NC InCK NC INTEGRATED CARE FOR KIDS

Guide to Integrated Care Teams and the NC InCK Shared Action Plan

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1.0 Purpose of This Guide

The first half of this guide provides education and resources for Family Navigators on the formation and convening of an integrated care team to improve care and support NC InCK members and families. NC InCK members in Service Integration Levels (SIL) 2 and 3 and their families will be supported by integrated, cross-sector care teams that assist families in meeting their goals and service needs.

Family Navigators will work with families to identify, convene, and collaborate with care teams to address needs in the core child service areas including health, social service, and educational needs. If you need additional support in any of the areas outlined below, please contact your assigned Integration Consultant by phone or email.

The second half of this guide prepares Family Navigators to work with a family and complete a Shared Action Plan (SAP). Shared Action Plans are offered to all children in Service Integration Level 3 and can be offered to children in Service Integration Level 2. The guide includes an overview of individuals involved in creating a SAP, instructions for how to work with families to prepare them for a SAP meeting, and guidance on how to complete each page of the SAP.

2.0 What is an Integrated Care Team?

An integrated care team is a family-led team of professional and natural supports that collaborate to support a NC InCK member and their family in meeting the health, education, and social service needs as identified by the family. In NC InCK, integrated care teams are intentionally cross-sector, including both healthcare providers and those from schools, early childhood, and, if applicable, sectors like child welfare and juvenile justice.

2.1 What are the benefits of NC InCK's Integrated Cared Team Model?

An integrated care team model:

- Provides a mechanism to comprehensively assess and support a child and family's health, social service, and educational needs over time.
- Reduces the burden on families to coordinate and communicate needs separately to each individual supporting their child.
- Allows sharing of responsibilities, resources, and knowledge between providers and reduces the duplication of services.
- Creates an avenue for shared collaboration among integrated care team members to help the family achieve the well-being goals for their child.
- Promotes child advocacy and family voice through a collaborative process.

NOTE: Convening an integrated care team can be a time intensive and complicated process and all care team members may not be able to join for all meetings. NC InCK's expectation is that the majority of care team members attend each integrated care team meeting and those not in attendance have the opportunity to contribute before and after the meeting.

3.0 How to Convene an Integrated Care Team

3.1 Step 1: Use the NC InCK Consent to Identify the Integrated Care Team

When a Family Navigator first meets with a NC InCK member and their family, the NC InCK Consent Form is one of the first items to complete. The NC InCK Consent form is designed to support a family to identify entities and organizations with whom Family Navigators can share information. That information might include documents used to coordinate the care for the NC InCK member. Individuals identified on the NC InCK Consent form can also access an NC InCK member's profile using NC InCK's VirtualHealth Integrated Care Platform. Using the NC InCK Consent Form can help with deciding who to invite to the integrated care team meeting.

3.1.1 Tips on Working with a Family to Build the Integrated Care Team:

- Focus on being family-centered. 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 integrated care team members.
- The most effective integrated care team will have a mix of family members, community supports, and professional supports (e.g., social workers, care managers, healthcare providers). Natural supports can also work with the family before the meeting to help them identify and prioritize what they would like to elevate to the integrated care team.
- The Family Navigator may help the family build their integrated care 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 so that they can share information, be sure to update the Consent form and share it with the family, integrated care team, and NC InCK Integration Consultant.

3.1.2 Some Examples of Questions to Ask in Order to Identify Individuals for an Integrated Care Team Include:

- Who do you go to first with questions or concerns about your child?
- Is there anyone else who works with your child regularly?
- Are there health care providers who regularly work with your child?
- Is there someone at school (or in child care) who you communicate with regularly about your child? If not, would it be helpful to identify someone to speak with?
- Some families also work with supports for food, housing, or legal concerns, like legal aid, child welfare, or juvenile justice. Does your family work with anyone from these services?

Table 1. Example members of an NC InCK integrated care team

Example members of an NC InCK integrated care team could include:
Guardian and NC InCK member
Family Navigator
Natural support like grandparents, other family members, neighbor, church member, coach
Primary Care Provider
Health care Specialist
Behavioral Health Provider
Speech or Occupational Therapist

Example members of an NC InCK integrated care team could include:
School Nurse, School Social Worker, or School Teacher
Early Childhood Provider: Head Start Family Engagement Specialist, Teacher
Child Welfare Social Worker
Juvenile Justice Court Counselor
In-Home Services Provider
Other Care Managers or Service Provider: Housing, Home Visiting, Counselors

TIP: Talk with the family in advance about completing the NC InCK Consent form, and have them collect names, organizations, and contact information in between meetings so that Family Navigators can list integrated care team members in the Consent form accurately the first time the form is completed.

3.2 Step 2: Identify Times and Topics for a First Integrated Care Team Meeting with the Family

3.2.1 Setting a Time

Family Navigators can work with the family to identify a few times for the first meeting. The best practice is to find something that aligns with the family's schedule. Face to face meetings are usually preferred, but, between the schedules of integrated care team members and the family, this may be a challenge. COVID-19 may also influence your decision to hold the meeting virtually versus in person. Doing what is most comfortable and beneficial to the family should be the top priority. If necessary, integrated care team meetings can also be completed using a hybrid approach.

