Partnership *for* Community Care

A Community Care of North Carolina Network

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

Our 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.

NETWORK OVERVIEW

What is Partnership for Community Care (P4CC)?

Partnership for Community Care (P4CC) is a non-profit organization comprised of: Primary Care Providers, Hospitals/Health Care Systems, County Health Departments and County Departments of Social Services. We are charged with improving the health outcomes and reducing the care costs of the Carolina Access Medicaid and NC Health Choice populations in Guilford, Rockingham and Randolph Counties. We are one of 14 similar networks participating in the statewide Medicaid quality improvement strategy called Community Care of North Carolina (CCNC). In addition to serving NC Health Choice and Carolina Access Medicaid populations, we help uninsured patients in Guilford County access medical care.

North Carolina is attempting to stop the rapid rise of health care costs in the Medicaid population while at the same time aiming to improve the quality of care and health outcomes. In states like North Carolina, the challenge in finding an innovative approach to address the quality and cost problem is much greater—it has a diffused population, with a significant percentage still living in rural areas; its medical services infrastructure remains dominated by small physician practices and loosely connected health organizations; and managed care penetration is low. To help address these challenges, North Carolina began in 1998 building regional community–based networks of providers - CCNC - that is statewide and provides the infrastructure to improve health care for all Medicaid beneficiaries.
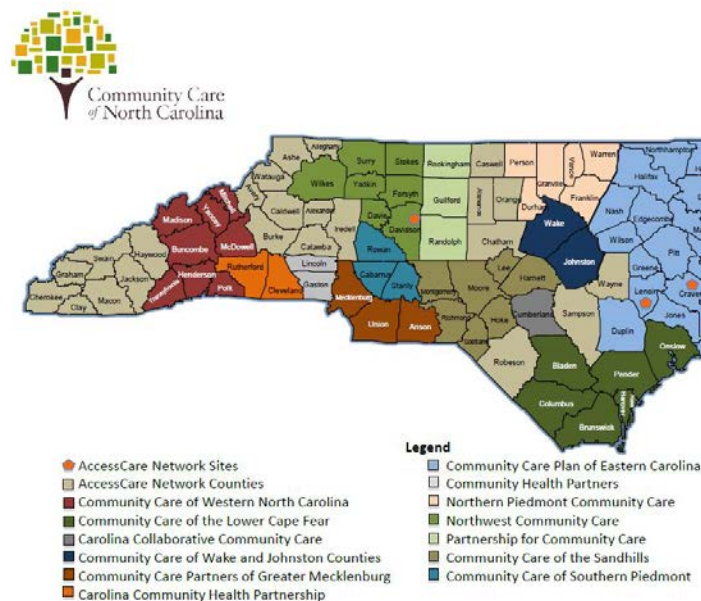
Source: CCNC September 2012

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

Our Leadership

Partnership for Community Care is led by Claudette Johnson, RN, MNA. Ms. Johnson has provided excellent leadership and has significantly increased the number of patients served during her tenure. P4CC is also led by our Medical Director: Marian Earls, MD, and Assistant Medical Director/QI Champion: Tiffany Gibson, NP.

Our Approach to Care

- Work directly with those community providers who have traditionally cared for North Carolina's low-income residents and build partnerships where providers can work together to meet patient needs and utilize existing resources.
- Develop our tri-county community network that manages Medicaid patients and Medicaid services as well as addresses larger community health issues.

Our Results

Yearly 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.

Provider Participation

The Medical Home

Built on the Medical Home model, Community Care matches each patient with a primary care provider to manage and coordinate care across providers and settings. We support the medical home by:

- Promoting best practices
- Providing Care Management services to high-risk patients
- Supporting clinical decisions at the point-of-care via Community Care's Provider Portal
- Analyzing performance data and providing practice-specific feedback for quality improvement

Participation Requirements of Primary Care Providers

- Perform primary care that include certain preventative services
- The ability to create and maintain a patient/doctor relationship for the purpose of providing continuity of care
- Establish hours of operation for treating patients at least 30 hours per week
- Provide access to medical advice/services 24/7
- Maintain hospital admitting privileges or have a formal agreement with another doctor based on ages of the members accepted
- Refer or authorize services to other providers when the service cannot be provided by the Primary Care Physician (PCP)
- Use reports provided by the Division of Medical Assistance (DMA) managed care section as guides in maintaining the level of care that meets the goals of CCNC
- To allow the case manager to access patient records for chart reviews
- To refer patients for case management services
- To have a representative from your practice attend medical management committee meetings held by your network
- Participate in yearly chart audits
- Provide pediatric developmental screenings and referrals / following up with Children's Developmental Services Agency (CDSA) or support services (pediatric/ family medicine practices)

In order to serve as a primary care physician in a CCNC network, the provider must first be enrolled with DMA as a Carolina ACCESS PCP. The provider will be required to sign a contract with P4CC.

