's well-being. For example, sharing the SAP enables all care team members to look on the integrated care team roster (page 2) so that they contact other integrated care team members to coordinate support for the NC InCk member. The Family Navigator will ensure both the Shared Action Plan and NC InCK Consent form are accessible using the following recommended methods. Families and authorized integrated care team members should be made aware which platform is being used and how to access it.

- **Electronic Medical Records (EMR):** Family Navigators may share the SAP with some integrated care team members through their entity's EMR. Attaching the SAP into a patient's chart can make it easier for health care providers to view and use the SAP to coordinate the NC InCK member's care. Family Navigators can also use other portals in their EMR to grant access to other integrated care team members and the family.
- **Secure Transmission or Hard Copy:** Family Navigators can use the method approved by their entity to securely transmit the SAP to integrated care team members using the email address and contact information provided. Families may also ask for a hard copy of the SAP to share with future care team members.
- **NC InCK's VirtualHealth Integrated Care Platform:** Integration Consultants can provide role-based access to the NC InCK VirtualHealth Integrated Care Platform for a NC InCK member's profile. This platform can be used for sharing documents with the caregiver and integrated care team listed on the signed NC InCK Consent form. The Shared Action Plan, NC InCK Consent, and any other documents shared with the family can be stored securely on this platform.
    - *NOTE: All Family Navigators are asked to securely transmit completed Shared Action Plans and NC InCK Consent to their paired Integration Consultant for incorporation in the child's profile on the NC InCK VirtualHealth Integrated Care Platform.*

6.6 Updating and Using the Shared Action Plan

The Guide to Integrated Care Teams and the NC InCK Shared Action Plan provides guidance on updating and using the Shared Action Plan.

The SAP should be updated when there is a major change in the health and well-being of a NC InCK member or a situation that the family feels it is important to share with the integrated care team to align support for their child. Examples may include:

- A new medical/behavioral diagnosis
- Change in family status

- Change in integrated care team members or contact information
- Change in goals

Ongoing feedback from families on their experience with the Shared Action Plan process will help to identify opportunities to improve the process – both at the individual level and at the NC InCK level.

7.0 Completing NC InCK Consent Form with Families

7.1 Consent Form Overview and Purpose

NC InCK designed its Consent Form (Appendix C) based on extensive feedback from families of NC InCK eligible members and experts operating similar models of information sharing and integrated care for children and adults.

The Consent Form supplied by NC InCK is intended to enable three areas of action to support integrated care of members in SIL 2 and SIL 3:

1. **Care Team Collaboration** on the needs of the NC InCK member and progress towards goals for individuals and entities specified on the form. For example, a school social worker and pediatrician from the school and the health system listed on the form could discuss a child's treatment plan.
2. **Sharing the NC InCK member's Shared Action Plan:** Any entity and individual listed on the Consent form can have access to the NC InCK member's Shared Action Plan for awareness of the integrated care team members, goals, needs, and family contact information. Family Navigators are responsible for securely sharing this document with the entities listed.
3. **Role-Based Access to the NC InCK Virtual Health Integrated Care Platform:** Individuals listed on the NC InCK Consent form with an email address for notification will receive access to the NC InCK member's limited profile on NC InCK's Virtual Health Integrated Care Platform. The platform will list integrated care team members, store the Shared Action Plan, and store the Consent form. Integrated care team members can also message one another on the platform if desired.

7.2 Consent Form Template

Please see the Appendix C of this document for the template Consent Form or view on the NC InCK website.

7.3 Training for Family Navigators on Consent

NC InCK has both a document and a video providing an overview of the NC InCK Consent process and guidance for what to discuss with the guardian and NC InCK member as Family Navigators walk through the Consent Form. Both can be found on the NC InCK website.

7.4 Completing and Sharing Consent Forms

Prepaid Health Plans, CCNC, and AMHs have flexibility in how they obtain consent to best meet their workflows and technological capabilities (e.g., Docusign, their own Care Management platform, email, etc.). NC InCK strongly recommends using a method that allows families to sign the document through their mobile phone.

To view NC InCK's brief video overview for obtaining consent from an NC InCK member's guardian, please visit the NC InCK website.

TIP: The NC InCK Consent Form lists places to specify contact information for specific integrated care team members including their phone and email. NC InCK suggests mentioning the form to the guardian and NC InCK member in advance so that they can reflect on individuals they'd like to include. That way families can come prepared with some of the phone and email information needed to complete the form.

7.5 Revoking Consent and Consent Expiration

Revoking: If guardians change their preferences and would like to remove Consent, Consent can be revoked at any time by emailing ncinckconsent@duke.edu and providing the NC InCK member's name.

Expiration: Consent forms are signed and active for as long as the member is enrolled in NC InCK. Consent is removed five business days after NC InCK is informed that the member is no longer enrolled. Situations that would remove enrollment include:

- Moving out of the five NC InCK counties
- Turning 21 years old
- Losing their Medicaid/CHIP insurance coverage

If consent expires, NC InCK will remove role-based access to the NC InCK member's VirtualHealth Integrated Care Platform profile. NC InCK will also notify Family Navigators of the member's enrollment status and remind them that the consent is no longer valid. If Family Navigators would like to continue sharing updated Shared Action Plans and maintain ongoing integrated care team collaboration, they will need to complete an alternative consent from their home entity to allow for such.

8.0 Checking-In Quarterly with Families

8.1 Purpose of Quarterly Check-Ins

Family Navigators will serve as a family's single point of contact for at least one year for NC InCK members in SIL 2 and SIL 3. They will serve as a regular, consistent touch point focused on an NC InCK member's well-being and their evolving needs through at least quarterly check ins. Family Navigators have flexibility to meet with the family and integrated care team more regularly based on the needs of the NC InCK member.

Family Navigators will be expected to reach out to their assigned NC InCK members at least quarterly, regardless of the completion of a Shared Action Plan. The goal of the quarterly check-ins is to follow up on previous support provided and identify, new or elevated needs lifted up by the family before a crisis, and take action to coordinate with the integrated care team to support new needs.

8.2 Template NC InCK Check-In Questionnaire

The check-ins should be family-centered and led by the family whenever possible. The optional NC InCK Check-In Questionnaire (under development) will be a tool to facilitate a productive conversation with the family and child. The NC InCK Check-In Questionnaire can be sent by the Family Navigator up to one month in advance and, again, a week ahead of the meeting to give the family time to go through the document and think about topics they would like to discuss at the time of the check-in. The Family Navigator can also use this tool to help support the check-in, using the questions to build a family-centered experience.

8.3 Scheduling and Conducting Quarterly Check-Ins

Tips for Scheduling and Preparing

- In the first meeting with the family, as Family Navigators, you can let the family know that you are available as a long-term support and, if desired, you can have quarterly check-ins to discuss how their child is doing. They should always be expecting your call.
- Set the date and schedule with the NC InCK member's guardian at a time that is most convenient to them. Let them know the amount of time to set aside and the sort of topics that will be covered.
- Ask the family if there are things you can do to help the check-ins feel more comfortable and productive for the family.
- Discuss and agree upon the form of communication that works best for the family, whether that is phone, video call, or in person.

Tips for Conducting Quarterly Check Ins

- Start the conversation on a light and fun note. Take the time to ask the family how they are doing and if they have done or have any fun plans coming up.
- Try to write down family details that the family may mention. Examples include: pet names, areas of interest, siblings and siblings names, school activities that the children may be involved in, etc. Ask about these details. It can help make sure the family feels cared for.
- Once you have initiated and built a rapport with the family, begin by addressing points in the questionnaire. It is important for families to feel their concerns are heard.

8.4 Follow-Up and Reflection after Quarterly Check-Ins

After the Check-In is completed, there may be several areas of follow-up for the Family Navigator, including:

- Sending out the updated Check-In Questionnaire template with notes to the family
- Following up with other integrated care team members to coordinate services
- Referring the family to new services and supports for their child
- Making notes to adjust the future check-in structure based on the needs of the family

9.0 Receiving Support from NC InCK Integration Consultants

9.1 Integration Consultant

Integration Consultants are NC InCK staff who support Family Navigators in meeting NC InCK members' health, education, and social service needs. They can provide advice and assistance on the NC InCK model components and service navigation. NC InCK model components might include onboarding members, completing NC InCK's Consent form, convening integrated care teams, and completing the NC InCK Shared Action Plan. The NC InCK Integration Consultant team includes sixteen members who are based in child welfare, Head Start, health departments, health plans, care management entities (CCNC, Local Management Entities) Duke, UNC, juvenile justice, and school nursing. Integration Consultants will focus their efforts on building capacity and support for children who could benefit from additional cross-sector integration support.