TIP: Some NC InCK members may be involved with agencies or services that already use an existing, valuable care team process. Family Navigators do not need to facilitate additional meetings but can use the existing meeting structure to enhance integrated care team collaboration. For example, if child has a regular meeting convened by Department of Social Services (DSS) or the school, coordinate with the family and the existing team to determine if the integrated care team meeting can be a portion or add-on to the time since some members of the integrated care team are already convening. Many of these meetings have existing priorities, but also have some time available for integrated care team alignment.

3.2.2 Setting Topics

NC InCK has provided a sample agenda for meetings in Section 6 of this guide. Family Navigators can review the agenda with the family in advance and decide what changes to make to best meet the needs of the family. Review this information with the family prior to the meeting to make sure they understand how the meeting will operate and talk about if there is anything they would like to discuss. Family Navigators can get additional example materials through their assigned Integration Consultant.

3.2.3 Approaches to Setting Topics

Option 1: Use the open boxes on the bottom of page 1 of the Shared Action Plan with the family prior to the integrated care team meeting to help the family brainstorm topics they'd like to address. Based on what families identify, walk through their responses with the integrated care team during the meeting to promote discussion. Family Navigators can also ask the family if any existing services need adjustments to better meet the needs of the child and whether they are comfortable if you raise those for discussion in the meeting.

Option 2: Work with the family to answer the following questions and see if any topics emerge:

- Identify strengths and interests:
  - What are some activities that your child enjoys?
  - What is your child interested in or particularly good at?
- Identify needs and opportunities:
  - Where could you use the most support for your child?
  - What would you like your child to be able to do or experience?
  - What is your greatest concern about your child's overall well-being?

3.3 Step 3: Contact the Entities Listed on the NC InCK Consent

By including entities and preferred contacts on the NC InCK Consent form, the guardian is granting the Family Navigator permission to reach out to each entity, share that their child is part of NC InCK, and invite each entity to join an upcoming integrated care team meeting. Family Navigators are also encouraged to share the NC InCK Consent form with each entity listed, so they know they have consent to communicate in order to coordinate the NC InCK member's care.

Example email to the integrated care team members:

SUBJECT LINE: Integrated Care Team Meeting for (Child's name)

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

We've been given your name and information from [NC InCK Member's Name] guardian. The family would like to invite you to a meeting of their care team.

[NC InCK Member's 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.

We are working to establish an integrated 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 integrated care team will collaborate at least once every 3 months to support [NC InCK Member's Name] needs.

Based on family availability, here are 3 time options for joining next month's integrated care team meeting. The family would greatly value your participation. The meeting will take place at [Insert Location or Virtual Platform]. We'll pick the option that is best for the most members, 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]

3.4 Step 4: Finalize the Meeting Time and Location and Send a Confirmation and Invitation

Family Navigators can communicate the final meeting time and any guidance on how to prepare to all integrated care team members. Best practice is to include all integrated care team members on the invite for awareness, even if they cannot attend the particular meeting. Family Navigators can send a meeting invitation to hold time on their calendar.

NOTE: Convening an integrated care team can be a time intensive and complicated process. All integrated care team members will not be able to join for all meetings. NC InCK's expectation is that the majority of integrated care team members attend each integrated care team meeting and those not in attendance have the opportunity to contribute before and after the meeting.

TIP: Call or message the family the day before the meeting to remind them and make sure they have what they need to attend. Family Navigators can also follow up on any questions families have before the meeting. Send an email reminder to the integrated care team as well. Or, if using Outlook, schedule messages in advance to send reminders so that communication is automated.

3.5 Step 5: Pre-populate the NC InCK Shared Action Plan with Information from the NC InCK Consent Form

All NC InCK members in SIL 3 and some members in SIL 2 are offered the opportunity to complete a Shared Action Plan. If the member is using a Shared Action Plan, page 2 provides an integrated care team roster for the member so that all entities receiving the form have any easy way to identify one another and communicate to support the care of the member. Using the entities listed on the NC InCK Consent form and the preferred contacts, pre-populate the table on page 2 of the Shared Action Plan.

TIP: More individuals and entities can be added to the SAP when you next meet with the family and integrated care team, but getting a head start by using those listed in the NC InCK Consent form can save time during the meeting. NC InCK has deliberately structured the NC InCK Consent form so that it is easy for Family Navigators to copy and paste information into the Shared Action Plan.

4.0 Facilitating Integrated Care Team Meetings

NC InCK focuses on two core values for supporting integrated care team convenings – child- and family-led and collaborative. Historically, child and family team meetings are designed to be strengths-based and solutions-focused. NC InCK's integrated care team meetings are not agency-specific and the goals come from the family, which make the meetings unique.

