Welfare Peer TA Webinar

New York City (NYC) Human Resources Administration (HRA) Wellness, Comprehensive Assessment, Rehabilitation, Employment (WeCARE) Program

Moderator: Louisa Fuller
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Louisa Fuller: Hello and welcome to the Welfare Peer TA Network Webinar, the New York City Human Resources Administration Program, Wellness Comprehensive Assessment Rehabilitation and Employment Program, or WeCARE.

This is your facilitator, Louisa Fuller, with the Welfare Peer TA Network. We are excited that you have joined us today. We have three presenters from New York City joining us. We have Seth Diamond, the executive deputy commissioner of the Family Independence Administration at the New York City Human Resources Administration. We also have Mike Bosket, the assistant deputy commissioner of the Office of Rehabilitation Services and the director of WeCARE operations.

As well, we have Mitchell Newburn of the FEGS Health and Human Services System, one of the WeCARE vendors.

This Webinar has been requested by many participants in many sites across the United States who are very interested in learning more about the WeCARE Program, which was implemented in 2005 by the New York City

HRA. And at this point, I'm going to actually turn it over to Seth Diamond in one minute.

If you look at the slide, our learning objectives are to learn about the WeCARE Program, its history, how the program operates, the assessment and referral system, the vendors, the case management components. And also, just learning strategies for how to implement a program in your own states, localities, and tribes.

In order to ask a question at the end of the - after the end of the Webinar, after all of our speakers have gotten a chance to present, we will take phone questions then and the operator will actually give instructions on how to pose a phone question. As well, if you would like to ask a question via the live meeting any time during the Webinar so you don't forget your question, you can click on the top, click on Q&A, type your question in the top box and then click on Ask to submit your question.

And at this point, I'll turn it over to Seth Diamond.

Seth Diamond: Okay, hello everybody, I'm glad to be with you. As Louisa said, my name is Seth Diamond and I oversee in New York City the Welfare Reform Program that we have implemented. And I'm pleased to be with you and I just want to spend a couple minutes explaining the context of WeCARE and then you'll hear a lot more detail about how WeCARE operates.

In the City, I think it's important to note that we very much view this program as a welfare reform program. And maybe that's obvious in some ways, but I think it's an important statement to make - that the expectation for most people in WeCARE is the same expectation that we have for everyone in our other employment programs, which is they will go to work. It does serve a

population that may take a little longer to get there or may not be able to work full time, at least initially or even on the longer term basis, and where people may have to have somewhat modified settings.

But we have made clear from the beginning, both internally and to the providers of the program, that our expectation is that work is the outcome and that we want to be clear with everybody who enters the program and who serves people in the program that we very much want to maintain our commitment to work as part of implementing WeCARE.

The need for WeCARE, I think, is something that we're all facing across the country. In the early days of welfare reform - and I've been with New York City since the beginning - we didn't have as much of a need for programs like this because there were many more people who were able-bodied, and our attention was initially focused, I think, on serving those people.

And we were very successfully obviously across the country. And we're at the point now where we have, I think, as in most places, the proportion of people who have greater service needs is much greater than it used to be. Also with participation rates being where they are and the need to try and meet the 50% rate or something close to that, I think it's forced all of us to take a look at all the services that we deliver and to make sure that we have services that can serve the entire spectrum of the public assistance population.

I think one of the things we've all learned, as we've [learned] in these intensive years of focusing on people on cash assistance, is that it's not a homogeneous population. And if you're going to adequately serve the full range of people on cash assistance, you need a variety of programs that meets the needs of, really, what is a diverse population.

You still have in most states - I think in New York too - some people who are able to go to work with relatively little assistance. Some people who are probably in the middle and - but with some trying and some intervention - could go to work. And then you have others who need more intensive services.

And WeCARE represents a program to broaden the reach of our services, to make sure we are serving the entire population and does properly provide the most intensive level of services that we provide in the City, there's often the most intensive level.

It's again structured, as you'll hear, very much to be as consistent as possible with the welfare reform requirements in terms of combining work and other kinds of services. Of course, we are conscious in the structure of the program and in the way we've designed the services to be attentive to people's needs. And that's one of the things you'll hear, but about how it's more customized than some of the other programs.

But again, the goal is to try and be as consistent as possible with our overall welfare reform program. And it's a very important piece of our overall service mix; it helps make sure that for anyone who comes into our offices in New York City, we have something to offer them. It may be a more intensive program if that's their service needs, or a less intensive program if they can - if they need less services.

But we have the full range and I think that's a very important component of welfare reform and really makes welfare reform true and that it can offer something for everyone. If you don't have a program that's doing that, I think you're doing a disservice to a significant portion of your population and not

providing the kind of services that really are consistent with what we should be doing overall for those on welfare.

So let me stop. And I don't know, Louisa, did you want to introduce Mike or do you want him to just jump right in?

Louisa Fuller: Mike, you can jump right in.

Mike Bosket: Good afternoon, everybody. My name is Mike Bosket and I am assistant deputy commissioner overseeing the Office of Rehabilitation Services. One of the programs for which we're responsible is the WeCARE program. And so I'd just like to build on some of the comments that Seth made prior.

We have done this presentation for a number of social service districts and have some ideas as to some of the questions some of you have. We want to specifically talk about how New York City got to the point of the WeCARE program. And as Seth has mentioned, welfare - New York City has been very involved with welfare reform since 1996 - and since both federal and state welfare reform laws - and has been very successful in our case load reduction from over 1.4 million about 15 years ago to about 300,050 or so on any given day now.

However, what we notice is that after the welfare - after we saw the reduction in the case load - that the individuals left of the case load represented individuals who may have more complicated health, mental health, or substance abuse programs, and who needed services that were more intensive in the services than the individuals that we were dealing with before.

So New York had a history of dealing with these people, but in different ways and in different forms and programs prior to WeCARE, including a program

that we called our PRIDE program. And we also had programs to assess these individuals and to get a better idea of their needs. But what we didn't have was one program that encompassed all of those services and made it like a one-stop shopping kind of service, so that from assessment to job placement or (unintelligible) obtaining social security benefits, we now have one program that can do that, and that is the WeCARE program.

The City also realized that because of the magnitude of the program and the amount of clients that are involved in any given day, it's about 24,000 clients, which represents about 8% of the case load for HRA, that we could not provide these services ourselves, which is also a lesson we learned prior from our other programs.

So in order to provide these services, the City decided to do it, complete an RFP process for vendors to provide medical assessment services, vocational rehabilitation services, and case management. We went through the traditional RFP process from that and from the selected vendors, FEGS Health and Human Service Systems, of which Mitchell Netburn is here, and he's going to speak from a vendor perspective a little bit later. And then FEGS subcontracts, its medical assessment services, through two New York State Article 28 providers to provide medical assessments.

