Working Through Barriers:

How the WeCARE Program Helps New Yorkers

New York City's Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE) Program

NYC Human Resources Administration
Department of Social Services

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Table of Contents

"I try to understand what the people in my class think of themselves and how they see the world, so I can help them get past the problems they face. I had one student who was very resistant to participating at first. He cursed me out twice! But I got him to do his resume properly, and after he got a job, he came back to see me, to apologize and to thank me for helping him."

—Lynn, Work Readiness Instructor

To Our Readers

Dear Fellow New Yorkers,

Perhaps the most important result of the welfare reform legislation of 1996 was the realization that public assistance recipients would go to work and hold on to jobs if they were only given the right incentives. The true heroes of welfare reform, before President Clinton, the Republican Congress, and the state agencies that implemented the program, were the millions of welfare recipients who proved critics' worst fears and low expectations wrong.

But that achievement has not been universal. As welfare caseloads have dropped, it appears that a rising portion of clients are prevented from joining the workforce by conditions that make day-to-day tasks in the regular workplace difficult: mental health conditions, physical problems, and substance abuse. And the brave new world of welfare reform was not designed to respond to the needs of these clients.

Under the leadership of Mayor Michael Bloomberg, New York City designed WeCARE (the Wellness, Comprehensive Assessment, Rehabilitation and Employment program) to address this gap. By providing individualized, holistic services, WeCARE helps clients with medical or mental health barriers to work move from cash assistance to jobs or federal disability benefits. Now in its fifth year, WeCARE has helped thousands of New Yorkers leave cash assistance for greater independence and self-sufficiency. And as the first program of its size and scope to serve this population of welfare recipients, we hope WeCARE will serve as a model for other cities and social service agencies.

The continued ambitious goals for work participation rates for welfare programs highlight the need to find appropriate jobs for cash assistance recipients with clinical barriers to employment. But this is not the only reason, nor is it the main reason, why social service agencies should devote resources to additional services for these clients. While some members of this group are unable to work, others can if they have the right support and the right accommodations. Until we extend them a chance at employment and independence from public assistance, the promise of welfare reform remains incomplete.

Robert Doar
Commissioner
New York City
Human Resources Administration/
Department of Social Services

"I had a thyroid problem and got very sick and couldn't work. I wasn't getting proper health care and lost my job. I came to HRA because my wife, kids and I needed help. I learned MS Word and they helped me put a resume together. I'm applying for a job as a superintendent of a building. There are good people at WeCARE who want to help you."

—Angel
Angel has been in WeCARE for two months and is actively looking for a job.

Introduction

In 2004, nearly a decade after the implementation of work-centered welfare policies in New York City, hundreds of thousands of cash assistance recipients, many of them single mothers, had left welfare for work. But a significant number of those who remained on cash assistance had complex clinical barriers to employment, including unstable medical and/or mental health conditions.

For a welfare client, a medical or mental health problem that presents a barrier to employment does not need to mean a lifetime of dependence on public assistance. With additional support to stabilize their conditions and prepare for, find, and keep jobs that can provide reasonable accommodations, a number of individuals in this group can work. Federal disability benefits can provide a larger, longer-term income source for disabled clients who cannot work. However, more than 20 million working-age Americans have health problems that fully or partially impede their ability to work, and a full three-quarters of them do not work at all.[i]

While New York City had some services in place for welfare clients with medical and mental health barriers in the early 2000's, they lacked the strong cohesion needed to keep clients progressing toward work. The City's Human Resources Administration/Department of Social Services (HRA), which provides social safety net programs, saw the need for a program that provided comprehensive services for welfare clients with clinical barriers to employment. In 2005, the Agency implemented WeCARE, the Wellness, Comprehensive Assessment, Rehabilitation and Employment program. WeCARE builds upon HRA's earlier services for this group, but integrates medical and social assessments; wellness services; vocational rehabilitation; job training, placement, and retention services; advocacy for federal disability benefits; and case management.

