Advocacy—Proactive/Reactive
A Model Volunteer Advocacy Program in Health Care

Paul Ruiz-Salomon, HSW, ALSW; Leonard Tuzman, MSW, ACSW; and Elaine Wolbrom, MSW, CSW

This article will describe the functions and the integration of volunteers in the Social Work Department of a large urban voluntary hospital for the purpose of providing advocacy services to an identified low-income disabled, aged population. The volunteer advocacy program began in 1976 and was initiated by the Department of Social Work Services at the Long Island Jewish Medical Center.[1]

The Department of Social Work Services, prior to 1976, perceived as a major component of the social work mission the provision of advocacy services to the hospital's population. The advocacy efforts were integrated into the practice of the individual social worker; volunteers were not included in any of the advocacy efforts up to 1976. The decision to involve volunteers in developing a more systematic and organized advocacy approach for the department was significantly helped by such external factors that were impacting on the clients within the health care system as:

1. emphasis on cost effectiveness;
2. restricted and repressive eligibility components within the entitlement systems that were responsive to a federal effort to cut back on the cost of Medicaid and public assistance;
3. increased separation of the service component from the provision of benefits within the entitlements structure;
4. a burgeoning interest in social welfare policy and advocacy by planning agencies, publicly funded legal agencies, and social workers in health care.

The impact of these changes was felt by the clients utilizing ambulatory care services at the medical center not only through increased fees, but also in reduced access to care, medication and transportation. In the ambulatory care area, the Department of Social Work Services began to call upon volunteers to assist a social worker to provide and maintain access to such services as Medicaid, public assistance, food stamps, and applications through maximizing the use of entitlements. For example, a large number of clients identified as Medicaid-eligible was assisted in applying for Medicaid; if they were denied Medicaid, volunteers assisted them through the adjudicative process. This effort became the first to

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Paul Ruiz-Salomon is coordinator of the Public Entitlements Program at St. Luke's-Roosevelt Hospital Center (SLRHC) and helped to implement the use of volunteers as entitlement advocates at Long Island Jewish Medical Center. In addition, Mr. Ruiz-Salomon has had extensive experience in the direct provision of services in social/political action task forces concerned with the AIDS crisis.

Leonard Tuzman is a co-founder and consultant to the Widowed Persons Service of Queens/Nassau, a group of widowed volunteers who provide outreach and support services to the recently bereaved. Mr. Tuzman developed a self help group of relatives of psychiatric patients at Hillside Hospital, the largest chapter of the Alliance for the Mentally Ill in New York State. Mr. Tuzman is administratively responsible for the volunteer program at Hillside Hospital.

In addition to being the current coordinator of the Volunteer Advocacy Program at Long Island Jewish Medical Center, *Elaine Wolbrom* has several volunteer interests: the Children's Medical Center at Long Island Jewish where she has been a member since 1968; FOCUS, a community residence for neurologically impaired young adults; and the Long Island Association for Children with Learning Disabilities.

be recognized as a concerted advocacy effort with the help of volunteers on the part of the Department of Social Work Services. Subsequently, this demonstrated success led to the formal organization of a volunteer advocacy program within the department which was supported by the hospital's office of volunteers and received the approval of hospital administration.

RESISTANCE TO THE VOLUNTEER ADVOCACY EFFORTS

Although the advocacy efforts were intended to benefit the hospital's fiscal status, there was a significant amount of resistance from individual social workers, from key hospital departments such as accounting, financial aid, the registrar's office and from the administration of the ambulatory care services. The personnel department was very much concerned about clearly delineated volunteer roles that would not usurp potential union positions.

