Community Health Partnership

Learning History

Clara Kyle is seated next to me in the Near Northwest Neighborhood Center, a two-story house on Lincoln Way Avenue in South Bend, Indiana. There are two 10-speed bikes in the meeting room, leaning against the wall, across the floor from our folding chairs. It is 8:30 in the morning; the air is already hot and will soon be steamy.
"I tell them that today is their lucky day," Kyle says to me.
On the wall across from where Clara and I sit is a sign that forbids cursing, fighting, smoking, weapons, drugs, destructive behavior, alcohol, touching of the opposite sex in a wrongful way, name calling, running, negative behavior and pets. The same wall tells those who visit to be kind to each other, to enjoy themselves and to have fun.

Eleven percent of Indiana's population is without health coverage at any given time; 85% is uncovered for less than two years, 50% for less than half a year. Extrapolated to St. Joseph county, approximately 27,500 people in St. Joseph's county are without coverage as you read this.

"This neighborhood has been flyered, but nobody's gone door-to-door yet," Kyle says. "When you ask people if they've seen the flyer, a lot of the time they remember it, but that's all. The flyers might get people interested a little bit, but they don't get you many phone calls. To get people to phone you, even about something like free health care coverage, you've got to talk to them face-to-face."

As the other volunteers come into the room and sit down, Janine Chambers passes out materials. She is the project manager of Community Health Partnership (CHP) and in charge of this morning's outreach activity; she is, however, more closely linked to organizations on the city's southeast side, and she defers to the Executive Director, Todd Zeiger, and to the Outreach Manager, Delores Harrison, who welcome us and explain the boundaries that have been set up, which streets we'll cover, how far north to go, how far west.

"Introduce yourself," Janine tells the dozen people in the room. "Smile, state your purpose, don't explain the program at length, just give an overview and ask if they're interested in follow-up. If they are, get their name and phone number. As a general rule, don't go inside. Sometimes the elderly will not want to stand in the doorway and will invite you inside. Decide case by case."

Barriers to health care:
Employer doesn't provide health care plan
Employee can't afford employer's health plan

Individual in transition between jobs
Individual not qualified for government assistance

We pair off and take our clipboards, our flyers, our maps out into the neighborhood. Clara and I and a man named John have been assigned to Sherman St. John takes the east side of the street, Clara and I the west. The first porch we walk onto is guarded by a white stuffed bear that is leaning against a porch pillar. Before we can knock on the door, a young woman comes out. She is dressed in a hospital-white uniform.

CHP has four primary goals:
Increase access to care for the uninsured
Improve coordination through an integrated social case management model
Improve the health status of a designated population through primary care
Create a replicable model for community-based health care delivery reform

"Hello," my partner says, "I'm Clara Kyle. I'm going around the neighborhood today, talking to people about a program called CHP that's giving away $10,000 of health coverage. Have you heard of the program?"
The woman says she hasn't. She locks the front door behind her.
"WhatÆs your name?" Clara asks. I worry that the woman might be offended by Clara's approach, and it occurs to me that the woman would be justified in pushing us off the porch. She doesn't. She tells us her name.
"Do you have health coverage?" Clara asks.
"I have insurance through my job," the woman says.
"Great," Clara says, handing over an orange-colored flyer. "If you know someone who needs health coverage, ask them to call this number."

CHP Partners
Memorial Hospital
PARTNERS Health Plan
Southeast Quality of Life neighborhood organization
Turning Point

The woman takes the flyer and walks with us toward the street. She and Clara talk while I look across the street at John on the front porch of a one-story brick house. "I'm not selling anything," he yells to a man on the other side of a screen door. "I just want to talk to you about a program for free health coverage."
"What?" the man calls back, leaning forward slightly, closer to the door, turning one of his ears toward John.
Clara and I go to the next house. No one is home. At the third house we meet an elderly man who has Medicare and a private, supplemental insurance. He is angry that the supplemental insurance doesn't want to pay the claims he has submitted. "I called them and they said that the charges didn't qualify. I asked them what did qualify. They gave me the run-around."

At the next house the woman who answers the door has insurance, but her daughter does not. The woman takes the CHP information and tells Clara she will talk to her daughter when she gets home from work.
We go an entire block without meeting anyone who qualifies for the program. Many of the residents are elderly and have Medicare, the others we talk to already have health coverage. No one is at home at half of the homes.

Qualifications for CHP
Ineligible for government assistance such as Medicaid and Medicare
Family income less than 200% of poverty level
Assets of less than $50,000
Unable to access employer-provided coverage
Health screening
Resident of St. Joseph County

At the first house on the next block, a woman answers our knock by leaning out a second-floor window directly above the front door. She is in her bathrobe, and I wonder why we have begun the canvassing so early in the morning. The woman says she has just begun to work for the city,

and she has health coverage. Clara explains the program anyway.
The woman, her arms resting on the sill of the window , tries to think of someone she knows who would be interested. Clara and I stand on the doorstep, looking up, like a pair of door-to-door Romeos. The woman tells us to leave our information in her mailbox. She'll pass it on.
I have read that 46 million Americans are without regular health coverage, and I'm surprised that we're having difficulty finding one of them. For those 46 million, acute care and primary care are often identical. Most of those 46 million Americans are high school graduates, most of them work and most of them are struggling, stranded between Medicaid and employer-provided insurance.
They are the Americans that President Clinton spoke of when he proposed health care reform. But his program was too ambitious, stepped on toes, turned too widely in the halls of congress and was eventually seen as impossible to feed and house. The reform effort lumbered off to die, but the 46 million Americans remained behind, ignoring the disquieting lumps, bouncing aspirins off serious symptoms and not quite getting their children in for regular check-ups.
The initial planning for CHP identified the following as necessary elements:
Hospital as basic resource and provider
Physician provider network
Neighborhood resources such as schools and community centers
Insurer/Administrator
Financing
Staffing

