ANNUAL REPORT 2012

Dear Supporters,

In Wake County, approximately 126,000 adults under age 65 are without health insurance. Our community has provided significant resources in an effort to better serve this population—clinics provide free or low-cost primary care, physicians donate specialty care, hospitals contribute charity care, and pharmaceutical companies supply free medications. Still, these resources are not enough to meet the demand in our community, and this fragmented care has left large holes in the continuity of care for patients.

We could do better.

We formed the CapitalCare Collaborative in 2006 with partnership from Wake County safety net providers—hospitals, county government, and health clinics—to start filling the gap. Our coalition came together to figure out how we could simultaneously improve healthcare quality for low-income, uninsured citizens while at the same time reducing the ever-increasing cost of care for providers.

It's taken years of hard work and dedication from our expert staff and committed partners to lay the groundwork, but this past year it has all paid off by seeing our **circle of care** approach come to fruition. All our programs are at full force helping the medically underserved of Wake County.

In the past, uninsured patients were treated in the moment with no ability for providers to understand an individual's medical history or their ability to lay a path to a healthy future. Now, with our innovative programs and approach, we track our clients' medical history and get them the long-term treatment and services they need to reduce their dependence on emergent care. Seeing the whole picture has allowed us to have a circle of care for every client.

The impact has been phenomenal. Denise Gregory, an Emergency Department (ED) nurse case manager at Duke Raleigh Hospital, recently shared her perspective. "CapitalCare has closed the gap for the self-pay population. The CapitalCare team is responsible for keeping people from being so sick that they need hospitalization. They don't just stop at getting them an appointment. They help keep people alive." I am so proud that our team has had this level of impact on our community.

For our partners, we've already seen an amazing return on investment. In 2012, we estimated that our programs have saved area hospitals and clinics **$2.5 million** in reduced emergency care costs. As we expand our reach, it's only going to grow from there.

For our partners and friends this will come as no surprise—we're not resting on our successes. In 2013, we are working to offer dental and pain management programs. There are numerous emergency room visits every day for dental and chronic pain. We know we can make a big impact in these areas as well as what we've already accomplished through our programs.

We continue to need support from our partners, stakeholders and individual donors to make all this possible for uninsured residents of Wake County. Our aspirations for 2013 mean we must reach even higher financial goals.

After you read our annual report, I hope that you'll join our circle of care and be part of the solution for our community.

Sincerely,

Lisa A. Rowe

Lisa A. Rowe,
Director, CapitalCare Collaborative

What is the CCC?

CapitalCare Collaborative is a leader in demonstrating how competitive health systems can work together to improve health outcomes and lower the costs of care for uninsured people.

Our innovative programs bring together community stakeholders—hospitals, clinics, and government—to improve the health of Wake County's medically underserved citizens. The magic is in how it gets done.

Many communities have free or low-cost clinics, homeless shelters, substance abuse programs, and other safety net programs to help people. In the past, these services were siloed and agencies often couldn't collaborate because of time or resources. As a result of our collaboration, we are all speaking the same language—the language of care.

We take a vested interest in seeing our clients thrive and succeed. They get the care they need—the entire continuum of care—so they can be productive members of Wake County.