Providers receive benefits from enrolling in Community Care...

- 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

For Patients

Partnership for Community Care (P4CC) provides registered nurse and social work care managers, pharmacists and other health care professionals to help you manage your health care. Our services are free to eligible patients.

- Our goal is to improve your health and overall quality of life.
- Our care managers will help you learn how to take care of chronic health problems like asthma, diabetes, and heart failure.
- Our care managers will work closely with you and your doctor to understand your health care needs.

Care Managers Help By:

- Going over your doctor's plan for your health
- Assisting you after a visit to the hospital or the emergency room
- Making follow-up appointments
- Helping you understand all of your medicines
- Coordinating your care across all of your doctors
- Helping you get the equipment and services you need
- Referring you to other programs
- Offering ways to eat healthy and stay active
- Talking with you on the phone, meeting you at your doctor's office, or meeting you in your home
- Answering your questions

Other Services

In addition to care management, you have access to other resources and services through P4CC:

- Nutrition services for helping you with your meal planning, diet, and exercise
- Pharmacy services to make sure you are taking the right medicine, at the right time
- We offer a program for low-income uninsured residents in Guilford County through the Guilford Community Care Network (guilfordccn.org)

> *"No one had ever taken the time to sit down with me and address every area of my health care. I am so thankful to have someone who really cares."*
> -Patient, Carolina Access Medicaid

6

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 Coordination 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

Transitional Care Nursing and Care Management

Ensure the full circle continuity of care that occurs between providers, hospital, and home

Transitional Nursing and Care Management is essential to everything we do. P4CC Care Managers ensure the continuity of care full circle that occurs between providers, hospital, and home:

- Helping patients and practices manage chronic diseases according to national evidence-based treatment guidelines
- Targeting care management services to help patients avoid unnecessary emergency room visits, hospitalizations, and readmissions
- Assisting patients with hospital transition to ensure medications, services, and equipment are in place and properly utilized
- Conducting medication reconciliation to ensure prescriptions are filled and no discrepancies exist
- Linking the patient back to the medical home after a hospital discharge
- Coordinating care with the medical home and other community agencies providing supportive services

Chronic Disease & Telemonitoring

A focus on high-cost diseases that significantly impacts quality of life

While the health challenges of any individual patient are unique, the prevalence of some diseases requires a coordinated, system-wide approach to care management.

Diseases targeted include:

- Congestive heart failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Hypertension

Telemoitoring - Helping you live a healthier life, in your own home

Our Telemonitoring Program provides daily re-mote nursing management of vital signs (blood pressure, blood sugar, pulse, weight) that helps people stay on track by identifying early warning signs of a worsening condition. The program is a fast and simple way for P4CC to see how you are doing, and provide immediate support in managing your health. With this new initiative we hope to decrease patients' visits to hospitals and emergency departments.

Our team of clinical professionals work together to provide care that meets the unique needs of every patient.

- Measures vital signs and weight from home daily
- Provides nursing management that helps participants stay on track
- Identifies early warning signs of a worsening condition
- Provides tips for diet, exercise and medication
- Offers peace of mind to participants and loved ones
- Gives you the confidence to enjoy the fullness of life at home

Patients are identified through certain criteria, recommendations made by Primary Care Physicians and/or specialists to collaborate with the Chronic Disease Nurse for at least 90 days to 6 months.

Behavioral Health Integration

Treating the whole patient

Providing comprehensive care coordination services to medically ill patients who have behavioral health needs.

MISSION: The Behavioral Health Integration Initiative (BHI) will support primary care practitioners seeking to incorporate behavioral health best practices in the evaluation and treatment of patients.

VISION: All primary care practices will use best practices to identify and treat behavioral health conditions including depression, chronic pain and substance use, and will use psychotropic medications in a safe and effective manner.