They are the people that we want to link to CHP, a hospital-funded effort to provide for the health needs of the working poor, on a small scale, locally, as a pilot program, serving those between affluence and government assistance; those who otherwise wait out an illness, watching it, hoping it will expire; seeking treatment long after it would be most effective.
The Community Health Partnership wants to change that expensive, acute-care, hope-for-the-best-and-treat-the-worst behavior with a safer and less expensive model.
Begun in 1994, CHP provides 2 years of health care for people who would otherwise skip routine checkups, ignore the need for health screenings, wait too long to investigate symptoms and too often use the ER as a source of primary care.
In the first three years of its existence, CHP causes the rate at which members use the emergency room to drop 97%, lowers the hospitalization rate 60% and creates an estimated savings of $826,047 to the health care system.

Memorial Hospital tithes 10% of its profit every year to a fund earmarked for community Health initiatives.

Ninety percent of the members served by CHP reported that the program meets their needs, 98% respond positively to the case management part of the program, and 100% say that they'd recommend the program to a family member or to a friend.

In addition, the CHP program crowds together, on a regular basis, neighborhood groups, health care providers and social service agencies. Trapped together, like labor-management negotiators, representatives of those institutions confuse, confront, trouble and frustrate each other. They also discover each other's talents and see health care from different perspectives.
But the most notable result of the program's first years is packed into a word often used by CHP members to describe the program: they call CHP a "blessing."

Lula Quinney, CHP member:

"Unless you haven't had health coverage, you don't know what it's like. You put doctor visits off because you don't have the money. And you feel OK, like I did before they found the

tumor."

In 1992, in the basement of his house, Alan Snell, M.D., is exercising on his Stairmaster. He has just returned from a Healthcare Forum conference at which Leland Kaiser spoke of the need for hospitals to partner with other institutions in the community.

Kaiser called on health care administrators to broaden the circle within which they operate, to leverage their resources, to see themselves not as providers of medical care but as community members. "If you can't safely walk six blocks in any direction from your hospital's front door," Kaiser said, "you're not doing your job."

Snell keeps walking on his Stairmaster. In his practice, he sees patients who are ineligible for insurance or government assistance and who show up in the emergency room needing treatment for preventable conditions. They are people who have no continuity of care, no regular primary care, no pattern of preventative treatments. Snell sees the same thing as he teaches residents at Memorial Hospital. He has spoken about the problem to Philip Newbold, CEO at Memorial Hospital of South Bend. He has also spoken to administrators at PARTNERS Health Plan, a managed care company jointly owned by Memorial and based in South Bend.

Snell steps down from the exercise machine. He is thinking of the tithing program at Memorial Hospital that was spun off of Leland Kaiser's suggestion that health care systems set aside, or tithe, 10% of their profits every year for programs that benefit their community's health. Plans are forming at Memorial to provide immunization services, health screenings, clinic care, congregational nurses and school-based educational programs.

Memorial is bubbling with ideas about spending that money. Why not, Snell wonders, use some of the money to provide health care to the working poor?

Snell contacts Newbold who, through a chance meeting earlier with Mary Cornils, a volunteer trustee for the Not For Profits Foundation, had learned of a program in Minnesota that echoed Snell's ideas. Newbold puts Snell in touch with Carl Ellison, Mark Chambers and Barbara Wheeler, administrators at Memorial who are committed to changing the way the hospital thinks about its relationship with the community. Their discussions flesh out Snell's idea and give it a name: the "Phoenix Project."

They get in touch with the Minnesota program, the Community Health Plan of Minneapolis. That program, sponsored by Fairview Hospital, features $10,000 of coverage, a two-year limitation for membership, case management and administration by a managed-care company.

What are the motivations for initiating a program like CHP

Social responsibility

Create a replicable model

Generate community cohesion

Create a financing-delivery system to deal with future government programs

Good exposure for institutions

Helps preserve tax-exempt status

Mark Chambers: "Alan was making a plea for the medical community to do something. I think he had a clinic model in mind, but he was also thinking about the Kaiser model of using untapped resources, of broadening the circle. So I talked to the people at Fairview Hospital who had run an insurance-type program for people who had lost their jobs and were without insurance. Fairview sent someone down to talk to us. We arranged conversations with physicians and some potential stakeholders. The health care manager that we contacted was Partners and for case management we were talking to an agency that's called Turning Point now but then it was Family and Children's Services, Inc.

"We thought that case management was the one thing that would make this program different from managed care. We felt that the population we would be serving would benefit from the kind of support that case management could provide, health care skills, life skills, that sort of thing. We could have done that ourselves, but we wanted to partner with others in the community. It turned out that there were problems in that partnering model that we didn't

anticipate."

