WAKE COUNTY MEDICAL SOCIETY COMMUNITY HEALTH FOUNDATION ANNUAL REPORT 2014

JOURNEY TO HEALTH

We strengthened our already amazing framework of care and stayed true to our mission while responding to changes.

FULFILLING OUR PROMISE

Dear Supporters,

As I sit here reflecting on this past year, I keep returning to one word. Resolute. We faced challenges this year. That is undeniable. We embraced an active role with the massive Affordable Care Act rollout. On the frontlines we educated and enrolled clients with the one thing they haven't had in a long time – hope for their healthy future. We faced political challenges, but we kept moving forward and doing the right thing for our clients, providers, and partners.

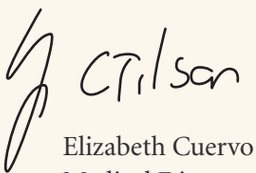
Throughout our challenges, we stayed true to our mission and goals. Our programs are making healthcare accessible for everyone in Wake County. Our continuing outreach and innovation means we're serving everyone from the homeless population to single-parent families to administering an exciting employee health plan for GlaxoSmithKline.

Community. For us community is at the center of all we do. Our provider- and community-centric models have resulted in incredible outcomes for clients and savings for providers and health partners. For example, in the past year, Capital Care Collaborative was able to reduce costs by an estimated $1,000,000 in the Wake County medical system through reduced emergency department use and client case management. Statewide audits showed our Medicaid program through Community Care of Wake and Johnston Counties to be equally effective at improving quality and reducing cost.

As much as I love the efficacy we've brought to the system, the client impacts continue to amaze me. People like Marzella have gone from being bedridden to walking miles every morning; and others from being homeless for more than a decade to having a place to call their own; from debilitating chronic disease to reclaiming an active life through careful health management. This is the epitome of a head-and-heart win-win scenario.

In 2014 and beyond, our resolute commitment to a healthy community continues. We were heavily involved in the Wake County Community Health Needs Assessment last year, and now we're helping to address the health care access problem in Wake County. We're also actively partnering to make Wake County the healthiest capital county in the nation.

As I close out my letter I'm filled with gratitude. Gratitude for our dedicated staff, for our generous supporters, and for our incredibly talented providers and partners. Thank you for being as steadfast as we have been throughout this journey. There's no way we could have done it without each and every one of you and I look forward to continuing to bring healthy futures to our community.



Elizabeth Cuervo Tilson, MD, MPH
Medical Director

About Wake County Medical Society Community Health Foundation.

With a focus on money-saving efficiencies for the healthcare system and serving the most vulnerable in our community, we've provided a systematic, coordinated approach to caring for our patients.

For providers, we've brought a coordinating resource that hasn't been readily available. We're able to guide them through the complicated medical system and connect a patient's providers together to create a continuum of care that works for all.

For patients, we're opening their eyes to new possibilities on their journey to health. They're discovering ways to get healthy and stay healthy. Most importantly, they're ending the crisis cycle of visiting the emergency department again and again.

Our emphasis on the medical home and community resources has made the difference for everyone involved. We believe in the power of the community to affect real change in a patient's health. We've seen it time and time again. The medical home model gives patients and providers a starting point for real, lasting health.

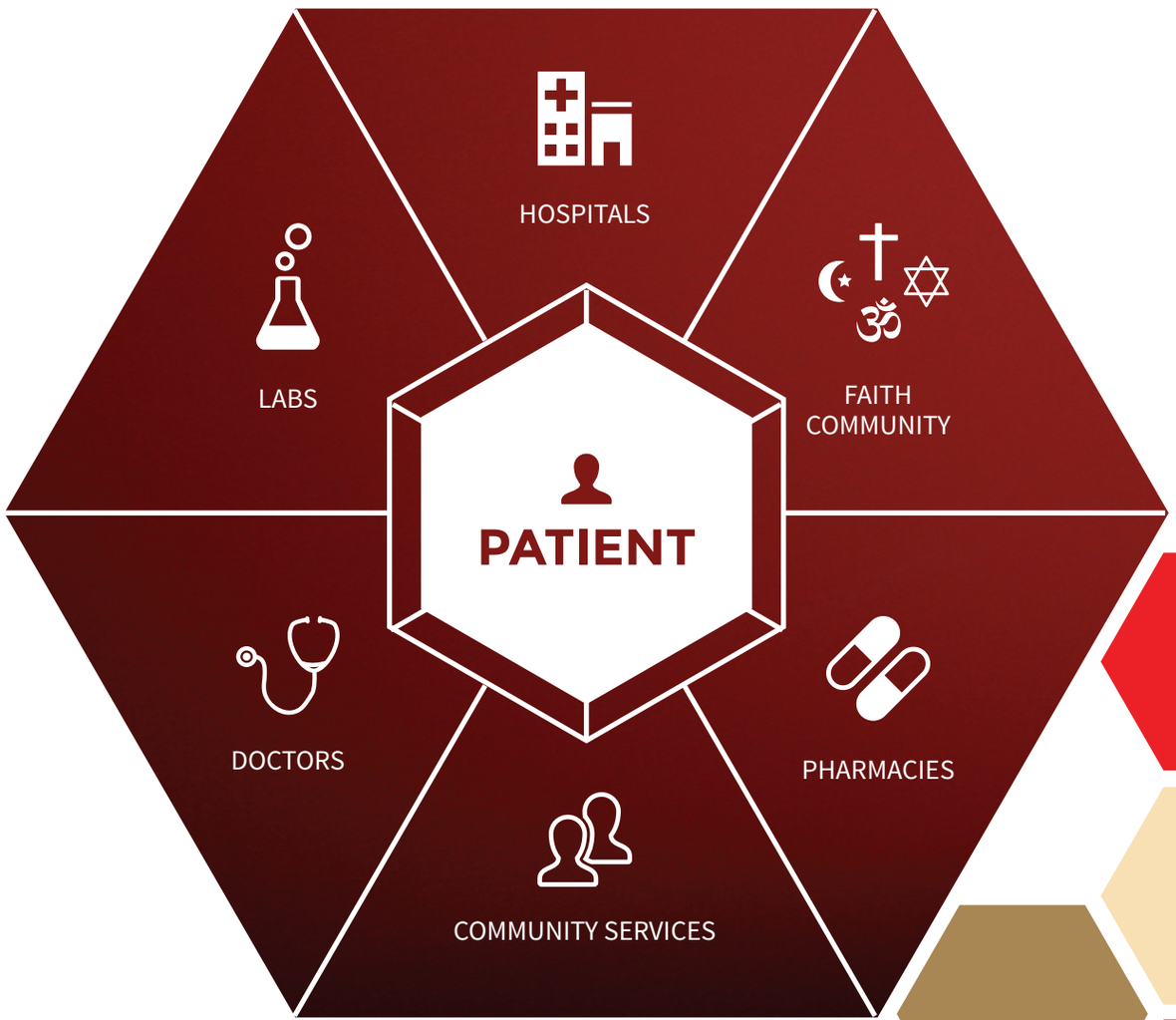
In this past year, our path has crossed with many others on our journey. Read on to see their stories and the impact our programs have all across our community.