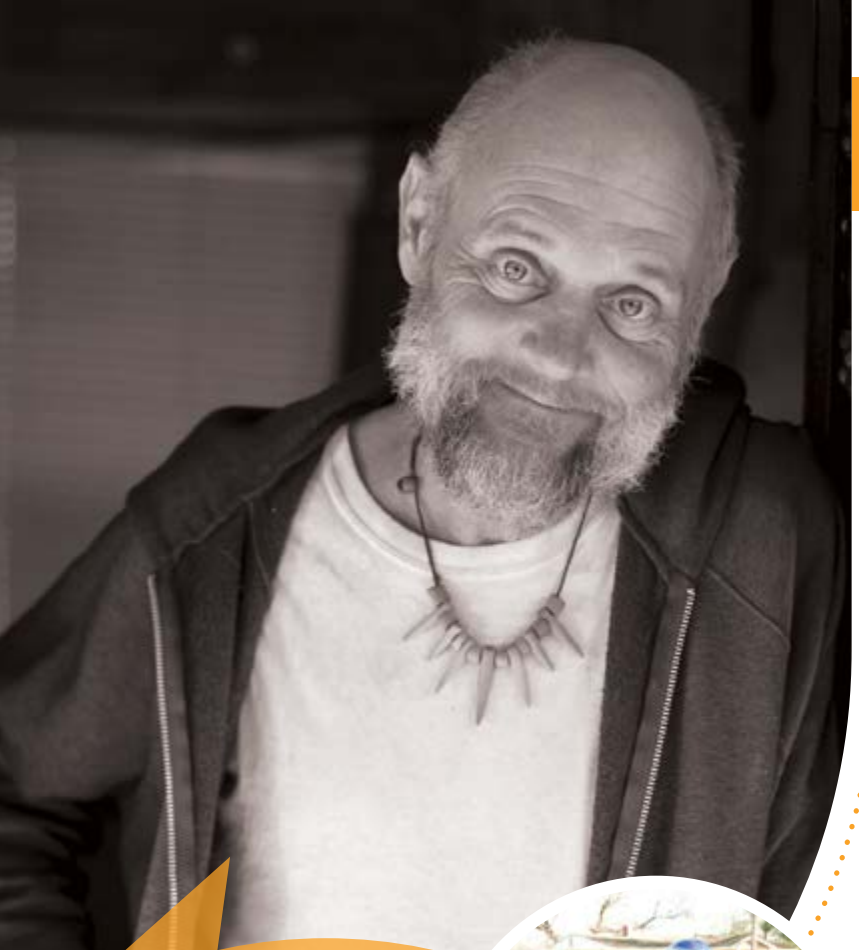
This holistic approach to care isn't easy. But it's the right thing to do. Lives have been transformed. New opportunities have revealed themselves. The monetary impact, in the form of reduced Emergency Room visits, has been huge for metro hospitals.

Read on to see some of the stories and the impact we've had in just a short time.

CAPITALCARE
Collaborative Programs

"It would be devastating for the community if CapitalCare went away. The CapitalCare team is creating wrap around services, so no one drops through the cracks."

Denise Gregory, Duke Raleigh ED Nurse Case Manager



MEET **Joseph**

On May 18, 2012, Joseph met Alexandra at a resources fair for ex-military personnel. At that moment, his life changed.

Joseph had served his country as a marine and a national guardsman, but that was a long time ago. After a divorce and losing a job, he used the survival skills learned in the military to live off the land eating squirrels and living in a tent.

He found his way to Raleigh and had been living under a tractor-trailer off Harrington Street for the last 3 years. Battling a list of illnesses – diabetes, heart conditions, asthma, depression, short-term memory loss, and post-traumatic stress disorder – Joseph had become emaciated and incredibly ill. He wasn't eating and often stayed under the trailer for days at a time.

Alexandra, a SSI/SSDI Outreach, Access, and Recovery (SOAR) case manager with CapitalCare, worked with Joseph to piece together his medical history and helped him get to doctors and a psychiatrist to prove that he was eligible for disability. With the funds from his disability, Joseph is now able to rent a trailer on the outskirts of Raleigh.

"This is the first time in 16 years I've been inside."

Alexandra helped Joseph get dishes, sheets and everything else to make it a home. "I didn't go outside for five days once I moved in." Alexandra recounted that Joseph took showers three times a day when he moved in – a simple luxury.

He's been putting on weight and is able to care for himself. Joseph takes his black scooter, which he purchased brand new in November, to the store to buy groceries and gets himself to doctors' appointments. "When I don't have my medicine, I just want to be by myself. Now I want to talk to people."

