Partnership *for* Community Care

A Community Care of North Carolina Network

Serving our most vulnerable citizens with a strong healthcare partnership

Empowering our community to improve the quality of their healthcare.

Care that is patient-centered, provider driven, community-based and cost effective

Serving Guilford, Randolph & Rockingham Counties

www.P4CommunityCare.org

North Carolina is attempting to stop the rapid rise of health care costs in the Medicaid population by aiming to improve quality of care and health outcomes. In 1998 North Carolina began building regional community–based networks of providers - Community Care of North Carolina (CCNC) - that is statewide and provides the infrastructure to improve health care for all Medicaid beneficiaries. CCNC has 14 networks across North Carolina's 100 counties.

Partnership for Community Care (P4CC) is your local network for CCNC. CCNC is a physician developed organization that provides medical homes for Medicaid enrollees. P4CC provides care management services for Carolina Access enrollees. North Carolina Division of Medical Assistance (DMA) has provided financing and aligned policy and regulation to support the development and operation of Community Care.

Our Approach to Care

Our goal is to work directly with local providers to better manage the Medicaid population and ensure consistent quality, medically appropriate and cost-effective health care services.

Our regional network is comprised of health care providers, hospitals, health departments, social service agencies and other community organizations.

Since we are under the DMA umbrella, we do NOT bill patients for our services. P4CC and network providers receive a per-member/per-month care management fee.

Our Results

Ongoing audits indicate that our member practices are improving their use of national, evidence based treatment guidelines, and case managers are helping patients better manage their chronic diseases. The results are improved quality of care, better patient health outcomes, and reduced care costs.

CCNC's statewide efforts saved **nearly $1 billion** in Medicaid costs from 2007 through 2010, and current evidence shows NC Medicaid saves 15% on patients after six months of enrollment in Community Care. Community Care's innovative, community-based approach received Harvard University's prestigious Innovations in American Government Award.

CCNC is Charged to save $149 million in the current Fiscal Year. (July 1, 2012 - June 30, 2013)

P4CC currently has 87 Providers in the Network and serves 85,000 enrollees

Want to learn more? Ready to get involved? Visit www.P4CommunityCare.org

Contact Brooke Kochanski: bkochanski@p4care.org or (336) 235-0930 ext 314

What is Care Management?

P4CC takes a patient-centered team approach to provide comprehensive care management services to Medicaid Carolina Access patients.

This includes but is not limited to:

- Coordination of services
- Disease state management education
- Medication therapy review
- Accompaniment to social and medical appointments
- Inpatient hospital visits (to assist in transition back to home)
- Referral to community agencies to meet social needs
- Referral for mental health needs
- Home visits

Our staff is comprised of Nurses, Social Workers, Psychiatrists, Pharmacists, Nutritionist, and Health Check Coordinators.

What does P4CC do for local medical practices?

- Enhanced care management fees ($2.50 per-member/per-month or $5.00 per-member/per-month for Age, Blind, Disabled ABD)
- Cost-effective support for disease management
- Care management services for patients
- Improved patient access to preventative, educational and support services
- Transitional care for hospitalized patients
- Medication reconciliation by Network Pharmacist
- Access to Provider Portal
- Support for Patient Centered Medical Home (PCMH)

Our Programs & Initiatives

- Transitional Care Nursing and Care Management: Ensure the full circle continuity of care that occurs between providers, hospital, and home
- Chronic Disease & Telemonitoring: Provide monitoring and follow up with chronic disease patients
- Behavioral Health Integration: Working together with primary care providers to ensure physical health and behavioral health needs are optimally met
- Chronic Pain Initiative: Responding to some of the highest drug overdose death rates in the country
- Pharmacy: Performing medication reconciliations to eliminate discrepancies
- Pregnancy Medical Home: Reducing infant mortality in North Carolina
- Palliative Care: Building awareness around end of life care needs and advance planning
- Early Intervention & Health Check Coordinators: Promoting the medical home for children's preventative health and sick care needs
- Nutrition Program: Providing nutrition education to patients to better care for their physical health
- Care Coordinator for Children (CC4C): Targeting high-risk, high-cost children from birth to age five for care management
- Children's Health Insurance Program Reauthorization Act (CHIPRA): Five-year quality demonstration to improve children's healthcare
- Assuring Better Child Health and Development (ABCD): Promoting healthy development, prevention and early intervention
- Child Health Accountable Care Collaborative (CHACC): Improving care for the state's most vulnerable children
- Uninsured Program: Providing access to health care services for low-income uninsured residents of Guilford County
- Quality Improvement: Assisting network practices with projects and initiatives to improve patient outcomes

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