CREATING A MEDICAL NEIGHBORHOOD FOR PATIENTS

For many patients, they simply don't know the resources available to them. When they enter our programs, they are surrounded by a variety of care options from the beginning. We coordinate the variety of services, practices, and community resources that make up the Medical Neighborhood.

We place the patients in the middle of this neighborhood, so that no matter what need they have we have a solution for them. For providers this creates a level of interconnected cooperation across specialties and types of medical services that's been difficult to achieve in the past.

The result is a cohesive process that works wonders for patients' outcomes, creates efficiencies for the providers and saves money in the healthcare system.



LIVING HEALTHY WORKSHOPS

KNOWLEDGE IS HEALTH

Meet Charles

It may be hard to imagine, but behind Charles's big smile is a man suffering from debilitating knee pain. Charles was an active kid who played football, but that bone-jarring activity, plus a long career in construction, put strain on his knees. These joints now hurt Charles so much that standing for a long time isn't an option, and the chronic pain forced him to quit his job as a local chef.

After leaving his job, Charles moved into the South Wilmington Street Center while he waited for disability payments to begin. There he met a counselor from CCWJC, Amber, who has put him on the path to a fresh start at a healthy life.

For years, Charles found it difficult to eat well or prioritize his health. He took three separate medications to manage his blood pressure without any signs of relief. Charles knew losing weight would help with the pain management, but he wasn't sure where to start. Our Living Healthy workshop, led by Amber, put Charles on the right path and gave him the tools he needed to succeed.

Living Healthy taught Charles how to advocate for his health and make healthy choices. With Amber's help, Charles has developed a new, healthier routine. Now, he eats very well, choosing to eat fruits and vegetables he's purchased from Wal-Mart or the local farmers' market. He exercises four times a week at his neighborhood gym and has already lost 12 pounds!

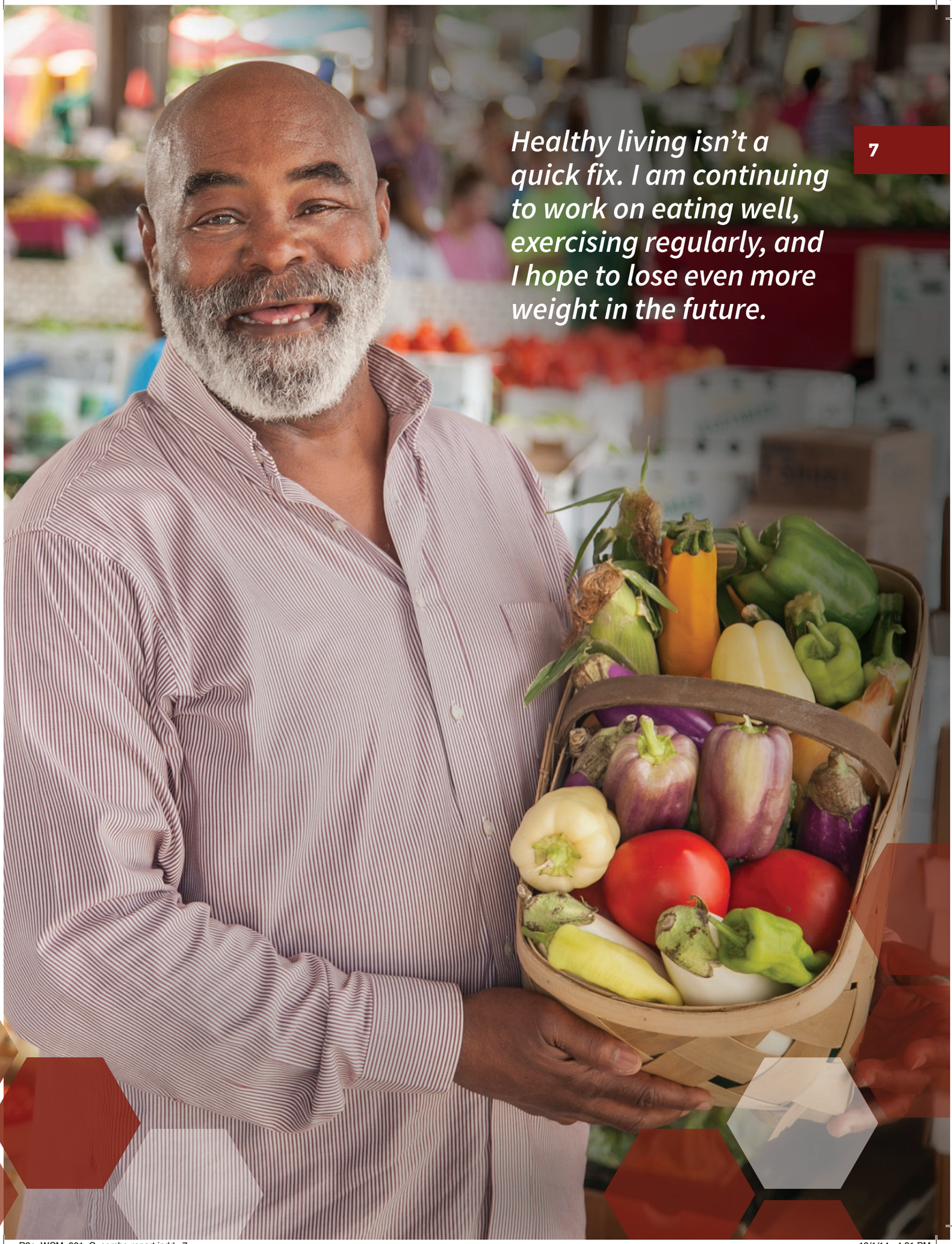
Charles shares, "Healthy living isn't a quick fix. I am continuing to work on eating well, exercising regularly, and I hope to lose even more weight in the future."

With a steady routine that has proven very successful for Charles, he is now committed to continuing on this road to feeling great and managing his health. Charles credits Amber with his new beginning: "Working with Amber and Community Care has been a great experience taught by nice people with positive attitudes. I wish there were more classes like the Living Healthy workshop."

LIVING HEALTHY

Living Healthy is a series of patient education workshops that helps individuals build the skills needed to break the symptom cycle in the management of their chronic illnesses. These programs are designed to do more than help people learn about their chronic conditions. Rather, they learn the skills and develop tools to better manage those conditions and live healthier, happier lives.

In 2013, we had 465 participants go through our Living Healthy workshops. That's 465 people who now have the knowledge to move toward healthy futures.


Healthy living isn't a quick fix. I am continuing to work on eating well, exercising regularly, and I hope to lose even more weight in the future.

Treating pain at the root.

PROJECT LAZARUS

Chronic pain is one of the top reasons for repeated Emergency Department usage and is a primary concern for primary care physicians. With the growth of prescription drug overuse and abuse, addiction, and unintentional overdoses, it was clear something had to be done.

Following a very successful test in Wilkes County, we launched our Chronic Pain Initiative/Project Lazarus. What makes this program successful is the community–physician partnership with CCWJC acting as the hub.

