NC InCK
NC INTEGRATED CARE FOR KIDS



NC Integrated Care for Kids (NC InCK)

Playbook for Health Care Providers

October 20, 2022

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Revision Table

Version	Date	Sections Revised
F_Provider Guide_Merged_10.20.2022	10/20/2022	APM updates

1.0 Purpose of this Playbook

Dear Health Care Providers,

This Playbook is intended to introduce you to the NC Integrated Care for Kids (NC InCK) model. Written by health care providers, the Playbook will provide information for you and your practice about how NC InCK hopes to partner with you in the important work of improving the health and well-being of children in our state. We do not expect you to read the entire Playbook at one time. Rather, we hope you will read sections when they become relevant. Throughout, you will see blue call-out boxes which emphasize, from our perspective as clinicians, how each component of the NC InCK model can help your patients and your practice.

The NC InCK model was designed by health care providers alongside families and community leaders – and acknowledges the following for clinicians:

- We understand the critical impact of social drivers of health – and want to help families address needs that aren't being met beyond the walls of the clinic
- We have limited time during appointments, making it difficult to effectively understand and address our patients' health, social, and educational needs
- We often do not know what other services our patients are receiving, particularly those delivered through schools or other community organizations
- We are often unsure who to talk with to coordinate and integrate supports for our patients

NC InCK is working to build more capacity across systems to support and bridge services where children live, learn, and play. With these considerations in mind, we hope as you engage with NC InCK, you remember these important points about the NC InCK model:

- NC InCK enhances **whole child care** for Medicaid-insured children through more holistically assessing a child's needs, supporting more integrated care for children, and investing resources in new ways for improved well-being outcomes.
- More of your pediatric patients are **newly elevated for care management** support that the Prepaid Health Plans (PHPs) and health systems will offer and that will be available to help you in caring for your patients.
- **Integrated care teams are convened around our patients with higher needs**. You will have the opportunity to participate in these convenings and will have access to a brief Shared Action Plan where the family's top goals and integrated care team members are listed.
- Providers participating in the NC InCK Alternative Payment Model regularly **receive actionable data on novel child-centered measures**, such as rates of kindergarten readiness, for children in their practice who are in NC InCK, and have the opportunity to receive additional financial resources linked to performance measures.

Please see **Table 1** below for a specific example of how NC InCK can help patients and health care providers. Please contact us at info@ncinck.org, or visit our website to learn more about becoming involved with NC InCK. We look forward to your partnership and thank you for all you continue to do to support the health and well-being of North Carolina's children.

Sincerely,

The NC InCK Provider Engagement Leads: *Dr. Charlene Wong, Dr. Rushina Cholera, Dr. Richard Chung, Dr. Carolyn Avery, Dr. Mike Steiner and Dr. Kori Flower*

Table 1. How will NC InCK Impact Patients and Health Care Providers



Meet David, a 3-year-old boy who just returned home from a **foster care placement.** David has **speech delay and asthma.** He is currently **not in formal childcare**, and his family is **facing housing instability** and **food insecurity** as identified on a Social Determinants of Health screening tool.

Key NC InCK Strategy	How NC InCK helps David	How NC InCK helps Health Care Providers
More holistically understand the needs of children	NC InCK brings together data from health, child welfare, and social screening. These integrated data elevate David as a child who would benefit from integrated care management. He will be offered a care manager, called a **Family Navigato**r, from his Prepaid Health Plan or Advanced Medical Home.	You will have the additional support of a **Family Navigator** to help provide care for David.
Integrate services for children who could benefit from additional support	David's assigned Family Navigator will support the family for at least one year and conduct quarterly check-ins. David's family will guide their **integrated care team** to work on the family's identified priorities. These priorities and plans are documented in a **Shared Action Plan** that is accessible by all of his integrated care team members.	You will likely be a part of David's **integrated care team**, which will also include providers from additional core child service areas (like his social worker or child care center director). You and other members of the integrated care team will have access to David's **Shared Action Plan**, which includes a list of who is on his integrated care team roster and their contact information.
Invest resources in what matters most	David's family may be offered more services to support his well-being, such as help in enrolling in high quality child care or providing home remediation services to prevent asthma exacerbations.	You will receive actionable data on your patients, such as what proportion of children are Kindergarten ready or families who experience unstable housing. Financial incentives to support whole child care will be available for health care providers that participate in the **Alternative Payment Model.**

2.0 Introduction to the NC Integrated Care for Kids Model

North Carolina Integrated Care for Kids (NC InCK) is a new government-funded model aimed at improving the way children and families receive care and support services.

2.1 Mission, Vision, Goals and Key Strategies

2.1.1 Mission:

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

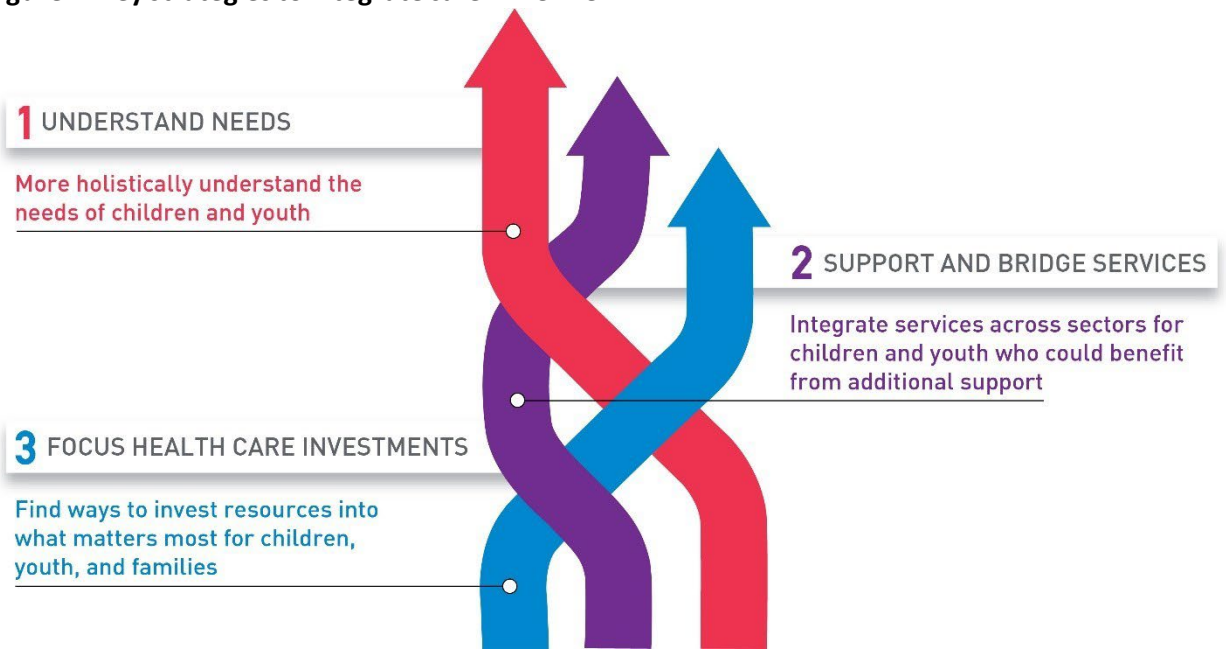
2.1.2 Vision

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.

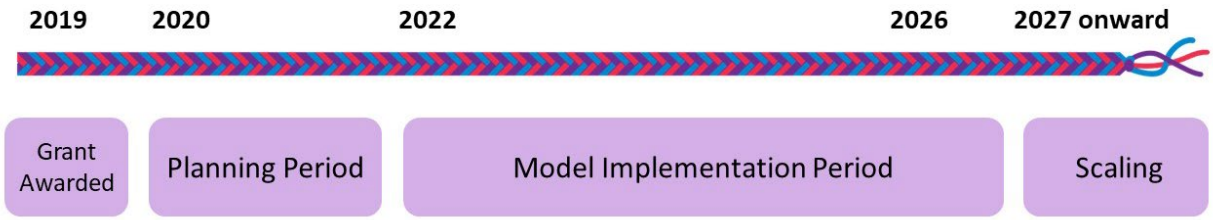
Figure 1. Key strategies to integrate care in NC InCK



2.2 Timeline

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

Figure 2. NC InCK Timeline



2.3 NC InCK Population

NC InCK is available to all children, from birth to age 20, who are insured by Medicaid or CHIP (NC Health Choice) in five central NC Counties: Alamance, Orange, Durham, Granville, and Vance. All children who receive insurance through Medicaid or CHIP (NC Health Choice) 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. Approximately 95,000 children are part of the NC InCK model.

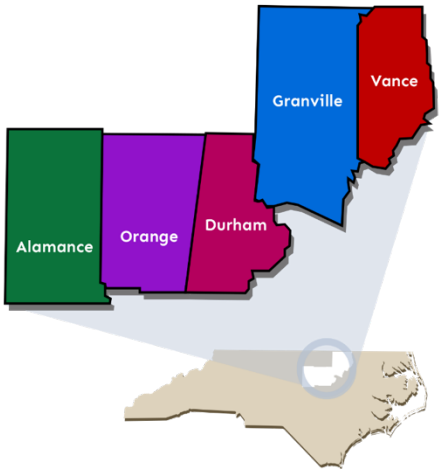


Figure 3. NC InC Counties

2.4 Core Child Service Areas

NC InCK works in 10 core child service areas, described in **Table 2** below:

Table 2. 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, nurtured, 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).	
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 prevention programs that work to reduce the number of children and families experiencing homelessness.	
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.	

Core Service	Description	Icon
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.	
Legal Aid	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.	

3.0 Understanding the Needs of Children and Youth

3.1 Overview of the Process and Rationale behind NC InCK's Strategy for Risk Stratification

A workgroup consisting of health care, core child service leaders and data specialists convened for more than 18 months to build a new pediatric risk stratification model, called Service Integration Levels (SILs). This stratification uses data that have been newly linked across the universal social drivers of health care needs screening required by NC Medicaid (i.e., assesses food, housing, interpersonal violence, and transportation), educational data provided by the Department of Public Instruction, and juvenile justice and child welfare data provided by the Department of Public Safety. Collectively, these data are used to stratify children into SILs that determine which children are elevated for additional services

The NC InCK SIL workgroup will evaluate the data algorithm and revise the algorithm as needed during model implementation.

What this means for providers

NC InCK is bringing together data and information about a child's health, educational experiences, and social context to more holistically assess a child's needs and stratify children into levels of additional support. Children will be assigned into one of three Service Integration Levels (SILs) using a pediatric focused algorithm. Children in SIL 2 and SIL 3 will receive outreach for additional care management services. This is the first time Medicaid has linked data with the Departments of Public Instruction and Public Safety to prioritize children for additional support.

3.1.1 Data Indicators used in Risk Stratification

Table 3 provides specific examples of indicators used in the data algorithm.

