

Legal Hotline Quarterly

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The Future of Legal Services Excerpts Part III from an article by Wayne Moore

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Beginning with the Fall 2001, LHQ has featured a series of excerpts from a comprehensive article on the Future of Legal Services. This excerpt focuses on the Brief Services and Referral Unit

(Read the article in its entirety at www.legalhotlines.org)

Brief Services and Referral Unit



I believe the third element of this infrastructure will be a unit that generally does not exist now. I call it the brief services and referral unit (BSR). It performs two important functions. First it develops the facts and issues of cases that are not resolved by the legal advice line; and it resolves those cases it can through legal advice and brief services. Secondly it serves as a referral center directing cases to the most appropriate delivery system for extended representation. There are several reasons that a BSR unit is needed. My experience with my own legal services program is that nearly 33% of the cases referred by the legal advice line to our staff attorneys and paralegals are closed with advice or brief services even though our legal advice line provides brief services. The legal advice line does not resolve these cases because they require investigation and document collection before the proper resolution of the case can be determined and it is inefficient for the advice line to perform these tasks. However

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these tasks can be performed using less expensive resources than experienced staff attorneys and paralegals.

Another reason for the unit concerns its referral function. The BSR insures that a case needing extended representation is sent to the most appropriate unit. For programs with specialty units, this insures that the case is sent to the right unit or units based on a full development of the facts and issues. For programs with a volunteer lawyers project (VLP), the BSR helps insure the VLP receives an ideal mix of cases. Often VLP units do not receive fully developed cases. This increases the risk of an inappropriate referral. Nothing discourages volunteerism more than receiving cases containing unwelcome surprises that require more time or a different expertise than anticipated. The BSR can insure that the VLP receives only fully developed cases.

Most VLP units receive too many cases in some areas (e.g., divorce) and too few in others thereby under-utilizing some volunteer lawyers and burning out others. The BSR can give the VLP the first choice of cases so that all volunteer lawyers are fully utilized while not being overwhelmed. Also, the BSR can insure that no advice or brief services cases are sent to the VLP. In an earlier paper, I calculated that VLP cases cost 55% of the cost of in-house cases. Since the legal work is free, the cost of VLP cases arises from the cost of recruiting the lawyers and referring and monitoring the cases. It costs about the same to refer an advice only case as an extended services case. Thus it is cheaper to handle advice and brief services cases in-house. The VLP should be reserved only for extended services cases.

Finally the BSR can help a program coordinate with other legal services programs serving the same geographical area. A program can enter into formal arrangements to refer specific extended services cases to the others while accepting certain extended services cases in return. The goal is for all programs to receive cases in areas of strong expertise and capacity and to refer cases in other areas so that the administration and monitoring of the referral process is not burdensome. This is particularly useful when the other programs only serve certain cli-

ents or provide a limited range of services. This process requires the programs to exchange ongoing information about their day-to-day capacity to accept these agreed-upon cases, so that no program is overburdened.

III. Brief Services and Referral Unit

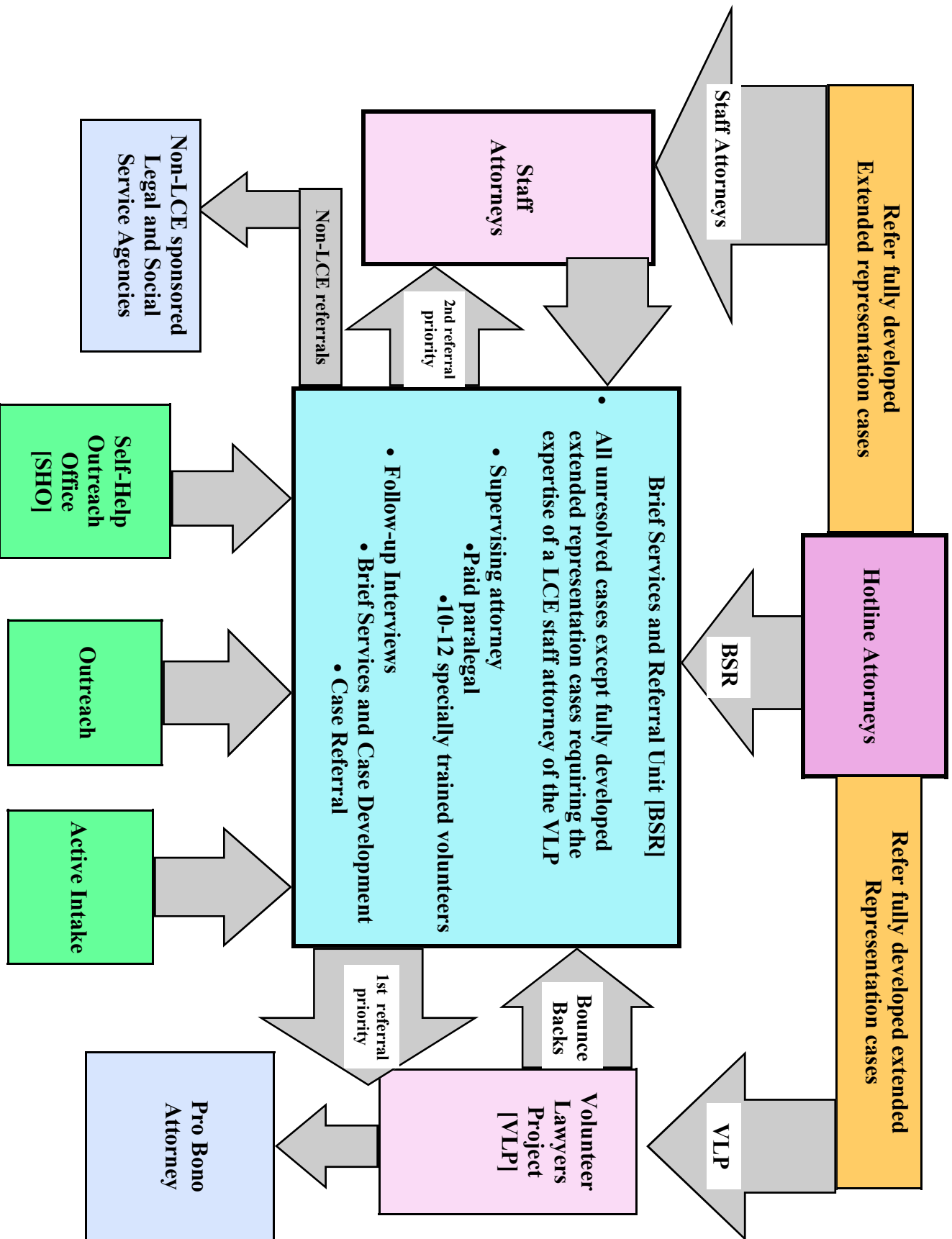


As mentioned earlier there are two primary reasons for a BSR unit: first, it provides a cost effective way to handle cases which do not require extended representation, but are not resolved by the legal advice line. Secondly it distributes extended services cases to other units inside and outside the program in a way that maximizes the use of resources that are internal and external to the program.