Our community partners include local hospitals and emergency departments, local health departments, primary care providers, pain management physicians, behavioral health and addiction specialists, faith-based programs, and law enforcement. Embracing the community from the beginning was important because prescription abuse is as much a community issue as an individual one. We guided providers in safely treating chronic pain and prescribing pain medicines, taught neighbors about recognizing chronic pain and drug abuse, and utilized intervention techniques to start patients on a path toward managing their pain.

> *This 360-degree collaboration has made all the difference. All around the community, there are now many more resources to turn to for help managing chronic pain and fewer that inadvertently support prescription drug abuse.*

Care with a personal touch.

Our boots-on-the-ground Community Care Management is the personal touch that makes our programs stand out and get results. We work on an in-person, one-to-one basis with patients to improve their health and quality of care, while reducing costs to the healthcare system.

How do we achieve all that? By becoming the hub between patients, providers, and community resources. This outcome-focused approach features a systematic use of data, connections between our healthcare systems, and a deep knowledge of community resources available for all facets of care for managing medical, social, and behavioral health conditions more effectively.

This one-to-one style, embedded in our community, is invaluable for meeting the unique and holistic needs of our patients.

HOME IS WHERE THE HEALTH IS

Our Transitional Care program works on two dual universal principals: patients don't want to go right back into the hospital after being discharged and the medical system needs to reduce the discharge–readmission cycle.

The key to the success of this program is in being proactive with patients and improving communication between them, their various caregivers, and our embedded staff.

Starting with our extensive Health IT network, we're connected to nearly all of the local hospitals, which means we receive timely information about discharges and identify patients most at risk of a quick readmission. We have medical professionals positioned at these area hospitals, and they start the transition process at the patient's bedside before discharge from the hospital or emergency room.

Our impact doesn't stop there. We make home visits and maintain contact to educate the patient, family, and caregivers on medication management, identifying warning signs of a worsening condition, and how to connect the patient to a medical home. We follow up with them every step of the way to becoming healthier and independent.

For providers, we represent the invaluable link between themselves, the patient, and the whole care spectrum, which includes hospitals and emergency rooms, primary care providers, pharmacists, community-based health programs, and government agencies. We serve as the glue that holds all of these very different systems together by creating links where none have existed in the past. The result of such cohesion has been improved outcomes for patients and greater efficiency for providers.

THE MANY TYPES OF PATIENTS

We actually interact with many patients — hundreds, even thousands. Most know us for our intensive work through the Community Care Management program. In fact, we see people across the whole spectrum, from those who just need resources, to those needing a primary care home, all the way to the most vulnerable who need some extra help in their journey to health.

INFORMATION AND OUTREACH (160,000 people)

- Broad population outreach and education
- Connection to Primary care
- Connection to Community resource

MEDICAL HOME INTERVENTION (50,000 people)

- Patient Education Materials
- Motivational Interviewing Training
- Quality Improvement and Workflow Support
- Patient and Practice level Data

CARE MANAGEMENT (1,000 people)

- High cost, high risk patients
- Home visits and practice visits
- Collaboration with providers
- Intense multi-disciplinary support

COMMUNITY CARE OF WAKE & JOHNSTON COUNTIES

Creating a better healthcare experience with equal parts intelligence and compassion.

ABOUT CCWJC

Community Care of Wake and Johnston Counties works to connect the most vulnerable patients to the appropriate care and to bring a higher level of efficiency to the medical system.

With our focus on best practices when treating chronic illnesses, working with community providers, and promoting primary care access, we've provided a stabilizing force and cost savings for clients and providers alike.

Our goal has been to change the way health care is delivered. With our feet firmly rooted in the communities our providers and clients call home, and with our eyes focused on outstanding outcomes for all, we are working hard to change the healthcare experience in North Carolina.

> *We started new, exciting initiatives in 2013 and expanded our most successful ones. Read on to see how our hard work has helped to improve patient outcomes.*

REDUCING THE CRISIS CYCLE FOR CHILDREN

In North Carolina, 1 out of every 20 children covered by Medicaid has a need for extra care due to complex, chronic illnesses. Many of them have been in a neonatal intensive care unit or pediatric intensive care unit due to their conditions. In fact, these 5% of children represent 53% of NC Medicaid's child-health expenditures. That means many of these kids are being readmitted again and again. It was time to do something about this problem.

The Child Health Accountable Care Collaborative (CHACC) program improves children's health through close cooperation between hospitals, primary care providers, and subspecialists.

Our care managers embedded in hospitals and specialty clinics work closely with hospital-based and specialty providers to navigate the complex services these fragile children need. Using the medical-home model, we match patients with a primary care provider and foster communication of the complex care plans between them and the specialists.

In addition, our patient coordinators focus on family-centered care to connect families and children to other supports and community-based services to help them through such difficult times. We believe this approach of caring for the whole family and facilitating provider collaboration has had, and will continue to have, a tremendous impact for our most vulnerable children.

> *CCWJC has helped us build and maintain invaluable relationships with our childrens' network of providers. We have seen a steady decrease in the number ED visits and hospitalizations since beginning our relationship with CHACC. I look forward to our continued collaboration.*
>
> — Rhonda Trunnell, RN BSN

CARING FOR MOMS

Healthy moms and healthy pregnancies make all the difference in the outcomes for newborns. Our work with the Pregnancy Medical Home program works with women covered by Medicaid to obtain consistent, quality, obstetrician care throughout their pregnancy to help babies be healthy from the start.

51% of deliveries in North Carolina are covered by Medicaid. That figure represents a huge opportunity to make a difference for the next generation and a huge potential for health care savings.

Through our network at CCWJC, 22 pregnancy-medical-home OB practices use risk screenings to identify the most high-risk pregnant women. Working together with our provider partners, OB care managers can steer the expectant moms' health back on track and give them a valuable medical resource to draw on from conception to delivery.

Our work doesn't end at delivery. In addition to making home visits and supporting moms during the pregnancy, care managers check in on Mom and Baby after the birth to ensure they receive postpartum care.

The hard work has paid off. We are seeing results and decreasing the percentage of babies born with low birth-weights. Our programs and partners have a real impact on our most important metric: happy, healthy babies.

SPIRITUAL CARE

TAKING CONTROL OF HER FINAL PLANS

Meet Rennie

It's never easy to think about death; in fact, most of us put it off until it's too late. t's never easy to think about death; in fact, most of us put it off until it's too late.

With three children, four grandchildren, and nine great-grandchildren, Rennie is the matriarch of a strong family. Although she isn't planning on leaving God's green earth anytime soon, she also doesn't want to leave her family in the dark about her end-of-life wishes. After a cardiac scare landed her in the hospital for 24 hours, Rennie knew it was time to get her final plans in order.

> *"I've seen too many families go through too much trouble when a loved one dies. I don't want my family to have to go through that."*

Once she returned home from the hospital, CCWJC's Spiritual Care program reached out to Rennie to set up a will, medical power of attorney, and an outline of her advanced directives to help her family make medical decisions in case she is unable to. Never charging her a dime, CCWJC's Joi Williams came to Rennie's home to help her complete the forms and get the signatures she needed to make it legally binding. Before she left Rennie's home, Joi had scanned the documents into the CCWJC Provider Portal, a database accessible by all Wake and Johnston County hospitals. Any medical caretakers Rennie is likely to encounter will now know her wishes.

