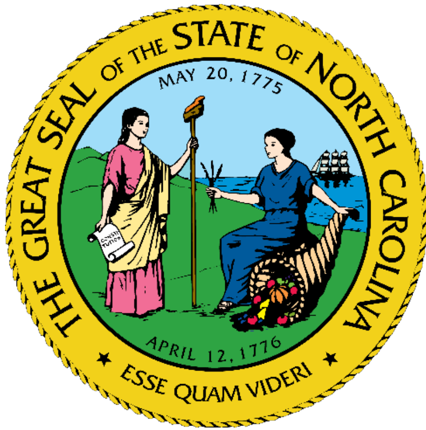


Quality and Population Health:

- Healthy Opportunities Pilot
- NC Integrated Care for Kids (InCK)

NC Area Health Education Centers and
NC Division of Health Benefits

RCC (Relay Conference Captioning)
Participants can access real-time captioning for this webinar here:
https://www.captionedtext.com/client/event.aspx?EventID=4923661&CustomerID=324

October 14th, 2021

Presenters

AHEC

- Carol Stanley - Host, Manager of Medicaid Transformation

DHHS

- Kelly Crosbie, Chief Quality Officer

Healthy Opportunities

- Amanda Van Vleet, Associate Director, Innovation / NQF Quality Policy Fellow

NC InCK

- Sarah Allin, InCK Managing Director
- Charlene Wong, Executive Director
- Richard Chung, Director of Population Health
- Nancy Madenyika, Lead Integration Consultant

Overview of Presentation

Question & Answer

Why Do We Need the Healthy Opportunities Pilots?

The Healthy Opportunities Pilots (the Pilots) present an unprecedented opportunity to provide selected evidence-based, non-medical interventions to Medicaid enrollees to address social needs within Medicaid managed care.

- Access to high-quality medical care is critical, but research shows up to 80 percent of a person's health is determined by social and environmental factors and the behaviors that emerge as a result.
- Pilot entities—including PHPs, Care Management Teams, Network Leads, and Human Service Organizations—will all play coordinated but distinct roles to provide "whole person care" to Pilot enrollees.
- The Pilots will test the impact of offering non-medical services on health outcomes and costs, with the ultimate goal of making them statewide offerings of the Medicaid managed care program
- Given their trusted relationships with members, care management teams play a unique role in identifying individuals who will benefit from Pilot services and connecting them to those services
    - Participating care management teams will be given resources, tools and infrastructure to execute their responsibilities (many of which they already do today!)

What Are the Healthy Opportunities Pilots?

The federal government authorized up to $650 million in state and federal Medicaid funding to test evidence-based, non-medical interventions designed to improve health outcomes and reduce healthcare costs for a subset of Medicaid enrollees.

- **PHPs will work with communities in three geographic areas of the state to implement the "Healthy Opportunities Pilots," as approved through North Carolina's 1115 waiver**
- **Pilot funds will be used over the demonstration period to:**
  - Support capacity building for "Healthy Opportunities Pilots Network Leads (NLs) and Human Service Organizations (HSOs), strengthening the ability of HSOs to deliver Pilot services
  - Cover the cost of federally-approved Pilot services, PHP and NL administration of the Pilots, payments to care managers for Pilot responsibilities, and value-based payments

The Pilots will offer services in the Four Priority Domains

Housing

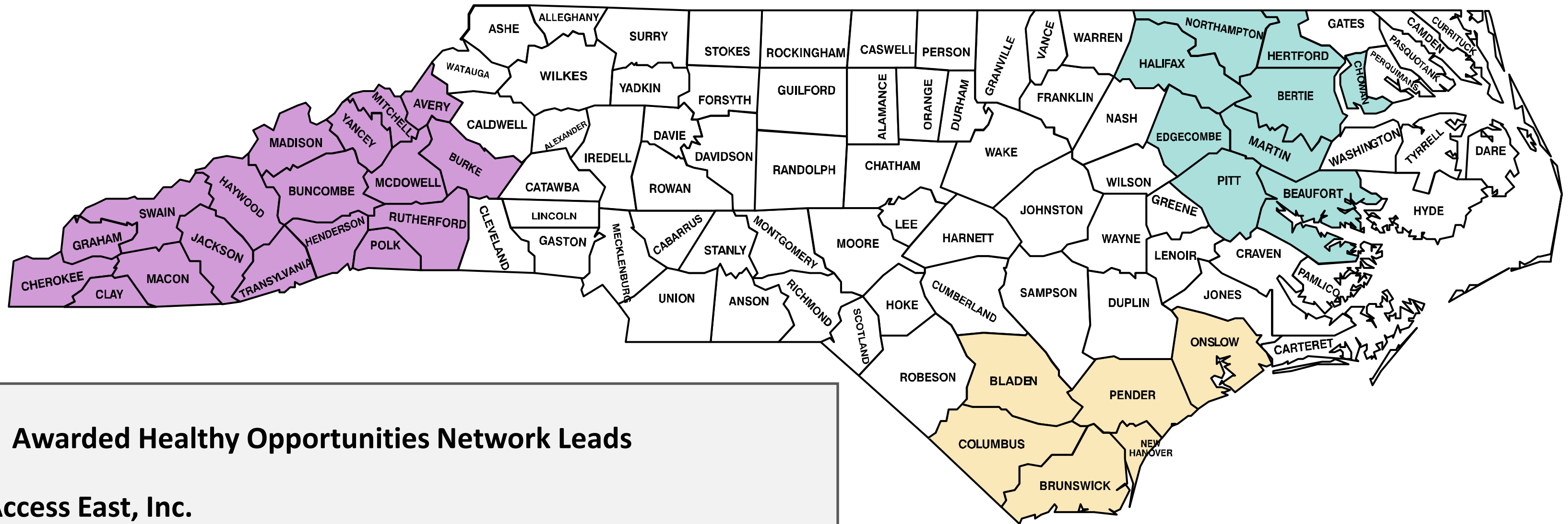
Food

Transportation

Interpersonal Violence

Awarded Healthy Opportunities Network Leads and Regions

DHHS has procured Network Leads (NLs) with deep roots in their community that will facilitate collaboration across the healthcare and human service providers.



Awarded Healthy Opportunities Network Leads

Access East, Inc.

Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt

Community Care of the Lower Cape Fear

Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender

Impact Health

Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

Who Qualifies for Pilot Services?

To qualify for pilot services, Medicaid managed care enrollees must have:

At least one Needs-Based Criteria:

Physical/behavioral health condition criteria vary by population:

- Adults (e.g., 2 or more chronic conditions)
- Pregnant Women (e.g., multifetal gestation)
- Children, ages 0-3 (e.g., Neonatal intensive care unit graduate)
- Children, ages 0-21 (e.g., Experiencing three or more categories of adverse childhood experiences)

At least one Social Risk Factor:

- Homeless and/or housing insecure
- Food insecure
- Transportation insecure
- At risk of, witnessing or experiencing interpersonal violence

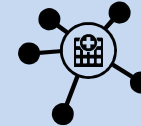
No Wrong Door—Entry Points into the Pilots

The Pilots utilize a "no wrong door" approach to identifying and enrolling individuals, ensuring that individuals who first show up at various "entry points" can efficiently undergo the Pilot eligibility through service delivery process.

Provider Referral

Referral from Pilot Participating HSO

Referral from Non-Pilot Participating HSO



Self/Family Referral

PHP Identification

Care Management Team Assessment

PHPs must ensure there are multiple mechanisms for providers, HSOs and members/families to submit referrals for Pilot eligibility to the PHP

What Services Can Enrollees Receive Through the Pilots?

