



## Best Practice: Addressing Health and Mental Health Barriers to Employment

REPORT UPDATED: MARCH 15, 2010

**CITY: NEW YORK CITY**

**POLICY AREAS: SOCIAL SERVICES: WORKFORCE DEVELOPMENT**

### BEST PRACTICE

The **Wellness, Comprehensive Assessment, Rehabilitation and Employment** (WeCARE) program helps underserved welfare recipients with health and mental health barriers to employment attain their maximum level of health and self-sufficiency.

### ISSUE

Nationally, welfare reform has had a dramatic impact on helping people move from welfare to work. However, welfare recipients with medical and/or mental health conditions have generally been left out of from benefiting from this successful shift in public policy. The WeCARE model provides services that enable social service districts and agencies meet their participation targets while helping recipients with health and mental health barriers to employment attain their maximum level of health and self-sufficiency.

### GOALS AND OBJECTIVES

WeCARE's goal is to help clients on welfare with clinical barriers to employment attain their highest level of health and self-sufficiency by providing customized services to identify and address their individual service needs. The steps are as follows:

- 1) determine an individual's employability through a comprehensive assessment,
- 2) link clients to treatment plans which stabilize their medical and/or mental health conditions that affect employability,
- 3) help clients obtain and retain employment, and/or
- 4) assist them in obtaining federal disability benefits if they are determined to be unable to work

### IMPLEMENTATION

Since 1997, New York City's welfare reform efforts have been very successful in reducing the cash assistance caseload by over 50%. However, a growing number of those clients remaining on the caseload were unable to benefit from HRA's traditional work programs because of their clinical barriers to employment. HRA developed WeCARE in order to give these clients an equal opportunity to transition from welfare to self-sufficiency.

When clients report medical and/or mental health conditions affecting their ability to participate in required work activities, welfare centers (called Job Centers) refer clients to one of two WeCARE contractors -- Arbor Employment and Training, Inc. or Federation Employment and Guidance Service (FEGS) Health and Human Services Systems, Inc. These vendors' medical subcontractors conduct a comprehensive biopsychosocial (BPS) assessments including complete medical and relevant specialty examinations, laboratory tests, and a psychosocial assessment. The BPS assessment determines a client's strengths and functional limitations. It also identifies clients who require emergency medical interventions due to untreated and sometimes previously undiagnosed, life threatening conditions.

Reviewing the findings of the BPS assessment and documentation from the client's treating community physician(s), a WeCARE physician determines an individual's employability and functional capacity. Clients may be found:

- "Fully employable" and are returned to their job centers for engagement in HRA's traditional employment programs.

## Best Practice: Addressing Health and Mental Health Barriers to Employment

- “Unemployable for twelve or more months” -- WeCARE works with these clients to apply for Federal disability benefits by preparing, submitting and updating the Social Security Administration’s disability application.
- “Temporarily unemployable due to unstable clinical conditions” -- WeCARE develops wellness plans with these clients, which includes linking them to treatment services, facilitating treatment adherence, and monitoring clinical progress. The wellness plan is completed when a client’s medical/mental health condition(s) are stabilized, resulting in a new employability determination. Regardless of their eventual work capacity, these clients are linked to needed treatment that they may have otherwise not received, improving their overall health and well-being.
- “Employable with limitations and are referred for WeCARE vocational rehabilitation services” -- Clients participate in a comprehensive vocational evaluation to more fully clarify their functional strengths, limitations, and need for any reasonable accommodations. An individual plan for employment is developed that provides a roadmap for the client to achieve his/her highest level of vocational functioning, including obtaining and retaining employment. Subsequently, clients participate in specialized work activities that include job search, work readiness, education and occupational skills training and a work experience program. Job placement, retention services and work supports are provided.

Case management, including escalating outreach through telephone calls, letters and home visits, is provided to clients to help them comply with and successfully participate in WeCARE activities.

Through the use of automated systems and electronic case records, WeCARE is able to efficiently track clients through all phases of the program and provide timely and seamless access to all available client information.

### COST

Annual cost of the WeCARE contracts is \$70 million. Approximately 1/3 of the budget is line item funding for case management services. The remainder is performance based on and earned by the vendors when they achieve the following outcomes: a) completion of the BPS evaluation, b) completion of a wellness plan, c) completion of a diagnostic vocational evaluation and an individual plan for employment, d) retention in employment for 30, 90 and 180 days, or e) federal disability awards.

### RESULTS AND EVALUATION

Utilizing a multi-disciplinary approach and an innovative performance-based payment structure, WeCARE has enabled tens of thousands of welfare clients to improve their health, wellness and self-sufficiency. It also has helped substantial numbers obtain and retain employment or federal disability benefits, resulting in a better standard of living. Important results include:

- Through December 2009, 248,313 individuals completed the BPS assessment since the program’s inception in February 2005. Of those:
  - 6% were determined to have no limitations to employment,
  - 42% were determined to be employable with limitations and in need of vocational rehabilitation services,
  - 35% were determined temporarily unable to work secondary to unstable or untreated medical conditions requiring a wellness plan, and
  - 17% were determined unable to work for 12 or more months and were referred for federal disability benefits.
- At any point in time, there are approximately 24,000 clients engaged in some component of the WeCARE process.
- From the program’s inception through 2008, performance improved every year in terms of federal disability awards, wellness plan completions and job placements. In 2009, performance continued to improve in first two areas while declining in the third.