At AARP/LCE, we are currently creating a brief services unit. The AARP/LCE BSR is staffed with a managing attorney, a full-time paralegal, and numerous non-attorney volunteers. The chart on the next page shows how cases flow to the BSR. The primary source of cases is the legal advice line. The advice line will refer all unresolved cases to the BSR except for those fully developed cases that clearly require the extended representation of experienced in-house staff or the volunteer lawyers unit.

The advice line also refers another category of cases to the BSR. These are cases closed by the advice line where it is essential that the clients follow the advice given. These cases are tickled by the advice line staff for follow-up by the BSR on a designated date. If BSR staff discovers that a client did not follow the advice, the BSR staff person or volunteer can reiterate the advice and continue to monitor the case or refer it elsewhere for extended representation. We have been operating this follow-up system for nearly a year and are pleased with the results. We have analyzed 165 closed advice line cases that were tickled for BSR follow-up. Of these, 141

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(85%) said they understood the advice; 24 (15%) said they did not. Although the sample is small, those most likely to understand the advice were slightly more likely to be female than male, and more likely to be married than single, divorced or widowed. However none of these variances were statistically significant.

Of the 165 cases, clients in 83 (50%) of the cases followed the advice, 6 (4%) tried to follow the advice and 76 (46%) did not follow the advice; 24 of these 76 did not follow the advice because they did not understand the advice.

The table below shows the outcomes depending on whether the advice was followed or not:

sues, and real estate; but differences in ranking were not statistically significant.

This follow-up project performs two important functions. First it provides a safety net to insure legal advice clients receive the best outcome possible. Secondly it collects information about the outcomes of cases, which is important for reporting purposes. We currently collect information on case outcomes using a system similar to that adopted in several other parts of the country (e.g., Cincinnati, New York State). In the past, the outcomes of cases closed by the advice line were recorded as “client received advice.” However we now record the actual outcome for the most important advice-only cases,

OUTCOMES										
	Favorable		Partially Favorable		No Change		Unfavorable		Case Still Pending	
	%	N	%	N	%	N	%	N	%	N
Followed Advice	63	52	6	5	6	5	12	10	12	10
Did not Follow Advice or Did not Understand	24	18	0	0	62	47	1	1	13	10

Holding constant for their other characteristics, clients were more likely to follow the advice if their income was lower, if they were male rather than female, and if they were never married, married or divorced rather than separated or widowed. Asians were less likely, and Hispanics more likely, to follow the advice than blacks or whites. For example, a client that was widowed was 35% less likely to follow the advice than one who was married, and women were 15% less likely to follow the advice than men.

Holding constant for client characteristics, clients were more likely to follow the advice when they had the following problems (ranked from more likely to less likely): job discrimination, income maintenance, consumer/finance, torts, health, guardianship/conservator ship, estate planning, family is-

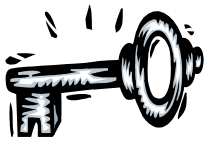
which can include the resolution of a dispute, collection of damages, avoidance of an eviction, etc. This provides a better picture of the true impact that our program is having on clients.

Since the decision to create a BSR, we have realized that many brief services cases come into our program by mechanisms other than the advice line. The VLP component of our program operates what we call an “active intake” project. As mentioned earlier, many VLP projects, including ours, underutilize some members of its volunteer lawyers panel. The goal of active intake is to find these cases and refer them to these underutilized attorneys. Another goal of the project is to detect legal problems through

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a legal check-up, before they become emergencies. The primary vehicles used for active intake are community clinics, participation in community events, and networking. The clinics are held in neighborhoods that are otherwise underserved by our program. They are held in places where our clients congregate such as public housing buildings, community service and recreation centers, and churches. These clinics are time consuming as VLP staff is responsible for scheduling, planning, publicizing, and conducting the clinic with the help of workers at the host agency. Community events are easier since others do the scheduling, planning, and publicity. These events include health fairs, senior expos, and community celebrations; the challenge here is to create a private environment for client consultations. Networking can include the inclusion of flyers in government notices of the denial, termination or suspension of benefits (e.g., Medicaid, Food Stamps, SSI). It also can include referrals from court clerks or community agencies of specific types of cases.



The key in all these methods is that the publicity for the clinic or the requests for referral specify only those problem areas sought by the VLP. Thus the clinic is publicized as pertaining only to consumer matters or Social Security/SSI problems. People with other types of problems are merely referred to the legal advice line. Those with the targeted problem are accepted as clients using intake protocols. However, our experience is that many of the cases received through active intake are not developed sufficiently to allow a referral through the VLP. As a result VLP staff develop a caseload of matters requiring development, advice or brief services. Now these matters will be referred to the BSR.

The BSR performs another important function for the VLP; it handles bounce-back cases (cases returned by the volunteer attorney because he or she can't finish the case). The BSR determines the status of the case and refers it to another resource.

Another source of undeveloped cases is circuit riding. Like many legal services programs, we have staff who regularly travel to community centers in low-income neighborhoods to conduct intake. Those cases that can't be resolved by advice or other on-site activity are brought back to the program for distribution to the VLP or staff attorneys and paralegals. Now these cases will be sent to the BSR.

Another recent effort to better utilize our resources involves preventative law, which is really a form of active intake. We have identified several major community problems, which need an orchestrated response. This includes the loss of homes for failure to pay property taxes and the eviction of seniors who, because of a mental incapacity or similar problem, are no longer paying rent.



Many low-income seniors in DC are losing their homes due to a failure to pay property taxes. These homes are being sold at a tax sales for as little as a few hundred dollars. Many of these seniors have considerable equity in their homes. To identify these seniors, we obtain a list of them from the DC tax agency. We write, call, and visit these homes until contact is made. Most cases can be resolved through non-legal assistance, by helping incapacitated seniors pay their bills or by arranging for a home equity loan or reverse mortgage. All these cases used to be handled by the staff attorney in charge of the project and a few law students. Now the simpler matters can be referred to the BSR.