Given the resistance described, one might expect that a program of this type would be doomed to failure. Yet, the history of the program has been much to the contrary. The authors believe that the program's success is due to the following key factors:

1. the firm commitment on the part of social work administration which had a clear philosophy that supported advocacy efforts;
2. the ability to frame the program to hospital administration guidelines and demonstrate that maximization of entitlements was not only in the interest of increased cash flow but also allowed the medical center to continue its stated commitment to providing services to all individuals within the community regardless of their ability to pay for services;
3. giving the advocacy assignment to a social worker who had a firm commitment to advocacy efforts and had developed significant political ties within the entitlement systems;
4. the program's willingness to work directly with the maze of bureaucratic structures and procedures existing within the entitlement systems. Many departments were unwilling to do this or did not have the prerequisite political and advocacy skills.

After eleven years the volunteer advocacy program is integrated within the Medical Center. It is a program that by design and structure can be responsive to shifting pressures to maximize reimbursement and cost containment in health care. The success of the program has been predicated on the ability to shift from a more generalized advocacy focus to increased knowledge of and skill in administering specific entitlement programs.

As health care cost containments and health care reimbursement become more specific to a disease focus, social problem focus, and a case mix approach, the advocate's efforts must be flexible enough to address these shifts. The organizational structure and design of this program which will now be described inherently support this kind of flexibility.

PROGRAM DESCRIPTION

There is currently a core of eight middle-aged female volunteers fulfilling the mandate of the Advocacy Program at Long Island Jewish Medical Center. The volunteers report directly to a social work coordinator who is also a member of the social work staff in ambulatory care. Only one of the volunteers has not had a work history in the human services; five of the women have worked in the educational system, and one woman in the field of social services. Although one woman had not had any viable paid work experience, she has been involved in the volunteer sector most of her adult years. All of the volunteeers are in the middle to upper income brackets and have college credits or have obtained their Masters degrees in an allied field.

The volunteers have committed themselves to the program for at least one day of the week, some work three days a week. The volunteers focus on social issues, change and advocacy which "includes a wide range of activities generally directed toward change—change in the way sys-

tems operate, institutions function, and rights and entitlements are protected or extended."[2] Their role is to help both the inpatient and outpatient population meet and maintain eligibility criteria for such Federal and State programs as Social Security Disability (SSD), Supplemental Security Income (SSI), Public Assistance (PA), Medicaid (MAP), Home Health Care (HHC), Food Stamps (FS), Winter Emergency Programs, and Emergency Aid to Families (EAF). They constantly negotiate with the myriad of municipal agencies to prevent denial of service, ameliorate access to or assist the client in getting reinstated for benefits. When these benefits are unfairly denied and informal negotiations and conference do not facilitate a favorable decision, the volunteers prepare the client for a fair hearing and will represent them, if appropriate.[3]

Through the efforts of the volunteers, precedents have been established on the state level for obtaining certain benefits for the clients. There have been many instances wherein the volunteers have influenced the regulatory and policy making bodies of the State and New York City Departments of Social Services to clarify and alter policy as it pertains to hospital benefits and services for the patients. The volunteers are often relied upon to provide consultation to the hospital's professional staff with regard to new regulations and procedures, updates on eligibility criteria, service access, and application processes.

As a result of the coordinator's and the volunteers' serving on important local and congessional committees related to entitlement programs, the program has received high visibility. The volunteers have been able to utilize their contacts to track cases and pinpoint systemic gaps in services.

ORGANIZATIONAL STRUCTURE

To have an exemplary volunteer program, the organization must develop a comprehensive management system for the volunteer program that is parallel to and compatible with its staff system. Volunteers deserve and require, precisely as paid staff do, job descriptions, supervision, training, recognition, and opportunities for growth and promotion.[4]

This type of program reflects the accelerating professionalism of volunteer services and emphasizes a collegial relationship among volunteers and staff. That relationship is based on mutual trust and on mutual respect for the skills each brings to the job and for what each accomplished.

ORIENTATION

Before any candidates become part of the program, they are given a brief history of the program. In addition, their functions are outlined in relation to the patient population and to the professional staff. This initial interview is used to assess the candidate's motivation, goals, strengths, and weaknesses and how he or she will perform in this setting. As the coordinator and volunteer begin to explore the components of the program, a beginning contract is established. The prospective volunteer then agrees to come into the program on a three week trial basis, during which time there is the opportunity to meet with the other volunteers, observe their work and talk to the professional staff. Each week she/he meets with the coordinator to discuss the program and the candidate's responsibilities. If, after the three week period an agreement is reached and both the coordinator and the candidate determine that there is a mutuality of needs, the candidate becomes a permanent part of the program.