Snell, Ellison, Wheeler and Chambers continue to chart what the program will look like. The circle is widened, admitting Janine Chambers, an administrator at Partners. "Hiring Janine Chambers," says Snell, "was key. She knew what is going on with the initiatives at Memorial, she had the social skills, the experience, and the urge for something new. So we sold the program to Partners as a learning lab."
The decision is also made to make the program available for two years to residents of 2 census tracts in southeast South Bend.
"We picked 2 years," Snell said, "because we wanted a way to stop the hemorrhaging if the plan didn't work. We didn't want to make promises we couldn't keep."
Alan Snell drives to Indianapolis with Carl Ellison to speak with the Insurance Commission: "What we were up to wasn't an insurance plan and we didn't want to be regulated as if it were, so Carl and I went down to meet with staffers to convince them that this wasn't an insurance plan. What we argued was that we were offering a charitable gift. At first they looked at us weirdly, but we explained that we were planning on partnering with a managed care company and that seemed to reassure them. That was after the Clinton reform plan had been rejected, and we were offering an alternative to that top-down model. We knew that we weren't going to make things worse, and I applaud the insurance commission for letting us experiment."

The initial planners identified the following critical success factors
Select physicians with good to excellent utilization experiences
Guarantee 100% withhold return
Apply CQI principles
Monitor outcomes, health status, utilization data to the population before program; similar population not served by the program; and regional, state, or national health status levels

On Dec. 1, 1993, Snell, Wheeler and Chambers meet at Memorial with representatives from Michiana Medical Associates, a physician provider network. A member of the hospital board is also at the meeting to support the proposed program. Phil Newbold speaks about the uninsured: "Nobody sees the uninsured as their problem. Forty two million people and nobody feels responsible because nobody can stand to think about the cost of bringing them into the system, but the thing is they are already in the system. They're using the ER and they're showing up at clinics with acute medical problems. So we spend huge amounts of money on expensive band-aids, quick fixes, temporary solutions to permanent problems. What we don't do is get upstream to solve environmental problems like abuse. Instead we impose a hidden tax on our patients or we pass the cost along to the government. What we're talking about with the Phoenix Program is another way of doing things, a way that's about partnering in the community to help people find their own resources to solve problems before those problems show up in the ER."
The 23 physicians at the Dec. 1 meeting are offered an alternative to the uncompensated care that they are, in most cases, already providing. In the Phoenix program they won't have to pick and choose between the charity cases that come in their door. Instead the physicians will be sent patients screened and enrolled by PARTNERS. The patient will pay a $5 co-payment and PARTNERS will pay the remainder of the cost of the office visit. Physicians began to sign up: 238 will be involved by the end of 1994.

Barbara Wheeler: "In addition to partnering with the docs, we also had to have neighborhood connections. One of the benefits of what we were doing was that we'd be building partnerships in the community.
"We were also concerned that we'd be so overwhelmed by demand that we couldn't coordinate, and that's why we limited the program initially to two census tracts on the south east side. That connection was a natural because we were already involved there. The neighborhood association in the southeast neighborhood, SEQL, was relatively new but we'd worked with

them already, and wanted to include them in this project.
"Then, early in 1994, we realized that we were pretty much ready to go, and no one had talked to the neighborhood people yet. We invited some representatives from the neighborhood to a dinner at the Wharf. We asked Mike Mather, Greg Mitchem, Conrad Damian and others to come.
"It was one of those situations where you know people but you really don't know them. I mean, there were no relationships yet, so there was a lot of 'I don't have any reason to trust you,' on the neighborhood side of the table. Especially since we were contacting them fairly late in the start-up process. There was sort of a 'Oh, so now you're going to check with us,' attitude. Like, 'You say you want us to be partners, but it sounds like you already have this planned out,' which unfortunately was true in a way.
"What made it worse was that the neighborhood had a lot of experience with institutions coming in and doing things to them rather than with them."

The Wharf is a restaurant on the north bank of the St. Joe River, across from South Bend's downtown and just north of the southeast neighborhood. The restaurant features seafood, it's atmosphere is dark, its furnishings nautical.

Mike Mather, pastor of the Broadway Christian Parish in the southeast neighborhood:
"They didn't really know how to approach us. I don't think they even knew what role they wanted us to play. They just wanted us onboard somehow. But it was like they'd gotten the plane up to 10,000 feet and then said, 'Jump on.' It doesn't work that way."

Mark Chambers: "I don't think we knew how to work in communities, in a partnership, I mean, with outside resources. We thought that we were bringing something of value to the neighborhood and we were looking for indigenous leaders. But there was a lot of skepticism at the meeting. I think Mike is wary of a project that comes into the neighborhood but is controlled from the outside. I spoke that night at the wharf and Carl spoke, and there was a slide presentation. And they were excited, but at the same time they had to establish a role for themselves. We talked about things like the exact territory to be covered and who would be eligible for the program. When the question came up as to why the neighborhood hadn't been contacted sooner, we tried to be sensitive to that. We said that we had wanted to get the preliminary work out of the way, and in retrospect, I think that was the right decision. I think we picked the right time to widen the circle."

Sherri Gibson, CHP member:
"One of the greatest things about the program was the prescription card. My oldest child has chronic head pain disorders. She was hospitalized on the plan, and lined up with a wonderful neurologist who continued to see her for nothing after my two years were up. His office calls are $200."