The eviction prevention project has used an education campaign to convince landlords and housing managers of low-income housing to contact us before evicting a senior. We match these seniors with social workers who investigate why the client is not paying rent. Most of these clients have been

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long-time, dependable tenants who suddenly stop paying rent. If the non-payment is due to a social problem experienced by the client, the social worker takes the necessary steps to address the problem and restore the payment of rent. LCE handles any legal aspects of the case including the establishment of a conservatorship, power of attorney or representative payee arrangement. Over 100 clients have been saved from eviction at a fraction of the cost of representing these clients in eviction proceedings. Again the simpler matters will be resolved by the BSR. As more of our resources are reallocated from expensive, one-on-one representation in court to preventative law, the BSR unit will become increasingly important.



Another source of BSR cases is our home visit paralegal that conducts intake in disabled clients' homes and returns the cases to AARP/LCE for assignment. Again undeveloped cases will go to the BSR and the rest will be assigned to in-house advocates.

The BSR will handle cases as follows. The non-attorney volunteers will meet with the BSR attorney manager at the beginning of the day to receive new case assignments and discuss open cases. Volunteers will spend the rest of the day making calls, writing letters and obtaining information from government and private agencies. The manager will complete cases requiring the intervention of a lawyer. Cases that are complex or involve tight timelines will be handled by the BSR staff paralegal. If, after development, the case requires extended services, the BSR will refer the case. The BSR will first consider outside resources such as a bar association program, a law school clinic, or some other underutilized resource in the community. Part of the responsibility of the BSR will be to enter into formal relationships with other agencies and legal services

providers to exchange cases in areas of underutilized resources. The BSR will need to continually monitor these referral sources for changes in their ability to accept cases. The best way to track this is for every agency to maintain, on a daily basis, its portion of a common website by posting case types the program is willing to accept through a referral. The goal is to provide every program with an ideal mix and volume of cases to efficiently utilize their resources. If this system works, there will not be as great a need for active intake. If no outside sources will accept the case, then the BSR will refer it to an in-house unit, giving priority to its pro se and VLP components.

The BSR's ability to make targeted referrals of cases to fully utilize existing resources and to cost effectively develop cases and resolve those needing only advice and brief services, will cause it to expand into a regional or statewide delivery system in the same way that the legal advice line has. Thus statewide and regional programs will evolve that use a variety of outreach mechanisms to address problems that don't require attorney representation. Cases that do require representation will be directed to a centralized intake and legal advice line. The advice line will refer most cases to a BSR. The BSR will resolve the advice and brief service matters and refer extended services cases to a variety of independent, local legal services programs.

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**MANAGEMENT INFORMATION EXCHANGE
TECHNOLOGY EVALUATION PROJECT
March 2002 Report***

The Management Information Exchange announces the launching of the Technology Evaluation Project (TEP). The purpose of the project is to create a national structure specifically to help Technology Initiative Grant (TIG) recipients evaluate the effectiveness of their projects. It is hoped - indeed, expected - that the effort will benefit more than just the targeted TIG grantees. There is a growing recognition in the legal services community that evaluation of program efforts is a core management function that should examine the effectiveness of current efforts and certainly be built into any major new effort undertaken. That is particularly true where there are significant costs associated with innovative efforts, as is the case with many technology initiatives.

MIE recently hired John Tull to serve as the project manager for TEP. John will bring his experience as a manager, his knowledge of evaluations of the legal services delivery system and his familiarity with technology to help this project serve the legal services community. In addition, the project has contracted with Summit Collaborative and Innovation Network, Inc., recognized experts in the field of evaluation, to work as an Evaluation Development Team to provide assistance in developing evaluation tools to be used by TIG grantees and by others. John and the Evaluation Development Team will work with a National Advisory Committee made up of persons from the field and others working with various aspects of technology and legal services delivery. In addition, they will consult with working groups of people from affected field programs who will provide guidance and feedback on specific aspects of the project. The evaluation designs will be field tested to assure their effectiveness and ease of use.

While TEP may help to answer broader questions about technology and legal services delivery, it is principally aimed at TIG grantees for FY 2001. It

is specifically focused on helping those grantees meet their responsibilities to the Legal Services Corporation to evaluate the projects which had been funded with their grants. The Technology Evaluation Project will focus on four specific outcomes.

- The first product of the process will be evaluation guidelines designed to provide guidance for legal services programs about how to evaluate their technology projects. The guidelines will help current TIG grantees, as well as others, consider what is necessary for effective evaluation of technology efforts and related aspects of service delivery. TEP will not itself evaluate technology grants, but rather will assist grantees as they design and implement their own evaluations to accomplish what is required under the terms of their grants. The guidelines will also help others in the legal services community approach their self evaluation needs with a better understanding of the importance of evaluation and how efficiently and effectively to accomplish it.
- The second product will be specific methodologies for evaluation, including instruments for the collection of data to ensure that the evaluations are soundly based. The evaluation instruments will be tailored to the specific needs of the TIG grantees and will be built around the variety of projects which had been funded. For instance, more than half of projects (28 of 50) are for statewide websites which are designed to accomplish a variety of purposes, including outreach to clients, supporting self representation by members of the client community, providing public information about legal services and specific programs, and linking advocates and other personnel together. One set of evaluation instruments will be designed specifically for these grants. One of the first steps of the project will be to identify other common themes among the grants in order to develop instruments which will be useful to them.
- The third product that TEP will produce is the training of legal services program staff on evaluation

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techniques. The training will be focused on how the evaluation methodologies and instruments developed for the grantees can be used by them.

- Finally, TEP will facilitate the provision of technical assistance to TIG grantees. The project will provide support to grantees to answer questions unique to their own projects.

The legal services community has a deep interest in evaluating the effectiveness of the technology initiatives that are underway. First, LSC is spending \$11.25 million over two years on technology initiatives with money appropriated by Congress. It is imperative that we demonstrate the many responsible and effective ways the money has been used to increase our capacity to serve our clients. Second, each program that undertakes a new initiative should know for itself and for its clients, how it is doing, whether it is making a difference and what adjustments in approach might enhance its ability to serve its clients.