TRAINING

The weeks that follow the trial period are scheduled for inservice training on entitlement programs and an orientation to the hospital systems. The training focuses on the mandate of the entitlement programs' eligibility criteria, and the application processes. In addition to these concrete service issues, the training involves an understanding of problem-solving interventions and advocacy skills, utilizing different roles such as enabler, facilitator, and negotiator, to effect a positive outcome. A third component of the training program targets developing interviewing skills consistent with the values and ethics inherent in social work practice. The volunteers are trained to function within a task modality. They

elicit, inform, advise, prepare, rehearse, represent, follow-up and are involved with closure of the issues. The focus of the training is on the activities involved in advocacy, not on the overall role of the advocate.[5]

CASE ASSIGNMENT

The coordinator meets with each volunteer once a week for approximately one hour to discuss each case to which the volunteer has been assigned. The assignments are made based upon matching the coordinator's assessment of the patient's needs to the volunteer's strengths, interest, availability and extent of knowledge of the relevant entitlement program.

In addition, the coordinator makes a differential assessment of the psychodynamic aspects of the patient's situation and/or the level of systemic intervention.

SUPERVISION

Supervision is both didactic and experiential. Developing an understanding of the patient through on-going role play is essential to the supervisory process. As stated earlier, all of the volunteers are in the middle to upper income bracket. The patients they encounter through referrals from the professional staff are from the lower socio-economic stratum or have become part of this group by virtue of their disability and inability to continue to be part of the work force. They are ethnic and racial minorities who are medically and/or emotionally disabled with limited familial and community support systems. It is crucial for the coordinator to help the volunteers get in touch with their own value perspectives (*i.e.*, biases, prejudices). Very often the volunteers see their roles as rescuers and find it difficult and frustrating when they are unable to implement or provide the stated goals for the patient. As they become more familiar with the bureaucratic system, they become more cognizant of the fact that they are helping a population that is frequently powerless to effect any real change. To help volunteers cope with their own frustration, the coordinator meets once a month with the entire volunteer staff. The agenda is established by both the coordinator and the volunteers. At this time the volunteers are able to share updates on cases, administrative procedures, and different interventions. Frequently the volunteers use this meeting to discuss their own styles of working with patients and how they impact upon the volunteer/patient relationship. If the styles become problematic, the volunteers, with support from the coordinator, explore alternatives. This meeting also serves to reinforce their accomplishments and maintains ongoing learning in addition to being socialized as a group.

INTEGRATION OF PROFESSIONAL AND VOLUNTEER

> *If there is a central truth about successful volunteer programs, it is that today an agency should see its volunteer program as an extension of its staff.*[6]

Because of the ever present time constraints, heavy case loads and the pending "Diagnostic Related Groups," the social worker views the advocate's interventions as an integral part of the ancillary system. The volunteers' participation on many community service committees has served as a forum for information gathering on regulations and procedures. This vital information has helped to demystify access to entitlements. Frequently, the volunteer staff is called upon to develop and disseminate entitlement and application fact sheets for professionals and clients.

As the volunteers receive affirmation and recognition of their work from the professional staff and the community,* their commitment to the program is intensified. They are motivated by their desire to make societal institutions work for the client.

Negative relationships between volunteers and professionals are regarded by many as the greatest single barrier to the effective use of volunteers. According to a report by the National Forum on Volunteering,

> *the resistance of helping professionals to volunteer involvement is . . . pervasive. In field after field—education, social services, museums and libraries, health care—the major barrier to effective volunteer involvement lies in the inability or unwillingness of paid helping profession-*

als to accept volunteers as legitimate partners in the helping process . . . .