Family Navigators hold the responsibility for convening and relaying information to the integrated care team based on the desires of the family. Below you will find tips that can help with facilitating the meeting, how to stay in contact with the integrated care team, and a few suggestions to common challenges.

4.1 Tips for Hosting the Meeting

1. Create an agenda for each meeting. We have provided an example meeting agenda to assist in this process in Section 6 of this guide.
2. Assign roles during the meeting. For example, ask someone to volunteer to be a time keeper and another person to volunteer as a note taker.
3. Ask the family what ground rules they want during the meeting to make them most comfortable.
4. Schedule a follow up meeting before the current meeting ends.
5. Give integrated care team members not present during the meeting an opportunity to review meeting notes and provide feedback.
6. Send any notes, action steps, and/or completed documents to the entire integrated care team within two days of the meeting.

5.0 Sample Integrated Care Team Meeting Agenda

Below is an example agenda with supporting context for the discussion in a NC InCK integrated care team meeting. The agenda can be modified based on the preferences of the family and Family Navigator. NC InCK used models such as Systems of Care, Child Welfare, and Family Team Meetings to inform some of the suggested approaches below. Family Navigators can receive additional meeting agenda recommendations through their assigned Integration Consultant.

5.1 Introductions

Ask care team members to share their name, entity (if applicable), and how they know the family.

5.2 Reviewing the Purpose of this Meeting

Establish the purpose of the meeting with the family ahead of time. As an example, ask the family to identify and prioritize goals related to behavioral concerns or the educational progress of their child. If the meeting is virtual, the Family Navigator can share the agenda and purpose on the screen during the call.

5.3 Creating Ground Rules

Ground rules may include things like:

- No interrupting
- Respect each other
- Allow integrated care team members to take a break if needed
- No cell phone use

- Standards of confidentiality.
- If the team gets "stuck" on a particular topic, the team can decide to put it in a "parking lot" and revisit later.

It is a good idea to ask families what ground rules are important to them prior to the integrated care team meeting and come into the meeting with a list that is shared with the larger team. It is also good practice to see if team members have additional ground rules to share.

5.4 Discussing Strengths and Needs of the Child

Discussing strengths will set a positive tone for the meeting and can also help integrated care team members get to know the child and family. The facilitator can start with asking the child and family a questions like, "What is going well right now for your child/family?" or "What activities does your child enjoy?" The facilitator should also ask integrated care team members to share strengths they have observed in the child and family.

Next, the facilitator can ask the family to identify goals or areas of concern they have for their child or the family. Integrated care team members can also be encouraged to share concerns or areas of growth for the child and family. The facilitator and integrated care team should support the family in prioritizing which areas are most important to address in the meeting.

5.5 Identifying Ways of Working Together

After the family has prioritized their goals, the facilitator should support the integrated care team in clarifying which members of the integrated care team are able to provide support to address each goal and how each goal will be addressed. If there are service gaps identified, someone on the integrated care team should be designated to assist with linking the family to services to meet that need.

If the child has a Shared Action Plan, these goals and action steps should be documented on page 3.

5.6 Reviewing Action Plan & Steps

The facilitator should review the goals and how the integrated care team members plan to support the family in meeting these goals, including, if possible, dates for completing tasks related to the goals.

5.7 Setting the Date for the Next Meeting

Prior to adjourning, the integrated care team should discuss plans for ongoing communication and set a date for the next meeting. The Family Navigator will identify who is responsible for sending out follow up information and the next meeting invitation.

Other Tips for Integrated Care Team Meetings:

- The facilitator can map out clear spaces for family voice and perspective during the meeting, including, taking a pause during the meeting to check in one on one so that they can gather the family's perspective on how things are going as well as any thoughts they haven't been able to raise.
- If the Family Navigator is new to meeting facilitation, create opportunities for them to shadow more experienced facilitators ahead of their first meeting.
- Follow up with the family after the meeting to thank them for attending and ask what went well and what they would like to see in future conversations.

5.7.1 Staying in Communication

NC InCK is requesting that integrated care teams convene at least quarterly with the family. During quarterly meetings, updates should be provided about progress on goals, addressing concerns, and discussing resources. Integrated care team members can also update any contact information at this time. New integrated care team members should introduce themselves.

Information may need to be shared outside of the quarterly meetings. Family Navigators should facilitate secure, accessible ways that the integrated care team can communicate, such as via phone or secure messaging. This is also important if a crisis arises for the child. Family Navigators may also follow up with an integrated care team member and to see if there are any barriers or concerns that are preventing them from participating on a regular basis.

6.0 Challenges and Solutions for Building an Integrated Care Team

Bringing together team members from various organizations with different goals is not easy. The Family Navigator will play a critical role in facilitating communication and engagement among the integrated care team. Below are some possible challenges many care teams face and tips and solutions to consider to support integrated care team members, children, and families in the NC InCK Model.

6.1 Low Engagement from Integrated Care Team Members

When you meet with the guardian to complete the NC InCK Consent form and care team roster, ask the caregiver about each integrated care team member's role and engagement with their family to better understand if additional or special considerations are needed to engage the member.