Finally, there are questions that many in the legal services community have regarding the effectiveness of new delivery approaches, many of which are based on new technologies. It is important that we as a community be able to answer the questions posed about the effectiveness of these new techniques. We need to know if, and how, they benefit clients. The evaluation of those questions needs to be unbiased and credible, to tell us if the new approaches work and to point the way to improve their effectiveness.

If you have questions about the Technology Evaluation Project, please contact John Tull at 303 258 9227 or jatassoc@earthlink.net, or MIE executive director Patricia Pap at :

617 556 0288 or ppap@m-i-e.org.

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Website of Interest

www.rapidocs.com

Have you ever wished your hotline advocates could prepare a living will or other simple document while speaking with the client on the phone?

Richard Granat of MyLawyer.com made the following announcement to the legal services world in March 2002:

“We are pleased to announce the launch today of a “dedicated and secure free legal document and forms portal for the legal services community powered by Rapidocs, our web-enabled document assembly technology... The resources within this site can be used immediately to add document assembly functionality to your legal information web sites and to your programs without a major capital investment or recurring cost.

Access to the site is free to legal service advocates and staff and pro bono attorneys serving the low income community. After you log in, you will receive a username and password and arrive at your own state specific web page that has over 90 interactive legal documents. We plan to add additional documents and court forms to each state page in the months to come. These are legal documents and forms that we ordinarily sell through our commercial web sites, which accounts for the fact that this web site has restricted access to members of the legal services community, defined broadly to include lawyers in private practice and clinical law school programs serving low-income individuals and families. Technical assistance in using Rapidocs templates is also available by e-mail or phone for free.

We see this site as experiment in using the Net to empower legal service programs to deliver legal services in alternative ways, informing the community about the concept of web-enabled document assembly, and exploring the potential for public-private partnering. I hope that it will be viewed by all in the same light.”

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Legal Hotline Self-Evaluation

By Wayne Moore

In an accompanying article I set out what I believe are the basic components of self-evaluation. Those that apply to legal hotlines are: client satisfaction, quality, client outcomes, productivity and reach. This paper discusses how programs can evaluate these facets of their legal hotlines or legal advice lines.



Client satisfaction can be measured annually, bi-annually or on a continuous basis by mailing client satisfaction surveys upon case closure. Survey return rates are often too low for precise measurement, but by comparing results over time, significant changes in satisfaction usually can be detected. Return rates of 10% to 20% are common while 30% is needed for reasonably reliable and valid results. AARP is beginning to insist on 50% return rates for accurate measurement. Higher return rates can be achieved through second and third mailings, by notifying the client at the end of a hotline call to expect (and respond to) the survey, and by supplementing the mail survey with telephone calls. We have found that another valuable use of surveys is to ask clients about service preferences. For instance we discovered that clients prefer the term “legal advice line” to “legal hotline” as the latter suggests the service is limited to dealing with emergencies. The surveys also found that clients preferred a scheduled callback hotline system to a hold or delayed callback system. One should expect survey results to show that at least 80% of the clients are very or somewhat satisfied on a five-point scale. Lower results deserve attention.

Quality is ultimately a subjective determination, but a program director can insure that good systems are in place to insure quality. Those we have found to be key to hotline quality are: 1) a review

system where a supervisor reviews all or a sample of hotline case notes on the same or next day and notifies staff of cases needing corrective action; case notes should include a complete listing of the relevant facts and a summary of the advice given; 2) quick reference materials such as the 70 – 100 most commonly presented questions and problems with complete answers and an up-to-date outline of the law of the major legal areas addressed by the hotline; we have observed a clear reduction in quality in programs that don't have these materials unless they have very experienced staff; and even experienced staff need to be informed of new developments in the law; 3) a regular opportunity for hotline staff to meet and discuss difficult cases, areas where advice has varied among the staff, operational problems, and new developments in the law; 4) attendance of hotline staff at CLE events, at a rate of 2-3 per year, and, ideally, access to other staff experts as needed to help respond to non-routine calls; and 5) the practice of sending clients a follow-up letter repeating the advice given verbally over the phone (although some programs use other techniques as discussed next).

Measuring client outcomes is a challenge because hotlines typically cannot do this without re-contacting the client. However, we have begun to do this with selected cases with great results. We use non-attorney volunteers to re-contact those clients identified by the hotline staff as needing follow-up because: 1) it was important that the client followed the advice, 2) it wasn't clear that the client understood the advice, or 3) important rights or property were at stake. If the outcome is positive, then these results can be captured for reports to management or funders. If the client did not follow the advice and the matter is still pending or if the outcome is negative, then the program may be able to intervene to achieve the desired result.



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For years we did not focus on the right measurements for determining hotline productivity. We focused on the number of cases closed per full-time equivalent hotline staff (FTE). The better measurements are the percentage of time that hotline advocates spend on the phone talking with clients and the average call length. In our Pennsylvania hotline, we found that staff was averaging 14-16 minutes per hour on the phone with clients with an average call length of 7-8 minutes. The number of cases closed per hour per FTE staff averaged two. After we focused on time spent on the phone, our productivity increased to 6 closed cases per hour per FTE, and staff averaged 42 minutes of each hour on the phone with clients. We found that our hotline staff was previously spending the majority of their time on administrative tasks such as entering demographic information and making callbacks. We have since transferred these administrative tasks to receptionists. These higher productivity figures were achieved using contract attorneys where there is no down time. However, if staff is used, these figures will be lower as some down time is necessary. However, the average time spent talking to clients per hour should not drop below 30 minutes without some review of hotline procedures to determine if they can be streamlined. Not much data is available on average call length, but more should be available as more programs begin to measure it. As mentioned, the average call length for our Pennsylvania hotline is 7-8 minutes.

The ABLE hotline in Toledo reports an average call length of 12.5 minutes, which includes family law cases, which average around 14.2 minutes. Using ABLE's longer times, one should expect 2.4 case closures per hour per FTE assuming an average of 30 minutes is spent on the phone with clients. "Closures" include cases referred to other parts of the legal services program for additional services but do not include ineligible clients or others who are screened out by the receptionist. Call length averages serve another purpose. It helps spot less productive attorneys who might need training on call management techniques or additional training in substantive law.

Reach is the final evaluation measure. This includes a determination of geographical reach and ethnic reach. One can now obtain software, which will produce a map of your clients by geographical area and compare this with the location of the low-income population using census data. Areas with concentrations of poor people, which are not equitably served by your program, can be visually spotted, helping to determine where more or better outreach efforts are required. Also the make-up of your clientele by race should compare with the percentage of racial minorities in your service area. Again underserved populations can be targeted for outreach.