North Carolina's 1115 waiver specifies services that can be covered by the Pilot. Examples include:

Housing

- Housing navigation, support and sustaining services
- Housing quality and safety inspections and improvements
- One-time payment for security deposit and first month's rent
- Short-term post hospitalization housing

Food

- Linkages to community-based food resources (e.g., SNAP/WIC application support)
- Nutrition and cooking education
- Fruit and vegetable prescriptions and healthy food boxes/meals
- Medically tailored meal delivery

Transportation

- Linkages to existing transportation resources
- Payment for transportation to support access to pilot services, (e.g., bus passes, taxi vouchers, ride-sharing credits)

Interpersonal Violence (IPV)

- Case management/ advocacy for victims of violence
- Evidence-based parenting support programs
- Evidence-based home visiting services

Key Entities' Roles in the Pilots

Care Management Teams

- Frontline service providers located at Tier 3 AMHs, LHDs, and PHPs interacting with beneficiaries
- Assess beneficiary eligibility for Pilot, identify recommended pilot services, obtain member consent for participating in the pilots, and provide care management to members enrolled in the Pilots, coordinating access to Pilot services, in addition to managing physical and behavioral health needs
- Manage members' care plan, inclusive of Pilot services, and track enrollee progress over time

PHPs

- PHPs will maintain ultimate responsibility for all Pilot activities—even if they are delegated to a care management team
- Manage a Pilot budget and pay HSOs for the delivery of Pilot services
- Approve which of their enrollees qualify for Pilot services and which services they qualify to receive
- Ensure the provision of integrated care management to Pilot enrollees

Network Leads

- Competitively procured by DHHS
- Develop, manage, and oversee a network of HSOs
- Receive, track and validate invoices from HSOs and submit them to the PHP
- Provide support and technical assistance for HSO network
- Convene Pilot entities to share best practices

Human Service Organizations

- Frontline social service providers that contract with the NL to deliver authorized, cost-effective, evidence based Pilot services to Pilot enrollees
- Participate in the healthcare delivery system, including submitting invoices and receiving reimbursement for services delivered

Tier 3 AMHs/CINs may be best positioned to execute many member-facing Pilot eligibility through service delivery responsibilities due to strong relationships with Members

Pilot Care Management Embedded in Medicaid Care Management

North Carolina is committed to providing Medicaid members "whole person care" including through the provision of care management that occurs at the local level.

The Fundamental Role of Local Care Management

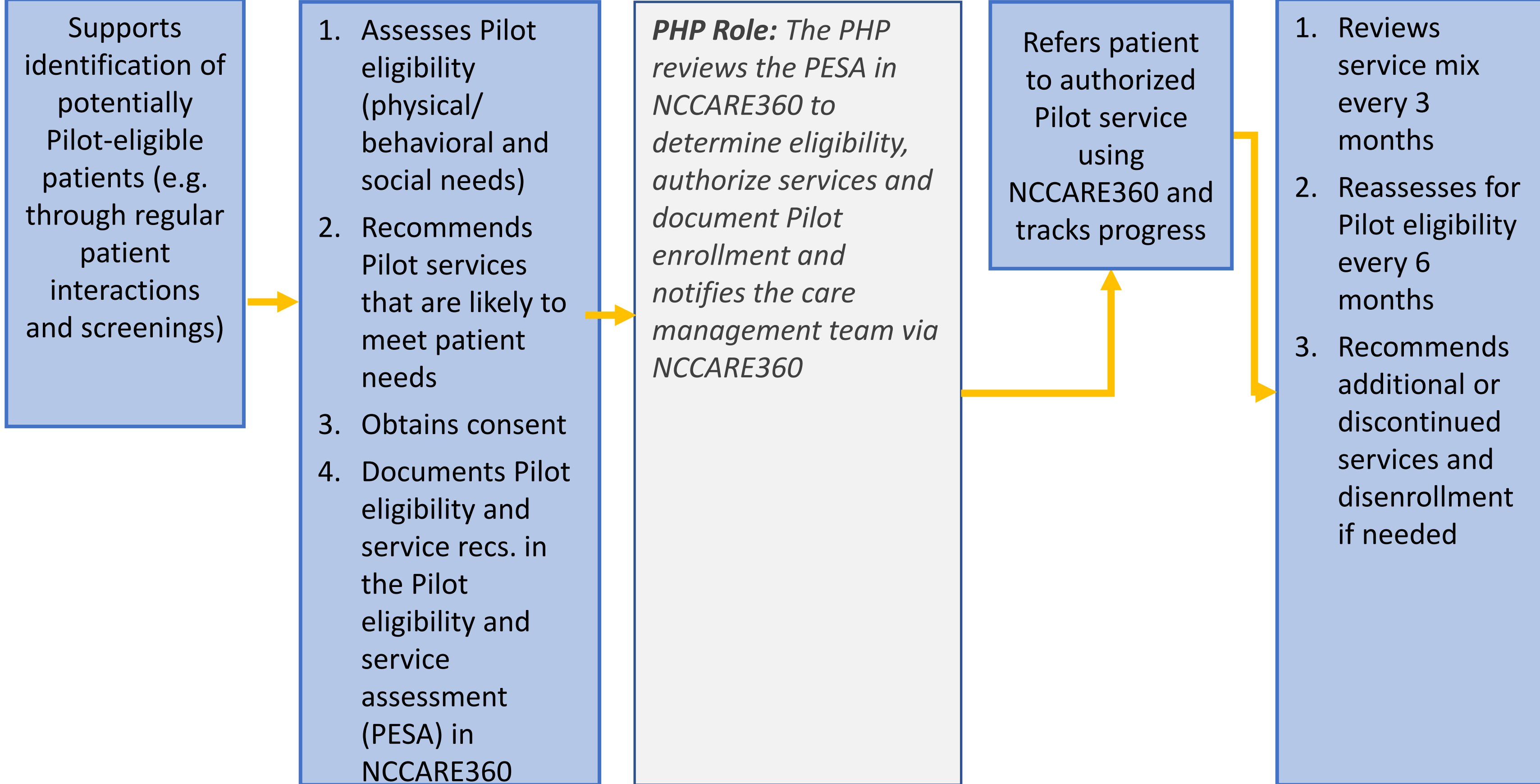
- Local care management teams located at Tier 3 AMHs/CINs, LHDs, and PHPs already have responsibilities related to addressing unmet resource needs (e.g., referrals to needed social services). The Pilots provide additional structure and resources to support care management teams in addressing the social needs of their patients.
- Individuals enrolled in the Pilots must receive comprehensive, integrated and intensive care management for their physical/behavioral needs in addition to their Pilot-related needs. Pilot-related care management should not be siloed or conducted separately from general care management.
- When a member enrolls in the Pilot who is not currently in care management, the PHP must ensure they begin receiving comprehensive care management services from an LHD, a Tier 3 AMH/CIN or the PHP itself.

Tier 3 AMHs will participate in Pilot-related onboarding and training prior to participating in the Pilots. Pilot-participating Tier 3 AMHs will receive an additional Pilot-specific care management PMPM for each member ***enrolled*** in the Pilots. This Pilot PMPM payment will be in addition to the Medical Home and Care Management payments received by Tier 3 AMHs.

Pilot Care Management Team Activities

Activity	Identifying Potentially Pilot Eligible Patients	Assessing Pilot Eligibility and Needed Services	Eligibility Determination & Service Authorization	Referral to Authorized Services	Review Service Mix and Reassess Pilot Eligibility

Summary of Essential Pilot Responsibilities



Care Management Teams will provide support for transitions of Pilot enrollees between health plans and other practices

Note: Care Management Team members can expedite referral to a limited number or duration of pre-approved Pilot services (described further on subsequent slides)

Integrated Care for Kids (InCK)

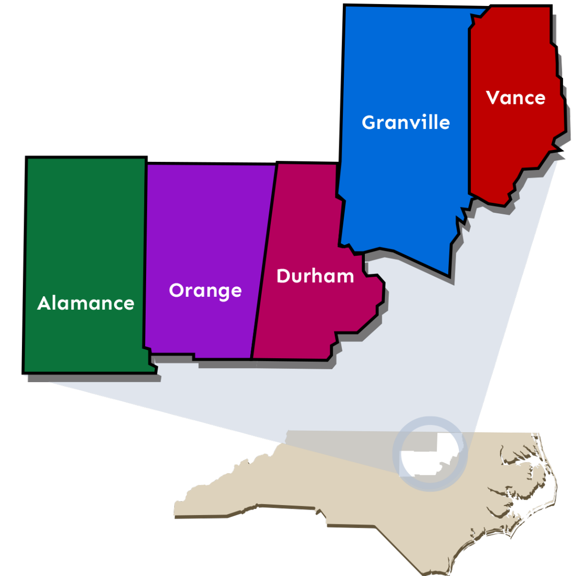
NC Integrated Care for Kids (NC InCK)