With CapitalCare and Alexandra's help, they have paid Joseph's back hospital bills through Medicaid. Joseph is seeing a primary care physician to help manage his health and keep him out of emergent care.

Now Joseph can look to the future. He is saving money to go visit his family in the summer. It's been 3 years since he was able to visit his family just 50 miles away in Person County. This is all with the ongoing support of Alexandra and CapitalCare.

"Alexandra is the world to me," Joseph said. "She's helped me out when no one else would."

"This is the first time in 16 years I've been inside."

Homeless Services and Project Access Program

With our programs, our team was able to connect patients like Joseph with the services he needed to get his life on track.

Homeless Services - You'll find the CapitalCare Homeless Services Team on the streets, in parks, camps, shelters, hospitals, and recovery facilities in Wake County building relationships with homeless men, women and families. After a meaningful connection is established and the needs of a homeless person are identified, the Team expedites referrals to quality medical, psychiatric, and substance abuse care for an individual, and creates a circle of care designed to affect long-term quality of life.

Our three homeless programs offer unique services, but work together to bring the most impact. *SOAR* focuses on assisting those who are disabled obtain benefits so they can gain access to income, health insurance, housing, and other needed services. *The Community Stability Program* works with homeless individuals who have an acute medical need to connect them with medical care and mental health services. Finally, our *Homeless Engagement Team* is an assertive outreach and engagement program that works with shelter residents and those living on the streets to get them on the right track for health and housing services. All three work to connect individuals to medical and behavioral health care, as well as housing.

In 2012 we:

- *Engaged 190 individuals*
- *Enrolled 47 in our new medical respite program*
- *Connected 74 with a medical home*
- *Connected 49 with mental health services; 59% have maintained these services for 3+ months*
- *Placed 60 in permanent housing*
- *Assisted 48 chronically homeless individuals with obtaining disability and Medicaid benefits (30 of these have obtained housing; all have been connected with a medical home)*
- *One year's worth of medical claim reimbursements for approved SOAR (disability assistance program) clients totaled an estimated $550,000*

Project Access - Formed in 2000, Project Access is a volunteer physician program that provides specialty and diagnostic health care services to uninsured Wake County residents. Beyond providing medical care, the program also coordinates the most efficient and cost effective methods possible for helping uninsured people get the care they need. Project Access is designed to aid physicians who want to volunteer their time and services to individuals who do not have access to quality healthcare because of financial barriers.

In 2012:

- *588 physicians provided care*
- *4,231 patients were impacted by Project Access services*
- *$15 million of donated care*

We increased the number of patients served by 12% this year. Project Access continues to focus efforts on recruiting the specialties highest in demand (including psychiatric and pain management specialties) and is partnering to receive funding that will allow for the recruitment of dental providers in 2013.

“I’m planning on **being around** for another **60 years!**”

MEET **Ann**

Ann has worked all her life, but health insurance was one thing that never fit into her single mom budget.

She cobbled together home remedies until, in 2011, her feet became swollen and painful. Her kids pleaded with her to go to the hospital, but as Ann puts it, “I wasn’t going to make no bills I couldn’t afford.” She eventually broke down and went into the Emergency Room at Rex Hospital. Her blood pressure was dangerously high at 199/150. They discovered she had blood clots in her leg and lung. They kept her in the hospital for a full week to get her symptoms under control.

At discharge, diagnosed with high blood pressure and edema, Ann had been put on new medications (including a twice-daily shot to manage her blood clots costing her $1,500 a box) and was dealing with a whole new set of health rules to live by. At first, she had to get her blood checked weekly to make sure her blood thinner was at the right dose. Ann didn’t qualify for Medicaid or Medicare and was not able to afford private health insurance. She didn’t know how she was going to pay for the ongoing costs of her medicine or healthcare.

The next week she got a call from Sandy at CapitalCare Collaborative. Sandy asked if she could help Ann find a medical home and resources to help cover her medical costs. Ann accepted the help and Sandy drove out to take her to a local, low-cost health clinic where Ann could qualify for community health care coverage and medications that she could afford.