One system that has worked well for us is to use Language Line in conjunction with our hotline. This is a commercial service, which can add an interpreter, using a conference call procedure, to any hotline conversation within 30 seconds or so. We distribute flyers to minority populations which explain, step-by-step, what will happen when they call our hotline in their native language. Language Line prepared these. The flyers tell clients how our phone will be answered, what to say when it is answered, and to wait 30 seconds or so for an interpreter to join the conversation. This technique has nearly doubled our calls from minorities. The Language Line cost is significant but can be financed by savings achieved by applying these evaluation principles to make your hotline more efficient.



Northern California Health Rights Hotline

The Legal Hotline Quarterly first profiled this hotline in its Spring 1998 issue soon after it's start up. HRH has compiled several years of experience into an article which appeared in the Center for Medicare Education Issue Brief, Vol. 3 No. 1, 2002 and is reprinted here with the permission of the Center for Medicare Education.

Setting Up a Hotline

By Shelley Rouillard and J. Bridget Sheehan-Watanabe.

ABOUT THIS BRIEF: Consumer assistance hotlines represent one important model for delivering health-care information to consumers. However, developing and managing such programs can be complicated. This issue brief presents some of the issues involved in setting up and maintaining a hotline, highlighting the experiences of the Health Rights Hotline, an independent consumer assistance program in Sacramento, California.



In recent years, hotlines have become a very popular way of providing “live” answers to consumers’ health-care questions. Within the field of Medicare education, hotlines have gained prominence through the 1-800-MEDICARE (1-800-633-4227) line maintained by the Centers for Medicare and Medicaid Services (CMS) and the State Health Insurance Assistance Programs, some of which have their own helplines. In addition, other advocacy organizations have also created their own hotlines, designed to provide independent consumer assistance.

However, while the premise behind hotlines seems simple in nature, the reality is that the issues associated with the implementation and management of these lines are complex. In this brief, we will discuss some of the issues – including costs -- you will need to think about as you develop and maintain a consumer assistance hotline at your organization, using real-life examples from experiences of the Health Rights Hotline, an independent consumer assistance program based in Sacramento, California.

Background

Designed as a source of free, independent assistance and information for health-care consumers, the Health Rights Hotline provides its services primarily through telephone counseling and community education and outreach. The Health Rights Hotline was intended to serve as a state and national model for independent assistance programs for consumers in managed health care systems. Over time, the Hotline’s services have expanded to include all health-care consumers including persons who receive care on a fee-for-service basis or who are uninsured.

As a model, one of the goals of the Health Rights Hotline is to bring consumers’ perspectives into the political dialogue around managed health care. The Health Rights Hotline encourages managed health care systems to better meet consumers’ needs by helping them understand consumers’ experiences with the health care system. The Hotline’s philosophy is to foster collaboration with the various health care stakeholders in order to improve consumers’ access to health care.

Designing the Program and Scope of Services

Deciding who to serve and how to serve them is a preliminary step in any hotline venture. You can determine the need for a hotline in your community by consulting with advocates and policymakers, and/or by conducting surveys or focus groups of the people in your area whom you want to be serve. It is important to identify existing resources so that the hotline can fill service gaps and work collaboratively with the resources that already are available.

During the development of the Health Rights Hotline, staff developed a list of key issues to consider.

- ***Independence:*** An overriding consideration was that the Hotline must be independent from the health-care system. To gain consumer confidence, consumer assistance hotlines must be viewed as unbiased sources of information and assistance, capable of conducting effective advocacy on behalf of consumers.
- ***Service goals and strategies:*** As with all projects, it is important to have clear goals and ob-

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jectives for your hotline at the outset. The Hotline assists individual consumers with their health care problems, conducts educational activities to help consumers understand how to navigate the health care system, and keeps abreast of changing health plan and medical group policies, as well as legislative and regulatory changes affecting the health-care delivery system.

- **Service delivery:** Although the primary mechanism for providing services is through a telephone hotline, it also was important that the Hotline have the capacity to provide face-to-face counseling in its offices and, when necessary, in clients' homes.
- **Cultural/linguistic and disability access:** Cultural diversity issues are critical for any organization wishing to provide consumer assistance. Consumers need to feel comfortable sharing their problems and issues with you, and that means being able to communicate with them in their language. The Hotline hired counselors who spoke Spanish, Hmong, Russian and Japanese, installed a dedicated TTY/TDD phone line and ensured its office was accessible to people with disabilities. The Hotline also contracts with a telephone language line to provide interpretation for callers who speak languages not available through Hotline staff.
- **Scope of services:** Once you've established your goals, you will need to lay out how you plan to achieve those goals, which includes the services that you are going to offer. Hotline counselors clarify consumer rights and responsibilities, refer consumers to appropriate resources, including health plan representatives, government agencies, and community organizations, and represent consumers in health-related disputes. Hotline staff also conduct educational presentations and advocate for policy changes to improve the health-care system.
- **Relationships with other related organizations:** It is important to acknowledge and involve other organizations in your area that may be providing similar services to yours. Recognizing the critical role that the local SHIP (in California, called HICAP -- Health Insurance Counseling and Ad-

vocacy Program) plays for many seniors and Medicare beneficiaries, the Hotline contracted with the local HICAP to base a counselor, who had been extensively trained on managed health care issues, at their offices. She was available as an expert resource on consumers' rights in Medicare Health Maintenance Organizations (HMOs) for the HICAP clients and volunteers.

Establishing an Advisory Committee

Input from stakeholders (e.g. consumers, health plans, employers, etc.) is fundamental to the success of a hotline. One of the Hotline's first activities was to establish an Advisory Committee that represented a broad range of managed health-care stakeholders. Among the issues to consider in deciding whom to invite to participate on the Advisory Committee are:

- **Workable Size:** It is important that your Advisory Committee be broad enough to reflect the various stakeholder interests, but still be manageable.
- **Local Focus:** The Advisory Committee should be locally based to foster collaboration and provide a common frame of reference.
- **Balance of Participants:** In selecting individual representatives, you may want to have a mix of perspectives. The Hotline included representatives from health plans and providers, consumers who had knowledge of or experience with particular medical conditions (such as cancer or mental health) or types of payers (such as Medicare or Medi-Cal), large and small employer representatives, and state legislative and regulatory staff.