If an integrated care team member does not reply to the initial email or can't attend the integrated care team meeting, the Family Navigator can try other approaches to secure their engagement, including:

- Call the integrated care team member rather than emailing
- Verify the integrated care team member's engagement with the child and family and their preferred contact method
- If another integrated care team member is now working with the family, obtain their information and speak to the family for consent to communicate with this new member
- Ensure the integrated care team member has your contact information and make a plan for follow up
- If the integrated care team member can't attend, see if someone else from the entity might be able to participate in the meeting on their behalf

6.2 Transitions in Integrated Care Team Members

The transition of an integrated care team member off the integrated care team is also a transition for the child and family. Sometimes these transitions are anticipated, and other times they are sudden. Use the following guidelines when experiencing a transition in the integrated care team:

- When building the integrated care team roster, the Family Navigator should inquire about any time limits to the supports each integrated care team member is providing to the family
- If integrated care team members know they are going to exit the team ahead of time, confirm they have communicated with the family to wrap up or transition any unmet needs

- If the transition is due to change in employment for the integrated care team member, help determine the replacement and engage the new staff member in the integrated care team with permission from the family

6.3 Challenges with Aligning Schedules and Meeting Platforms

Finding a meeting time that works for everyone (including the family, Family Navigator, and integrated care team members) can be difficult. First, we suggest talking with the family to learn what works best for them. The following guidelines can be helpful when trying to find a meeting time to aligns with everyone's schedules:

- Ask the family for two or three times that would work best for them and share the options with the integrated care team members.
    - Tip: There are no cost scheduling platforms that you may find helpful, such as Doodle or Rally. Family Navigators can also create a Google Form survey or Microsoft Form survey to schedule a meeting time.
- While meeting face-to-face is preferred, integrated care team meetings can also be conducted through a secure virtual platform or a conference line. An option to dial into a face-to-face meeting can also be offered for integrated care team members with limited time or inability to travel.
- Offer integrated care team members a chance to contribute to key agenda items like strengths and concerns, integrated care team roster, and goals before and after the meeting if they cannot attend.
- Send notes from the meeting and all action items to all integrated care team members, even if they couldn't be there.

6.4 Changes in Guardianship of a Child or Youth

Integrated care teams can be particularly valuable when supporting a child and family under the circumstances of guardianship changes. They also carry historical knowledge of the child's needs and their progress towards goals. New guardians should be added to the integrated care team, and a meeting should be arranged to ensure critical information is addressed in a timely manner. The Family Navigator should inquire about additional changes as a result of a change in guardianship (e.g., physical residence of child, family members the Family Navigator can continue to communicate with, type of guardianship, or if a new NC InCK Consent form is required).

6.5 Steps to Take in the Case of Unclear Goals and Actions

The NC InCK Shared Action Plan is one tool to help guide integrated care team meetings. Page 3 of the SAP outlines family goals, which integrated care team member is helping with each goal, and the steps to be taken toward each goal.

- In Section 6 of this guide, you will find a link to an agenda. This agenda will aid in ensuring steps are taken to address goals and actions each meeting and that the members of the integrated care team are expecting this discussion to occur.
- At the end of each meeting, make sure to leave time for anyone to ask questions and to review the actions, who is responsible for each action, and when the next meeting will take place.
- Share notes and/or the SAP with the integrated care team via a secure method after the meeting. This will help all members, including those not present, stay informed.

6.6 The Family Does Not Want to Include a Provider in the Integrated Care Team Meeting

Families have full choice on who is included in their child's integrated care team. If the family identifies a specific person and/or entity that they do not want on the integrated care team, the Family Navigator should use their best judgement when engaging in a discussion with the family about their preferences. Below are some steps to take when this challenge arises:

- Ask the family if they are willing to share the reasons behind their preferences.
- If appropriate, help the family weigh the pros and cons of this integrated care team member's involvement. For example, if the family does not want to include a member from the child's school, but the child could benefit from coordination and support from the school, the Family Navigator could provide education, examples, and support to the family on ways to involve the school.
- Ask the family if they are willing to consider a "trial period" of integrated care team involvement
- If consent to the child's integrated care team is not provided following exploration and further discussion with the family, the Family Navigator can document the conversation.
- The Family Navigator should revisit this decision with the family as needed.

For ongoing challenges involving integrated care team engagement, please reach out to your assigned Integration Consultant for advice and solutions.

6.7 Engaging Medical Providers in the Care Teams Process

Primary care and specialty medical providers are often trusted allies for families regarding decisions about children's health and well-being. If families choose to include the medical provider in the care team process, the following are tips for Family Navigators on how to engage health care providers:

- Reach out by email, phone, fax and/or shared electronic record systems. Do not hesitate to reach out in multiple ways. Establishing a communication pathway with the medical provider is essential.
- When emailing a medical provider, put key points at the top of the email. Be specific with the key questions or concerns for their input.
- Knowing the provider may have limited time to participate, request an alternative care team designee in the clinic such as a nurse clinician or specialty care manager.
- Emphasize the non-medical related value that InCK brings such as collaboration with schools or other community entities.
- Medical providers tend to respond when families ask them directly, so family navigators can support and encourage the family to communicate requests directly with the provider.