And they provide services for our clients who live in Manhattan, Staten Island, and the Bronx. Additionally, we have Arbor Education and Training, who provide medical assessment services and vocational rehabilitation services through subcontractor relationships, as well as vocational rehabilitation services themselves. And they serve our clients that live in Brooklyn and Queens.

Next slide, please. So the model is before you now and this is the model that we - the WeCARE model that has been applied. What we need to say is clients are identified right from the get-go when they come in to apply for benefits or when they come in for recertification of existing cash assistance benefits.

Part of our application, our recertification process, is the completion of an employment plan. And in that employment plan, clients are asked if they have any medical or mental health barriers to their ability to work. Should a client answer yes to one of those questions, they are automatically referred to a WeCARE site. The WeCARE site they go to is determined by where they live and what is the most convenient for them.

The entry point for all WeCARE clients is through a medical assessment process that we call the bio-psycho-social assessment. The bio-psycho-social assessment includes the completion of a psycho-social that's done by case managers who are Bachelor's level and above. And it assesses the client in the areas of education, legal, housing, work history, familial constellation, and all the other areas that could impact on a client's ability to work.

They additionally complete a laboratory assessment that includes the taking of vitals, X-rays, EKGs, and urinalysis. Following that, all of our clients see what we call is a Phase 1 physician. The Phase 1 physician reviews all medical documentation that the client is encouraged to bring with them and completes a review of systems with the client, a physical examination of the client and reviews all of the information that's been collected on the client, from the psycho-social process.

These Phase 1 physicians, it's important to point out their area specialty is focused on - not unnecessarily the disease and the management of disease -

but it's how does a particular illness impact an individual's ability to perform work? So as an example, an individual who comes in with high blood pressure and claims that they cannot work because of their blood pressure, the physician's job at this point is to determine if that condition exists.

And then what is the impact on the - on that person's ability to perform work? and what are the limitations that they may have on the person's ability to perform work? And the program's focus is not necessarily on what the weaknesses of the client are but rather what are the strengths of the client and trying to figure out what is it that a client can do versus what it is a client can't do.

Should a physician, when they're assessing a client, feel that the client has a condition that is outside their area of specialty, we also have 19 FEGS specialists at the - that can be referred to. Those include psychiatry, dermatology, ophthalmology, neurology and cardiology - those are our most frequently used.

The Phase 2 physician in these cases would assess the client in terms of whatever the unique illness that's their area of specialty and how that particular illness impacts on their ability to perform work-related requirements.

Following the bio-psycho-social assessment, each client is determined to have what we have called functional capacity outcomes. Essentially, the functional capacity outcome speaks to the client's ability to work and at what level the client can work. And the clients are informed of their functional capacity outcomes through a comprehensive service plan.

In a comprehensive service plan, the client sits down with a case manager from one of the vendors, at which point they go over all the information that's collected from the vendor staff, from the medical assessment, from the psycho-social, and discuss with the client what we have determined what are their functional limitations and their functional strengths to be.

And based on that, the client has then put down a pathway of service specific to that client's needs. And we have four particular pathways of service, the first being fully employable.

Next slide, please. A fully employable client would be a client who, at the Job Center, has claimed that they have a medical or mental health barrier to employment, has gone through our assessment processes. But in that assessment process, it's determined that while the client may have that potential barrier to employment, it is not significant enough to really present itself as a barrier of employment.

So these clients are considered to be fully employable and are sent back to our Job Centers and are referred to our normal cadre of job services for other individuals in New York City to help them find employment.

What's important to point out though, is that this particular functional capacity outcome doesn't meant that the individual doesn't have medical or mental health conditions. It means that those conditions are such that they're under control and do not represent a barrier to employment.

Our second FCO are clients who require what we call a wellness plan. This would be a client who comes to us and presents with an uncontrolled or unstable medical or mental health condition. Oftentimes, it's important to point out that the clients themselves may or may not be aware of these

conditions. As an example, sometimes when a client comes through for a medical assessment, the first time that they're told that they have something like diabetes or high blood pressure could be as an - as a result of our assessment process.

So to fully assess and fully understand the person's capability to participate in work-related assignments, we need to first get those conditions under control. So we engage these clients in what are called wellness plans. In a wellness plan, the client has designed a one-on-one relationship with the case manager, whose job it is to help that client access care for whatever conditions may be unstable or untreated. That may include referral to new providers if the client doesn't have those providers or it could also include advocacy with existing providers if the client does have an existing treatment provider but perhaps can't get in there quick enough or hasn't seen that provider in some time.

The client's responsibility during this period of time, which can be 30, 60, or 90 days, is to comply with all requirements of their treatment, to keep all medical appointments, and to keep in contact with the wellness case manager assigned to them by the vendor. That's usually a one time a month, face-to-face contact. And throughout the month, it may be telephone calls or others so that the vendor knows that the client is keeping their responsibility. These are eligibility-based appointments, meaning the client, in order to remain eligible for cash assistance, must comply with these plans.

At the end of the wellness plan, it's determined what the functional capacity is based on the end of that wellness plan. So we have three possible outcomes. It could be that the client's medical or mental health condition that warranted the wellness plan has been fully resolved or under control. And then, that medical or mental health condition no longer represents a barrier to employment, so that client is considered fully employable.

And like the slide before, those clients are sent back to the job centers to be referred to one of our normal job-seeking programs, like Back to Work. It could also mean that the client is now determined to be able to participate in vocational rehabilitation services or to participate to work on some level, but they're going to need assistance and accommodation to do that. And we'll discuss that further in a future slide. Or it could mean that the client is determined to be potentially eligible for federal disability benefits. Clients who are potentially eligible for disability benefits are those who are determined to be unable to participate in work activities for 12 or more months.

Next slide, please. So now we'd like to talk about those clients that are determined to be appropriate for vocational rehabilitation services. And this is probably what makes the program the most unique in terms of other job programs or other work-related programs nationally. In vocational rehabilitation services, all clients start with what we call a diagnostic vocational evaluation.

This assessment battery allows us to work with the clients and allows us to give assessments to the clients to identify the areas that are their strengths or identify the areas that they have interests, what their aptitudes are, and identify those areas that the client would be most successful in, in terms of employment.

The end of the (DVE) process is completed by the - an individualized plan for employment. The individualized plan for employment contains all the client - the results of the diagnostic and vocational evaluation, as well as what the short- and long-term employment goals are for the client.

Now this could include both employment or education and training if education and training are determined to be appropriate goals for the client, as well to achieve employment.

In vocational rehabilitation services, we provide job coaching, job search. Additionally, the case manager works with the client in terms of trying to engage them and keep them engaged in all activities of the program. Additionally, all clients are assigned to work experience programs that are consistent with what their goals are from their IP in terms of employment. And all clients are also given job readiness services.

