Mission

Empowering our community to improve the quality of their healthcare. Improving access, maintaining quality, reducing costs of medical care in Guilford, Rockingham and Randolph Counties.

Our Purpose

Identifying and minimizing barriers to healthcare by helping primary care providers in our network to better utilize evidence-based disease state management guidelines. Providing Care Management services to patients to reinforce what their provider's treatment plan is and to better manage their chronic conditions.

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Effective 9/24/2012

Partnership *for* Community Care

A Community Care of North Carolina Network

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

Serving Guilford, Randolph & Rockingham Counties

NETWORK OVERVIEW

What is Partnership for Community Care (P4CC)?

A regional partnership of primary care providers, hospitals, departments of social services, and community organizations. We are one of 14 similar physician-led networks participating in the statewide Community Care of North Carolina (CCNC) initiative.

Our objectives are to:

- Improve health outcomes and reduce care costs for Medicaid, NC Health Choice children, select dually-eligible Medicare/Medicaid, and privately-insured enrollees in our geographic footprint
- Promote integrated communities of care using the medical home, evidence-based medicine, and health information technology
- Support patients through the continuum of care, providing care management services to high-risk, chronically ill patients

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.

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: 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
- 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

Provider Participation

Providers receive benefits from enrolling in Community Care. Benefits include:

- Per Member Per Month Management Fee
- Care Management Services linked to every practice for high-risk patients with emphasis on transitions in care
- Access to P4CC multidisciplinary team, including Behavioral Health specialists
- Access to comprehensive patient data and care alerts through Community Care's Provider Portal
- Free patient education and disease management tools
- Free educational meetings offering Level I Continuing Medical Education (CME) credits
- Access to practice Performance Reports for cost, utilization, and adherence through Community Care's Informatics Center

Primary Care Providers help P4CC by...

- Providing a Medical Home to manage and coordinate patient care
- Implementing evidence-based treatment guidelines
- Utilizing Community Care's Informatics Center and other data to implement continuous quality improvement
- Referring eligible patients with chronic medical conditions for care management
- Collaborating to resolve medication discrepancies and other health concerns
- Utilizing the Preferred Drug List (PDL) and prescribing Medicaid covered over the counter (OTC) medications