It's hard for anyone to think about such important decisions, but it's sometimes impossible for low-income populations to get access to attorneys or learn about the resources available. Because of CCWJC's Spiritual Care program, needful people have access to important end-of-life services regardless of their ability to pay.

"This is something I needed to do for my family," Rennie explained. "The Community Care team had such a personal touch. It feels good to be prepared."


This is something I needed to do for my family. It feels good to be prepared.

Reaching people where they are.

When there's a commitment, such as we have, to reaching people before they go to the hospital or before their conditions worsen, that means going where they are. We do just that with our Spiritual Care and First in Health programs. Both programs have the same approaches, but they are designed for different audiences.

SPIRITUAL CARE

We believe all people, regardless of religious preference, deserve high-quality health care. In our Spiritual Care program, we focus on holistic care just like we do for all of our clients. The only difference is from where we reach out to them.

Our Spiritual Care coordinator is a clinical chaplain trained to address the spiritual and emotional needs of patients and their families. She connects our clients to and collaborates with local faith communities to bring resources, education, and awareness to their parishes.

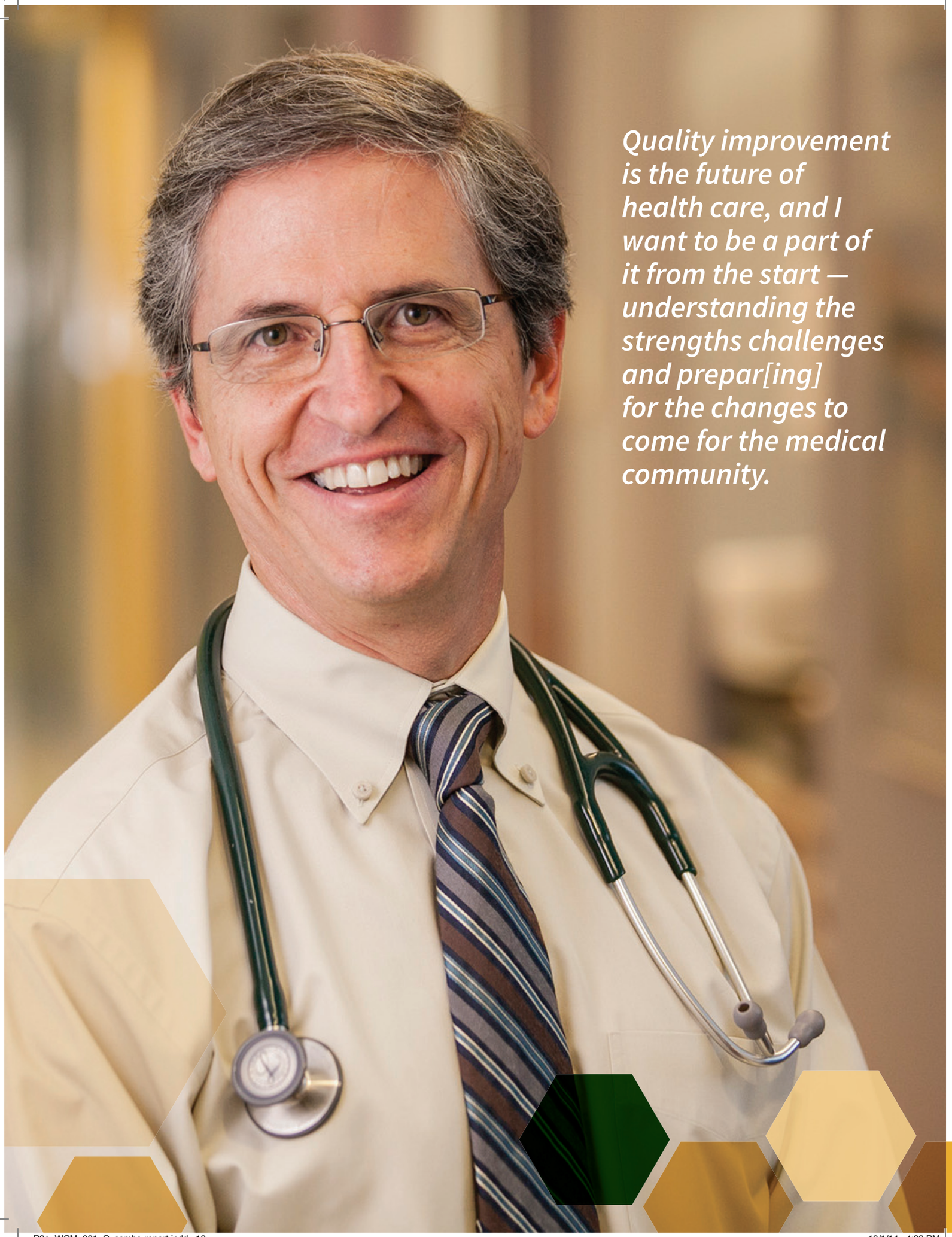
The biggest impact we've seen from the Spiritual Care program comes in the form of cooperation between our coordinator, the patient, and their family when palliative care and end-of-life care planning in needed. Our Palliative Care Initiative walks families through the end-of-life process with the utmost sensitivity toward their beliefs while ensuring their loved ones receive the best care to make them comfortable.

FIRST IN HEALTH

It's no secret that many of us spend more time at work than we do at home. In 2013, CCNC created an innovative partnership with GlaxoSmithKline (GSK) to test out a medical home model for their employees. This is the first public–private partnership to bring models developed for the Medicaid population to private employers. We're excited to bring our years of expertise to this new population.

The medical-home model for GSK employees works the same way as our model for other patients. We aim to get illnesses treated through primary care, or specialists if needed, thus reducing the number of hospital visits and stopping small health problems from turning into large ones. In addition, we reached employees where they are by bringing our nutrition and wellness classes to the workplace.

We're proud to announce that we've enrolled 1,700 GSK employees and have 86 participating primary care practices. We believe in this model and believe it could be the new way businesses improve their employees' health and lower health care costs.


Quality improvement is the future of health care, and I want to be a part of it from the start — understanding the strengths challenges and prepar[ing] for the changes to come for the medical community.

QUALITY IMPROVEMENT PAYS OFF

Meet Dr. Robert Ferrall, Western Wake Pediatrics

Because of the dedication of local providers, quality improvement (QI) programs are raising the level of health for all patients in Wake and Johnston Counties. Providers engaging in QI programs are given the tools to meet higher standards and improve the care of their patient population. With a well-trained staff, access to evolving technologies, and a network of professionals dedicated to improving health services for patients, such programs create the foundation for a healthier community.

Dr. Robert Ferrall is bringing that level of success to his practice and patients in Wake County. Seven years ago, with the help of CCWJC, he achieved Patient-Centered Medical Home recognition from the National Committee for Quality Assurance for his practice, Western Wake Pediatrics. Since then, he's moved his clinic further up the ladder of quality improvement, becoming more engaged in the program and services CCWJC provides.

Community Care of Wake and Johnston Counties has been there to help Dr. Ferrall every step of the way toward QI. The steps to achieving QI certification can be difficult to navigate, but CCWJC has identified areas where providers can be supported. Dr. Ferrall relates, "CCWJC has been very helpful in facilitating the certification process and making sure my experience was a smooth one."