While other districts have designed programs for cash assistance clients with complex barriers to employment, many provide a specific service, work with particular subgroups, and/or are implemented in districts with small caseloads. WeCARE differs in the range of services it includes and its scale: it serves approximately 24,000 clients at a given time, and New York City refers all cash assistance clients with medical or mental health conditions that prevent them from working to the program. In the four years since its initiation, WeCARE has helped tens of thousands of New Yorkers attain greater independence and improve their health and standard of living. The program provides a model for how other municipalities—particularly major cities—can serve this group of clients effectively and help those with temporary or partial barriers to employment move toward work. Providing these services has become especially important with the passage of the federal Deficit Reduction Act in 2005, which contained stricter work participation requirements for welfare programs.

"I hadn't had a job in three years when I came to WeCARE, but every day, I came in and put my heart into it. I've worked for six months for a private maintenance contractor at a WeCARE site, and I earn enough that I'm off PA. I try to inspire everyone here, even though it's not my job."

—Sabrina
Sabrina works at the building that houses Arbor Education and Training, LLC's WeCARE facility in Brooklyn.

Background & Context

Similar Programs

Historically, most local social service districts have exempted cash assistance recipients with physical or mental health barriers from work requirements. However, several states and local districts have created programs for this population. Programs include:

- Adult Rehabilitative Mental Health Services (Ramsey County, MN)
- Department of Workforce Services Social Unit (Utah)
- Disability Screening Services (Los Angeles, CA)
- Diversified Employment Opportunities (Davis Co, UT)
- Partnerships for Family Success (Anoka County, MN)
- Promise Jobs Disability Specialist Initiative (Iowa)

WeCARE differs from these programs because of its integrated nature and its size—the above districts either have small populations compared to New York City or provide services for a specific subgroup. However, WeCARE and these programs share several elements in common that Mathematica Research, Inc. highlights as best practices:

- Individualized services
- Comprehensive assessments
- Service plans that combine work and support, and allow participants to make progressive steps toward employment
- Ongoing support after job placement
- Case management
- Assistance with the federal disability benefits application process for clients who may qualify[ii]

In the 1990s, HRA worked with a number of local providers and state agencies to refer cash assistance clients with varying degrees of disability to wellness services or vocational rehabilitation, or help them apply for federal disability benefits. New York City's cash assistance caseload dropped by half between 1995 and 2000, as hundreds of thousands of former clients went to work. But an internal 2002 HRA analysis revealed that clients who reported they were unable to work due to medical or mental health conditions sometimes waited weeks or months for medical assessments or referrals to post-assessment services. Others cycled between medical assessments and vocational rehabilitation because they revealed unexamined health problems after being referred to the vocational rehabilitation provider.

The way services were delivered exacerbated these problems. An HRA-contracted vendor performed medical assessments while a state agency oversaw vocational rehabilitation contracts, and as a result, the programs were disjointed. Because provider payments were not linked to outcomes, there was little incentive to move clients through the program efficiently. Case management services were also weak or non-existent: clients had to schedule their own wellness appointments and report regularly to the medical vendor on their progress, even though the conditions that prevented them from working could also make it difficult for them to do these tasks. As a result, many clients failed to comply with cash assistance requirements and a significant number had their benefits temporarily reduced or their cases closed.

HRA saw that clients with clinical barriers to employment would be better served if they could participate in a range of services that were overseen by a single agency or provider organization; if they underwent holistic, upfront assessments; and if case management were improved and vendor contracts changed. In response, the Agency developed the WeCARE model and contracted with two vendors to implement the program.

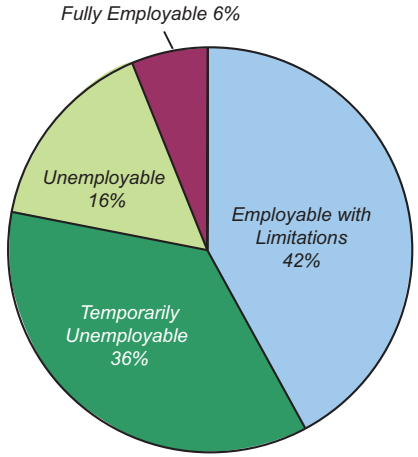
The WeCARE Model

New York City cash assistance clients are referred to WeCARE if they report that they cannot work due to medical or mental health conditions. Each client first completes a comprehensive biopsychosocial (BPS) assessment, which includes a medical evaluation; an integrated psychological and social, or psychosocial, evaluation; any relevant medical specialty evaluations; and core laboratory tests. WeCARE providers also review any clinical documentation from clients' own physicians or care providers. Most clients who are recommended for BPS assessments complete them: nearly 47,000 assessments (84 percent of referrals) were completed in 2008, and nearly all clients referred for additional specialty evaluations completed those as well.