The ultimate goal of our BRS programs is job placement - and can place all of our clients in jobs. And that's done through specific job development activities with each client. Upon placement, all clients are - receive retention services for 180 days post-placement. And in those services, the vendor works with the client to try and help them with any transitional benefits that they may be entitled to. Also helps them in terms of any issues they may be having with employment and keeping that employment. And should the client lose their job, it would also help the client in terms of replacement services.

The last functional capacity outcome that we have is those clients who we determine through this process are potentially eligible for federal disability benefits or social security. In this scenario, what we do is we assist the clients who don't have existing applications, and completion and submission of the application to social security.

For clients who already have existing applications and social security, the case managers at the program help the clients in terms of strengthening those applications by submitting any of the medical or mental health information we've gathered through our assessment process, and submitting that to social

security and completing any other forms that would help in terms of supporting existing applications.

Additionally, while clients are pending social security, they are offered case management services and links to treatment providers if they have medical or mental health needs that are currently not being met.

If the social security application is approved after it's initially put in, the client's case is then closed in our program in WeCARE. If it is not approved, the City has a specialized unit that helps all of our clients to file for an appeal with SSI on the initial decision.

So I'd just like to talk a little bit about our program outcomes. Since the program inception, which was in 2005, we have completed somewhere in the area of 250,000 bio-psycho-social assessments at this point. And in terms of the breakdown of our SCOs, it's about - we have found about 6% of our clients to be fully employable upon completion of our SCO - of our assessment process. About 42% of clients are engaged in VRS services, and we assist those people in attempting to find employment. Thirty-five percent of clients, upon complete of a bio-psycho-social, are found to have a condition that requires a wellness plan.

And as I just discussed, those clients then end up either as fully employable in VRS services or potentially eligible for federal disability. And about 17% of our client case load, we found eligible for - potentially eligible for - social security.

In terms of our outcomes in the first 5 years of the program, we've had over 11,000 job placements, and about 74% of those clients have retained their employment at 6 months. Twenty-seven percent of clients who complete our

DVE process become placed in jobs. This is an important statistic because it shows if we can get the clients in to complete the DVE process, that a 27% placement rate post is very good, especially if you even compare it to programs like VESID, where clients come to the program and voluntarily ask for some sort of vocational services. So this compares favorably to other programs similar to ours in types of vocational rehabilitation services, even though our population has usually more and pervasive and difficult problems.

The program to date has over 18,500 social security awards and over 38,000 wellness plans completed. And I think this is an important one for us to talk about because it's not an outcome measure that the City has any real fiscal gain from because if we move people to jobs and if we move people to SSI, clearly that leads to case load reduction.

But the 38,000 people who have unstable or untreated conditions now have stable or treated conditions. And in some ways this is - one could argue that this will save Medicaid dollars, because these are individuals who have used tertiary care or other sorts of emergency care for medical conditions that now could be stable. And then there not only are fiscal savings there in terms of Medicaid dollars, but also just moral and ethical savings in terms of what we've done in terms of improving people's lives.

The next slide shows you the improvements that the program has made over the past 5 years. With the fifth year being projected, we don't have the number through December yet. But you do see that the program has experienced growth in each of the 5 years that we've been running it, other than job placements. But I think nationally this - everyone would see this is a trend for 2009 - that because of the economic factors that are extraneous to the program, we are projecting about a 25% decrease in placements for 2009. But all of our other outcome measures are actually showing positive growth.

Next slide, please. So what are some of the findings that we've had from the program and what do we think makes this program so successful? Outreach is something that we built into the program right in the beginning because we knew that these individuals - who we already know have medical, mental health, or substance abuse problems - may be more difficult to engage.

So in every aspect of the program, rather than immediately moving to sanction or immediately moving to infracting clients, we allow clients - we allow the vendors to outreach to the clients to help the clients to complete whatever processes they need to do and to allow for further engagement of those clients.

As I mentioned, in reference to clients who require wellness plans - another one of our findings that when clients first come in for the first time - they're seeing the program at the medical site, we're finding a lot of urgent and critical and medical needs at that point. So a number of times a week, we're having clients who are transmitted from one of our medical assessment sites to an emergency room for some life-threatening condition.

In terms of what is the constellation or what are the most prevalent diseases we're seeing? Those would be, in order of presentation: psychiatric, depression and anxiety, orthopedic problems, respiratory - especially asthma - cardiac problems, and diabetes.

And then lastly - and I think this is something that nobody will be surprised at - many of the individuals that we're dealing with have- cope more - with medical, mental health, and substance abuse disorders, and that these all present unique and challenging problems to employment.

Next slide - so what do we think, why do we think the program's been successful, or what have we done other than those? We think it's successful because of holistic assessments. Rather than it just being a medical - strictly a medical assessment, it includes mental health assessment and a psycho-social assessment - all areas that impact not (unintelligible), but combined on an individual's ability to engage in work-related activities or to obtain employment.

As I mentioned from the beginning, we think one of the strengths of the program is the continuum of integrated services under one umbrella so that we don't have parsing out of services, which then creates sometimes a revolving door between the different service providers.

We believe that the clinical focus and the support that we give to the clients has helped to make the program more successful. The proactive wellness plan that really facilitates and encourages clients to be compliant with their medical or mental health treatment has really helped us in the end, in terms of completion of wellness plans, that our vocational rehabilitation starts with an assessment.

And it starts with an assessment that's not unlike the medical assessment we do at the front door, where it helps us to assess the client's strengths as well as the client's limitations. And it helps us to direct where the client might be more successful, both in initial job placement and in career growth.

And lastly, the importance of case management services and the - how imperative they are to all of these services and helping the clients to move through all aspects of the program, and engaging those clients with that one-to-one relationship, and to resolve any problems that they may be having as

well as to ultimately get them into employment or to help them with social security benefits.

And that's it for my part of the presentation. I'd like to introduce Mitchell Netburn, who is the executive director for FEGS WeCARE.

Mitchell Netburn: Good afternoon, except for those I guess on the West Coast, where it's still morning. My name is Mitchell Netburn and I'm senior vice president at FEGS Health and Human Services System, overseeing the WeCARE program.

If you go to the slide that just says about WeCARE - and I'm just going to very, very briefly and again why it's relevant, talk a little about FEGS. So it's been around about 75 years, and they're a very large health and human services system agency.

And the WeCARE program is both a relatively complex program, but also very large in scope. And I think it does take a large agency to be able to support that. So that's one of the things that's relevant about the size of our agency, and the fact that we've dealt for many years with dealing with mental health issues, other health issues, domestic violence, et cetera, et cetera. Because as Mike explained, this is a very holistic program and we're looking at all of those factors that are influencing a client's ability to enter back into the workforce.