Throughout the QI process, Dr. Ferrall's practice identified a need for a dedicated asthma clinic for more specialized care outside of regular appointments. His practice is now able to provide more in-depth quality of care, complete with follow-up appointments and personalized education with a nurse practitioner.

While the QI process is never finished, Dr. Ferrall has seen an uptick in bottom-line benefits. Beyond the practical benefits of increased reimbursement from private insurers, Dr. Ferrall's practice also receives ongoing training for his staff and access to in-depth data and research. He's made connections with fellow providers in the region and has found new ways to better his practice and care for his patients.

"Quality improvement is the future of health care, and I want to be a part of it from the start—understanding the strengths challenges and prepar[ing] for the changes to come for the medical community.

"Not only has my practice benefited from a well-trained staff and more access to information, we have seen an increase in patients served and a cost savings with increased insurance reimbursements.

> *"Having resources like those provided by Community Care are a vital asset to our community's success. Wake County's children are healthier because of it."*

We are your partners in care.

PROVIDER SERVICE AND QUALITY IMPROVEMENT

Providers are the engine of our programs. They are on the frontlines with us to help our patients learn the skills they need to become healthier. The goal of our Provider Services Team is to encourage a higher level of collaboration between providers and improve quality for all.

With an eye on data and a strong focus on patient outcomes, we formulate ways to support providers in following the best practices and activities that deliver higher quality of care and effective cost management. We also look at the whole picture and provide necessary tools that make it easier for practices to navigate the complex Medicaid system.

Our team is trained in the science of QI and helps practices apply that methodology to a variety of clinical areas, while making the improvement sustainable and financially viable. In the past, we have worked with practices on improving their transitional care workflow and asthma and diabetes chronic-care models. We've helped providers achieve Patient-Centered Medical Home (PMCH) recognition and meet Meaningful Use requirements with their Electronic Health Records (EHR) and have focused on pediatrics and preventive care with our CHIPRA program.

North Carolina was one of nine states to receive additional federal funding for focusing on improving the quality of care for children.

In addition to practice-based QI, we engage the community in care by collaborating with community partners like the County Department of Social Services and the Division of Medicaid Assistance Managed Care. We also link providers with community and educational resources for their patients.

The result is a higher standard of care for patients, meaningful relationships established between patients and providers, and reduced healthcare costs for the whole system. We believe this new model of health benefits patients and providers alike.

CAPITALCARE COLLABORATIVE

When a healthcare network comes together, the result is phenomenal.

ABOUT THE CCC

It takes a strong foundation to create lasting change, and that's exactly what we've done at CapitalCare Collaborative (CCC). Through community partnerships and our innovative programs, we've brought together stakeholders—hospitals, health clinics, and local government—to improve the health of Wake County's medically underserved citizens.

Our goal was to fill in the holes in our community's healthcare safety net. In the process of meeting that goal, we devised systems to connect people to the various agencies that serve the uninsured and to support them along the way. Once we were all speaking the same language of care, real magic happened.

Our holistic approach, in which we surround our clients with the resources and support they need along with an extra human touch, is what sets us apart. Our impact on people's lives has been profound, and the monetary value to Wake County hospitals from improved health and reduced hospital visits is estimated to be about $1 million a year in savings.

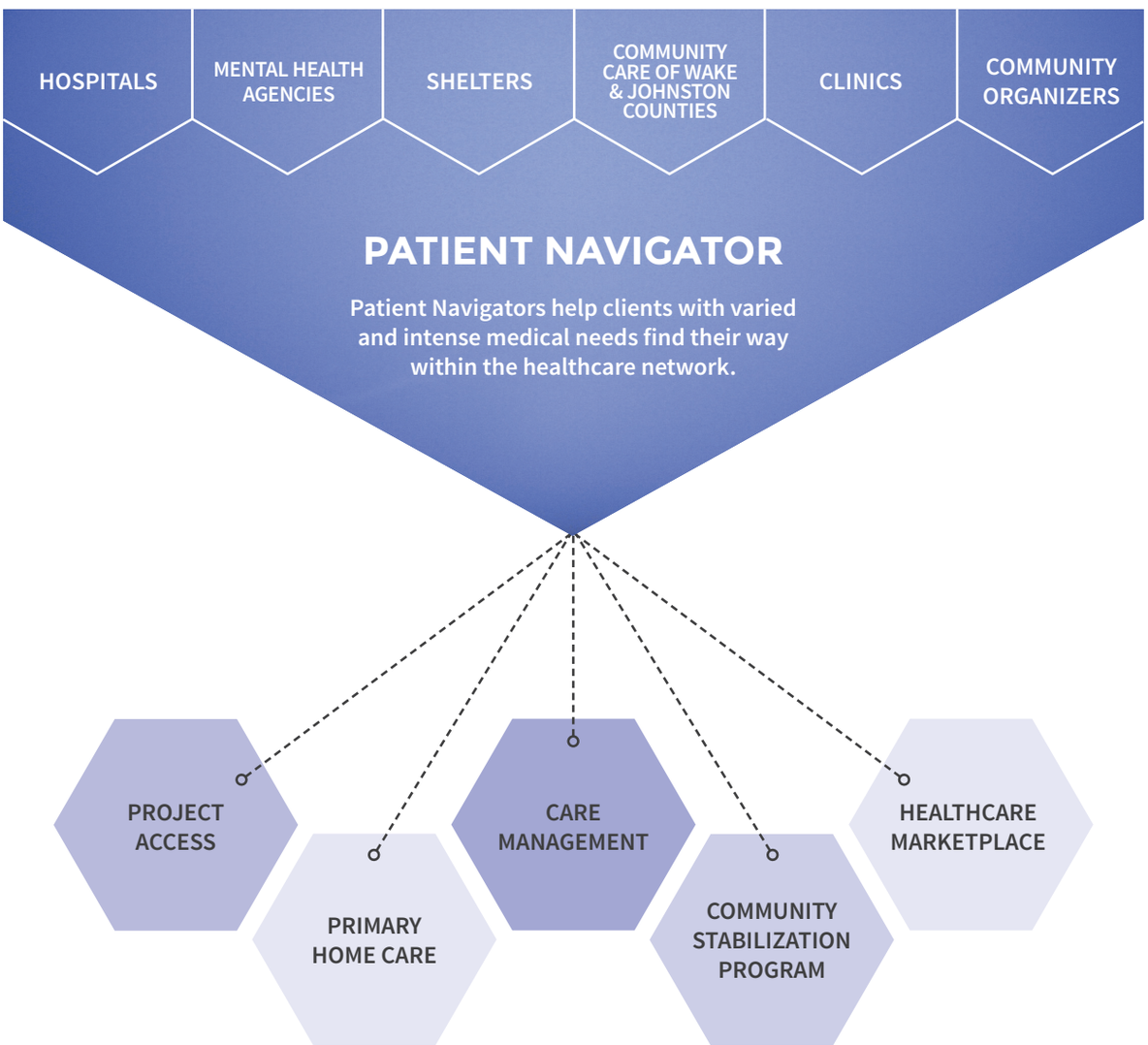
The stories in the next pages illustrate our impact and what that has meant for Wake County's medical network. Read on!