These attitudes include the ill-defined professionalism that dictates that only those who are specially trained can provide human services, an insecurity about their jobs or their own capabilities, fear that volunteers will act as monitors and evaluators of their efforts, fear that in times of budget reduction they may be replaced by volunteers, and ignorance about the capabilities and commitment of volunteers.[7]

Sensitive to these factors, the Department of Social Work Services has taken concrete steps to establish a positive attitudinal and didactic rapport between volunteers and professionals. The volunteers have met with many of the professional staff on an individual basis to ascertain how they can best facilitate the work of the professional. The volunteers became part of the social work department through attendance at divisional and interdivisional staff meetings wherein a collaborative atmosphere prevails. A feedback loop to the professional allows for an integration of advocacy tasks with a broad case management approach. Professional social workers are able to include entitlement information and avoid the stress inherent to the advocacy process in their case practice.

ADVOCACY ACTIVITIES

The volunteers are involved primarily in direct case interventions with a population which, applying for a range of entitlement programs, has been denied benefits and wants to reverse that decision; has been terminated from benefits and seeks reinstatement; has applied for benefits and has not yet received a determination. These broad categories involve the advocates' efforts either to change the pattern of decision-making within the entitlement system or to attempt to increase the probability of a specific decision being reached. The scope of the advocates' activity can range from an individual telephone call to an entitlement agency which can clarify a client's situation (status), to the full process of working with the client from the point of application award to denial or through the fair hearing process and the award of benefits.

As the program coordinator and the volunteers have developed increased expertise on administrative regulations and procedures and laws of the range of entitlement programs, the nature of the advocates' activity has moved from general inquiry and information gathering to administrative and procedural change in specific cases. As the program developed, success around the application process began to increase. Referrals were coming into the volunteer group on a more timely basis from hospital staff, increased proficiency in the application process led to a reduction in denials, and increased systemic contacts in the entitlement programs facilitated a more speedy determination of award for the client population. From a cost benefit perspective, the successes of the volunteer interventions led in many cases to improved cash flow for the Medical Center, as well as dramatic recovery of monies for both the client and the Medical Center. In many cases, new sources of revenue for the clients were tapped.

With the success of the program came a dramatic increase in the numbers of referrals coming from previously resistant hospital staff. This increased activity allowed for more appropriate referrals to the advocacy program and increased the activities and decision-making on the part of other staff in their day-to-day contact with patients related to entitlement programs.

The following four case examples reflect interventions that resulted in systems changes in the entitlement programs, maximization of benefits to clients, as well as improved cash flow for the Medical Center.

Systems Case Example

The New York City Home Care Program has historically been difficult to access, causing long delays in discharging patients from costly hospital beds. In addition, for patients to be eligible for New York City Home Care, they must have Medicaid. For patients without Medicaid, the approval process may take an additional thirty (30) days. To assist the social workers in discharging patients, the Advocacy program developed a data schedule identifying the separate agencies' func-

tions with mandated time frames. The schedule clearly focused on the problem areas and pinpointed the agency to be contacted for problem resolution. If the social worker was unable to ascertain why the agency was unresponsive, the advocate volunteers used their informal channels to effect an answer. Many times, if they were unable to obtain one through the bureaucratic line practitioner, the volunteer moved up to the supervisory level.

Individual Case Examples

An infant was hospitalized during January and June of 1983. Unbeknownst to the hospital, the infant had Medicaid coverage. As a result of the hospital's not knowing about the Medicaid status of the infant, they billed the father $18,422.00 for inhospital treatment. The father, with an annual income of $13,000, could not afford to pay, and was receiving letters from the hospital's collection agency. In March of 1984, the family, feeling frightened and frustrated, contacted the Advocacy Program. Through the investigative efforts of a volunteer, the infant's Medicaid number and dates of coverage were obtained and a D.S.S. statement of eligibility was confirmed. All of the medical costs for hospital and physician services (approximately $28,000.00) were recovered through Medicaid reimbursement.

