



Community Care of North Carolina

Committed to Improving the Health of Our Communities

The New CCNC

We've streamlined our operations, adapted our program to serve new populations, developed new cost structures to meet marketplace needs, and expanded our capabilities to serve multiple payers and their members.

Our long-term mission remains the same, but our new approach is state of the art. We are committed to improving the health and quality of life of all North Carolinians through person-centered care and community collaboration.

Who We Are

Community Care of North Carolina is the nation's largest and longest-running medical home system.

Care teams led by physicians, focused on local patients across 100 counties

We're your family's doctor and your child's pediatrician. We're partners with North Carolina's largest independent physician network, Community Care Physician Network. We're the care manager who stays connected to you. We're your home-town pharmacist. We're paramedics and public health workers and community health workers. CCNC is embedded in hospitals, both large and small, across all 100 counties in North Carolina.

Our physician-led, multi-disciplinary care teams coordinate care across settings and over time.

CCNC is nationally accredited by the NCQA and is one of the first to earn this credential in complex care management.

Together we know North Carolina's communities from the mountains to the coast in ways that are unmatched and that produce better patient outcomes, higher patient and physician satisfaction, and lower health care costs.

What We Do

We build on decades of experience working collaboratively with physicians to develop best practices.

- Inpatient needs
- ER utilization
- Readmissions
- Costs
- Outcomes
- HEDIS scores
- Compliance
- Quality
- Reporting

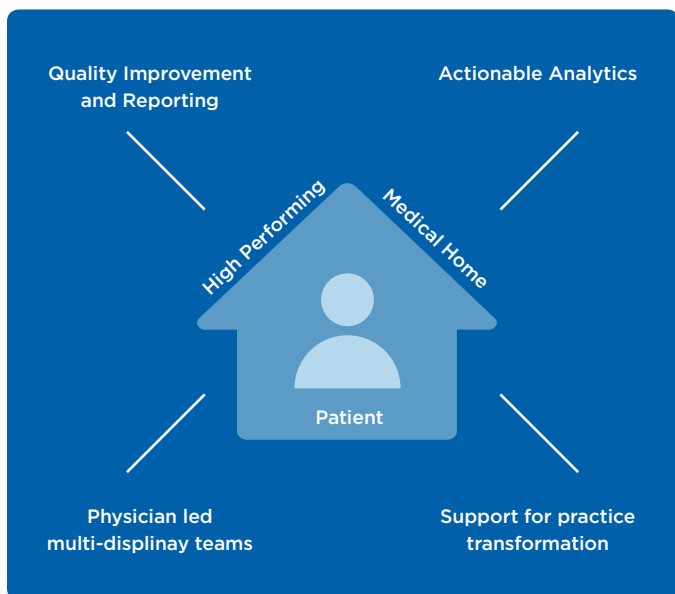
CCNC transforms quality reporting and patient data into actionable strategies to raise HEDIS scores, improve health outcomes, and lower costs for the patient, the payer, and the community.



CCNC identifies complex patients having multiple doctors and taking many medications for timely, appropriate care management.

We help keep people out of the emergency department, and post-discharge, CCNC reduces chances of hospital readmission.

We provide home visits to patients needing special assistance, watch out for drug interactions, and help remove barriers to better outcomes such as transportation, lack of secure housing, or poor nutrition.



We identify behavioral health issues and integrate a mental health component into primary care practices.

CCNC's Pregnancy Medical Home program, the only statewide pregnancy medical home program in the nation, reduces pre-term births and the need for neonatal care.

Our proven approach to population health management delivers better health outcomes at lower costs with higher physician and patient satisfaction ratings.

Problems We Solve

Targeted interventions: Focusing care management on high-cost/high-need patients isn't enough; we focus on impactable patients.

Infrastructure and Relationships: We're ready to introduce you to the communities we serve so you can develop the relationships you need for success. CCNC is the largest system of medical homes and we've been doing this work longer than anyone else. In fact, more than 6,000 providers, 1.7 million patients, and 9 million taxpayers benefit from CCNC's work today.

“The return on investment from care management intervention is 2- to 3- fold higher with (CCNC's) impactability-based targeting...”

—Population Health Management, 2017

Statewide Coverage: Participating physicians, pharmacists, and care managers serve all 100 counties. CCNC core program standards are consistent across the state with modifications tailored to meet specific community resources and needs.

Reputation and Experience: Decades of innovation, collaboration, and experience count. CCNC will help your company control its costs, boost patient and physician satisfaction scores, and improve patient outcomes.

For more information, please contact:

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Accountability

Collaboration

Excellence

Innovation