More than connecting Ann with the services she needs, “Ms. Sandy,” (as Ann calls her) has become a big part of her life. The connections that the CapitalCare team makes with their clients are personal.

“Ms. Sandy opened a lot of doors, you know. She let me know I didn’t have to be in this alone.”

As the matriarch of the family, her health is important to Ann, “I’m planning on being around for another 60 years.” Her blood pressure and edema is now under control. She is no longer taking those expensive shots and is seeing her primary care physician regularly to keep her health in check.

“Without Ms. Sandy’s help, I don’t know where I’d be,” Ann said. “If I needed her to come pick me up to go to the doctor, she would. If something happened, I could pick up the phone, call Ms. Sandy, and she’d help me out.”

CareScope + MedData Programs

CapitalCare takes the time to coordinate patient care to get them into community provided medical, mental health, and human service programs. Without this assistance, many patients don't know where to turn for help; many simply give up.

Case Management Program - Our Nurse and Social Worker programs provide case management to those with chronic, complex medical conditions, as well as those that are high emergent care users. Our Patient Navigator helps clients who simply don't know about the resources available to them. Our focus is on getting clients connected with primary care homes, improving health outcomes through patient education, transportation assistance, and home visits, plus ensuring utilization of clinics rather than hospitals for care where appropriate.

In the past year we:

- *Connected 400 people to a medical home, exceeding our goal by 14%*
- *Reduced hospital emergency room visits from case management clients by 60%*
- *Reduced inpatient visits by 80%*

CareScope - The organizational brain behind our circle of care, the initial focus of CareScope was on development of a community Health Information Exchange to collect demographic and clinical data to track details about hospital and clinic visits, diagnoses, as well as program status and outcomes.

CareScope has become a rich data resource allowing us to see both community-wide and individual level trends reflecting which hospitals clients go to for care, how often, and for what kinds of issues.

When our partners use CareScope, it means we can identify and intervene with a client to get them the care they need for long-term health problems. By following our clients' progress from hospital to primary care to specialty care, this system has helped us improve our clients' health and reduce emergency room costs for our partners.

Furthermore, this data has provided us and our partners the ability to better target people for care, plan for programs and services, and track the impact of our interventions.

MedData - For many of our clients, affordable medicine is all that stands between their old life and moving forward with renewed health and opportunities. MedData Services has become the most widely used subscription-based Prescription Assistance Program and is heralded as the most efficient, user-friendly program available.

With some medication costs running into the hundreds or even thousands of dollars per month for the uninsured, access and affordability are paramount. Through the MedData system, partner clinics are able to obtain free or low-cost prescriptions for patients and track usage. Many of the uninsured's trips to the emergency room are to receive medication, even for chronic conditions.

In 2012, Prescription Assistance Applications were submitted through CareScope and medications were received at a value of $4.9 million for 7,626 applications submitted for nearly 2,000 people - further reducing the costs of ED visits either for medication or due to complications from going without.