Conrad Damian, high school teacher, resident of the southeast neighborhood, guest at the Wharf on the night of the meeting:
"I moved to the neighborhood in 1969. I've stayed because I got to know people there, and I can afford the house that I live in. I like it there, and I want to help, but I'm skeptical by nature. And I'm twice as skeptical when someone wants to buy me dinner. I went to the Wharf thinking, 'What do they want?'
"Janine Chambers presented slides on the Minneapolis program and she talked about what they were proposing for South Bend. It was a noble goal. I liked that they were focusing not just on health but also on home. But I was worried about entanglements. Would we end up partnered in something for life. They talked about how they were going to do things, and it sounded like they wanted us to rubber stamp their plans. I was noncommittal. They asked if we'd be interested in working with them. There was a lot that I didn't understand, but they had been low-powered, non-coercive. I agreed to work on a panel to review their ideas."

Greg Mitchem, neighborhood advocate, guest at the Wharf dinner: "Here I was talking to some strangers. What are they after? Do they just want to use us for something? We didn't want to be turned into guinea pigs for a project. We wanted to make sure that whoever was put in charge of things at the neighborhood level was someone whose experience wasn't second-hand from the TV.
"We ended up talking that night about our kids and about food and about other things that help you get to know each other a little bit. That's what you have to do if something like that is going to work. Janine ended up asking me to be on a committee and I agreed."

Mike Mather: "Relationships are about talking and listening. I think that's what they have to learn. A hospital can't act outside its doors the way it does inside its doors. They're an institution, we're a community. Working in this community is about failure because that's just another step to learning what to do. That's hard for a system like a hospital to understand."

Janine Chambers: "Mike Mather called me the day after we'd met at the Wharf. He wanted to speak with me, and when we met again, he told me that he wanted Memorial to return to Minneapolis with Conrad and with others from the neighborhood. I told him that I had seen the Minneapolis program and discovered that they didn't really serve the working poor the way we intended. The program in Minnesota served a suburban area because that's where their clinics were.
"I thought that Mike's insistence on sending people there was a way of testing me to see if I was willing to invest some resources in people. I thought that it would be better for all of us to go to Duluth which was another program that we had heard about. None of us had seen that program, and I thought it would be a better use of our time. And while Mike didn't take me up on that offer, I think I had passed his test."
Mike Mather: "I begged Janine to take a group from the neighborhood to Minnesota. I even offered to raise the money, but I was never taken up on the offer, and for the life of me I don't see why not. But despite that, there is progress. In the old days they would never have invited us to be at the table at all. Now we may be late to the table but we're there. And this really is a good idea. It's a wonderful idea, focusing on people who are falling through the cracks, on people who need a helping hand. And using us to get the word out was the right way to go.

On May 12, 1994, the program begins, ceremoniously, at the Southeast Neighborhood Partnership Center. Physicians have been recruited, eligibility defined, staff hired, case management initiated, legal status arranged, target area identified, intake assessment formulated, and discharge procedures established. The partners in the project are Memorial Hospital, Partner's Health Plan, Michiana Medical Associates, Family & Children's Services, and South East Quality of Life neighborhood association. Balloons, punch, cake, coffee, guests, buttons, refreshments, brochures, handshakes, name tags, and smiling speakers launch the CHP. Enrollment begins at the opening ceremony and the number of members rises throughout the first year, but not at the rate that had been expected. The fear of over enrollment was, according to Mark Chambers, "woefully exaggerated."
The program struggles the first year with problems endemic to any start-up venture: office managers don't get the word about billing; members are unable to afford the agreed-upon co-payment; the phone lines that had been put in don't work. Less predictable is a more significant problem: having flung the doors open, having offered $10,000 dollars worth of virtually free coverage, the program discovers that it has relatively few applicants.

Janine Chambers: "The neighborhood representatives saw the problem as one of trust. The southeast side has not had positive experiences with large institutions, and we had this new idea. Plus during the intake we ask personal questions, and the experience of some people is that being too honest can lead to trouble. And people tend to cling to old patterns of behavior, like delaying treatment or seeking care in the ER.

Mike Mather: "I went and talked to (Publisher) Jack (McGann) at the (South Bend) Tribune about the articles they'd run on the way the slow enrollment for the free health coverage. I asked him what he thought the message was when you write about a community that isn't taking free health care? The message is that the people in the community are stupid. And that ignores the fact that people in this neighborhood are used to being ripped off not so much by robberies, but by people showing up and offering a deal that's too good to be true. How are people supposed to know right away that this isn't another one of those rip-off deals?"

In the fall following the kickoff event in the southeast neighborhood, CHP begins an aggressive attempt to "sell" the program: flyers are distributed, TV and radio coverage solicited, presentations made in neighborhood schools, and volunteers - including the CEO of Memorial Hospital - work the neighborhood door-to-door.
The results are disappointing. Enrollment still lags behind expectations. A program that has been set up to serve 300 people is, by October of 1994, serving only 70.
From October 1994 to January 1995, the program pays neighborhood residents to go door-to-door. Bonuses are awarded for sign-ups and for following up with phone calls.
By January, enrollment has risen to 135. After the first of the year, mass mailings and promotions are added to the mix. Enrollments continue to increase, and by the end of the program's first year, 215 people are being served.