It may be challenging for the medical provider to attend meetings, however, that provider remains an integral part of the care team and Family Navigators are encouraged to seek out alternative ways to involve them in the care team process.

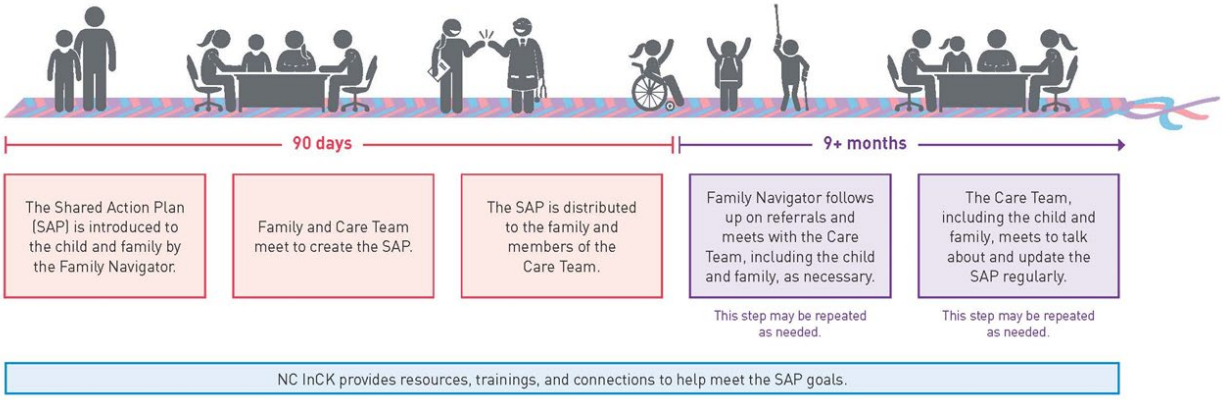
7.0 Overview of the Shared Action Plan

The Shared Action Plan (SAP) is a shareable, living document created in collaboration between the Family Navigator, family and the child's integrated care team to encourage coordination among integrated care team members and a family's natural supports to best meet the child's health, social, and educational needs. The Shared Action Plan serves as a valuable tool in building partnerships with families and promotes communication and integrated care coordination among families and care team members. The Shared Action Plan supports a more open dialogue, faster updates to integrated care team members, and more efficient work in order to meet the needs of a child.

The Shared Action Plan was developed through an intensive two-year design process with teams of family members, care managers, social workers, physicians, and implementation science specialists. Most importantly, families advising NC InCK led the design of the Shared Action Plan by sharing their experience using other care plans and their challenges coordinating care for their children. The NC InCK team also reviewed over 100 care plans and talked with experts on care plans from health care, schools, early care and education, and child welfare. Formal technical assistance from the Centers for Medicare and Medicaid Services and the Lewin Group was provided on the Shared Action Plan. Multiple rounds of usability testing with partners in Summer 2021 further refined the Shared Action Plan design.

The Shared Action Plan includes several sections: the family's preferences and strengths, a list of integrated care team members and their contact information, and the family's personal goals.

Figure 1. Overview of the Process for Shared Action Plan Creation



The Shared Action Plan can be a valuable tool for all children, even if they already have an existing care plan**.** Existing care plans can be created in silos and may only focus on one provider's approach to treatment. In contrast, the Shared Action Plan is, by design, collaborative across sectors and created in partnership with families. The Shared Action Plan lists individuals the family has identified as collaborators in their child's progress toward unified goals and is made easily accessible to those involved in their child's care.

7.1 Shared Action Plan Benefits for NC InCK Members and Their Families

Cross Sector and Brief: The SAP builds upon the strengths of care plans across sectors to create a family-centered, shareable, and brief tool to facilitate cross-sector conversations with families. Families requested that the plan be shorter and easier to understand than traditional plans. They also requested that goals be more cross-cutting to support their child's health and well-being. The SAP is completed in a process guided by the family and includes input from the child's integrated care team.

Shareable: Families requested that the plan be easily shareable. The SAP and NC InCK Consent form have been designed to allow the SAP to be shared with the family's permission to those involved in the care of the child. The SAP can be shared on the NC InCK VirtualHealth Integrated Care Platform or other electronic systems that can allow access for the family and their integrated care team members.

Care Team Alignment and Communication: Families also asked that the SAP make it easier to communicate across their integrated care team by including a list of integrated care team members with

their contact information. The SAP creation process encourages both making the team list and conversations between integrated care team members and the family on how they will communicate moving forward.

7.2 Who is Involved in Creating the NC InCK Shared Action Plan?

Families are central to the development of the Shared Action Plan (SAP). The SAP should highlight the strengths and needs of the child and family from their perspective. At least one of the child's guardians who is knowledgeable about the child should participate in completing the SAP. A child's guardian (parent, legal guardian, or other legal caregiver) can sign the NC InCK Consent form to share the SAP. Families are encouraged to include youth, if age-appropriate, for whom the SAP is being created to share their perspective.