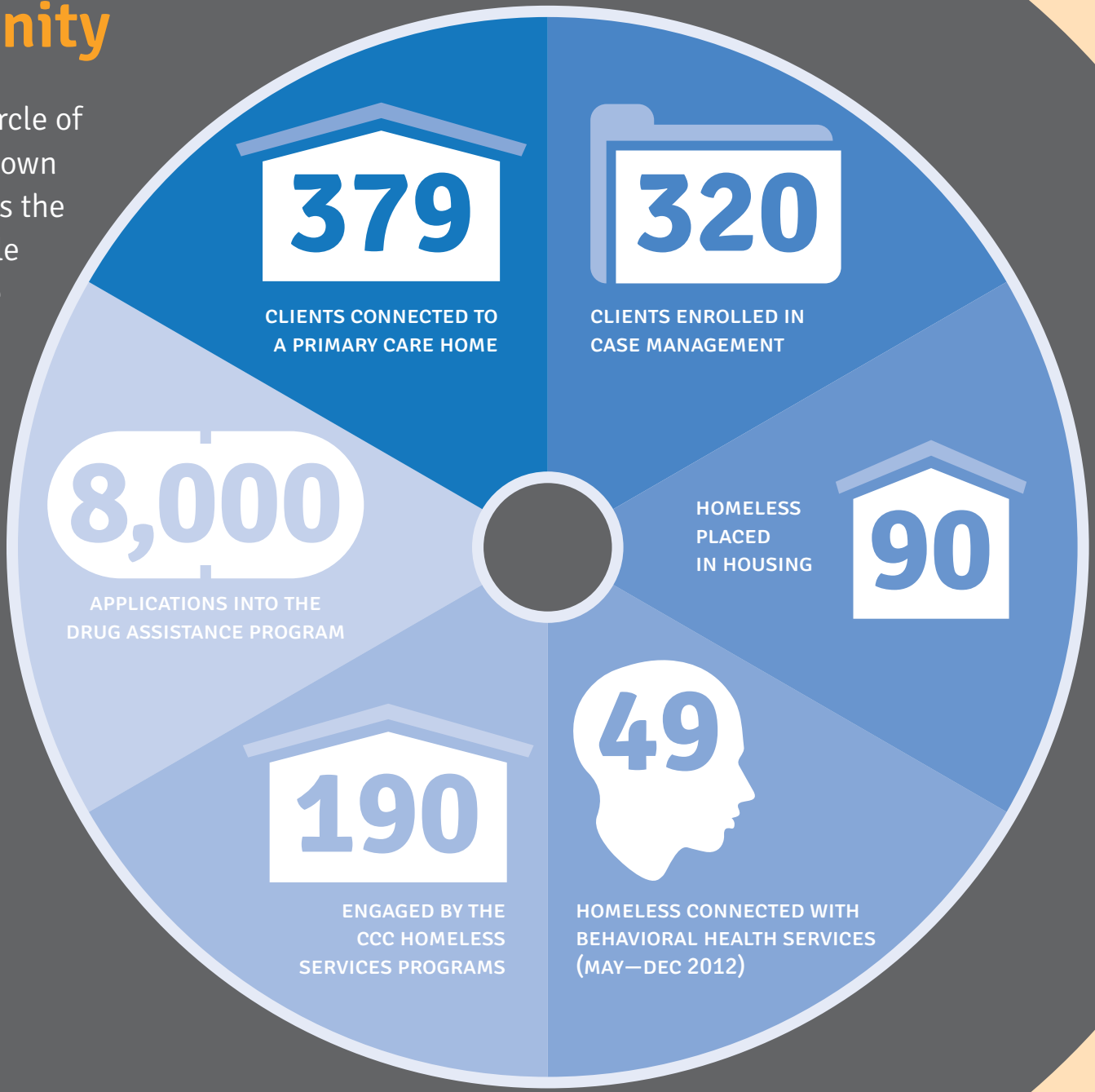
"Since January 2012, **7,626 Prescription Assistance Program applications were submitted** through CareScope.

A recent study in FL found a **40% reduction of ED visits** when people were enrolled in Prescription Assistance Programs."

