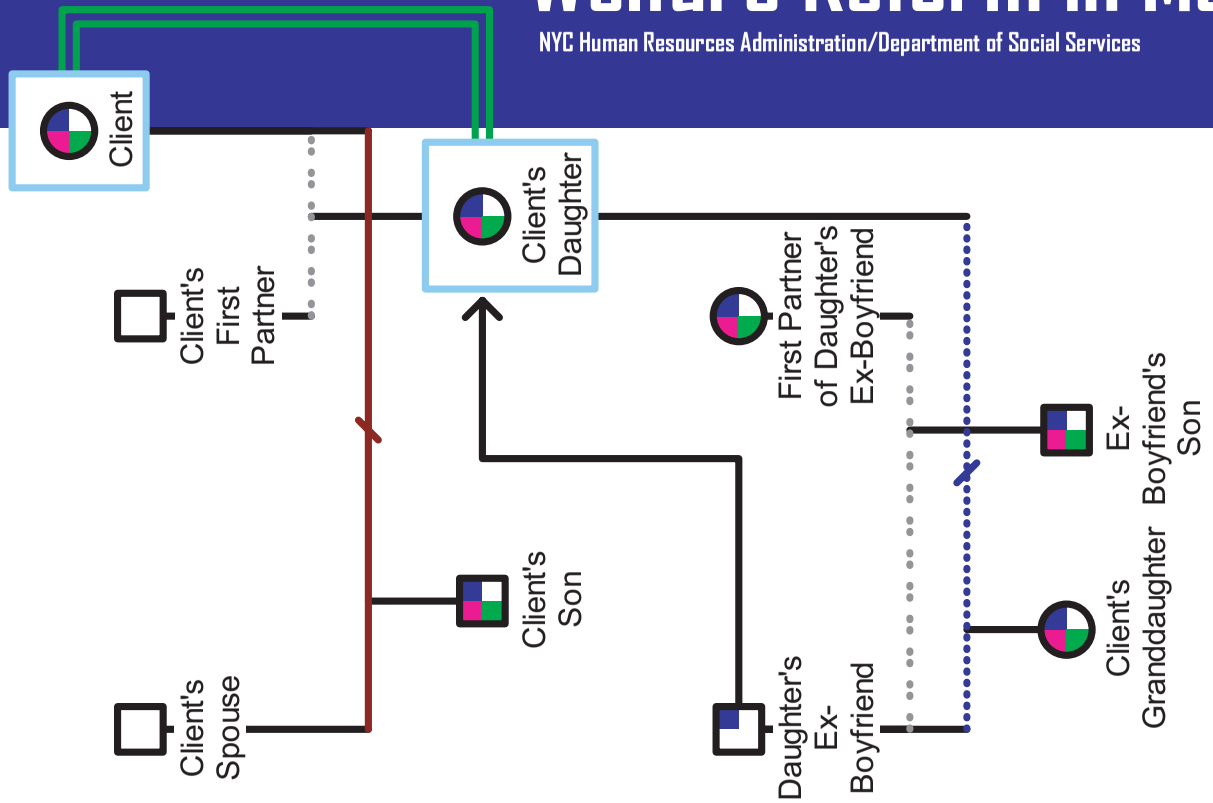
Welfare Reform in Motion...

NYC Human Resources Administration/Department of Social Services



Welfare Reform in Motion...

It is self-evident that the best welfare reform is to keep people from needing welfare in the first place. That means directing services to the young people most at risk of becoming welfare recipients…. It also should be a national priority to help the hundreds of thousands of Americans who have moved off public assistance continue to succeed. **— Mayor Michael R. Bloomberg**
May 15, 2002

The City of New York

Welfare Reform in Motion...

Human Resources Administration/
Department of Social Services
Verna Eggleston, Administrator/Commissioner

New York, New York

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Foreword

There is no domestic policy that is more complex, more politically charged and more important to the future of this country than social welfare. New York City has been the crucible for the implementation of federal social welfare legislation since the federal government mandated public assistance programs for the first time through the 1935 Social Security Act.

Whether it is the size of the City, the diversity of its population, the density of its neighborhoods, or the added fiscal burden put on the City by New York State's cost-sharing mandates, the City has had a unique challenge to develop programs that would meet the needs of its most vulnerable populations.

At the time when Verna Eggleston was appointed by Mayor Michael Bloomberg and began her tenure as Commissioner of the New York City Human Resources Administration (HRA) in January 2002, the unemployment rate had jumped from 5.7% in January 2001 to 7.5% in January 2002 – from December 2000 to June 2003 New York City had lost 240,000 jobs. Still traumatized by the September 11th terrorist attack, we began the new year and the new administration in the midst of a national recession. This was a critical moment in New York City's history.

The City's new HRA Commissioner had to face the enormous challenge by addressing the problem of displaced workers and their families; not just by ensuring that they received entitled benefits, but also by helping them back into the workforce. Over 400,000 people had been enrolled in disaster Medicaid post 9/11. With a 45% staff vacancy rate in the Medicaid department, each person who received emergency public health insurance was interviewed for eligibility and certified for ongoing care. A crisis of enormous proportions was averted.

The Commissioner was a policy visionary, a manager with decades of experience in operations at HRA and in the non-profit agencies that serve the City's welfare population. The Commissioner successfully led the City through this precarious period, preventing the crisis that all the pundits were predicting. She understood that the success of the Bloomberg administration would depend on her capacity to develop and implement humane and effective policy for the City's dislocated workers, as well as the working poor, chronically unemployed and those who would never work.

Commissioner Eggleston created special programs to address the needs of those workers and their families victimized by 9/11 and the economic recession, but that was only the beginning of her work. Commissioner Eggleston was also a bold innovator. Under her leadership, HRA is a national model for implementing TANF reform. The Commissioner's approach has been unique. She looked at her agency's work from the perspective of a manager and a visionary. She understood that real reform can't just be about changing rules, but must also be about changing practice

and placing greater focus on the agency's mission of moving people to their maximum levels of self sufficiency. This cultural change occurred in the largest social services agency in the country – HRA has 16,000 employees and serves 3 million clients through its diverse services and programs.

Commissioner Eggleston's approach has echoed Mayor Bloomberg, "if you can't measure it you can't manage it." This has applied to both clients and contractors. She has successfully used data to develop both policy and programs. For the new HRA, under Eggleston's leadership – services can no longer be a revolving door for clients. She has committed her agency to providing sustainable employment, not just reducing the rolls. Contractors can't simply place clients in employment; they must ensure that they stay employed. She has materially expanded the availability of support services like food stamps and Medicaid, to keep New Yorkers in the workforce. In collaboration with the Health and Hospital Corporation, a Medicaid office has been placed in every public hospital, and some private hospitals, in New York City. Today, people can also access food stamps in these offices, as well.

The hallmarks of Commissioner Eggleston's policy innovations have been flexibility in service delivery and addressing the complex barriers to employment, especially for the long-term public assistance recipients. The signature program of the Commissioner's first term has been WeCARE. Through research and evaluation the Commissioner determined that the large majority of those individuals who continued to receive public assistance for more than five years had considerable medical and mental health barriers to work. Extraordinary amounts of money were being spent on these clients and they were not getting healthier or any closer to self-sufficiency. In a brief conversation the Commissioner explained her strategy to me. She said, "We will talk to the clients and find out from them what they think they can do and we will work with them so they can achieve their own goals of work and wellness." WeCARE has been expanded from its original pilot, built on the Commissioner's original insight that services must be customized so that each individual can reach his or her highest level of self-sufficiency.

New York City has always been a challenge to the rest of America, always foreshadowing social and economic trends and showing the nation its extraordinary strengths and its tragic weaknesses. The work of New York City's Human Resources Administration under Commissioner Verna Eggleston shows New York City government at its best. The lessons in this volume are important for anyone interested in improving the lives of the poor in this nation.

Ester R. Fuchs, Ph.D.
Special Advisor to the Mayor for Governance and
Strategic Planning
Professor of Public Affairs, Columbia University, on leave

Preface

At the outset of this administration, Mayor Bloomberg asked that we examine the success of the first round of welfare reform and develop a plan that would ensure our continued success. At the same time, New York City needed to submit to the Federal government a plan for reauthorization of the Temporary Assistance for Needy Families (TANF) program, the blueprint for that first round. After many discussions with the Mayor, in which we heard his thoughts about reform, we knew that the Bloomberg plan needed to meet the many clients we served, exactly where they were.

We presented many ideas to the Mayor. We proposed improved customer service, specialized programming, cost savings and efficiency through automation, and most importantly, finding a more cost-effective way to serve long-term clients on our rolls. Engagement became the key phrase. In order to accomplish full engagement, we needed to identify the problems that kept many from engaging at all.

The first task was to begin the process of infrastructure-building. Working closely with members of the executive staff, we set out to evaluate Human Resources Administration/Department of Social Services' organizational structure, to ensure that it would support any plans that we would implement. This included, but was not limited to, examination of physical plant, technology, and both permanent and temporary staffing.

The second task was to develop a plan for restructuring services. It was important to align all service departments so that there would be no obstacles in the path of clients reaching their maximum levels of self-sufficiency. All nineteen Medicaid offices, as well as many Family Independence Administration and HIV/AIDS Services Administration offices have been converted to model centers. Enhancements were made to our Office of Program Reporting, Analysis and Accountability (OPRAA), allowing us to develop new tracking systems for quality assurance.

The third task was to shape policy that would support our efforts. More than forty legislative proposals were submitted to the federal and state governments, including our on-time submission of a comprehensive TANF reauthorization plan to the Federal government.

Verna Eggleston
Administrator/ Commissioner
New York City Human Resources Administration/
Department of Social Services

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Introduction

After assuming office, Mayor Michael R. Bloomberg presented to the public the vision for the next phase of welfare reform, including recommendations for Temporary Assistance for Needy Families (TANF) reauthorization. The plan focused specifically on three important elements: welfare prevention, job placement and job retention. Key to implementation was a commitment to finding flexibility in the delivery of essential services by streamlining and improving systems and reducing waste. His objectives were to support individuals and families who had successfully transitioned off public assistance (PA), provide future generations with the tools and resources to remain self-sufficient, and require participation in activities tailored to meet individual and family needs for those continuing to receive cash assistance. The City's plan emphasized personal responsibility and accountability while remaining sensitive to the multiple challenges to self-sufficiency encountered by disadvantaged New Yorkers.

At the beginning of the Bloomberg Administration, 459,056 New Yorkers were receiving PA. This included 81,511 individuals who had reached their five-year lifetime limit for federal cash assistance, Temporary Assistance for Needy Families (TANF) and were converted to Safety Net Assistance (SNA). SNA is a New York State mandated program that is equally funded by the state and locality and provides cash assistance to eligible individuals, couples and families that are not eligible for TANF. Human Resources Administration/Department of Social Services (HRA/DSS) saw enrollment in SNA rise and New York City's costs increase as a growing number of individuals reached the TANF time limits. At the same time, the composition and needs of the PA caseload had changed since implementing New York City's welfare reform. The development of new approaches to assist the individuals remaining on PA in reaching their maximum level of self-sufficiency and helping those who had already become self-sufficient to remain off of public assistance was salient.

At this time, an increased proportion of the City's PA caseload consisted of fully and partially unengageable individuals who were unable to participate in work activities because of multiple and complex barriers to employment. These individuals needed more than traditional supports such as food stamps or childcare to become self-sufficient. Many suffered from untreated and/or unstabilized medical and mental health conditions, domestic violence, substance abuse, as well as homelessness and other issues that challenged their potential for employment. Despite the best efforts of HRA/DSS programs and services, these clients remained reliant upon cash assistance. In order to efficiently and effectively serve these individuals and others who had successfully transitioned into the work world, HRA/DSS needed to abandon the policy of "one size fits all" social service programming and move toward a more comprehensive and individualized model of service delivery.

To meet the changing needs of the caseload and achieve the goals in the City's welfare reform plan, HRA/DSS required restructuring and a new direction. The administration and staff moved quickly to examine and identify service delivery approaches that were sufficiently flexible to meet every HRA/DSS client "where they are." In an era of decreasing TANF funding, they also identified methods to conserve costs by streamlining and automating operations to tailor services to accommodate individual and family needs, and to restructure, retool, and reform the manner in which HRA/DSS conducted its business. Toward this end, the executive team drew upon the experience and expertise of their 16,000 employees. Through structured forums, roundtables, retreats, and workgroups, staff from various program areas developed clear and measurable plans to enable the organization to meet its goal of elevating every individual on PA to their highest level of self-sufficiency. In their 2005 report, former HRA/DSS Commissioner William Grinker and his co-author Dennis Smith refer to the current management of social service delivery in New York City by stating, "…this is the first administration that has made management reform citywide the center of its agenda and backed its agenda with resources and strategic appointments."[1]

HRA/DSS also examined the laws and regulations governing social service programs. In order to customize and individualize service delivery, it was determined that some requirements needed change. As the law allows, HRA/DSS applied for legislative waivers. One of many that were granted waived the requirement to conduct certain food stamp recertification interviews over the telephone via an interactive voice response system.

In keeping with this administration's approach to include internal staff in its planning activities, it has sought out the input of community stakeholders. The Commissioner's Advisory Board, representing clients, advocates and service providers evaluated and reconstructed the processes of service delivery. One result of these cooperative relationships produced was the customer-oriented reception area in the HASA model offices. Guided by the Mayor's larger vision of collaboration, Commissioner Eggleston presented a "One City, One Client, One Plan" model. Agencies were asked to come together collaboratively, and work on one joint project. The first initiative was homelessness. At the first meeting, commissioners from all the city agencies that receive TANF funding joined Commissioner Eggleston to strategize on working consistently to achieve TANF goals. The first "One City, One Client, One Plan" initiative, the One City/One Community Project focused on homelessness. The decision to locate it in Bedford Stuyvesant was due to the high number of families from that area who end up in the Department of Homeless Services system. This project proposes to provide integrated case management to residents of Bedford Stuyvesant who are receiving services from multiple City agencies, and coordinate these services and the demands on the client with an end to improved outcomes, including preventing homelessness. "Commissioner Eggleston promotes self-help, self-sufficiency, and personal responsibility, but always with compassion, empathy, and an unusual level of

sensitivity to the insensitivities of large bureaucratic organizations," said Poul Jensen, Chair, HRA/DSS Citizens Advisory Committee.

There has been a noticeable shift in the way HRA/DSS responds to changes within the social, political, and economic environment. "To their amazement, welfare advocates are getting the welcome mat instead of the bum's rush from Verna Eggleston, the city's new welfare chief," *Daily News*, February 4, 2002.[2] Previously, the organization tended to react to unanticipated crises. The current approach forecasts problems before they arise, and crafts solutions to effectively minimize and solve them. HRA/DSS has been able to accomplish this largely due to the shift from intuitive to evidence-based policymaking. Restructuring enables specific departments to effectively manage their problems. Through a firm commitment to data-driven individualized services and public accountability, innovative programs, such as WeCARE, are assisting individuals and families not just in achieving, but also in sustaining, their highest degree of self-sufficiency.

1. Meeting the Challenges of TANF II: The City's Plan

Retention and Prevention

Either as a retention strategy for those leaving public assistance or as a preventive measure for those who are employed but struggling to make ends meet, work supports such as food stamps, Medicaid, child care, and child support can often bridge the gap between public assistance dependence and independence. Work support programs reflect the commitment to job retention and welfare prevention. The administration has successfully expanded the availability of employment supports for working New Yorkers. Medicaid enrollment has grown from just over 1.7 million in 2002, to more than 2.6 million in 2005 (see Chart 1). Similarly, food stamp enrollment has grown from under 800,000 to nearly 1.1 million (see Chart 2).

Recent HRA/DSS data demonstrate a correlation between the issuance of food stamps and the issuance of cash assistance. As the public assistance rolls decline, the Food Stamp rolls rise (see Chart 3) suggesting that food stamps are a vital support for those transitioning from welfare to work and for those trying to remain self-sufficient. To ensure that food stamps are available to all eligible New Yorkers, HRA/DSS made changes to the food stamp application process by automatically enrolling into the program disabled individuals receiving Supplementary Security Income (SSI) as well as individuals leaving public assistance. These changes have been accomplished while achieving a 4.3% error rate in 2004, the lowest in the HRA/DSS recorded history, resulting in a federal grant award of almost one million dollars to assist in automating the Food Stamp program application process.

HRA/DSS has also substantially expanded access to public health insurance, to ensure health wellness supports for those who have left public assistance for the workforce and those striving to maintain self-sufficiency. Public health insurance makes preventative and on-going medical care available for working individuals and their families and minimizes the devastating costs of medical emergencies that might otherwise create the need for cash assistance. Much of New York City's success in this area has been realized by separating the public assistance program from the public health insurance program and by simplifying public health insurance application and enrollment procedures. By providing employed New Yorkers, who receive few or no health insurance benefits with access to programs such as Medicaid, Child Health Plus A, and Family Health Plus, the Mayor is moving his job retention and welfare prevention goals forward.

To promote parental responsibility accountability and ensure that families are receiving necessary financial support from non-custodial parents, in August of 2003,

the Mayor authorized the transfer of the City's Office of Child Support Enforcement (OCSE) to HRA/DSS. More than 50% of child support cases involve families that are former public assistance recipients and 17% involve current public assistance cases. On average, OCSE collects $4600 per family annually often enough money to bridge the gap between a family's dependence on public assistance and its self-sufficiency.