The **Family Navigator** is the primary contact who coordinates and integrates services for families in the NC InCK model. For children who could benefit from additional cross-sector care integration and support (e.g., assigned to SIL 2 or 3), the Family Navigator is responsible for bringing together their family and integrated care team to create a Shared Action Plan. 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 (e.g., United, HealthyBlue) or their care management entity (e.g., Duke, UNC, CCNC). The Family Navigator works directly with the family to meet their health and well-being goals as their single point of contact and coordinates with integrated care team members who are working alongside the child and family.

The **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, social, and educational needs identified by their family. A core component of the SAP is page 2, with a list of integrated care team members and their contact information so that the team members can more easily and regularly communicate to coordinate support for the NC InCK member. Family Navigators will work with families to identify, convene, and collaborate with integrated care teams to address the family's goals for their child. All integrated care team members should be included in developing the Shared Action Plan, including meetings, emails, and conversations to create and update a child's Shared Action Plan.

NOTE: NC InCK acknowledges that convening an integrated care team can be a time intensive and complicated process and understands that all integrated care team members may not be able to join all SAP meetings. NC InCK's expectation is that the majority of care team members attend each key SAP meeting, and those unable to attend are given an opportunity to provide feedback and contribute before or after the meeting (e.g., by email or in a follow-up meeting).

8.0 Preparation for the Shared Action Plan Meeting

Step 1: Familiarize Yourself with the Shared Action Plan: Education and training materials are available to the Family Navigator in the appendix of this guide and at www.ncinck.org to support preparation, completion, and updating of the Shared Action Plan. These resources include NC InCK's Shared Action Plan template and examples of completed Shared Action Plans. If Family Navigators need additional support on the Shared Action Plan process, please reach out to your assigned NC InCK Integration Consultant.

Step 2: Identify the Integrated Care Team to Invite: The Shared Action Plan will always be developed with the guardian's input and, if age-appropriate, the youth's input. To develop a list of integrated care team members and natural supports to participate in the SAP meeting, please see Section 3 of this guide.

Step 3: Prepare the Family for Participation in the SAP meeting: Family Navigators should take some time with the family to both explain the purpose and goals of the SAP and prepare them for the meeting.

Optional: Use the open boxes on the bottom of Page 1 of the Shared Action Plan with the family prior to the integrated care team meeting. Page 1 identifies strengths of the child and areas of concern for discussion. Discussing these in advance can also help the family brainstorm topics they'd like to bring up with the integrated care team. Family Navigators can also ask if current services need to be adjusted to better meet the child's needs (e.g., transportation to appointments, when service is offered) and whether they are comfortable if you raise those for discussion in the meeting. Family Navigators can then help raise the family's responses with the integrated care team during the Shared Action Plan meeting.

Step 4: Invite the Integrated Care Team to the SAP Meeting and Set a Time: After identifying the integrated care team members, Family Navigators can work with the family to identify a few times for a Shared Action Plan meeting. NC InCK recommends a one-hour meeting for the first convening to complete the Shared Action Plan. Finding a time and place that is convenient for the family is best practice. While face-to-face meetings are usually preferred, a virtual option can be used. Doing what is most comfortable and beneficial for the family should be the top priority.

For a template email invitation to care team members, please see Section 3.3.

TIP: If there is an existing recurring meeting with the family, please consider using this time to complete the Shared Action Plan. Using an existing meeting can reduce the burden on the family and team members.

NOTE: NC InCK acknowledges that convening an integrated care team can be a time intensive and complicated process, and understands all care team members may not be able to join for all SAP meetings. NC InCK's expectation is that the majority of integrated care team members attend each SAP meeting and that those not in attendance have the opportunity to provide feedback and contribute to the SAP either before and/or after the meeting.

Step 5: Pre-populate the NC InCK Shared Action Plan with Information

Page 2 of the NC InCK Shared Action Plan builds the integrated care team roster for the NC InCK Member so that all the entities receiving the form have any easy way to identify one another and communicate to support the NC InCK Member's care.

Two NC InCK documents can support pre-populating a portion of this section:

1. The NC InCK Consent form, which includes a list of the family's preferred contacts
2. NC InCK's SAP Supplemental List of Current Services Received (Section 4)

TIP: More individuals and entities can be added to the SAP in subsequent meetings with the family and integrated care team. You can get a head start and save time by using those listed in the NC InCK Consent form. NC InCK has structured the NC InCK Consent form and the care team list on page 2 of the Shared Action Plan similarly so that it's easier for Family Navigators to copy and paste information.

9.0 Completing the Shared Action Plan

Page 1

Child and Family Background: This section gives a snapshot of the child and family, including their hopes, values, and preferences. This section can be helpful in building trust and a relationship with the family. The Family Navigator can pre-populate the child and family demographics and then verify accuracy with the guardian.