Advisory Committees can provide significant input into the development and management issues. For the Hotline, the Committee offered suggestions as to program design and evaluation, service protocols, training materials, educational materials, staff training, outreach and promotion, and data collection and reporting.

Involving Key Stakeholders

As mentioned earlier, it is important to develop good relationships with those people and or-

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ganizations involved in and affected by the work that you are going to do. The Health Rights Hotline has developed and maintained constructive working relationships with the major stakeholders in its local health-care delivery system, particularly the managed health-care system. Some ways in which to develop these relationships include:

- **Individual meetings with stakeholders:** In-depth meetings with health plans, medical groups, health systems, regulators and purchasing groups were held prior to the Hotline's launch. The Hotline also holds ongoing meetings with various stakeholders to discuss findings from call data and any identified trends or issues arising from Hotline calls.
- **Soliciting input through mailings:** Periodic letters have been sent to key stakeholders requesting feedback on programmatic issues, including program protocols and data collection, analysis and reporting.
- **Sharing data on consumers' concerns:** Each year, the Hotline provides statistical data and case summaries to each health plan and medical group serving the Sacramento area. These reports identify the issues faced by health care consumers but do not contain any caller-specific information that could be used to identify a particular consumer.

Developing the Telephone System

Clearly one of the most important decisions that you will make with regard to your hotline is deciding on a telephone system. The Health Rights Hotline made an early decision to answer all calls "live," understanding consumers' frustrations with "phone trees" that ask you to "press one for this, two for that." With that in mind, the Hotline purchased an automatic call distribution (ACD) system to answer Hotline calls. (Many companies use an ACD system for their customer service departments.) The Hotline's ACD system is basic, but still cost about \$45,000.

Hotline counselors "log onto" the system, ready to answer calls as they come in. Calls are routed from person to person. If all the counselors are busy, then the caller hears a message asking them to wait for the next available counselor. After about

30 seconds, callers hear a second message suggesting that they might want to call back at a later time. (Since the average length of time for a Hotline intake call is about 24 minutes, someone could be on hold for a long time if all the counselors are assisting other callers.) The Hotline found that most people will not remain on hold for more than about 1½ minutes.

Developing Your Management Information System

Another critical choice for your organization is deciding on the management information system (MIS) that you will use to track your calls and the services and advice provided to callers. The requirements for your system should be driven by your data collection and service goals. The MIS needs to be easy to use and allow counselors to input caller information directly into the database while on the phone. Staff at the Hotline identified four primary functions for their MIS:

1. case management;
2. information and referral;
3. demographic and health-care system data collection; and
4. time tracking.

The Hotline evaluated a number of software programs including those used by legal services organizations, information and referral agencies, and health plans. The cost and time to develop a wholly customized program also was considered. Ultimately, the Hotline decided to purchase a software program called CLIENTS, a Windows-based (Access) program designed for legal services case management, which could be modified to meet their needs. The total cost of the initial purchase and modification of CLIENTS was approximately \$30,000.

However, deciding on your MIS is only the first step. Once it is installed, you must also be prepared to deal with ongoing maintenance and changes. The Hotline contracts with a programming consultant who has made necessary modifications and provides ongoing support for the application. Ongoing programming costs, for fixes and changes, cost \$5,000-\$6,000 per year. (These costs were higher in the first couple of years, but have decreased over time.)

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Establishing Protocols

“Protocols” are your policies for how callers should be assisted by counselors -- both at intake and on an ongoing basis. These should be developed early in the planning process. The first contact a consumer has with your hotline is with the person answering the phone. The manner in which calls are answered and the sensitivity demonstrated by the person answering the phone are essential for a caller to develop a sense of trust and confidence in the program. Having established protocols also helps to ensure consistency in how questions are answered from one caller to another.

Initially, the Hotline’s main efforts toward developing protocols and the methods to serve individual consumers consisted of meeting with health plans and other stakeholders, and collecting complaint and issue categorizations from an array of sources. Research was conducted on other consumer programs, including programs serving Medicaid managed care members. A goal of the program in designing complaint categories was to make it comparable to data collected by other entities such as health plans, state regulatory agencies, Medicare, and HICAP.

The Hotline eventually developed written protocols for counselors and scripts that address specific calls or issues including intake, follow up survey, confidentiality, print material availability, confirming referral, collection of demographic information, callers fear of retribution for having contacted the Hotline, basic information about the Hotline, and program funding.

Developing a Training Program

Counselor supervision and training are essential to providing high quality service and collecting credible valid data. Hotline counselors undergo an extensive training program that provides them with the basics in an array of areas, including consumers’ health-care rights and rules governing employer-based, Medicare, Medi-Cal and other types of health plans, health plan practices, interviewing and communication skills, and negotiation skills. New counselors listen in on calls with experienced counselors and complete case exercises before they begin providing services.

Quality control and ongoing training are a high priority and require a significant investment of management and counselor time. Hotline management staff provide counselors with informal daily supervision, twice-monthly individual supervision sessions, weekly case conference, data collection/protocol review, and ongoing training sessions.

Staffing

Staffing for a hotline will vary depending on your program’s size, design and budget. The Health Rights Hotline has 12 full time staff members – a Program Director, Supervising Counselor/Attorney, seven full-time Counselors, Office Manager (who also serves as the Hotline’s computer system and data manager), Policy Analyst, and Receptionist. The current counseling staff includes three bilingual Spanish/English counselors and one bilingual Hmong/English counselor. The Hotline does not use volunteers to provide direct services.

Some advice: A hotline should have a full time outreach/education coordinator who is responsible for generating and conducting presentations, attending health fairs and other community events, and developing promotional and educational materials. If possible, the positions of the office manager and database administrator should be separate so that there are adequate resources to manage the day-to-day office operations and to maintain the computer system and generate reports from hotline data.

Handling Calls

In addition to developing protocols or scripts for how calls should be answered, figuring out the mechanics of answering calls is an important implementation issue. On the Hotline, initially two counselors were logged on the ACD for four-hour shifts, with a third counselor assigned as “backup.” When the calls came in rapidly (not a common occurrence, but generally happened when there was some media attention for the Hotline), the back up counselor would log on and take calls as well. All the phones in the Hotline have the capability to connect to the ACD.

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After using this intake system for nearly two years, the Hotline analyzed the types of calls that it was receiving. The level of calls the Hotline received was much lower than we had anticipated during the planning period. The counselors felt that too much of their time was spent “waiting for the phone to ring” and that constant interruptions reduced their ability to effectively manage their caseloads.