Given the significant increase in the proportion of fully and partially unengageable clients on the PA caseload, the reauthorization of TANF by Congress, and the transition of increasing numbers of PA recipients from TANF to SNA, it became imperative for New York City to define its plan for the next phase of welfare reform. In May 2002, Mayor Bloomberg publicly announced the City's strategies. In the wake of the dramatic declines in the City's welfare rolls, a key component of the plan was to support job retention by individuals who had successfully transitioned off the welfare rolls. To continue to reduce the caseload and encourage the movement of future generations away from dependence, he also articulated a strategy of welfare prevention. Finally, to address the increasingly pressing issue of individuals with multiple and complex barriers to employment, the plan also included a provision to provide flexibility in service delivery.

Flexibility: The Changing Face of the Remaining Caseload

To better meet the needs of the majority of individuals who remain on PA, HRA/DSS has developed two new approaches to service delivery. A large percentage of those individuals who have not made the transition from welfare to work suffer from extremely complex barriers to employment, including medical and mental health problems, substance abuse, domestic violence and other, equally debilitating social and environmental problems. Under a plan to customize and individualize services, partially and fully unengageable individuals who report medical and/or mental health limitations to employment are referred to the Wellness, Comprehensive Assessment, Rehabilitation, and Employment or WeCARE program. WeCARE is designed to holistically assess each individual's unique needs and provide, or refer, him or her, to a continuum of appropriate services that address medical, psychological, social, environmental, vocational and educational impediments to self-sufficiency.

A much smaller percentage of individuals remain on the welfare rolls despite their ability to participate in work-related activities. Many of these individuals are under sanction, which means that their family's public assistance grant has been reduced because they have failed to comply with work requirements. Since 2002, the number of sanctioned cases increased from 13,826 to 16,341, an 18% growth (see Chart 4). Some individuals do not understand that they are being sanctioned. Others are uncertain as to why they are being sanctioned or how they can comply with their individual requirements to have their grants restored. Those individuals who have been in sanction status for more than 60 days are now referred to the newly created Family Independence Administration (FIA) Intensive Services Center to receive

information about and opportunities to participate in work activities. The center also provides HRA/DSS with the opportunity to identify any underlying barriers to employment, and investigate instances of potential fraud.

2. Lessons of TANF I

At the peak of public assistance dependency in 1995, the City had 1.1 million recipients on its welfare rolls. In 2002, at the beginning of the Bloomberg administration, the number of public assistance recipients had declined by almost 58% to 459,056 recipients. The 1996 Federal Welfare Reform Law required the abandonment of the old welfare entitlement system in favor of a temporary system of support requiring work participation that would lead to self-sufficiency. Locally, HRA/DSS pursued policies focused on the full engagement of the PA caseload in employment activities of the caseload, fraud detection, and performance measurement and outcomes for services provided by both contract vendors and HRA/DSS itself. A period of economic growth and prosperity both nationally and locally provided fertile soil in which employment and self-sufficiency initiatives could take root.[3]

Fraud Detection

This sizeable number of people receiving welfare in New York City was partially attributable to the fact that a systemic front-end investigation of individuals applying for public assistance did not exist. An individual could apply for and potentially receive cash benefits under more than one case, name, or address. Also an individual's resources and income were not stringently examined. Therefore, there was no way to ensure that those who were receiving public assistance truly needed it.

In the early 1990s, the HRA/DSS Bureau of Fraud Investigation took the first steps towards establishing a front-end investigation process. Teams of investigators were outstationed in several welfare centers to provide on-site investigations of PA applications deemed suspicious by case workers. About the same time, the 1992 Laws of New York added a provision requiring the State's local social service districts to establish a front-end investigation system. HRA/DSS created the Bureau of Eligibility Verification (BEV),[4] to implement a comprehensive front-end investigation process that over time began to employ sophisticated technological and biometric tools. These efforts substantially reduced welfare fraud in New York City.

An investigation by BEV became part of the application for PA benefits. Through the use of the Automated Listing of Eligibility Requirements Tracking System (ALERTS), which collects and aggregates collateral client data, detailed investigations of an individual's resources, eligibility, residency, identity, and income are conducted to ensure that the public assistance applications are both factual and complete. Additionally, HRA/DSS utilizes finger-imaging technology to confirm client identity and prevent fraud, thus preventing the same person from establishing multiple cases under assumed identities.

Full Engagement

During the first phase of welfare reform, HRA/DSS pursued a policy of full engagement of the caseload. Full engagement means that at any given point, the administration knows that individuals and families are actively engaged in activities that promote self-sufficiency. An individual is considered to be engaged if he or she is employed or participating in work-related activities such as a work experience assignment, education and training, substance abuse treatment or wellness plans. The concept of full engagement also extends to those adults in the process of being assigned, assessed, sanctioned for noncompliance, or appropriately classified as exempt from work activity. Additionally, HRA/DSS makes a distinction between those individuals who are currently able, and those who are currently unable to participate in work activities and tracks the engagement levels of its caseload on a weekly basis (see Report 1). Individuals are "engageable" or "able-bodied" if they are currently participating in or are in the process of being assigned to approved work activities. Individuals are "partially unengageable" if they are temporarily unable to work due to an unstable medical or mental health condition(s), are awaiting or appealing a decision regarding an application for federal disability benefits (SSI/SSDI) or are awaiting a medical assessment appointment. Finally, individuals are "fully unengageable" if they are indefinitely unable to participate in work activities, e.g., are over 60 years old.

The compilation of weekly engagement reports allows HRA/DSS to understand and track client movement, making it possible to mobilize resources and tailor services to meet individual client needs. By charting client engagement levels every week and breaking the caseload down by case categories, the engagement reports also allow HRA/DSS to examine changes in the caseload over time. These time-series analyses have been particularly useful in identifying clients with multiple barriers to employment. As illustrated in the chart (see Chart 5), a large proportion of the current caseload is either partially or fully unengageable, indicating that many current clients are facing multiple barriers to self-sufficiency. The reports have also tracked changes over time by case type, showing that the current caseload represents an increased number of cases that have converted from TANF to Safety Net benefits due to limits of federal cash assistance (see Chart 6). As stated in testimony before Congress, "As people have moved into employment and as the caseload has dramatically decreased, those remaining have become more challenging to serve…Today's TANF clients, especially those experiencing serious health, mental health or disability issues, need a broader range of critical services plus adequate time to enable them to overcome the barriers that prevent them from achieving and maintaining self-sufficiency," David Hansell, HRA/DSS Chief of Staff.[5]

Caseload Dynamics

The public assistance caseload consists of individuals seeking both short term and long term assistance. Some leave PA because they reached their maximum level of self-sufficiency while others chose not to continue. As reported by Dr. Swati Desai, Executive Deputy Commissioner of HRA/DSS Office of Program Reporting Analysis and Accountability, in any given month, approximately 13,000 people enter into the system and approximately 14,000 people leave the system. According to Dr. Desai,[6] "some of those who enter receive only one-time assistance without full opening."

Performance Measurement and Contracting

Some of the most valuable lessons HRA/DSS has garnered from the first phase of welfare reform revolve around the manner in which the organization collects and analyzes its data. Many advances have been made in the ways data is used to manage services and contracts, particularly those relating to job placement and training. Prior to the advent of the JobStat system in 1999, there was very little connection between the data collected on the indicators and client outcomes. This resulted in a voluminous collection and accumulation of data with little meaningful relationship to the manner in which clients were being served or the quality of the services provided.

JobStat changed this relationship by using data to clarify the caseload and focus on client engagement. HRA/DSS began to collect data on outcome indicators such as job placement and retention as well as process indicators like employment plan initiation and completion rates. This data was compiled and disseminated in a timely manner due in large part to technological support from the HRA/DSS management information system called New York City—Work, Accountability, and You (NYCWAY). NYCWAY, among other things, tracks clients through employment activities and interfaces with the New York State Welfare Management System (WMS). Currently, JobStat is in version 6.0 and its indicators have expanded to capture a growing number of specific measures of engagement and employment retention as well as key process measures. "I was, and continue to be, impressed by this demonstration of performance management in action – where it matters most, at the front lines,"[7] Richard P. Nathan (Co-Director of the Rockefeller Institute), in reference to JobStat.

The success of JobStat in measuring and managing job placements in 1999 encouraged HRA/DSS to employ a similar model to evaluate the performance of its many Employment Services and Placement (ESP) and Skills Assessment Placement (SAP) vendors. VendorStat emerged in 2000 as a means to hold service vendors accountable for their performance and open up a dialogue regarding their successes and shortcomings. Like JobStat, VendorStat provides HRA/DSS with more than just data on performance indicators; it brings together all parties associated with client outcomes to discuss successes and challenges. In a JobStat meeting, center managers

and staff sit with central management to discuss the performance of individual centers and explore how customer service and efficiency can be improved. Similarly, VendorStat meetings facilitate dialogue between HRA/DSS and contracted service providers.

Out of these structured dialogues emerged competition, a new concept for center staff and vendors that continues to fuel the pursuit of excellence. While the explicit purpose of these performance measurement tools is to collect and disseminate timely information on key indicators and utilize these data to inform management practices, the transparency promoted by the systems has allowed for comparison among like providers. Thus, healthy rivalries have emerged both among job centers and vendors resulting in improved services to clients as well as maximized value for the taxpayers that help support client services.

Performance measurement systems have also had a powerful impact on the way HRA/DSS manages its Requests For Proposals (RFPs) and contracts. By selecting and tracking indicators that are relevant to desired client outcomes (job placement, retention milestones, wage increases, etc.), HRA/DSS is able to hold vendors accountable for those outcomes and develop contracts that are increasingly performance-based. No longer are service contracts constructed to pay for vendor line items, such as staff salaries, materials, or other service costs. Instead, contracts are designed around payment milestones, with payments to vendors only when a client achieves certain measurable results.

Initially, contracts concentrated on job placement rather than job retention. Vendors were paid for placing clients into jobs and related work readiness programs. However, as JobStat and VendorStat became more refined and in keeping with the Mayor's plan, the administration shifted focus away from the short-term goal of placement and towards the more productive goal of retention, HRA/DSS's contracts also changed. Under current employment contracts, milestones have been adjusted to offer greater financial rewards to those vendors who are able to demonstrate sustained job retention for HRA/DSS clients. While vendors are still paid for basic job placement, there is now a much larger incentive to ensure that clients retain their jobs.

These changes reflect the commitment of the Bloomberg/Eggleston administration to producing sustainable employment for clients rather than simply to reducing the welfare rolls. The focus of contracts, as well as employment-related data collection, has shifted from basic job placement to the more dynamic process of promoting job retention and career advancement, moving the direction of programming and planning towards more meaningful client outcomes. As Grinker and Smith note in their 2005 report: "HRA has made the transition in many areas of its work, first to an outcome measurement orientation, and then to using outcome measures to manage—from performance measurement to performance management."[8]

3. Understanding the Caseload

Within HRA/DSS, clients who face complex and multiple barriers to self-sufficiency are described as partially or fully unengageable. Given their unique circumstances, these individuals require additional individualized and often intensive services to support their transition from welfare dependence to self-reliance. Understanding that a certain proportion of New York City's PA clients have always faced medical and mental health barriers to employment, HRA/DSS previously developed programs and strategies for engaging these clients in wellness and vocational rehabilitation activities. While not every endeavor was completely successful in achieving self-sufficiency for every client, each program represented an important step on the learning curve. This led to the design and implementation of the Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE) program, an innovative multi-faceted and customized approach to service delivery. As such, the successes and limitations of these programs need to be discussed, as do the lessons that each project has taught HRA/DSS.

Initial Strategies for Addressing the Partially and Fully Unengageable Population

Medical Evaluations

In 1995, HRA/DSS expanded its contracts with an independent medical assessment firm to require medical evaluations for clients who claimed they could not work due to a medical condition. Clients were referred to the vendor from Job Centers so that their health complaints could be explored in greater detail through a formal medical evaluation. These medical evaluations resulted in a Functional Assessment Outcome (FAO) for each client. FAO's were classifications that dictated a person's ability to participate in work activities.

Several different FAO's were available to categorize clients based on their ability to work. Individuals who were found to be fully employable without limitations were referred back to Job Centers to resume their job search. Those who were deemed employable with limitations were referred to the Personal Roads to Individual Development and Employment (PRIDE) program for vocational rehabilitation services. Clients who were unable to work due to a temporary medical condition, such as a broken leg, were given short-term work deferments based on expected recovery time. Those individuals who were shown to be fully unemployable due to medical limitations that would last for at least 12 months, were required to apply for federal disability benefits—Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI).

If the medical assessment vendor found an individual to be unemployable due to an unstable or untreated medical condition, a wellness/rehabilitation plan was

developed around the medical condition(s) the client reported limited his or her ability to work. Under this plan, clients would receive a 90-day work exemption with the requirement that they independently schedule an appointment to see a physician within a specific time frame to treat and stabilize their condition. Throughout their work exemption, clients were required to call a toll-free number to report on the status of their medical appointments and treatment. If the client failed, without good cause, to comply with these administrative requirements, even if they were attending and complying with treatment, their cases would be closed and the client would have to reenter the HRA/DSS through the front door at FIA Job Centers.

Throughout their wellness plans, it was the client's responsibility to navigate their way through program requirements: advocate to obtain medical appointments within specific time frames, telephone the medical vendor biweekly, and ensure that their treating physician returned required information to the medical vendor regarding treatment progress and employability by the end of the wellness period. Given the very nature of a serious, unstable medical condition, many clients were not able to manage all of these tasks on their own and were, therefore, unable to demonstrate administrative and clinical compliance with their wellness plans. While certainly well intentioned, this approach did not consistently provide the supports necessary for clients to obtain, and effectively participate in, consistent medical treatment. Rather, clients often cycled between medical evaluations and Job Centers, seeking to prove what had already been established: that they were ill and needed medical care to reach their highest degree of self-sufficiency.

Another issue surrounding the wellness plans involved their focus primarily upon those complaints that clients asserted as barriers to employment. For example, if an individual claimed that he/she could not work due to asthma, the asthma became the focus of the contractor's medical evaluation and subsequent wellness plan. Once the asthma was stabilized, the client was then returned to their Job Center for referral to work activities. Often, upon return to their center, a client would raise another medical condition that had previously existed, but that he/she did not raise, and therefore it had not been addressed in the earlier medical evaluation. Although the client did not identify this condition in the first medical evaluation, this medical condition also prevented the client's participation in work activities. The identification of an additional health condition would require an additional assessment, an additional FAO, and the expenditure of additional HRA/DSS resources, all of which were aimed to maximize an individual's self-sufficiency with regard to the newly revealed medical complaint. This process would often repeat itself over and over for an individual client because the contractual obligation of the medical contractor was to assess employability impacts of medical conditions identified by the client, as opposed to exploring any and all client medical conditions that affected a client's work participation.

The payment structure of the medical evaluation contracts unintentionally facilitated the movement of clients in and out of HRA/DSS and through various program areas. This occurred because the vendor was paid for completing medical

evaluations, no matter how many times a year an individual received them. There were little contractual incentives for the vendor if the client's chronic condition was stabilized, if the client completed a wellness plan, or achieved any other desirable health outcomes. As well intentioned as this contract was, it inadvertently contributed to the circular movement of clients through the medical evaluation and wellness programs and repeatedly spent resources on clients who were not achieving their optimum levels of wellness or self-sufficiency. In spite of this, the approach to independent medical evaluations proved to be an invaluable learning tool for HRA/DSS as it strived to customize services to promote optimal degrees of individual and family wellness.

PRIDE Vocational Rehabilitation

Clients whom the medical evaluators found to be employable with limitations were referred to the Personal Roads to Individual Development and Employment, or PRIDE, program, which was a cooperative effort between the New York State Department of Labor, New York State Department of Education (SED), and HRA/DSS. Upon entry into the program, clients received an intake interview by a HRA/DSS PRIDE worker to determine education and employment background as well as childcare needs. After the initial intake was completed, the client was referred to the PRIDE vendor whose location was nearest the client's home. PRIDE vendors were under contract to SED to provide PRIDE services. The vendors worked with clients to complete an additional employability assessment to determine individual client strengths, limitations, and level of job readiness. Based upon the outcome of this assessment, clients were referred to either Work-Based Education (WBE) for GED preparation or other educational services, or Work Experience and Training (WET) for vocational rehabilitation. Counselors from the New York State Office of Vocational and Educational Services for Individuals with Disabilities (VESID) the single state agency for vocational rehabilitation in New York State, were outstationed in each of the PRIDE vendors' various locations around the City to assist in the vocational rehabilitation process.

Originally intended to accommodate only those clients who were employable but required specialized services, PRIDE also accepted individuals who were employable with more substantial limitations. The goal of the program was to expose employment-limited clients to work and work-readiness activities in a supportive environment while providing employment preparation and vocational rehabilitation services, as applicable. Activities included education, work readiness, and Work Experience Program (WEP), job search, job placement, and retention services. PRIDE also had contracts with independent living centers that helped appropriate clients complete and submit applications for federal disability benefits. The PRIDE vendors were paid a fixed daily rate per client, regardless of client outcomes, and also received milestone payments for completing client assessments, job placement and retention.