9.2 NC InCK Integration Consultant Role and Responsibilities

Each Integration Consultant is assigned a panel of approximately 800 NC InCK members for whom they are responsible for supporting the Family Navigators in fulfilling the requirements of the NC InCK model, tracking members' high level engagement and progress, and providing advice to support Family Navigators in meeting their assigned members' needs across NC InCKs 10 core child service areas. The Integration Consultant has the following responsibilities to the NC InCK Family Navigator:

9.2.1 Model and Service Linkage Support:

1. Transmitting and walking through the NC InCK onboarding packet for new Family Navigators
2. Providing light touch assistance and training on the NC InCK Consent form
3. Providing light touch assistance and training on the NC InCK Shared Action Plan
4. Providing advice on forming and convening integrated care teams
5. Responding to support requests regarding navigating services and barriers for the NC InCK member across NC InCK's core child service areas
6. Advising on transitions in care between health plans, health systems, or eligibility changes

9.2.2 Capacity Building for Pediatric Care Management:

7. Hosting monthly Integrated Care Rounds focused on pediatric integrated care to support the broader cohort of Family Navigators
8. Identifying system level barriers to integrated care and working as a team with other Integration Consultants to propose and implement solutions
9. Providing capacity building and NC InCK model training to their home agency and partner entities

9.2.3 NC InCK Record Management:

10. Confirming the NC InCK member's status and engagement in integrated care with the Family Navigator
11. Storing the completed NC InCK Consent form and NC InCK Shared Action Plan on NC InCK's VirtualHealth Integrated Care Platform to share with integrated care team members
12. Creating role-based access to NC InCK's VirtualHealth Integrated Care Platform for integrated care team members listed on the NC InCK member's Consent form

9.3 Assigning NC InCK Integration Consultants to Family Navigators

Each Family Navigator will have an assigned Integration Consultant available to provide support and assistance on the NC InCK model and linkages to services across NC InCK's 10 core child service areas. Integration Consultants will have a specific panel built around approximately 800 NC InCK members from SIL 2 and SIL 3; however, Integration Consultants interact only with Family Navigators, not the families themselves.

The large panel size of Integration Consultants means that they are available for technical assistance to Family Navigators, but they do not serve in a direct care role or on integrated care teams. An Integration Consultant's panel is determined by a combination of factors including their expertise, their home entity, and the effort to create a specialized team of Integration Consultants for the care management teams serving NC InCK members (CCPN, CCNC, Duke PHMO, UNC Health Alliance).

The table below details the approach NC InCK uses to map panels for each Integration Consultant. Integration Consultant assignments are transmitted to PHPs, CCNC, and AMH Tier 3s each month from NC Medicaid, so that Family Navigators can proactively contact Integration Consultants when they need assistance or would like to relay key documentation. If NC InCK members meet multiple criteria, they are assigned in the order of the table to an Integration Consultant.

Integration Consultant Changes: As a child's enrollment status or attribution changes, NC InCK will also shift panels of Integration Consultants to maintain alignment between the entity housing the Family Navigator and the Integration Consultant.

Table 2. NC InCK Integration Consultant Panels

Characteristics of InCK Member	Additional Characteristics	Integration Consultant(s)	Home Entity
Juvenile Justice engagement	Any engagement (from intake to probation) in the last 12 months	Judy Lawrence	Juvenile Justice
Medicaid Direct: eligibility due to foster care status	Member is in active foster care placement	Melissa McDonald	Orange County DSS CCNC
Community Alternatives Program for Children	Current enrollment		Nurse Consultant
NC Medicaid Tailored Plan enrollment	Meets criteria for Tailored Plan enrollment in July 2022	Nikeya Cole	Alliance Vaya Nurse Consultant (Overflow)
Duke PHMO attributed for care management	Under 11 years old 11 years or older By Member's PHP Enrollment Additional capacity	Brie Dorsey Judy Lawrence Ashley Woolard LaShawnda Massey Diana Vandergrift Tami Hilton Nancy Madenyika	Head Start Juvenile Justice AmeriHealth CCH Healthy Blue United Duke PHMO
Community Care Physicians Network attributed for Care Management	Current attribution to AMH Tier 3 served by CCPN By Member's PHP Enrollment	La'Shanda Person Ashley Woolard LaShawnda Massey Diana Vandergrift Tami Hilton	Granville-Vance Health Department Orange County Health Department AmeriHealth CCH Healthy Blue United Wellcare
UNC Health Alliance attributed for care management	By Member's PHP Enrollment	Ashley Woolard LaShawnda Massey Diana Vandergrift Tami Hilton	AmeriHealth CCH Healthy Blue Wellcare

	Additional Capacity	Ashley Saunders	UNC Health Alliance
Enrolled in Standard Plan, but AMH Tier III is	By Member's PHP Enrollment	Ashley Woolard LaShawnda Massey Diana Vandergrift Tami Hilton	AmeriHealth CCH Healthy Blue United Wellcare

If you are unable to locate the Integration Consultant for your NC InCK member or have other questions about your NC InCK member's assigned Integration Consultant, please email or call Lead Integration Consultant, Nancy Madenyika, with your request (Nancy.Madenyika@duke.edu or 919-452-0178).

9.4 Contacting an InCK Integration Consultant

Table 3. NC InCK Integration Consultants

Name	Home Entity	Phone	Email
Nikeya Cole	Alliance	919-667-4750	ncole@alliancehealthplan.org
Ashley Woolard	AmeriHealth	984-245-3617	awoolard@amerihealthcaritasnc.com
LaShawnda Massey	Carolina Complete Health	980-985-8614	lashawnda.massey@carolinacompletehealth.com
	Community Care of North Carolina		
	Division of Public Health – School Nurse		
Nancy Madenyika, Lead	Duke Health System	919-452-0178	nancy.madenyika@duke.edu
La'Shanda Person	Granville-Vance Health Department	252-492-7915 ext. 248	lperson@gvdhd.org
Brie Dorsey	Head Start		bdorsey@fcrinc.org
Kristen Moore	Healthy Blue		kristen.moore@healthybluenc.com
Judy Lawrence	Juvenile Justice		
Melissa McDonald	Orange County Health Department	919-245-2835	mmcdonald@orangecountync.gov
Ashley Saunders, Lead	UNC Health Alliance		Ashley.Saunders@unchealth.unc.edu
Tami Hilton	United Wellcare	252-515-4889	tammera_hilton@uhc.com

10.0 Supporting NC InCK Members' Needs in NC InCK's 10 Core Child Service Areas

10.1 Overview of the 10 NC InCK Core Child Service Areas

NC InCK's 10 core child service areas have been specified by CMS and have been selected as key supports that children and families need for the well-being of their child. No one individual can be an expert across these different systems, but the Family Navigator's goal is to understand a family's needs in these areas and bring together the integrated care team to support these identified needs. NC InCK has developed core child service guides with county-specific resources in each of these areas that can be used by the Family Navigator to address needs across these services. In addition, Integration Consultants will be available to provide consultation in each of the core child service areas.

10.2 NC InCK Core Child Service Guides and Uses

NC InCK created tailored core child service guides for Family Navigators to better understand the services available in the NC InCK service area for NC InCK members and their families. Guides are also focused on how Family Navigators can best work with integrated care team members in each of these areas to meet the needs of a NC InCK member. Core Child Service Guides can be found on the NC InCK website.

Table 4. NC InCK Core Child Service Guides

Behavioral Health	Overview of behavioral health managed care organizations, range of services offered in each county based on need, and guidance for Family Navigators supporting NC InCK members seeking behavioral health services
Child Welfare	Overview of both the Child Protective Services and Foster Care teams in child welfare and recommendations for how Family Navigators can best work with staff from both teams to meet the needs of NC InCK members engaged with or transitioning out of child welfare services
Care Team and Shared Action Plan	Concrete guidance and best practices for identifying, onboarding, and convening an integrated care team that is driven by the needs and preferences of a NC InCK member and their family, in-depth guidance and tips for completing and sharing the NC InCK Shared Action Plan
Early Childhood	Overview and contact information for the large set of services available in early childhood and recommendations on which services may be the best fit for NC InCK members based on family needs and preferences, including Pre-K, home visiting, child care, parenting services, Head Start, and others available in the five county NC InCK service area
Food	Guidance on what a Family Navigator can do to support a family that is facing food insecurity, categories by each NC InCK county, including both public benefits and private programs
Housing	Overview of county-specific services and programs for Family Navigators to use when supporting a family navigating housing instability, including recommendations for Family Navigators based on income, family composition, and availability
Legal Aid of NC	Overview of the most common reasons families reach out for support from Legal Aid (housing, benefits access, education supports) and concrete

	guidance on preparing families for the intake process to determine Legal Aid eligibility and fit for support
Public Health	Overview and eligibility guidance for a subset of recommended services offered through public health programs and local health departments, including dental services, CMARC for young children, and the NC Infant Toddler Program (CDSA)
Schools	Guidance for how a Family Navigator can engage with a child's school to gather information about a child's needs and to develop a plan for supporting a child, recommendations and contact information for whom to contact within each school district and school building

10.3 NC InCK Alternative Payment Model (APM)

The NC InCK Alternative Payment Model (APM) will be a **five year, targeted incentive program** in the five NC InCK counties, beginning July 2022 through December 2026. Alternative Payment Models are designed to improve patient experiences and health outcomes while reducing cost. APMs promote child-centered care by linking payment to the delivery of high-quality and cost-efficient care. They also give practices the flexibility to best meet the needs of their patients. This includes providing services that may not traditionally be reimbursed in fee-for-service payment approaches (e.g., coordinating care for social needs).