After finishing the BPS assessment, a WeCARE physician determines whether the client falls into one of four "functional capacity" categories: whether he or she is employable or may be eligible for federal disability benefits. This determination guides the services offered during the later phases of the program:

- Clients who are employable with limitations participate in vocational rehabilitation (VR), which includes specialized work experience, education, training, job search, and/or work readiness activities. VR begins with an in-depth vocational evaluation that further clarifies clients' functional strengths, limitations, and needs for accommodation.

WeCARE Clients by BPS Outcome
February 2005-January 2009



- When clients have unstable medical or mental health condition(s) that render them temporarily unemployable, WeCARE develops "Wellness Plans" for them and links them to community-based treatment, provides case management and clinical support to facilitate treatment adherence, and monitors clinical progress to help them become healthier.

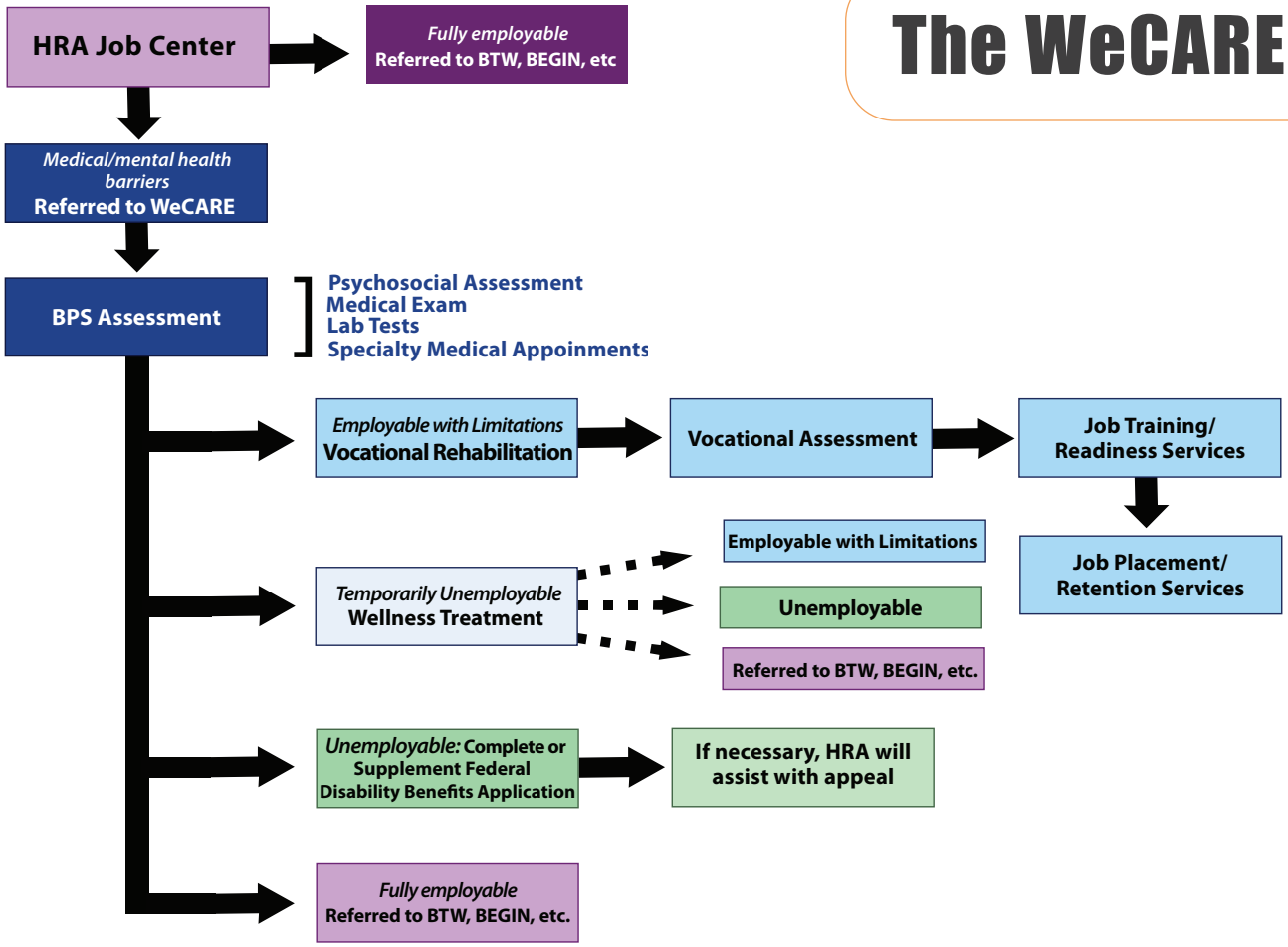
- WeCARE helps clients who are found to be unemployable for 12 or more months apply for federal disability benefits by preparing and submitting the Social Security Administration's disability application. HRA also helps clients appeal their cases if they are denied benefits. Clients who have already applied receive assistance to strengthen their applications and to keep clinical conditions stable.