HOW OUR APPROACH WORKS

At CCC we use an informed approach that utilizes medical systems, referrals from partner agencies, and the impressive experience of our Patient Navigators. They take clients with varied and intense medical needs, and a healthcare network that is often complex and difficult to navigate, and make it work for both patient and provider.

They are the hub that makes healthcare work for our clients.

Sometimes all a client needs is information, encouragement, and a bit of direction, while others need more guidance and support to find their way in the healthcare realm. For the latter, we help them continue their journey to find the services the need through CCC programs that have a proven track record of success.




I see others suffering from the same illness, and I want to help them. I want my experience with lupus and CapitalCare to be a blessing to someone else in need.

CASE MANAGEMENT

ONE STEP AT A TIME

Meet Marzella

Marzella just wanted to get back to work, but her health stood in the way, stopping her from fulfilling her own desire to help others.

Diagnosed with lupus over a year ago, chronic pain and depression plagued Marzella. She couldn't get out of bed most days. After yet another visit to Duke Raleigh Hospital's ED as an uninsured patient, she connected with CCC's Case Management Program and now has a partner on her road to health.

Previously, Marzella visited the ER several times a year, hoping to receive treatment for her many health issues. She didn't have money readily available for doctor's office co-pays or medical bills; the ER seemed to be the only resource for treatment where she wouldn't have to worry about payments until later.

With her husband holding down a regular job, it was hard for Marzella to qualify for Medicaid. Because of her disabling medical condition, she had to leave her career as a nursing assistant, and they couldn't afford private health insurance.

Although her medical problems started with lupus, Marzella's health profile is complicated. She takes around a dozen pills a day to manage a myriad of conditions and help her feel better. For a chronic disease with many symptoms, a one-size-fits-all treatment is no solution. With help from CCC Case Manager Anthony Vance, Marzella coordinated a comprehensive care plan to treat each of her illnesses properly and effectively. Her primary care provider also referred her to the CCC's Project Access program, and Marzella now has access to the specialists she needs to treat her medical conditions.

As an uninsured patient, assessing your medical needs and coordinating multiple doctors and medications can be a daunting task. Case Managers like Anthony guide their clients through this difficult process and show real results. As Marzella explains,

"It's been hard to find anyone even interested in my situation, but Anthony is. He does regular check-ins; he genuinely cares about helping me get better."

With Anthony and the CapitalCare Collaborative team's help, Marzella is getting back to the life that she loves. A healthier lifestyle, medication, and stress management have all brought her lupus under control. A year after not being able to get out of bed due to pain, Marzella starts each morning by walking two miles with her husband.

She's working toward being well enough to return to employment and is anxious to meet her second grandbaby this fall. After getting on top of her health struggles, she has a newfound determination to better herself and help others.

Blazing the trail to create health for all begins with knowing the right direction.

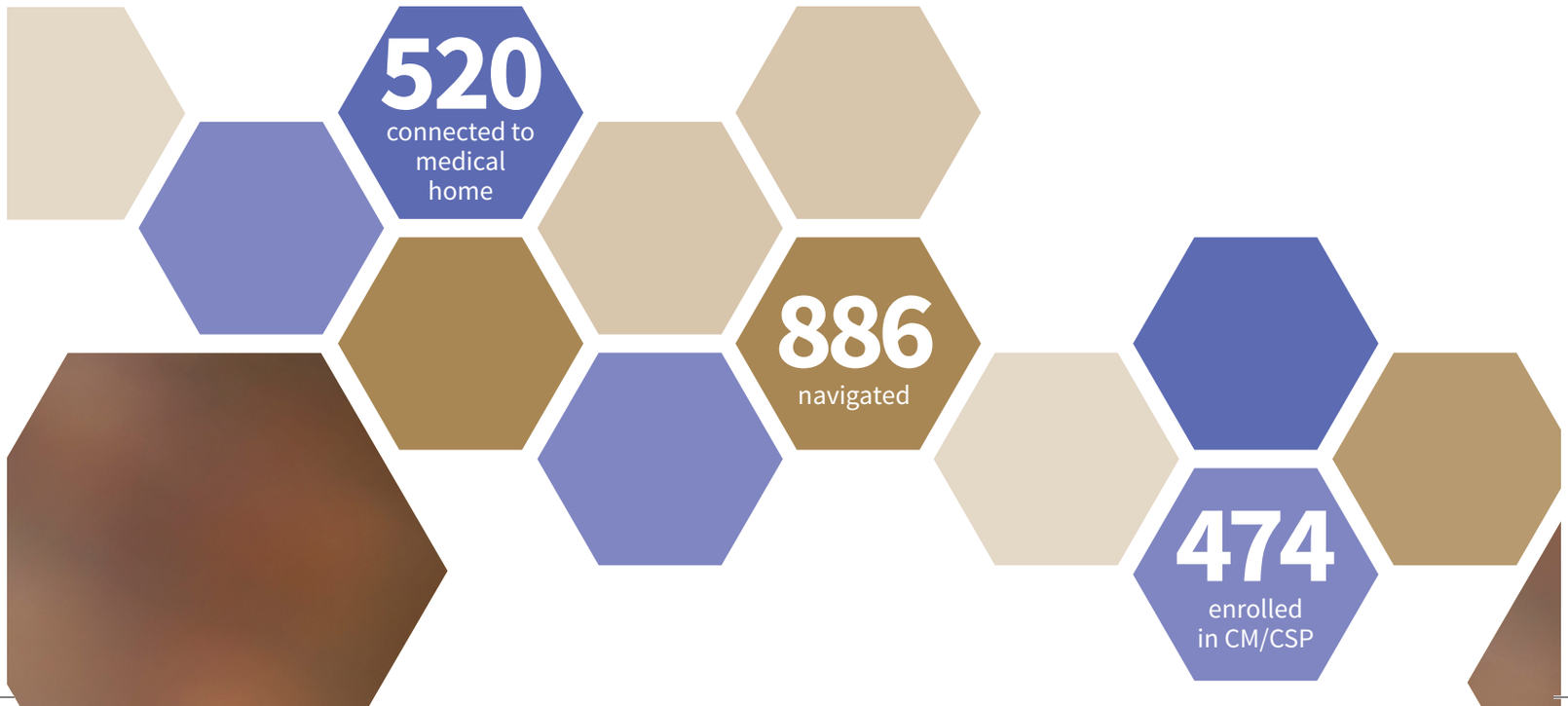
PATIENT NAVIGATION

Sometimes the hardest thing in health care is knowing whom to turn to. Our **Patient Navigators** help illuminate the path to care and end the cycle of ED visits for non-emergency care or for worsening conditions that could've been avoided with access to medical care, medication, and preventive services.

Our biggest goal is to connect our clients with a medical home. Without a home base for their health, those without health insurance either live in doubt about their care and let chronic conditions go untreated, or they go from crisis to crisis in the ED. That's no way to manage health for the patient, the community, or the overall health system.

The CCC stepped in with a commitment to identify and use all resources available to connect 520 at-risk patients with high-frequency ED visits to a medical home—exceeding our goal by 15%.