Questions to ask: The second half of the first page focuses on the strengths, interests, and needs for the child and family. Examples of questions you can ask include:

Identify strengths and interests:

- What are some activities that your child enjoys?
- What is your child interested in or particularly good at?
- What are some traditions, celebrations, or rituals your child enjoys participating in?

Identify needs and opportunities:

- Where could you use the most support for your child?
- What would you like your child to be able to do or experience?
- What is your greatest concern about your child's overall well-being?

TIP: Let the family know that you hope to learn how best to support them and that understanding what matters most to them will help with this. If age-appropriate, encourage the child or youth's involvement in the process too.

Page 2

Integrated Care Team Roster: Children and families with different health, social, and educational needs frequently rely on a variety of services, providers, and resources for support. Families requested an easy way to see and share their whole integrated care team list with contact information.

Use this page to identify and list the names, roles, and contact information of professional and natural supports who care for the child. Professional service providers can include clinicians, coordinators of care, educational supports, social workers, and others. Natural supports can include trusted family members, friends, coaches, and others. 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.

To help create this roster, ask the questions listed in Section 9 of this guide.

Page 3

Action Plan: The Shared Action Plan has been designed with input from families so that families' goals are the top priorities in the SAP. The SAP has also been intentionally designed to lift up the health, social, and educational prioritized goals of families. The family and integrated care team can create up to five goals. NC InCK recommends starting with three goals. The SAP will be updated on a regular basis, and it has been designed to be easy to add new goals as needed. Each goal will be assigned an integrated care team member with concrete steps that they will take to support achieving the goal.

Questions to ask: You can help families express their goals by asking:

- What are your top goals for the health and well-being of your child?
- Where could you use the most support for your child?
- What would you like your child to be able to do or experience?
- What is your greatest concern about your child's overall well-being?

TIP: Taking time to understand the family's personal goals for their child will help members of their integrated care team prioritize what services to offer. Ultimately, active listening creates increased opportunities for communication and collaboration among integrated care team members to support a family.

TIP: To update the Shared Action Plan goals, use a pdf editor like the most recent version of Adobe Acrobat or a free pdf editor like Sedja, and save time from creating a completely new plan.

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 the first call with the guardian, the Family Navigator can use this page to help the family determine which core child services they have received in the last year, including current providers. The guardian can determine which of these providers they would like to be part of their Shared Action Plan development.

If an area of need or a gap is identified, the Family Navigator can check the "support needed" box and consider helping the family develop a goal to address that need or submit a referral on behalf of the family.

TIP: The Family Navigator may also inquire about services not listed on the supplemental page. It is possible the Family Navigator may have to help the family with exact details of their service providers by doing some additional research. Please refer to the integrated care team formation section of NC InCK's Care Team Guide for additional support.

10.0 Sharing the Shared Action Plan after the Meeting

Sharing and using the Shared Action Plan after completion is critical to increasing the impact of the SAP convening, cross-sector team conversations, and the SAP development for improving a child's well-being. The Family Navigator will make both the Shared Action Plan and NC InCK Consent form accessible using at least one of the following recommended methods. Families and authorized integrated care team members should be notified of how to access the SAP.

1. **Electronic Medical Records (EMR):** Family Navigators may share the SAP with 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 child's care. Family Navigators can use available portals in their EMR to grant access to other integrated care team members and the family. If an entity's EMR is unable to grant access to integrated care team members outside of that entity, the Family Navigator should use one of the methods below to ensure other integrated care team members (e.g., school counselor, social worker) can also access the child's SAP.
2. **Secure Transmission or Hard Copy:** Family Navigators can use a method approved by their entity to securely transmit the SAP to integrated care team members using the email address and contact information provided. Families or integrated care team members may also ask for a hard copy of the SAP.
3. **NC InCK's VirtualHealth Integrated Care Platform:** NC InCK is pleased to make this platform available for sharing the SAP. Family Navigators can work with their assigned Integration Consultant who can provide role-based access to the child's profile on NC InCK's VirtualHealth Integrated Care Platform. The SAP can be linked on the child's profile for easy sharing with the family and integrated care team members listed on the signed NC InCK Consent form. The Shared Action Plan, NC InCK Consent form, and any other documents shared with the family can be stored securely on this platform.

Before Finalizing: Integrated care team members who were unable to attend the SAP integrated care team meeting should have a chance to review and provide feedback on the SAP before it is finalized and shared.

NOTE: All Family Navigators are asked to securely transmit completed Shared Action Plans and NC InCK Consent forms to their assigned Integration Consultant for posting on the child's profile on the NC InCK VirtualHealth Integrated Care Platform.

11.0 Reporting and the Shared Action Plan

Prepaid Health Plans (PHPs) and Clinically Integrated Networks (CINs) participating in the NC InCK model are required to document the date a Shared Action Plan is completed through monthly reporting to NC Medicaid. PHPs use the **BCM051** and CINs use the **Patient Risk List Version 2.0** for reporting. NC InCK will use data supplied through these reports to:

1. Monitor SAP completion rates. Integration Consultants will assist in identifying barriers to completion and offering any additional supports needed.
2. Calculate performance on the Shared Action Plan performance measure for the NC InCK Alternative Payment Model.