Table 3. Data indicators used in Risk Stratification

Category	Examples of data used to assess needs
SDOH Needs	Food, housing, transportation needs from Care Needs Screen Social Deprivation Index for member address Temporary Assistance for Needy Families (TANF) eligibility Healthy Opportunities (HOP) screener results
Education	Number of school absences and suspensions Early intervention- infant to toddler program enrollment within past year
Juvenile Justice	Placement in detention or development center Probation status
Child Welfare	Current foster care placement Recently returned home from foster placement
Guardian	Casehead substance use during pregnancy Casehead qualifies for Tailored Plan Psychiatric admission within past year Medicaid eligible due to disability
Medical Complexity	Care Management for At-risk Children (CMARC) enrollee Community Alternatives for children (CAP/C) enrollee Pediatric Medical Complexity Algorithm, Level 3 Tailored Plan eligible
Health Care Utilization	Antispychotic Rx In-home mental health services Mobile crisis response use within past year Hospitalizations

Category	Examples of data used to assess needs
	Inpatient days ER visits Total paid cost Under-utilization of healthcare services

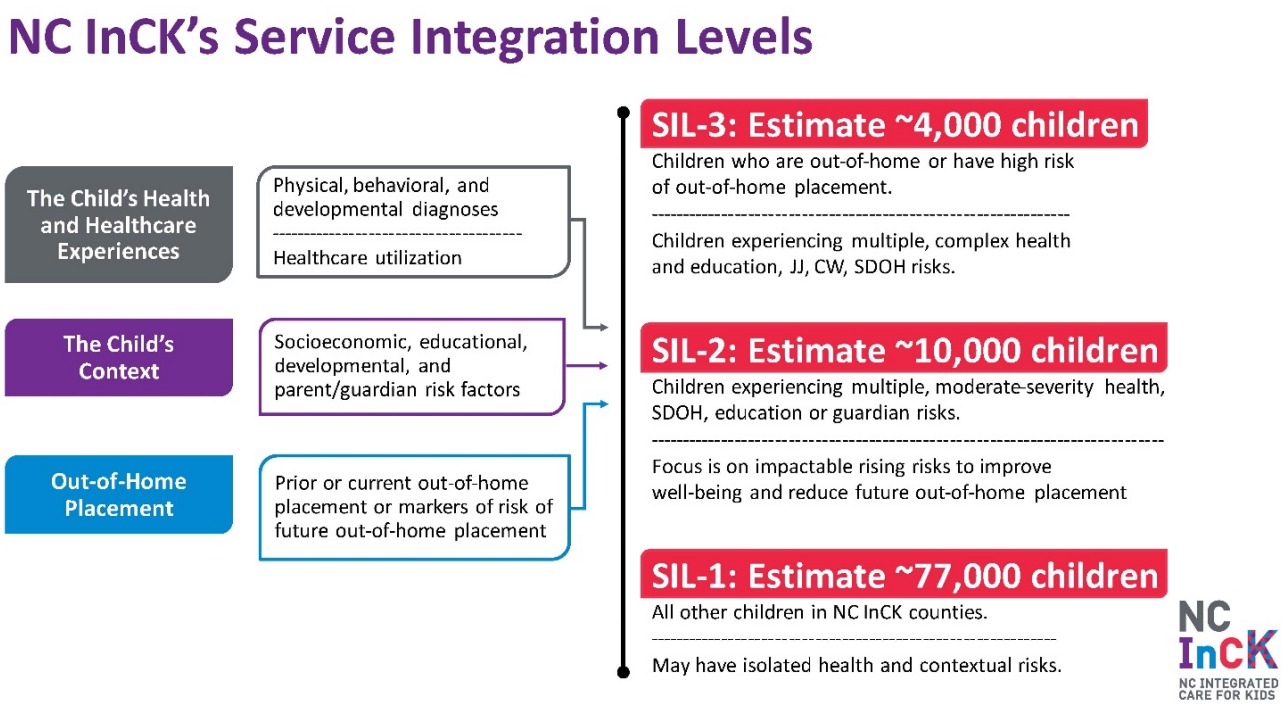
If your clinic would like more details on the SIL algorithm and approach to risk stratification, please contact Dr. Richard Chung (richard.chung@duke.edu).

3.2 Assignment of Children to SIL 2 and 3 for Integrated Care

The NC InCK SIL assignment process considers data insights across health and non-health domains (**Figure 3**). Any positive data elements within a category will represent a positive risk contribution as part of the SIL assignment process.

- **SIL-3** will include children and youth who are out-of-home at the time of SIL assignment, have had recent out-of-home placement, or have specific indicators of rising risk towards out-of-home placement (including hospitalization), or have demonstrable health complexity and contextual risks across all three core domains (socioeconomic, educational, guardian).
- **SIL-2** will include children with demonstrable health complexity and contextual risks in at least two core domains.
- **SIL-1** will include all other NC InCK-attributed children not in SILs 2 or 3.

Figure 3. Service Integration Level Assignment



3.3 Approach to updating SIL level assignment

A child's SIL assignments will be updated on a **monthly basis** to ensure proactive, real-time response to beneficiary needs. Any rise in SIL assignment (SIL 1 → 2 or SIL 2→ 3) will trigger proactive engagement by a child's Family Navigator to address any rising risk. Note that children can only move to a lower SIL

assignment (e.g., SIL 2 → 1 or SIL 3 → 1) on an annual basis, not on a monthly basis. Therefore, once a child is assigned to SIL 2 or SIL 3, that child is guaranteed the opportunity to receive additional services for one full year.

4.0 Providing Integrated Services for High-Needs Patients

Health care providers are often among the most trusted members of a family's integrated care team. Families may ask you about the NC InCK model. We have several resources linked to the documents on our website below and in the Appendix that you can use and distribute to families:

- NC InCK's Family Talking Points (Appendix A-1)
- NC InCK Family One Pager (Appendix A-2)

4.1 Key Role: Family Navigators

4.1.1 Identification and Assignment of Family Navigators

Family Navigators are existing Prepaid Health Plan (PHP), Community Care of North Carolina (CCNC), or Advanced Medical Home (AMH) Tier 3 staff, such as care managers or community health workers. The Family Navigator is not an employee of NC InCK. PHPs/CCNC/AMHs 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

What this means for providers

Health care providers often identify critical needs (such as in food, housing or safety) but may not have the time or resources to find and connect families to effective supports in the community. Family Navigators can help providers by connecting and coordinating supports for 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 (i.e., PHP, AMH Tier 3, or CCNC) is responsible for designing a process to assign a child a Family Navigator and communicating the assigned person with the child's guardian.

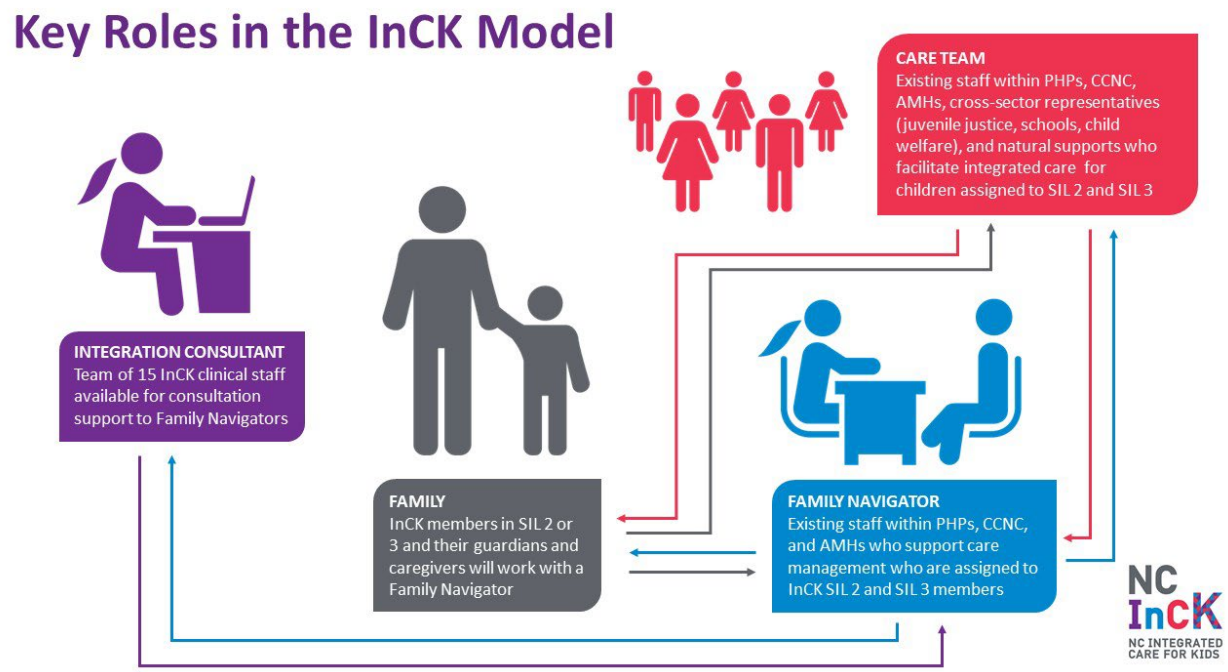
For NC InCK members attributed to AMH Tier 1 and 2 practices, PHPs are responsible for care management of SIL 2 and SIL 3. For NC InCK members attributed to AMH Tier 3 practices, the AMH or Clinically Integrated Network is responsible for care management.

Care management lead entities will know which members are in SIL 2 and 3 based on information provided to PHPs, AMH Tier 3s, and CCNC in the Care Management report (BCM051) and Patient Risk List (AMHs).

For more details, The NC Department of Health and Human Services Advanced Medical Home (AMH) Provider Manual provides in-depth guidance for AMH 3s participating in the NC InCK model.

4.1.2 Role and Responsibilities of the Family Navigator

Figure 4. Key Roles in the NC InCK Model



As a part of the NC InCK model, Family Navigators contact families in SIL 2 and SIL 3 to discuss the NC InCK care management model and request consent. For those children in SIL 2 and SIL 3 who agree to participate in integrated care, Family Navigators fulfill the following responsibilities:

1. Serve as consistent **point of contact for the family**
2. Foster **longer-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 and conduct **regular check-ins** with the NC InCK member and their guardian (at least quarterly and can be more frequent).
3. Convene and communicate with an **integrated care team** as defined by family (e.g., including their primary care provider, schools, early childhood education, child welfare, and other core child service providers)
4. Support completion of a **NC InCK Consent Form** for applicable members (Appendix A-3)
5. Support completion of a **Shared Action Plan** for applicable members (Appendix A-4)
6. Support the member's care needs across NC InCK's **10 Core Child Service Areas** (see Table 2)

1. Serve as consistent point of contact for the family

Family Navigators take on the role of single point of contact for children assigned to SIL2 and SIL3. The Family Navigator 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 for 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**.

2. Foster longer-term support and conduct regular check-ins

Unlike many other care management roles, the Family Navigator is intended to serve as longer-term support for families. Family Navigators support a child 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 can be more frequent. The check-ins should focus on the goals of the NC InCK member and integrated care team coordination needs.

3. Convene integrated care teams

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.

Family Navigators are responsible for creating integrated care teams based on the needs and wishes of NC InCK member and their family from the following domains, as applicable to the NC InCK Member:

- Health care providers (e.g., primary care providers, specialists, behavioral health provider)
- School care providers or supportive roles (e.g., nurse, counselor, social worker, teacher)
- Early childhood providers (e.g., staff from early intervention, day care or pre-K teachers)
- Child welfare (e.g., case manager, in-home service provider)
- Juvenile Justice (e.g., court counselor)
- Other social service providers (e.g., home visiting)
- Key adults who play a supportive role in the NC InCK member's care and wellbeing, as identified by the family (e.g., extended family, neighbors)

What this means for providers

Convening of an **integrated care team** for a child will promote linkages and collaboration among caring professionals across sectors who are involved in promoting the health and well-being of the child and their family. Meetings will support a shared understanding of the child's key issues and the family's priorities so that their needs can be addressed in a coordinated way. For health care providers, the integrated care team convenings will offer the opportunity to collaborate in support of better outcomes for their patients.

Family Navigators are responsible for coordinating integrated care team meetings based on the needs and wishes of NC InCK member and their family. Family Navigators receive training from NC InCK on how to convene and coordinate integrated care teams, including the best way to involve health care providers. 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 child's well-being goals.
- Promotes child advocacy and family voice through a collaborative process.

For more information on Family Navigator training, please see section 4.2.2.