An examination of the PRIDE program highlighted the extent to which clients were cycling and recycling between medical evaluation and PRIDE participation. When clients were referred to PRIDE, they often presented additional health complaints not addressed in their original medical evaluation. Under the PRIDE contracts, vendors were permitted to return clients to HRA/DSS if the clients reported new medical conditions that they said interfered with their ability to participate in program activities. Thus, an inadvertent revolving door was created; clients spent a tremendous amount of time and effort trying to demonstrate that they were too ill to participate in work activities and HRA/DSS invested a wealth of human, programmatic and fiscal resources to assess, treat and rehabilitate them. As this struggle was occurring, clients were not progressing towards their highest degree of wellness or self-sufficiency, thus failing to maximize the limited amount of time they had to receive TANF benefits.

HHC Wellness Plans

In 2002, HRA/DSS initiated a partnership with the NYC Health and Hospitals Corporation (HHC) to address some of the problems clients were experiencing in completing their wellness plans under the original medical evaluation contracts. In particular, the relationship with HHC sought to facilitate timely client appointments with primary care and specialty physicians, monitor client attendance at medical appointments, and facilitate the completion and submission of written reports to the medical contractor on client progress in treatment. Under the agreement, seven HHC sites would accept clients whom the HRA/DSS determined to have medical barriers to employment and who required wellness plans. The relationship with HHC allowed clients to be seen by a primary care physician within five days of referral. The HHC physicians also provided specialist referrals within 14 days, if required. Additionally, these sites provided the required physician reports and offered consistent feedback on client progress with their individual wellness plans.

This enhanced relationship with medical providers helped streamline client services. Although the program served a relatively small group of HRA/DSS clients, it represented a valuable step towards the development of a comprehensive model of care. It demonstrated that HRA/DSS could improve customer service and client outcomes through strategic partnerships. Through the program, client time and administrative resources were conserved through expedited appointments and subsequent treatment. Clear and consistent lines of communication and reporting were established between HRA/DSS, HHC, and the medical evaluation vendor. This resulted in stronger client engagement and compliance with wellness plans and further informed the development of the current WeCARE program.

100 Cases Study

Given the experiences of HRA/DSS with specialized programs aimed at addressing multiple barriers of the partially and fully unengageable clients and the Mayor's call to effectively serve these clients, it became clear that HRA/DSS

required a more precise understanding of its caseload. In an attempt to identify any existing differences among those clients who asserted medical obstacles to employment and those who did not, Commissioner Eggleston issued an Executive Order to conduct an extensive and thorough evaluation of a sample of the PA caseload. Ultimately, this "100 Cases Study" supplemented the lessons learned from previous efforts to engage partially and fully unengageable clients and further aided in the development and design of the current WeCARE program.

In August 2002, an initial random sample was identified. This sample consisted of clients who had reported an inability to work due to medical issues and for whom HRA/DSS had scheduled a medical assessment between January and April 2000. Later, a second random sample was identified; it was comprised of individuals on PA who did not have medical assessments scheduled with HRA/DSS's independent medical assessment contractor within the same period of time. (This was because they had not, at that time, claimed that they were unable to participate in HRA/DSS work activities due to a physical or mental health condition.) Retroactive samples were taken to capture the greatest amount of relevant client data in an expedited fashion. The goal of collecting these two samples was to identify patterns and trends among the medical assessment group and determine if any of these relationships occurred in the general public assistance population. Because the data collection systems at HRA/DSS were not set up to capture the nuanced details of clients' medical cases, a longitudinal approach to data collection was implemented, taking monthly "snapshots" of each sampled client's case engagement status.

To paint a clear picture of client case engagement and progress across time, categories of engagement were created, color coded, and then charted. Engagement categories included:

- Employed
- Receiving, or awaiting the outcome of a medical assessment
- Incapacitated due to a health condition
- In sanction, conciliation, or fair hearing process
- Receiving SSI or application pending
- Participating in substance abuse treatment
- Caring for a sick or disabled family member

When the engagement levels and patterns of the two groups were compared, striking differences emerged. Among those clients asserting medical barriers to work, there existed distinctive and counter-productive engagement patterns (see Reports 2, 3, 4). It became evident that a great many of these clients were cycling in and out of the system, resulting in multiple assessments and high rates of non-compliance. These clients were also spending month after month awaiting medical assessments and outcomes, potentially using up their limited TANF time without pursuing the treatment, wellness, and rehabilitation programs they required to achieve self-sufficiency. Finally, analysis of individual medical records illustrated that these clients also had multiple barriers to employment activities, not the least of which were extremely complex medical conditions.

Additional analyses of average Medicaid costs and claims among the 100 cases and the control group were undertaken in an attempt to quantify the cost of services being provided to the two groups. These fiscal analyses revealed a significant difference in health care costs between the two samples. Average Medicaid costs for the study year May 2000-May 2001 for clients claiming an inability to work due to medical issues were $8,021; the individual yearly payments ranged from $0 to $338,000. The average costs for the control group were smaller. Average Medicaid costs for the study year May 2000-May 2001 for clients not claiming an inability to work due to medical issues (the control group) were $4,322: the individual yearly payments ranged from $0 to $197,000. It appeared that clients with medical barriers to employment were spending a substantial amount of Medicaid money. Taxpayer dollars were being spent on both ends of the system, and client status was not changing: at the end of the day they had achieved neither wellness nor employment. This study demonstrated the need to reevaluate the manner in which HRA/DSS engaged clients facing medical and mental health barriers to work (see Reports 5, 6).

This study, its results, and their application in the restructuring of HRA/DSS represent a crucial turning point in its unfolding history. Intuitively, staff and management understood that there was something inherently wrong with the way clients with medical barriers were being served under previous programs. They had articulated problems with both the medical evaluations and the vocational rehabilitation services that were in place to help clients as they transitioned into the workforce. However, the execution of this research and its use as a foundation for programmatic and structural changes enabled HRA/DSS to shift from intuitive policymaking to policymaking grounded by factual information. This "evidence-based" policymaking enabled HRA/DSS to logically reframe its organizational structure and program areas, and align all of their respective components toward achieving a clearly defined outcome: the highest level of self-sufficiency possible for each client and their family.

HRA/DSS continues to track the original 100 cases and the control group. Each case study consists of numerous summaries and data collected from a wide variety of databases. To analyze and track each case, the multitude of collected information needed to be captured in a single document. To better portray the realities facing individual families, a graphic organization tool, called a genogram, is being employed to map out the circumstances and family structure of many of the cases in the study. Similar to a family tree, a genogram allows for a visual depiction of the complex and multifaceted relationships that may exist within and among families to whom HRA/DSS provides services. Not only does this tool enable close examination of family dynamics, but it also allows for the identification of cross-generational dependence and recurrent themes among cases (see Genograms A, B, C, D, E).

The research required to produce an individual genogram is laborious and time-consuming. Multiple records for an individual client must be researched across time to ensure accuracy. Often, an individual client is found to have connections to more than one family, therefore, multiple family histories need to be researched.

Depending upon the complexity of the family and its social relationships, an individual genogram may take months to compile. Despite these facts, the genogram has proven to be an important tool for efficiently presenting and articulating the multiple barriers to independence an individual or family may face. Genograms have also demonstrated the need to view and serve clients within the context of their families and social relationships, as these constructs strongly impact an individual's ability to become and remain self-sufficient.

The larger purpose of the genograms is to delve further into current caseload so as to design services that are both appropriate and customized to mitigate any and all barriers a family may be facing as it works towards self-sufficiency. Often, when an assessment is limited to the head of household, the individual may appear fit for work activities. However, when that assessment is expanded to encompass the clients' family, serious barriers are revealed. Perhaps there are sick children in the household, or someone is a victim of domestic violence or chemically dependent. There may be family members with medical, psychological, or behavioral issues. All of these possibilities can greatly impact an individual's ability to fully participate in work activities and, until these barriers are identified, the human service provider cannot effectively engage the client.

The genogram effort with regard to the "100 Cases Study" reveals that individual family stories are complex and varied, and need to be fully understood before the most appropriate package of services and supports can be developed. The genograms allow for a micro-level assessment of each client, enabling HRA/DSS to provide truly individualized customer services. While at first glance, it may appear that such personal treatment is much more costly than the Agency's previous "one size fits all" approach, in reality, tailoring services to meet individual family needs is likely to be more cost effective as its goal is to give each individual and family exactly what they need, as opposed to the full menu of benefits, assistance, and entitlements.

Each program and initiative discussed in this section represents a valuable learning experience for HRA/DSS and a stepping-stone towards the current approach of customizing services based on individual client's and/or family's needs. Careful consideration and planning went into the development of the comprehensive service model upon which WeCARE was built. A primary goal of WeCARE has been to stop fragmenting client services and provide holistic assessments designed to identify and address any and all client barriers to independence. Such a model required that HRA/DSS expand its focus to the family and social environment in which the client was functioning. Additional activities and goals for the comprehensive services model included the following:

- Biopsychosocial evaluations that identify all of an individual's and family's barriers that prevent clients from achieving their highest level of functioning
- Simultaneous interventions

- Intensive case management aimed at coordinating client services and outcomes
- Consensus among client and Agency goals to ensure client participation in his or her own treatment process
- Clearly defined and measurable program and client outcome goals
- Reasonable time limits for clients to receive services
- Use of performance-based contracts with payments tied to desired client and program outcomes

Understanding the Role of the Father

Fathers Study

Large components of TANF legislation involved the promotion of marriage and family as well as the reduction of out-of-wedlock births. While this was a smaller component of the first phase of welfare reform, it has played an important role in the reauthorization of TANF. Family preservation appears to have a logical relationship with the goal of ending dependence on public assistance. This is due to the fact that, in theory, two parent families have a greater potential to provide income, childcare, and social supports, than a single parent can contribute alone.

In an attempt to better understand the role of fathers within the public assistance caseload, HRA/DSS began to research families from its public assistance caseload with a focus on the role of the father in the family. This "Fathers Study" also employs the genogram tool to demonstrate the potentially complex relationships between an individual parent and their children. A single man may have children with several women, creating different families. While it is certainly not the norm for HRA/DSS clients, this cross-family fathering pattern is prevalent enough to require a re-evaluation of the TANF goal of family promotion. If a man has children by three different women, how does the concept of marriage manifest itself to the benefit of all of the children involved? How can human service organizations work to facilitate this man's engagement with and support of all of his children? These are extremely sensitive and complex policy questions that HRA/DSS is examining through the use of genograms (see Fatherhood Study Genogram).

4. Changing the Culture

The City's plan for welfare reform required HRA/DSS to reevaluate and alter the way it was delivering services as well as the services themselves. The evidence yielded by research into the partially and fully unengageable client base demonstrated the need for new and innovative programming to mitigate barriers to self-reliance. To accomplish these tasks and remain effective and relevant in the lives of its clients, an expansion of HRA/DSS's institutional perspective was required. By inviting the diverse voices of employees, clients, and stakeholders into a meaningful dialogue about welfare reform, HRA/DSS was able to develop strategies for implementing change. These dialogues have not only helped to improve customer service and tailor programs to better meet client needs, but they have also changed the culture of social service delivery, both within HRA/DSS and the larger human service provider community of New York City.

Commissioner Eggleston has often noted that her best resources are her human resources. Those resources were harnessed to address her first priority—departmental restructuring. Through a series of retreats and workgroups aimed at redefining the culture of HRA/DSS, staff contributed feedback and ideas to management. Community roundtables and advisory committees allowed for the inclusion of stakeholder voices in the development of objectives that would help meet larger goals. A "top-down" management approach is not always effective, particularly within an organization as large and diverse as HRA/DSS. As such, the administration encouraged its staff to think about the challenges the executive team was facing and identify innovative solutions to address them. In this way, 16,000 diverse minds and voices were invited to share ownership of the organization that they work hard to operate.

From the start of the administration, Commissioner Eggleston convened a series of retreats and workgroups to bring together key stakeholders from all departments and agencies. Staff collaborated to define and address the most pressing issues facing HRA/DSS and develop an agenda to guide its future work. These workgroups produced the seeds that ultimately grew into an ambitious restructuring plan, particularly as they related to the development of innovative programs such as WeCARE.

Retreats and Workgroups

TANF Reauthorization: At the start of TANF part II, reauthorization became the biggest legislative priority of HRA/DSS, establishing the foundation for future organizational plans. The workgroups developed proposals and strategies to prevent welfare dependence, support employment retention for those who left the rolls, and allow HRA/DSS the flexibility to meet each client exactly where they are, assisting them as they strive for their highest personal level of self-reliance.

In an effort to implement the City's TANF plan, workgroups were established to develop strategic plans to meet the goals of retention and prevention. Dedicated workgroups also addressed the development of a comprehensive service model, a redesign of the intake and assessment process, and strategies for fostering culture, building teams, and promoting customer service. Once again, these groups tapped into various human resources from across HRA/DSS. In addition to their individual job functions, the members of these groups volunteered to meet regularly and analyze each topic to help develop a clear strategic plan to realize the goals for the next phase of welfare reform. In March 2003, these groups reported their findings and recommendations in the form of comprehensive reports, complete with internal and external research, timelines for implementation, and opportunities for collaboration within the larger social fabric of New York City's human services community.

Retention: The retention workgroup's charge was to, "provide concrete and feasible retention strategies for implementation by HRA/DSS, which improve the employment retention of the participants whom the Agency serves…also increasing their self-sufficiency."[9] Recommended strategies conceive of the client as a whole, and consider individual needs, barriers, and strengths.

The workgroup engaged in research and solicited feedback from community stakeholders, former clients, front line case managers, employment vendors, childcare experts, and community-based organizations. Based upon their findings, the retention workgroup recommended that the Agency make changes in several key areas including childcare, employment and training programs, housing, and case closing protocols.

Prevention: The mission of the prevention workgroup was to develop a strategic plan for HRA/DSS aimed at coordinating, influencing and creating policies and programs that will lead youth at-risk for welfare dependence towards self-sufficiency through positive engagement.[10] The group defined prevention as a construct that encompasses three key components: the removal of barriers to health and human development, developing life-skills among young people, and developing attainable educational and occupational goals. Additionally, the group targeted two specific populations for prevention strategies: youth who are receiving public assistance and those young people who are at risk of needing public assistance because they are experiencing challenges to self-sufficiency.

The workgroup explored research and data from within the City as well as from outside sources to identify risk factors that may predispose youth to welfare dependence. Commensurate with the Commissioner's model of "One City, One Client, One Plan," the workgroup's primary recommendation was that HRA/DSS actively collaborate with representatives from all appropriate Mayoral agencies, faith and community-based organizations, managed care providers, labor organizations, and businesses that market to youth and families. By working collectively to improve parenting skills, increase the role of non-custodial parents in the lives of

their children, promote health and wellness, and develop after-school, summer, and mentoring programs for youth, many of the barriers to self-sufficiency that children and youth face can be mitigated before the culture of dependence is passed on to yet another generation.

Comprehensive Services: To address the complex needs of those clients who remain on public assistance due to medical, mental health, and/or substance abuse barriers, the comprehensive services workgroup developed a clinical model of seamless, holistic, enhanced services for unengageable and work-limited clients and their families.[11] Based upon the previous experience of HRA/DSS with medical assessments, vocational rehabilitation, and wellness plans, the workgroup recommended that the comprehensive services model be targeted towards specific populations with multiple and complex barriers to employment.

After careful consideration of the varied needs of the proposed recipients, the workgroup narrowed the primary target group to those clients who are temporarily exempt from work due to untreated and/or unstable medical and mental health conditions and those clients whose treated, stabile conditions limit their ability to participate in the workforce.

The workgroup also analyzed potential cost benefits and risks associated with implementing a comprehensive services model. Perceived financial benefits include:

- Reduction in the costs associated with clients churning or repeatedly moving in and out of engagement systems
- Improved participation, employment, and retention outcomes, which will reduce costs associated with public assistance dependency
- Reduction in costs associated with client reliance upon City emergency services
- Reduction in costs associated with service duplication within HRA/DSS and across delivery systems.

The perceived costs to the City involve increased use of medical services and reduction in the savings previously associated with clients being dropped from the public assistance rolls. Finally, the workgroup developed a flow chart of proposed comprehensive services and anticipated client outcomes (see Comprehensive Service Model (CSM) flow Chart 7).

Intake/Assessment: The goal of the intake and assessment workgroup was to examine and redesign the methods by which individuals entered HRA/DSS and were assessed for services. Paramount to the redesign was the notion that a plan for self-sufficiency needed to be established at intake. Additionally, the group sought to develop intake and assessment tools and mechanisms that allowed for quick and appropriate access to services, links to healthcare providers, as well as holistic and simultaneous assessment of barriers and strengths. Their efforts culminated in the following assessment model, whereby clients are screened and referred for health

and mental health issues, substance abuse, domestic violence, employability, and eligibility immediately upon engagement with HRA/DSS (see Chart 8).

The efforts of the Comprehensive Service Model and Intake/Assessment workgroups informed new program development, restructuring, and retooling within HRA/DSS, helping to create the new WeCARE program and Intensive Services Center and refine the manner in which clients are referred for specialized services. Their ideas also played a role in the retooling of the HIV/AIDS Services Administration (HASA).