Separately, NC InCK asks all Family Navigators to securely transmit completed Shared Action Plans and NC InCK Consent forms to their assigned Integration Consultant so that NC InCK can store and maintain SAPs in the NC InCK VirtualHealth Integrated Care Platform and share profile access with integrated care team members listed on the NC InCK Consent form.

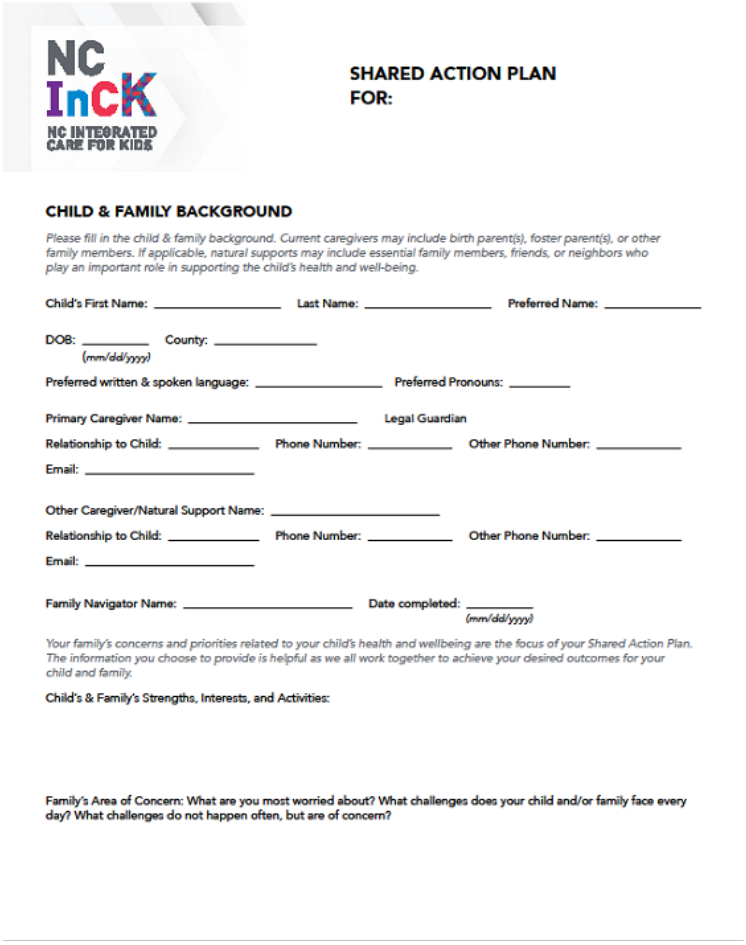
11.1 Updating the Shared Action Plan

Version 2 of this guide will have additional guidance on the process for updating the Shared Action Plan.

12.0 Appendix

Appendix 1. Template Shared Action Plan

[Download the template at this link](#).



NC InCK
NC INTEGRATED CARE FOR KIDS

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?

Appendix 2. Example Completed Shared Action Plan

[Download the example at this link.]

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

13.0 Glossary

Family Navigator: the primary contact who coordinates and integrates services for families in the NC InCK model. Family Navigators are existing staff 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 organization. Family Navigators may also be care coordinators from juvenile justice or child welfare.

NC InCK Consent form: lists places to specify contact information for preferred integrated care team members, including their phone and email.

NC InCK VirtualHealth Integrated Care Platform: 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).

Integrated Care Team: anyone who provides care services and supports a child in NC InCK to help meet their health, educational, and social needs. The integrated care team includes existing staff within health care (i.e., PHPs, CCNC, AMHs), those in other core child service areas (i.e., juvenile justice, schools, early care and education, public health, child welfare, mobile crisis response, Legal Aid), and natural supports (e.g., neighbors, extended family) identified by the family.

Integration Consultant: a team of NC InCK staff who support Family Navigators as they work to meet these needs for children and families across sectors. They can support the completion of Shared Action Plans for children and families. The NC InCK Integration Consultants are based in child welfare, Head Start, health departments, health plans, Duke, UNC, juvenile justice, and schools nursing.

Shared Action Plan (SAP): a shareable, living document created in collaboration between the Family Navigator, family and the child's care team to encourage coordination and communication among all care team members and trusted natural supports. Key components of the SAP include preferences and strengths, a list of care team members and their contact information and the family's personal goals.

Service Integration Level: each child in the NC InCK model will be assigned a Service Integration Level (SIL) of 1, 2, or 3 based on their potential benefit from improved integration of services and their risk for out of home placement. A child's SIL will be used to determine what kind of support services are offered to the child and family. The process used to generate the SIL has been developed specifically for children and accounts for their health, education, and social service needs. The SIL will be updated monthly to capture changes in the support a child needs over time.