4. Use of NC InCK Consent Form

For each member in SIL 2 and SIL 3, Family Navigators use the NC InCK Consent Form (Appendix A-3) to support a child's integrated care team. This consent enables:

- The creation of a page for a child on InCK's VirtualHealth Integrated Care Platform where a child's contact information, SIL, and Shared Action Plan are stored;
- The child's contact information, SIL, and Shared Action Plan to be shared with entities identified by a families as a part of a child's integrated care team
- The integrated care team to convene in support of a child's health, social and educational needs
- *Note*: The legality of direct communication between members of a child's integrated care team is determined by the entity in which the integrated care team member is employed.

What this means for providers

The NC InCK consent process is designed to support collaboration among a child's integrated care team. Families will specify which entities and individuals can share information and collaborate for their child's care. For example, NC InCK Consent Form can facilitate a conversation between a child's school social worker and a health care provider so that they can provide better integrated care for the child.

5. Complete the NC InCK Shared Action Plan

The Shared Action Plan (Appendix A-4) is a shareable, living document created through collaboration among the Family Navigator, family and the child's integrated care team. The Shared Action Plan serves as a valuable tool in building partnerships with families and promotes communication and integrated care coordination between the family and care team members.

The Shared Action Plan was developed through an intensive 2-year design process with teams of family members, care managers, social workers, physicians, and implementation science specialists.

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.

More information regarding the value of the NC InCK Shared Action Plan can be found in the NC InCK Guide to Integrated Care Teams and the NC InCK Shared Action Plan posted on the NC InCK website.

6. Support service referrals in NC InCK's 10 Core Child Service Areas

As outlined in **Table 2**, NC InCK's Core Child Service Areas include: Early Childhood, Schools, Juvenile Justice, Child Welfare, Legal Aid, Housing, Food, Health Care and Behavioral Health Care, and Mobile Crisis Response.

Family Navigators help children in SIL 2 and SIL 3 in accessing any relevant support needed across core child service areas. This includes new NC InCK requirements for care managers to provide assistance in

filling out and submitting applications for WIC, Free and Reduced Lunch, and school-based services for members with exceptional needs.

4.2 Integration Consultants

4.2.1 Identification and Assignment of Integration Consultants

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. Integration Consultants can support the completion of Shared Action Plans for children and families.

The NC InCK Integration Consultant team includes 16 members who are based in different core child services (Table 4).

What this means for providers

Integration Consultants are an important new part of the support infrastructure to assist children and families in meeting their goals. In general, Integration Consultants will work most closely with a child's Family Navigator rather than directly with a health care provider or with the family.

Integration Consultants focus their efforts on building capacity and cross-sector, integrated support.

Table 4. NC InCK Integration Consultant Sites

Integration Consultant Site	Core Child Service Area
Duke Health (Lead Site and Integration Consultant)	Health Care System
UNC Health (Lead Site and Integration Consultant)	Health Care System
Alliance Health	Behavioral Health Care Management
AmeriHealth Caritas	Managed Care Organization (PHP)
Carolina Complete Health	Managed Care Organization (PHP)
Granville-Vance Health Department	Health Department & Early Childhood
Orange/Durham County Head Start	Early Childhood
Healthy Blue	Managed Care Organization (PHP)
NC DHHS, Division of Public Health	School Nursing
NC Department of Public Safety	Juvenile Justice
Orange County Department of Social Services	Child Welfare and economic supports
Orange County Health Department	Health Department & Early Childhood
United Health	Managed Care Organization (PHP)
Vance County Department of Social Services	Child Welfare and economic supports
Vaya Health	Behavioral Health Care Management
Wellcare	Managed Care Organization (PHP)

4.2.2 Roles and Responsibilities of Integration Consultants

Integration Consultants will conduct monitoring and surveillance of NC InCK members in all three SILs to promote their receipt of integrated care. For NC InCK members in SIL 2 and SIL 3, Integration Consultants will ensure that an NC InCK member's caregiver is connected to a Family Navigator.

Integration Consultants train Family Navigators to serve in their roles, including:

- Consultation and education for Family Navigators on topics that emerge from the 10 NC InCK core child service areas.
- Best practices guides and support for the creation of a cross-sector integrated care team. Topics for the guides include: Early Childhood , Legal Aid, Behavioral Health, Integrated Care Teams and SAP Guide, Child Protective Services, Foster Care Services, Public Health, Education, Housing, Food.
- 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 care platform.
- NC InCK will offer virtual capacity building events, minimally each month. A team of Family Navigators from each entity should attend at least 60% of all Family Navigator capacity building events organized by NC InCK each year.

Integration Consultants implement strategies for improved cross-sector coordination of care management:

- Co-design the NC InCK service integration model;
- Use population data for systems improvement;
- Develop and enhance the Shared Action Plan;
- Strengthen capacity within their core child service area;
- Strengthen partnerships among core-child service areas;
- Convene stakeholders for data analysis, quality improvement, and model enhancement.

4.3 NC InCK VirtualHealth Integrated Care Platform

4.3.1 Overview of the NC InCK VirtualHealth Integrated Care Platform

VirtualHealth's Helios platform is used nationwide by healthcare and care management entities. Many entities in NC also use the platform, such as CCNC. The NC InCK VirtualHealth Integrated Care Platform is a care management platform that InCK Integration Consultants, families and integrated care teams can access to facilitate more integrated care coordination for children in Service Integration Levels 2 and 3. Integrated care team members will have access to a child's VirtualHealth profile based on a family's preference and consent. These users will be able to view basic information, care management contacts, and the Service Integration Level for children as well as upload and view key documents like a child's Shared Action Plan that includes the care team roster. The NC InCK VirtualHealth Integrated Care Platform can also facilitate secure messaging between Integration Consultants and active care team members on the platform. The NC InCK VirtualHealth Integrated Care Platform meets requirements for HIPAA privacy standards for child information.

4.3.2 Virtual Health Integrated Care Platform Uses

Functionality of the platform that supports integrated care and the NC InCK model includes:

- **Shared Action Plan** (Appendix A-4) Storing of completed and updated versions

- **Integrated Care Team Roster**: A list of the latest care team members, roles and contact information as supplied by the Family Navigator to the Integration Consultant
- **NC InCK Consent Form** (Appendix A-3): Storing of completed and updated version for reference
- **NC InCK member information**: NC InCK latest data on member demographics, PCP, health plan and assigned Family Navigator

4.3.3 Requesting Role-Based Access for NC InCK's Virtual Health Integrated Care Platform

To protect NC InCK member personal health information and the sharing of key documents created to support the member, only individuals listed on the NC InCK Consent Form with their email address can be added as a user on NC InCK's VirtualHealth Integrated Care Platform. Family Navigators can submit updated versions of the consent form at any time to their Integration Consultant to add new users, such as primary care providers. VirtualHealth's role based access is for individuals, not entities, so individuals must be specified on the consent form.

NC InCK Integration Consultants are responsible for creating role-based access for 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 to which members of the care team the guardian has given access.

Although primary care providers are not required to obtain role-based access, they can request access on the NC InCK Consent Form. To do so, please email Lead Integration Consultant Nancy Madenyika (nancy.madenyika@duke.edu). She will review the child's consent form, and if appropriately completed, create role-based access within 5 business days. Full names and email addresses will be needed to set up role-based access to Virtual Health.

Once role-based access is granted, NC InCK Integration Consultants will provide a brief guide for logging into and viewing child information in the NCInCK VirtualHealth Integrated Care Platform.

4.4 Partnership with NCCARE360

NC InCK has partnered with and promotes the use of NCCARE360, an online service referral platform, for NC InCK members and their families. Several health care system partners, including Duke and UNC, have integrated NCCARE360 within their electronic health records to facilitate easier service referrals during clinic appointments based on results of social drivers of health (SDOH) screening.

NCCARE360 functionality includes:

- **Documentation of care needs screening** for SDOH needs.
- **Closed loop referrals**: Offers options for selecting service providers on the platform, making referrals, and receiving confirmation on whether the entity contacted and/or served the referred individual. NCCARE360 allows for closed loop referrals for many of NC InCK core child service areas, including food, housing, early childhood, education, and health care.
- **Reports and data extracts** on NC Medicaid enrolled members receiving referrals by service type and resolution of referrals.

Integration Consultants provide support to Family Navigators on using NCCARE360 for service referrals.

5.0 Participation in the NC InCK Alternative Payment Model (APM)

5.1 Overview of the NC InCK Alternative Payment Model (APM) Structure

The NC InCK alternative payment model (APM) will be a 5-year, targeted incentive program in the 5 NC InCK administrative counties, beginning in quarter 4 of 2022 through December of 2026. Eligible beneficiaries will be Medicaid/CHIP-insured from birth to age 20 in Standard Plans. As part of the care management and Advanced Medical Home (AMH) flows, NC DHB will send a monthly NC InCK attributed member list to PHPs on a new modified Risk List (SIL File) with their assigned Service Integration Level (SIL). PHPs will then flow this information to providers via the Patient Risk List.

What this means for providers

The NC InCK APM is an opportunity for financial resources to be linked to services and supports that more holistically address the needs of children, some of which are not reimbursed under traditional fee-for-service payment models.

The NC InCK APM is designed to promote and reward child-centered care by linking payments to achieving goals in areas such as Kindergarten Readiness or food insecurity, while giving practices flexibility to work with families in ways that best meet their needs.

The APM is structured in two stages to reflect a glidepath to more advanced payment models and different levels of readiness to take on risk among practices and payers. At launch, the NC InCK APM will be called InCK Foundation, which includes AMH incentive payments, through Health Plan contracts, linked to reporting and performance against benchmark targets defined further in subsequent sections. AMH practices that choose to participate in InCK Foundation will have the opportunity to transition to InCK Advanced in subsequent years. InCK Advanced may include shared savings and/or losses for achieving benchmark targets for performance and total cost of care and/or prospective payments for meeting quality benchmarks. Further details on the InCK Advanced APM will be designed by the NC InCK APM Working Group and will be released at a later date. InCK APM measure results will be available as preliminary performance reports for baseline years 2019-2021 in calendar year 2023, and in2024 for performance during calendar year 2023.

5.2 APM Performance Measures

The NC InCK APM Working Group comprised of leadership representation NC Medicaid, CINs and all five PHPs has designed a payment model that links incentive payments to meaningful measures of child well-being with the goal of increasing resourcing and flexibility for practices to support more whole child care approaches.