The NC InCK APM has been co-designed with leaders from NC Medicaid, all five PHPs, Clinically Integrated Networks (CINs) in NC InCK's five counties, and other stakeholders. The NC InCK APM will launch in July 2022. NC InCK's APM includes incentives for reporting and achieving goals in the areas of:

- Kindergarten Readiness
- Housing instability
- Food insecurity
- Completion of a Shared Action Plan for children with higher needs
- Screening for clinical depression and documenting a follow-up plan
- Emergency department utilization
- Disparities by race and ethnicity in well child visit completion in the first 30 months of life

Below we've listed a subset of those measures that Family Navigators may be engaged in supporting and point to additional resources that can help Family Navigators contribute to meeting APM outcomes as requested by their leadership teams.

- Kindergarten Readiness Supports
- Food and Housing Insecurity
- Well Child Checks

11.0 Using NC InCK's VirtualHealth Integrated Care Platform

11.1 NC InCK's VirtualHealth Integrated Care Platform Overview

VirtualHealth's Helios platform is used nationwide by healthcare and care management entities. Many entities in NC also use the platform. NC InCK will use its own instance of VirtualHealth to house profiles for each NC InCK member in SIL 2 and SIL 3. NC InCK's VirtualHealth Integrated Care Platform has the capacity to store key documents on NC InCK members, to present demographic information on NC InCK members, to house an updated integrated care team roster and contact information, and to facilitate secure messaging between Integration Consultants and active integrated care team members on the platform.

11.2 NC InCK's VirtualHealth Integrated Care Platform Uses

Specific components of each NC InCK member's NC InCK VirtualHealth Integrated Care Platform profile can be shared with integrated care teams based on the completed NC InCK Consent form, including the Family Navigator. The platform supports integrated care and the NC InCK model by:

- Storing completed and updated versions of the Shared Action Plan.
- Listing the latest integrated care team members, their roles, and their contact information as supplied by the Family Navigator to the Integration Consultant.
- Storing a completed and updated version of the NC InCK Consent form for reference.
- Allowing in platform messaging for the NC InCK Integration Consultant and other integrated care team members with active role-based access.
- Housing NC InCK's latest data on NC InCK member demographics, PCP, health plan, and assigned care managers.

11.3 Requesting Role-Based Access for NC InCK's VirtualHealth Integrated Care Platform

NC InCK Integration Consultants are responsible for creating role-based access to Family Navigators and integrated care team members for NC InCK's VirtualHealth Integrated Care Platform. The Integration Consultant will use the completed NC InCK Consent form to determine which members of the integrated care team the guardian has given permission to access.

To request access, please email your matched Integration Consultant and attach the completed NC InCK Consent form. Integration Consultants will review the NC InCK Consent form, and, if appropriately completed, create role-based access within five business days. Integration Consultants will need full names and email addresses to set up role-based access to NC InCK's VirtualHealth Integrated Care Platform.

Once role-based access is set up, NC InCK Integration Consultants will also supply a brief guide for logging into and viewing information on the NC InCK Member in the NC InCK VirtualHealth Integrated Care Platform.

11.4 Importance of Completing the NC InCK Consent for NC InCK VirtualHealth Integrated Care Platform Access

To protect NC InCK members' personal health information and the sharing of key documents created to support members, only individuals listed with their email addresses on the NC InCK Consent form can be added as a user on NC InCK's VirtualHealth Integrated Care Platform. Family Navigators can submit

updated versions of the NC InCK Consent form at any time to their Integration Consultant to add new users. NC InCK's VirtualHealth Integrated Care Platform's role-based access is for individuals, not entities, so NC InCK must have individuals specified on the NC InCK Consent form.

NOTE: Guardians can cancel their Consent at any time by emailing ncinckconsent@duke.edu. The Integration Consultant will notify the assigned Family Navigator within five business days if NC InCK has received a cancellation request for a NC InCK member.

12.0 Family Navigator's Role in Transitions for NC InCK Members

12.1 Overview of Transitions

NC InCK members will undergo transitions in their eligibility for Medicaid, the NC InCK model, and move between health systems and health plans. All of these influence the care management a NC InCK member receives, and may also impact a Family Navigator's role in providing integrated care. In this section we detail some recommended practices for NC InCK-specific warm handoffs and transitions for NC InCK members. These can be a complement to your entity's existing practices for care management warm handoffs.

12.2 Changes in NC InCK Eligibility

There are three reasons that NC InCK members may lose eligibility:

- NC InCK member turns 21 years of age
- NC InCK member loses Medicaid or CHIP insurance coverage
- NC InCK member's Medicaid administrative county is not one of the five NC InCK counties

Some of these coverage losses may not provide a long timeline for Family Navigator to transition materials to the family or integrated care team members, while an NC InCK member "aging out" of NC InCK presents a longer timeline for preparation.

12.3 NC InCK member loses Medicaid or CHIP insurance coverage

In this instance, the Family Navigator should work with the integrated care team and family to determine who would be able to provide ongoing service and assist the family in reaching their goals. The Family Navigator can re-share the latest Shared Action Plan with the integrated care team and family and help establish new pathways for communication on the needs of the NC InCK member. The Family Navigator can also provide education about how to obtain health insurance or support re-enrollment if coverage loss isn't a result of lost eligibility for Medicaid or CHIP. Lastly, before closing out the case, the Family Navigator should provide the youth and family with information about no or low-cost resources in their community that can still support their health (for example, sliding scale health clinics).

12.4 NC InCK member moves from service area or turns 21 years of age

In this instance, the health plan or care management entity can choose to continue to pair the Family Navigators with the member and their integrated care team to provide ongoing services similar to the NC InCK model. Family Navigators can still convene the integrated care team and meet with the family for quarterly check-ins.

If the Family Navigator is no longer able to be a part of the integrated care team because the member has moved out of one of the NC InCK counties, the Family Navigator should follow the protocol from their entity in providing a warm handoff to a case manager in another county and notify the integrated care team and family of the change.

12.5 Changes in Family Navigator

A Family Navigator may need to change for a variety of reasons, usually associated with a change in the entity that is responsible for providing care management to the NC InCK member. Updated information

for the new Family Navigator should also be submitted through the Patient Risk List (BCM051) to NC Medicaid on a monthly basis.

12.6 Family Navigator role change within the same entity

The original Family Navigator should notify the Integration Consultant that the NC InCK member is transitioning off their caseload and, if available, share the contact information of the new Family Navigator. The original Family Navigator should reach out to the new Family Navigator and discuss the case with them. This would include sharing the Shared Action Plan, the NC InCK Consent form, and any quarterly check-in notes. The original Family Navigator can also provide information on any follow-up, next steps, or referrals. The original Family Navigator should connect the youth and family to the new Family Navigator by phone. Finally, the new Family Navigator should contact the integrated care team members to notify them of the role change. NC InCK also suggests checking your entity's warm handoff process to make sure you have followed the protocol for your entity.

12.7 Family Navigator role change to a different entity

The Family Navigator should inform the Integration Consultant of the change. The original Family Navigator should attempt a warm handoff with a case manager at the receiving health plan. This could be done by contacting the access department to refer the NC InCK member for care management. If a new case manager is assigned, the Family Navigator could follow the steps in the above scenario. The original Family Navigator should contact the family and integrated care team with an update that there has been a change in health plans or care management entity and Family Navigator. If the new contact information is available for the new Family Navigator, that information can be included. Lastly, the Integration Consultant will follow up with the new responsible entity to learn if a new Family Navigator has been assigned and provide the individual with the necessary documents. Updated information for the new Family Navigator should also be submitted through the Patient Risk List (BCM051) to NC Medicaid on a monthly basis.