Culture, Teambuilding, and Customer Service (CTC): The purpose of the CTC workgroups was to create a series of recommendations on the subject of HRA/DSS facilities, technology, communication, organizational structure, staff development and incentives. The recommendations strived to be consistent with a leadership organization that fosters a cooperative, collaborative environment. The CTC workgroup also developed an action plan under which each of their recommendations could be implemented.

To guide its efforts, the CTC workgroup established a mission statement "to develop effective strategies aimed at streamlining operations, enhancing customer services, fostering cultural change and teambuilding in order to move staff and clients towards positive and rewarding outcomes"[12] They determined that the achievement of specific key goals were prerequisites to conducting business with clients in a professional, effective, and efficient manner. These goals involved:

- Aligning responsibility areas and centers within the organizational structure to ensure that programs and operations have clearly defined lines of communication and accountability

- Creating and maintaining open lines of communication among all stakeholders to ensure unequivocal, consistent dissemination of HRA/DSS mission, values, and goals

- Providing incentives and opportunities for advancement to staff to promote career development, longevity, and pride in self and work

- Continuing to cultivate a fully trained staff

- Advancing a model of customer service that informs clients of available HRA/DSS services, benefits, and assistance and moves customers through facilities in a quick, efficient, and respectful manner

- Renovating HRA/DSS service and administrative facilities

- Providing every HRA/DSS employee with a networked computer and ergonomic, professional workstation

- Creating interfaces between all major HRA/DSS computer systems to promote integration, functionality, and user friendliness

The findings and suggestions of the CTC workgroup played a very large role in the restructuring and retooling processes, serving as a blueprint for change in many cases such as the Model Office Initiative, training initiatives, as well as agency-wide and departmental restructuring.

Commissioner's Forums

To create stronger linkages between HRA/DSS staff and leadership, Commissioner Eggleston set out very early in her administration to meet every single one of her 16,000 employees and make herself available to answer their questions, address their issues, and thank them for their tireless efforts. While her daily interactions with staff brought her closer to meeting that goal, she immediately established an annual meeting of HRA/DSS staff and leadership known as the Commissioner's Forums.

The first Commissioner's Forum was held in July 2002. These events have been organized annually with a different theme ever since. Each year, every staff member receives an official invitation to the Forum from the Commissioner. Held at the Javits Center, the Forums provide an opportunity for the Commissioner and her executive staff to speak about new initiatives, as well as departmental and agency challenges and achievements. Staff are also given the opportunity to address questions to the Commissioner and her Executive Team.

In addition to a commitment to answer every question posed to her at the Forum, the Commissioner also established an e-mail address so staff can ask her questions or voice concerns about the organization. Thousands of e-mails have been received, tracked, and answered. Each and every e-mail was acknowledged and forwarded to relevant program areas, communicating the Commissioner's personal commitment to customer service and encouraging the same level of interest at every level of the organization including programs, managers, and staff.

5. Strengthening Community Involvement

A critical component in the success of the organizational and programmatic changes within HRA/DSS has been the inclusion of community voices in the decision-making process. To provide an opportunity for stakeholders and communities to make their voices heard in a structured and effective manner, it made reconnecting with them a top priority of the administration. Commissioner Eggleston encouraged HRA/DSS staff to, "open the doors, open the windows, and let the people in!"[13] These words are most powerfully manifested in the establishment of the Commissioner's many advisory boards. The advisory boards, in conjunction with Mayor Bloomberg's commitment to settle many of the City's long-standing lawsuits, have promoted a climate of cooperation among the many parties invested in promoting positive outcomes for HRA/DSS clients. "After eight years of being persona non grata at the end of City Hall, it's certainly a change."—Steve Banks, Director of the Legal Aid Society's Homeless Rights Project, as quoted by the *Daily News.*[14]

Commissioner's Citizens Advisory Committee: This committee brings together clients, providers, and advocates from all program areas. It advises the Commissioner on areas of special concern, promoting an open, receptive climate and encouraging the participation of key stakeholders in shaping the work of HRA/DSS. The committee represents a viable feedback mechanism that facilitates input from a variety of stakeholders, keeping the administration in touch with the needs of the community. The dialogue that has emerged from the quarterly meetings has helped to develop programs and policies and maintain the communication that is a prerequisite to well-informed models of customer service.

Legal Advisory Committee: This committee was re-established at the beginning of the current administration in an attempt to open HRA/DSS to new ideas and solutions, establishing trust with the legal advocacy community while reducing litigation. During the first 100 days of the Bloomberg administration, the Commissioner and the staff of HRA/DSS's Office of Legal Affairs (OLA) met diligently with advocacy groups to openly and honestly discuss challenges and propose solutions. These ongoing meetings have led to a focus on the common ground that HRA/DSS shares with client legal advocate groups, which is the well-being of the clients. While these meetings do not produce absolute agreement on every issue, the dialogue and trust that the Legal Advisory Committee has established over the past four years has facilitated the development and rollout of innovative programs such as WeCARE and the Intensive Services Center.

HASA Advisory Board: Mandated by Local Law 49, the board has been established under the current administration to advise HRA/DSS on the subject of service and benefits provision and access for New Yorkers living with symptomatic HIV/AIDS. Comprised of eleven members, six of whom are eligible for HASA services due to their HIV/AIDS health status, the board meets quarterly to develop recommendations for the Commissioner. As the lives of persons living with HIV/AIDS continue to be extended through new medications and treatments, the board will become an increasingly vital tool in shaping HASA services to improve clients' quality of life and guide them toward new levels of independence.

Research Advisory Board: Adhering to the notion that evidence should guide policy and programs, a Research Advisory Board was also established, through which HRA/DSS collaborates with local universities, think tanks, and preeminent scholars from a variety of academic fields to pursue best practices.

6. Restructuring: The Umbrella Model of Service Delivery

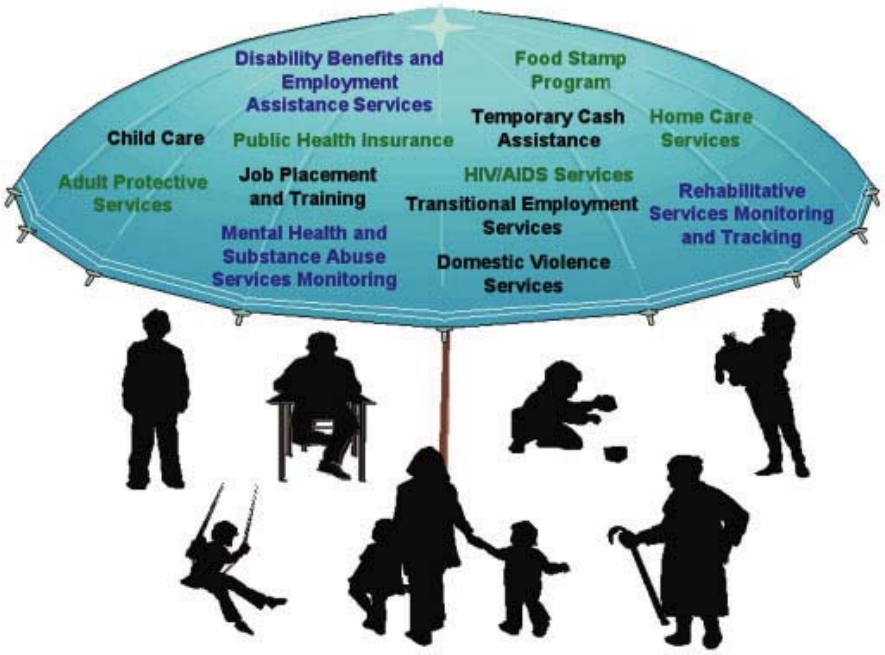
The evidence yielded by the "100 Cases Study" demonstrated a need for new program areas to address the medical and mental health barriers to self-sufficiency faced by an increasing number of clients. Additional research and programming was needed to address the growing percentage of able-bodied, sanctioned clients. The tremendous challenge of restructuring an agency of nearly 16,000 employees, three million clients, and many responsibility areas was realized through the development of internal collaborative relationships.

Clients enter HRA/DSS through one of three service routes: benefits, assistance, and entitlement. However, the desired outcome is the same for all clients: the achievement of their highest degree of self-sufficiency. Commissioner Eggleston utilized this understanding to conceive of an "umbrella" model of service delivery (see umbrella, p. 30). "The overwhelming goal is to get people to self-sufficiency… You take all the services you can and wrap them around the family," said Commissioner Eggleston in a *New York Times* interview.[15] This umbrella, in conjunction with the later findings of the workgroups and "100 Cases Study", was used to guide the restructuring of HRA/DSS. Under the umbrella plan, related programs and services have been more closely integrated, resulting in improved coordination and accountability, clearer, more effective leadership, as well as cost and resource conservation.

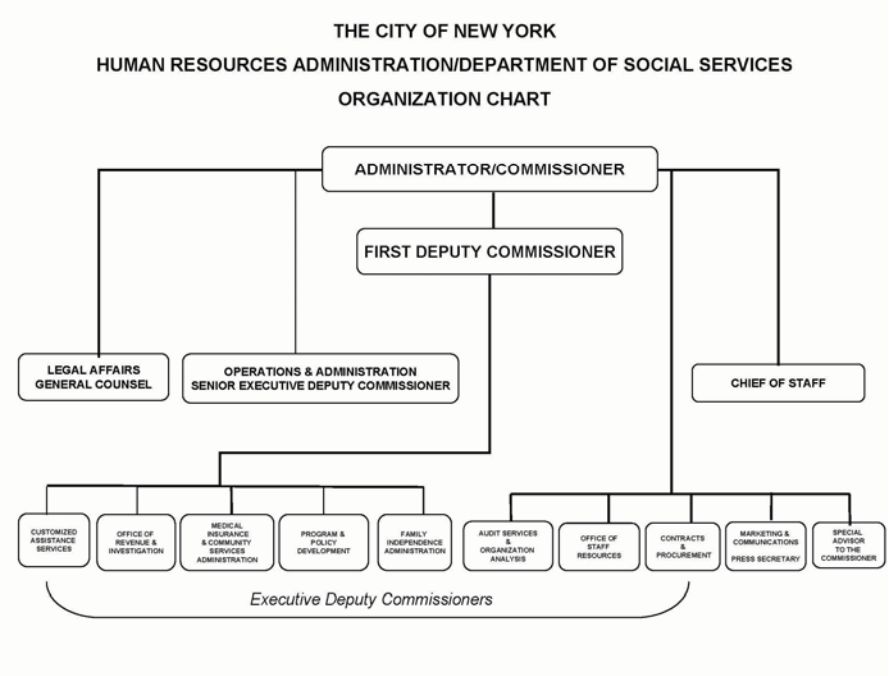
The primary work in the umbrella model was to show that work with families cannot be limited by interactions with the case head alone. As seen in the diagram, there are multiple issues that a family can face, and that at any given time, more than one service may be required to lead them as a family to self-sufficiency.

Commensurate with the findings of the CTC workgroup, a new organizational structure was created, dividing HRA/DSS into two distinct areas of management: services and operations (see organization chart, p.31). A seamless continuum of service provision was created and clear lines of accountability were established. Reporting and communication were improved within the organization. Additionally, certain program areas were moved and restructured internally to promote optimum efficiency and improve client services.

The Umbrella Model of Service Delivery



To support the umbrella, restructure was important. Commissioner Eggleston restructured based on the way services were to be delivered. If you perform family work, you must map out their problems.



The organizational restructuring aligned services, including program areas, under the First Deputy Commissioner. It aligned associated operations and administration under a Senior Executive Deputy Commissioner. By establishing clear areas of responsibility and defined channels of communication, the new organizational structure promoted improved accountability.

In addition to an overall organization restructuring, individual programs and services were moved to promote efficiency by co-locating related departments and to reflect administrative priorities. To better facilitate and support client disability claims, the Supplemental Security Income (SSI) and Disability Application/Appeals Unit (DAU) was moved to the new Customized Assistance Services program. To improve and streamline medical and support services for persons living with HIV/AIDS, the HIV/AIDS Services Administration (HASA) was moved into the Medical Insurance and Community Services Administration (MICSA). This move reflects a firm commitment to providing quality medical care and improved quality of life to those clients whose health is compromised by HIV/AIDS.

Other program areas were moved to change the channels of reporting. For instance, the Investigation, Revenue and Enforcement Administration (IREA), formerly known as the Office of Revenue and Investigation, was moved under the First Deputy Commissioner to facilitate maximum interaction and information sharing with various program areas. IREA also provided a home for the Office of Child Support Enforcement (OCSE) when it was returned to HRA/DSS from

Administration for Children's Services (ACS). The Office of Legal Affairs was moved to directly report to the Commissioner. In this position, the Office of Legal Affairs can better provide legal guidance and litigation support to HRA/DSS and preserve the authority of administrative leadership. Additionally, HRA/DSS established an Office of Legislative Affairs to include the organization's voice in policy debates and developments. This new office allows HRA/DSS to advocate more aggressively for legislative changes that support program operations and the delivery of services to clients.

Departmental Restructuring

A key component of the restructuring process required individual departments and program areas to reflect on their roles in helping people reach their maximum level of self-sufficiency so they can remain or return to the community of their choice. Throughout the process, departments were asked to pay special attention to streamlining services and improving interagency coordination. By placing a focus on the elimination of administrative and programmatic redundancies, vital fiscal and human resources were conserved while client services were improved.

Investigation, Revenue and Enforcement Administration (IREA)

In August 2005, The Office of Revenue and Investigation (ORI) was designated as a new responsibility area and renamed the Investigation, Revenue and Enforcement Administration (IREA). This change highlights the importance of fraud elimination and revenue maximization to the current administration. IREA supports program integrity by deterring fraud in the public assistance, Medicaid, and Food Stamp Programs. IREA is also responsible for the recovery of overpayments due HRA/DSS.

In August of 2003, IREA became the home of the City's Office of Child Support Enforcement (OCSE). Given the vital role that child support plays in the achievement of self-sufficiency, the movement of OCSE to HRA/DSS helps realize the prevention and retention goals of the welfare reform plan.

OCSE helps ensure that non-custodial parents provide financial support for their children, providing services to public assistance and non-public assistance parents regardless of income. The office assists in the location of non-custodial parents, establishes paternity, monitors court issued child support orders and collects and enforces payments. OCSE is firmly committed to assisting low-income, non-custodial parents in meeting their child support obligations through employment opportunities.

Office of Legal Affairs (OLA)

Through Executive Order 696, Commissioner Eggleston mandated that the Office of Legal Affairs embark upon a restructuring process aimed at establishing one legal voice that works to shape and defend the many laws and statutes that govern the operation of HRA/DSS. Due to OLA's role as the legal representative of the agency, its restructuring plan has implications for every department and service area within HRA/DSS. Previously, individual service areas spent an inordinate amount of time in the process of locating and preparing case-specific paperwork for various legal actions. Under the restructuring plan, OLA has worked to develop areas of expertise among staff attorneys and utilize electronic case management systems so that attorneys may effectively defend programs with minimal imposition upon those who provide direct client services. In this way, OLA is able to improve the effectiveness of its operations while reducing litigation-related burdens to the individual program areas. Additional highlights of OLA's restructuring plan include:

- The establishment of a Service Programs and Operations division to support and reflect the newly established divisions of the same name within HRA/DSS, similarly promoting a clear management structure within the Office of Legal Affairs.

- The creation of an Administrative Services Unit to allow attorneys to focus exclusively on individually assigned duties and more effectively support HRA/DSS.

- The creation of a Medical Insurance and Community Services Administration (MICSA) legal unit complete with program-specific managing attorneys to eliminate duplication of effort and promote legal expertise regarding specific types of medical services.

Medical Insurance and Community Services Administration (MICSA)

MICSA manages HRA/DSS public health insurance programs as well as its medically related social service programs, providing New Yorkers with a wide range of health related services. Through an intense effort among staff and leadership, this program area, which was formerly known as the Medical Assistance Programs, was subsumed under a new responsibility area, MICSA and restructured to reflect its commitment to providing enhanced access to quality medical care and related social services.

The most notable feature of the MICSA restructuring involves the movement of the Agency's HIV/AIDS Services Administration (HASA) to MICSA. Previously, HASA was an entity of itself, one of the first City agencies in the country established to address the HIV/AIDS pandemic of the 1980s. Recognizing that the primary need of HASA's clients is medical, HRA/DSS decided to move HASA under the umbrella

of MICSA, to keep the health and wellness of clients with advanced HIV and AIDS central to the work of the administration.

In addition to HASA, MICSA oversees the following program areas:

- Medical Assistance Program (MAP)
- Adult Protective Services (APS)
- Home Care Services Program (HCSP)
- Non-Public Assistance Food Stamp Program (NPA/FS) for unengageable consumers

Under the Medical Assistance Program, MICSA also administers the following public health insurance programs, which support both public assistance clients and other New Yorkers, enabling them to live healthier, more stable lives:

- Medicaid (MA)
- Child Health Plus A (CHP A)
- Prenatal Care Assistance Program for Pregnant Women (PCAP)
- Family Health Plus (FHP)
- Family Planning Benefit Program
- Medicaid Buy-In Program for working people with disabilities
- Medicare Savings Programs

Office of Contracts/Office of the Agency's Chief Contracting Officer (ACCO)

The Office of Contracts is responsible for procuring goods and services for HRA/DSS in a fair and equitable manner and at optimum cost. To increase the efficiency with which the Office of Contracts manages its many program-generated Requests for Proposals, the office was restructured to create a Program Assistance Unit. The Program Assistance Unit reports directly to the Deputy Agency Chief Contracting Officer, streamlining and consolidating the contract process from the point of solicitation to the actual award of a contract. The unit supports the program areas by directing and managing the Request for Proposals to ensure adherence to rules and requirements prior to final vendor selection and contract award. Additionally, the unit assesses the need for assistance and training in each program area and oversees regular training on the procurement process for procurement staff.