If you go to the next slide, where it talks about the overview of FEGS and, sort of, circle, FEGS is a little unusual in that we actually have a fair number of for-profit and not-for-profit subsidiaries. And one of the relevant ones there is called All Sector Technology.

One of the things that's unique about this program is that in the original RSP, the New York City Human Resources Administration required that there be electronic records for the clients, that it be basically a paperless system. And as everybody knows, there's a big discussion going on now about moving the health profession to that, and it is slowly getting that way.

Well, at this point, over 5 years ago that is how this system was developed, and working with medical providers and requiring them to have their physicians solely use an electronic database and, really, case management system was quite a challenge then. And we actually had to develop technology to know such technology existed. And that's - we were able to rely on the resources of one of our subsidiaries for that.

If you go to the next slide, we'll talk about our mission and vision statement. Clearly, we're here supporting acceptance that really is originally New York City's Reform Initiative. That is how WeCARE is seen - as just one part of many that New York City is utilizing to implement welfare reform and ultimately move as many people off of welfare cash assistance into employment, if they are able to work. So we see that WeCARE is a critical component in helping to carry out that initiative.

And I just want to touch upon the vision statement. I think one of the things there that we really look to our clients to do is really to inspire us as well. It's not just enough that they go back into the workforce, but we really use them as peers to get that message across to other clients.

But also, we really are trying to change the mindset of our clients, many of whom really had disability for a long time and may have been told by friends and family members and those in the medical profession as well that they could not work because of their disabilities. And we're offering changing

what is years - and sometimes decades - of them thinking that way. And so one of the things we really want to do is for them to go back into their communities and become role models for their families and others.

We've put together on the list a list of our values - and touch on some things that I just said about respecting our clients and really seeing us continually advancing them.

I'm going through these slides a little quickly because I - this presentation wasn't made to stand on itself - but Mike over many of them. These slides entitled, The Client Flow – often, when I'm meeting with new staff, this is a complex program, as Mike went into the details. And we try to boil it down as simple a slide as possible, so sometimes those things take a long time. This slide actually took a long time to put together.

But you can see all of our clients are referred to us by the New York City Human Resource Administration. The first place they go is to a licensed medical clinic. And then they receive vocational rehabilitation services, mostly employment. And that would be the most direct flow.

Many of the clients will go either to that SSI track initially, or will go into that wellness program that Mike talked about. And from there, either go back - go into the SSI program - or to the vocational rehabilitation services.

But the way to supply this program is after a comprehensive medical assessment Our job as the provider is to get that client either a job or SSI approval. And that's really what we focus on our staff. Now, to keep that always in mind that that is the goal - because sometimes our clients do require intense services, as Seth and Mike were saying. And sometimes you get very

wrapped up in that. But we always want to keep the focus on getting a job, if clients in that track, or getting them SSI.

The next slide is very similar to the one that Mike had, which is a good thing - we're on the same page. In terms of the client flow, we just have much more detail on that chart that I was just talking about.

Then the next slide, just to tell some of our location and the subcontractors. One of the few direct services FEGS does not offer is licensed medical services under what in New York State is called an Article 28 license. Basically that's a license for clinics, hospitals, et cetera.

And so we have offices ourselves in New York City - within the five boroughs of New York City, within Manhattan, where we serve clients from Manhattan as well as Staten Island. And then we have an office in the Bronx, where we serve the Bronx clients.

We've subcontracted in Manhattan with a well-respected community-based provider called the Institute for Family Health. And we have a clinic that is just dedicated to this program, a clinic that serves no other clients.

In the Bronx, we currently have two facilities that are operated by Bronx Lebanon Hospital, a very large urban hospital also focused on finding a lot of community services. And I'll talk towards the end in just a couple of minutes about how important those relationships are with those medical providers.

On the next slide, you see a table of organization. Provided, this is just to show to some degree the complexity of the program and the amount of organizational support that it takes. There's a lot of support from our chief operating officer, Jonas Waizer, and our chief executive officer, Gail

Magaliff, who are really very involved in this program - literally almost daily - in some ways. Obviously, it's primarily my responsibility.

And one of the things is we do have a medical director on my staff, even though we're not directly providing those services, we do need to oversee the two vendors that are providing those medical services as well as a tremendous amount of training for our staff on medical issues. Most of our staff do not have medical backgrounds, yet they're dealing with clients. All by definition either have medical or mental health backgrounds - a challenge.

And so it is very important that we have a person on staff for quality assurance, ongoing training, reviewing cases, and really learning as much as possible about this sort of unique part of medicine, which is how do various disabilities impact a person's ability to work?

Then there's - we have sort of a Number 2 person under me, so to speak, who oversees really all of our kind of case management services, is the way to think of that. And we've really broken that down, and we separated it out, vocational services under one person, and then separately, the wellness program that Mike talked about as well as the SSI program.

And given the intense focus and the whole point of this program is getting people to jobs. We really separated that out, in and of itself, to put that focus on that, and have a specialized unit for that. The staff, for instance, overseeing our clinics, and then really somebody who handles all of back office operations aspects of this, which there's a lot of IT issues that come up, (unintelligible), et cetera.

So it just also gives me a sense of the scope of the operation needed to support this. On the next page is a variety of units that we have. And these are solely

dedicated to the WeCARE program. So these are not part of FEGS' overall finance department, et cetera. These are all staff of (unintelligible) reporting to me in these various specialties.

And as Mike had mentioned, outreach is a big component. We have a specialized unit that really reaches out to the client (unintelligible) coordination unit. And just in case managers are doing that at certain times, it really helps having a specialized unit to do that. Quality assurance, as I mentioned before - we kind of split that between medical and the non-medical parts of the program. Then you see my contact information there on the left page.

What I want to talk about from the provider perspective a little, some of the things that work. And I think one of them is the model. Mike and Seth sort of explained the history of this program developing.

But I think some of the unique things that we see as a provider and having had a lot of experience in employment services, as I mentioned for about 75 years. But also, we were involved in the - what's sometimes referred to as a precursor to this program that Seth mentioned - called the PRIDE Program. And we have many other contracts with New York City and, specifically, the Human Resources Administration.

One of the things that's really unique about this program that we think really works is the one-stop shopping model, that a client comes to us and they get the medical assessment, it's (unintelligible), I have staff there along with the subcontractor staff. They know they're coming to a FEGS facility, meeting with our staff, the staff will explain to them the next steps.

And so when they're coming to get those other services, whether it's a vocational rehabilitation service or wellness, et cetera, it - they kind of feel that it's all being provided by one entity. And we really try to establish a culture from that very beginning - of respecting the client and what they should expect in this program.