- Clients who are fully employable are assigned to one of HRA's other employment programs, such as the Back-to-Work (BtW) program of job search and work experience activities or the BEGIN basic instruction program.

Each WeCARE client is assigned a case manager who specializes in the client's assigned program component. The level of the case manager's involvement ranges from "supportive" to intensive, depending on the client's needs. Case managers' duties include assisting unemployable clients with federal disability applications, facilitating treatment for temporarily unemployable clients, helping clients who are employable with limitations search for jobs, and conducting outreach when clients are not fully engaged in the program.

Approximately 24,000 client cases are in WeCARE at any one time, which amounts to around 7 percent of New York City's entire cash assistance caseload. The program's annual budget is approximately $70 million, and it is funded by federal, state, and city tax dollars.

The WeCARE Process

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2
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EXIT
EXIT

WeCARE Innovations

Several components of WeCARE directly address shortcomings in HRA's previous efforts to serve clients with clinical barriers to work, and help WeCARE serve clients more effectively. These characteristics also distinguish WeCARE from other districts' efforts to serve the same or similar populations.

- First, each client undergoes a comprehensive clinical assessment upon entering the program, rather than a medical evaluation focused on specific problems the client reports. This approach helps avoid unnecessary repeat assessments, allows WeCARE providers to address clients' conditions and the interactions between them holistically, and sometimes reveals serious medical problems of which clients were previously unaware, such as hypertension, diabetes and irregular heartbeats.

  A client who returns to the program after being disenrolled—because he or she did not comply with cash assistance requirements, contested the outcome of a BPS assessment through New York State's fair hearing process, or left cash assistance for personal reasons—does not need to repeat the BPS assessment if he or she has completed one within the last year. To help these clients reenter the program quickly, WeCARE developed "Clinical Review Teams" (CRTs) to determine if there has been a change in their health/mental health conditions.

> *"WeCARE does not give in to the idea that people with medical or mental health barriers cannot work. We help clients understand their strengths, not just their limitations."*
>
> —Dr. Frank Lipton, HRA Executive Deputy Commissioner, Customized Assistance Services

- Second, WeCARE integrates services from assessment to job placement or advocacy for disability benefits into one program, whereas in the past, different services were overseen by different providers. WeCARE services are provided by two vendors, Arbor Education and Training, LLC and FEGS Health and Human Services System, Inc., which HRA selected through a competitive bidding process. Each vendor is responsible for all WeCARE components within the New York City boroughs it covers, although some services, such as medical assessments and some VR services, are sub-contracted to other organizations. Combined with stronger case management, this structure helps make clients' transitions between different program components smoother.

- Third, a WeCARE case manager supports each client and monitors his or her progress throughout participation in the program, providing a level of support tailored to the client's needs at that time. Insufficient case management weakened New York City's previous efforts to serve this population. Although intensive case management is a key component of some specialized and smaller programs for welfare clients with barriers to employment, not all WeCARE participants need such a high level of engagement, and with 24,000 clients in the program, providing case management on a "continuum" is more practical and cost-effective.