## Best Practice: Addressing Health and Mental Health Barriers to Employment

- Over 19,000 clients found unemployable by WeCARE have been awarded federal disability benefits. In 2009, there were 6,959 federal disability awards, 23% more than in 2008 and slightly more than the total number of awards in the first three years (2005-2007) of program operations. There are currently over 11,000 federal disability initial applications pending with the Social Security Administration (SSA).
- Almost 40,000 clients have successfully completed wellness plans, by stabilizing underlying clinical conditions affecting their employability. In 2009, there were 11,265 Wellness Plan completions, 14% more than in the previous year and nine times as many as in 2005, the first program year.
- More than 11,000 WeCARE clients have obtained employment. In 2009, 2,329 WeCARE clients were placed, 24% fewer than in 2008, but three times the number placed in year one.

### TIMELINE

January 2002	Bloomberg Administration begins analysis of those individuals who have not left cash assistance, determines growing proportion of those who indicate medical/mental health conditions, documents they continue to cycle through existing processes without moving to self-sufficiency or disability benefits
June 2002	Initial Design of WeCARE program circulated to HRA Executive staff
July 2002	Request for Proposal (RFP) development begins
August 2002 – February 2003	Analysis of WeCARE costs and subsequent changes to the program design and RFP
July 2003	Final WeCARE RFP with Agency Commitment for Costs and Staff
August 2003	RFP Released
August – September 2003	Issue Formal Responses to Potential vendor's questions regarding the RFP
September 2003	RFP Evaluation Committee Convened
October 17, 2003	Proposals Opened
December 2003	Workgroups convened to address and develop HRA's WeCARE policies and procedures, identify issues to be incorporated into WeCARE contracts, identify and develop HRA technology and management information systems to support WeCARE
January 2004	HRA staffing needs identified and work begins with HRA's Human Resources Department to identify and recruit appropriate staff
February-March 2003	Selection of two WeCARE vendors
April 2005	Contract negotiations begin
June 2004	Contract with Arbor Employment and Training, Inc. finalized

## Best Practice: Addressing Health and Mental Health Barriers to Employment

July 2004	Arbor Contract approved by City Law Department
September 2004	Contract with FEGS Finalized
October 2004	FEGS contract approved by City Law Department
December 24, 2004	Contracts Registered by Comptroller
February 2005	First participants referred for a biopsychosocial assessment during three month start-up
March 2005	Full Implementation of WeCARE program
December 2007	WeCARE contracts renewed

### LEGISLATION

August 22, 1996	Personal Responsibility and Work Opportunity Act Instituted Temporary Assistance to Needy Families (TANF)
August 20, 1997	New York State Welfare Reform Act
October 30, 1997	NY State Office of Temporary and Disability Assistance, Administrative Directive (ADM-23) Public Assistance (Family Assistance) Changes Resulting from the Welfare Reform Act
April 12, 1999	Federal TANF Final Rule
Jan 19, 2001	Federal Policy Guidance Issued from the Office of Civil Rights on Prohibition Against Discrimination on the Basis of Disability in the Administration of TANF
February 7, 2002	Federal Administration for Children and Families (ACF) Reporting Requirements Issued
February 8, 2006	Signing of the Deficit Reduction Act of 2005 Reauthorizing TANF with new requirement of 30 hours participation in work related activities
June 29, 2006	Federal TANF Interim Final Rule (recalibrates the base year for calculating the caseload reduction credit and changes state work participation rates)
February 5, 2008	Federal TANF Final Rule (finalizes state work participation rules)

### LESSONS LEARNED

WeCARE was designed to be a dynamic program allowing for changes to improve operations and outcomes. This concept was built into WeCARE contracts requiring vendors to modify their program models, if needed. Described below are some of the lessons learned in administering the WeCARE program:

- A large public welfare agency has the capacity to modify traditional approaches to service delivery and develop clinically focused services to provide clients with functional limitations to employment, thereby providing an equal opportunity to transition from welfare to work.

## Best Practice: Addressing Health and Mental Health Barriers to Employment

---

- A significant proportion of welfare clients who have traditionally been labeled, or view themselves as unable to work, can become productive and reach a higher level of self-sufficiency.
- Outreach, one component of case management, appears to be an effective tool in increasing engagement in work, education and other WeCARE activities.
- A number of individuals require emergency medical intervention at the time of their BPS assessment.
- The most common medical problems are psychiatric, orthopedic, respiratory and cardiac.
- A proactive approach to Wellness Plans that links clients to treatment in the community facilitates improvement in unstable clinical conditions.
- Physicians need training to better understand employability issues, reasonable accommodations, and vocational rehabilitation services.
- Approximately 20% of the individuals who complete a diagnostic vocational evaluation are able to obtain employment and retain it for at least six months.

### TRANSFERABILITY

The WeCARE model can be useful to any agency working with individuals that have health and/or mental health conditions and has either a purpose, or understands the value, of helping them reach their highest level of health and sufficiency.

### CONTACTS

- Robert Doar  
Commissioner  
City of New York Human Resources  
Administration (HRA)  
180 Water Street  
New York City, NY 10038  
(212) 331-6000  
(212) 331-6214
- Dr. Frank R. Lipton  
Executive Deputy Commissioner  
City of New York Human Resources  
Administration (HRA)  
180 Water Street  
New York City, NY 10038  
(212) 331-6000  
(212) 331-6214
- Mike Bosket  
Assistant Deputy Commissioner  
WeCARE Operations, Office of Rehabilitation Services  
City of New York Human Resources Administration 180 Water Street  
New York City, NY 10038  
(212) 331-6000  
(212) 331-6214