Examples of this type of change may include:

- A child moving from a CCPN to a Duke primary care practice
- A child moving between PHPs
- A child moving between a PHP and foster care eligibility or Tailored Plan eligibility

Appendix A. Shared Action Plan

Shared Action Plan Template

Example of Completed Shared Action Plan

Appendix B. Family Navigator Tools

Family Navigator FAQs

Checklist for Family Navigators with New InCK Member

Template for Contacting New InCK Member Families

Family Navigator Checklist for Each InCK Member	Done
WEEK 1 – Assignment of InCK Member, Initial Outreach, InCK Consent	-
Once the NC InCK member is assigned, review the NC InCK member's Service Integration Level and conduct chart review in your internal electronic medical record for the member (for more information see Section 12.2)	
Conduct initial outreach to NC InCK member's guardian or NC InCK member to initiate care management and the NC InCK Model	
Describe care management and support in the NC InCK model and the Family Navigator role. Confirm willingness to participate in services.	
Assess the NC InCK member's strengths and needs in 10 core child service areas	
Complete NC InCK Consent form and use it to formulate member's cross sector integrated care team	
(if applicable) Discuss Shared Action Plan and set up plan for completing with integrated care team	
Review next steps with the NC InCK member and schedule next conversation	
WEEK 2 – Service Linkages and Integrated Care Team Contact	-
Provide linkage to services for any needs identified in the 10 core child service areas.	
Initiate outreach to identified integrated care team members listed on NC InCK Consent form. Share NC InCK Consent form with integrated care team members.	
(if applicable) Schedule time to complete the Shared Action Plan with integrated care team and guardian(s). **TIP:** Use an existing meeting at school or DSS if one already is already occurring and use 30 minutes for the Shared Action Plan.	
Contact NC InCK member's assigned Integration Consultant with participation status and completed NC InCK Consent form.	
WEEKS 3-6 – Follow Up on Service Linkages and SAP Completion	-
Follow up on linkages to services for any needs identified in the 10 core child service areas.	
Communicate any care coordination needs or service gaps with applicable integrated care team members.	
Convene the integrated care team, including the family, to discuss the NC InCK member's strengths and goals and establish ways of working together over time with the family.	

(if applicable) Complete the Shared Action Plan with integrated care team, including guardian(s) and NC InCK member.	
(if applicable) Send the completed Shared Action Plan to integrated care team, family, and Integration Consultant.	
Continuing	-
Convene with the NC InCK member as necessary to meet open care needs across the 10 InCK core child service areas.	
Convene with the integrated care team members as necessary to meet open care needs across the 10 InCK core child service areas.	
Update the NC InCK Consent and the Shared Action Plan as needed based on changes to the integrated care team or the family's goals.	
Quarterly (every 90 days)	-
(Optional) Send NC InCK Quarterly Check-In Questionnaire to guardian in advance.	
Schedule quarterly check-in at a time convenient for the guardian.	
Convene for regular check-in with NC InCK member.	
Communicate and align with the integrated care team members listed on the NC InCK Consent form if new needs are identified or if needs persist.	
Transitions in NC InCK Enrollment	-
Family Navigator changes: Report changes in Family Navigator staff to Integration Consultant and schedule warm handoff with receiving Family Navigator	
Ending NC InCK enrollment: Confirm that NC InCK member plans to end NC InCK enrollment due to completion of goals, loss of eligibility, or NC InCK member's request to end NC InCK services	
Ending NC InCK enrollment: Inform Integration Consultant of discharge date from NC InCK services and reason for discharge	

Family Navigator Outreach Email to Care Team Members

Dear [Integrated Care Team Member Name or Entity Name],

We've been given your name and information from [NC InCK Member's Name] Guardian as a person who supports [NC InCK member Name]'s care and well-being. They also lifted you up as an important voice to have represented on the care team we're forming to support [NC InCK Member's Name].

[NC InCK Member Name] is receiving care management through [Family Navigator's organization] and I serve as their Family Navigator. [NC InCK Member's Name] Guardian has provided Consent (attached here) for me to communicate with individuals in your entity to coordinate the child's care and work more closely with you to meet their needs. I'm supplying the Consent, so you can also have it in your records for communicating with me.

Our goal for [NC InCK Member's Name] is to set up a formal care team that includes you and the other entities listed on the Consent, so that we can all better understand the role we're playing to support the child and communicate more quickly with one another when a need arises. The care team will collaborate at least once every 3 months to support [NC InCK Member's Name] needs.

I'm reaching out to invite you to join for a 1-hour integrated care team meeting that includes [NC InCK Member's Name] Guardian and the other entities and individuals listed on the Consent. The meeting will be focused on hearing about [NC InCK Member's First Name] strengths and needs, getting to know other integrated care team members, and establishing ways of working together as an integrated care team to meet their goals.

Here are three time options for participating in the conversation. The meeting will take place at [Insert Location or Virtual Platform]. We'll pick the option that is best for the most members of the integrated care team, since we know not everyone may be able to participate.

Please respond with which time you can join by [Insert Date], so I can include you in planning.

[Insert Date and Time 1]

[Insert Date and Time 2]

[Insert Date and Time 3]

Many thanks for your support,

[Your Name]

Appendix C NC InCK Consent Form

Appendix A. Shared Action Plan

Shared Action Plan Template

Example of Completed Shared Action Plan

SHARED ACTION PLAN FOR:

CHILD & FAMILY BACKGROUND

Please fill in the child & family background. Current caregivers may include birth parent(s), foster parent(s), or other family members. If applicable, natural supports may include essential family members, friends, or neighbors who play an important role in supporting the child's health and well-being.

Child's First Name: ____________________ Last Name: ____________________ Preferred Name: _______________

DOB: __________ County: ________________
(*mm/dd/yyyy*)

Preferred written & spoken language: ____________________ Preferred Pronouns: _________

Primary Caregiver Name: ___________________________ Legal Guardian

Relationship to Child: ______________ Phone Number: _____________ Other Phone Number: _____________

Email: ___________________________

Other Caregiver/Natural Support Name: ___________________________

Relationship to Child: ______________ Phone Number: _____________ Other Phone Number: _____________

Email: ___________________________

Family Navigator Name: ___________________________ Date completed: __________
(*mm/dd/yyyy*)

Your family's concerns and priorities related to your child's health and wellbeing are the focus of your Shared Action Plan. The information you choose to provide is helpful as we all work together to achieve your desired outcomes for your child and family.

Child's & Family's Strengths, Interests, and Activities:

Family's Area of Concern: What are you most worried about? What challenges does your child and/or family face every day? What challenges do not happen often, but are of concern?

CARE TEAM ROSTER FOR:

Please insert name and contact information for all people who are responsible for ensuring the well-being of the child. You may include the service providers and natural supports you feel are most important for the child's care. This roster will be used to communicate about any care coordination needs.

Who*	Relationship/Agency	Name	Phone and Email	Additional Info
Guardian/ Legally Responsible Person				
Other Family/Natural Supports				
Primary Care Provider				
Family Navigator				

*(These may also be chosen by the family from the supplemental page)

ACTION PLAN

Choose 3 priority goals (and up to 5) that you would like to prioritize to ensure the health and well-being of the child.

GOAL	WHO (Name of the person supporting goal)	IS DOING WHAT (Will take this action)	PROGRESS
			Date: ___________ *(mm/dd/yyyy)* Start date: ___________ *(mm/dd/yyyy)* Check in date: ___________ *(mm/dd/yyyy)* Completion date: ___________ *(mm/dd/yyyy)*
			Date: ___________ *(mm/dd/yyyy)* Start date: ___________ *(mm/dd/yyyy)* Check in date: ___________ *(mm/dd/yyyy)* Completion date: ___________ *(mm/dd/yyyy)*
			Date: ___________ *(mm/dd/yyyy)* Start date: ___________ *(mm/dd/yyyy)* Check in date: ___________ *(mm/dd/yyyy)* Completion date: ___________ *(mm/dd/yyyy)*
			Date: ___________ *(mm/dd/yyyy)* Start date: ___________ *(mm/dd/yyyy)* Check in date: ___________ *(mm/dd/yyyy)* Completion date: ___________ *(mm/dd/yyyy)*
			Date: ___________ *(mm/dd/yyyy)* Start date: ___________ *(mm/dd/yyyy)* Check in date: ___________ *(mm/dd/yyyy)* Completion date: ___________ *(mm/dd/yyyy)*

SAP Follow Up Date: ___________ *(mm/dd/yyyy)*

Please use this page to ask the family if they have used any of the services listed in the last year. If they say yes, please check the corresponding box. If you identify an area of need, please check the "support needed" box and consider helping the family develop a goal to meet that need. If there is a referral needed (examples include food, housing, etc.), the Family Navigator should make arrangements with the family to submit referrals in order to assist the family in meeting that need.

Service Area	**Current Services Received and/or Care Plans Completed in the Last Year**	
Physical Health	Primary care Specialty care Dental Physical health care plan created with health professional (list name of plan & organization of provider): ________	PT/OT/Speech Home Health/Medical Equipment Support Needed
Mental Health & Intellectual Disabilities	Outpatient Behavioral Health Services In-home Services Person-Centered Plan of Care (PCP) Comprehensive Crisis Plan (CCP) School-based Psychological Services	Residential or In-patient Psychiatric Services Individual Service Plan (ISP) Utilization of Mobile Crisis Response Service Support Needed
Education & Schools	Care Coordination for Children (CC4C) Exceptional Children's Program Individual Family Service Plan (IFSP) In- or out- of school suspension Behavior Plan Individual Health Plan Other accommodations/equipment needs at school	Early Intervention (Infant-Toddler Program) School counseling Individualized Education Plan (IEP) 504 Plan Emergency Action Plan Support Needed
Food	Supplemental Nutrition Assistance Program (SNAP) Women, Infants, & Children (WIC) program Food Pantry	Other Food Program Support Needed
Housing	Section 8 Housing Voucher Stay in shelter Needs help to pay utilities and water	County Housing Authority Experiencing homelessness Support Needed
Juvenile Justice	Diversion plan/contract Probation Individualized Service Plan (ISP)	Child and Family Team (CFT) plan Post Supervision Release (PRS) Plan Support Needed
Legal Services	Has requested assistance from Legal Aid of NC or Disability Rights of NC Support Needed	
Child Welfare	In-home Services Foster Care Therapeutic Placement	Kinship Care Support Needed

SHARED ACTION PLAN
FOR: Sophia Grace Augustono

CHILD & FAMILY BACKGROUND

Please fill in the child & family background. Current caregivers may include birth parent(s), foster parent(s), or other family members. If applicable, natural supports may include essential family members, friends, or neighbors who play an important role in supporting the child's health and well-being.