This result is tremendous for both patients and providers. In the last year alone, we've moved many clients out of the crisis cycle for their health care and into long-term management and proactive prevention to treat their illnesses. For providers, the numbers are simple and powerful: ED visits for our clients were down 53% and inpatient admissions were reduced by 77%. The bottom line, in dollars, comes out to an estimated $1,000,000 in savings for Wake County's medical system. This is care that works for all.



"Nothing makes us feel better than positively affecting the oral health of our patients. It is our duty to provide dental care for the underprivileged in whatever small ways we can because we believe that smiles are contagious."

— Mark Wainright, DDS

PROJECT ACCESS

Project Access physicians generously donate their time to provide a much needed service for our clients. Specialty and diagnostic care are two of the most challenging types of health care for our clients to acquire. Lack of knowledge about available resources and how to access them, transportation to offices, understanding of their medical conditions, and financial barriers all conspire to reduce access to specialty and diagnostic care for this population.

This year, nearly 500 physicians donated critical specialty care to help our clients. In that time period, 3,987 people received the services and care that had been out of reach to them for so long. Those treatments included surgery, knee replacement, chemotherapy, MRIs, psychiatric sessions, and even dental procedures—life-changing and life-saving care. Project Access was the catalyst for their journey to healthy practices.

We believe the numbers speak for themselves:

- 500 participating physicians
- 3,987 patients served
- $15 million in donated care

WHAT'S NEXT

We are so excited to announce that dentistry, one of the greatest medical needs for low-income adults in our community, is coming to the Project Access program. We began working to fill this client need in 2013 and are currently recruiting dentists willing to provide dental services in their offices. We have also partnered with the Wake Smiles dental clinic to recruit clinic dentists and connect clients to their services.

We look forward to expanding this program and offering it to more clients in 2014, with a goal of 25 participating dentists by the end of 2014!

Patients served:
3,987

500
participating physicians

$15
million
in donated care

COMMUNITY STABILIZATION

(RE)STARTING THE JOURNEY

Meet Kevin

What if everything you had ever worked for was gone? Your career, your home, your health? That is exactly what happened to Kevin. A cancer diagnosis started a downward spiral that took everything away. He finally hit rock bottom this year, living in a shelter, and is now starting to put his life back together.

That life was picturesque. A senior systems engineer at a major health-insurance company, Kevin had a 4-bedroom house with a basketball court to play hoops with his three kids. It was a "normal" life.

But a diagnosis of Hodgkin's lymphoma in 2007 hit him hard. During treatment, he had to resign from his job. A follow-up diagnosis of severe cardiomyopathy left his heart weaker and weaker. He now has a pacemaker to kick-start his heart and maintain regular heartbeats. The removal of a tumor in his back left him with chronic back pain that makes it hard to get out of bed some mornings.

Kevin's health wasn't his only battle. A lifelong addiction to alcohol reared its ugly head. As he described it, "When I had physical, emotional, or spiritual pain, I drank."

His goal has always been getting back to work, but the rollercoaster of problems with his health and succumbing to his addiction set him back every time he tried.

Then something clicked. Kevin didn't want to live that way anymore. He moved to North Carolina in early 2014 to be closer to his sisters and father, checked himself into detox, and started walking his road to recovery.

Kevin was referred by a local hospital to CCC's Community Stabilization Program (CSP) embedded at the South Wilmington Street Center. Through the CSP, Kevin was provided with a dedicated medical bed to aid in stabilizing his condition so he could move forward again with his life. He explains, "They were vital to getting me walking on the right path."

Dave and Tara, case managers with the CSP, worked closely with Kevin to understand, develop, and meet his goals. The CSP team connected him with a primary care home, ensured his access to and supply of medication, helped him make and keep regular appointments with a therapist, and connected him with local support group meetings and resources such as clothing, meals, locks to secure his valuables in the shelter, and a 31-day bus pass for transportation to his numerous medical appointments.

CSP helped Kevin navigate the services available through Wake County, and later, to apply for health insurance through the Affordable Care Act. Kevin's gratitude is plain: "They were always there for me, giving me an open ear and concrete advice."

Kevin is now moving into a 2-bedroom apartment in Cary. He's back to building computer systems for his brother-in-law's company, often taking advantage of the free Wi-Fi at local coffee shops and indulging in his remaining vice—a good cup of coffee.

As Kevin says, "I'm so grateful for CapitalCare. They helped me see the pathway out. My new apartment represents a place where I can start rebuilding my family. This is a new chapter in my life."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Rolling up our sleeves to do the hard, and rewarding, work.

Our Community Stabilization Program (CSP) has always been about connecting clients to the right care and the right partners on a one-to-one basis. This year we've continued our hard work – ensuring that nearly every client that we work with is connected to a medical home.

Our CSP team works tirelessly to connect homeless individuals who have been hospitalized with acute medical needs to medical care and behavioral health services as well as to basic resources like medication, food, and housing.

This one-on-one approach has reaped rewards for patients through better quality of care and life. To assist providers, we navigate the clients' needs between appointments, checking in on their shelter or home-health needs and providing a conduit of expertise on the complex medical system.

GOING BEYOND

The Community Case Management Program coordinates and evaluates services needed for our uninsured clients with ongoing medical and behavioral health conditions. Our approach to clients and the community is a big part of what makes us special. Using strategic and successful patient-care models, our community case managers have made huge strides in outcomes for patients and in the bottom line for providers.

What we've found to be the secret to our clients' successes is the little things that end up actually being big breakthroughs. Our clients get to appointments on time because they have learned the importance of getting care and keeping appointments, we routinely remind them of appointments, and we arrange for or provide transportation until longer term transportation options can be identified. They take their medications correctly because we're educating them on the benefits and checking in to make sure they do and introducing them to evidence-based self-management programs. They get healthier because health is a process and we're helping them create positive habits today for a better tomorrow.

> *We do it because it's the right thing to do for our clients and for the providers.*

AFFORDABLE CARE ACT RESULTS

The biggest change in the healthcare landscape in the past year has been the Affordable Care Act (ACA). For so many of our clients, the Act represents something that was simply unattainable in years past: quality, affordable medical insurance.

As we see it, the catch is a medical system that's as complex as ever. Upon ACA's passing, our community's citizens not only needed help signing up, they also needed to understand what it meant for them.

The CCC has long had a focus on increasing access to health care for the uninsured, so when the opportunity arose to join a consortium applying for federal funds to employ Marketplace navigators, it was an easy decision. This initiative fit well within our mission, and because of our partnerships and collaborations, we were confident we could play a key role in connecting people with affordable, comprehensive coverage.

Our involvement with the ACA in North Carolina started early on. We collaborated with other organizations to lead the charge on consistent messaging and coordination of community outreach efforts. We also worked with our organizational partners to gain the most reach for that messaging as possible through their networks. In addition, the CCC became a Certified Application Counselor (CAC) Organization. This allowed CCC staff to become trained as CACs so they could better assist uninsured clients.

During the first open enrollment period (October 2013 through March 2014), we

- provided education and outreach,
- explained how the subsidies work and what the Medicaid coverage gap meant, and
- assisted approximately 2,000 individuals with ACA questions and 1,000 with in-person enrollment assistance.