South Bend Tribune Editorial: "What if someone offered virtually free medical care and no one took them up on the offer. That nearly sums up the experience of Memorial Hospital . . . in South Bend's near southeast side. Qualified residents there have been extraordinarily slow in signing up for the program. . . . Qualified individuals who take the time to study what they are being offered should snap up this opportunity."

Janine Chambers: "When you're looking at populations in need, certain segments are totally disenfranchised. They can find food and shelter - they can survive, but they don't often have the skills to make the transition to permanent insurance. They weren't the population that we originally envisioned, but during the first year we wanted members and were often signing up the most needy instead of those who had the greatest chance for success.
"By the end of the first year we were beginning to have an unacceptable level of noncompliance. Too many members weren't showing up for meetings with the case manager. Too many members weren't meeting the agreed-upon conditions.
"We began to realize that if we wanted to serve the population that we were getting, the population most in need, we would have to change our model. We would have to put case workers into homes and provide transportation and intensive counseling.
"But even if we had the resources to switch over to that model, two years wasn't long enough for real changes to take place. The model we had originally chosen was designed for a population that valued health coveragethe working poor, and we weren't getting as many of those enrolled as we had expected."

In August of 1995, a year after the program had begun, outreach efforts are suspended. The CHP operations group plans to shift the focus of enrollment from mailings and promotions to school-based educational programs. The enrollments over the next few months come in slowly, almost solely from direct referrals.
By the end of the program's first year, the number of members begins to drop.
CHP appears to be going backwards, and problems with enrollment are compounded by strains in case management. The first case manager has left. The operations group wants more aggressive case management, frequent follow-ups over the phone, and more frequent face-to-face meetings between the case manager and CHP members.
The new case manager tells the operations group that she will stress to CHP members the

importance of transitioning to permanent health care by finding a job that provides that benefit.

Letter to the South Bend Tribune: "[Your] article and editorial play into stereotypes and prejudices about people in the southeast neighborhood. What would have been more appropriate would have been an article focusing on the promise and creativity of two large institutions - Memorial Hospital and Partners health maintenance organization - working with a neighborhood organization to provide health care to uninsured citizens. Word about the program is not yet in every home in our neighborhood - and there is some suspicion about being taken advantage of in this situation. This will be met by spreading of the word by those who are enrolled, as well as increasing efforts by representatives from all these groups. Such efforts at collaboration are slow, but this is building support and trust from the ground up. . . . I hope that in the future Tribune reporters and editors will be able to turn their eyes to such endeavors and see the glass as half full, rather than half empty.
Sincerely, Rev. Michael Mather

The membership of the operations group changes in the second year as Bruce Greenberg, the new CEO of Partners, joins the group: "When I first saw CHP, I thought, 'It seems like a socialist program, and I hate things like that. Nearly 40% of the budget was going to administration and case management. That's a terrible cost-benefit situation.
"The operations group felt case management was such a big part of the program, and nobody wanted to question it, but I lobbied hard against it. I thought that it was intrusive. Nobody wants some white person in an office telling them how to live their life. And when the case manager would talk about making 40 phone calls to a member to set up an appointment and never getting a return call, I thought, 'Why are you calling back so much? If they don't want what you have to offer, fine. I also questioned the wisdom of limiting the definition of 'community' or neighborhood to a specific geographic location."

Janine Chambers: "Some of the confusion at Turning Point came out of the perception that the goal of case management was to get people into jobs. But that's way too huge. We want goals like helping people know how to talk to a placement officer, and we didn't define that clearly enough. We had not thought through what case management should do - to help people clarify, to help them take inventory of their assets, to help them with their own capacities."

WHAT IS CASE MANAGEMENT?

Members meet a minimum of once every six months with their case manager.

The case manager provides a direct line of support for members as they learn to use the CHP program.

The case manager helps members find appropriate resources: entitlements to public insurance, affordable housing, occupational training, and employment opportunities.

Finding and using resources become the goals set by the member.
At each meeting, the member rates the success of their goal attainment and sets new goals.

Conrad Damian: "The thing that troubled me was the split between trying to provide health care and trying to tell people how to live. It would have been better if they'd concentrated on health care.
"When they started doing case management, I think they were surprised at how many people didn't necessarily want to live like them, to move into the middle class; and they might have been surprised at how many people didn't have the skills to make that move.
Pat Hancock, Supervisor at Turning Point: "When the program first started, I thought that they

wanted us to say, 'Get a job.' But they targeted the poorest neighborhood in the city where a lot of people don't have the necessary skills to go out and get a job with benefits.
"And the neighborhood was skeptical because of the perception that this was some kind of government freebie that had strings attached. So even though CHP pushed hard in the neighborhood, some people that were approached didn't value what was being offered. They felt that if the program was good, why was it difficult for us to get people to sign up. Plus the forms that are used are so detailed and there's too many of them, especially the one on health status and needs assessment. One of the questions asks, 'Is it important to you to go on vacations?' Another one asks 'Is it important to join clubs?' These are people living in the southeast neighborhood. They're too busy trying to survive to worry about taking vacations and joining clubs.
"If members go into case management and set unrealistic goals, like getting a job with insurance, they're set up for failure, and they don't want to fail. They don't like the way that feels. So they avoid the case manager if they can, and the first case manager we had felt overwhelmed."