An Innovative Model to Promote Child and Family Wellbeing in Central North Carolina

The project described is supported by Funding Opportunity Number CMS 2B2-20-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

NC Integrated Care for Kids (NC InCK) Basics

- **Children who will be served by NC InCK: All Medicaid and CHIP-insured children in this 5-county area**
  - Birth to age 20
  - Regardless of where they receive medical care
  - ~90,000 children
- **NC InCK model launches in January 2022**
- **A coalition of partners has come together to design & implement NC InCK with a 7-year, $16M grant from CMS. Lead organizations:**



NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

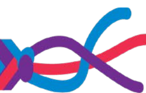
NC InCK is integrating care across these core child services for children and families

1. Schools
2. Early Care and Education
3. Food – SNAP, WIC, Food banks
4. Housing
5. Physical and Behavioral Healthcare
6. Public Health Services – Title V
7. Social Services – Child Welfare
8. Mobile Crisis Response
9. Juvenile Justice
10. Legal Aid

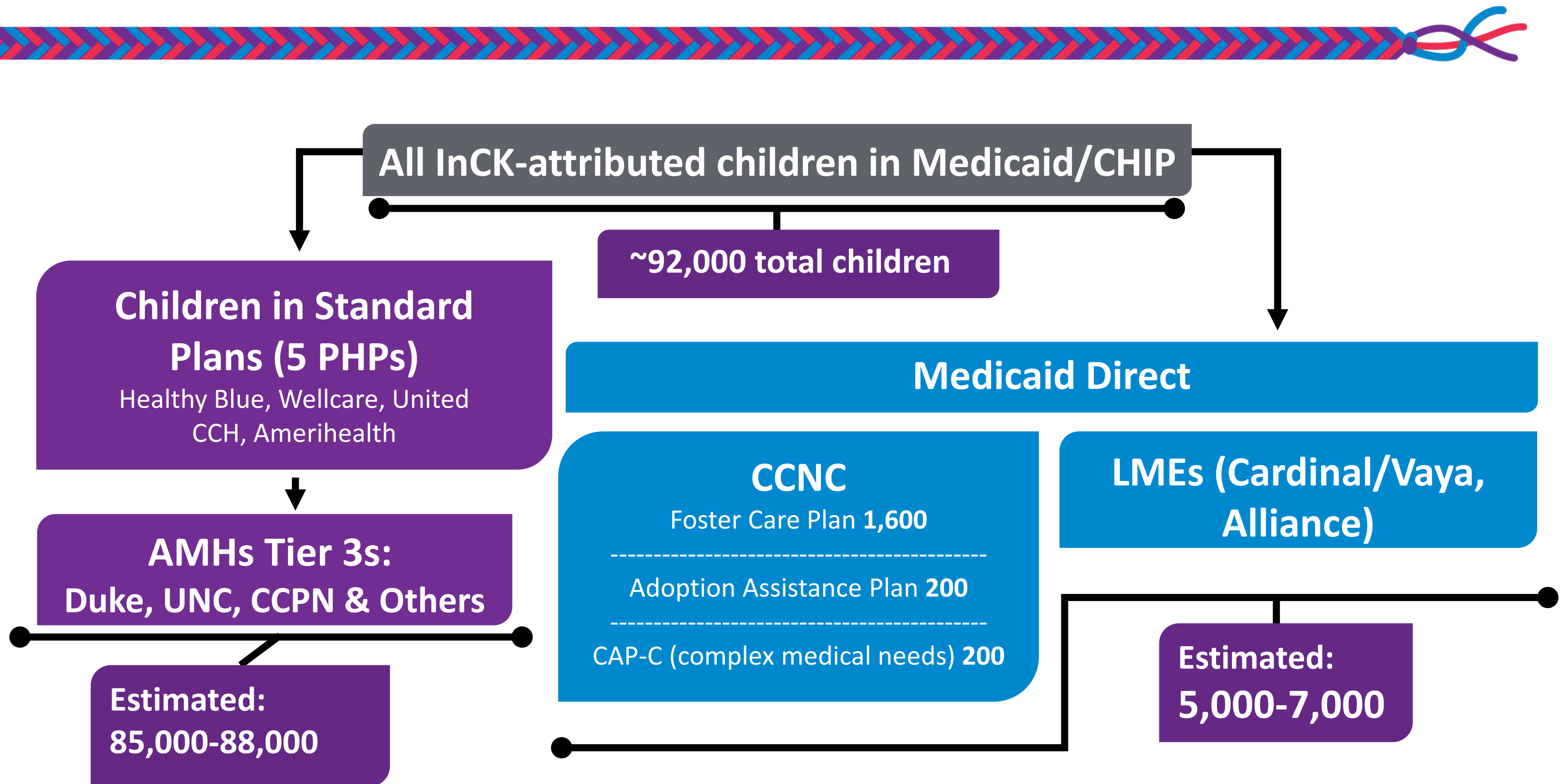
What NC InCK Means for Health Care Providers

- NC InCK will **enhance whole child care** for children insured by Medicaid in 5 central NC counties, optimizing multi-system integrated care and resources for improved health outcomes.
- More of our pediatric patients will be **newly elevated for care management** that the PHPs, health systems/AMHs will offer and that will support us in improving child well-being.
- **Care teams will be convened around patients with higher needs**. We 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 care team members are listed.
- We will regularly **receive actionable data on novel child-centered measures**, such as rates of kindergarten readiness, among children in our practices who are in NC InCK.

NC InCK NC INTEGRATED CARE FOR KIDS



The Ecosystem of Health Care Providers and Payers involved in NC InCK



Estimates from DHB data from early 2021

NC InCK NC INTEGRATED CARE FOR KIDS

Ecosystem and estimates reflect entities responsible for care management in January 2022 when NC InCK launches

Three Key Strategies to Integrate Care for Children in NC InCK

1 UNDERSTAND NEEDS

More holistically understand the needs of children and youth

2 SUPPORT AND BRIDGE SERVICES

Integrate services across sectors for children and youth who could benefit from additional support

3 FOCUS HEALTH CARE INVESTMENTS

Find ways to invest resources into what matters most for children, youth, and families

Overview: InCK's Service Integration Levels

Health and Healthcare

Physical, behavioral, and developmental diagnoses

Healthcare utilization

The Child's Context

Socioeconomic, educational, developmental, and parent/guardian risk factors

Out-of-Home Placement

Prior or current out-of-home placement or markers of risk of future out-of-home placement

SIL-3: Estimate ~4,000 children

Children who are out-of-home or have high risk of out-of-home placement.

Children experiencing multiple, complex health and education, JJ, CW, SDOH risks.

SIL-2: Estimate ~10,000 children

Children experiencing multiple, moderate-severity health, SDOH, education or guardian risks.

Focus is on impactable rising risks to improve well-being and reduce future out-of-home placement

SIL-1: Estimate ~77,000 children

All other children in NC InCK counties.

May have isolated health and contextual risks.

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Merging New Data to Stratify Children in InCK

Value: NC InCK will integrate data beyond administrative healthcare data in a child-focused risk model.