Our Circle of Care Ripples Across the Community

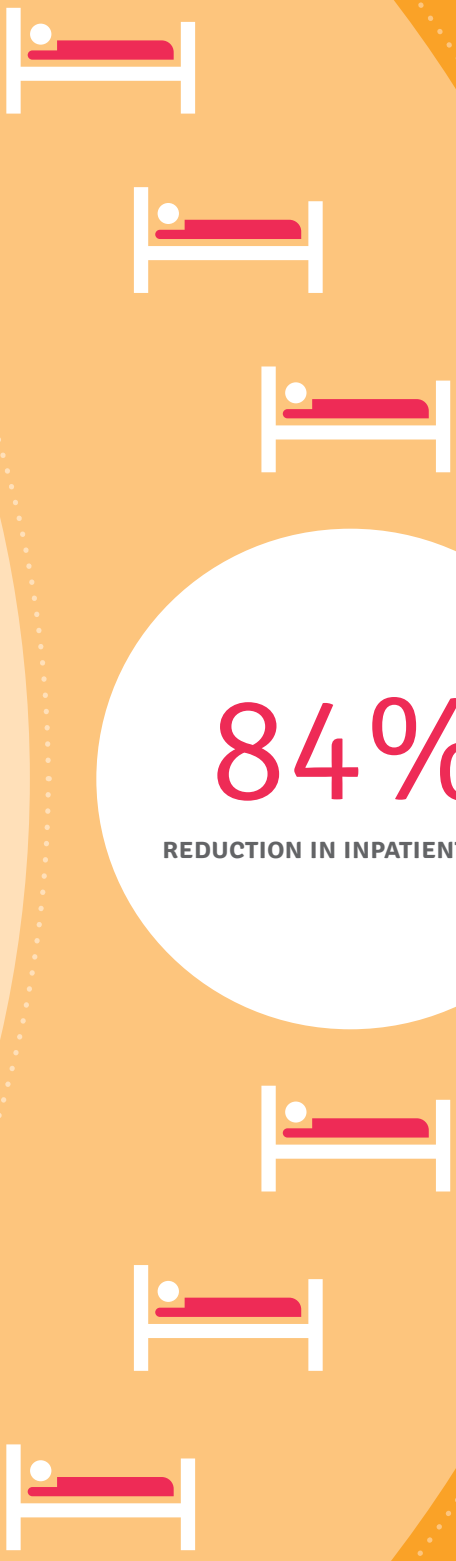
Since the CapitalCare Collaborative circle of care approach was launched, we've shown that impacting individuals' lives affects the entire community—from moving people off the streets and into housing all the way to lowered healthcare costs.

In the past year, we've helped people get care for lifelong illnesses, provided a path to residence and self-sufficiency for homeless clients, and helped low income individuals afford expensive treatment and prescriptions. At the same time, we've saved local providers millions of dollars through reduced Emergency Care visits and connection to benefits.



66%

REDUCTION IN ER VISITS



84%

REDUCTION IN INPATIENT CARE

$550K

IN MEDICAID REIMBURSEMENT

+

$2.5 mil

SAVED IN REDUCED HOSPITAL VISITS

=

OVER

$3,000,000

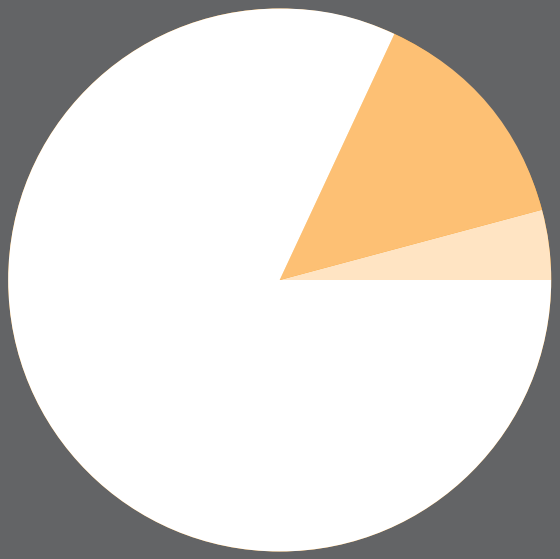
IN SAVINGS AND
REDUCED ED IMPACT

Financials

10%
State & County Awards
$95,000

90%
Grants & Private Contributions
$917,000

TOTAL **$1,012,000**



14%
Central & Management
$135,100

4%
Fundrasing
$33,150

82%
Program Support
$773,175

TOTAL **$941,425**

Funders

BlueCross BlueShield of North Carolina Foundation
An independent licensee of the Blue Cross and Blue Shield Association

REX UNC HEALTH CARE

WAKE COUNTY NORTH CAROLINA

Duke Raleigh Hospital
DUKE UNIVERSITY HEALTH SYSTEM

THE DUKE ENDOWMENT
SPIRIT OF GENIUS. LEGACY OF HOPE.

