COMMUNITY CARE
PHYSICIAN NETWORK

Advanced Medical Homes

Supporting Advanced Medical Homes

Under North Carolina's Medicaid Transformation plan, practices attesting as Tier 3 Advanced Medical Homes (AMHs) can receive care management revenue and value-based payments from health plans for meeting quality targets.

That opportunity comes at a price: Tier 3 practices take on significant new functions such as risk stratification and care management. Without the right partner this could be cost prohibitive and time-consuming.

"My practice intends to attest as a Tier 3 Advanced Medical Home through CCPN. Why would we try to build in-house care management, amid all these changes, when we have access to local, accredited, proven, and world-class care managers who know our practice and our patients!"

— William Stewart, MD
Sandhills Pediatrics

But there's a safer route: partnering with CCPN, a statewide, physician-led clinically integrated network. At no cost for CCPN members, you get a trusted, experienced partner to meet obligations and open the door to Tier 3 incentive payments.

Advanced Medical Home Tier 3 Status

CCPN Can Take You There!

Risk Stratification

Risk stratify all empaneled patients. We use an evidence-based and scientifically-validated analytics model that risk-stratifies patients based on "impactability" – the probability of benefiting from care management intervention.

Care Management

Provide care management to high-need patients. We have a robust care management program that has served the Medicaid population for over two decades and is nationally accredited by the National Committee for Quality Assurance (NCQA).

Key components of the care management program include:

- Local, licensed, and trained care management staff
- Patient assessment and screening
- Patient-centered care plan and web-based care management documentation platform
- Communications that keep primary care clinicians informed on patient progress
- Patient education
- Medication management
- Relationships and referral contacts established with community partners to address social determinants of health

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919-926-3894

Care Plan

Use a documented care plan for high need patients. We use a person-centered care plan that is informed by a comprehensive needs assessment, clinical guidelines, and patient goals.

Admissions, Discharges, and Transfers (ADT)

Track beneficiary utilization, including ADT for empaneled patients. We receive ADT notifications three times a day from most hospitals across the state, allowing care managers to utilize real time admission data to perform transitional care for high-need patients.

Transitional Care Management

We use ADT and other information to initiate transitional care management for patients at risk for re-admission and other patients who are considered high risk post-discharge. Our standardized processes optimize the effectiveness of transitional care management, resulting in a 27% reduction in inpatient admissions and a 48% reduction in potentially preventable readmissions.

CCPN Can Take You There

Tier 3 status represents new financial opportunities, but also a quantum leap in what's expected of your practice. Don't risk trying to take on all these functions yourself! Make CCPN your trusted partner as you move into the complex world of value-based reimbursement.

CCPN leverages Community Care of North Carolina's award-winning care management and actionable analytics to work in collaboration with CCPN practice support to ensure that your practice thrives in the value-based care environment.

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About Community Care Physician Network

CCPN is a physician-led, clinically-integrated network that helps primary care physicians deliver high-quality, cost-effective care. CCPN's experience and infrastructure turn data into actionable insights and drive quality improvement, measurement and reporting. Through CCPN, physicians work with peers to improve patient care and coordinate care across conditions, providers, settings and time. CCPN helps you better manage your complex patients while hitting quality targets under value-based reimbursement arrangements.

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