And in many of the other programs, the (unintelligible) to the WeCARE program, such as the PRIDE program, the clients received their medical assessment from another provider. And so that was really not fully integrated into the program and, to some degree, staff at FEGS or (unintelligible) - well, the medical, what you're hearing (unintelligible) - that's not really relevant to what I'm here to help you with today. I'm here to help you get a job.

I'm simplifying that a little bit, but there was a little bit of truth to that. It's very much in silos, and the client went on Monday to get their medical assessment from one provider, and on Tuesday to somebody else to deal with (unintelligible), and on and on. It was something very confusing for the clients, and the staff really didn't integrate their interactions with the clients. And I think ultimately it made it less successful. And so I think really one of the most critical things here is that all of the services the clients are receiving are under our purview.

And whether it's the services we've already mentioned or if it's child care issues, domestic violence counseling, that may come up at any stage of the process that's needed. Housing issues, et cetera, et cetera - our contract with the City requires us to provide those services and not to just say, "well, go somewhere else for them; that's not what we're here to help you with." We really view people as whole people, and we can't expect somebody to show up in our facilities, getting training for 35 hours a week or to work 35 hours a week.

If they're worried about a sick parent at home or child care for the children, we've really got to address those issues to be as successful as they can. So I can't stress really about how critical I think that model is.

And I think along with that is having the medical assessment done, ultimately through a contract with the City. And I know in many jurisdictions, they rely on the medical assessments that clients themselves have had done from their treating physicians or community-based physicians. That information is obviously very critical and we give a lot of weight to that, how physicians look at that. We ask the clients to bring it in - if they don't have it, we get that information because they've obviously had an ongoing, long-term relationship, sometimes, with their community providers.

But this is a very specialized assessment we're looking at is, can - what is this person's ability to work or not to work? And this is not something that traditional physicians have been training to do, and they're really looking at the client from a different perspective, treating them, having that ongoing relationship. And we really work with our physicians to look at it very much from that assessment point of view.

So I think that the part of this whole process with really a comprehensive full review of systems. We're not just looking at the one issue the client may raise, if it's medical or mental health. We're really looking - is it a full physical exam of a very, very high quality? Our doctors are not only required to be licensed, but to be board-certified in their respective specialties. That really forms what I sometimes refer to as the foundation that the rest of the program is built on.

So just as a building is only going to be as good as the foundation it's built upon, all the services we provide to that client are only as good as the medical assessment that was done initially. As I said earlier, my staff, we're not medical - medically trained - or experts. And so we really rely on what the doctor is telling us - if the person can work or not. And if they can work, the doctor is required to be very specific and tell us what accommodations that client may need in the workplace, or what limitations there are to employment.

So for some clients, it may be as simple as they need an ergonomic chair because of a bad back. The clients who are with certain mental health issues, may not be able to use public transportation during rush hours - being in a crowded train or bus will be overwhelming for them. So we need to know that and find them a job that can accommodate that.

Some clients may be able to lift, but only a certain amount per hour. And it's critical that the doctors let us know all that information. And I think the fact that the system is electronic, there is a number of my staff, case managers, they don't have 50 folders with 50 different names of clients on them and lots of pieces of paper in them and there's none of that. It really is a paperless system. Sometimes clients bring in documents, we - obviously those are on paper but we scan them in. We actually have a unit that does just that.

And one thing that helps is the clients don't have to tell the story over and over again. I've worked in the field for many years and it's one of the complaints I've often heard from clients. Some of the stories are difficult to tell, embarrassing, et cetera. And it's frustrating for clients to spend time repeating them.

So here, any one of my staff can see the entire client record and just really talk about the specifics about certain issues that need to be addressed. It is also great from a quality assurance point of view. At any point, any of my managers, myself, medical director, can look at a client record and really see the whole record; we can see what physicians are doing and almost address them on the spot. So I think that is another critical thing.

The relationship with the (unintelligible), I think, is very critical. This was a very large program and really hadn't been done before. I think in many ways, it's still unique. And particularly in the beginning, a lot of back and forth and I think the City did a great job designing it. And with any design, it needed some modifications, and they were really very open to hearing those suggestions. I won't say we always agreed with everything but, all in all, it's been a great relationship.

I think it's been critical and the program is complex in that size, to have that ongoing relationship with the funder and be able to raise issues with them. Along that (unintelligible), this is a performance-based contract. And so the best bulk of the funding that FEGS received, we only received if we achieved meaningful outcomes for our clients. And they were certain what referred to as "milestones" in the contract.

So when that initial medical assessment is completed, if that's done in a certain timeframe, which is actually quite short - 17 days - we get a payment. And then, so skipping a couple of them, you go to the employment, we don't get a milestone payment when a client's employed because it's relatively easy to get a client for (unintelligible) a day and that's really not helping them. So we get a payment if the client has been employed for 30 days and at 90 days and 180.

Obviously, that is what this problem is about and those are the meaningful outcomes. And so what I was saying, certainly keeping you up at night, sometimes and there's a tremendous amount of pressure on the providers, and I think if I can talk to a vendor that covers the other two boroughs, they would say the same thing - is that ultimately it keeps our feet to the fire, so to speak, and it keeps us focused on really making a difference in those client's lives, getting them those tools, training, skills that need to get meaningful employment.

And rather than just meeting with them every week and saying yes, we've met with them and we've sent them on the job interview, there's no payments for those because in and of themselves, those things are somewhat meaningless. Obviously they're steps on the way to full employment.

So I think performance is the nature of this - certainly from the City. It means they are using taxpayer dollars only to fund things that are really sitting in under the umbrella of welfare reform and helping citizens of New York become gainfully employed. But it really keeps the pressure on us in certain ways and keeps us focused on really helping those clients.

There's a similar one for that SSI contract. We only get paid when the Social Security Administration approves that application. And so there's a lot of work that goes into applying for that, but we don't get paid when we file it. Because again, what the City wants is a quality application filed. And the proof of that is once it's awarded.

And then sort of last (unintelligible) Mike did touch upon this, is we saved a lot of lives in this. Literally, almost every day somebody from one of our sites is sent to the emergency room, sometimes doctors have literally stopped an exam in the middle and their client's blood pressure is so high and symptoms

along with that, that the doctor feels that that client can't wait to see a physician and get on blood pressure pills. Certain mental health, where somebody's really active suicidal, or homicidal intentions and the like.

And so just from what Mike had said, sort of a moral but ethical point of view, it's critical, but it certainly has saved dollars in terms of non-essential emergency room visits or other types of interventions. So that's critical.

And then I'll wrap up with just some of the challenges that have been. One, I think, is as critical as it is of having a relationship with the medical providers and it is - it took us a little while to realize how much training we needed to do with the physicians.