To foster teamwork and collaboration among program areas, the Office of Contracts has initiated a series of agency-wide contract manager meetings. These meetings occur bi-weekly on various levels within the organization and are effective tools for the consistent dissemination of information and updates. These meetings

also create achievable program milestones, promote an open dialogue among all procurement staff, and help to ensure accountability in contracting across program areas.

In July 2004, the department achieved a high level of confidence from the Mayor's Office of Contract Services in response to the exceptional efficiency and oversight demonstrated by the ACCO's Office. As a result, the ACCO of HRA/DSS was delegated Level III authority, which carries with it the ability to approve a wide variety of procurements, up to $5 million. In addition, the ACCO's Office completed its FY 2006 contracting awards with a 96% completion rate.

7. Removing Barriers to Self-Sufficiency: Customizing Services

The next phase of welfare reform emphasized a need for personal accountability. However, it was also sensitive to the variety of barriers to self-sufficiency that some New Yorkers face. Through previous experiences and recent research, HRA/DSS developed a better understanding of its clients who, despite the best employment-related efforts, remained on the City's public assistance rolls. This understanding has allowed HRA/DSS to craft groundbreaking new programs designed to remove individual and family barriers to self-sufficiency and move previously partially engageable and fully unengageable clients toward their highest degree of independence.

Customized Assistance Services: Wellness, Comprehensive Assessment, Rehabilitation, Employment (WeCARE)

In order to meet clients with multiple barriers to employment where they are and begin to address the findings of the "100 Cases Study" and the comprehensive services workgroup, a new program area, Customized Assistance Services (CAS), was created. CAS is a highly specialized office that provides direct services and clinical expertise in the areas of health, mental health, and substance abuse to other HRA/DSS program components. CAS has several functional units including the Visiting Psychiatric Service, the Placement Assessment and Client Tracking Unit, and the Office of Rehabilitation Services. It manages several large substance abuse assessment and case management contracts and is the lead division on clinical and substance abuse issues. CAS also administers the WeCARE program, which provides customized services to clients with medical, mental health, and/or substance abuse conditions to aid them in achieving wellness and economic self-sufficiency. If the client has only substance-abuse problems, they are referred to another program for services.

The WeCARE program model was developed through an extensive collaboration among staff from various parts of HRA/DSS, including the Family Independence Administration, Medical Insurance and Community Services Administration, the Office of Legal Affairs, Operations and Administration, and the Agency Chief Contracting Officer. The program was informed by previous programmatic and contracting experience as well internal and external research on the subject of clients with functional limitations who have multiple barriers to employment. Early in the planning process, serious consideration was given to developing clear and comprehensive operational guidelines for program services as well as systems for tracking and monitoring client progress.

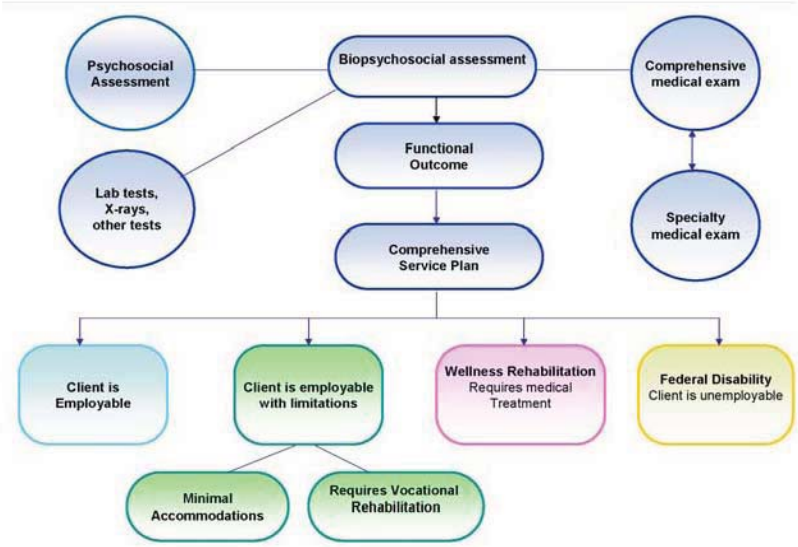
In July 2003, upon securing necessary funding, HRA/DSS issued a Request for Proposals for WeCARE. Administrators and staff worked collaboratively to develop and negotiate performance-based contracts to operate the program. Vendors were selected to serve clients from two regions of the City. Prior to the launch of the WeCARE program, an extensive orientation was conducted at each of the HRA/DSS Job Centers to familiarize staff with the program. Additionally, all HRA/DSS public assistance operations staff were trained in referral, coding, and tracking protocols and related electronic data management tools. After extensive planning and preparation, the program received its first clients on February 7, 2005.

Under the WeCARE program, vendors have responsibility for clinical case management and operate under strict guidelines regarding the manner and timeframe in which clients are to be served. They are responsible for facilitating the initial biopsychosocial (BPS) assessment in a timely manner, which includes a comprehensive medical examination, laboratory tests and x-rays, and a psychosocial assessment, as well as any specialty tests or examinations the client may require. Based upon the functional outcome of the BPS assessment, a comprehensive service plan (CSP) must be developed to address the client's health, mental health, along with social and vocational barriers to employment including those that result from problems within the client's family. The vendor is also responsible for implementing a client's CSPs.

The goal for WeCARE clients is for them to attain their highest level of function and help as many as possible attain health, wellness and self-sufficiency. After the BPS assessment, clients can be deemed either to be fully employable, employable with limitations, in need of treatment for an unstable medical condition that affects employability, or unemployable. Clients who are found to be employable with no limitations are referred back to the HRA/DSS Job Center for participation in work-related activities. Clients who are found to be employable with limitations are provided services based upon the severity of their functional limitations. Those who need minimal accommodations are matched to appropriate work activities that provide the necessary accommodations. Clients with more serious limitations are provided with vocational rehabilitation services. Those who are found to be in need of medical treatment due to an untreated or unstable condition receive an individualized wellness/rehabilitation plan that includes case management, health

education, and linkages to appropriate treatment providers. The status of these medically unstable clients is periodically reviewed to check their progress in following their wellness plan. Finally, clients who are found to be in need of Supplemental Security Insurance/Social Security Disability Insurance are assisted in their application for Federal Disability benefits as well as any appeals (see HRA Customized Assistance Services Chart below).

HRA Customized Assistance Services



Some very important features of the WeCARE program separate it from previous programs. Foremost is the holistic focus and comprehensive nature of the medical assessment. Under previous programs, identification of the client's barriers to employment was fragmented and then treated sequentially, resulting in clients churning through programs. WeCARE addresses and identifies all barriers to client self-sufficiency immediately and addresses them simultaneously in a coordinated fashion. Second, close monitoring and tracking of client progress through their Comprehensive Service Plans ensures that clients are constantly engaged in appropriate activities that move them closer to self-sufficiency. Through close monitoring of a client's wellness plan and as their functional limitations are documented, WeCARE is able to identify those clients who are in need of Federal Disability benefits.

Family Independence Administration (FIA): Intensive Services Center

In addition to providing necessary cash assistance and other benefits, FIA is the division of HRA/DSS that assesses and refers public assistance recipients to appropriate work-related activities by developing individualized plans for self-sufficiency. This work is carried out in the Administration's twenty-nine job centers and two specialized sites. Through a detailed assessment process, clients are enrolled in comprehensive employment programs, which incorporate elements such as work experience, job search and placement, as well as vocational, job skills training, and educational programs. Staff within job centers also assist clients in achieving their personal goals for self-sufficiency by determining and monitoring client eligibility for nutritional and wellness supports such as food stamps and Medicaid. While this division was reorganized under previous administrations, it has received special attention in the current administration's restructuring plan so that it may provide appropriate services, supports, and investigation with regard to cases with specific barriers to employment that cannot otherwise be addressed by WeCARE.

Conceived of as a site to provide intensive focus on cases with severe barriers, the Intensive Services Center was opened on May 9, 2005. Some clients fail to participate in work-related activities despite their ability to do so. Many of these individuals are under sanction due to this noncompliance, meaning that their family's public assistance grant has been reduced. It was decided that the first group of cases to receive intensive services would be those clients who had either been sanctioned for at least 60 days or had a history of noncompliance with work assignments.

In an effort to better understand and serve this growing segment of the caseload, the HRA/DSS Office of Program Reporting, Analysis, and Accountability (OPRAA) conducted a detailed survey of sanctioned clients. In 2004, 210 HRA/DSS customers currently under sanction were questioned regarding the details of their sanctions. While the survey revealed that the vast majority were aware of their sanction status (79%), a sizeable portion were unaware their sanction was even in effect (21%). Of those who were aware of their sanction, over one-quarter were unsure of the reason for their sanction. Additionally, of those who were aware of their sanction, 31% cited childcare or child health problems as a reason for noncompliance and 19% cited domestic violence or personal health problems.

The results of this survey helped inform the policy and philosophy of the Intensive Services Center in several key ways. First, the center uses every client contact to explain the employment system and stress the benefits and importance of participating in required activities. The center is also committed to addressing any barriers to employment through assessment and referral for needed services. Finally, to ensure the integrity of its operations, the center is equipped to investigate instances of potential fraud.

Since its opening, more than 10,000 sanctioned cases have been transferred to the Intensive Services Center location on 16th Street in Manhattan. The program

provides on-site assessment staff, childcare staff, fraud investigators, and Credentialed Alcohol and Substance Abuse Counselors (CASACs) to immediately address any barriers to employment through assessment and referral services. There is also a Substance Abuse Job Center and a WeCARE center co-located within the building that houses the Intensive Services Center, to expedite the referral process.

In addition to addressing and removing barriers to employment, the Intensive Services Center staff explain the employment system to the client, discuss possible work-related activities and identify the consequences of failing to comply with these activities. Able-bodied clients are encouraged to comply with their work-related activities through engagement in an immediate demonstrated compliance process, which, upon completion, will result in lifting their sanction. Demonstrated compliance requires that clients under sanction participate in a five-day in-house WEP assignment. Clients that successfully complete this demonstration have their sanctions lifted on the fifth day and are given a WEP assignment. Upon completing four weeks in their WEP assignment, these cases are transferred back to a regular job center.

Customized Services for Special Populations

Building upon the concept that the best services are provided by those with expertise, HRA/DSS developed specialized job centers to address clients' special needs. Within these Job Centers, employment services are customized to meet the precise needs of clients who, due to their status within a special population, require different service options. Current specialized job centers are designed to meet the needs of refugees and immigrants, veterans, homeless clients, individuals struggling with substance abuse, individuals with barriers to employment, employed clients, child-only cases, and seniors:

- WeCARE Hubs (Manhattan, Brooklyn, and the Bronx) provide services for clients who are participating in WeCARE because of medical or mental health conditions that present significant barriers to employment.

- Union Square Job Center houses a dedicated center for clients with substance abuse disorders referred to treatment by HRA/DSS.

- Refugee immigrant centers, primarily for those clients with language barriers, provide services in language acquisition that prepare limited English-speaking adults for the workplace. This includes integrated skills enhancement, English language classes, and work experience.

- The Veterans Services Center serves public assistance cases where at least one household member is a veteran and, helps veterans to obtain the special benefits and services to which they are entitled.

- The Riverview Job Center primarily services public shelter residents.

- The Colgate Job Center primarily provides transitional benefits to working families.

- The Family Service Call Center services active child-only cases whose payees are not in receipt of public assistance.

- The Senior Works Center serves public assistance clients who are over 60 years old and assists Seniors in procuring the employment hours necessary to receive their Social Security benefits.

8. Retooling: Supporting Services Through Technology, Performance Management, and Infrastructure

The evolution of HRA/DSS as an organization whose policy and program decisions are grounded in evidence has been achievable, largely due to advances in the way data is collected, managed, and analyzed. Through collaboration among Operations and Services staff, HRA/DSS has been able to develop its own technological applications, infrastructure models, and performance measurement tools, all of which interact to provide a clear depiction of the variegated caseload. As the public assistance rolls shift toward an increasingly complex population of clients, this ability is particularly crucial because current PA recipients require more intensive, individualized services. In order to manage both individual client progress towards varied degrees of self-sufficiency as well as the complex menu of services assisting in that process, a solid technological and infrastructural foundation is essential.

Departmental Retooling Plans

HIV/AIDS Services Administration (HASA) Plan[16]

The HIV/AIDS Services Administration has been in existence since the 1980s and was one of the first and most comprehensive local government responses to the epidemic in the nation. HASA initially engaged in providing enhanced public assistance, case management, and housing assistance to clients with advanced HIV and AIDS. Since the introduction of anti-retroviral drugs and treatment regimens in the mid-1990s, many of HASA's clients are living longer lives of improved quality. For this reason, HASA has undergone a period of reevaluation and retooling, focusing on methods to improve and enhance service delivery to meet the changing needs of its clients.

Through a series of roundtable discussions and planning sessions, which included HASA staff, management, advocates, and clients, priorities for client services emerged and strategic plans were developed to address those priorities. Key among them was the implementation of the Model Office at HASA locations, in order to deliver high quality services in the most comprehensive, efficient, and dignified manner possible. While the HASA Model Offices would share the same basic features as the existing Medicaid Model Offices and Model Job Centers, specific alterations needed to be made to tailor services to HASA clients.

The HASAWeb information system is a web-based repository that bundles all client-specific data together into a user-friendly system. The system allows workers to view a client's housing history, demographics, assessment outcomes, service plans, case notes, food stamps and public assistance budgets, and community-based resources in one location, promoting the provision of a full menu of services tailored to meet the needs of each individual client.

- Staff from HRA/DSS Customized Assistance Services Disability Appeals Unit (DAU) are stationed on-site at HASA Centers to maximize the ability of clients to receive all of the Social Security Administration benefits to which they are entitled. Not only do DAU workers assist in completing and submitting initial applications for Social Security Disability (SSD) and Supplemental Security Income (SSI), but they also support clients through the appeals process, including representation at hearings.

- Credentialed Alcohol and Substance Abuse Counselors (CASACs) are also out stationed at all HASA Centers to assist workers in identifying HASA clients who may have alcohol and drug abuse problems and referring them for treatment. HASA clients are motivated to participate and remain in treatment programs that best suit their individual needs. The effort to engage drug and alcohol-dependent HASA clients in treatment activities is pivotal as treatment can improve client quality of life, reduce the risk of HIV transmission, and increase adherence to medical treatment regimens.

- On-site representatives are present at HASA Centers to provide information about the benefits of enrollment in managed care, particularly HIV Special Needs plans specially designed for people living with HIV/AIDS. Clients are enrolled in managed care on a voluntary basis.

- HASAStat integrates client and HASA Center data to evaluate Center performance and facilitate dialogue among Center staff and supervisors. Every month, a HASAStat report is generated for each of the 12 HASA Centers. Indicators of Center performance are tracked through the system and each Center is given a composite score to indicate its success in meeting the various indicators. While many of the performance measures, are similar to those in Job Centers or Medicaid Offices, HASAStat also tracks indicators specific to the work of HASA, most notably, court mandated timeframe indicators. Examples of such indicators include: client case-by-case financial assessment provision timeliness, timeliness of public

- assistance applications, and timeliness of immediate need and expedited food stamp issuance.

In addition to providing improved services within HASA Centers by expanding upon the Model Office design, HASA has also developed several new initiatives aimed at improving and expanding services for New Yorkers living with advanced HIV and AIDS. These initiatives have grown out of strong partnerships with New York City's medical and social services communities and represent a firm commitment on the part of administration to transform its service delivery.

- By the end of 2004, HASA had entered into Memoranda of Understanding with 53 commercial emergency housing providers, eliminating sub-standard facilities, improving quality control, and standardizing the per diem rate for emergency housing. Additionally, all emergency housing providers are now required to develop linkages with service providers such as medical and mental health facilities and rehabilitation centers and refer clients for these services as required.

- To ensure that HASA's limited supply of non-emergency supportive housing is dedicated to those clients with the greatest medical need, HASA is piloting a Comprehensive Health Assessment Team at the Jerome Avenue Model Office, where housing staff work in concert with a clinical team to determine the most appropriate type of supportive housing for each medically-needy client.

- The Single Point of Access/Accountability (SPOA) initiative has been developed to provide a single point of entry for clients into the non-emergency supportive housing system. It is designed to address clients' supportive and independent housing needs, ensure comprehensive, accurate, timely, and efficient processing and tracking of housing applications, and create an appropriate housing match with clients based upon their specific needs.