Table 5. NC InCK Performance Measure Benchmarks for InCK Foundation

Performance Measure	Tier 1 (50% quality payment)	Tier 2 (75% quality payment)	Tier 3 (100% quality payment)
Kindergarten Readiness Rate	Aware***	Aware	Aware
Primary Care Kindergarten	Documented on 20% panel	Documented on 40% panel	Documented on 60% panel

Readiness Bundle			
Food Insecurity and Housing Instability Screener	Document on 20% panel	Documented on 40% panel	Documented on 60% -> 80% panel
Food Insecurity Rate	Aware	Aware	Aware
Housing Instability Rate	Aware	Aware	Aware
Shared Action Plan for children in SIL 2 and SIL 3	Plan documented for 5% SIL-2 and 10% SIL-3	Plan documented for 10% SIL 2 and 20% SIL 3	Plan documented for 10% SIL 2 and 30% SIL 3
Screening for Clinical Depression & Follow-Up Plan	Documented on 20% panel	Documented on 40% panel	Documented on 60% panel
Ambulatory Care: ED visits	Stable compared to 2-yr historical baseline	2.5% lower than 2-yr historical baseline	5% lower than 2-yr historical baseline
Well-Child Visits in First 0-15 Months of Life (Disparity Measure)	Increase **Black/African American rate 5% x 1 year** and overall rate is stable (+/- 1%) or improving*	Increase **Black/African American rate 10% x 1 year** and overall rate is stable (+/- 1%) or improving	Increase **Black/African American rate 15% x 1 year** and overall rate is stable (+/- 1%) or improving
Well-Child Visits for Age 15-30 Months**	Aware	Aware	Aware
Total Cost of Care	Aware	Aware	Aware

*If there is no existing disparity (defined as an AMH's Black/African American rate for this measure being no more than 2% below the white rate), an AMH will qualify for a Tier 1 payment if their overall rate meets or exceed the Standard Plan target for this measure.
**These two rates collectively are referred to as "Well-Child Visits in the First 30 Months of Life (W30)" in HEDIS specifications.
***Aware above is defined as an InCK performance measure not explicitly linked to an incentive payment, but shared with PHPs and providers for awareness of quality measure performance

The following performance measures are included in the NC InCK APM:

Table 6. NC InCK APM performance measures

Measure	Brief Description
Cross-Sector NC InCK APM Performance Measures	
Kindergarten Readiness Rate (Aware)	% of Kindergarten students at or above development and learning expectation in the *Early Learning Inventory*, an observation-based formative assessment completed in schools that assesses 5 domains of early learning and development
Primary Care Kindergarten Readiness Promotion Bundle	% of patients birth to 5 years who received Kindergarten Readiness Promotion Bundle defined as a minimum of 5 universal and need-based interventions based on their eligibility and age

Screening for Housing Instability	% of InCK-attributed children who have been screened for housing instability using the standardized survey questions from the Medicaid Care Needs Screener
Housing Instability Rate (Aware)	% of survey respondents who answer one or more of the three standardized housing stability survey questions from the Medicaid Care Needs Screener with 'yes'
Screening for Food Insecurity	% of InCK-attributed children birth to age 20 who have a documented response to at least one of the standardized Hunger Vital Signs survey statements.
Food Insecurity Rate (Aware)	% of survey respondents who answer one or both of the standardized Hunger Vital Signs survey statements with 'often true' or 'sometimes true'
Health Care NC InCK APM Performance Measures	
Ambulatory Care: ED visits	Rate of emergency department (ED) visits per 1,000 beneficiary months among children up to age 19.
Screening for Clinical Depression and Follow-Up Plan	% of NC InCK-attributed patients age 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter.
Shared Action Plan for children in SIL-2 and SIL-3	Percentage of children in NC InCK assigned to risk tiers called Service Integration Level (SIL) 2 or 3 who have a Shared Action Plan that is accessible* to the child/family and their cross-sector care team members. *Accessibility is measured by the availability of the Shared Action Plan on a platform accessible to all members of the care team and the family of the InCK beneficiary. Families and care team members will be able to access a children's Shared Action Plan on NC InCK's Virtual Health Platform or other digital platform hosted by their Standard Plan or Advanced Medical Home (e.g., EHR or other care management platform).
Well-Child Visits in the First 15 Months of Life (Disparity Measure)	The percentage of NC InCK-attributed children who had the following number of well-child visits during the last 15 months: -Children who turned 15 months old during the measurement year with six or more well-child visits. - This measure has been selected as the priority equity measure in NC InCK based on historical persistent disparities between 15-month-old Well-Child Visits between Black/African American and White infants. The Department will assess whether disparities have narrowed through performance improvement, specifically for the subpopulation experiencing the disparity, in addition to consideration of overall performance improvement for each plan's respective enrolled population as compared to their Standard Plan peers.
Total Cost of Care (Aware)	To Be Determined Based on NC Medicaid Guidance

"Aware" above is defined as an InCK performance measure not explicitly linked to an incentive payment, but shared with health plans and providers for awareness of quality measure performance

How will providers receive NC InCK performance measures reports?

Providers and practices will receive reports on their patients – both for their full population of children attributed to NC InCK and for children assigned to each PHP. Performance reports will be stratified by race, ethnicity, and county to allow insights on potential disparities.

How will NC InCK measures be linked to payments?

Beginning in 2023, NC Medicaid will determine whether practices are achieving performance benchmarks for the NC InCK APM measures. Please refer to NC InCK Performance Measure Technical Specifications Manual for detailed benchmark targets. A practice's performance on each measure will be assessed across all of their InCK-attributed children – across all PHPs with whom they are contracted. This type of assessment that combines or pools together all children in the Standard Plans is called pooled performance measurement.

5.3 The NC InCK Kindergarten Readiness Promotion Bundle

5.3.1 Overview of the NC InCK Kindergarten Readiness Promotion Bundle

The Kindergarten Readiness Promotion Bundle is a set of interventions that primary care providers often already employ to help promote kindergarten readiness. The actions included in the bundle are delivered from birth to age 6 and promote the five domains included in North Carolina's definition of kindergarten readiness: health and physical development, social and emotional development, language and communication development, cognition and general knowledge, and approaches toward learning. The Kindergarten Readiness Promotion Bundle aims to encourage and give credit to providers for taking actions that promote kindergarten readiness. Participating practices have the chance to receive financial incentives for successfully delivering the Bundle as part of the NC InCK Alternative Payment Model (APM).

What this means for providers

Primary Care Providers already play a key role in supporting kindergarten readiness among young children. NC InCK presents an innovative opportunity to bolster existing kindergarten readiness promotion efforts by including kindergarten readiness in the NC InCK Alternative Payment Model.

5.3.2 Components of the Kindergarten Readiness Promotion Bundle

The Kindergarten Readiness Promotion Bundle includes **universal components** that are applicable to all children at specific ages and flexible **need-based components** for children with specific needs**. Need-based components** can be delivered in clinic or through referral.

Children have received the Bundle if they receive <u>any five of these components at a well visit.</u> Practices do <u>not</u> have to provide all components of the Bundle, and do not have to provide all components of the Bundle at every visit. Practices may find that the more components of the Bundle they have in place, the easier it will be to deliver the Bundle for a high percentage of children and qualify for incentive payment. Therefore, practices may want to develop some new components, and work toward greater consistency for components that are already part of office workflow. NCCARE360 may facilitate delivery of some Bundle components; therefore, it may be helpful to have a workflow in place for using NCCARE360.

Table 7. Summary of NC InCK Kindergarten Readiness Bundle Components

		BIRTH TO 3	3 TO 5
UNIVERSAL	Conduct well visit	✓	✓
	Office-based literacy promotion	✓	✓
	Developmental screening	✓	✓
	Social-emotional screening	✓	✓
	Fluoride varnish	✓	
	Hearing and vision screen		✓
NEED-BASED			
	Refer to Pre-K		✓
	Refer to CDSA	✓	✓
	Refer to Exceptional Children's program	✓	✓
	Provide/refer to parenting support program	✓	✓
	Provide/refer to early childhood mental health program		✓
	Refer to community-based literacy program	✓	✓

5.3.3 Documentation and Coding of the Kindergarten Readiness Promotion Bundle

On September 1, 2021, the State of North Carolina instituted the use of CPT Category II Code 1003F (Level of Activity Assessed) for documentation of the Kindergarten Readiness Promotion Bundle for the Integrated Care for Kids (InCK) program. This is a non-reimbursable code that captures Bundle delivery and enables measurement of rates of Bundle delivery to determine financial incentives. **Providers will need to document the Kindergarten Readiness Promotion Bundle using the applicable overall Bundle code 1003F.** Practices should also establish consistent electronic documentation methods for each component of the Bundle. No reimbursement is provided for the Bundle code (CPT 1003F); however, many individual components of the Bundle can be documented, coded, and reimbursed as described below and in the Health Check guide.

The **Kindergarten Readiness Promotion Bundle code (CPT 1003F)** should be billed with all applicable modifiers. This is important because practices will be able to receive data on two specific Kindergarten Readiness activities that have not typically been captured: **office-based literacy promotion** and **referral to PreK.** Using these modifiers will allow practices to track these two specific components of kindergarten readiness activities promotion. Providers should:

- Use CPT 1003F with modifier SE when bundle is delivered and includes **office-based literacy promotion**
- Use CPT 1003F with modifier TS when bundle was delivered and includes **referral to PreK**
- Use CPT 1003F with modifiers SE and TS when bundle was delivered and includes **both office-based literacy promotion and referral to PreK**
- Use CPT 1003F without a modifier when the bundle was delivered but did not include PreK or office-based literacy promotion

The Kindergarten Readiness Promotion Bundle can be delivered for all well child visits from birth until the 6th birthday. The appropriate Bundle codes should be added to usual CPT and diagnosis codes for well child visits.

NC Medicaid will distribute a bulletin on the NC InCK Kindergarten Readiness Bundle in March, 2022.

5.3.4 Kindergarten Readiness Promotion Bundle Components

Universal Components

Most of the following components of the Bundle are familiar to children's health care providers as components of high-quality well child care, and are part of Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/Health Check guidelines. They apply universally to all children from birth until the 6th birthday. Providers can complete delivery of the Bundle by documenting 5 or more of these components at all well visits (birth until the 6th birthday) for children who do not have additional identified needs.

Table 8. Universal Components of NC InCK Kindergarten Readiness Bundle

Component	Description
Conduct Well Visit	Conducting a well child visit at each age indicated by NC Health Check Program Guide/EPSDT Guidelines is part of the Bundle. Health care providers should simply document well visits using the applicable CPT and diagnosis codes (for example, diagnosis codes Z00.121/Z00.129 with CPT codes 99391/99392/99393). Since the Bundle applies to all empaneled children in a practice, many practices will benefit from active outreach to identify and schedule children in need of a well visit. **More children coming for well visits means more opportunities to deliver and receive credit for the Bundle.**
Provide Office-Based Literacy Promotion	Practices should use the following criteria to determine that they are providing office-based literacy promotion: • Provide a new book at each well visit • Counsel caregivers about benefits of early book sharing Reach Out and Read is a national program that enables practices to meet these criteria. Practices that have a Reach Out and Read program can use this to meet the Office-Based Literacy Promotion component of the Bundle. Providers should apply the modifier SE with the Kindergarten Readiness Promotion Bundle code (1003F) to document their use of Reach Out and Read as Office-Based Literacy Promotion. Practices that do not yet have a Reach Out and Read program may want to consider starting one with support and assistance from the Reach Out and Read regional office, NC DHHS, and NC InCK. Practices that want to use alternative approaches to conducting office-based literacy promotion should ensure they meet the above criteria.