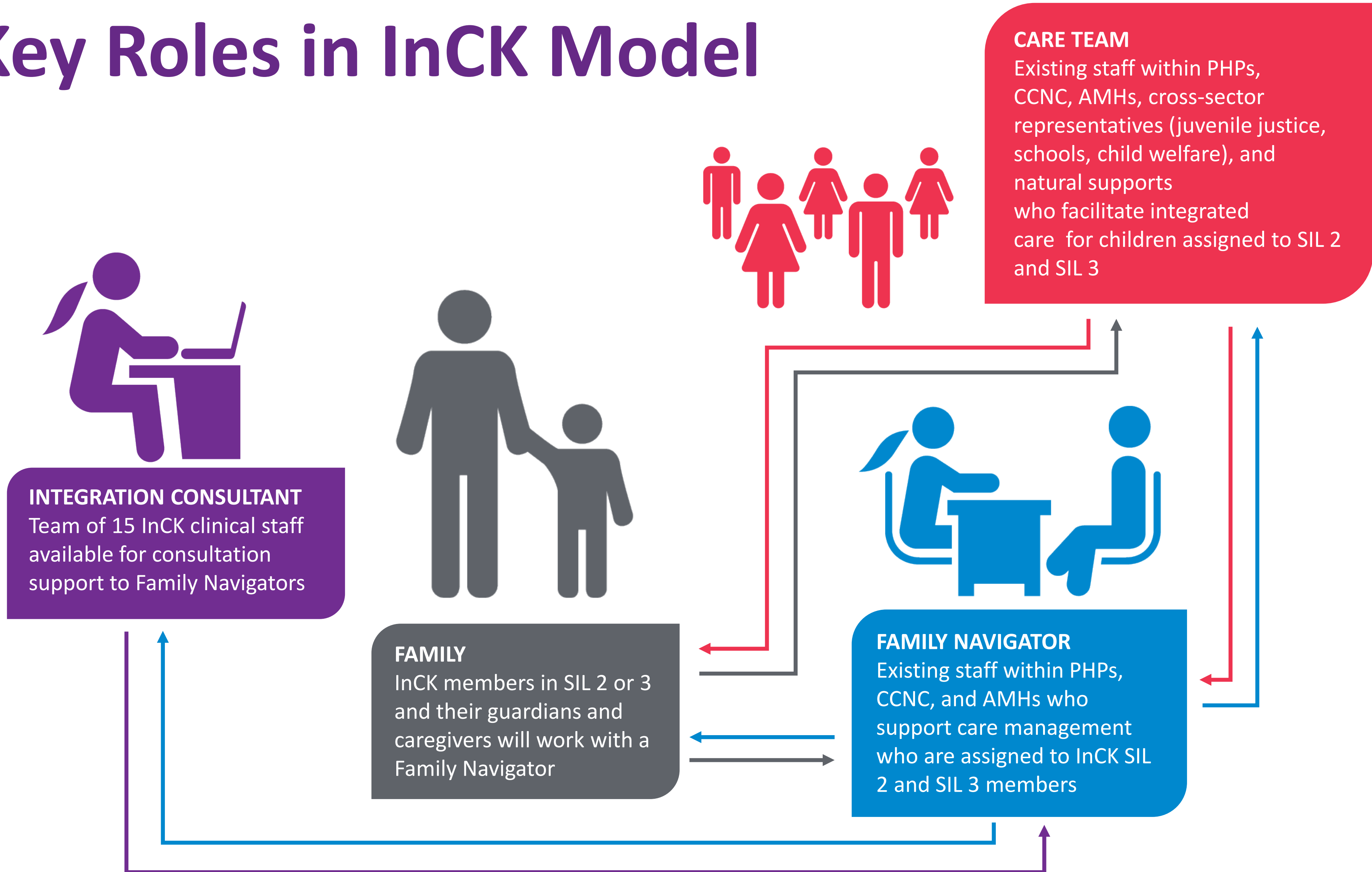
Category	Examples of Data used to Assess Needs
SDOH Needs	• Food, housing, transportation needs from Care Needs Screen • Social Deprivation Index for member address
Education	• # of school absences and suspensions
Juvenile Justice	• Placement in detention or development center • Probation status
Child Welfare	• Current foster care placement • Recently returned home from foster placement
Guardian	• Casehead substance use during pregnancy • Casehead qualifies for Tailored Plan
Medical Complexity	• Pediatric Medical Complexity Algorithm, Level 3

N★C DPS DEPARTMENT OF PUBLIC SAFETY PREVENT · PROTECT · PREPARE

Public Schools of North Carolina State Board of Education

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Key Roles in InCK Model



Family Navigator: A family's primary contact

Engaged InCK Members assigned to SIL 2 and SIL 3 will receive integrated care support from a Family Navigator

Who: Existing PHP, CCNC or AMH staff serving as family's primary contact.

Role: The Family Navigator is an existing PHP/CCNC/AMH staff member who works directly with the family and care team to meet the member's health, social, and educational goals.

Components of Family Navigator Role:

1. Serve as consistent Point of Contact for family
2. Foster long-term support of member and family
   - 1 year for engaged members with at least quarterly check ins for assessment of needs and support
3. Convene and communicate with care team as defined by family (e.g. schools, early childcare, child welfare)
4. Support member's care needs across InCK's 10 core child service areas
5. Support completion of Shared Action Plan and InCK Consent (for applicable members)

AMHs have flexibility on assignment and staffing of the InCK Family Navigator Role.
Examples: Care Manager, Community Health Worker, RN, BSW, Population Health Specialist, MSW

Integration Consultant Support of Family Navigators

Integration Consultants are **available to all Family Navigators** (in PHPs, CCNC or AMHs) who provide integrated care to InCK members in SIL 2 and SIL 3.

Capacity building includes **one-on-one consultation, group trainings & convenings, & written guides**.

Consultation and education for Family Navigators within the 10 NC InCK core child service areas

Training for family-centered completion of **Shared Action Plan**

Best practices guides & ongoing support for creating a **cross-sector care team** with representatives from core child services critical to a child's success

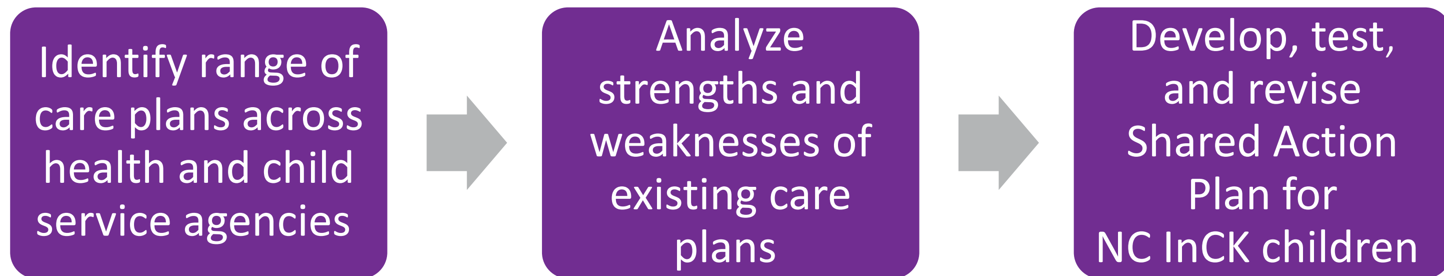
Beneficiary Transition Support: Health plan changes; coverage lapses; aging out

Support for InCK Operations: VirtualHealth + Consent

Monthly integrated care rounds focused on a core child service area and capacity building topics for pediatric care management

Developing the Shared Action Plan (SAP): Our process

Goal: Create Shared Action Plan for improved **family-centered, whole-child** service coordination



DESIGN PRINCIPLES BASED ON DEVELOPMENT PROCESS:

- **Simple and strengths focused** → 3-page document is easy to navigate
- **Completed by family** in collaboration with Family Navigator → Alignment with family's priorities
- **Perspective of family** prioritized in care team development → Those who know family best across systems are engaged in care
- **Accessible to family** and shareable → Reduce burden on family of relaying key information and decrease likelihood of information gaps