Most physicians went to medical school to treat people. And no matter how many times we would say, this program is not about treatment, it's about assessment - assessment, not treatment.

The reality is that is very hard to change physician's view of that. They're always wanting to treat. And one of the ways we've explained how often we do want the client to get treated, and other parts of the program are geared for that, and our case manager making sure our clients have physicians to go to, they're going to those appointments; we follow up.

But initially, many of the physicians put a lot of clients into, let's say, that wellness program. This client needs treatment. Now, we understand they need treatment, but right now - can that client work? can they not? And so many people obviously, who are getting ongoing medical treatment are in the workforce. And so that was critical.

And frankly for some doctors, they didn't feel comfortable in the program, and so we've learned over time to really screen doctors early on and really explain this, because it's not going to work if you don't have a doctor that's fully committed to the program. And as I said earlier, that is the foundation of the program - is that a good assessment by the physicians - so it's critical to have that.

I think one of the other things changing the client perspective is obviously a challenge, as in any cash assistance program. But with clients with disabilities, so often they have been told that they cannot work, and we're trying to change that perspective. So often when I meet with new staff or I meet with clients, I'll say maybe, yes, you do have disabilities, and sometimes it's multiple disabilities.

But the reality is that maybe, you can only do 2% of the jobs that are out there. And we like to refer to that as great news because that means 2 out of every 100 jobs you can do rather than saying, you can't do 98% of the jobs and therefore, you can't do any, which we feel is very disempowering frankly. And so we're not expecting the clients on their own to find their 2% of the jobs, we'll get them the skills they need to get those and help them through job developers find those jobs. But we really do refer to that as really good news.

And then I think the last thing I think is that, due to our clients all having some disability, the sort of supports they need, the training they need, really has to be very individualized to their disability. And there are a lot of jobs that they can't do successfully because of their disabilities.

So it requires a lot of individual work. And given the scope that we're dealing with - about 25,000 clients a year - that is a challenge to always to do that, to

remind our staff that each client is different and to some degree with the changing economy, we're now seeing higher functioning clients. And that poses other challenges as far as staff. They don't need some of the basic assessments we've traditionally done, nor are they suitable for entry-level employment. But that is certainly a challenge.

So with that, I'll wrap up and I think we're ready to take questions.

Louisa Fuller: Yes, thank you, Seth, Mike, and Mitchell. That was a great review and we have had lots of questions come in over the Web as you've been talking. I'll ask the first question and then Operator, actually right before I ask the first question, can you remind people on how to register a question by phone?

Operator: I sure can. Ladies and gentlemen, if you would like to register for a question, please press the 1 followed by the 4 on your telephone.

Louisa Fuller: Okay. The first question - Where do your funds come from to pay for the vendors who provide the client assessment?

Man: Do you want to answer that?

Mike Bosket: Well, it's a combination of TANF money, most of it is TANF money. There's some state funding in there, I think, too. But most of it is our TANF funding - yeah.

Louisa Fuller: Okay. How do you handle individuals who refuse medical or mental health assistance?

Mike Bosket: Well, the - it's an eligibility requirement. So as an example, our bio-psycho-social assessment process or any of the appointments that are there that are

meant to do an assessment are actually part of an eligibility process. So refusal - the initial refusal to comply with the initial process - actually impacts on the individual's eligibility to continue to receive cash assistance benefits.

Mitchell Newburn: Well, that does come up occasionally in the clinic. Not so much with the physical exam but very often we (unintelligible) to do - have a lab analysis. Not drug screening really, but just general part of the assessment. Sometimes they'll object to that for a variety of reasons, and some have raised religious reasons. That has not been validated that we put that up. We will allow those that have one done recently to bring that in and accommodate it.

But as Mike said, one of the things we claim this is not a voluntary program, it's mandatory and it's important.

Mike Bosket: And I mean, additionally, we don't go right to case closure infraction. Considering the fact that many of these clients have mental health issues and the staff at the vendor site, many of them are mental health professionals.

The first level would be to explore that resistance and try and figure out why it is the client is refusing to comply or doesn't want to comply with the assessment process and then trying to deal with any of the concerns that they may have. I mean, that is the first step and outreach is used, as an example, for that process to help clients to try to comply.

But ultimately, it is impressed upon the client that - to comply with these appointments is a condition of eligibility for cash assistance.

Louisa Fuller: Great. The next question is - Do you have any issues of client privacy and sharing information?

Mitchell Newburn: No, I mean, we have client set as a whole slew of confidentiality, agreements that they signed. And we stressed to our staff (unintelligible) the requirement and we explained that to the client. So we do an orientation at the clinic, it's really one of the first things we do with clients and we really stressed all that and explained it.

And that really has not come up. At this point, we've seen over 100,000 clients.

Mike Bosket: HRA collects a consent from the client when they're referred to the program that allows the vendor, as they're collecting the information, to share it back with us. And in the vast majority of the cases the clients agree to and sign that consent, which covers all HIPAA and in New York State, substance abuse-related and alcohol-related information.

If the client chooses not to provide that consent, they are asked by the vendor at various points of the program to sign the consent, with explanations as to why signing a consent that allows for the sharing of their information, how that would be helpful to them. And most of the time, it's not that often, we get clients who continue - if they make - refuse to sign the consent initially. But most of the time, most of our clients do end up signing consent that allows for the sharing of information.

Louisa Fuller: This one has several questions, but what percentage of WeCARE clients are approved for SSI after the initial application?

Mike Bosket: Well, right now, that's hovering in the high 40s, it's about 48%, 49% are approved upon initial application.

Louisa Fuller: And what is the average wait time for an ALJ hearing in New York State?

Mike Bosket: Yeah, well, that could be a long time. Unfortunately, after denial to an ALJ decision, I mean, I don't have that statistic off the top of my head. But I can tell you 2 years plus is not unusual.

Mitchell Newburn: On the initial application, we've been pretty...

Mike Bosket: Initial applications are - we're getting decisions around the 7-month mark. But if an ALJ decision is included, add another 12 to 14 months to that initial 7 months.

Louisa Fuller: And this last question, which was related to all of these I'm assuming, lastly, what was the cost per client? I think that might be a question overall for WeCARE clients and maybe specifically if there's a specific cost for SSI.

Mike Bosket: Well, so, the only way we can do cost per client is we can tell you what the annual budget is for the program. And you have to understand, we in New York City, like everybody, has gone through several rounds of budget cuts. And so this program has gone through several rounds of budget cuts.

The original funding level 6 years ago was about $70 million a year, and we've gone through several rounds of budget cuts, is all I can say. Some of the figures we're still working on. We can then, if you just go by the amount of clients that have been in the program, it's about $1,500 per client, if you go by the number of clients who've been in the program divided simply by the budget costs. And that's the easiest way for us to figure that out, is around $1,500 per client.