KATE B. REYNOLDS CHARITABLE TRUST

The Clark Grew Health for Homeless Project

WakeMed
WakeMed Health & Hospitals

Partners

Alliance Medical Ministry provides quality primary and acute care for low-income, uninsured adults on a sliding scale basis.

Duke Raleigh Hospital offers Wake County residents a complete range of hospital care and, in fiscal year 2012, it performed $69 million in charity care at cost.

Open Door Clinic offers primary care for low-income individuals in addition to specialty care, counseling, prescriptions, immunizations, referred consults and diagnostics and labs.

Rex HealthCare provides a wide range of acute and specialized hospital care including about $60 million in charity care annually.

SouthLight's mission is to eliminate addiction, abuse and misuse of drugs, including alcohol, in the communities they serve.

Wake County Human Services works to anticipate and respond to the public health, behavioral health and the economic and social needs of Wake County residents and to coordinate and sustain efforts that assure safety, equity, access and well-being for all.

Wake Health Services comprised of four clinics in Wake County, this organization serves adults including those who are homeless, uninsured, on Medicaid, and privately insured.

WakeMed Hospital with five campuses, this hospital system provides 85% of Wake County's charity care.

CCC Steering Committee Members

Megg Rader, *Executive Director, Alliance Medical Ministry*
Dr. Tara Lewis, *Medical Director, Alliance Medical Ministry*
Pat Kramer, *Director, Case Management, Duke Raleigh Hospital*
Dr. Ted Kunstling, *Chief Medical Officer, Duke Raleigh Hospital*
Dr. Linda Butler, *Chief Medical Officer, Rex Healthcare*
Bernadette Spong, *Senior VP of Finance, Rex Healthcare*
Roy Tempke, *Director, Case Management, Rex Healthcare*
Dr. Peter Morris, *Executive Director, Urban Ministries/Open Door Clinic*

CCC Steering Committee Members (con't)

Dr. Gary Greenberg, *Medical Director, Open Door Clinic*
Pablo Escobar, *Administrative Director, Open Door Clinic*
Regina Petteway, *Director – Office of Community Affairs, Wake County Human Services*
Dr. Betsey Tilson, *Medical Director, Community Care of Wake and Johnston Counties*
Susan Davis, *Executive Director, Wake County Medical Society – Community Health Foundation*
Penny Washington, *CEO, Wake Health Services, Inc.*
Dr. Doris Batts-Murray, *Medical Director, Wake Health Services*
Dr. West Lawson, *Chief Medical Officer, WakeMed Health and Hospitals*

Associate Members

Dr. Sumera Hayat, *Clinic Medical Director, Mariam Clinic*
Leona Doner, *Executive Director, Shepherd's Care Medical Clinic*
Tad Clodfelter, *Executive Director, SouthLight*

CCC Staff Members

Lisa Rowe, *Director*
Sandy Steigerwald, *Nurse Case Manager*
Anthony Vance, *Social Worker*
Brenda Bohorquez, *Patient Navigator*
Ashley Gunter-Teague, *Patient Coordinator*

Homeless Programs

Alex Hartfield, *SOAR Specialist*
Jane Smith, *Homeless Engagement Nurse*
Tara Jaworski, *Shelter Nurse*
Dave Mullin, *Homeless Case Coordinator*

Project Access Staff Members

Pam Carpenter, *Manager,*
Bobbi Burns, *Enrollment Specialist*
Rosa Almanzar, *Enrollment Specialist*

CapitalCare Collaborative
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919-792-3676 • capitalcarecollaborative.com

To make a referral, call the CCC Referral Line at 919-792-3676.

Be a part of the circle of care. Donate today by mailing a check payable to **CapitalCare Collaborative**.