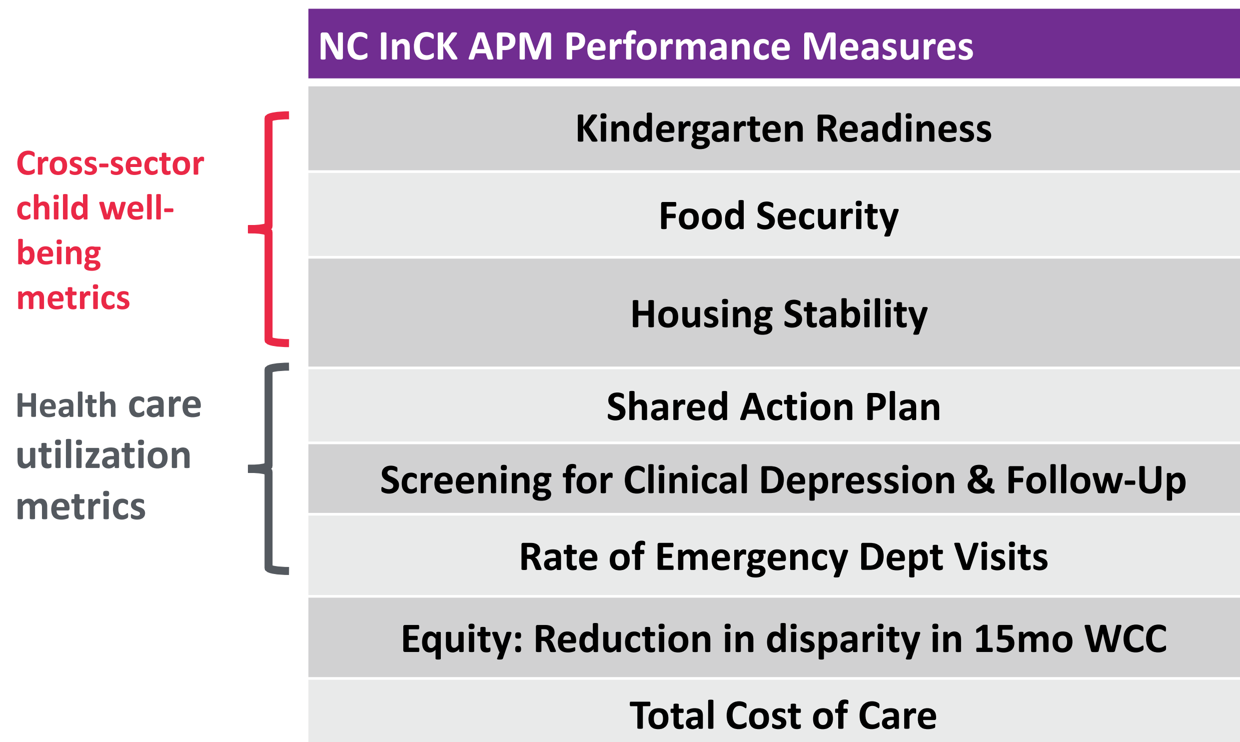
Platforms which support NC InCK's Integrated Care

- **Identification of NC InCK-attributed children** in SIL 2 & SIL 3
- **Integrated care panel management** & notes for members in SIL 2 & SIL 3
- Storage and sharing of InCK **Shared Action Plan** and **Consent**
- **Role Based Access** for care teams wishing to use the platform

- NC InCK has been working closely with NCCARE360 to:
  - Encourage community-based organizations to **utilize NCCARE360** to streamline social service referral processes
  - **Support frontline providers in making referrals**: Food, housing, early care and education

Investing in Health: NC InCK's Alternative Payment Model

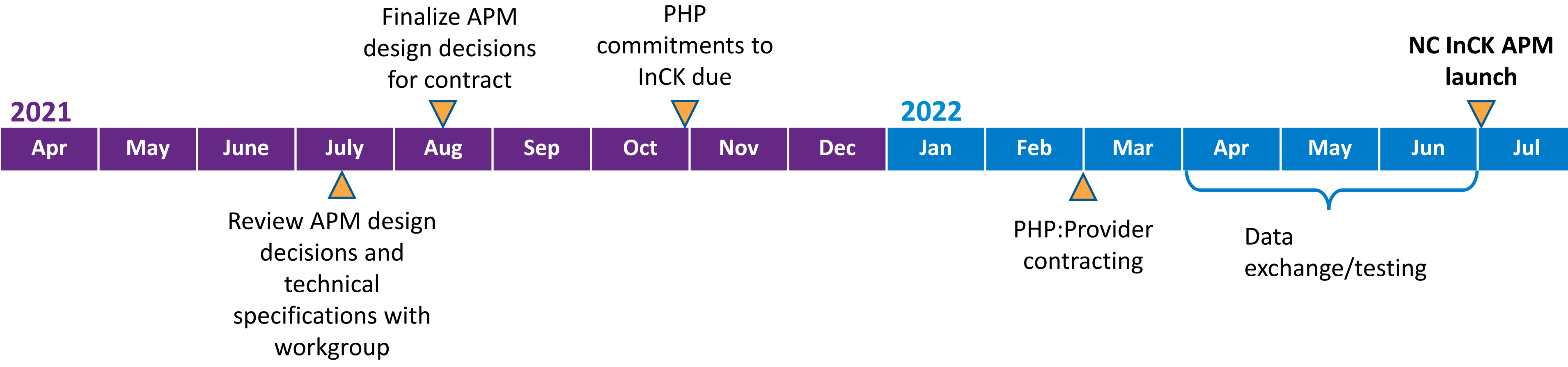
- NC InCK has been working with the PHPs and health systems to design a payment model that **links incentive payments to more meaningful measures of child well-being**
- **Goal**: Increasing funding and investments for child well-being
- Two tiers reflect a **glidepath to more advanced payment models** and different levels of readiness to take on risk: InCK Foundation → InCK Advanced



	NC InCK APM Performance Measures
Cross-sector child well-being metrics	Kindergarten Readiness
	Food Security
	Housing Stability
Health care utilization metrics	Shared Action Plan
	Screening for Clinical Depression & Follow-Up
	Rate of Emergency Dept Visits
	Equity: Reduction in disparity in 15mo WCC
	Total Cost of Care

The NC InCK APM has been designed over the last 2 years by a Working Group with leadership representation from Medicaid, CINs, and all 5 PHPs

NC InCK APM Timeline



Implementation – Key Dates:

- **July 2022:** Launch of NC InCK APMs
- **Jan 2025:** If participating since July 2022, provider organization transitions to InCK Advanced
- **December 31, 2026**: CMS-funded program ends

Health Care Provider Engagement Strategy Timeline

InCK Orientation
Phase 1: Through October 2021

- **Meet individually with clinics** with >2000 InCK-attributed children
- Present in key **Medicaid forums** (e.g., AMH TAG)

InCK Champions
Phase 2: October – December 2021

- Identify & deepen connections with **InCK champions**
- **Disseminate provider newsletters** through NC InCK, NC Peds, and NCAFP
- **Focused conversations with CIN leadership** about NC InCK, including the APM

Practice launch support
Phase 3: January – June 2022

- **Support practices** as NC InCK launches in January 2022
- **Support PHPs** in encouraging APM participation by AMHs

Trainings & Technical Assistance
Phase 4: June 2022 – beyond

- **Training** on NC InCK care integration components
- **Technical assistance** for practices participating in NC InCK's APM (launch July 2022)

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Beneficiary Engagement Strategy

- **NC InCK Flyers and FAQs** and what it means to be part of NC InCK written for families to be shared with:
  - Children's health care providers
  - Care managers
  - NC Medicaid enrollment staff
  - PHP outreach teams

- A **section on the NC InCK website for families** including:
  - Overview of NC InCK
  - Integrated care support, including information for families on each of the core child services

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NC InCK Timeline

January 2022: Launch of NC InCK model

2020	2021	2022	2023	2024	2025	2026
Planning Period		**Implementation Period**				

July 2022: Launch of NC InCK Alternative Payment Models (APMs)

NC InCK NC INTEGRATED CARE FOR KIDS

You’ve Got Questions?

We’ve Got Answers!

Healthy Opportunities Pilots Overview - Appendix

Pilot Service Fee Schedule (1 of 3)

The Pilots represent the first time Medicaid funding will systematically pay for health-related social services for a broad subset of Medicaid enrollees. The CMS-approved fee schedule, based on the Department's 1115 waiver, defines and prices Pilot services. All Pilots will adhere to the fee schedule's rates in their payment practices.

	Service Name	Fee Schedule Rate
Housing Services	Housing Navigation, Support and Sustaining Services	$373.66 PMPM
	Inspection for Housing Safety and Quality	$250 per inspection*
	Housing Move-In Support	1-5+ BR: $900- $1,250*
	Essential Utility Set-Up	$500 for utility deposits, arrears or reinstatement*
	Home Remediation Services	$5,000 per year*
	Home Accessibility and Safety Modifications	$10,000 per lifetime of waiver demonstration*
	Healthy Home Goods	$2,500 per year*
	One-Time Payment for Security Deposit and First Month's Rent	• First Month's Rent: 110% Fair Market Rent (FMR)* • Security deposit: 110% FMR x2*
	Short-Term Post Hospitalization Housing	• First Month's Rent: 110% Fair Market Rent (FMR)* • Security deposit: 110% FMR x2*

* Indicates cost-based reimbursement up to the fee schedule cap

The Pilot Service Fee Schedule provides more detail on each Pilot service, including a service description, anticipated frequency and duration, setting of service delivery, and minimum eligibility criteria to be approved for the service.