Component	Description
Conduct Developmental Screening to Identify Risk for Developmental Delay	Developmental screening is required though the North Carolina Medicaid Health Check program at the 6-month, 12-month, 18- or 24- months, and ages 3, 4, and 5-year visits. To improve developmental screening, practices can ensure that a valid standardized and structured screening tool is used, and that screening is done at all expected ages at a minimum. Developmental surveillance should also be incorporated at every Early Periodic Screening preventive care visit. Any concerns raised during surveillance should be promptly addressed with standardized developmental screening even when developmental screening is not required to be done at that age. Early identification and intervention for developmental problems are important. The ABCD approach helped many NC practices implement and improve developmental screening. Details on implementing and improving developmental screening are in this ABCD overview and summary on screening and surveillance. For more information about developmental surveillance and screening see: https://publications.aap.org/pediatrics/article/145/1/e20193449/36971/Promoting-Optimal-Development-Identifying-Infants and https://www.brightfutures.org/development/early/overview_screening.html Practices should document developmental screening as is currently advised in the NC Health Check Program Guide and code using **CPT code 96110** and modifier EP.
Conduct Social-Emotional Screening	Early behavioral and emotional problems and concerns in infants and young children are common but are not reliably identified or treated. Bright Futures guidelines recommend a psychosocial/behavioral assessment at every well child visit starting within the first month of life. Social-emotional screening is also important when maternal depression or other social needs are present, and should be accompanied by eliciting child and family strengths. Screening can be done through validated social-emotional screening tools which can facilitate first steps toward identifying early risks for childhood emotional and behavioral challenges. Providers should conduct social-emotional screening and apply **CPT code 96127** with the EP modifier. Examples of social-emotional screening tools for infants and young children include but are not limited to: • Ages and Stages Questionnaire: Social Emotional 2 (ASQ SE-2) (2 - 60 months) • Brief Infant and Toddler Social Emotional Assessment (BITSEA) (12-36 months) • Early Childhood Screening Assessment (ECSA) (18-60 months) • Baby Pediatric Symptom Checklist (included as Part of the Survey of Well-Being of Young Children or SWYC) • Preschool Pediatric Symptom Checklist (Included as Part of the SWYC) • Strengths and Difficulties Questionnaire (3 -16 years)

Component	Description
	Additional information about social emotional screening is here: https://publications.aap.org/pediatrics/article/135/2/384/33387/Promoting-Optimal-Development-Screening-for
Apply Fluoride Varnish	To maintain oral health and prevent caries, AAP recommendations and the NC Medicaid Health Check guidelines indicate that that once teeth are present, fluoride varnish may be applied to all children every 3-6 months from tooth eruption to 3 ½ years. Providers should follow all guidance in the NC Medicaid Physician Fluoride Varnish Services Clinical Coverage Policy. To capture fluoride varnish application as part of the Kindergarten Readiness Promotion Bundle, health care providers should apply **CDT codes D0145 and D1206.**
Conduct Hearing and Vision Screening	Consistent with NC Medicaid Health Check guidelines, objective vision screenings should be performed at well visits annually from age 3 to age 6 years. Providers should document vision screening and apply usual vision screening codes **(99173/99177).** Objective hearing screening is also expected for the Health Check program annually for children ages 4 through 6 years using an audiometer (auditory sweep) or otoacoustic auditory emission (OAE) tool. This component of the Bundle should be documented by providers using usual codes **(92551/92552 +EP).**

5.3.5 Need-Based Components of the Kindergarten Readiness Promotion Bundle

Many children will benefit from programs, connections, and referrals that are based on their specific needs. Children's health care providers can promote kindergarten readiness by actively connecting children to the following need-based components of the Bundle as applicable.

Table 9. Need-Based Components of NC InCK Kindergarten Readiness Promotion Bundle

Component	Description
Refer to PreK	Children who are 3 years of age or older and are not yet in a PreK program can be referred or connected to a high-quality PreK program, including NC PreK, HeadStart, or private preschool. To meet this component of the Bundle, practices may use one of the following methods: • Provide on-site assistance with PreK application completion • Connect families to an application counselor or child care referral specialist who assists with application and selection of a PreK program such as through Child Care Referral Central (Alamance, Caswell, Person, Franklin, Granville, Vance, Durham, Orange, Wake). Families may be connected: • Through NCCARE360 • Through a warm handoff by phone: 1-855-EARLY-ED or 1-855-327-5933 or https://www.childcareservices.org/families/find-child-care/

Component	Description
	• In Durham County, the Durham PreK line is an additional option: 1-833-773-5338 or https://durhamprek.org/dpk-application/ • If a phone call to begin the PreK application process cannot be made while the child is in the office, the caregiver can be provided with the phone number and the practice can place a follow up call to confirm that the caregiver successfully contacted the PreK application counselor. Printed NC PreK referral information materials can also be requested by email at: Referral@childcareservices.org Providers should document referral to PreK and **use the TS modifier in combination with the Bundle code 1003F** in order to document and track PreK referral.
Refer to Children's Development Services Agency (CDSA)	Referring children from birth to age 3 for early intervention services can promote multiple aspects of development and help to put services into place that facilitate kindergarten readiness. Children may benefit from referral to a local CDSA (Children's Developmental Services Agency) if they have: • Developmental delay • Specific diagnosed physical or mental conditions which have a high probability of resulting in developmental delay. A complete list of conditions that result in eligibility for the Infant-Toddler program is here: https://beearly.nc.gov/data/files/pdf/EligibilityDefn.pdf For children meeting one of these criteria, referral to CDSA will meet this component of the Bundle. Children's health care providers should document CDSA referral within the medical record. Children's health care providers may want to consider developing a system that allows referrals to the CDSA to be tracked and followed up so that they may confirm that children are connected with needed services. Practices may want to consider adding the following to facilitate workflow: • Standard referrals or orders to the CDSA • Use of NCCARE360 to refer children to the CDSA
Refer to Exceptional Children's Program	Children who are 3-5 years of age and not yet in kindergarten can receive screening and evaluation for developmental concerns through the local school districts and their Exceptional Children Preschool Programs. Referring children from 3 to 5 to these programs can help to put services into place that facilitate kindergarten readiness. Children may benefit from referral for screening and evaluation if they: • Have a developmental delay • Received services previously through the CDSA Health care providers can use the **Physician Notification to Exceptional Children form** located at this link refer children as described in this Process Flow Chart.

Component	Description
	Providing the parent with contact information for the Exceptional Children's program to School District Preschool Coordinators will also meet this component of the Bundle. Practices may also want to consider using NCCARE360 to make this referral. Children's health care providers should document Exceptional Children's Program referral within the medical record. Additional information about the Exceptional Children's Program is here: https://www.dpi.nc.gov/districts-schools/classroom-resources/office-early-learning/preschool
Provide/refer to parenting support program	Young children's caregivers may benefit from parenting support and engagement programs from birth to age 6. These programs may facilitate kindergarten readiness directly, through activities such as literacy promotion and parent-child play which promotes cognitive, social-emotional, language and motor development, and indirectly, through supporting caregivers and promoting early relational health. Parenting support and engagement programs can occur in the office, remotely, or within the home or other settings. Health care providers are encouraged to connect families with programs that have a strong evidence base. Recognizing that local and culturally tailored parent engagement efforts may also be important but may not yet have accumulated a substantial evidence body, providers are encouraged to consider referral to these programs as appropriate. Programs that include the following criteria are included in this component: • Programs that have a minimum of 2 planned contacts with caregivers • Programs that have structured training for program leaders Programs that provide parents the opportunity to practice parenting skills promoted during the program are especially encouraged. a. Programs that meet the criteria for parenting support include, but are not limited to, the following: b. Triple P Positive Parenting Program c. Incredible Years d. Parents as Teachers e. Child Adult Relationship Enhancement in Primary Care (PriCARE) f. Healthy Steps for Young Children g. Family Connects h. Healthy Families America i. Nurse Family Partnership j. Project LAUNCH k. Project DULCE l. Video Interaction Project

Component	Description
	Health care providers can refer all interested caregivers to parenting support and engagement programs at all well visits. This component of the Bundle has been met when health care providers document referral in the medical record. Health care providers are encouraged to consider using NCCARE360 to refer to parenting support and engagement programs.
Provide/refer to early childhood mental health program or service	Children from birth to age 6 may benefit from early childhood mental health services. Early mental health challenges may be identified through parent concerns, through social-emotional screening, or through observation during the well child visit. Children's health care providers are encouraged to refer young children to services and therapists who have experience with young children and have expertise with evidence-based therapies for young children. These include but are not limited to: parent-child interaction therapy, child-parent psychotherapy, and child-parent relationship therapy. Children's health care providers can meet this component of the Bundle for children who need it by referring children to: • An on-site behavioral health therapist • Off-site therapists or other mental health professionals To identify appropriate trained therapists for young children, providers can use the following NC Child Treatment Program Provider Roster. Providers can contact the North Carolina Psychiatry Access Line (NC-PAL.) for assistance with therapy and evaluation: 919-681-2909, https://ncpal.org/. This component of the Bundle should be documented in the medical record.
Provide/refer to community-based literacy program	In addition to in-office literacy promotion (described above), children benefit from having access to a selection of books in their homes. Several community-based literacy programs offer free books and literacy supports to families, including home visiting focused on language development. These supports are offered at no cost to participating families. Examples of programs that apply to this component of the Bundle include: • Dolly Parton Imagination Library • Book Babies through Book Harvest • Raising a Reader Family literacy program (Orange County) • Ready4K Text message literacy curriculum (Durham) To meet this component of the Bundle, practices should provide information about these free programs and assist families with registering for them. This component of the Bundle should be documented in the medical record.

5.3.6 Kindergarten Readiness Measurement

Practices will receive practice-level data feedback about the **percentage of children who receive the Kindergarten Readiness Promotion Bundle.** In addition, practices will receive feedback about the percentage of children who received the Bundle and: 1) were referred to PreK, and 2) received office-based literacy-promotion.

Practices will also be provided with aggregate data on **rates of kindergarten readiness.** In North Carolina, kindergarten readiness is measured in schools using the *Early Learning Inventory*. By viewing practice-specific kindergarten readiness data, practices will be able to adjust their approaches to promoting kindergarten readiness.

5.3.7 NC InCK Support for Kindergarten Readiness Promotion Bundle

NC InCK provides the following resources to enable providers to deliver the Kindergarten Readiness Promotion Bundle:

Care integration support: NC InCK Integration Consultants are available to advise care managers on linkages to more Early Childhood services in their communities. Integration Consultants have developed detailed electronic guides to share information about kindergarten readiness-related activities, programs, and services.

Implementation support through:

- Care Managers at Medicaid Prepaid Health Plans or Advanced Medical Homes who can conduct outreach to children in need of well visits and connect children to services
- Training and coaching by Prepaid Health Plans
- NC InCK Early Childhood Innovation Committee support in identifying and addressing service gaps. This committee consists of representatives from early childhood care and education, behavioral health, social services, and other sectors vital to early childhood well-being and kindergarten readiness promotion. The committee will be working to build community organization capacity for kindergarten readiness services and programs.

Further innovation support: Practices may choose to partner with NC InCK on selected pilot projects to address service gaps in promoting kindergarten readiness.

5.3.8 Sample Improvement Steps for Kindergarten Readiness Promotion Bundle

Practices have flexibility in the resources, programs, and services they select to deliver the Kindergarten Readiness Promotion Bundle. This allows providers to tailor the Bundle to meet the needs of local communities. Below are examples of strategies that practices have used to facilitate delivering the Bundle:

- **Electronic health record modifications**. Practices may find that it is most efficient to document the Bundle using standardized documentation procedures, such as standard order sets for children under age 6, and incorporating Bundle components into electronic well child check templates. Examples are shown in the subsequent section.
- **Addition of on-site programs and services.** If gaps exist in access to specific programs and services, such as parenting support programs or mental health services, practices may want to consider developing on-site or virtual programs. Alternatively, practices may want to partner with community agencies to offer these, or provide access to programs that are offered

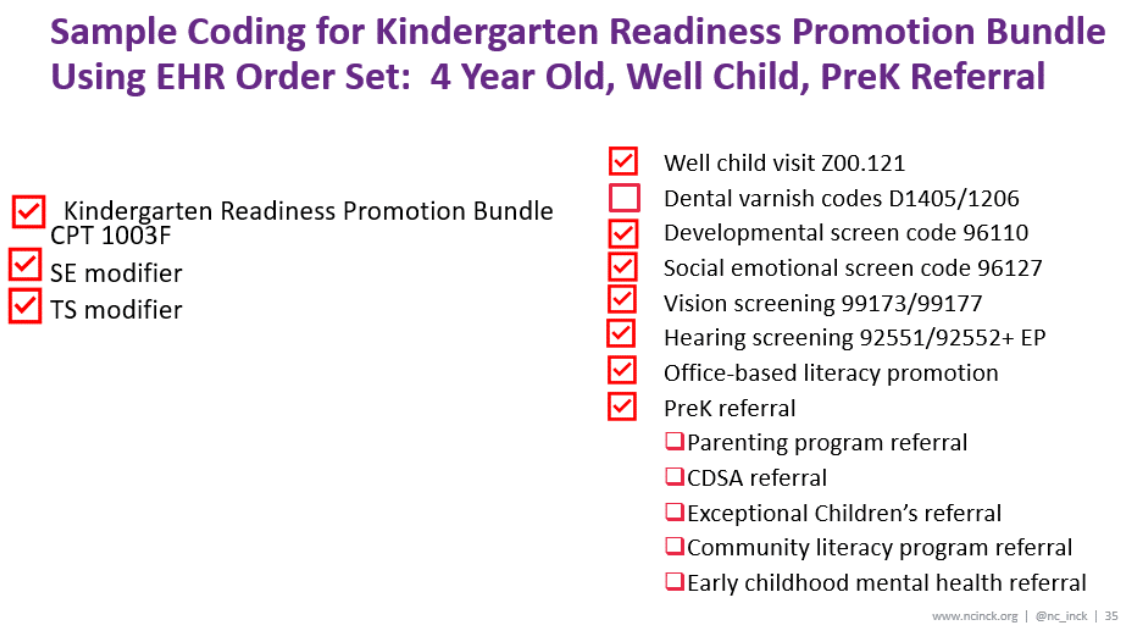
virtually. The enhanced payments available through the NC InCK APM may help to support such additional programs and services.