- Fourth, HRA created performance-based contracts for vendors. Few clinically-oriented programs that work with individuals with functional limitations have been able to successfully adopt a payment structure that rewards results for clients rather than the amount of services provided. Vendors are paid based on completed BPS assessments, wellness plans, and vocational evaluations; federal disability awards for clients; and job retention after 30, 90, and 180 days. Vendors are not paid for assessing the same client more than once per calendar year, nor are they paid for services that are provided outside contractual timeframes. These milestone payments fund two-thirds of the WeCARE vendors' contracts; the remaining one-third of funding is provided through line-item reimbursements for case management services.

- Finally, HRA and the vendors use automated systems to record case information and scan client documents for storage. Vendors use their own systems to record detailed case information and BPS assessment notes; they also enter data into HRA's cash assistance client tracking system, which contains built-in checks to preserve data integrity and accuracy. This makes it easier for WeCARE staff to track clients' progress and to aggregate and analyze data, and ensures that clients' case information will be available if they move from WeCARE to HRA's regular cash assistance program.


F·E·G·S

"When I had my back operation, I couldn't work and didn't know if I would walk again. I was in a wheelchair when I came to HRA. They sent me to WeCARE and I was given therapy at a hospital. Within months, I was walking again. My job developer helped me get an interview with a graphics company. They hired me and I have been employed for almost one year."

—Aldo, former WeCARE client

Stacey, Aldo's former Case Manager, says Aldo was very motivated to look for employment, which helped him succeed. *"He always has a smile on his face and is willing to put a smile on someone else's face,"* she said.

Outcomes

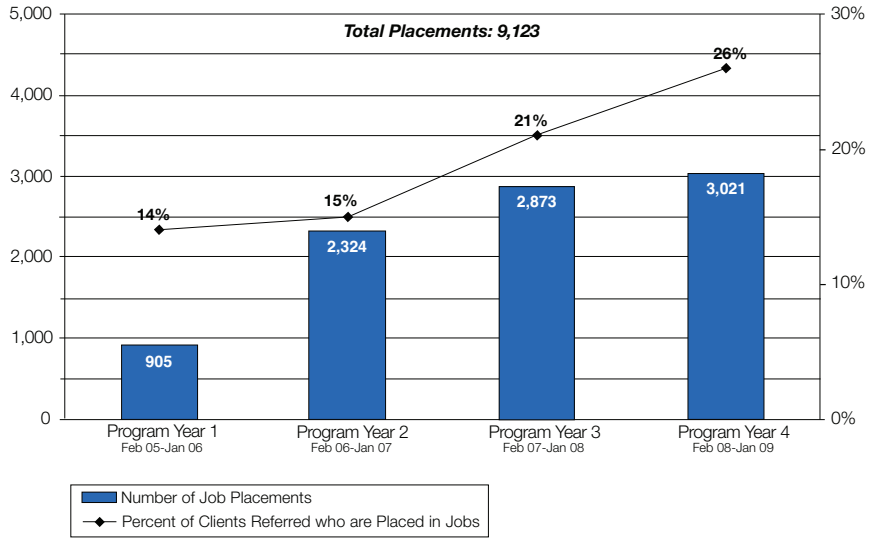
WeCARE's impact is measured by its ability to help clients find and keep jobs, complete wellness plans, and obtain federal disability benefits. By these standards, the program has improved throughout the past four years. HRA and the vendors strive to continue improving the quality of services provided and clients' quality of life.

Job Placement and Retention

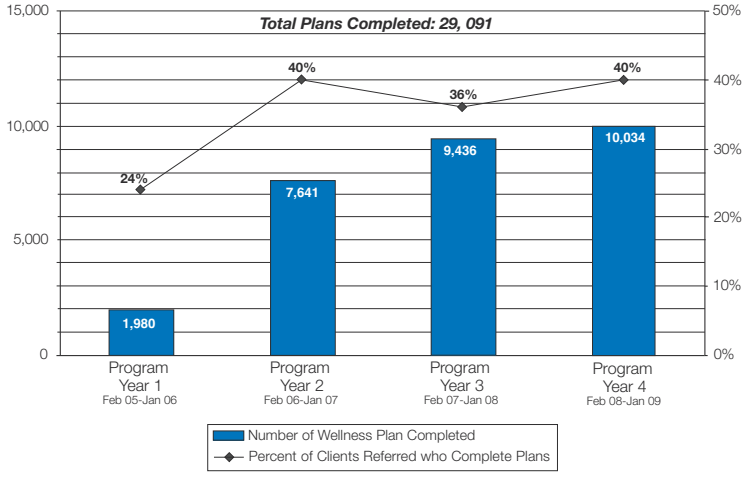
In total, WeCARE has placed more than 9,000 clients in jobs. The WeCARE vendors' success at making job placements, the most difficult component of the program, has improved markedly throughout the past four years: from Program Year 1 to Year 4, the number of clients who obtained jobs more than tripled and the rate at which clients who completed a vocational assessment were placed in jobs nearly doubled. The number of clients obtaining employment increased the most from Year 1 to Year 2, by 2.5 times—an increase that could be due in part to growth in referrals to the program and the buildup of WeCARE's operations. However, the placement rate grew most rapidly in Years 3 and 4, and despite the current economic crisis, in Year 4, there was a small increase in the number of job placements and the placement rate grew by almost 25 percent.