PROGRAM GOALS:

1. Assist primary care providers in the use of best practice toolkits for behavioral health conditions including depression, chronic pain, and substance use
2. Collaborate with LME/MCOs and behavioral health providers to optimize care of patients with concurrent medical and behavioral health conditions
3. Increase safety monitoring of off-label prescribing of antipsychotic medication for children
4. Reduce off-label prescribing of antipsychotic medication for anxiety, sleep and as mono-therapy for depression in the adult population
5. Educate network pharmacists and care managers regarding best practices for behavioral health diagnoses, treatment, and follow-up

P4CC collaborates with area hospitals, inpatient psychiatric facilities, behavioral health providers, medical practices, and Critical Access Behavioral Health Agencies (CABHA).

The integration of behavioral health and primary care begins to break a "silo" system of care that too often fails to meet the needs of those patients who have both behavioral and physical comorbidities.

Chronic Pain Initiative

In conjunction with non-profit organization Project Lazarus we are responding to some of the highest drug overdose death rates in the country.

The issue of chronic pain represents a complex interaction between biological, psychological and social variables. While prescription painkillers, especially opioids, can be used effectively in the treatment of chronic pain, when used incorrectly they can be deadly. Epidemic levels of unintentional deaths by poisoning, particularly from opioids, are having a profound effect across the U.S., and even more so in North Carolina's communities, where death rates exceed the national average.

Goals of the CPI Program:

- Reduce opioid-related overdoses
- Optimize treatment of chronic pain
- Reduce inappropriate use of pain medications (Opioids)

How P4CC Can Help:

- Chronic Pain Initiative Toolkit for Providers, Emergency Departments and Care Managers
- Work with Care Managers
- Training and technical assistance needed for program implementation
- Follow-up surveys to help determine the ongoing needs in your practice

An evaluation published by members of the Project Lazarus study team found that the implementation of their program in Wilkes County generated a 47% reduction in the overdose death rate from 2009 to 2010.

Pharmacy Program

Performing medication reconciliations to eliminate discrepancies

Pharmacists joined CCNC network teams in 2007 due to an increase of high-risk, blind, aged, and/or disabled patients with diverse medication profiles and prescribers, making them prone to multiple medication-related problems. Network pharmacy goals emphasize improving global patient outcomes and decreasing overall health care costs. Over time, pharmacists in CCNC have proven their ability to help reduce overall healthcare costs and decrease patient hospitalizations.

Partnership for Community Care Pharmacy Team

Our staff consists of one clinical network pharmacist, one clinical pharmacist and a pharmacy technician. These pharmacists manage highly complex patient populations and focus on improving healthcare outcomes.

One major role of the Network Pharmacist is piloting effective outreach strategies to achieve the goals of local and statewide NC Medicaid pharmacy initiatives that include but are not limited to: the Preferred Drug List (PDL), the Antipsychotics, Keeping it Documented for Safety Program (A+KIDS), Adult Safety with Antipsychotic Prescribing Program (ASAP), Brand Name Drug Prior Authorization Request Program (BRANDs), and the Narcotic Lock-In Program.

The Network Pharmacist also serves as an informational resource for network physicians, case managers, and community pharmacies on general drug information and NC Medicaid pharmacy policy.

The main focus of the clinical pharmacist's activities is medication management. Medication management includes reviewing medication reconciliations completed by case managers and communicating any medication issues with the primary care provider. The goals of medication management are: improving the quality of care through appropriate drug therapy, reducing preventable hospital readmissions and emergency department (ED) visits.

Pregnancy Medical Home

Reducing infant mortality in North Carolina

The NC Division of Medical Assistance, the NC Division of Public Health and CCNC are working together to develop a new program designed to provide comprehensive, coordinated maternity care to pregnant Medicaid patients. The program aims to improve the quality of maternity care, improve outcomes for mothers and babies, and reduce medical care costs.