- **Identified staff member to support kindergarten readiness efforts.** Practices may want to consider identifying a specific staff member who can assist with kindergarten readiness-related efforts, such as helping caregivers complete PreK applications. The enhanced payments available through the NC InCK APM may eventually help to support staff member time.

5.3.9 Potential Electronic Health Record Modifications to Facilitate Delivery of Kindergarten Readiness Promotion Bundle

Standard electronic health record order sets may help providers to deliver the Bundle efficiently, and enable capture of data so that incentive payments to practices can be applied appropriately. Below are examples of how the Bundle code and modifier might be combined with typical well child diagnosis and CPT codes.

Figure 5. Sample Coding for Kindergarten Readiness Promotion Bundle



Sample Coding for Kindergarten Readiness Promotion Bundle Using EHR Order Set: 3 Year Old, Well Child

- ☑ Kindergarten Readiness Promotion Bundle CPT 1003F
- ☑ SE modifier
- TS modifier

- ☑ Well child visit Z00.121
- ☑ Dental varnish codes D1405/1206
- ☑ Developmental screen code 96110
- ☑ Social emotional screen code 96127
- ☑ Vision screening 99173/99177
- ❑ Hearing screening 92551/92552+ EP
- ☑ Office-based literacy promotion
- ❑ Parenting program referral
- ❑ PreK referral
- ❑ CDSA referral
- ❑ Exceptional Children's referral
- ❑ Community literacy program referral
- ❑ Early childhood mental health referral

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Sample Coding for Kindergarten Readiness Promotion Bundle Using EHR Order Set: 3 Year Old, Developmental Delay and Behavior Problems

- ☑ Kindergarten Readiness Promotion Bundle CPT 1003F
- SE modifier
- TS modifier

- ☑ Well child visit Z00.121
- ☑ Dental varnish codes D1405/1206
- ☑ Developmental screen code 96110
- ☑ Social emotional screen code 96127
- ☑ Vision screening 99173/99177
- ❑ Hearing screening 92551/92552+ EP
- ❑ Office-based literacy promotion
- ❑ PreK referral
- ☑ Parenting program referral
- ☑ CDSA referral
- ❑ Exceptional Children's referral
- ❑ Community literacy program referral
- ❑ Community literacy program referral
- ❑ Early childhood mental health referral

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Additional resources for implementing the Kindergarten Readiness Promotion Bundle are in the Kindergarten Readiness Promotion Bundle: Provider Resources table (A-5) . For more information about the Kindergarten Readiness Promotion Bundle, please contact Dr. Kori Flower at flower@email.unc.edu .

6.0 NC InCK Areas of Focus and Innovation for Health Care Providers

6.1 Behavioral health

NC InCK is committed to supporting the behavioral health of children and youth. Below are several key NC InCK initiatives and supports for primary care practices in the InCK counties.

Table 10. NC InCK Supports for Behavioral Health Initiatives

NC InCK Supports for Primary Care Practices: Behavioral Health
Partnership and Support for North Carolina Psychiatry Access Line (NC-PAL). Providers can call (919) 681-2909 for *free* pediatric psychiatry consultative and educational support in the five NC InCK counties. The NC-PAL consultation phone line is available Monday-Friday from 8am-5pm for clinicians across the state, and can connect callers to Master's-trained Behavioral Health Consultants and Child and Adolescent Psychiatrists for guidance on a variety of pediatric behavioral health issues. NC-PAL also offers free practice didactic sessions on topics of practice choice. **If you or your clinic is interested in learning more about NC-PAL or scheduling a didactic session, contact Chelsea Swanson at chelsea.swanson@duke.edu or ncpal@duke.edu**
REACH Institute's Patient-Centered Mental Health in Pediatric Primary Care (PPP) Mini-Fellowship for primary care providers. Patient-Centered Mental Health in Pediatric Primary Care (PPP) trains clinicians to diagnose and treat mental health conditions they see every day in practice. This program will teach clinicians how to manage the most common issues in the primary care setting , saving referrals to mental health specialists for complex cases. Participants learn not only to diagnose and treat patients but also to refer families to appropriate supports such as cognitive behavioral therapy. **If you or your clinic is interested in learning more about REACH training, contact Chelsea Swanson at chelsea.swanson@duke.edu or ncpal@duke.edu**
Support for implementing collaborative care models in primary care through partnership with NC-PAL. In addition to the consultation line, NC-PAL is available to work with practices interested in implementing integrated care processes, including collaborative care to enhance screening, treating and managing patients with behavioral health concerns. Clinicians and program staff can work with practice staff to assess current processes, advise on model development and provide support during implementation. **If you or your clinic is interested in learning more about integrated care support through NC-PAL, contact Chelsea Swanson at chelsea.swanson@duke.edu or ncpal@duke.edu**
Improve access to and utilization of crisis services, including mobile crisis response for pediatric behavioral health emergencies. NC InCK is working with local stakeholders to: • Create a guide of the crisis service array within NC InCK counties, which will soon be available on our website • Support enhanced data collection and reporting strategies regarding the outcomes of youth engaged with crisis services • Provide enhanced pediatric mental health training for crisis providers through partnership with NC-PAL

The NC InCK's Behavioral Health Work Group advises on best approaches to improve the behavioral health of children in NC InCK with a focus on understanding access to the array of crisis services in each community and bolstering the provision of quality behavioral health care in primary and specialty care settings. Members include behavioral health leaders from Managed Care Organizations, Duke, UNC, and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services within NCDHHS.

6.1.1 Collaborative Care

In 2018, NC Medicaid approved the use of Collaborative Care Billing codes, which are available in Standard Plans. The codes were first deployed in Medicare for a model of care where a primary care provider bills for the work of a team that includes a master's trained behavioral health consultant who maintains a registry of patients with behavioral health conditions, does behavioral health case management with these patients and consults on a weekly basis with a psychiatrist. This model has been shown in over 70 trials and in a meta-analysis to improve depression outcomes and to improve performance on the CMS measure of depression screening and follow-up. Collaborative care provides a node for connectivity to resources & the larger behavioral health system that practices are currently lacking.

- These codes are currently underutilized. In NC Medicaid only 1,000 patients in 2019 had collaborative care billed. The codes reimbursement is quite generous and can easily cover costs associated with model, but requires effort to set-up (i.e. access to psychiatry and BH consultant, understanding how to use codes)
- A readiness assessment tool (MeHAF Assessment) can be used to identify practice strengths & weaknesses and promote data-driven implementation of collaborative care. - Outcomes: Collaborative care implementation will give primary care practices the infrastructure to effectively:
    - Screen and develop follow up plans for depression
    - Monitor psychotropic prescribing, particularly of antipsychotics
    - Identify and connect patients to local behavioral health resources
    - Decreased costs of care

If you or your clinic is interested in working with NC InCK to integrate collaborative care into your practice, contact Chelsea Swanson at chelsea.swanson@duke.edu or ncpal@duke.edu .

6.1.2 Mobile Crisis Response

Mobile Crisis Response (MCR) offers an immediate way to connect with trained behavioral health professionals who can:

- Assess the crisis
- Determine the safety of the person in crisis and those around them
- Identify next steps for treatment

Clinicians can call local Mobile Crisis Agencies for guidance when helping a patient experiencing a behavioral health crisis. Mobile Crisis Response can offer an alternative to receiving care in an Emergency Department in some circumstances.

MCR professionals serve children and adults, and can travel to a person in crisis.

What to expect when calling Mobile Crisis

Someone will answer your call live and listen to your concerns and immediate needs. Be prepared to give as much information as possible when you call including:

- Your name
- Information about the person in crisis:
  - Name
  - Medicaid number
  - Date of birth
  - Diagnoses
  - Medications
  - Medical issues of concerns
  - Brief psychiatric history
  - Family issues or concerns
  - History of aggression or law enforcement involvement
  - Current concern

What this means for providers
NC InCK's governing bodies allow for critical and diverse perspectives to inform and guide its activities. For health care providers, this means that they can be confident that the additional supports and elevated care their patients are receiving were developed collaboratively by youth, families and partners in attempts to best address the holistic needs of children.

If the person in crisis is able, they must offer consent for a MCR professional to come to your location over the phone.

Depending on your needs, a MCR professional may come to you for further evaluation and to determine appropriate next steps. Next steps might include:

- Education on how to prevent crises
- Access to crisis stabilization interventions
- Development of a crisis plan for current and future use
- Linkage to ongoing services
- Assistance with voluntary and involuntary hospitalization

Table 11. Mobile Crisis Response Agencies in the InCK Counties

Agency	Phone Number
Daymark Recovery Services	Both agencies can be reached at **866-275-9552**
Freedom House Recovery Center	

If you have questions about Mobile Crisis Response or other crisis services in your area, contact Chelsea Swanson at chelsea.swanson@duke.edu or ncpal@duke.edu.

7.0 Governing Bodies and Leadership Councils

NC InCK values the leadership of families and youth. As such, deep engagement of our NC InCK Partnership Council and complementary Family and Youth Councils is a top priority.

7.1 Partnership Council

The NC InCK Partnership Council is the model's governing body and includes members representing all core child service areas and individuals who work in each of the five NC InCK counties. The NC InCK Partnership Council has convened virtually on a quarterly basis this year.

Organizations represented on the Partnership Council include:

Alamance-Burlington Public Schools

Alliance Beh Health

AmeriHealth Caritas

Blue Cross/Blue Shielf of NC

Book Harvest

Burlington Pediatrics

Cardinal Innovations

Carolina Complete Health

Community Care of NC

Duke Pop Health Initiative

El Futuro

Franklin-Granville-Vance Smart Start

Granville Vance Public Health

Granville/Vance Health Dept

Hunt Institute

Legal Aid

Moms Rising

NC Child Parent Advisory Council

NC Child Welfare Family Advisory Council

NC DHHS

NC DPS

NC Families United

NC Healthy Schools

NC Medicaid

NC WellCare

Orange County DSS

Orange County Health Dept

Porch Communities NC

UNC Health Care

United HealthCare

7.2 Other Leadership Councils

Other leadership councils that are engaged in guiding the development and implementation of the NC InCK model are the NC InCK Family Council and Youth Council. The Family Council is made up of caregivers of children enrolled in Medicaid or CHIP whose perspective and lived experiences inform the NC InCK model. The Youth Council is made up of teens and young adults (ages 13-20), the majority of whom are insured through Medicaid or CHIP, and want to work with other leaders to make a difference for children and families in their communities.

Appendices

A-1 Family Talking Points

NC InCK NC INTEGRATED CARE FOR KIDS

NC InCK Basics for Families

What is NC InCK?

North Carolina Integrated Care for Kids (NC InCK) is a model aimed at better connecting the people who support children and families in meeting children's health, education, and overall well-being goals.