Medical Assistance Program (MAP) Plan[17]

This administration has been extremely successful in providing public health insurance to New Yorkers in need, increasing Medicaid enrollment from 1.7 million in January 2002, to 2.6 million by November 2005. Continuing the City's successful HealthStat initiative and utilizing the knowledge gained through enrollment and recertification of individuals for Disaster Relief Medicaid (DRM) in the months following September 11th, HRA/DSS has undertaken a number of actions designed to improve access to public health insurance, simplify application and renewal procedures, improve customer service, and increase program efficiency while conserving administrative costs. With regard to these recent actions, Brinbaum and

Haslanger (2004) note that, "These efforts have made a difference, as more New York City residents are enrolled in public coverage than at any time in the past."[18]

Expanding Access: HealthStat, which began in February of 2000, is a Citywide initiative that seeks to enroll uninsured New Yorkers in public health insurance programs. In response to the HealthStat initiative, HRA/DSS aligned eligibility for food stamps and Child Health Plus A (CHP A), since children who are eligible for food stamps are also eligible for CHP A coverage. In conjunction with the MIS team at HRA/DSS, the Medical Assistance Programs (MAP) unit developed a computer program that expedited enrollment of 15,000 children in CHP A, which greatly increased the enrollment in this program. Additionally, HRA/DSS has increased its enrollment efforts throughout its community offices by improving customer services and accepting applications for children eligible for Child Health Plus B coverage in order to allow "one stop shopping" for families. Previously, families would have to apply separately for CHP B coverage, as it is not administered by HRA/DSS. HRA/DSS also operates the City's HRA Medicaid Helpline telephone service, which allows families to renew their Medicaid coverage or determine their eligibility for public health insurance through a guided process that can be utilized from the privacy and convenience of their homes. Additionally, a recent enhancement to the Medicaid Helpline allows customers to change their address over the phone, a process that previously required a visit to a Medicaid community office.

HRA/DSS operated a "client representation" program for many years in which outside organizations assisted consumers with the completion of Medicaid applications and submitted them to a central site for eligibility determination by MAP staff. This program proved to be an important tool for both HRA/DSS and the State Department of Health, and has informed the design of the State's current facilitated enrollment program. Facilitated Enrollment (FE) has allowed HRA/DSS to expand access to public health insurance by giving community based organizations and managed care plans Facilitated Enroller status and allowing them to screen clients and complete Medicaid, CHP, and Family Health Plus (FHP) applications, while retaining Local Department of Social Services (LDSS) responsibility for eligibility determinations.

Simplifying Application and Renewal Procedures: The simplification of the application and renewal process was first developed through the administration of Disaster Relief Medicaid (DRM). Following the traumatic events of 9/11, HRA/DSS correctly anticipated an immediate and increased need for public health insurance. However, given the tremendous damage to the City's infrastructure and the absence of electronic data management systems, the standard 16-page Medicaid application needed to be simplified. Through negotiations with state and federal officials, MAP was able to implement a one-page application with self-declaration of identity and income to enroll over 343,740 New Yorkers in DRM in just four months. Not only was this an achievement of epic proportions, but it also set the precedent for the simplification of Medicaid renewal processes.

In January 2002, the goals of simplified renewal were further realized when the State of New York's face-to-face interview requirement for Medicaid recertification was eliminated. In response to this newly found flexibility, the MAP division of HRA/DSS developed a mail renewal program. Incorporating consumer feedback, MAP developed a single-page renewal form, preprinted with household information extracted from New York State electronic records. Consumers need only to make necessary corrections, send in proof of income and any other changes, sign, and return the form to continue their benefits. Consumers who have not returned their renewal forms and minimal supporting documentation within 30 days receive a reminder by mail. The result of this initiative has been a 30% increase in renewal rates, with over 80% of current recipients of renewal forms responding to the simplified form. The larger implication of this finding is that these numbers represent individuals who are not cycling in and out of health care, who are therefore able to maintain wellness for themselves and their families, and who are continuously supported in their employment efforts.

HRA/DSS has also used Interactive Voice Response (IVR) to increase the availability of information to consumers. The IVR system allows consumers automated access to the status of their renewal application in five languages (English, Spanish, Haitian Creole, Mandarin, and Russian). The IVR service is available 24 hours a day, seven days a week.

Improving Program Efficiency: HRA/DSS remains committed to the use of performance measurement tools to improve management practices. As the administration has moved to realize the City's vision for flexible, individualized services designed to serve the City's diverse clientele, it has become increasingly important to expand performance measurement tools to individual program areas. MAPModelStat was implemented in November 2004 and manages the performance of each of the Agency's 19 Medicaid Model Offices. Meetings are held every two weeks to review individual site performance on indicators related to case processing, customer service, quality, and program administration. Additionally, each Medicaid Model Office has a scoreboard which posts each site's performance on application intake, number of cases processed, staff attendance and errors rate, to keep all staff actively engaged in the pursuit of office goals.

HRA/DSS has been diligently pursuing opportunities to realize efficiencies. New York City is in the final phases of implementing the 1115 Medicaid managed care waiver, which was designed to increase health care access and coordination of client care while containing the cost of services. Through managed care programs, HRA/DSS expects to realize cost savings while maintaining the quality of client care.

IREA Medicaid Fraud Prevention Plan[19]

> HRA has absolutely no tolerance for those who would betray the trust of the people we serve. We will not compromise our integrity.
> —Commissioner Eggleston on Medicaid fraud.

In response to growing concern regarding Medicaid fraud in New York City, and to preserve Medicaid as a vital support for many New Yorkers who have either left public assistance for work or are in the process of making that transition, the Investigation, Revenue and Enforcement Administration of HRA/DSS pursues a number of initiatives to identify and prevent consumer fraud. Working in collaboration with the New York State Attorney General's Medicaid Fraud Unit and the New York State Department of Health (NYSDOH), IREA strives to investigate and prevent prescription drug fraud on all levels.

Since the inception of IREA's Prescription Drug Fraud Program in January 1999, its Bureau of Fraud Investigation (BFI) has conducted more than 6,949 prescription drug fraud investigations that resulted in 1,180 (17 percent) arrests and 1,542 (22 percent) case closings. More than 2,600 Medicaid recipients have been placed on restriction, which means that they are assigned to a designated pharmacy to have their prescriptions filled. Almost $16 million in fraud dollars have been identified, and more than $4 million in cost avoidance has resulted from these investigations.

Some initiatives that seek to prevent prescription drug fraud include the use of uniform serial numbered prescription forms, printed on non-reproducible, non-erasable paper, and required pre-approval for high-cost prescription drugs with a potential street market, such as Serostim. Serostim is a drug prescribed to help build strength in HIV/AIDS patients, but which is often diverted into illegal markets and utilized by healthy individuals to build muscle mass. Based on the BFI's recommendation, NYS DOH placed Serostim on its list of pharmaceuticals that require prior approval before a pharmacy is allowed to fill a prescription. Implementation of this recommendation produced a drop in the number of prescriptions filled each month. Total monthly costs for Serostim prescriptions declined from a high of $5 million in July 2001 to less than $1 million monthly in July 2005.

IREA is also taking steps to reduce waste through strategies that are aimed at eliminating duplication of services. BFI assists the New York State Office of Temporary and Disability Assistance under the Medicaid Interstate Duplicate Assistance (MIDA) match program, which identifies recipients or household members having active Medicaid cases in New York City and outside of New York State. BFI resolves these cases through field address verification, and, if the person identified via the match does not live at the address of record, the case is referred to the HRA's Medical Insurance and Community Services Administration (MICSA) for

closure or to remove the person living out of state from the case. For FY 2005, 611 cases were closed, with a cost saving of $678,210.

BFI matches persons with Medicaid coverage with lists of persons incarcerated to ensure that there is no duplication of benefits. The NYC Medicaid Region Prison Match averages 2,500 cases per year. In FY 2004, 1,528 cases were closed based on BFI's investigative findings, and in FY 2005 alone, 1,869 cases were closed, resulting in a total savings of $4.95 million.

The Public Assistance Reporting Information System (PARIS) Match is a federally-run matching program that seeks to identify public assistance recipients who may be collecting benefits in two or more states simultaneously. Twenty-six states are currently involved in the program and other states are added periodically. Matches found for New York State are sent to the New York State Office of Temporary and Disability Assistance, which controls the public assistance and Food Stamp cases and sends Medicaid-only cases to NYS DOH. New York City cases are referred to HRA and BFI investigates the referrals.

In operation since 1999, the PARIS Match program has identified 8,016 cases a year on average, and has resulted in 2,656 public assistance case closings, for a total savings of $24,623,880. Closing the public assistance case also closes the Medicaid portion of the case, and in FY 2005 alone, 379 cases were closed for a savings of $1,624,008.

Model Office Initiative: Technology and Facilities that Promote Customer Service

In the not so distant past, a welfare or Medicaid office was the dreary epitome of a cold bureaucracy. The surroundings were outdated and dingy. Workers' metal desks were partitioned together to physically separate case workers from clients. The workspace was strewn with bundled electrical and telephone wire connecting phones and electrical systems. Clients could spend hours, if not entire days, in crowded waiting rooms, sometimes just to drop off or pick up documentation.

With the advent of welfare reform, administrators at HRA/DSS began to examine the connection between individuals and the environment in which they functioned. It became clear that if the programmatic focus was to be on moving clients into the workforce, professionalism needed to be injected into the environments in which clients were being served. Welfare offices were converted into Job Centers and the buildings in which these centers were housed were renovated to reflect the professionalism that the organization expected of its clients. While it represented a step in the right direction, much more needed to be done to increase efficiency and promote client-centered services in these environments.

The Medical Assistance Programs (MAP) at HRA/DSS pioneered the Model Office in 2001 to improve client services. MAP enlisted the services of a consulting

firm that works primarily with health care providers to retool and redesign clinics to promote efficiency. The consultants worked with the Medicaid offices to draw upon the expertise of the line staff, creating teams within each office to examine the services being provided, collect baseline data, and make recommendations on how the office could run more efficiently. What developed out of these planning sessions were technological applications, and physical and process changes that have been applied throughout various program areas to fundamentally change the way HRA/DSS interacts with clients.

Model Offices substantially improve the physical environment of HRA/DSS offices and centers while profoundly enhancing customer service. The redesigned main reception area welcomes clients with its inviting design and warm customer service representatives. In FIA and HASA Model Offices, reception staff utilize a ticketing system to provide an initial need assessment, routing, and tracking services so that clients are directed to appropriate services quickly and efficiently. Information systems allow reception staff to quickly and accurately assist arriving clients by permitting them to verify case information, confirm the time and location of client appointments, and issue numbered, color-coded tickets that direct clients to appropriate service areas. Clients visiting Model Offices to drop off or pick up information or paperwork reduce the amount of time they spend in the centers by utilizing the Customer Service Information Centers. In some HASA and job centers, this effort is supported through automated kiosks enabling clients to take care of their information needs quickly and independently.

To date, all 19 Medicaid offices, eight job centers and four HASA Centers have been converted to Model Offices. All of these facilities share the goals of decreasing client wait time, providing courteous, helpful efficient services, and increasing morale of both clients and staff through the intelligent employment of infrastructure, technological, and human resources. The Model Offices are a benchmark of quality that continues to expand throughout HRA/DSS.[20]

Technological and Infrastructure Supports

Underpinning much of HRA/DSS's recent success in monitoring and improving customer service have been the technological tools that allow for the meaningful aggregation, analysis, and retrieval of data. Moving the Management Information Systems (MIS) department to a high-tech facility strengthened these technological tools and support. By collaborating with line staff and center management, MIS designed numerous applications to aid employees as they carry out their job functions. In February 2004, MIS completed the move of its Data Center from 111 8th Avenue in Manhattan to the Metrotech Center in Brooklyn. The new facility boasts modern infrastructure, capable of supporting all of the administration's ambitious technological initiatives. Co-located within the Metrotech center are a variety of commercial and municipal high-tech clients, ensuring a strong electronic

foundation from which computer and telecommunications applications can be launched. The Data Center also houses:

- State-of-the art computer training facilities
- The Agency's Enterprise Data Warehouse
- A Network Operations Center, which monitors the performance of all of networked sites
- A replication of server applications installed at the 34th Street Data Center, strengthening the HRA/DSS network in the case of a Citywide emergency
- A Print-to-Mail facility, which automates postage and bulks mailings for optimum postage savings.

Automated Listing of Eligibility Requirements Tracking System (ALERTS): ALERTS is a Web-based computer system that is used by HRA/DSS Investigation, Revenue and Enforcement Administration (IREA) to manage reviews of public assistance applications and active cases, verify eligibility, and recover overpayments. ALERTS pulls in collateral client data from various computer systems within and outside of HRA/DSS. ALERTS continues to be enhanced by IREA's Systems team and the MIS Department of HRA/DSS through ongoing design and development efforts.

By compiling data such as residence history, employment history, unemployment benefits, and credit reports, into one location, ALERTS allows workers to have comprehensive electronic information for each client, and enables them to shorten interview time. The application has promoted efficiency so well that ALERTS received the Best of New York award for the "Best Application Serving a Department or Agency's Business Needs" in 2005.

Interactive Voice Response (IVR): Among other things, IVR is the system that supports InfoLine, a touch tone, multilingual telephone service whereby clients and vendors can access information, inquire about the status of applications, and learn about HRA/DSS services and programs. InfoLine is available to serve clients 24 hours a day, seven days a week and is connected to the City's automated "311" telephone information service.

Eligibility Data and Image Transfer System (EDITS): Although still in its early stages, EDITS automates the paper flow between Medical Assistance Program providers and the Medical Insurance and Community Services Administration (MICSA) through the electronic transfer of data, images, and automated entry of eligibility information into the State's Welfare Management System. Instead of sending hard-copy application packages, the authorized submitter electronically transmits data streams of application information and images of verification documents, reducing the timeframe for applications and eligibility determinations. In reference to EDITS, the authors of the 2004 United Hospital Fund publication *Bringing Information Technology Innovation to New York's Public Health Insurance Programs* write, "In New York, HRA has taken the lead role in IT innovation for

Medicaid applications within New York City, laying the groundwork for the development and use of electronic applications.[21]

New York City, Work, Accountability, and You (NYCWAY): NYCWAY was originally designed to track client progress through the Work Experience Program. Since its implementation in 1995, HRA/DSS has expanded the system to meet changing needs, providing case management tools for caseworkers, including interfaces to client employment plans. It is used by every job center and hundreds of vendor staff to track the agency's entire employment system and provides critical performance measurement data to HRA/DSS.

NYCWAY's most recent modifications allow staff to track clients through WeCARE and the Intensive Services Center. It supports WeCARE by recording the outcomes of biopsychosocial assessments, monitoring compliance with Customized Service Plans, following clients through vocational rehabilitation, and monitoring the interface between vendors, subcontractors and HRA/DSS. The Intensive Services Center also receives support from NYCWAY, as it tracks clients through demonstrated compliance and subsequent work activities.

Paperless Office System (POS): POS is a computer system that has revolutionized the eligibility determination process at HRA/DSS job centers. POS creates an electronic customer case record for every client and organizes client data and documentation into a database. This enables workers to locate customer information quickly and to access records from their individual workstation. POS has successfully improved worker productivity and customer service, decreased center traffic by reducing client paperwork burden, and improved the overall quality of center operations.

Substance Abuse Tracking and Reporting System (STARS): STARS facilitates the exchange of information between HRA/DSS and its substance abuse treatment vendors by allowing vendors to submit client information on program participation, employment, graduations, discharges, substance abuse test results and transfer requests. The application allows client progress in and compliance with treatment plans to be monitored and supports the work of Customized Assistance Services.

Automated Child Care Information System (ACCIS): ACCIS is an automated payment system for childcare providers that HRA/DSS shares with the New York City Administration for Children's Services (ACS). It supports the provision of safe and reliable childcare for clients participating in work readiness training, ongoing medical treatment, and work activities by tracking the availability of day care slots among formal providers as well as child attendance. It also expedites payments to participating childcare providers. Recently, ACCIS has been upgraded to process and approve data entered through an Interactive Voice Response System called CAPS (Childcare Automatic Phone System). This upgrade expands admission to ACCIS to authorized telephone users.

Payment and Claiming System (PaCS)*:* PaCS tracks payment requests for client job placement and retention milestones as employment vendors achieve them and payment requests relative to performance for HASA vendors as well. Not only does the system expedite payments for well-performing vendors, it does so by selecting the most advantageous funding stream for an individual client's circumstances.

Enterprise Data Warehouse (EDW): EDW pulls data from a variety of sources within and outside of HRA/DSS and centralizes it for reporting, querying, and analysis. This allows staff to analyze caseload dynamics, do mandated reporting, contain costs, increase revenues, manage budgets, place liens, detect fraud and abuse and respond to auditors. Currently, the system houses three terabytes (three thousand billion bytes) of data.

Family Care Tracking System (FACTORS): FACTORS is a case management database that is used by social service staff at the HIV/AIDS Services Administration (HASA) and Adult Protective Services (APS). The system bundles all aspects of a client's case in a single electronic location, including demographic, housing, medical, and treatment information. This allows staff to provide individualized medically appropriate services for clients in an efficient manner.

AdminStat: AdminStat is an overall performance measurement tool for administrative functions planned for early 2006. AdminStat is unique in terms of performance measurement and management systems, as it seeks to track indicators related to overall administrative functions. Markers of performance related to Management Information Systems, General Support Services, Finance and Staffing are all tracked and monitored to provide an overall picture of the support elements to which the global functioning of HRA/DSS are tied. Of equal value are the meetings which occur to discuss the results of AdminStat reports, as they bring together key representatives of technology, infrastructure, human and financial resources to troubleshoot problems before or as they arise and engineer efficient and effective solutions.