Child's First Name: Sophia Grace   Last Name: Augustono   Preferred Name: Sophie

DOB: 07/8/2006 (mm/dd/yyyy)   County: Orange

Preferred written & spoken language: English   Preferred Pronouns: She/Her

Primary Caregiver Name: Jersey Augustono   ☑ Legal Guardian

Relationship to Child: Father   Phone Number: 919-999-8888   Other Phone Number: n/a

Email: jerseyaugustono@doggies.co

Other Caregiver/Natural Support Name: Ebony Dorsey

Relationship to Child: Mother   Phone Number: 919-888-7777   Other Phone Number: n/a

Email: ebonydorsey@doggies.com

Family Navigator Name: Bryson Knight   Date completed: 11/30/21 (mm/dd/yyyy)

Your family's concerns and priorities related to your child's health and wellbeing are the focus of your Shared Action Plan. The information you choose to provide is helpful as we all work together to achieve your desired outcomes for your child and family.

Child's & Family's Strengths, Interests, and Activities:

Sophie mostly stays to herself reading or painting. Sophie currently lives with her dad and siblings (ages 9, 11, 13, 16). Sophie lives full time with her dad and visits with her mom for 2 weeks in the summer and rotates holidays. Sophie's parents divorced several years ago. As a group, the family enjoys taking a big vacation once a year, going to sport events and planting flowers in the garden by their house. Sophie is enrolled in a ballet class and attends that 2x a week. Sophie also enjoys working out several times a week and running 5 miles a day.

Family's Area of Concern: What are you most worried about? What challenges does your child and/or family face every day? What challenges do not happen often, but are of concern?

n & anxiety, bipolar disorder and an eating disorder. Sophie shared she wants to spend more time with her mom doing an activity she enjoys. Ebony stated she would like more time with all of her children but due to a court order she is unable to do that. Sophie stated when she does visit her mom, her mom is usually at work but that she would prefer they do at least 1 activity together during her short stay. Jersey and Ebony also expressed concerns with Sophie eating small amounts of food and being unsure how to help her. Jersey and Ebony stated Sophie has lost a significant amount

CARE TEAM ROSTER FOR: Sophia Augustono

Please insert name and contact information for all people who are responsible for ensuring the well-being of the child. You may include the service providers and natural supports you feel are most important for the child's care. This roster will be used to communicate about any care coordination needs.

Who*	Relationship/Agency	Name	Phone and Email	Additional Info
Guardian/ Legally Responsible Person	Father	Jersey Augustono	919-999-8888 jerseyaugustono@doggies.	Jersey has primary custody of Sophie
Other Family/Natural Supports	Mother	Ebony Dorsey	919-888-7777 ebonydorsey@doggies.com	n/a
Primary Care Provider	Generations Family Practice	Elizabeth Stern	919-777-6666 no email	n/a
Family Navigator	United Health	Tami Thebest	919-555-4444 tamithebest@uh.com	n/a
School	Orange County Public Schools Social Wo	Lauren Jones	919-444-3333 ljones@orange.com	Open office hrs every Wed from 10a-12p
Dance Instructor	Julie's Ballet School	Julie Pierce	919-333-2222 julie@yahoo.com	n/a
Psychiatrist	A Better Way Therapy	Richard Allen	919-222-1111 rallen@therapy.com	Has a standing appointment etw on Thursday's at 4
Nutritionist	Yummy Food LLC	Emily Eatss	919-111-0000 emily@yummyfood.com	Standing appointment 1x month

*(These may also be chosen by the family from the supplemental page)

ACTION PLAN

Choose 3 priority goals (and up to 5) that you would like to prioritize to ensure the health and well-being of the child.

GOAL	WHO (Name of the person supporting goal)	IS DOING WHAT (Will take this action)	PROGRESS
Plan 1 activity for December when Sophie visits Ebony	Sophie & Ebony	Sophie and Ebony will plan an activity for Sophie's visit with Ebony in December	Date: 11/30/2021 *(mm/dd/yyyy)* Start date: 12/1/2021 *(mm/dd/yyyy)* Check in date: ______ *(mm/dd/yyyy)* Completion date: ______ *(mm/dd/yyyy)*
Learn and put into practice ways for Sophie to eat more food	Sophie & Emily	Sophie & Emily will meet 1x a week virtually or over the phone to discuss nutrition and find foods that Sophie is interested in. Sophie and Emily will also review the amount of food Sophie is eating to work toward her eating more food	Date: 11/30/2021 *(mm/dd/yyyy)* Start date: 12/6/2021 *(mm/dd/yyyy)* Check in date: ______ *(mm/dd/yyyy)* Completion date: ______ *(mm/dd/yyyy)*
Investigate if there is a way to amend the current custody order	Jersey & Ebony	Jersey and Ebony will work together to see if there is a wy to amend the current custody order so Ebony can have more time with her children.	Date: 11/30/2021 *(mm/dd/yyyy)* Start date: 12/6/2021 *(mm/dd/yyyy)* Check in date: ______ *(mm/dd/yyyy)* Completion date: ______ *(mm/dd/yyyy)*
			Date: ______ *(mm/dd/yyyy)* Start date: ______ *(mm/dd/yyyy)* Check in date: ______ *(mm/dd/yyyy)* Completion date: ______ *(mm/dd/yyyy)*
			Date: ______ *(mm/dd/yyyy)* Start date: ______ *(mm/dd/yyyy)* Check in date: ______ *(mm/dd/yyyy)* Completion date: ______ *(mm/dd/yyyy)*

SAP Follow Up Date: 02/25/2021 *(mm/dd/yyyy)*

Please use this page to ask the family if they have used any of the services listed in the last year. If they say yes, please check the corresponding box. If you identify an area of need, please check the "support needed" box and consider helping the family develop a goal to meet that need. If there is a referral needed (examples include food, housing, etc.), the Family Navigator should make arrangements with the family to submit referrals in order to assist the family in meeting that need.

Service Area	Current Services Received and/or Care Plans Completed in the Last Year
Physical Health	✓ Primary care Specialty care ☑ Dental PT/OT/Speech Home Health/Medical Equipment Support Needed Physical health care plan created with health professional (list name of plan & organization of provider): Augustono
Mental Health & Intellectual Disabilities	☑ Outpatient Behavioral Health Services In-home Services Person-Centered Plan of Care (PCP) Comprehensive Crisis Plan (CCP) ☑ School-based Psychological Services Residential or In-patient Psychiatric Services Individual Service Plan (ISP) Utilization of Mobile Crisis Response Service Support Needed
Education & Schools	Care Coordination for Children (CC4C) Exceptional Children's Program Individual Family Service Plan (IFSP) In- or out- of school suspension Behavior Plan Individual Health Plan Early Intervention (Infant-Toddler Program) ☑ School counseling Individualized Education Plan (IEP) 504 Plan Emergency Action Plan Support Needed Other accommodations/equipment needs at school
Food	☑ Supplemental Nutrition Assistance Program (SNAP) Women, Infants, & Children (WIC) program Food Pantry Other Food Program Support Needed
Housing	Section 8 Housing Voucher Stay in shelter Needs help to pay utilities and water County Housing Authority Experiencing homelessness Support Needed
Juvenile Justice	Diversion plan/contract Probation Individualized Service Plan (ISP) Child and Family Team (CFT) plan Post Supervision Release (PRS) Plan Support Needed
Legal Services	Has requested assistance from Legal Aid of NC or Disability Rights of NC Support Needed
Child Welfare	In-home Services Foster Care Therapeutic Placement Kinship Care Support Needed

Appendix B. Family Navigator Tools

Family Navigator FAQs

Checklist for Family Navigators with New InCK Member

Template for Contacting New InCK Member Families

Frequently Asked Questions for Family Navigators

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Frequently Asked Questions for Family Navigators

What is North Carolina Integrated Care for Kids (NC InCK)?