The Hotline tested, and ultimately implemented, a new intake method. A receptionist answers all incoming Hotline calls. She screens calls and forwards appropriate calls to the designated “Lead Counselor.” The Lead Counselor assists the caller. If the Lead Counselor is on the phone with a caller, the receptionist takes a message for the Lead Counselor to call back. Counselors attempt to contact the person within 24 hours and try at least two times to reach callers. The receptionist handles all misdirected calls, routes ongoing case calls to the appropriate counselor, and refers out-of-area callers to resources in their communities.

Collecting Data and Quality Control

Accurate data about your callers can be an incredibly useful tool for planning and evaluation purposes, as well as for funding proposals that you may generate. The Health Rights Hotline requires counselors to collect a significant amount of data from callers. Required data fields include: payer type (e.g. commercial, Medicare, Medi-Cal); health plan; plan type (e.g. HMO, PPO, FFS); medical group; the health condition that relates to the difficulty; zip code; referral source; issue categories (up to 3 issues can be coded per case); and personal

demographic information such as age, gender, ethnicity, education level, employer type, size of household, and household income. The Hotline uses 62 distinct issue categories to code callers’ issues and problems. In addition, the Hotline tracks the subject of the dispute using 28 subject areas (e.g. dental care, emergency services, home health, mental health, maternity, or surgery).

The Supervising Counselor reviews a sample of each counselor’s cases to ensure the accuracy of the data collected, ensure that all counselors are collecting data in a similar fashion, and to check the quality and completeness of advice and referrals given. The sampling rate is 1 out of 10 cases per counselor per quarter. The sample size is increased if a counselor’s error rate is higher than an established standard. Most counselors pass review at the first level, although some counselors consistently have all of their cases reviewed for accuracy.

Analyzing Call Volume and Time Spent on Cases

At the beginning, the Hotline benefited from a lower than anticipated volume of calls because it allowed the counselors and management staff to spend more time on refining protocols, training, and refining the information infrastructure. Counselors spend significantly more time on cases than was originally projected. Nearly 60% of the Hotline’s cases take between 30 minutes and 5 hours to resolve. The average time spent on these cases is 1.5 hours. The table below compares the projected time spent on cases to the actual time spent on cases during the Hotline’s first three years of operation.

Case Type	Original Projection	Original Projection	Actual Experience (7/97-6/00)	Actual Experience (7/97-6/00)
	Percent of Cases	Average Time per Case	Percent of Cases	Average Time per Case
Brief Cases (< 30 minutes)	70%	.5 hours	35%	.3 hours
Medium Cases (30 minutes-5 hours)	20%	2 hours	59%	1.5 hours
Long Cases (> 5 hours)	10%	7 hours	6%	13 hours

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Communicating a Clear Message

Developing a clear and consistent message and public image is critical to the success of your hotline. These enable you to become a trusted member of the community – an organization that consumers will turn to when they have problems. During its first six months the Health Rights Hotline contracted with a local communications firm. Through its communications consultant, the Hotline conducted focus groups of consumers who had experienced difficulties with their health plans, developed a program name and image, developed initial educational and promotional print materials, and conducted a test “launch” of the Hotline in a small part of its service area.

Working with the Media

Local newspaper and TV reporters can be strong allies to promote a consumer assistance hotline. Over the years, a Hotline can establish itself as an “expert” on consumers’ perspectives. Through the data collected and individual case stories, the Hotline can illustrate consumers’ real-life experiences on particular health care issues. While the Health Rights Hotline has had mixed success at getting “promotional” coverage by the news media, it has been able to have a number of consumer education messages placed as side-bars in local newspapers describing the basic steps consumers can take to resolve problems. The Hotline frequently is called to provide a case story that illustrates a particular problem being covered by a reporter.

Conducting Community Outreach and Education

The Hotline’s outreach activities have two goals: 1) to educate consumers to be informed, effective and empowered users of the health care system; and 2) to promote the Hotline as a resource for those who have questions or problems. Letting people know about the availability of its services, and evaluating which vehicles have been most effective in generating calls to the Hotline, have been two of the Hotline’s biggest challenges.

...{T}he primary sources of referrals to the Hotline come from community agencies (14%), people who heard about the Hotline at a presentation, health fair or other community event (13%), the telephone book (11%), news stories (11%), and other individuals such as family members or friends (“word-of-mouth”) (10%). The Hotline tested TV advertising and direct mail as part of its outreach plans, but both of these were found to be very expensive compared to the volume of calls generated. TV ads generated only 9% of calls; postcards 5%.

Through community education materials, presentations and attendance at community events, consumers learn how to use the health care system, how different types of coverage work, how to choose among health plans and medical groups, how to work with health care providers, and how to learn about health conditions. Community education events also serve to educate the community about the services provided by the Hotline. The Health Rights Hotline has also produced a variety of materials to educate consumers on how to navigate the health care system. Consumer materials are distributed to Hotline callers, to attendees of health fairs and consumer conferences, and via the Hotline’s web site – www.hrh.org

Using Data to Influence Policy-Making

Information on the experiences of the consumers served by a Hotline can be used to educate policymakers, health plans and provider groups, regulators, other advocates, and the public. Combined with individual case stories that illustrate the issues that consumers encounter in the health care system, data is a powerful tool for identifying and bringing attention to consumer problems. Data collected by a Hotline can be used to identify the extent of problems different consumers experience in the health care system; it shows which consumers are having problems, which types of problems are most common, and which problems are experienced disproportionately by different groups of consumers. Finally, data also can be used to track consumer problems over time.

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Evaluating the Hotline

There are a number of different methods that you can use to evaluate the effectiveness of your hotline. Evaluation of the Health Rights Hotline followed two paths. First, the Hotline instituted a number of mechanisms to evaluate its own services (e.g. follow-up surveys of clients served, and soliciting feedback from health plans and providers through regular meetings). Second, the Funders contracted with an independent evaluator, The Lewin Group, to assess the Hotline's processes and outcomes. The cost for the evaluation was approximately \$430,000 and included a survey of Sacramento area households, interviews with various health care stakeholders, surveys of consumers served by the Hotline, and analysis of the effectiveness of the Hotline's education and outreach activities.

The findings from The Lewin Group's evaluation of the first 18 months of the Hotline were published in the January/February 2000 issue of the journal, *Health Affairs*. The Lewin Group "found substantial evidence that the hotline helped consumers to resolve their problems and increased satisfaction with the problem-resolution process and the available assistance resources."