Why does NC InCK exist?

We want all children to be healthy and thriving and are working with funding from the federal government to make that a reality for more children and families. NC InCK works to improve children's health and well-being, allow children to be at home in safe and nurturing families, and invest public dollars in new ways that focus on more meaningful measures of child well-being.

Who?

Which children are included in the NC InCK model?

Children from birth to age 20 who live in Alamance, Durham, Granville, Orange and Vance Counties and who receive health insurance through Medicaid or the Children's Health Insurance Program (CHIP) are automatically enrolled in the NC InCK model.

Who is involved in designing and supporting the NC InCK model?

NC InCK is building solutions across programs that serve children, so that we can better work together for children and families. NC InCK works with the doctors and health insurance plans involved in children's health care, schools, early care and education, food, housing, public health services, child welfare, juvenile justice, Mobile Crisis Response, and Legal Aid.

When did NC InCK start and how long does it last?

The NC InCK model will run from 2022 to 2026. All services at NC InCK are optional. The teams leading NC InCK have been working together to design and plan for the model since 2020.

Do families need to do anything differently to have their child supported by the NC InCK model?

Children are automatically enrolled in NC InCK based on their age, where they live, and their insurance. There is no need to sign up for NC InCK. Children will still be able to see the same doctors and receive the same services. NC InCK aims to make more supportive services available to more families and connect the teams who work with children for better coordination.

Supports Available to Families in NC InCK

Family Navigator:

Some families in NC InCK have the option to work with a **Family Navigator**, who in most cases will be the care manager working with a Medicaid plan or your health care provider. Based on a family's preferences, a Family Navigator can be a family's main contact for understanding a child's needs through conversations and assessments, achieving your goals for your child's health and well-being, and

coordinating the care team that you identify for your child. The Family Navigator can support your family through regular check-ins over a year.

Child's Integrated Care Team:

A child's integrated care team is a group of people connected to a child who come together to support a child and family in reaching their health and well-being goals. This team can include professionals from systems a child interacts with (like their doctor's office, school or child care center) and others who provide support to their child and family (like neighbors, coaches, or mentors). The Family Navigator is responsible for working with a family to identify and bring the integrated care team together to better support the child and family.

Shared Action Plan:

The Shared Action Plan (SAP) is a document created by a family, their Family Navigators and their integrated care team to encourage coordination and communication among all Care Team members. The Shared Action Plan (SAP) is 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.

Note: The Shared Action Plan can be a valuable tool for any child, even if they already have a care plan. The Shared Action Plan is a shorter and simpler document that families have asked for and that can be easily shared across a child's integrated care team. In these ways, the Shared Action Plan can be a nice pair to an existing care plan for your child.

NC InCK's Integration of Care

NC InCK Integration Consultants support Family Navigators in connecting with resources to meet a child's health, educational, and social needs. These Integration Consultants can help your Family Navigator connect your child to programs and resources in any of these service areas, if needed: health care, schools, early child care, food, housing, public health services, child welfare, juvenile justice, Mobile Crisis Response, and Legal Aid.

Educational and Resource Guides for Families

NC InCK provides educational and resource guides for families. These include information about the NC InCK model, training and overviews for key parts of the model (like the Shared Action Plan and Consent), and resources developed by NC InCK staff and Legal Aid with information about each of the core child service areas.

NC InCK NC INTEGRATED CARE FOR KIDS

Other FAQ Topics

NC InCK's Integrated Care Platform:

NC InCK's VirtualHealth integrated care platform is available for families to more easily share documents and information with your child's integrated care team. Through a consent process, families can sign onto this platform and decide which of their child's care team members they want to also have access.

Families who need support with the NC InCK VirtualHealth Integrated Care Platform should contact Nancy Madenyika at nancy.madenyika@duke.edu.

Data in NC InCK

NC InCK brings together information from multiple sources to give a more complete picture of a child's health, education, and social service needs as well as a family's needs. These data are used to identify children who would likely benefit from additional support so that more support can be offered to those families.

NC InCK Consent

Your Family Navigator will give you the opportunity to provide consent for your child to have more NC InCK supports.

This NC InCK consent provides permission for:

- The integrated care team to communicate and support health, social and educational needs of the child
- The child's Information to be shared with their integrated care team
- The creation of a page for your child on NC InCK's VirtualHealth integrated care platform where you can choose to share your child's information and Shared Action Plan with their integrated care team

Medicaid Transformation

Recently, North Carolina's Medicaid program has changed the way it provides health insurance through Medicaid Transformation. NC InCK is not a type of health insurance. NC InCK works with all of the new Prepaid Health Plans and health systems to connect children and families to additional supports available through Medicaid and in other systems.

Note: To learn more about Medicaid Transformation, please visit Medicaid's website.

Learning More about NC InCK

Website

The best place to find up to date information on NC InCK is at NC InCK's website: www.ncinck.org/families

NC InCK NC INTEGRATED CARE FOR KIDS

Contact

If you have general questions about NC InCK, please email info@ncinck.org. For specific questions or requests related to InCK Authorization, please email ncinckauthorization@duke.edu

Get Involved

There are many ways to get involved and support the NC InCK model:

- Family Council: The Family Council is made up of caregivers of children enrolled in Medicaid or CHIP whose perspective and lived experiences inform the NC InCK model.
- Youth Council: The Youth Council is made up of teens and young adults (ages 13-20) who are insured through Medicaid or CHIP and want to work with other leaders to make a difference for children and families in their communities.

If you are interested in participating in either the Family Council or Youth Council, please email info@ncinck.org

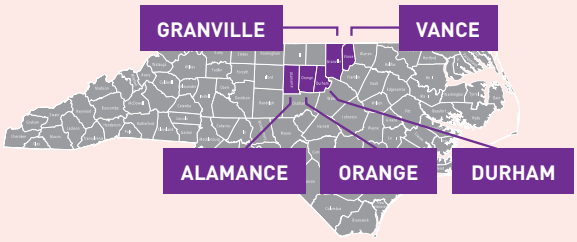
A-2 Family One-Pager



Information for Families

NC InCK
NC INTEGRATED CARE FOR KIDS

What is 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.

Who: All children and youth from birth to age 21 who are insured by Medicaid or NC Health Choice and who live in Alamance, Durham, Granville, Orange, or Vance counties will be automatically enrolled in NC InCK.

Why: NC InCK works to improve children's health and well-being, allow children to be at home in safe and nurturing families, and invest public dollars in new ways that focus on more meaningful measures of child well-being.

What: NC InCK is building solutions across programs that serve children so that we can better work together for children and families. NC InCK works with the doctors and health insurance plans involved in children's health care, schools, early care and education, food, housing, public health services, child welfare, juvenile justice, Mobile Crisis Response, and Legal Aid. All services at NC InCK are optional.

When: NC InCK launches in 2022 and will operate through 2026. The teams leading NC InCK have been working together to design and plan for the model since 2020.

What does this mean for families?

- Children are automatically enrolled in NC InCK based on their age, where they live, and their insurance. Parents do not needto do anything extra to enroll their child in NC InCK.
- Children will still be able to see the same doctors and receive the same services. NC InCK is working to make more supportive services available to more families and to connect the teams who work with NC InCK members so that supports are better coordinated.
- Some families in NC InCK have the option to work with a **Family Navigator**, who, in most cases, will be a care manager assigned to your family by your Medicaid plan or health care provider. For these families, a Family Navigator can support them in achieving their health and well-being goals for their child and coordinating the integrated care team that the family identifies to support their child.
- Some families will also have access to tools available in NC InCK, like a Shared Action Plan, to help all of your child's integrated care team members know your top goals and your child's health and well-being or the NC InCK Integrated Care Platform to more easily share documents and information with your child's integrated care team.
- Families can access information and resource guides about the following services that may be available to support their child's health and well-being:

NC InCK will integrate services across 10 child core service areas

- Physical and Behavioral Health
- Early care & education
- Food
- Housing
- Title V maternal and child services
- Mobile Crisis Response Services
- Juvenile Justice
- Child Welfare
- Legal Aid
- Schools

Frequently Asked Questions

1. What is a Shared Action Plan?

The Shared Action Plan is a document created by a family, their Family Navigators and their integrated care team to help all of your child's care team members know your top goals you're your child's health and well-being. The Shared Action Plan also includes a list of the integrated care team members you have identified for your child, which will make it easier for them to get in touch with each other. The Shared Action Plan can be easily updated and shared with anyone you choose.

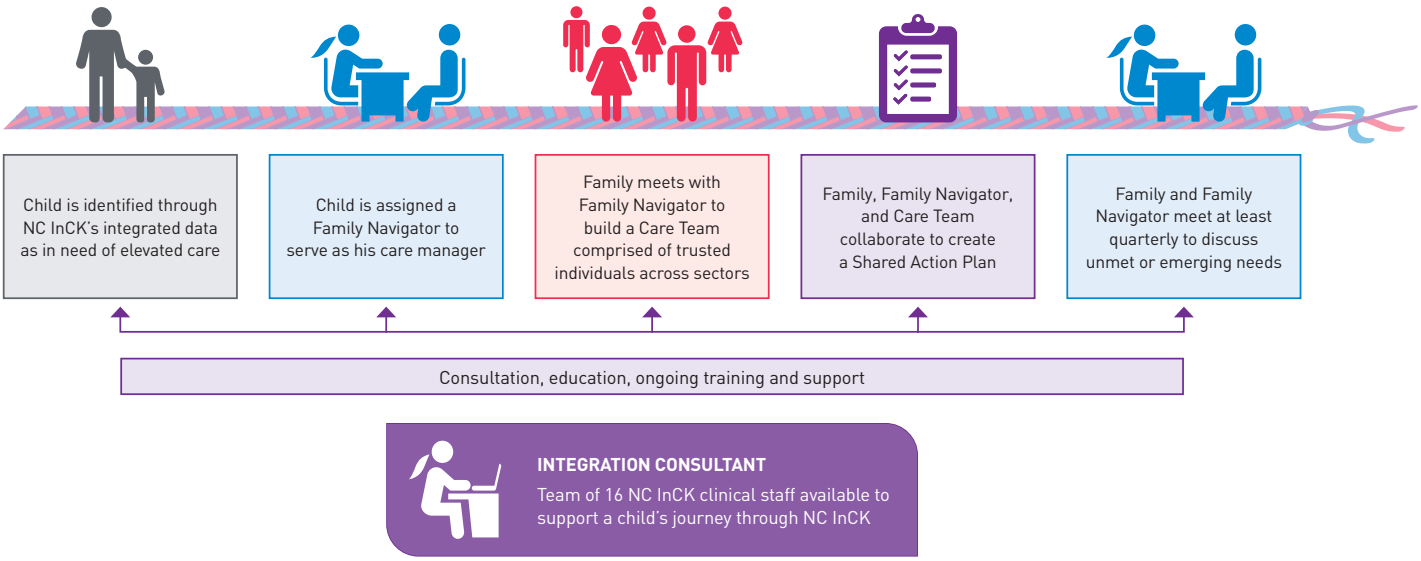
2. What is the NC InCK Consent Form?

Your Family Navigator will give you the opportunity to provide consent for your child to have more NC InCK supports. Entities listed on the NC InCK Consent will have permission to:

- View the family's contact information, care management information and Shared Action Plan
- Convene with the family and collaborate regularly in support of the child's health, social, and educational needs
- View a child's page on NC InCK's VirtualHealth Integrated Care Platform where contact information, care management information, and a copy of the consent and Shared Action Plan are stored

Information will be treated with the highest confidentiality standards mandated by applicable law.

A Child's Journey with NC InCK



Visit our web site at www.ncinck.org to learn more

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A-3 Consent Form

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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.