North Carolina Integrated Care for Kids (NC InCK) is a new model aimed at improving the way children and families receive care and support services. **NC InCK will launch for all Medicaid- and CHIP-insured children from birth to age 20 in Alamance, Orange, Durham, Granville, and Vance counties on January 1, 2022.**

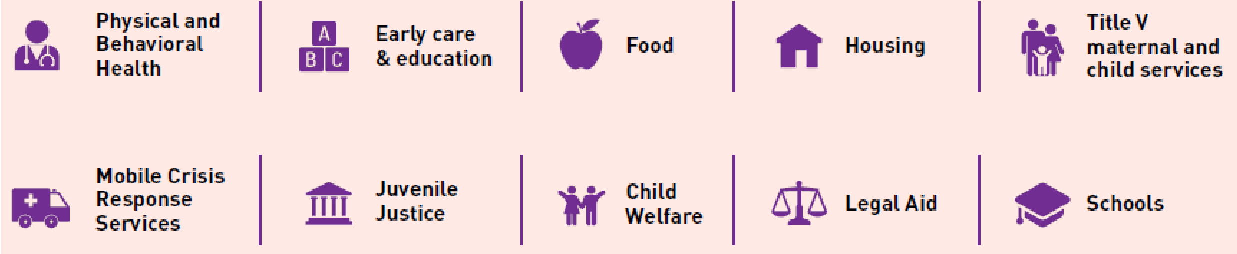
Vision: Healthy, thriving children, youth, and families living in a collaborative community

Mission: Partnering with communities to support and bridge services where children live, learn, and play

What are the core responsibilities of a Family Navigator?

The Family Navigator is a family's primary contact for integrated care. The Family Navigator's main responsibility is to coordinate cross-sector services for NC InCK members by working closely with their family and identified integrated care team members. The Family Navigator will:

- Work directly with families to help meet their health and well-being goals.
- Serve as a consistent point of contact for a family for one year through at least quarterly contacts to assess progress towards goals, identify emerging challenges, and connect to services.
- Convene the member's integrated care team, inclusive of the member's family, and coordinate meetings and communication among the individuals on the integrated care team.
- Support a member's care needs across NC InCK's ten core child service areas, which include:



- Support the completion of a Shared Action Plan (SAP) for a subset of members.
- Support the completion of the NC InCK Consent Form to allow for integrated care team collaboration, sharing the NC InCK SAP, and access to NC InCK's NC InCK VirtualHealth Integrated Care Platform.

How do the ten core child service areas relate to the Family Navigator role?

NC InCK's ten core child service areas are designed to bring together many of the key services and individuals that families may interact with or need support from to advance the well-being of their child. The Family Navigator's goal is to understand a family's needs in these areas and bring together the integrated care team to support these identified needs. NC InCK has developed a core child service guide with county-specific resources in each of these areas to be used by the Family Navigator to address needs across these services. In addition, Integration Consultants will be available to provide consultation in each of the core child service areas.

Who can be a Family Navigator?

Family Navigators are existing Prepaid Health Plan (PHP), Community Care of North Carolina (CCNC), or Advance Medical Home (AMH) Tier 3 staff, such as a care managers or community health workers. The Family Navigator is not an employee of NC InCK. PHPs/CCNC/AMH Tier 3's have flexibility on who they assign to the Family Navigator role. A few examples of positions that could serve as a Family Navigator are:

- Care Manager
- Community Health Worker
- Nurse (RN)
- Social Worker (BSW or MSW)
- Population Health Specialist

Many entities are considering a team structure for care management based on the needs of the NC InCK member. These entities should assign one of those team members to the role of Family Navigator. The assigned Family Navigator should be introduced to the family as the consistent, supportive contact for the NC InCK member's care needs and integrated care team coordination.

Given the timeframe of the Family Navigator role (one year), the Family Navigator may change for a family. PHPs/CCNC/AMH Tier 3s should have plans for communicating these changes to the family directly and in a timely manner.

How will NC InCK train and support Family Navigators?

By January, 2022, NC InCK will offer written materials and guidance to support Family Navigators in fulfilling their responsibilities. Resources will include:

- An NC InCK Family Navigator Handbook
- Training on completing the SAP and NC InCK Consent Form
- A best practice guide for quarterly check-ins with families
- Service guides for NC InCK's ten core child service areas

NC InCK will have a team of 15 Integration Consultants based across the core child serving sectors to assist Family Navigators as they fulfill their responsibilities. Ongoing support provided by the Integration Consultants will include:

- Consultation and education for Family Navigators regarding topics which emerge from the ten NC InCK core child service areas.
- Best practice guides and support for the creation of a cross-sector integrated care team.
- Monthly Integrated Care Rounds focused on a core child service area and capacity building topics for pediatric care management (e.g., combatting housing instability or enhancing mobile crisis response).
- Support and training on NC InCK's VirtualHealth Integrated Data Platform.

NC InCK will offer virtual capacity building events, at least once a month. Family Navigators should attend **at least 60%** of all Family Navigator capacity building events organized by NC InCK each year.

How will Family Navigators interact with Integration Consultants?

Family Navigators will be matched to an Integration Consultant with expertise aligned with the needs of their NC InCK members. North Carolina Medicaid will send the assigned Integration Consultant's name and contact information to PHPs and CCNC on a monthly basis. Integration Consultants will receive the contact information for NC InCK members' assigned Family Navigators on a monthly basis through the Care Management report (BCM051).

Integration Consultants will communicate with Family Navigators about the NC InCK member's enrollment in the model and offer support to Family Navigators in contacting and working with members' families. Integration Consultants will be available to Family Navigators by phone and email. Both methods of contact will be supplied to the PHP, CCNC, and AMH Tier 3 through a Service Integration Level (SIL) Stratification file sent monthly.

Why would a Family Navigator contact an Integration Consultant?

A Family Navigator may contact an Integration Consultant for a variety of reasons, including:

Advice and service linkages:

- Advice on meeting an NC InCK member's needs
- Education and resources on the ten core child service areas
- Resources and training for completing the NC InCK SAP and NC InCK Consent Form
    - *Note: Integration Consultants do not complete these documents. Instead, they provide resources and support to Family Navigators to aid in completing these documents.*
- Resources and training on convening integrated care teams and conducting quarterly check-ins with NC InCK members and integrated care teams

Submitting information to Integration Consultants:

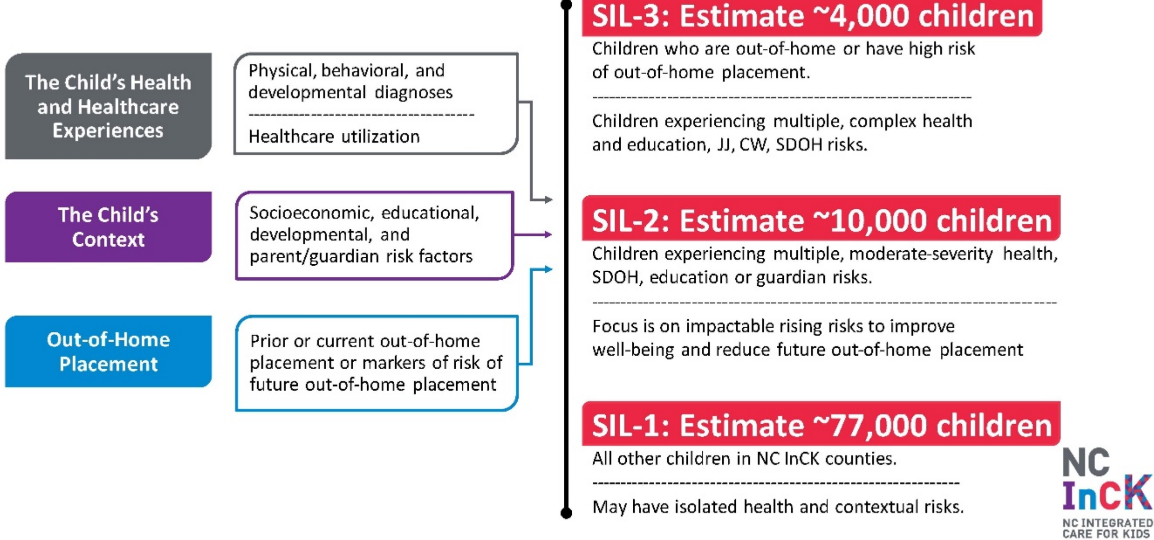
- An NC InCK member's engagement status with the Family Navigator
- Submitting an NC InCK member's completed SAP and NC InCK Consent Form to be uploaded on the NC InCK VirtualHealth Integrated Care Platform

Other resources and supports:

- Requesting access to the NC InCK VirtualHealth Integrated Care Platform
- Coordinating attendance for NC InCK trainings

What is a Service Integration Level (SIL) and why does it matter to the Family Navigator?

All NC InCK-attributed children will be stratified into Service Integration Level (SIL) 1, 2, or 3 based on the potential benefits they may receive from improved integration of services and their risk for out of home placement. NC InCK members in SIL 2 and 3 will be assigned to Family Navigators and will receive a set of NC InCK-specific interventions based on their SIL.



How will Family Navigators be assigned to NC InCK children and families?