WeCARE tracks clients' job retention at three and six months after placement. Nearly all clients who retain jobs for at least three months keep them for the full six, a pattern found throughout HRA's employment programs. 82 percent of WeCARE clients placed in jobs retain them for at least three months, and 74 percent for the full six months; overall, 86 percent of HRA clients placed in jobs retain them for at least three months and 80 percent retain them for six months.[iii]

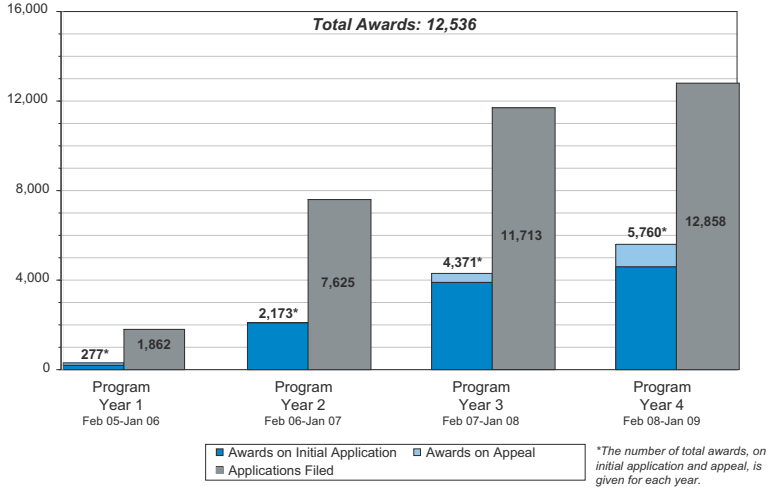
Job Placement: Yearly Totals and Rates, February 2005-January 2009



Wellness Plan Completion: Yearly Totals and Rates, February 2005-January 2009



Clients Awarded Federal Disability Benefits and Disability Applications Filed, February 2005-January 2009



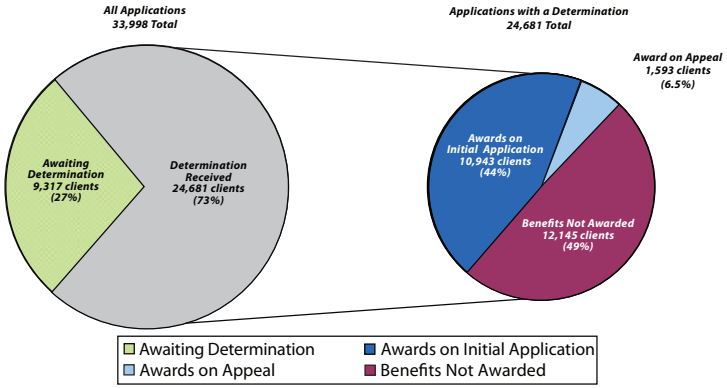
Wellness Services for the Temporarily Unemployable

More than 29,000 clients have successfully completed wellness plans, stabilizing the underlying clinical conditions that affect their health and ability to work. The number of clients who completed wellness plans increased almost four times from the first to the second year of WeCARE, and continued to improve at a slower rate after that. The percentage of clients assigned to this program component who completed it rose from 24 percent in Program Year 1 to 40 percent in Year 2, and while it fluctuated downward in Year 3, it has remained essentially stable around 40 percent since the second year.