Pilot Service Fee Schedule (2 of 3)

	Service Name	Fee Schedule Rate
Food Services	Food and Nutrition Access Case Management Services	15-minute interaction: $12.51
	Evidence-Based Group Nutrition Class	One class: $21.60
	Diabetes Prevention Program	Phase 1 (16-class program): $264.12 Phase 2 (16-class program): $99.04
	Fruit and Vegetable Prescription	$200 per month*
	Healthy Food Box (For Pick-Up)	Small box: $85.04 Large box: $136.06
	Healthy Food Box (Delivered)	Small box: $90.04 Large box: $141.06
	Healthy Meal (For Pick-Up)	$4.14 per meal
	Healthy Meal (Home Delivered)	$4.87 per meal
	Medically Tailored Home Delivered Meal	$5.05 per meal

* Indicates cost-based reimbursement up to the fee schedule cap

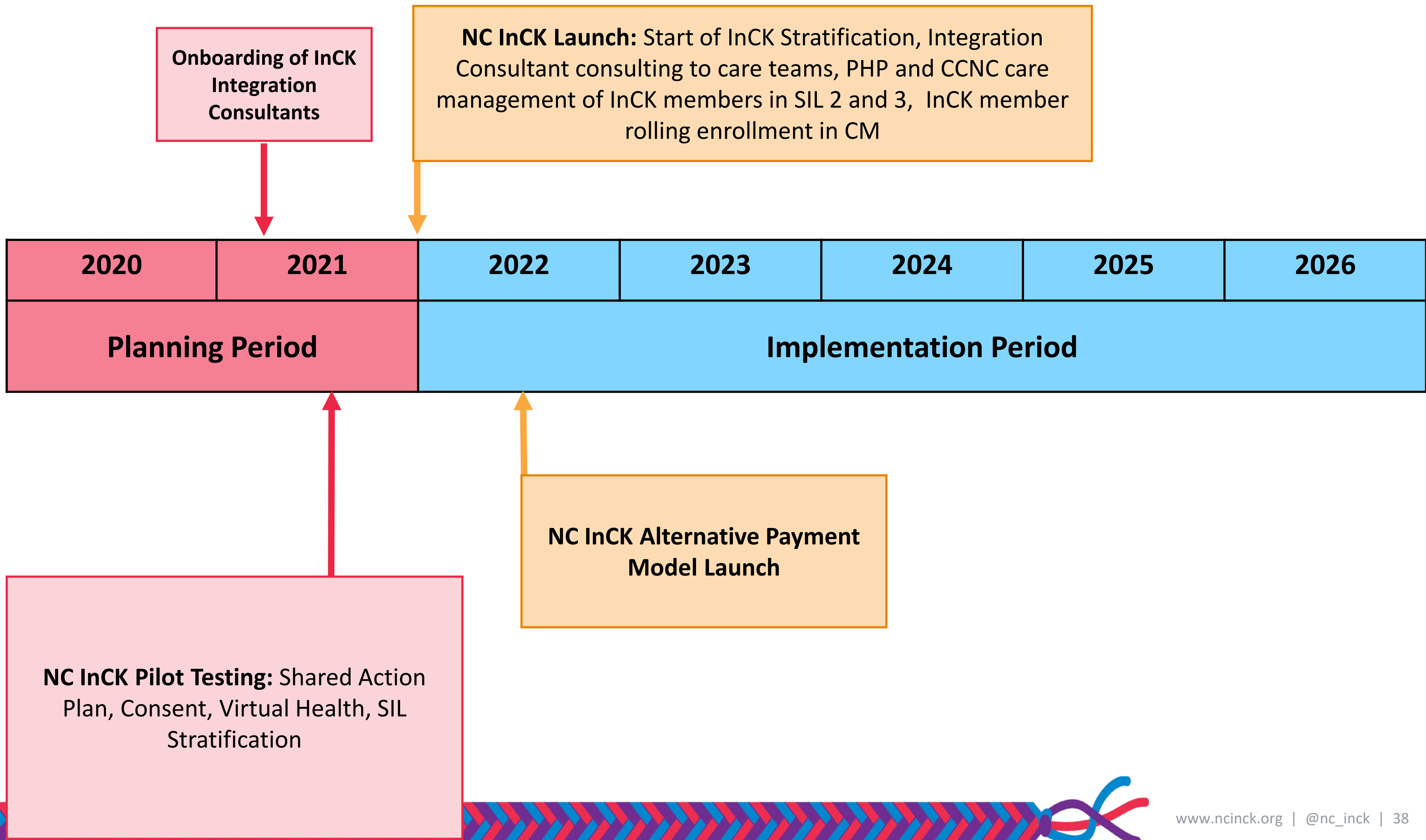
Pilot Service Fee Schedule (3 of 3)

	Service Name	Fee Schedule Rate
Interpersonal Violence (IPV) Services	IPV Case Management Services	$209.37 PMPM
	Violence Intervention Services	$152.44 PMPM
	Evidence-Based Parenting Curriculum	One class: $21.50
	Home Visiting Services	One home visit: $63.43
	Dyadic Therapy	$68.18 per occurrence
Transportation Services	Reimbursement for Health-Related Public Transportation	$102 per month*
	Reimbursement for Health-Related Private Transportation	$204 per month*
	Transportation PMPM Add-On for Case Management Services	$71.30 PMPM
Cross-Domain Services	Holistic High Intensity Enhanced Case Management	$470.23 PMPM
	Medical Respite	$206.98 per diem
	Linkages to Health-Related Legal Supports	15-minute interaction: $23.83

* Indicates cost-based reimbursement up to the fee schedule cap

NC InCK Overview - Appendix

NC InCK Timeline



InCK Awardees

State	Awardee Name
Connecticut	Clifford W. Beers Guidance Clinic
Illinois	Ann & Robert Lurie Children's Hospital
Illinois	Egyptian Health
New Jersey	Hackensack Meridian Health Hospital
New York	New York Department of Health
North Carolina	**Duke Health in partnership with NCDHHS, UNC**
Ohio	Ohio Department of Medicaid
Oregon	Oregon Health Authority

How NC InCK Plans to Achieve Integrated Care

More holistically understand the needs of children

- **Data Driven Needs Assessment** to assign a child to 1 of 3 Service Integration Levels
- **Use of cross-sector data** from state child welfare, juvenile justice, school attendance & suspensions
- Identify children and youth who could benefit from care management support

Integrate services for children who could benefit from additional support

- **InCK Integration Consultant** to support care managers in resource navigation
- Identify a **Family Navigator** for long-term support of children and families
- **Shared Action Plan** for families and care team members
- Access to **InCK VirtualHealth platform** to support care team collaboration

Invest resources in what matters for children and families

- Develop **Alternative Payment Models (APMs)** that link payments to meaningful measures of child well-being
- Identify, advocate for, and reward interventions which address **health inequities**

Area 1: Holistically Understand Needs of Children

Summary

- Overview: InCK's Service Integration Levels (SILs)
- Merging new cross-sector data to stratify children in InCK
- NC InCK SILs and PHPs/AMHs

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Data Used to Stratify Children into SILs

Current Out-of-Home Placement Flag*

- Juvenile Justice residential placement (current)
- Foster Care plan eligible (current)

Out-of-Home Placement Risk Flag

- Prior foster care plan eligibility (within past year)
- Adoption assistance plan enrollee (entry within past year)
- Juvenile Justice engagement (higher severity)
- ≥ 3 hospitalizations within past year
- ≥ 30 inpatient days within past year
- Residential treatment within past year
- Skilled nursing facility treatment within past year
- Psychiatric inpatient admission within past year

Health Designation Flag: one or more of

- Care Management for At-risk Children (CMARC) enrollee
- Community Alternatives Program for Children (CAP/C) enrollee
- Pediatric Medical Complexity Algorithm (PMCA) level 3
- Tailored Plan eligible

Healthcare Utilization Flag: one or more of

- Antipsychotic Rx within past year
- In-home mental health services within past year
- Mobile crisis response use within past year
- ≥ 4 ER visits within past year
- Medicaid paid cost > $5,000 within past year
- < 5 years old without any claims within past 2 years despite continuous enrollment

Socioeconomic Flag: one or more of

- Healthy Opportunities Screen (≥ 2 positive): Food, Housing, Transportation, Violence
- Temporary Assistance for Needy Families (TANF) eligible
- High Social Deprivation Index (SDI) score
- Juvenile Justice engagement (lower severity)

Education Flag: one or more of

- Chronic school absences within past year (2019-2020)
- Frequent short-term suspensions within past year (2019-2020)
- Expulsion within past year (2019-2020)
- Early intervention - infant-toddler program enrollment within past year

Guardian Flag: one or more of

- Guardian Tailored Plan eligible
- Guardian psychiatric admission within past year
- Guardian Medicaid eligible due to disability
- Guardian substance use during pregnancy or perinatal depression within past 2 years

Stakeholder Escalation Flag

- Child flagged by family or other stakeholder for case review due to perceived risk

***Out-of-Home Placement:** Currently resides or is at risk for out-of-home placement **OR** prolonged or multiple inpatient admissions. This refers to placement in a psychiatric hospital, residential care center, skilled nursing facility, correctional facility, foster care (including kinship care), or juvenile detention.