Priority risk factors include:

- History of preterm birth
- History of low birth weight
- Multiple gestation
- Fetal complications
- Chronic conditions which may complicate pregnancy
- Unsafe living environment (e.g., homelessness, inadequate housing, family violence)
- Substance or tobacco use
- Late entry into prenatal care
- Missing two or more prenatal appointments without rescheduling
- Unanticipated hospital utilization Emergency Department or Labor & Delivery triage visits, ante partum hospitalization
- Physician request for care management assessment

Medicaid recipients with any of these priority risk factors will receive an assessment from a pregnancy care manager. These are not the only reasons why a patient may need pregnancy care management, and a provider can request an assessment at any time.

text4baby™
A free service of the National Healthy Mothers, Healthy Babies Coalition

Text **BABY** to **511411** & get **FREE messages** on your **cell phone** to help you through your pregnancy & your

Palliative Care

Building awareness around end of life care needs and advance planning

Despite the best in medical science and technology, many patients with advanced, life-limiting illnesses suffer needlessly in the final stages of their lives and die in ways that leave their families with legacies of pain. The growing number of people living with chronic, incurable illnesses highlights the urgency of developing pathways of care that ensure provision of high quality care while avoiding unnecessary and unwanted care in the final phases of life.

Aims of the Palliative Care Program

1. Improve information distribution and access to hospice and palliative care services
2. Enhance patient autonomy through increased use of advance care planning communication in primary care practices and patient families
3. Develop and distribute clinical tools for pain and symptom management, psychological, spiritual and practical needs appropriate for primary care practices serving seriously ill patients

How P4CC can help:

- Coordinating care and facilitating communication between patients families and providers
- Enhancing patients' sense of personal control over the medical direction of end of life concerns
- Assisting patients with advanced care planning and decision-making that reflects their personal values and preferences

What are "Advanced Directives"?

An Advance Directive is a legal document that allows you to direct your health care providers and loved ones, in advance, about what you would or would not want done for you, in the event that you could not speak for yourself. We encourage all people to discuss advanced directives with medical providers and families.

Advanced Directives include documents such as the Living Will, Healthcare Power of Attorney, Do Not Resuscitate (DNR), Medical Order for Scope of Treatment (MOST) form, or the Five Wishes.

Early Intervention

Promoting the medical home for children's preventative health and sick care needs

The goal of the Health Check Coordinator is to ensure children fully utilize their medical home for preventative health and sick care services for children ages birth thru 21. Health Check Coordinators assist Medicaid Carolina Access patients with early detection of childhood diseases, ensure that patients receive full knowledge of their insurance benefits and provide necessary information or transportation needs. The counties in our network are Guilford, Randolph and Rockingham.

Benefits of Health Check Coordinators

No Show List

- Rescheduling missed appointments
- Scheduling sick visits
- Scheduling well check exams
- Make referrals to Care Managers for chronic health issues
- Make sure well checks are current (Every Year)

Educational Benefits

- Preventing extreme Emergency Room usage
- Explaining the severity of making Doctor's appointments
- Insuring they have a medical home
- Help finding a primary care provider
- Patient care advocate

Benefits of an Annual Well Check Exam

- Comprehensive physical exam
- Comprehensive health history
- Nutritional assessment
- Anticipatory guidance/health education
- Measurements, blood pressure, and vital signs
- Developmental screening including mental, emotional and behavioral
- Immunizations
- Vision and hearing screenings

Nutrition Program

Patient Driven – Goal Oriented – Change in Lifestyle

What services do we provide Patients?

- Nutrition education to better explain their health conditions and how it relates to what they eat
- Activities to help reinforce the knowledge they have learned
- Specialized recipes tailored to fit a patient's dietary needs
- Support while adapting to the new lifestyle
- Weekly nutrition newsletter highlighting community activities, nutritious recipes and grocery specials

What services do we provide Practices?

- Workshops and classes for patients
- Educational groups for patients
- Educational materials and work books for Providers
- Individual home visits with Care Managers
- Nutrition trainings for Providers

For a provider wanting to obtain a nutrition referral / consultation for their patients - Send consult through the Care Manager

Determine your goals and develop a plan with us!

Did you know an extra 100 calories a day that you don't burn off can make you gain 10 pounds in a year?

WE CAN HELP! Small changes make a difference! What will your first change be?

Care Coordination for Children (CC4C)

Care Coordination for Children (CC4C) is an at-risk population management program that serves children from birth to 5 years of age who meet certain risk criteria. The main goals of the program are to improve health outcomes and reduce costs for enrolled children.

The CC4C Program began March 1, 2011 as a partnership between Community Care of North Carolina (CCNC), the NC Division of Public Health (DPH) and the NC Division of Medical Assistance (DMA).