A 27-year old black woman with a long and productive work history was receiving psychotherapy and attended a weekly support group for individuals with Lupus Erythermatosis. Her illness severely limited her ability to carry out routine activities of daily living and prevented her return to employment. Since the initial diagnosis, she had one hospitalization for gangrene and numerous emergency room visits due to Lupus complications. The patient found herself persisting to get her "life back in order" yet finding herself unable to cope with all the situational and physical changes that had taken place. Forced to become a Public Assistance (welfare) recipient, as she had applied for SSD three times within a three year time span, her physical and mental condition deteriorated dramatically. The Advocacy staff intervened upon a request by her social worker. They obtained all the pertinent medical and psychological data, reviewed the SSD file on the patient, prepared her for a SSD hearing and represented her. Not only was a favorable decision rendered, but SSD payments were retroactive dating back to the initial application. She was awarded Social Security benefits monthly beginning in August of 1982. Public Assistance retrieved $8291.40 of her SSD/SSI retroactive check. The change in her Disability category and financial status has played an important role in enhancing the patient's self image.

Negotiations with a local income maintenance center led to agreement to process welfare applications for the psychiatric patients at the Hillside Division as a condition of discharge planning. Prior to this the patients had to go the welfare center after being discharged. The application took a minimum of thirty days. For many patients this is a process they could not handle. Due to the delay, some patients could not receive medical/psychiatric services and could not pay for housing and other needs.

This article has described the integration of volunteers into a social work program of a large voluntary hospital where a mission of the department was to provide advocacy services to patients. Health care in the past twenty years has moved very dramatically into an era of cost containment and within this environment social work programs are examined for a cost benefit and a reimbursement perspective. Many social work functions within this cost containment framework are often faced with elimination or reduction. The advocacy efforts of the Department of Social Work would have been minimized if volunteers were not involved. To this extent, volunteers can be seen as a supplement to social work activity which can enhance the quality of care delivered to patients. Where funds do not exist for an increase of staff, local volunteers can be drawn into areas that reflect changes in social policy as evidenced by the volunteers' role in the project as a response to cutbacks and reduced access to entitlement programs.

The introduction of a volunteer advocacy program into a health care setting must recognize the following organizational principles: positive institution and

staff relations; a clear statement of the goals and objectives of the program; assessment of the needs of the populations to be served; an organizational structure that takes into account standards and practices of the volunteer; support and feedback systems for volunteers that will assist them in their integration with professional staff; a work environment where the volunteers can share both their achievements and failures.

The volunteer advocacy program shows that volunteerism can be an integral part of the service delivery system of a social/health agency. The advocacy tasks offered the volunteers an experience which challenged their abilities, enhanced their sense of individual worth, built friendships and created a new sense of fulfillment. Health Care professionals need to feel less threatened and more creative in developing programs that can utilize volunteer efforts, reduce the barriers to volunteer and professional collaboration, and include volunteers as advocates for increased equity and justice within the social welfare system.

* On November 14, 1984 the Advocacy Program received an award from the New York City Mayor's Voluntary Action Center for all its efforts on behalf of the Queens population.

FOOTNOTES

[1]Long Island Jewish Medical Center is a 870 bed voluntary hospital located in Queens and Nassau Counties in New York City. The volunteer advocacy project is based at Long Island Jewish Hospital—a tertiary care general hospital.

[2]Manser, Gordon. Volunteer. *Encyclopedia of Social Work Supplement* 17th edition. Washington, D.C.: National Association of Social Workers, 1983, p. 179.

[3]Fair Hearing relates to due process in public entitlements. (*i.e.*, SSD).

[4]Seider, Violet M. and Kirschbaum, Doris C. Volunteers. *Encyclopedia of Social Work*. 17th edition. Washington, D.C.: National Association of Social Workers, 1977, p. 1890.

[5]Sosin, Michael and Caulum, Sharon. Advocacy: A conceptualization for social work practice. *Social Work*, January 1983, Vol. 28.

[6]Manser, *op. cit.* p. 171.

[7]*Ibid*, p. 173.

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