Family Navigators will be assigned to NC InCK members in SIL 2 and 3. The NC InCK member's care management entity (either a PHP, CCNC, or AMH Tier 3) is responsible for designing a process for assigning a Family Navigator and communicating with the NC InCK member's guardian. Based on information recorded by PHPs, CCNC, AMH Tier 3s in the BCM051 report, NC InCK Integration Consultants will contact Family Navigators to determine which NC InCK members in SIL 2 and 3 are engaged with a Family Navigator.

When will Family Navigators begin working with NC InCK members?

The risk stratification process, which will place children into their SIL, will start in February 2022. North Carolina Medicaid will send members' SIL levels to Standard Plans and CCNC in mid-February 2022. PHPs will send the SIL as a priority population on a modified Patient Risk List to AMH Tier 3s affiliated with NC InCK members in late February. PHPs and AMH Tier 3s should then start the process of identifying care management staff to serve as Family Navigators for all NC InCK members in SIL 2 and 3. Each subsequent month, the integrated data algorithm will be administered and any elevation in member assignment to SIL 2 and SIL 3 will be communicated.

How will a Family Navigator get consent from families in NC InCK?

PHP, CCNC, and AMH Tier 3's have flexibility in how they obtain consent to best meet their workflows and technological capabilities (e.g., Docusign, their own Care Management platform, email, etc.). Family Navigators will receive detailed training on the NC InCK consent process prior to serving in the Family Navigator role. NC InCK will provide PHPs and AMH Tier 3s with the template NC InCK Consent Form for completion and related FAQs. The NC InCK Consent Form lists places to specify contact information for preferred integrated care team members, including their phone and email.

How will NC InCK communicate with families?

NC InCK Integration Consultants will not have direct contact with families, but they will work to help support the Family Navigators' communications with families with the following resources:

- A "NC InCK Families" tab on the NC InCK website (ncinck.org)
- FAQs for primary care providers serving NC InCK members
- Targeted beneficiary talking points to describe the NC InCK model for:
    - Primary care providers
    - Call center and Medicaid eligibility staff
    - Family Navigators

What is a Shared Action Plan (SAP) and how does it relate to the Family Navigator role?

The SAP is a living document created in collaboration between the family, Family Navigator, and the child's integrated care team to encourage coordination and communication among all integrated care team members. The SAP is different from other care plans because it is family-centered, shareable, and brief. Key components of the plan include family preferences and strengths, a list of integrated care team members, and child and family personal, educational, and social circumstances. The plan also includes the family's personal and clinical goals, assignment of responsibilities, agreed-upon strategies, and an anticipated timeline for the family's goals based on their needs and resources. All children in SIL 3 and a portion of children in SIL 2 will be offered the opportunity to create a SAP.

What is an integrated care team and how does it relate to the Family Navigator role?

An integrated care team is cross-sector team of professional and natural supports that collaborate to support NC InCK members and their families as they strive to meet their health and well-being goals. For NC InCK members in SIL 2 and 3, the Family Navigator is responsible for working with the family to identify and convene an integrated care team and then support the integrated care team by providing ongoing assistance to the NC InCK member and their family.

What do Family Navigators need to report to NC InCK?

Family Navigators are responsible for providing a copy of the completed NC InCK Consent Form and SAP to their assigned Integration Consultant via email or the NC InCK VirtualHealth Integrated Care Platform. Family Navigators may also be asked to provide updates to Integration Consultants on how families are engaging in integrated care.

What is NC InCK VirtualHealth Integrated Care Platform and how will Family Navigators use it?

The NC InCK VirtualHealth Integrated Care Platform is the integrated care platform used to store data and documents and to track the progress of NC InCK members. The primary users of the platform will be NC InCK Integration Consultants, who will access a NC InCK member's SIL and demographics as well as contact information for their Family Navigator as reported by PHPs, CCNC, and AMH Tier 3s to North Carolina Medicaid. The NC InCK VirtualHealth Integrated Care Platform will house the SAP and NC InCK Consent Form that Family Navigators complete with the NC InCK member (in addition to being stored within a system's own care management platform or electronic health records). NC InCK can give access

to the NC InCK VirtualHealth Integrated Care Platform to any Integrated care team members that a family lists on the NC InCK Consent Form.

Note: Other entities in North Carolina also use VirtualHealth as a vendor for their care management platforms (e.g., CCNC and United Healthcare), but these instances do not interact with one another.

How will the Family Navigator role change my organization's current care management model?

Below is a draft crosswalk of the NC InCK requirements alongside North Carolina Medicaid's existing PHP/AMH Tier 3 requirements to support planning for the NC InCK model.

	Attributed Members	Stratification	Stratification Frequency	Care Needs Screening	Comprehensive Assessment
All Medicaid Members	All members enrolled in plan	PHPs risk stratify based on DHB priority category (Risking Risk, High Unmet Resource Need, LTSS, etc.) PHPs also assign risk level of high, medium, and low	Varies by plan's methodology	All members receive 3 attempts for completion within 90 days of enrollment	Based on clinical judgement PHPs/AMHs conduct assessments on members who would benefit from one in order to develop a comprehensive care plan.
NC InCK Members	Members age 0-20 whose Medicaid administrative county is one of five NC InCK counties (Alamance, Durham, Granville, Orange, Vance)	NC InCK/ DHB assign all members SIL of 1, 2, or 3. SIL 1, 2, 3 become a new priority category for PHPs/AMHs	Monthly – While elevation to SIL 2 or 3 can occur monthly, members cannot be de-escalated to a lower SIL until the end of the	Target of **80% of NC InCK members** completing Healthy Ops (SDOH) screening questions each calendar year; **Healthy Ops questions asked every 6 months**	All NC InCK members assigned to SIL 3 get outreach for a comprehensive assessment

			calendar year (12/31)	**for SIL 3 members**	

	Integrated care team Assignment	**Care Manager Staffing**	**Length of CM**	**Frequency of Contact**	**Service Navigation**
All Medicaid Members	PHPs/AMHs assigned to care managers	Specifications outlined in Medicaid to PHP contract	Based on needs of member and clinical judgement of the care manager	Based on clinical judgement of the care manager	Care Manager is required to coordinate with all aspects of a member's life
NC InCK Members	All NC InCK members in SIL 2 and 3 are assigned to a Family Navigator (FN) within the AMH Tier 3 or PHP (depending on which is responsible for care management). The FN is part of the member's care management team.	A FN should be a RN, MSW, BSW, LPN, CHW, Population Health Specialist with experience and training in working with youth/families.	SIL 2 and 3 members who have engaged with the FN and care management team will receive supports from the FN for 1 year	SIL 2 and 3 members will receive outreach from the FN at least once quarterly	InCK emphasizes that FN should coordinate with all aspects of a member's life including: -Schools -Early childhood -Child welfare -Juvenile justice

	Care Plans	Identifying Broader integrated care team	Consent	NC InCK Integration Consultant
All Medicaid Members	Completed for each member who needs one based on clinical judgment. Includes: goals, medical needs, interventions, as well as social, educational, and other services	Integrated care team identification and convening is based on the needs of member and judgement of the care manager	Responsibility of PHP and AMH (entity doing care management) to obtain necessary consent for information sharing on member	Not assigned to care managers of general Medicaid members
NC InCK Members	All SIL 3 members, and a portion of SIL 2 members, receive outreach from FN to complete NC InCK Shared Action Plan; initial targets are 30% of all members in SIL 3 and 10% of SIL 2 all members complete Shared Action Plan based on PHP/AMH choice	FNs will work with family to complete integrated care team roster and convene integrated care team to coordinate communication and progress towards goals; Members may include schools, child welfare, PCPs, specialists, BH providers, juvenile justice, and natural supports	FNs will support families in completion of NC InCK Consent Form to empower SAP sharing, integrated care team coordination, and access to NC InCK VirtualHealth Integrated Care Platform; FN sends any completed consents to Integration Consultant	1 Integration Consultant assigned to each FN (via SIL stratification report); available for consultation on pediatric integrated care and service referrals; offers training and resources for FNs on child services, Shared Action Plan, consent, and integrated care teams.

Family Navigator Checklist for Each InCK Member	Done
WEEK 1 – Assignment of InCK Member, Initial Outreach, InCK Consent	-
Once the NC InCK member is assigned, review the NC InCK member's Service Integration Level and conduct chart review in your internal electronic medical record for the member (for more information see Section 12.2)	
Conduct initial outreach to NC InCK member's guardian or NC InCK member to initiate care management and the NC InCK Model	
Describe care management and support in the NC InCK model and the Family Navigator role. Confirm willingness to participate in services.	
Assess the NC InCK member's strengths and needs in 10 core child service areas	
Complete NC InCK Consent form and use it to formulate member's cross sector integrated care team	
(if applicable) Discuss Shared Action Plan and set up plan for completing with integrated care team	
Review next steps with the NC InCK member and schedule next conversation	
WEEK 2 – Service Linkages and Integrated Care Team Contact	-
Provide linkage to services for any needs identified in the 10 core child service areas.	
Initiate outreach to identified integrated care team members listed on NC InCK Consent form. Share NC InCK Consent form with integrated care team members.	
(if applicable) Schedule time to complete the Shared Action Plan with integrated care team and guardian(s). **TIP:** Use an existing meeting at school or DSS if one already is already occurring and use 30 minutes for the Shared Action Plan.	
Contact NC InCK member's assigned Integration Consultant with participation status and completed NC InCK Consent form.	
WEEKS 3-6 – Follow Up on Service Linkages and SAP Completion	-
Follow up on linkages to services for any needs identified in the 10 core child service areas.	
Communicate any care coordination needs or service gaps with applicable integrated care team members.	
Convene the integrated care team, including the family, to discuss the NC InCK member's strengths and goals and establish ways of working together over time with the family.	