CC4C Services

Services provided by CC4C care managers are tailored to patient needs and risk stratification guidelines. A comprehensive health assessment, including the Life Skills Progression1, assists the care manager in identifying a child's needs, plan of care and frequency of contacts required. Contacts occur in medical homes, hospitals, in the community and in children's homes.

Medical Homes

Each child served by CC4C is linked to a specific Medical Home and CC4C Care Manager. The Care Manager works closely with the local medical practice serving as the child's Medical Home to coordinate roles and responsibilities and ensure the child obtains necessary care. CC4C staff also work in close collaboration with their local CCNC networks to access care management histories, Medicaid claims and other vital records, and to coordinate care management services. CCNC networks also assist in quality improvement and in evaluating program effectiveness.

Referral criteria:

- Children with Special Health Care Needs (chronic physical, developmental, behavioral or emotional conditions) who require health and related services of a type and amount beyond that required by children generally.
- Children exposed to severe stress in early childhood, including:-- Extreme poverty in conjunction with continuous family chaos (Recurrent physical or emotional abuse, Chronic neglect, Severe and enduring maternal depression, Persistent parental substance abuse, Repeated exposure to violence in the community or within the family)
- Children in foster care who need to be linked to a Medical Home
- Children in neonatal intensive care needing help transitioning to community/Medical Home care.
- Children with "potentially preventable" hospital costs identified under methodology developed by Treo Solutions, Inc.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

Five-year quality demonstration to improve children's healthcare

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA or Public Law 111-3) reauthorized the Children's Health Insurance Program (CHIP). CHIPRA finances CHIP through FY 2013. It will preserve coverage for the millions of children who rely on CHIP today and provides the resources for states to reach millions of additional uninsured children. This legislation will help ensure the health and well-being of our nation's children.

CHIPRA Category A

A Quality Demonstration Grant that experiments with and evaluates the use of new and existing measures of quality for children.

Categories for the Core Quality Measures:

Prenatal, Immunizations, Screenings, Well Child Visits, Availability (access to Primary Care Providers), Upper Respiratory (antibiotics use), Dental Varnishing, Emergency Department, Asthma, Attention deficit hyperactivity disorder (ADHD), Mental Health, Diabetes, Modified Checklist for Autism in Toddlers (MCHAT), Obesity, Foster Care

CHIPRA Connect (also known as Category C)

Provider Models Enhancing Care for Children with Special Health Care Needs

Learning Collaborative which will enhance Medical Home Model for children with special health care needs (CSHCN) with a focus on social-emotional, developmental and behavioral, and mental health.

Promotes the use of routine screens for children of all ages with special emphasis on: Maternal Depression, Autism, School Age, Adolescent Screens

Uninsured Program

Providing access to health care services for low-income uninsured residents of Guilford County

The Uninsured Program is a program that helps people without health insurance access comprehensive medical care. It is NOT a Health Insurance. The program is made up of a network of generous doctors and other healthcare providers. These doctors provide healthcare services to eligible adults. P4CC partners with GCCN to complete the eligibility and enrollment for patients into the program. Once patients were enrolled they are eligible for other services provided by P4CC. This includes Case Management, Transitional Nursing, community referrals, pharmacy referrals, nutrition, disease education, medication education, etc.

There are over 70,000 adults in Guilford County that have no health insurance and are unable to afford private insurance. Partnership for Health Management's Uninsured Program is here to help you improve and maintain your health. To be eligible for the program you must be 19 years or older, income eligible, live in Guilford County and cannot have any form of health insurance, including Medicaid or Medicare. You must have an annual income at or below 200% FPL (federal poverty level which is for an individual $21,780 and a family of four (4) $ 44,700.)

The Uninsured Program Provides the Patient:

Coordination of healthcare needs, Coordination of specialty care needs, Intensive and individualized case management services, Onsite eligibility and enrollment, Assistance with program approved medications through Guilford County Dept. of Public Health Pharmacy & Medication Assistance Program (MAP), Assistance with dental care referrals provided by primary care physician, Assistance with a medical home

Statistics

Guilford County covers 649 square miles and has 446,189+ residents. Of the estimated 446,189 people living in Guilford County, approximately 73,215 individuals are un/underinsured, according to the Cecil G. Shep Center for Health Services Research at UNC Chapel Hill. 88.5% of those with a household income of $50,000 or more reported having at least one health care provider, as compared to 72.4% of those with a household income of less than $50,000.