Janine Chambers: "In a community there are resources that people are not aware of, and as you become aware of what's out there, things become manageable. It's the case manager's job to open doors, to turn on light bulbs. The case manager is looking to establish relationships, to discover what links the member already has in the community."

Word of mouth and direct referrals continue to be the main source of enrollment throughout the first half of the program's second year. Membership continues to decline as the number of members being discharged outpaces the number of new enrollees.

John Hagen, Ph.D., President, Health Strategies, Inc., consultant to CHP: "At the end of the first year we had a falling fill rate, so we studied what marketing would do. TV was an option, but the concern was how to handle the response, and how to get requirements across in 30 seconds. Plus we felt that for a program like this to work, a certain level of trust had to be earned, not just claimed. So we started working through schools and we thought of churches as well, but they were somewhat guarded."

Alan Snell: "In the second year, with terminations, we flattened out, but Janine led us in new directions. We went into schools, into churches, and we were aggressive with referrals. Plus we started talking about expansion."
Conrad Damian: "I think the expansion was premature. I think there were still people in the southeast neighborhood who could have been reached. They were actually turning people away who needed health care services."

Cindy Tanner, member, CHP: "I'm self-employed. I have a day care in my home, so I didn't have health insurance. And what I did was doctor my daughter Mikali at home as long as I could. Then I heard about the Partner's program through the school where Mikali goes, and then I was contacted here at home. I joined and now I'm able to get her in right away when she gets sick. And it helps too when the woman who comes from Partners talks to me about some of the other things that are available like the clinic in this neighborhood where they'd treat Mikali. I'm so grateful for this program."

John Hagen: "While the program had intended to target the poor rather than a middle class population, they saw more people than they expected with chronic employment problems; people who were transient or without the skills needed for the program.
"The operations group realized that they had been operating under unreal expectations. Expanding the area they served beyond the southeast neighborhood became an option.
"They were hearing from people literally across the street or a few blocks away from the southeast neighborhood who wanted to enroll but couldn't.

"Ultimately, equity drove the expansion. First CHP opened up to people in neighboring census tracts; then the program started making itself available through certain agencies that served all of South Bend. Agencies that were in contact with people eligible for the program but who didn't live in the southeast neighborhood."

Carolyn Heart, member, CHP: "Getting on the program meant I could finally get a mammogram. I had always put that sucker off because they want $55 up front. With the program I got the mammogram and a wellness check. I even got a physical. And it was more than all that. It was the way I stopped worrying all the time that somebody in the family was going to get sick."

Mike Mathers: "They shouldn't have expanded into other areas until they'd gotten it right here. They expanded their boundaries to get the numbers they wanted, but they could have gotten those numbers here. I had a woman who came to me, interested in the program, she lives right through the alley. She had heard about it and wanted to talk to someone. I asked someone from the program to look in on her. The next day she said, 'This is a great program.' She was right across the street from someone who was already on the program, and she hadn't heard about it yet."

Janine Chambers: "We had tried door-to-door and promotions and flyers, but we couldn't meet our enrollment goals. We had tried media coverage, and there would always be a flurry of calls, but they would mainly be from people outside the southeast neighborhood - people who wanted to enroll and who were qualified otherwise but who just didn't live in the right part of town.
"We were hearing especially from adjacent neighborhoods, and we finally expanded into two neighboring census tracts. That was our first expansion. When we expanded again, we were able to refer back to old phone calls from people who hadn't qualified earlier because of location, and because of that, we got over a hundred new members."
Mark Chambers: "We don't want to throw away the concept of neighborhood involvement, but we came to realize that we would never reach our enrollment goal if we didn't expand. We probably should have opened it up sooner, but I believed, and I still believe, that it's important to let community approaches play out as long as possible. We have to realize that transforming neighborhoods takes a long time, and that if we're interested in helping that happen, it isn't a two-year thing."

By the end of the second year, expansion has taken place and enrollment is no longer an immediate concern. The nature of case management, however, is still unsettled.
Bruce Greenberg, Partners CEO: "I haven't much experience with the population that CHP is serving, but I don't buy that those without health care coverage want to go to the ER just because it's convenient. I don't believe they want to be second-class citizens like that. I think they want primary care just as much as anybody else.
"So I didn't think that we should be spending money on case management that could be better spent on creating more primary care. Take that money that's being spent on administration and counseling and put it into a building, and staff it with two docs. Put the primary care there and people will come to it. And if people aren't taking advantage of case management, stop offering it.
"That's what I argued to the operations group. At least, I said, let's try to test the thing and see if it's of any value. Let's set up a control group. Let's enroll people in the program without case management, and see what their experience is like."

Pat Hancock, Supervisor at Turning Point: "So many people want numbers, and they want things to happen fast, but there are clients who don't want the hassle, clients who you can't rush from one stage to another.

"You have to remember that if you save 10 out of 100 people with case management, you've done something. I had a woman in here the other day who cried for an hour because she didn't qualify for Medicaid. You can't rush her out. But what you do for that woman won't always work right away or show up in the numbers. Sometimes the benefits come much later. First you have to help people get into public housing and arrange utility hookups and counseling services and school enrollment. A goal like getting a job often comes after a lot of other things.
"I'm not saying that getting a job isn't an important goal; it is. But it can't be the only goal, even with the population that enrolled after they expanded beyond the southeast neighborhood."