(if applicable) Complete the Shared Action Plan with integrated care team, including guardian(s) and NC InCK member.	
(if applicable) Send the completed Shared Action Plan to integrated care team, family, and Integration Consultant.	
Continuing	-
Convene with the NC InCK member as necessary to meet open care needs across the 10 InCK core child service areas.	
Convene with the integrated care team members as necessary to meet open care needs across the 10 InCK core child service areas.	
Update the NC InCK Consent and the Shared Action Plan as needed based on changes to the integrated care team or the family's goals.	
Quarterly (every 90 days)	-
(Optional) Send NC InCK Quarterly Check-In Questionnaire to guardian in advance.	
Schedule quarterly check-in at a time convenient for the guardian.	
Convene for regular check-in with NC InCK member.	
Communicate and align with the integrated care team members listed on the NC InCK Consent form if new needs are identified or if needs persist.	
Transitions in NC InCK Enrollment	-
Family Navigator changes: Report changes in Family Navigator staff to Integration Consultant and schedule warm handoff with receiving Family Navigator	
Ending NC InCK enrollment: Confirm that NC InCK member plans to end NC InCK enrollment due to completion of goals, loss of eligibility, or NC InCK member's request to end NC InCK services	
Ending NC InCK enrollment: Inform Integration Consultant of discharge date from NC InCK services and reason for discharge	

Family Navigator Outreach Email to Care Team Members

Dear [Integrated Care Team Member Name or Entity Name],

We've been given your name and information from [NC InCK Member's Name] Guardian as a person who supports [NC InCK member Name]'s care and well-being. They also lifted you up as an important voice to have represented on the care team we're forming to support [NC InCK Member's Name].

[NC InCK Member Name] is receiving care management through [Family Navigator's organization] and I serve as their Family Navigator. [NC InCK Member's Name] Guardian has provided Consent (attached here) for me to communicate with individuals in your entity to coordinate the child's care and work more closely with you to meet their needs. I'm supplying the Consent, so you can also have it in your records for communicating with me.

Our goal for [NC InCK Member's Name] is to set up a formal care team that includes you and the other entities listed on the Consent, so that we can all better understand the role we're playing to support the child and communicate more quickly with one another when a need arises. The care team will collaborate at least once every 3 months to support [NC InCK Member's Name] needs.

I'm reaching out to invite you to join for a 1-hour integrated care team meeting that includes [NC InCK Member's Name] Guardian and the other entities and individuals listed on the Consent. The meeting will be focused on hearing about [NC InCK Member's First Name] strengths and needs, getting to know other integrated care team members, and establishing ways of working together as an integrated care team to meet their goals.

Here are three time options for participating in the conversation. The meeting will take place at [Insert Location or Virtual Platform]. We'll pick the option that is best for the most members of the integrated care team, since we know not everyone may be able to participate.

Please respond with which time you can join by [Insert Date], so I can include you in planning.

[Insert Date and Time 1]

[Insert Date and Time 2]

[Insert Date and Time 3]

Many thanks for your support,

[Your Name]

Appendix C NC InCK Consent Form

NC InCK Care Team Consent

Child/Patient Name: ______________________________

Child Date of Birth: ____ / ____ / ____

Parent/Legal Guardian ("Guardian") Name: ______________________________

Guardian Primary Language:

Does the Patient or the Guardian require an interpreter? ☐ Yes ☐ No

North Carolina Integrated Care for Kids (NC InCK) is a model to advance the well-being of children insured by the Medicaid and CHIP health insurance programs in five counties – Alamance, Durham, Granville, Orange and Vance. NC InCK aims to support and bridge health, social and education services for children from birth through age 20.

I, [Patient / Guardian name] ____ agree that Duke University Health System, Inc., and Duke University, including their physicians, employees, trainees, students, and contractor affiliates (collectively, "NC InCK") may access, receive, or share health, social and educational ***information related to the Child/Patient*** to strengthen integrated care coordination for the Child with the Care Team, who include the Child's health providers, care managers, schools and education supports, child welfare offices, social service providers and other persons supporting the Child.

This Authorization is to:

1) Allow the Care Team to communicate and support health, social and educational needs of the Child;
2) Share the Child's Information with the Care Team;
3) Grant access to the Child's profile on InCK's VirtualHealth platform for the Care Team; and
4) Share the Child's InCK Shared Action Plan with the Care Team (if one is created).

How does sharing benefit a Child?	NC InCK designed this authorization to help your Child's Care Team more easily identify and discuss your Child's care needs and coordinate their care.
How will the information be shared?	The information could be shared in conversations between the past, current and future Care Team, through messaging or online health platforms, verbal and written communication. The information could be shared through the Child's profile on the InCK VirtualHealth platform (see more details below) including any document uploaded by NC InCK, the Care Team or the family.

Who will have access to the information?

Any of the Care Team listed below will be able to share information about the Child's care needs, access to the Child's Shared Action Plan and InCK VirtualHealth profile.

What will be shared?

- Child's information, including name, date of birth, address, and county of residence.
- Guardian contact information, including name, address, county of residence, telephone and email.
- Medicaid information, including the Child's current Medicaid plan, the primary care provider's name, email, telephone number.
- Care management information including the organization responsible for providing care management for the Child, care needs and service needs identified for the Child, information on levels of support for the Child, and the name and contact information of care manager(s).
- Shared Action Plan is a brief, family-centered tool that includes contact information for Care Team members, Child's strengths, prioritized goals for the Child and family, and plans to achieve those goals. Some children and youth in the InCK model complete a Shared Action Plan to enable a Care Team and family to work together to support the Child.
- Child's ongoing care and service needs, including the Guardian's requests for services for the Guardian and the Child to help with meeting their goals for the Child.

This information will be collectively referred to as "Child's Information" for purposes of this Authorization.

Information shared without Authorization

HIPAA allows sharing of the Child's Information to permit providers to treat the Child and to receive payment.

Can I cancel this Authorization?

Yes, you can cancel this authorization at any time by emailing ncinckconsent@duke.edu. Please read below for more information on cancelling your authorization. For further information or assistance, you can reach out to NC InCK at the same email address.

Specifying the Care Team: The Care Team includes current and future organizations and individuals coordinating to meet the health, social and educational needs of the Child. Guardians must specify the "Entity" (practice, school, organization or agency) here for the authorization to enable Care Team information sharing. Guardians may also specify a "preferred contact" at each Care Team; however, the Care Team may share information with others within the Care Team entity to coordinate the Child's care.

Physical and mental health service providers for the Child (for example: Pediatrician, Primary Care practice, specialists, or therapists):

Practice Name	Preferred Contact (Name and Role)	Phone	Email

Schools and Education Supports (for example: The Child's school, Child Care Center)

School or Center	Preferred Contact (Name and Role)	Phone	Email

Child Welfare Offices (Social Worker) or Juvenile Justice Offices (Court Counselor)

Office Name	Preferred Contact (Name and Role)	Phone	Email

Food/nutrition support or housing services for the Child (for example: WIC Program Coordinator):

Organization/Agency	Preferred Contact (Name and Role)	Phone	Email

Others supporting the Child (for example: Neighbors, Coaches, Other Family or anyone else):

Organization/Agency *(if applicable)*	Preferred Contact (Name and Role)	Phone	Email

I understand that I may **cancel this Authorization** in writing **at any time** by submitting my written cancellation request (the "Cancellation Request") to: ncinckconsent@duke.edu. I understand that my cancellation will not apply to any information already released as permitted by this Authorization. I understand that for the information shared by NC InCK or the Care Team with third parties for the purposes described in this Authorization, NC InCK may not retain control over the further use or disclosure of such information by those third parties or other future recipients, and may no longer be protected by federal privacy laws.

I understand that **signing this Authorization is my choice** and **I may refuse** to sign this Authorization. If I do not sign this Authorization, certain Care Team members, the Child and their family will not have access to VirtualHealth, and some of the integrated planning features it offers. The Care Team will continue to provide care to the Child, and I will receive bills associated with the Child's medical care.

This Authorization will expire upon the earlier of: (i) the fifth (5th) business day following the date the Child is no longer enrolled in the InCK model; or (ii) the fifth (5th) business day following the date on which NC InCK receives a Cancellation Request at ncinckconsent@duke.edu.

Patient/Parent/Legal Guardian Signature: ______________________________

Print Name: ______________________________

Relationship to Patient: ______________________________

Date: ______________________________