Federal Disability Benefits

Over 12,500 WeCARE clients have been awarded federal disability benefits through the program, and the number of clients who receive benefits has grown significantly each year. In Year 2, eight times as many clients received benefits as in Year 1; the number of awards doubled from Year 2 to Year 3 and grew by an additional 30 percent from Year 3 to Year 4. Another 9,300 initial federal disability benefit applications from WeCARE clients are currently pending with the Social Security Administration, and almost 6,000 more are in the appeal process and have yet to be decided.

Percent of Applicants Awarded Benefits, Denied Benefits, and Awaiting Determination: February 2005-January 2009



WeCARE has a demonstrable impact on its clients' ability to obtain these benefits. Approximately half of clients who apply for benefits through WeCARE receive them upon either their initial application or their first appeal. Because the application process takes many months, it often spans multiple program years, so WeCARE's cumulative award rate is tracked. For first-time applicants, WeCARE's award rate, 44 percent, is significantly higher than the national award rate for first-time applicants, which is approximately 30 percent.[iv] Approximately 70 percent of WeCARE clients who are denied benefits and appeal the decision receive them.

Lessons Learned

WeCARE is ambitious in its scope and its mission to serve all New York City cash welfare clients with medical/mental health barriers to work. While praised for their work, HRA and the vendors have also learned from challenges and criticism in the past four years.

Moving from Design to Implementation

From the beginning, WeCARE has had to evolve in response to unexpected circumstances. In the program's first two years, many more clients than expected were referred for BPS assessments. HRA and the vendors adjusted to the increased client volume over time, but HRA also reduced the number of repeat referrals by implementing the Clinical Review Teams (CRTs) in January 2007. Since then, more than 55,000 clients have reentered WeCARE through the CRTs. For clients who did not respond to mail or phone calls, HRA had planned for WeCARE case managers to make home visits, but due to staffing constraints, home visits are only used in special circumstances. Finally, HRA had planned for the cash assistance program to serve WeCARE clients through cash assistance offices, or Job Centers, customized for them. But as the result of a lawsuit, HRA changed its plans and serves WeCARE clients at Job Centers throughout the City.

Quality Control and Customer Service

Providing high-quality services is a priority for WeCARE. HRA has monitored the vendors' performance since 2005, but the Agency was delayed for two years in hiring an independent quality assurance reviewer. A 2008 audit by New York City's Comptroller recognized several of HRA's effective monitoring techniques but also identified some weaknesses in HRA's vendor oversight procedures and noted the delay in hiring the independent reviewer.[v] HRA has implemented many of the audit's recommendations to address these gaps.

In 2007, a local advocacy group put out a report that praised WeCARE's design but criticized its implementation.[vi] Though the report's findings were not statistically significant, HRA responded to several of its recommendations and directed the vendors to implement client forums and suggestion hotlines, emphasized the importance of individualizing VR plans, and created a mechanism to ensure that vendors review client-provided medical documentation.

Perspectives on Clients' Conditions

Integrating medical, wellness, and disability services with VR sets WeCARE apart. These disciplines often view clients differently: doctors are trained to diagnose and treat illnesses and disabilities, while VR providers evaluate clients' strengths and the accommodations they need to work. As a consequence, it has taken time for WeCARE providers to ensure their medical staff take an employment-centered approach, and WeCARE physicians sometimes draw different conclusions than clients' own care providers about whether or not clients are employable.

WeCARE's VR component has faced challenges in finding the best way to serve clients who are assessed as being able to work with reasonable accommodations, but who think of themselves as unable to work. WeCARE work readiness instructors and case managers try to help these clients gain the confidence they need to succeed in the workplace, in addition to specific skills. It has also been harder for WeCARE to engage clients in VR than in the other program components. Around 40 percent of case managers' outreach efforts succeed for clients assigned to VR, 60 percent for wellness services, and 80 percent for clients receiving help with federal disability benefit applications.[vii] While this is an ongoing issue for WeCARE, it may become less of one as work requirements for clients with barriers to employment become more accepted.

Final Note

WeCARE has shown that social service agencies can give clients with clinical barriers to employment opportunities to move from welfare to work, and that they can do so on a large scale. Using a holistic approach that integrates multiple disciplines, an innovative performance-based payment structure, and sophisticated tracking systems, WeCARE has helped tens of thousands of cash assistance clients find and keep jobs, improve their health, and/or obtain federal disability benefits, improving their standard of living and self-sufficiency.