Louisa Fuller: Great. Operator, do we have any questions on the phone?

Operator: No, ma'am, we have no questions on the phone line.

Louisa Fuller: Okay, I have a lot more questions here. In the WeCARE assessment model, are services provided in one location?

Mitchell Newburn: Services are. The clients go to the medical clinics, and those are not where all the other services are. So other than for the medical assessment, all other services are provided in one single location.

Now the only real exception to that, we do sometimes obviously send clients on job interviews. There are certain trainings that are off site. In New York City, there's something called work experience program, or WEP, where basically clients - it's like a unpaid internship at a not-for-profit. And those would be off site.

But in terms of all the case management services, whatever (contract) that client's in, whether it's wellness at SSI or the location (realization), the model that we have (unintelligible), all of those are in one single location.

Mike Bosket: All right - and we should point out that there are actually four discreet service locations. Arbor has one, and Brooklyn one, and Queens and (unintelligible) and Manhattan one and the Bronx. So even the clients who live in Brooklyn, Manhattan, Bronx, and Queens all have centralized offices where they go for post-medical assessment services. And all the services, as Mitchell said, other than the WEP program and, clearly, job development, which would involve interviews off site - are provided under one roof in each of those locations.

Mitchell Newburn: And I do think that's important - it goes back to that one-stop shopping model for clients. There was a short period when we did have in the Bronx our SSI and our wellness program in a separate building - it was nearby, but

separate. And it frankly didn't work as well because they had to come to our main building, and we told them what the doctor decided and they had to go to the other building. And we actually felt that it was not as good as having it all under one roof, and we did bring it back under one roof.

Louisa Fuller: Okay. Do you have the total number of bio-psycho-social assessments for 2009 completed in 2009 or maybe 2008 if you don't have the data yet?

Mike Bosket: I don't have the data with me today. But if people want discreet annual numbers, I can certainly get you that. I can tell you that it's around 45,000 a year, typically, is what the numbers are. And in the 5 years of the program, the completed BPSs are around 250,000 at this point.

Mitchell Newburn: One thing to point out is we have a very high rate of completion. If the client shows up for that initial assessment, it's well in the...

Mike Bosket: 81...

Mitchell Newburn: Yeah, 81% completion of that which, compared to other clinics, it's a very, very high completion rate. I think part of it is we - it goes back to the one-stop shopping model. We really try to alleviate their anxiety, concerns.

Mike Bosket: Well, a lot of the reasons for non-completion is that the case for some might be rejected prior to the vendor's ability to complete, or other reasons that are beyond the vendor's control.

Mitchell Newburn: Yeah. And as I mentioned before, we have 17 days to complete that initial assessment. And I just want to walk through that because it's - I think it helps that (unintelligible) completion rate, but it also gives clients a sense of the model. That means if they come into the clinic on Day 1 and that doctor feels

they need to see the cardiologist, that means that in less than 17 days they're going to get an appointment with that cardiologist, they're going to see that cardiologist. That cardiologist is going to write up a report, which is going to go back to the initial physician who saw the client. And then that physician is going to make a determination if the client is employable or not. And then let us know all of that with enough time to have that client come in by that 17th day to explain that decision.

So, I know myself, it takes longer if my primary care physician asked me to see a specialist. It can often be weeks and weeks until that happens. And so I think it's been - it was one of the requirements of the City that had to be our primary with our medical providers that that had to be arranged.

But I think that one thing is it gives the clients the sense from the very beginning, wow, I'm getting really great services, and this program is about moving me forward in my life. And that message comes across very clearly early on.

Louisa Fuller: I have, I think, three or four more questions and then we'll - I'll see - if there's anyone else on the phone. I think you've already started to answer this question before. But in terms of funding for medical exams, where do you get that, and do you contract services through an RSP?

Mike Bosket: Well, as the (unintelligible), I think which was essentially the first question, is where does the funding come from for the entire program? And as I mentioned, the funding level currently between both vendors per year is around $63 million. Most of that money comes from TANF funds. The remainder of the money comes from the state, with some contributions from the City as well. If I remember exactly, it's 50% TANF, 25% state, 25% City, but I may be a little bit wrong on that application.

In terms of the payment for the medical assessment, that is all included in part of that funding. And it's through a contractual process. We contracted - the City has contracted through an RSP process with FEGS and Arbor. And it was clear in that RSP process, but they had to subcontract with medical providers to provide the medical assessments.

They then each separately negotiated those rates of reimbursements to the medical providers for the provision of those medical assessments. I can tell you that the City is now looking into part of the funding that is be used for payment for the medical assessment process. We are investigating the ability to actually bill Medicaid for the completion for some of the - for some parts of the medical assessment process - as a way for us to maximize and increase our funding streams.

Mitchell Newburn: The important thing, up until now, all of the medical assessments, whether by specialist or lab results and EKGs - those are all included within the actual WeCARE contract. And they're very rare, like a stress test, a few of those might be billed to Medicaid.

Mike Bosket: Right.

Mitchell Newburn: We also, just to make it clear, don't provide directly the ongoing treatment that clients receive. So we will work with them to make sure they've got a provider or make referrals to them - for them. And that ongoing treatment may be paid by Medicaid, but the assessments are not.

Louisa Fuller: This goes back to the SSI route. In addition to the strength of the initial application of the participant, what partnerships and relationships are in place

that are - have you found most successful to the initial application approval rate?

Mitchell Newburn: One is, if a client has been in that wellness program - so that means, a period of one to three, in a rare exception up to 6 months, where they've been getting ongoing treatment. And then at the end of that period, that treating physician will say, "I tried my best to stabilize this condition but was unable to." The client is unemployable for a year or more, and therefore is recommended for SSI.

It is critical for us to get all the reports from that physician, all the treating reports and ultimately that final report because that's really what forms the basis of that SSI application. So that's critical.

Even for clients where they physician they've seen in our clinic says they're disabled, sometimes often, because they're so disabled they might have some ongoing medical or mental health provider. And getting also that supporting documentation from those providers is critical. We don't pay them for it, we don't have an ongoing relationship with those providers. So sometimes that can be a bit of a struggle. But we're explaining that we're there to help the client. Because it we don't have that, all we have to rely on is what the physician who saw the client during our assessment phase has written up. And that's all based on one - in general, one single visit of about an hour, with a fair number of tests.

There might be one or two specialist reports supporting that. But again, those aren't ongoing relationships. So it's important to those community providers for us to get that information from them.