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NC INTEGRATED CARE FOR KIDS

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: _____

A-4 Shared Action Plan

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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)

NC InCK
NC INTEGRATED CARE FOR KIDS

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): _____
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

A-5 Kindergarten Readiness Promotion Bundle: Provider Resources Table

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Well-Child Visits

Program	Alamance	Durham	Granville and Vance	Orange
NC Health Check Program Guide	https://www.nctracks.nc.gov/content/dam/jcr:06af7224-6d9a-42ba-a767-11751e1fb6cf/Health_Check_Billing_Program-Guide-2021_FINAL.pdf			
Bright Futures Guidelines	https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx			

Office-Based Literacy Programs

Program	Alamance	Durham	Granville and Vance	Orange
Reach Out and Read Participating pediatric offices are provided age-appropriate books to distribute to parents at well-child visits	http://www.alamancechildren.org/literacy-programs.html	http://dpfc.net/our-work/literacy/reach-out-and-read/	http://fgvsmartstart.org/reach-out-and-read/	http://www.orangesmartstart.org/family-support-programs/

Developmental Screening

Program	Alamance	Durham	Granville and Vance	Orange
Developmental Screening	The CDC's Learn the Signs. Act Early program has FREE resources and recommendations for integrating developmental surveillance into health supervision visits. CDC's "Learn the Signs. Act Early." campaign AAP's Screening Technical Assistance and Resource Center (STAR Center) AAP's Practice Resources to Implement Developmental Screening Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents Bright Futures: Children with Special Health Care Needs AAP Pedialink Free Short Online Course on Developmental Screening			

Social-Emotional Screening

Program	Alamance	Durham	Granville and Vance	Orange
Social Emotional Screening	https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/Developmental-Behavioral-Psychosocial-Screening-and-Assessment-Forms.aspx AAP's Screening Technical Assistance and Resource Center (STAR Center) AAP Screening Technical Assistance and Resrouce Center (STAR Center) Screening Tools (Select "social emotional development" to filter for social-emotional screening tools)			

Fluoride-Varnish Resources

Program	Alamance	Durham	Granville and Vance	Orange
Into the Mouth of Babes (IMB) Program	https://publichealth.nc.gov/oralhealth/partners/IMB.htm			

Hearing and Vision Resources

Program	Alamance	Durham	Granville and Vance	Orange
Early Childhood Hearing Screening Resources	NC Medicaid Health Check Guide AAP Hearing Screening Recommendations Early Hearing Detection and Intervention (EHDI) (CDC) – Resources related to hearing loss in children.			
Early Childhood Vision Screening Resources	NC Medicaid Health Check Guide AAP Clinical Report on Vision Screening AAP Instrument Based Vision Screening Policy Statement			

Refer to Pre-K

Program	Alamance	Durham	Granville and Vance	Orange
NC Pre-K Registration	Alamance County Pre-K	Durham County Pre-K	Vance County Pre-K Granville County Pre-K	Orange County Pre-K
Child Care Resource & Referral (CCR&R)	CCR&R Resources			

Refer to Child Developmental Services Agencies (CDSAs)

Program	Alamance	Durham	Granville and Vance	Orange
Children's Developmental Services Agencies (CDSAs)	Greensboro CDSA	Durham CDSA	Durham CDSA	Durham CDSA

Refer to Exceptional Children's Program Resources (Age 3-5)

Program	Alamance	Durham	Granville and Vance	Orange
Exceptional Children's Programs	ABS Keisha Banks 336-438-4120	DPS Leslie Greene at 919-560-3933 Erica Manning at 919-560-2000 ext. 26262 (Spanish speaking families)	**GCPS** Hattie Mathis Yates (admin specialist) (919) 693-1103 alexanderh@gcs.k12.nc.us Donna Bowling-Critcher (Program Specialist) (919) 693-1103 ext. 101272 critcherd@gcs.k12.nc.us Chenita Roberts (Preschool Specialist) (919) 693-1103 ext. 101290	OCS MaryAnn Baldwin Program Specialist – Secondarymaryann.baldwin@orange.k12.nc.us Drew Collins Program Specialist – Autism drew.collins@orange.k12.nc.us Barbara Bossen EC/Pre-K Program Specialist 919-245-4006 ext. 18002 barbara.bossen@orange.k12.nc.us

Program	Alamance	Durham	Granville and Vance	Orange
			robertsc@gcs.k12.nc.us VCS General Phone # 252-492-2127, ext. 2401 Tonya Moseley (Program Specialist) tmoseley@vcs.k12.nc.us Dorothy Johnson (Program Specialist) dorjohnson@vcs.k12.nc.us	Chapel Hill Carrboro City Schools Phone: 919-967-8211 Sheila Borrero EC Coordinator 919-967-8211 ext 28201 sborrero@chccs.k12.nc.us Erin Watts EC Coordinator ewatts@chccs.k12.nc.us Thea Wilson EC PreK Coordinator 919-918-2153 ext 23104 twilson@chccs.k12.nc.us
Exceptional Children's Referral Form	Physician Notification to Exceptional Children Preschool Program			

Early Child Mental Health

Program	Alamance	Durham	Granville and Vance	Orange
Early Childhood Therapist Roster Use this roster to search for therapists certified in early childhood and specific modalities	Searchable Roster of Early Childhood Therapists			
NC-PAL	North Carolina Psychiatry Access Line (NC-PAL.) for assistance with finding early childhood therapy and evaluation: 919-681-2909, https://ncpal.org/			
Cross Roads Cares Non-profit organization for survivors of sexual assault or abuse; clinicians that can provide PCIT, TFCBT and CPT to young children, located in Burlington.	https://www.crossroadscares.org/child-advocacy-center-cac			
Cardinal Innovations	https://www.cardinalinnovations.org/Members/How-Coverage-Works		https://www.cardinalinnovations.org/Members/How-Coverage-Works	https://www.cardinalinnovations.org/Members/How-Coverage-Works
Center for Child and Family Health (CCFH)		https://www.ccfhnc.org/		
Cone Health Located in Burlington PCIT offered, accepts Medicaid	Cone Health Medical Group			

Program	Alamance	Durham	Granville and Vance	Orange
Duke Children's Evaluation Center		https://ipmh.duke.edu/content/division-child-family-mental-health-and-developmental-neuroscience		https://ipmh.duke.edu/content/division-child-family-mental-health-and-developmental-neuroscience
EChO		https://www.exchangefamilycenter.org/professionals/early-childhood-outreach-for-providers		
El Futuro		El Futuro		
Kids Path A program of Hospice of the Piedmont and Hospice of Randolph that provides grief counseling for kids. It is designed to meet the special needs of children and teens who have experienced the death of a loved one.	Kids Path			
Kidscope				KidSCope

Program	Alamance	Durham	Granville and Vance	Orange
READY Project The Center for Child and Family Health convenes partners in early care and education, pediatrics, family support, mental health, and homeless services in a unified strategy called Responsive Early Access for Durham's Young Children (READY).		READY Project		

Parenting Support Programs- Resources

Program	Alamance	Durham	Granville and Vance	Orange
Adolescent Parenting Program Provides direct case management services to teen parents and their children ages 0-5 which focuses on parenting support, education and employment	http://fgvsmartstart.org/adolescent-parenting-program/		http://fgvsmartstart.org/adolescent-parenting-program/	http://fgvsmartstart.org/adolescent-parenting-program/
Community Response Program Home-based services for up to 6 mos for children B-5 with closed CPS cases or cases screened out at intake; focus is on strengthening protective				http://www.orangesmartstart.org/family-support-programs/

Program	Alamance	Durham	Granville and Vance	Orange
factors that reduce risks for further CPS involvement				
Triple P Positive Parenting Program Parents of children ages 2-12 learn skills to build relationships w/ their child, manage challenging behaviors and prevent problems from occurring	https://www.triplep-parenting.com/nc-en/find-help/find-a-provider/	https://www.triplep-parenting.com/nc-en/find-help/find-a-provider/	https://www.triplep-parenting.com/nc-en/find-help/find-a-provider/	https://www.triplep-parenting.com/nc-en/find-help/find-a-provider/
Fatherhood of Durham Provides strength-based, family driven, individualized and community-based services, including employment, education, housing and referrals to other agencies. Fatherhood of Durham is committed to providing its fathers with quality services.		Fatherhood of Durham		
Incredible Years Free 14-week class that focuses on building a nurturing relationship w/ child and managing challenging behaviors	http://www.alamancechildren.org/incredible-years.html			
Kaleidoscope Play and Learn Free weekly play group for caregivers of children B-5 to help increase parenting skills, understand healthy	http://www.alamancechildren.org/kaleidoscope-play-and-learn.html			

Program	Alamance	Durham	Granville and Vance	Orange
child development and support early learning and kindergarten readiness				
Kindergarten Transition Program Supports the transitional needs of families and teachers of 4 and 5yos preparing to enter Kindergarten (i.e. family to school connections; community to school connections; Ready Set Go training for parents)			http://fgvsmartstart.org/kindergarten-transition/	
Parents as Teachers Free 15-week parent education program	http://www.alamancechildren.org/parents-as-teachers.html		http://fgvsmartstart.org/parents-as-teachers/	
Children's Home Society of NC (Healthy Steps) Specialize in education and prevention programs, family preservation, and adoption and foster care.				Healthy Steps
Helping Each Adolescent Reach Their Spark (H.E.A.R.T.S.) (H.E.A.R.T.S.) is a 501(c)3 non-profit organization that educates and equips pregnant and parenting adolescents with the tools needed to become		H.E.A.R.T.S.		

Program	Alamance	Durham	Granville and Vance	Orange
independent and self-sufficient.				
Infinite Possibilities Provide social services to women and men in Henderson, NC, who are homeless, at-risk, or victims of domestic violence.			Infinite Possibilities – Vance County:	
Village of Wisdom Develops tools and resources that help parents, teachers, and students create ideal learning environments for Black and Brown learners.		Village of Wisdom		

Disclaimer: NC InCK has developed these resources as a service to providers. This list does not constitute official endorsement of clinicians or agencies. It is intended for informational purposes only and is not meant to replace consultation.

Community-Based Literacy Resources

Program	Alamance	Durham	Granville and Vance	Orange
Book Harvest- Book Babies Book Babies partners with families of Medicaid eligible children to develop their child's early language and literacy skills		Book Babies @ Book Harvest		
Dolly Party Imagination Library B-5 Reading program that sends each child one book	http://www.alamancechildren.org/literacy-programs.html	http://dpfc.net/imaginationlibrary/	http://fgvsmartstart.org/dolly-partons-	http://www.orangesmartstart.org/dolly-partons-

per month until their 5th birthday			imagination-library/	imagination-library/
Families Learning Together Initiative For stay-at home caregivers of children B-5 whose first language is not English; helps both child and caregiver build literacy skills to prepare for child's entry into school				http://www.orangesmartstart.org/family-support-programs/ https://www.orangeliteracy.org/fl Contact: Alice Denson 919-914-6153 Adenson@orangeliteracy.org
Public Library Literacy Programs Libraries frequently have programs that engage children with scheduled programming, which also lends support for busy parents.	https://www.alamance-nc.com/library/kids/early-literacy/	https://durhamcountylibrary.org/for-kids-and-families/	https://granville.lib.nc.us/children-teens/for-children/ https://www.perrylibrary.org/research/education/childrens-resources	https://applibrary.orangecountync.gov/iii/calendar/month/C&P=%7C0%7C1%7C4&R=0;jsessionid=8CB32A24425FA77B206E2F4AC69C2CD3?lang=eng&suite=def
Ready4K Ready4K is a free text message curriculum for parents and caregivers of		http://dpfc.net/our-work/literacy/ready4k/		

children age birth to eight that gives them the information they need to help build their children's language and literacy skills by the time they start kindergarten.				