Once open enrollment ended, we got to work educating the community on the special enrollment period options and providing resources to connect the newly insured to preventive and primary care using their new insurance.

We're proud of our ACA work and happy to see that so many of our neighbors now have access to quality health care.

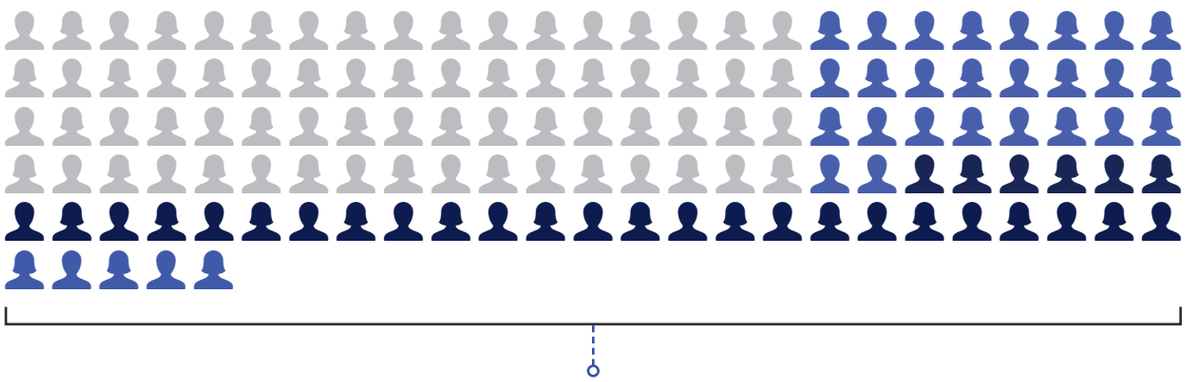
After ACA: The safety net is as important as ever.

The ACA was a huge boon for thousands of Wake County residents who didn't have access to quality, affordable health insurance. In 2013–14, we made great strides in enrolling our uninsured neighbors.

Not everyone has benefited from the ACA, though, and there are still many who are too poor to receive subsidies for their insurance and can't afford a policy premium without assistance.

Where does that leave us? The bright spot is that many North Carolinians have more health security than they did a year ago, but many others have been left out of the new options and are at risk of falling through the safety net.

We are here to pick them up and make sure quality health care is available to all.

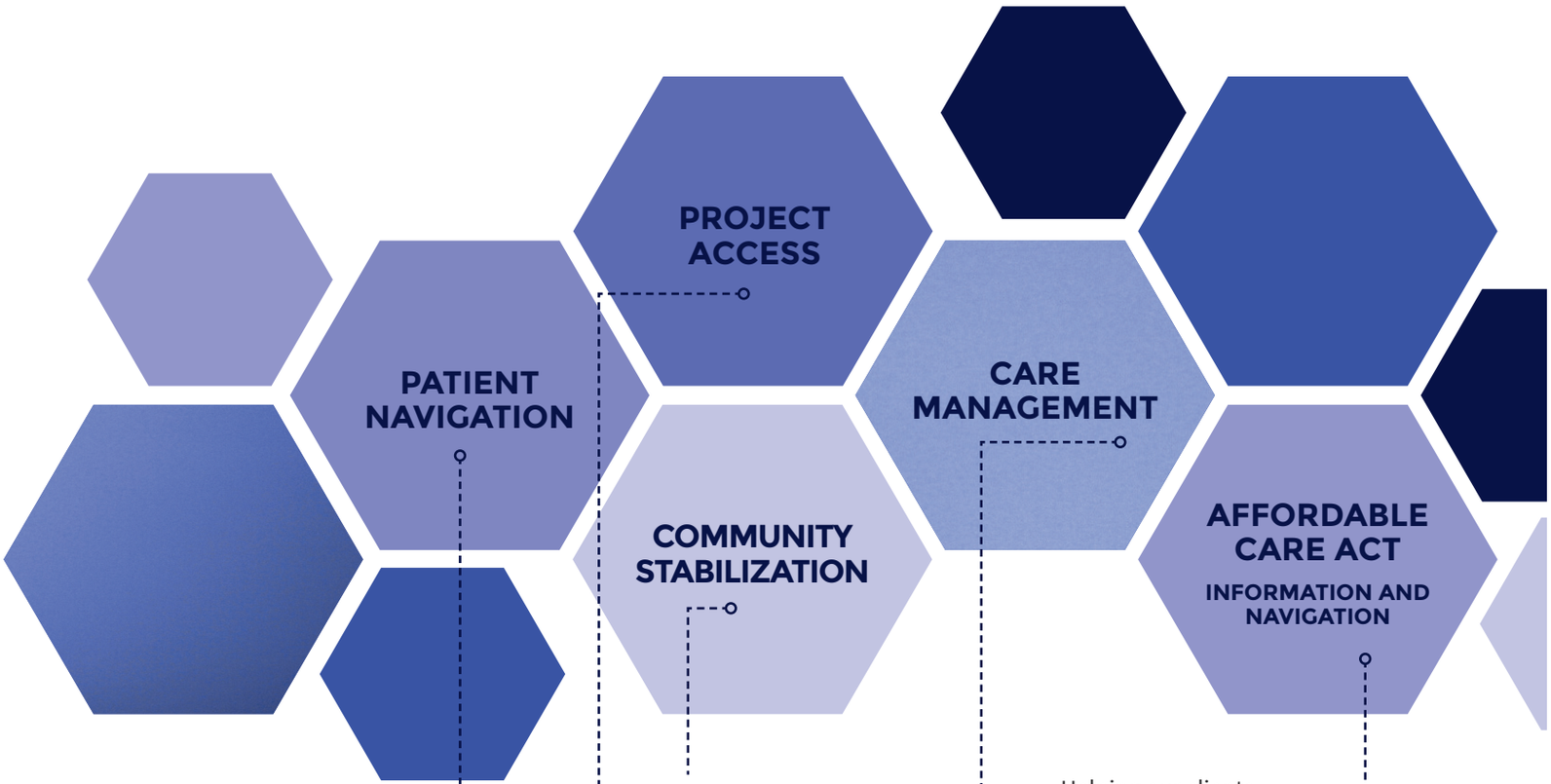


130,000 were uninsured in Wake pre-Open Enrollment 2013–2014.
Of them, and **26,000** were in the coverage gap
Of them, **35,000** are estimated to be newly insured.
Less than **10%** of that group did not qualify for a tax credit and more than 90% did.

74,000 adults are uninsured
and ineligible for premium tax credits

Of the still uninsured, **25,000** are
being seen at safety net clinics

WHAT WE'RE DOING.



Guiding clients to a medical home while saving money for the health system through increasing efficiencies and interventions.

Working with our extensive provider network to bring specialty care to the underserved populations.

Improving quality of care and creating new possibilities for our homeless clients while reducing the strain on area hospital EDs and inpatient units.

Providing a one-on-one enhanced level of support with a personal touch that shows clients the way forward to a healthy future.

Helping our clients receive affordable, quality health insurance through our education and outreach efforts.

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