Area 2: Support and Bridge Services

Summary

- Integrating care across services
- Integration Consultant Role and support offered to PHPs, AMHs, and CCNC
- Assignments of Integration Consultants to Care Teams
- Family Navigator Role Overview
- InCK Shared Action Plan Overview
- Additional InCK Tools: VirtualHealth Platform and Consent

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Resources Available to PCPs in NC InCK

- **Capacity building** on core child service areas through group trainings, convenings, and resource guides
- **Technical assistance** for assessing and addressing non-clinical needs:
  - What to do when a child is experiencing food insecurity or housing instability
  - How to support a child to promote Kindergarten readiness
  - How to utilize new codes/modifiers for non-clinical interventions
- **Facilitated communication and collaboration** across practices and sectors to share promising interventions for children

INTEGRATED
RE FOR KIDS

InCK Integration Consultant

Lead Consultant UNC — **Integration Consultant Leadership Team** — **Lead Consultant Nancy Madenyika, Duke**

- **Local Health Department**
  - Granville Vance Health
  - Orange Co Health
- **DSS-Child Welfare**
  - Orange DSS
  - Local DSS
- **PHP's**
  - Wellcare: Missy Burrell
  - United: Tami Hilton
  - CCH: LaShawnda Massey
  - Healthy Blue: Diana Vandergrift
  - Amerihealth Caritas: Amy Davis
- **Cardinal**
- **Alliance**
- **Head Start**
- **Dept of Public Safety (JJ)**
- **Title V (School Nurse)**

Integration Consultant Support of PHPs, CCNC and AMHs

Integration Consultants are experienced clinicians (social work, nursing) focused on supporting care teams in implementing pediatric integrated care

Integration Consultants are embedded across key child service areas to improve integrated care and offer cross sector consulting to PHP, CCNC and AMHs serving InCK members

PHP-based Integration Consultants currently advise InCK leadership on key components of InCK model design

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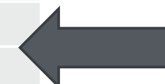
Assignment of Integration Consultants to SIL 2 and 3 Members

Order	Criteria		Consultant Assigned
1.	Juvenile Justice engagement 12 months from today's date		Juvenile Justice
2.	Currently enrolled in Medicaid Direct Foster Care or Adoption Plan		Orange County DSS
3.	Child in foster care placement within 12 months from today's date		Orange County DSS
4.	Current enrollment in CAP-C		School Nurse Consultant
5.	CMARC enrollment		Granville Vance Health Dept and Orange Health Dept
6.	Meets future criteria for Tailored Plan enrollment		Alliance and Cardinal
7.	Attributed to Duke-affiliated AMH		Duke and Head Start
8.	Attributed to UNC-affiliated AMH		UNC and School Nurse
9.	Enrolled in Standard Plans, Not at UNC or Duke		
		+ enrolled in Amerihealth	Amerihealth
		+ enrolled in CCH	CCH
		+ enrolled in Healthy Blue	Healthy Blue
		+ enrolled in United	United
		+ enrolled in Wellcare	Wellcare

Consultant Assignment to care teams will be based on identifiable characteristics of the InCK member



Care Team members embedded in PHPs will connect with their PHP's Integration Consultant

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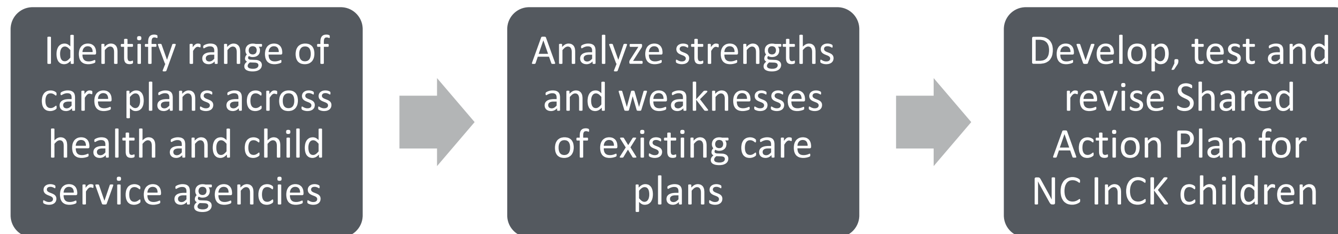
Developing the Shared Action Plan (SAP): Our process

Goal: Create Shared Action Plan for improved **family-centered, whole-child** service coordination



1. **National review of over 120 existing care plans** across various core child service areas
2. **Interviewed frontline care managers in health and child service agencies to learn:** who develops care plans and based on what assessments, where are they stored, how they are shared, how their effectiveness is evaluated
3. **Hosted focus groups with families** to learn about their experiences with the development and use of care plans for their children
4. **Co-designed the Shared Action Plan based on analysis** in collaboration with families, physicians, care managers, DSS and Juvenile Justice representatives
5. **Usability Testing** on the Shared Action Plan from July to October
   - United and Amerihealth both participated in feedback

Components of the SAP

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.

First Name: ________ Last Name: ________ Preferred Name: ________

DOB: ________ (mm/dd/yyyy) County: ________

Preferred written & spoken language: ________ Preferred Pronouns: ________

Primary Caregiver: ________ 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: ________ 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?

CURRENT ENGAGEMENT WITH HEALTH AND SOCIAL SERVICES & PLANS OF CARE

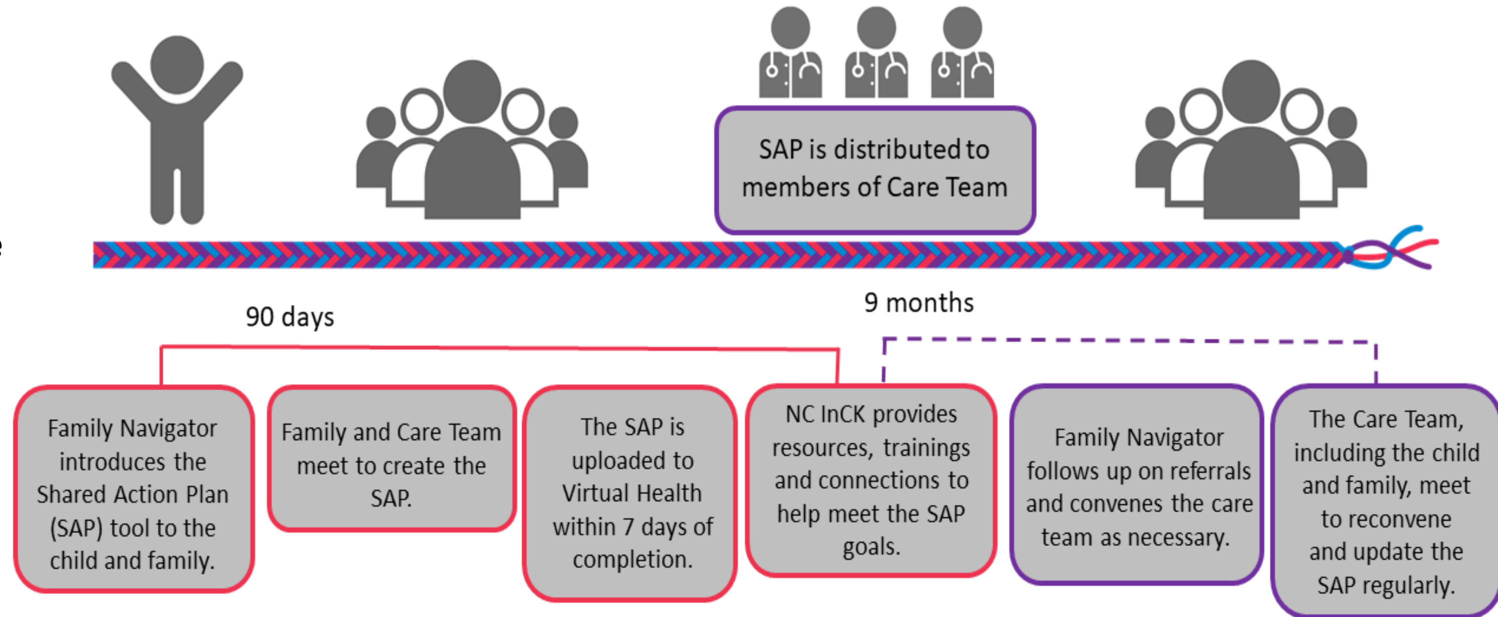
Who*	Agency	Name	Phone and Email	Other way to contact
Guardian/ Legally Responsible Person				
Family Contact 1				
Primary Care Provider				
Family Navigator				