Potential Sources Of Funding

At its inception in 1996, the Health Rights Hotline was funded by three of California's premier health care foundations. Over four years, these foundations provided almost four million dollars for the program and its evaluation. In 2000, a fourth foundation provided a grant that funds a significant portion of the Hotline's operations through June 2002.

The Health Rights Hotline presently receives no funding from health plans or health-care providers. The Hotline does not receive government funding at this time, though for its long-range sustainability it will have to rely on government funding. Foun-

HRH funders are:

The California Endowment

The California Wellness Foundation

The Henry J. Kaiser Family Foundation

Sierra Health Foundation

dations are not likely to support these types of efforts indefinitely.

Beyond foundation funding, other potential sources for consumer assistance hotlines include:

- **Tobacco Litigation Settlement Funds.** Many states around the country are receiving funds as a result of the tobacco litigation settlement. States and/or counties could make these funds available for funding independent assistance programs to help consumers access needed health care.
- **Counties.** Some counties may be required to have "ombudsman" programs for different populations such as mental health, children, or older adults. Consumer assistance hotlines could contract with a county to provide advocacy services to distinct populations. Some counties have obtained federal waivers under their indigent health-care programs that provide funding for independent assistance programs. Independent programs that help people maintain and effectively use their health care coverage potentially may be funded as a support service for people who are transitioning from welfare to work.
- **State Departments.** Some states have created consumer assistance programs within their departments of health, human services, or insurance. Some programs may contract with community organizations to conduct outreach to specific populations such as Medicaid beneficiaries, Medicare beneficiaries and low income families with children who may be eligible for the CHIP (Children's Health Insurance Program). There also may be opportunities to contract with the state to conduct training of health-care providers on, for example, the rules and benefits under Medicare, Medicaid and/or private insurance programs.

In Conclusion

Setting up a hotline to assist consumers with their health-care problems requires careful planning. Adequate planning time is a luxury that many programs may not have, but to the extent possible, it is important to build that time into your work plan.

Independent consumer assistance programs are expensive. Substantial sums are required to ade-

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quately staff, train, supervise and evaluate counselors and to review the quality and accuracy of the data collected and the advice provided. Many of the problems raised by health-care consumers are severe and often require a considerable amount of time to research issues, provide appropriate advice, consult with the various entities involved in the issues, and negotiate solutions on behalf of callers. However, with adequate planning, training, and management, hotlines that provide assistance to health care consumers can have a tremendous impact not only on the lives of individual callers, but also on the health-care system.

About the Authors

Shelley Rouillard is the Program Director of the Health Rights Hotline, an independent health care consumer assistance program operating in the Sacramento, California area. She is one of the founders of the Hotline, established its extensive call handling and data collection protocols, manages the Hotline operations, and oversees the Hotline's data analysis and reporting activities.

J. Bridget Sheehan-Watanabe is a Policy Analyst and Staff Attorney at the Center for Health Care Rights in Los Angeles, CA. She analyzes Hotline data, writes reports and provides expertise to Hotline counselors on managed health care policies and programs.

The **Health Rights Hotline**, the first independent consumer assistance program serving all health consumers, began providing services in July of 1997. Administered by the Center for Health Care Rights (CHCR) and Legal Services of Northern California (LSNC), the Hotline provides services to health care consumers in four northern California counties – El Dorado, Placer, Sacramento and Yolo. Since its inception, the Hotline has served more than 12,000 individuals. The Health Rights Hotline's mission is to empower consumers to understand and exercise their health care rights and to improve the health care system for all consumers by identifying systemic problems and solutions.

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From the Frontline

*By Carol Matthews**

JUST SAY NO



At the recent Equal Justice Conference in Cleveland a panelist remarked that one of things a hotline attorney has to do a lot is say NO. No, you are not eligible; no we can't help you; no, you haven't got a case. What a hotline attorney likes to do is to say YES. The reason I like being a hotline attorney is that I spend a lot more time saying yes than saying no. Or at least that is my subjective impression. When I can really help the client by explaining to him what the problem is and then what the solution is and how he can do it himself, then the time flies. When I have to tell the client that I cannot help her time seems to drag. (Especially, when the client isn't taking no for an answer.)

Of course some 'nos' are quicker than others. No, we don't handle criminal matters. No, we don't consider 36 elderly even if you do feel as old as the hills. These are the easy rejections. I suspect this is partly because I have absolutely no doubt in my own mind that these are not my cases. A quick referral to the right place, the Public Defender or legal services and I can move on, guilt-free.

Conflict of interest refusals are easy for the attorney but hard for the caller. I understand very well why I cannot talk to the opposite party but the caller frequently doesn't. The caller thinks I ought to *want* to be informed of the lies my client is telling me, or to hear their side of the story. I have no qualms about telling the caller that I have a conflict and it would be unethical for me to talk to them, and that if they don't understand they will just have to take my word for it, but I know a lot of callers are still baffled by their rejection.

It is often very hard to explain to a client why they do not have a good case. What has the statute of limitations got to do with justice? Hearsay? But my sister-in-law told *me* what happened; why does she have to repeat it in court? Well, I didn't actually

read the contract but I'm sure it didn't say anything important. It isn't any fun explaining to a client with a personal injury case that while liability may be clear the damages are so small that no private attorney will take the case. Sometimes, the best the hotline can do is coach the client to present his case in a less paranoid, more sympathetic light: Keep the focus on his injuries and loss of wages and not on the malicious stranger of dubious parentage who deliberately caused the accident. Giving this sort of advice is called not sending the client away empty handed, but not by the client .

Sometimes the client must be told no because the program doesn't handle that type of case. If another program does then a referral may suffice. But what if one strongly suspects that no one else is going to want this case. What then? The honest answer is the client should be told that his case is not one that he is likely to get help with. In many instances the temptation is to pass the client along out of a reluctance to be the one to say no.

There are times when the hotline refusal is totally unequivocal. I have refused to find a lawyer to accompany an elderly gentleman to the DMV so that he can be sure of renewing his driver's license though failing the eye test. My hotline colleagues have refused to send someone to a client's home to trim the shrubs, or to clip toenails, or to discipline the grandchildren. Sometimes, even the hotline has to *Just Say No*.



**Carol Matthews is an attorney with the Legal Counsel for the Elderly Hotline in Washington D.C. Please email her your comments and ideas for columns from the hotline advocate's point of view.*