According to a report by the Guilford County Department of Public Health - The State of Guilford County's Health 2006 - The percentage of adults with health insurance has dropped from 88.6% in 2001 to 81.4% in 2005. Currently, 10% of children and 19% of adults are estimated to be without health insurance, totaling more than 11,000 children and 52,000 adults.

Quality Improvement

Assisting network practices with projects and initiatives to improve patient outcomes

 CCNC has used performance measurement and feedback to help meet its goals of improving the quality of care for Medicaid recipients while controlling costs since 1998. Quality measurement is intended to stimulate or facilitate quality improvement (QI) efforts in CCNC practices and local networks, and to help evaluate the performance of the program as a whole. Despite rapid growth in CCNC enrollment and number of participating practices, CCNC clinical leaders have remained committed to monitoring quality at the individual practice level, engaging providers in the QI process and reporting on progress at the practice, county, network, and statewide level.

Connecting your patients to the community resources you need

We work with Improving Performance in Practice (IPIP) Program Quality Improvement consultants. They can work with provider office staff on the development of an electronic patient registry, planned care templates and guides, access to evidence-based treatment protocols, and other quality improvement measures. Participation in IPIP is free of charge and can provide up to 20 hours of CME for participating providers. If you have questions please contact us!

QI Mission

To seek constructive solutions to agency problems that impede the improvement of staff function and effective and efficient delivery of healthcare services for our population in Guilford, Randolph and Rockingham counties. The QI team addresses this mission through coordination of research, collection of information, and analysis of viable options. This Mission is to support the greater Mission of our Agency, "Empowering our community to improve the quality of their healthcare." To provide exceptional QI support to our agency through data analysis, professional training and timely response.

TREO Data Management

TREO applies 3M™ methodology for tagging whether an admission, readmission or ER visit was "potentially preventable." Patients are flagged for priority based on whether they had more "potentially preventable" hospital services relative to other people in their risk group (CRG).

CMIS (Case Management Information System)

A secure web application intended for the users of participating CCNC Networks. It integrates components of the CCNC Standardized Plan with accepted care management processes allowing care mangers to build and work with a patient-centric, comprehensive care plan. This system is managed and developed by the informatics center of NCCCN, Inc. https://cmis.n3cn.org/

Provider Portal

Provider Portal was released in August 2010 to improve patient care coordination for NC Medicaid recipients. Providers and other members of the care team may access care team contact information, visit history, and pharmacy claims history for their Medicaid-enrolled patients. Population management and quality reporting is also available. Available to practices, hospitals, and agencies engaged in quality improvement and care coordination through Community Care of North Carolina.

About the Provider Portal

This CCNC Provider Portal was released in August 2010 to improve patient care and care coordination for North Carolina Medicaid recipients. Providers and other members of the care team may access care team contact information, visit history, and pharmacy claims history for their Medicaid-enrolled patients. Population management and quality reporting is also available for primary care medical home providers. The portal is available to practices, hospitals, and agencies engaged in quality improvement and care coordination through CCNC.

Secure Web access to the Medicaid patient record

- Contact information for the patient's primary care and specialist physicians, mental health services provider, Health Check coordinator, DME supplier, home health or personal care service provider, and pharmacy
- Visit history (including inpatient, emergency department, office visit, and imaging history)
- Medication list and pharmacy claims history
- Laboratory results when available and clinical alerts indicating when recommended care is overdue
- Contact information for care management or clinical pharmacy consultation through CCNC

Why use the Provider Portal?

The Provider Portal provides key information from Medicaid claims and other sources that may be missing from the patient provider chart or electronic health record. The portal allows providers to:

- View patient encounter information that occurred outside of your local clinic or health system (including hospitalizations, ED visits, primary care and specialist visits, laboratory and imaging).
- Review medication regimen (including fill history and adherence indicators; and whether medications have been prescribed by other providers).
- Access a compendium of low-literacy patient education materials, and evidence-based practice tools for screening and assessment, health coaching and disease management.
- Retrieve medication information for patients in multiple languages, in video or print format
- Access population management reports and quality metrics for your own patient population

Need More Information?

Contact Us:

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