At an operations group meeting in December 1995, Bruce Greenberg raises the case management issue: "I want to talk about the role of case management. I want to talk about what it's supposed to do and whether or not it is doing it. And I want to talk about whether or not it is so intrusive that it's discouraging enrollment."

Janine Chambers: "Case management has always been one of the components of this program. It's one of the things that makes the program unique."
Case Manager: "That's true, but I don't think the majority of the enrollees want case management or even need it particularly."
Greenberg: "Then why are we doing it?"
L.D. Williams, CEO of Family & Children's Services, Inc.: "Anyone who qualifies for enrollment in CHP, anyone who is in transition, surely needs some sort of case management, whether they say they do or not."
John Hagen: "A focus group response was very positive toward case management. Some of the participants said that they wanted more not less contact."
Janine Chambers: "It's clear that we have to determine the effectiveness of case management. It is a major component of this program, and we need to agree on what its role is."
Out of this discussion will come the decision to authorize research by John Hagen on the effectiveness of case management. One group will be provided health coverage but will not be tracked through the case management program. The satisfaction, the patterns of use of healthcare services and the increase in health status of that group will then be compared to the population that received case management.
Also at this meeting, the goal of 750 members is set. Enrollment will have to double to meet that goal. In February 1996 Clara Kyle is hired as outreach worker. She will be the contact person for the outreach efforts in schools, churches, businesses and in the neighborhoods.

Clara Kyle: "When they hired me, I thought that people would respond to me being trustworthy and honest and sincere. I thought that those things would help me recruit people.
"But when I started, my being sincere didn't make people start showing up for appointments to fill out the application forms. So I started going to people's homes. And if there was a community gathering of some sort, I'd go to that. I was always recruiting. In a grocery store or walking down the street. I'd walk right up to people and tell them that it was their lucky day. I'd tell them that I was going to give them $10,000 of health coverage. I already knew most of the people I saw, or I knew their parents. But still they'd ask me, 'What's the catch?' I'd say, 'There is no catch. Would I be doing this if there was a catch?' Then I'd tell them that I'd even do the first step if they'd just stop over to the partnership center.
"One lady told me that she couldn't come because she had three babies at home, so I went to her. I go to their houses whenever I have to, but I still tell them about all the activities that are available at the partnership center. I tell them about the services, I mean, that are available there.
"The thing to remember is that the people I talk to are struggling to control their lives, and they don't know how to keep appointments. They just don't know how. I call them the night before they are scheduled to see me, and I call them the next morning again, and sometimes I'll stop by the day before and remind them.
"One thing I never mention is charity. I use the word coverage, and I make sure that they

understand that it's not a major medical policy. $10,000 over two years. That's what I say. Then I do the paperwork with them and tell them that they'll be receiving a card and a call from a case manager who will want to meet with them.
"Sometimes they get the case manager on the phone when she first calls them and they're like, 'Who is this?' That sort of thing is why I like to make my contacts face-to-face whenever I can. When I'm done talking to them, I say 'What part of my speech didn't you like?' When I put it to them that way, they become more open. They say, 'Sis, I liked everything you said, and I'm going to go ahead and do this.'"

In July 1995, two years after the program began, its second case manager resigns. Within a month, Beth Ditmire is hired. A file audit at Turning Point improves the organization of the data with which she will be working. The operations group sets clear, achievable goals for Ditmire as the number of members begins to rise, 34 applications in July alone.
The program is now growing at a rate that, if sustained, would double enrollment in a year.
Beth Ditmire's office is on the second floor of the partnership center in the southeast neighborhood. Her door is across from the landing at the top of the stairs. Talk from the reception area rises to the top of the stairs and creates a background, like Muzak, to conversations in the case manager's office, a small room containing a desk and two chairs. No one visiting the office can sit very far from Ditmire: "My job is to provide encouragement. To give people a different perspective on their lives, and ideas on what they can do to improve their lives. That might be something as simple as helping them get better at finding resources.
"I also talk to people about personal issues, family issues. I work with them on the tendency to blame other people for the situation they're in - it's my husband's fault, it's the agency's fault, it's the judge's fault. I try to help them realize that they're responsible for their own future.
"That's not how I start, though. The process starts with the information Clara gets at intake and on the enrollment and medical questionnaire. That information helps me get ready for the first meeting where I tell them how the program will work for them. I do a needs assessment, and we talk about things that were indicated on the survey that they filled out.
Usually when people come in I begin by discussing issues of hygiene or literacy or depression. I look for little steps that a person can take to get started. The final step - getting a job with health care benefits - sometimes can't be done in two years. Sometimes the final step for the member is going back to school or getting the GED.
"Most people are extremely open with me. Many of them have the need to talk with someone about their problems. A lot of the time they want to stay past the time that they've been scheduled for. Other times it's a challenge to build rapport, and I have to be careful to watch for things that the member is not ready to talk about.
"A lot of what I do after that initial meeting is put people in touch with resources in the community. Sometimes a client will not even want to talk about the possibility of getting a job because she's taking care of her children at home. So I ask who else is at home that could help out. I ask where the father is. I ask about child care.
"If they're not considering work because of a disability, I ask them about that. How disabled are they? Have they applied for benefits? Sometimes I refer them to the vocational rehabilitation program.
"Again, a lot of what I do is to get the members to take a good look at what is limiting them and at what resources they havepersonal resources and resources in the community. Then I try to get them to take those first small steps toward making a change.
"When the member exits the program, we do an exit interview to measure their health status and their level of satisfaction."