ACTION PLAN

GOAL	WHO (Name of the person)	IS DOING WHAT	BY WHEN (By this date)	PROGRESS
Start date Check in date Completion date			Date	Date Met goal Satisfactory Progress Needs more time/assistance Goal needs modification
Start date Check in date Completion date			Date	Date Met goal Satisfactory Progress Needs more time/assistance Goal needs modification
Start date Check in date Completion date			Date	Date Met goal Satisfactory Progress Needs more time/assistance Goal needs modification
Start date Check in date Completion date			Date	Date Met goal Satisfactory Progress Needs more time/assistance Goal needs modification
Start date Check in date Completion date			Date	Date Met goal Satisfactory Progress Needs more time/assistance Goal needs modification

Draft Timeline: NC InCK Shared Action Plan (SAP)

Start: Family engages in Care Management



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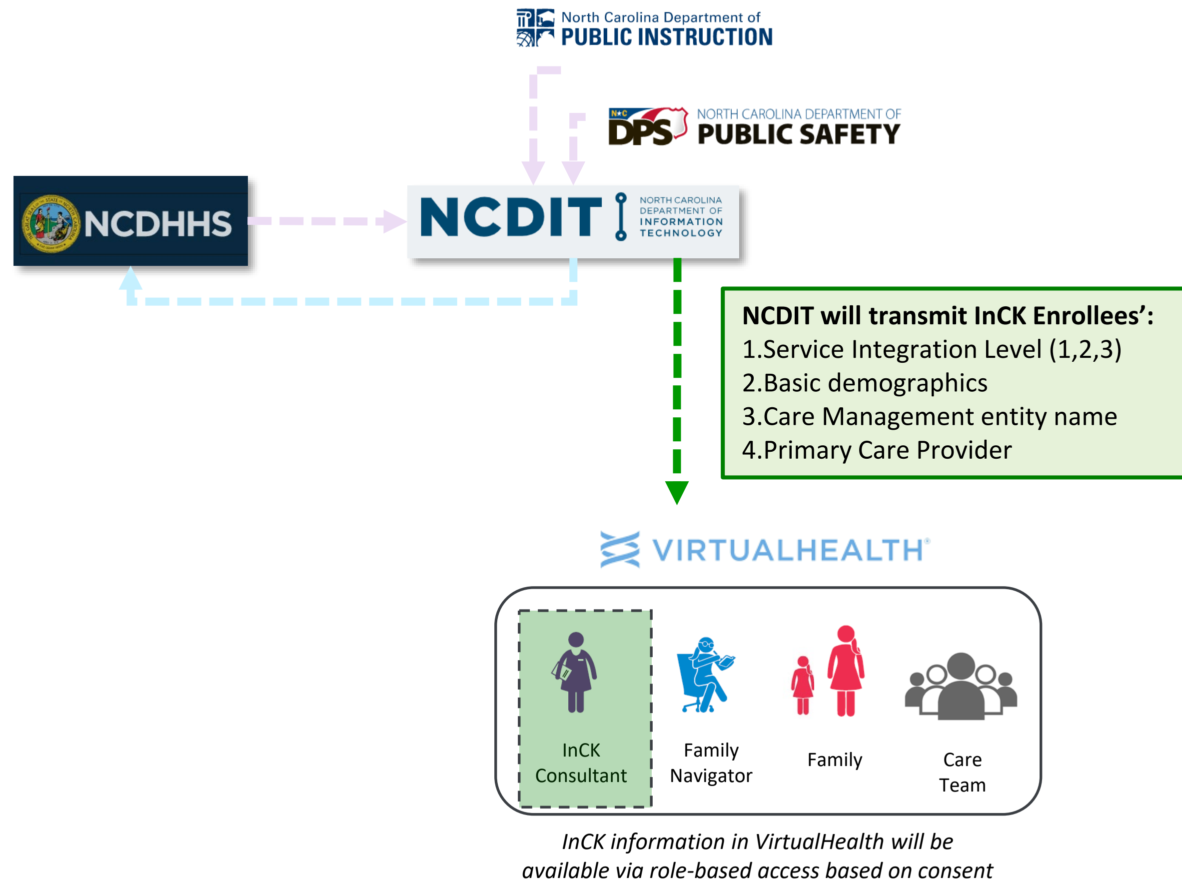
VirtualHealth & Duke BAAs/DSAs

Why BAAs/DSAs Are Needed:

- Consultants will do NC InCK panel management on Virtual Health
- Access to PHI on InCK members and records on interactions and services

- **Each PHP has been asked to sign Duke's BAA and Data Security Agreement by Sept 15, 2021**
- NC InCK and Duke will hold open office hours on **August 24 at 9am for questions on the BAA and DSA documentation.**



InCK information in VirtualHealth will be available via role-based access based on consent

Area 3: Focus Healthcare Investments (APM)

Summary

- NC InCK is working with the PHPs and health systems to design a payment model that **links incentive payments to more meaningful measures of child well-being**
- These Alternative Payment Models (APMs) will change how money flows between Medicaid, the PHPs, and our practices
- **Goal**: Increasing funding and investments for child well-being

NC InCK
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NC InCK APM Structure

- NC InCK APM will be a **5-year, targeted incentive program** in the 5 NC InCK counties, beginning July 2022 through Dec 2026. Eligible beneficiaries will be Medicaid/CHIP-insured individuals birth to age 20 in Standard Plans.
- Two tiers reflect a **glidepath to more advanced payment models** and different levels of readiness to take on risk
- The default option for participation is the **InCK Foundation**, built on pay-4-reporting and pay-4-performance as providers build capacity and infrastructure. Provider organizations participating in InCK must transition to **InCK Advanced** from InCK Foundation after 2 years, which includes shared savings/losses.

	InCK Foundation	InCK Advanced
Primary Care Kindergarten Readiness Bundle	**Pay-4-Reporting** for documenting Kindergarten Readiness Bundle	**Shared Savings/Losses** for improving Kinder. Readiness rate
Screening for Housing Instability	**Pay-4-Reporting** for screening & addressing + screens	**Shared Savings/Losses** tied to housing instability rate benchmark
Screening for Food Insecurity	**Pay-4-Reporting** for screening & addressing + screens	**Shared Savings/Losses** tied to food insecurity rate benchmark
Shared Action Plan for children in SIL-2 and SIL-3	**Pay-4-Reporting**	**Shared Savings/Losses** tied to completion rate benchmark
Screening for Clinical Depression & Follow-Up Plan	**Pay-4-Performance**	**Shared Savings/Losses** tied to measure benchmarks
Ambulatory Care: ED Visits	**Pay-4-Performance**	
Equity: Well-Child Visits in first 30 months of life	**Pay-4-Performance**	
Total Cost of Care	**Aware**	**Shared Savings/Losses** tied to TCOC benchmarks