This report highlights several aspects of WeCARE that can be summarized as two concepts: comprehensiveness and customization. WeCARE is designed to serve all cash assistance clients with clinical barriers to employment, not just a subset with specific issues; all services for these clients are integrated into one program; assessments look holistically at clients' health and try to identify all potential barriers to employment; and case managers who follow clients throughout the program provide continuity. These characteristics lay the foundation for WeCARE to customize services. Comprehensive assessments help WeCARE identify clients' strengths and needs up front and design service plans to meet them. Integrated services make it easier to carry out that plan, and case managers track clients' progress and changes in their needs. Finally, performance-based contracts and the efficient use of technology have helped WeCARE run smoothly.

Other districts can draw on WeCARE's model and New York City's experiences translating the program from theory to practice. Some already do: WeCARE has received visitors from U.S. and foreign social service agencies who hoped to learn about the program. HRA will continue to improve WeCARE in years to come, and New York City hopes that other districts will be able to learn from its experiences to benefit their own residents.

Endnotes

[i] U.S. Census Bureau (2008). Disability Data from the Current Population Survey (CPS) ASEC, Table 2. Retrieved from: http://www.census.gov/hhes/www/disability/disabcps.html.

[ii] Derr, M. (2008). Providing Specialized Personal and Work Support; Derr, M. & Pavetti, L. (2008). Creating Work Opportunities; Martin, E.S., Pavetti, L. & Kauff, J. (2008). Creating TANF and Vocational Rehabilitation Agency Partnerships; Pavetti, L., Derr, M. & Martin, E.S. (2008). Conducting In-Depth Assessments. All published in Washington, D.C.: Mathematica Policy Research, Inc.

[iii] Information on WeCARE and HRA program outcomes comes from HRA administrative data as of February 2009.

[iv] A combined award rate of 30 percent on initial application is given for the Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs in: U.S. General Accounting Office (1997). Social Security Disability: SSA Actions to Reduce Backlogs and Achieve More Consistent Decisions Deserve High Priority (GAO publication T-HEHS-97-118). Testimony before the Subcommittee on Social Security, Committee on Ways and Means, House of Representatives, 6.

More recent data was obtained from the Social Security Administration's annual reports on the SSI and SSDI programs for 2007. The percentage of SSDI applicants awarded benefits upon their initial application averaged 31 percent from 1996 to 2006; while a similar figure was not available for the SSI program, total award rates—for initial claims and appeals— for applicants ages 18 to 64 was 25 percent for 2006. Citations: Social Security Administration (2008). Annual Statistical Report on the Social Security Disability Insurance Program, 2007 (SSA Publication No. 13-11826), 139. Washington, D.C.: U.S. Government Printing Office. Social Security Administration (2008). SSI Annual Statistical Report, 2007 (SSA Publication No. 13-11827), 132. Washington, D.C.: U.S. Government Printing Office.

[v] City of New York, Office of the Comptroller, Bureau of Management Audit (2008). Audit Report on the Oversight of the WeCARE Program Contractors by the Human Resources Administration (Comptroller's Report MG08-083A). New York, NY: City of New York.

[vi] Kasdan, A. and Youdelman, S. (2007). Failure to Comply: The Disconnect between Design and Implementation in HRA's WeCARE Program. New York, N.Y.: Community Voices Heard.

[vii] Sample outreach data provided by a WeCARE vendor for October-December 2007.

Other References

Berry, C., Smith, D., Kuhlman, J., Margulies, R., Oakley, L. & Wilbur, K. (2008). WeCARE Process Evaluation: Final Report. New York, NY: New York University Robert F. Wagner Graduate School of Public Service.

City of New York, Human Resources Administration/Department of Social Services (2002). New York City's Welfare Population: A Case for Fully/Partially Unengageable Cases.

City of New York, Human Resources Administration/Department of Social Services (2006). Welfare Reform in Motion. New York, NY: Author.

Doar, R. (2007). Testimony before the General Welfare Committee, New York City Council on the Wellness, Comprehensive Assessment, Rehabilitation and Employment Program (WeCARE).

Acknowledgements

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Michael R. Bloomberg
Mayor

Human Resources Administration
Department of
Social Services

Robert Doar
Commissioner