Rodney Hubbard, a CHP member whose son's severe asthma is treatable by medication that Rodney could not afford until joining the program: "I needed this coverage for my kids. It was a real blessing. I recommend CHP to a lot of people, and I've sent people over to the partnership

center lots of times to apply."

In the third year of the program, a new approach to case management settles in. Members are asked to think about the decisions that they are making and the resources that are available to them, the alternatives, the different ways of thinking about themselves and about their health. During the third year, forms are simplified, data collection improved and individual goals moved closer to where the members are when they join the program. The rate of disenrollment for non-compliance falls. CHP members are beginning to call to reschedule missed appointments, something not often seen in the first two years.
Also in the third year, Clara Kyle reaches further out into the community, into schools, businesses and programs such as congregational nursing; in addition, she links up with referral sources such as Workforce Development Services and the Minority Business Development Coalition. By December enrollment has reached 750.

Christina Pace, CHP member whose daughter has had a damaged ear drum reconstructed:
"They all said she needed a specialist, but [before the program] I just couldn't afford it. Because of the program, I feel I can take my children in to see a doctor before something gets worse. To me it's the community helping the community. You can see who you're helping and you can see it's being used wisely."

As the third year ends, Memorial commits to continued financial support, estimating that at the current rate of growth, the program will be serving 765 members by the end of 1997. By December 1997, enrollment does in fact reach 750. By that time, the enrollment area includes all of St. Joseph County. In fact, demand is beginning to stress the capacity of the program, as Indiana has entered the realm of welfare reform and hundreds of people, usually women, are no longer eligible for Medicaid. A second outreach worker is hired, and a second case manager is on staff. Over 250 physicians/providers are involved with CHP - more than 80 of them primary care providers. Health care providers from outside St. Joseph County and from outside the state are beginning to show an interest in replicating the program.

Bruce Greenberg: "I have learned. I know now that there is a relationship between providing health care and social issues. It's more than just arranging physician care. And others have learned too. They've learned that there's a limited amount of money and that you do have to be flexible. I think we've brought CHP a long way. I think the program has benefitted from a conservative and disciplined business perspective."

Marco Mariani, City Planner in South Bend: "If you're going to help a community, at some point you're going to have to decide if you're going to put your efforts into the physical or the social - into buildings and streets or into people. A lot of times the city has to concentrate on the physical, but thank God there's programs like CHP that can concentrate on people."
Mike Mather: "People used to go to the clinic and wait hours, sometimes most of a day. CHP has changed that. It's made primary care important for people and that's valuable. People's attitudes have changed, behavior has changed."

John Hagen: "The program helps people who don't know how to use the system. We've broached a subject that's larger than number of visits to the doctor: the program is working on larger health care determinants."

Phil Newbold: "You don't get your health through a physician. You get your health through the decisions that you make every day, and CHP is trying to help people make better decisions."
Alan Snell: "We've lowered costs and raised health care habits. We've created value while

using fewer resources."

Janine Chambers: "The people that are doing this all have skills and expertise, and while the organizations they work for may operate differently, each partner brings something of value to the process. The difficult thing is to trust enough that you can open up and receive what other people have to offer."

The northwest neighborhood has gotten hotter, the air more still. Women are coming out onto their porches, laying rugs across railings, setting out sun tea; children, one in a diaper, are playing in front yards; men who are working on cars parked along the curb stop to watch us as we loop down the street, walking onto porches, watching for dogs, knocking on front doors.
"My name is Clara Kyle," Clara tells the woman who opens the next door on Sherman. The trees are fewer here, the sun hotter. We are standing on a stoop covered by a small roof that comes out from the front of the house like a lip. "We're going around the neighborhood today, talking to people about a program called CHP that's giving away $10,000 of healthcare coverage. Have you heard of the program?"

The woman shakes her head from side to side. A little girl is standing next to the woman, holding onto her leg, watching us.
"Do you have health coverage?" Kyle asks.
"I could buy it at my job, but it costs too much," the woman says, taking one of her hands away from the door she's holding open and laying that hand onto her daughter's head.
"What's your name?" Clara asks. The woman gives her name and listens while Clara talks about the program, assuring the woman that there is no catch. The woman tells us that her child has been sick, staying home from school, causing the woman to miss work.
"Then this," says Clara, "is your lucky day."

From the author

CHP is a program for the working poor, for those who cannot get healthcare coverage because it is not available through their jobs or because they can't afford what their employer offers.
CHP is not an entitlement, a subsidy, an act of charity, or an insurance program. CHP is a breathing space. It is an opportunity to live for two years with primary care. It is counseling on life skills. It is hope and it is a pause - a respite from the ER model. It can be a bridge from uninsured to insured. It is a borrowed rain coat, a temporary seat belt. It is a chance to come in out of the cold for two years.
CHP is a coming together of provider, administrator, counselor and neighborhood. It is the difficult, rancorous, unpleasant and sometimes joyful joining of hands.