Personnel and Staffing Support Initiatives

Customer service begins with the way HRA/DSS treats its own employees. To engender a positive work climate within all divisions and stress the importance of human resources, HRA/DSS has made substantial improvements in personnel and staffing. Changes such as the return of the HRA/DSS Police, expanded training programs, and a focus on clear and efficient personnel decisions are all designed to support staff, provide them with opportunities and improve their working conditions. Not only have these efforts produced a greater degree of professionalism and job satisfaction among employees, they have also significantly improved customer service for HRA/DSS clients.

Return of the HRA/DSS Police: To ensure the safety of HRA/DSS employees and clients, this administration made it a priority to return peace officers to job centers around the city. Imbued with the legal authority to make arrests, peace officers deter potential incidents before they escalate and become a danger to clients and employees. This critical support allows HRA/DSS workers to serve clients in a respectful and safe environment, and has significantly improved morale. In addition to these efforts, HRA/DSS is advocating that New York State pass legislation to make it a felony to assault agency service personnel.

Staffing Initiatives: Reflecting the administration's commitment to improve client services, the Office of Staff Resources (OSR) established its own customer service department to respond quickly to personnel questions and issues raised by HRA/DSS staff. In addition, OSR continues to focus on expanding training opportunities for staff, including developing relationships with local universities.

Historically, HRA/DSS as well as other City agencies have used "per diem" employees to expand the workforce without a corresponding increase in "headcount." Since per diem employees are not viewed as permanent City employees, they were not always eligible for all available fringe benefits. In 2004 Commissioner Eggleston converted all 1900 per diem to per annum employees providing full benefits to and therefore boosting the morale of these staff. Moreover, the HRA/DSS headcount now truly reflects the actual numbers of staff employed by the agency, reinforcing its philosophy of truthfulness and transparency in government. In keeping with the commitment to the organization's workforce, HRA/DSS has dramatically reduced its reliance on temporary workers, who were assigned to HRA/DSS but who were paid by temporary staffing agencies. As of December 2005, the use of temporary staff is under 300, and the agency has set strict budgetary and organizational guidelines so that future temporary workers are not hired for long periods.

Training Initiatives

> HRA's training unit is at the forefront of all computer-based training, interactive training, and in granting courses towards offering college credit to employees.[22]—Mike Forte Director Training Citywide Training Center

To further the goal of career development and standardize operations, HRA/DSS offers a variety of agency-wide and program specific training and professional development classes. All classes are designed to expand employee skills and knowledge, and improve customer service; they prepare employees to meet the challenges of their current positions and also provide them with the tools to advance within the organization.

OSR Training: New York City Government's First Corporate University is located at HRA/DSS. Under the leadership of OSR's training division, it has been serving as a model for other training operations throughout the city. Technology has allowed

for an expansion of training capacities. New interactive state-of-the-art training classrooms provide HRA/DSS staff with the opportunity to benefit from teleconferences, computer-based learning and "I-link" programs. The classrooms link to a large citywide network with Hunter College School of Social Work, the Citywide Department of Administrative Services and the City Municipal Building. Trainer support in the utilization of this newly developed equipment is continually available.

OSR established a Training Resource Center for HRA Trainers and Managers. The Resource Center houses books, videotapes, training curriculum, computer-based tools for data collection and copies and hand-outs of past teleconferences. Staff can drop in or schedule appointments as needed.

The attempt to enhance employee performance usually begins with training but does not end there. To close performance gaps, a wide range organizational development strategies and interventions are available as well, including areas such as problem identification activities, team building, strategic planning, operational planning, process re-engineering activities, training needs-assessments, performance-measurement, and position competencies.

The Supervisory Development Institute prepares supervisors to meet the challenges of leadership in changing times and introduces them to contemporary supervisory leadership and practice. Topics covered include situational leadership, effective coaching, forms of feedback, planning, organizing, problem solving, motivation, decision-making, and empowerment.

The Customer Service Institute is designed to align all HRA/DSS employees around a consistent set of principles and procedures regarding customer service. Over the course of several days, employees are instructed on the value of self-awareness as it pertains to quality customer service. Staff are taught to utilize their strengths to enhance face-to-face communication, telephone contacts, and written correspondence.

A tiered approach of training institutes ensures a dedicated commitment to grow employees at every level of their career. OSR and its partner institutions provide 150 days of basic skills and professional development programs, graduate level certificate programs, "Train the Trainer" development classes, (limited) associate degree credit granting programs, State sponsored teleconferences, executive level coaching and advanced supervisory training.

9. Reforming: Changing the Business of Government

The changes to date in HRA/DSS reflect a commitment to accountability as an essential and key component of government. Therefore, HRA/DSS seeks to ensure the highest levels of integrity for its own operations and the programs it funds. This vigilant approach to oversight demonstrates its commitment to delivering quality, cost effective services, held to the highest standards of integrity and accountability. HRA/DSS' 16,000 employees and the City's taxpayers can be sure that resources are well spent and produce effective outcomes. The emphasis on integrity and accountability are most apparent by the use of internal oversight boards.

Creating Greater Oversight

- The **Contract Review Board (CRB)** is an accountability mechanism that places prudent distance between HRA/DSS contracts and its programs and executive leadership. To ensure that program area contracts are aligned with broader administrative goals, and to eliminate service redundancies, the Board reviews all procurement actions and makes recommendations before the Commissioner potentially gives her approval. This practice helps to preserve the integrity of the contracting process and inform the administration of the agency.

- To instill the human resources division with similar levels of accountability and fill vacancies in an equitable and efficient manner, the **Personnel Review Committee (PeRC)** assesses all hires, promotions, and disciplinary actions. Aside from promoting fairness and uniformity in personnel actions, the PeRC also centralizes these functions and their administration in one location, allowing managers to spend less time monitoring and processing human resources actions and more time serving clients.

- The recently-established **Audit Review Board (ARB**) fosters sound audit practices that promote programmatic, fiscal, and regulatory integrity within HRA/DSS. This board will provide independent cross-departmental oversight and review of audit-related activities. The ARB will make recommendations to the Administrator/Commissioner with respect to audit policy, planning, corrective actions and follow-up reporting for specific audits based on its review of the findings, risks, and weaknesses identified.

Complementing this internal oversight is HRA/DSS's movement towards evidence-based policy making. This strategy reflects a commitment to accountability by collecting accurate and timely data on client outcomes, publicly reporting it via the HRA/DSS website, and utilizing it to guide internal management and policy decisions. HRA/DSS policy, which is clearly rooted in factual evidence, in turn informs the organization's participation in public debate on issues of social services, and ultimately supports funding requests. It is this commitment to understanding the caseload through data collection and analysis, as well as its ongoing success in reducing the public assistance rolls and increasing public health insurance enrollment in New York City that has made HRA/DSS a respected voice at all levels of government on welfare reform and social service delivery.

Shaping Government Policies

Federal Policy

Presenting TANF Plan to Congress: The City's plan for the second phase of welfare reform represented an extremely important departure from previous TANF policies. It seeks to view the client in a holistic sense, as an individual and within the context of a family and larger community. It recognizes the variety that is inherent in each client's needs, barriers, and ultimate independence, and seeks the flexibility necessary to meet and address them. The plan was presented in the United States Congress to the House Ways and Means Committee, to inform federal lawmakers of the challenges that remain in moving public assistance-dependent clients towards independence and the tools that are required to meet these challenges. Due to the tremendous success HRA/DSS has experienced in reducing the City's public assistance caseload, this testimony was given serious consideration by the nation's legislators.

On February 10, 2005, Commissioner Eggleston's Chief of Staff testified on the next phase of welfare reform in front of the Subcommittee on Human Resources of the House Committee on Ways and Means. In his presentation, he detailed the City's proposal for TANF reauthorization,[23] stressing New York City's commitment to the original goals of welfare reform, while asserting the need for flexibility to realize the goals of welfare prevention and employment retention.

The Chief of Staff also articulated the complex needs of New York City's remaining caseload and described HRA/DSS's programmatic approach to move these clients to their highest level of self-sufficiency, i.e., WeCARE. He asserted that if New York City is to effectively treat and move fully and partially unengageable clients towards self-reliance and meet proposed increased federal participation rates, any reauthorization of TANF must count a client's participation in rehabilitation and treatment activities towards their core work activities. He further argued that increased participation rates must be met with commensurate increases in TANF funding for education, training, job placement, and special population programming,

as well as increases in the Child Care and Development Block Grant and the Social Services Block Grant urging that these funds be extended to provide enhanced transitional supports for families who have left public assistance for work.

State Policy

Medicaid Reform Recommendations: As HRA/DSS continues to provide health and wellness supports to the many New Yorkers who rely upon public health insurance, the Bloomberg/Eggleston Administration asserts that Medicaid must be reformed in a manner that protects the health of our most vulnerable New Yorkers, the viability of local governments, and the future of the health and medical research sector of our economy. This means searching for administrative cost savings that do not interrupt or limit the provision of medical benefits to needy citizens.

The administration has advocated that the federal government extend the length of the Medicaid authorization period to two years for all recipients, beginning with children. This change will expand consumer access to Medicaid and Medicaid Managed Care programs, ensuring continuity of care. By beginning with children, an especially vulnerable group, HRA/DSS will be able to pilot this program, collect and analyze data and perfect it for eventual rollout to adult consumers.

Safety Net Training Bill: While various stakeholders and legislators saw the bias inherent in denying education and training activities to single Safety Net participants and those without dependent children, HRA/DSS endeavored to draft and advocate for legislation that expanded education and training to these clients while preserving the authority of the State of New York and its Social Services Districts. Over the course of many months, the HRA/DSS Office of Legislative Affairs and Family Independence Administration (FIA) worked closely with the Mayor's Office, advocating that the New York State Legislature and Governor Pataki adopt legislation that affords all Safety Net clients, regardless of family status, the same options granted TANF clients in developing a balanced and well-rounded path towards self-sufficiency. Due in part to the past successes of HRA/DSS in moving clients off public assistance through a combination of education, training, and work experience, the State passed Chapter 380 of the Laws of New York in 2004, and officially expanded the education and training activities in which Safety Net participants without dependent children can participate for purposes of complying with public assistance work requirements.

Presumptive Eligibility for Children: Upon application to Child Health Plus A, HRA/DSS is proposing that all children would receive presumptive eligibility for 90 days, thus granting them immediate access to health care coverage while final eligibility is being determined. The presumptive coverage would allow children, many of whom may have health and developmental care needs, immediate access to medical care. This policy will also allow community partners an important role in expediting coverage for children in need.

Local Policy

HIV/AIDS Housing Initiatives: Through ongoing dialogue with the HIV/AIDS advocacy community and local legislature, HRA/DSS has worked to inform the adoption of three key pieces of HIV/AIDS housing legislation through the New York City Council. This legislation represents the commitment of HRA/DSS and its HIV/AIDS Services Administration (HASA) division to provide clients living with symptomatic HIV/AIDS access to the benefits, entitlements, and/or assistance they need to maintain their health and improve the quality and independence of their lives. These laws are in addition to Local Law 49, which established HASA and mandated the provision of benefits and services to eligible persons with clinical/symptomatic HIV illness or with AIDS.

- Local Law 32 requires HASA to provide expanded quarterly reports to the City on the services and housing the Administration provides to persons living with symptomatic HIV/AIDS. These reporting requirements align with the indicators tracked through the existing HASAStat performance measurement system and improve Agency transparency and accountability.

- Local Law 50 requires HASA to provide an application for medically-appropriate non-emergency housing to every qualified client at first contact as well as assistance in locating this housing. The law further specifies that HASA must provide to an eligible client a first referral to an appropriate and available non-emergency housing option within 90 days of placement in emergency housing.

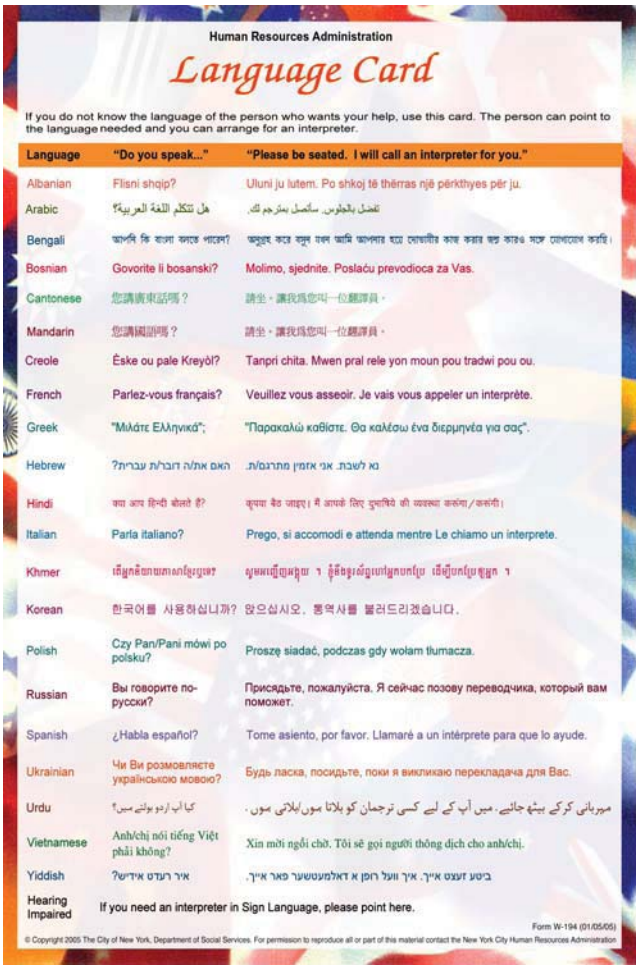
- Local Law 51 supports HASA's development of a central referral system to track the availability of emergency and non-emergency housing. Such a system will serve both to expedite medically appropriate housing placements for HASA clients and monitor conditions at contracted facilities.

Multilingual Agency Communications: Local Law 73: Prior to the enactment of Local Law 73, which requires City agencies to provide meaningful access to benefits and services for all individuals, regardless of English language proficiency, HRA/DSS was in the process of translating some of its food stamp-related client contact forms into nine languages, six of which are now defined as "covered" by Local Law 73. "Covered languages," which include Arabic, Mandarin, Haitian Creole, Korean, Russian, and Spanish, are those into which all documents must eventually be translated. Since the enactment of the law, HRA/DSS has worked diligently to develop and execute an implementation plan that will bring operations into compliance with the requirements of the law.

The Office of Refugee and Immigrant Affairs (ORIA) serves as the coordinating point within HRA/DSS to ensure compliance with Local Law (LL) 73. In an attempt

to prioritize document translation, ORIA conducted a survey of program areas that ranked documents based upon frequency of use. The resulting data is being utilized to determine the order in which untranslated documents will be converted into covered languages.

To address the access needs of clients speaking languages both covered and not covered by LL 73's translation dictate, HRA/DSS has developed and distributed a card containing a question about language fluency to all of its offices. The card, which is translated into 17 languages, allows clients in need of services to identify their language of fluency. HRA/DSS staff can then make arrangements for the provision of an interpreter to assist in translating information about services. Additionally, the telephone service InfoLine is staffed with bilingual operators who have access to additional interpreter services in the case they do not speak the caller's language of fluency (see Language Card below).



Human Resources Administration

Language Card

If you do not know the language of the person who wants your help, use this card. The person can point to the language needed and you can arrange for an interpreter.

Language	"Do you speak..."	"Please be seated. I will call an interpreter for you."
Albanian	Flisni shqip?	Uluni ju lutem. Po shkoj të thërras një përkthyes për ju.
Arabic	هل تتكلم اللغة العربية؟	تفضل بالجلوس. سأتصل بمترجم لك.
Bengali	আপনি কি বাংলা বলতে পারেন?	অনুগ্রহ করে বসুন যখন আমি আপনার হয়ে দোভাষীর কাজ করার জন্য কারও সঙ্গে যোগাযোগ করছি।
Bosnian	Govorite li bosanski?	Molimo, sjednite. Poslaću prevodioca za Vas.
Cantonese	您講廣東話嗎？	請坐。讓我為您叫一位翻譯員。
Mandarin	您講國語嗎？	請坐。讓我為您叫一位翻譯員。
Creole	Èske ou pale Kreyòl?	Tanpri chita. Mwen pral rele yon moun pou tradwi pou ou.
French	Parlez-vous français?	Veuillez vous asseoir. Je vais vous appeler un interprète.
Greek	"Μιλάτε Ελληνικά";	"Παρακαλώ καθίστε. Θα καλέσω ένα διερμηνέα για σας".
Hebrew	?האם את/ה דובר/ת עברית	נא לשבת. אני אזמין מתרגם/ת.
Hindi	क्या आप हिन्दी बोलते हैं?	कृपया बैठ जाइए। मैं आपके लिए दुभाषिये की व्यवस्था करूंगा/करूंगी।
Italian	Parla italiano?	Prego, si accomodi e attenda mentre Le chiamo un interprete.
Khmer	តើអ្នកនិយាយភាសាខ្មែរឬទេ?	សូមអញ្ជើញអង្គុយ ។ ខ្ញុំនឹងទូរស័ព្ទហៅអ្នកបកប្រែ តើចង់ឲ្យបកប្រែជូនអ្នក ។
Korean	한국어를 사용하십니까?	앉으십시오. 통역사를 불러드리겠습니다.
Polish	Czy Pan/Pani mówi po polsku?	Proszę siadać, podczas gdy wołam tłumacza.
Russian	Вы говорите по-русски?	Присядьте, пожалуйста. Я сейчас позову переводчика, который вам поможет.
Spanish	¿Habla español?	Tome asiento, por favor. Llamaré a un intérprete para que lo ayude.
Ukrainian	Чи Ви розмовляєте українською мовою?	Будь ласка, посидьте, поки я викликаю перекладача для Вас.
Urdu	کیا آپ اردو بولتے ہیں؟	مہربانی کرکے بیٹھ جائیے۔ میں آپ کے لیے کسی ترجمان کو بلاتا ہوں/بلاتی ہوں۔
Vietnamese	Anh/chị nói tiếng Việt phải không?	Xin mời ngồi chờ. Tôi sẽ gọi người thông dịch cho anh/chị.
Yiddish	?איר רעדט אידיש	ביטע זעצט אייך. איך וועל רופן א דאלמעטשער פאר אייך.
Hearing Impaired	If you need an interpreter in Sign Language, please point here.	