Mike Bosket: I mean, I'd also like to build on what Mitchell is saying is, it's important to recognize that the client - our client's situations change. So a client who completed a BPS and who at one point may have been engaged in work-related activities, it could be that the medical or mental health condition that they have deteriorates. And so they go to a wellness plan as a way to kind of stabilize that.

And at the end of the wellness plan, it's determined that they're eligible for social security. I think just to build on his point that the information that the WeCARE vendors are collecting - whether that be right from the medical assessment or the client's ability to participate in work-related activities that they're no longer able to participate in - the client's compliance with the wellness plan and all the medical documentation that's gathered during that time, all of that information can help to strengthen the social security application, if we have that information.

Louisa Fuller: I have just a few more questions and then I think I'm going to close to our poll. One question that came is looking to see whether or not Arbor Education and Training, what kind of services it provides. I think perhaps you can answer it provides similar services, such as FEGS, or if they're additional services.

Mike Bosket: Both vendors are contractually required to supply the same services. Our Arbor Education and Training, like FEGS, does vocational rehabilitation services themselves, wellness plans themselves, application and supplementation of Social Security applications themselves. So all of the same, essentially, case management and service delivery components that Mitchell described that FEGS does, and what we described as the model Arbor does.

The only difference with Arbor is, Arbor does have one subcontract for a small piece of their vocational rehabilitation services, and that's for the individuals who live in Queens. So other than that, Arbor directly provides all contractual services other than the medical assessment services.

Louisa Fuller: Does the program utilize public health nurses for medical assessments at all?

Mike Bosket: At this point, the program - we have made a conscious decision that, especially at the BPS level, that all physicians - that physicians only. And not only physicians, but only board-certified physicians. That decision was made as a way to insure high-quality comprehensive assessments and the determinations made through that processes.

We do use nurses in a program that's called the Clinical Review Team, which Clinical Review Team allows the vendors and allows us - if there's been - if a client has been assessed in the past year at a medical assessment site and has been participating on the program at some level, but there's been a change in the client. Maybe they were in a car accident or maybe a condition - their blood pressure that was prior controlled is no longer - is now not stable any longer. There is a vendor on site in the same service delivery locations where they're doing SSI, wellness planning, and BRS have what we call Clinical Review Teams that are staffed by nurses and social workers and overseen by a board-certified physician.

In those specific scenarios, we do allow nurses and social workers to meet with a client, go over with the client any medical documentation that the client may have, interview the client. And based on that, make a determination if the (FCOs) that the client currently has is appropriate or not. Currently, that's the only way we're using nurses in the program.

Louisa Fuller: Final question - What has been the response of community providers and mental health clinics and other health providers in the New York City area to the WeCARE program?

Mike Bosket: Well, I could answer that in a number of ways. Clearly, there are community groups and activity. I'll answer first from a political standpoint. Clearly, there are community advocacy groups who, not just WeCARE, but are back to work in other welfare-to-work programs are not the most supportive. Although I would say one thing is that even those groups that do not agree with welfare reform have commented on the comprehensive nature of the WeCARE model and the good intent behind the WeCARE model. So I'll answer that way first.

Secondly, in terms of medical providers and clinical providers in the area, I think most of them - many of them at this point actually have dealt with our clients because of their providing wellness services to our clients. I think for them, it could be somewhat of a relief if you're a medical provider. Because if you have clients asking you to make determinations if they can work or not and now you don't have to do that. You can send them to WeCARE and have a physician who doesn't have a personal relationship with that client make a determination, which, therefore, in some ways can ease the relationship with the professional relationship a client has.

I often will, when I do a presentation, talk about a time when I had conjunctivitis - pink eye. And my doctor wrote me a letter for a week to get out of work because I had a personal relationship with this doctor. So if you remove that personal relationship in terms of making decisions about people's ability to work, it can sometimes improve that relationship with that particular provider and the client.

And I think that the provider is the medical, and clinical providers in the area at this point are very familiar with the program. They may not like the paperwork they have to fill out in terms of, especially, wellness plans and what does the progress look like.

But I think at this point, most of - especially the larger institutional providers are very used to the program and actually see the utility of the program. One could even argue that through identification of clients and wellness plans, some of these providers have seen - are getting consistent referrals and new patients from the program because we're referring clients to them who need services.

So I think that I will say there is often contention among community-based physicians who may feel a client may have a different take on if a client can work or not. But I want to build on the point that I made and that Mitchell made, that community-based physicians aren't trained in terms of determining a person's ability. They're trained in diagnostics and treatment.

And so I think in many ways, it's been a learning experience. But that at this point, the medical and clinical community in the New York City area is familiar with the WeCARE program and in many ways supports it.

Mitchell Newburn: I completely agree with Mike. The vast majority of the medical and mental health providers we deal with have been very cooperative. There is the paperwork and the sort of pressure on the timeframe that can sometimes be a bit burdensome. And I would say, there are some providers that we really no longer make referrals to. It really negatively impacts that client, if we can't get those documentations.

And so over time we've learned which ones those are, and we just don't make referrals to them. But we really - and again, it always goes back to education and we explained what the purpose of the program is, and if we don't get this information, (unintelligible) certainly their ability to get SSI or the timeframe that gets them back in the workforce.

I think one of the things we did see a little more in the beginning was enough (unintelligible) because it's very high volume, even in New York City. For example, in the Bronx, many of our clients need the mental health services and many of them are Spanish speaking. There just weren't that many mental health Spanish-speaking providers.

And so it took us a little while to find them all because of the clients on their own may not have accessed those services. And so that was something we had to work and find that capacity. But we've gotten over that. But other than that, it's been quite a good relationship.

Louisa Fuller: Okay, great. I want to thank all three of you for really sharing a lot about the WeCARE program. As you can tell by the number of questions and by the number of site visits that have been conducted through the Welfare Peer TA Network, a lot of people are interested in learning more about the program and how they can possibly set something similar up in their home states.

I want to let everyone know that there will be a transcript and audio recording and a copy of all the questions available probably with the next 3–5 days. And at this point, I'm going to actually put up a poll question. If you felt that the speakers had valuable information to share, you can click on the screen next to Strongly Agree, Agree, Unsure, Disagree or Strongly Disagree.

Okay, the second poll question, the logistics of the Webinar ran smoothly. Poll Question 3, I'm more informed about the history and structure of the WeCARE program. I will be able to apply the knowledge presented today to my program. Okay, and I learned strategies for implementing a similar program in my agency.

Wonderful. Operator, did we have any more questions on the phone?

Operator: No, ma'am, we had no question on the phone line.

Louisa Fuller: Okay, wonderful. Well, I will say thank you again for everyone who participated in the Webinar and to our presenters. Thank you so much for taking the time to share a lot about the WeCARE program. Everyone have a great day.

Man: Thank you, Louisa.

Louisa Fuller: Thank you.

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