Frequently Asked Questions for Family Navigators

Contents

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.**

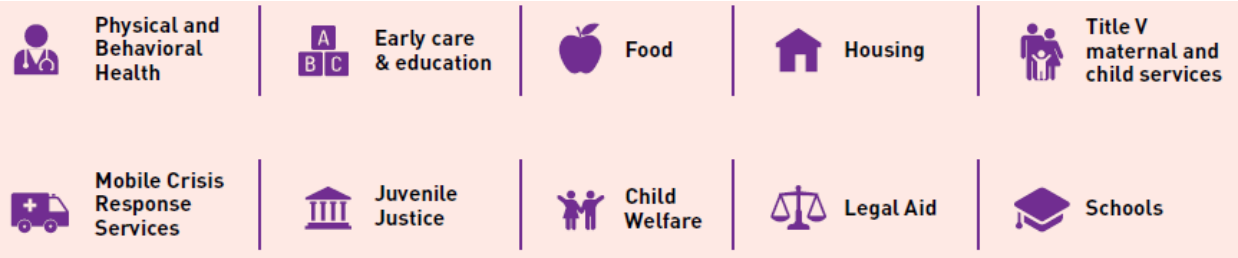
Vision: Healthy, thriving children, youth, and families living in a collaborative community

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:

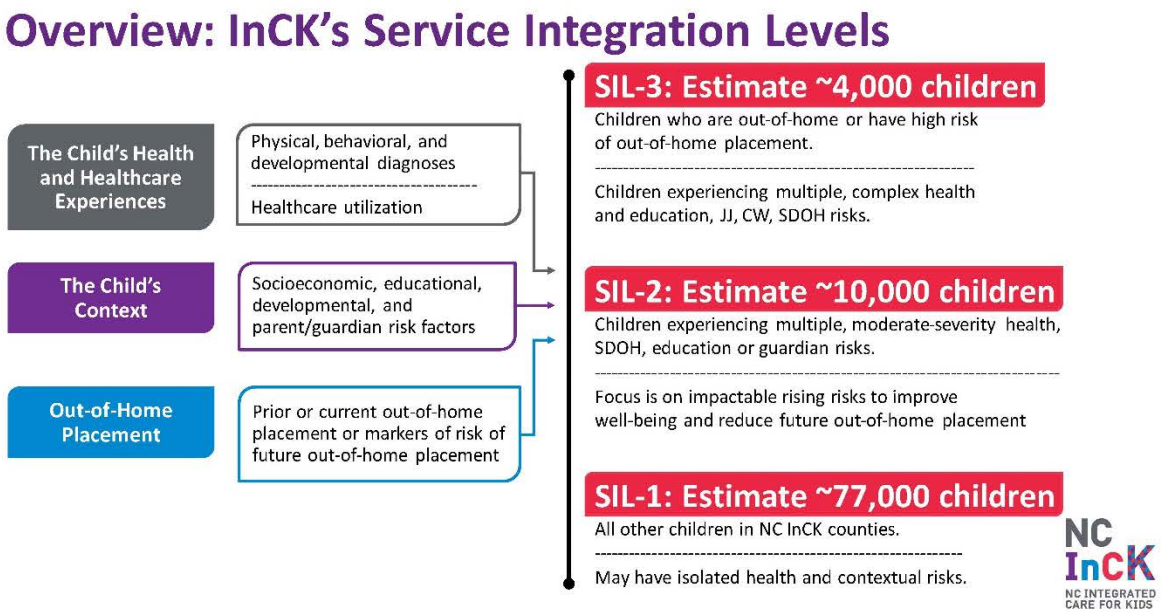
- An NC InCK member's engagement status with the Family Navigator
- Submitting an NC InCK member's completed SAP and NC InCK Consent Form to be uploaded on the NC InCK VirtualHealth Integrated Care Platform

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.