Form W-194 (01/05/05)

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10. The Continued Need for Flexibility

HRA/DSS is committed to eliminating fraud, increasing client movement towards self-sufficiency, and tracking, monitoring and analyzing the performance of its programs, as well as its administrative operations. If this groundbreaking work in the areas of welfare reform and social service delivery is to continue, HRA/DSS will require ongoing flexibility from the State and Federal government entities that oversee it.

On a federal level, HRA/DSS will require the flexibility to ensure treatment and rehabilitation services for clients with multiple barriers to employment. This involves expanding the definition of activities that count towards TANF work participation rates to include the treatment, wellness, and rehabilitative activities provided by the new WeCARE program. Such activities are fundamental precursors to employment for many of the clients who remain on public assistance. Their wellness must precede their work activities and be acknowledged for what it is—a stepping-stone towards self-sufficiency.

On the New York State level, HRA/DSS will need continued flexibility and adequacy in TANF funding. The funding must allow the freedom to tailor services to meet the needs of individuals and families and select the funding stream that is most appropriate for the services rendered. Additionally, HRA/DSS will need to work with the State to develop procedures for Safety Net Assistance that clearly distinguishes it from TANF. Presently, too many families reach their federal five-year time limit for cash assistance and are automatically enrolled into Safety Net. While this protocol underscores New York State's commitment to care for its poor, enrollment procedures should support the efforts to move clients toward their highest degree of self-sufficiency in a meaningful timeframe.

Many of ideas for HRA/DSS's exciting innovative programs and activities over the past four years have come from the local community of New York City. Continued and expanded collaboration among community organizations, non-profits, advocacy groups, as well as City agencies and leadership will ensure that HRA/DSS can continue to provide superior services aimed at improving the lives of New Yorkers. By maintaining a constant dialogue with the City's many stakeholders, practices and services will continue to be informed by a broad range of expertise and perspectives, resulting in a truly comprehensive and responsive menu of service options. Not only have these relationships eliminated barriers and promoted mutual understanding among people and groups often previously characterized as adversarial, but they have also harmonized resources and energy to produce unprecedented improvements in client services and outcomes.

Through brave internal efforts and collaborative relationships with stakeholders, HRA/DSS is prepared to meet the challenges of the next phase of welfare reform: increasing the availability of food stamps and health care, providing a continuum of

care for the City's partially and fully unengageable clients, supporting job retention among those who have left the public assistance rolls, and preventing the perpetuation of a culture of dependence. So that its stance may remain strong and its bold new initiatives take root, HRA/DSS requires continued flexibility to meet each client "where they are" and help them move to their highest possible level of self-reliance.

11. Looking Ahead

Commissioner Eggleston led the restructuring, retooling, and reforming of HRA/DSS based on the lessons learned from the past and the evidence produced by evaluating the caseload, as shown in the example of the 100 Cases Study. The restructuring and new programs such as WeCARE reflect her "Umbrella Model of Service Delivery" which addresses the needs of the whole family.

HRA/DSS leadership and staff are actively planning for the future. The legislative agenda for 2006 supports current and future programs and policies. Commensurate with the objective of "point-of-entry" human service, HRA/DSS has developed a set of goals designed to provide clients with expedited access to needed services in a variety of program areas.

Legislative Agenda for 2006

The Legislative Agenda for 2006 concentrates on achieving the statutory authority to support the goals for the next phase of welfare reform. Retention, prevention, and the flexibility to address individual barriers to employment remain central to HRA/DSS's goal of promoting the highest degree of client self-reliance. Many of the federal advocacy initiatives introduced by HRA/DSS over the past four years with regard to the goal of prevention, retention, and flexibility are realized in the TANF reauthorization legislation included in the Deficit Reduction Act (DRA) of 2005.[24] These include: maintaining the full funding of the TANF block grant, reauthorizing TANF through 2010, and maintaining both the 50% work participation rate and the 30-hour client work week. Also included in the legislation are several child support provisions that mirror HRA/DSS recommendations voiced during a Congressional staff visit last year.

Although these represent potential legislative gains for HRA/DSS and the City of New York, TANF remains a focus on the federal and state levels. Current advocacy efforts are committed to ensuring that the reauthorization implementation and language preserve and build upon local flexibility to count education, rehabilitation, and wellness activities toward the federal participation rate. HRA/DSS has also crafted federal and state legislative solutions to the unintended dilemma created by the increased New York State minimum wage. While the increased minimum wage is intended to improve the quality of life for the working poor, it inadvertently disallows an increasing pool of HRA/DSS clients to receive full credit for participation in work activities. This is due to the fact that the client public assistance awards are calculated on the basis of the previous state minimum wage. While the minimum wage has increased in New York State, the size of the federal public assistance award remains the same. The awards are increasingly insufficient to support the minimum hours required for participation in work or core activities, pursuant to federal regulation and state law. Several HRA/DSS proposals would amend state law to allow New York City to receive credit toward the federal work

participation rate for its universal engagement and employment barrier removal efforts.

To ensure the integrity of the City's administration of Medicaid, HRA/DSS will advocate a series of proposals designed to support fraud detection and enforcement efforts. Additionally, HRA/DSS will advocate for legislation that protects the growing population of vulnerable adults. This includes victims of domestic violence, who are the focus of a proposal to safely secure child support orders by allowing domestic violence victims to testify at court hearings by telephone, audio-visual, or other electronic means, rather than in person.

New Initiatives

"Back to Work"

HRA/DSS will implement its new "Back-to-Work" program, providing welfare-to-work services to employable public assistance recipients. Under this program, a single vendor will work with a client from assessment through placement and retention in a job, allowing for the establishment of stronger client-provider relationships. These intensive and consistent interactions are designed to further the goal of seamless service delivery, while providing a single point-of-entry for employment services. The "Back-to-Work" program also seeks to increase job placement and retention rates, as the fully performance-based contracts place greater emphasis on job retention and career advancement.

HRA/DSS also intends to streamline its former Work Experience Program (WEP) directly into its "Back-to-Work" contracts. This will connect WEP workers more closely to long-term job training plans aimed at matching clients with jobs that best fit their talents. By improving coordination of skill development, education, and job placement, a greater number of public assistance recipients will be positioned toward self-sufficiency and long-term job retention. To coordinate HRA/DSS Job Centers with "Back-to-Work" training and education programs, each Job Center will be assigned a single "Back-to-Work" vendor. The vendor will have its own staff on-site at the Job Center to meet participants the same day they are referred. "Back-to-Work" vendors will also be able to refer individuals in need of English language skills, adult education, or GED classes to HRA/DSS education programs.

Child Care Integration

Consistent with the single point-of-entry philosophy, HRA/DSS and the Administration for Children's Services (ACS) are working together to integrate and improve services and to establish a single child care program for the City of New York.

The goals of the child care integration initiative include:

- Development of a single set of citywide child care policies and procedures, so that eligibility, enrollment, and payment processes are clear and accessible to families and child care providers.

- Improved continuity of the child care subsidy and child care services so as to minimize disruptions to caretaker employment and children's early childhood experiences, regardless of changes in custodial.

- Enhance integration between HRA/DSS and ACS with regard to the administration of the child care program.

- Streamline the child care information system (ACCIS).

- Demonstrated city commitment to a single early care and education system, with child care unification as the first step.

- Ensure continuation of child care for eligible, employed individuals on or transitioning from public assistance.

- Ensure that eligible families leaving the HRA/DSS transitional child care system continue to receive seamless child care in the ACS system.

Improved Services for Seniors and the Disabled

HRA/DSS will work with the New York City Department for the Aging, New York City Health and Hospital Corporation and other city human services agencies to create the most comprehensive eldercare program in the history of the City of New York. Recommended measures include:

- A coordinated program to protect seniors and disabled individuals who are subject to eviction proceedings, to ensure that housing courts are aware of their vulnerable status and that all possible interventions, including the new rent increase abatement program for disabled individuals, have been accessed.

- Formation of an interagency committee to develop recommendations for improved coordination of services for isolated and vulnerable adults with physical and/or mental impairments. Many of these individuals are currently referred to the HRA/DSS Adult Protective Services (APS) program as a last resort because other interventions have failed to protect them from harm.

- City support for the creation of a statewide registry and a mandated reporting requirement for abuse against elderly and/or disabled adults.

- Strengthened discharge planning requirements for hospitals and home care agencies to ensure that services are in place when elderly and/or disabled individuals are released from care.

Public Health Insurance Enrollment Initiatives

The Mayor has made a firm commitment to enroll uninsured children in public health insurance programs. In pursuit of this goal, HRA /DSS and other city agencies will more effectively utilize facilitated enrollers (FE) to target and enroll uninsured children throughout the City, while enhancing integrity protections. To ensure that eligible children retain their coverage, HRA/DSS will:

- Continue to advocate for federal legislation to allow New York State to extend the certification period from one to two years under the Child Health Plus program.

- Utilize the food stamp record to identify Medicaid-eligible families receiving food stamps and seek parental concurrence to enroll uninsured children.

- Utilize the Eligibility Data Imaging Transfer System (EDITS), currently used by HRA/DSS to process Medicaid applications for pregnant women, to process Medicaid applications from facilitated enrollers (FE) and hospitals.

- Pilot alternative means of renewing insurance coverage. HRA/DSS has achieved significant increases in response rates through mail renewal, and will now review prototypes for telephone renewal as a means of further improving retention rates for children.

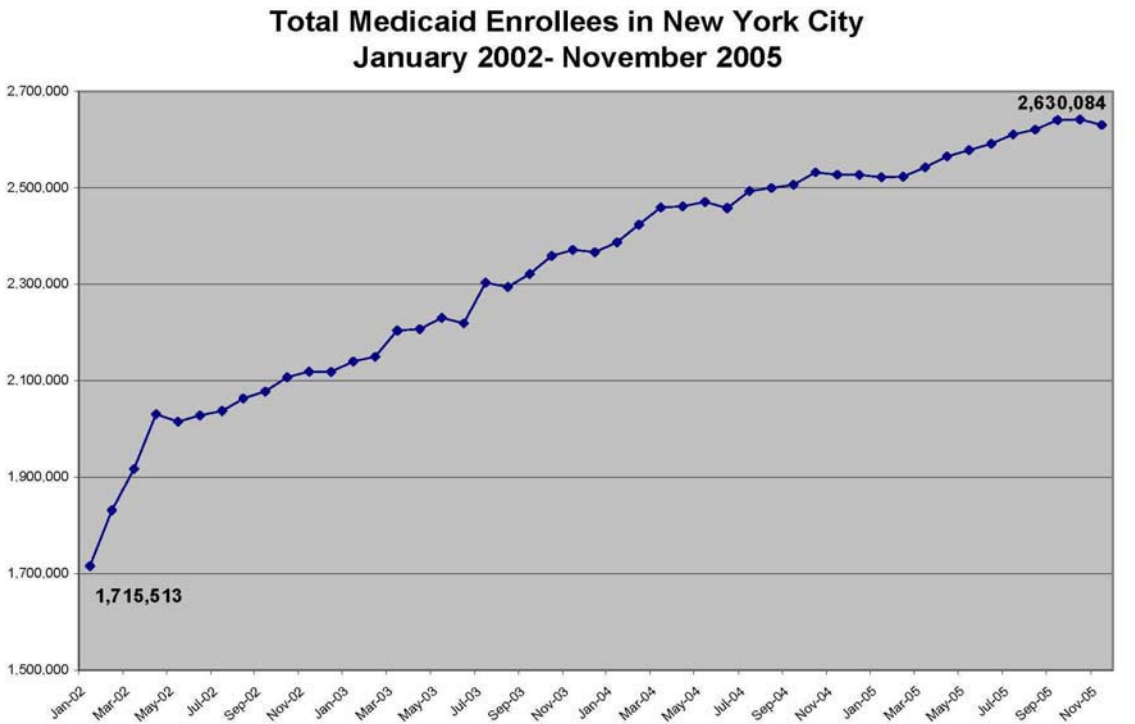
Home Care Points-of-Entry Initiative

Under the direction of the Governor's Office, the New York State Office for the Aging and the New York State Department of Health are collaborating to establish a statewide Points-of-Entry system for long-term care. This system, a major component of the interim report of the Governor's Health Care Reform Working Group, will provide easy access to information, assistance, and screening for consumers, caregivers, and providers on long-term care options. HRA/DSS and the New York City Department for the Aging will work jointly to develop a user-friendly Points-of-Entry system for New York City designed to assist consumers and their caregivers by providing comprehensive, unbiased information and assistance to all individuals seeking information on long-term care regardless of age, disability, or payer source.

As HRA/DSS looks ahead, the cases, data, and caseload will continue to be studied and analyzed. Commissioner Eggleston's "One City, One Client, One Plan"

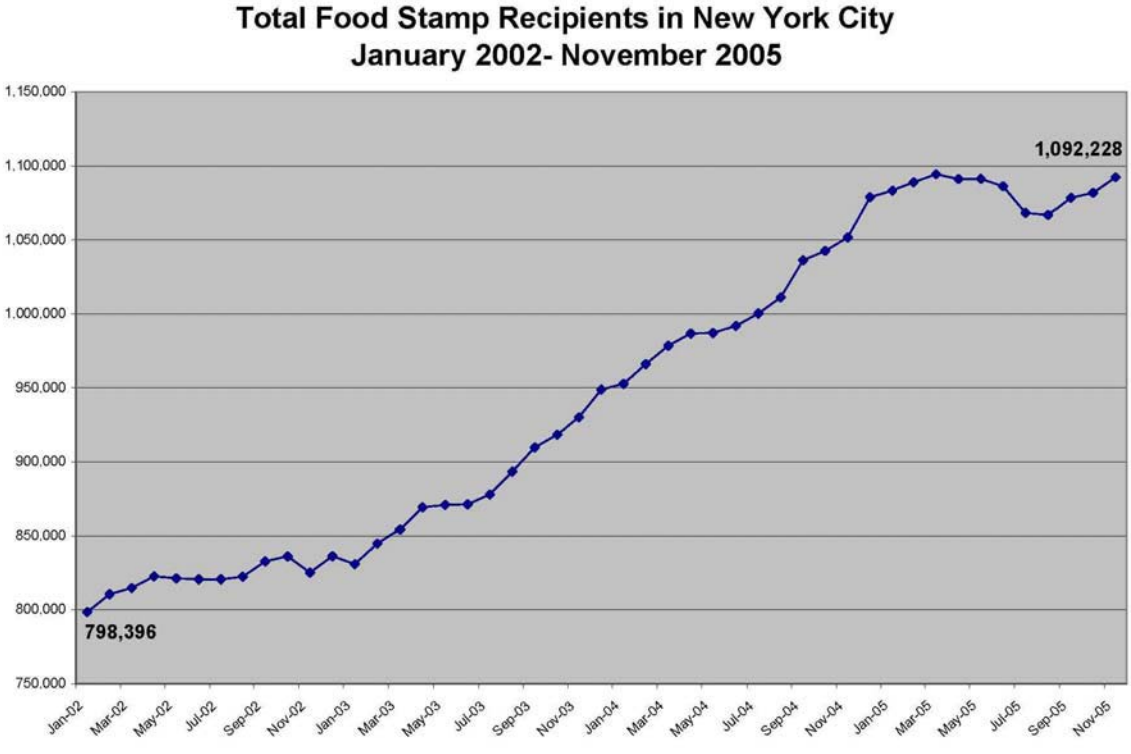
model is realized as collaboration with other agencies and stakeholders work to refine service delivery. All contribute to the goal of assisting clients in reaching their maximum levels of self-sufficiency so that they can return to the community of their choice.

Charts, Reports and Diagrams



Welfare Reform in Motion...

Chart 1


Total Food Stamp Recipients in New York City
January 2002- November 2005
1,150,000
1,100,000
1,050,000
1,000,000
950,000
900,000
850,000
800,000
750,000
1,092,228
798,396
Jan-02
Mar-02
May-02
Jul-02
Sep-02
Nov-02
Jan-03
Mar-03
May-03
Jul-03
Sep-03
Nov-03
Jan-04
Mar-04
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Jul-04
Sep-04
Nov-04
Jan-05
Mar-05
May-05
Jul-05
Sep-05
Nov-05

Chart 2

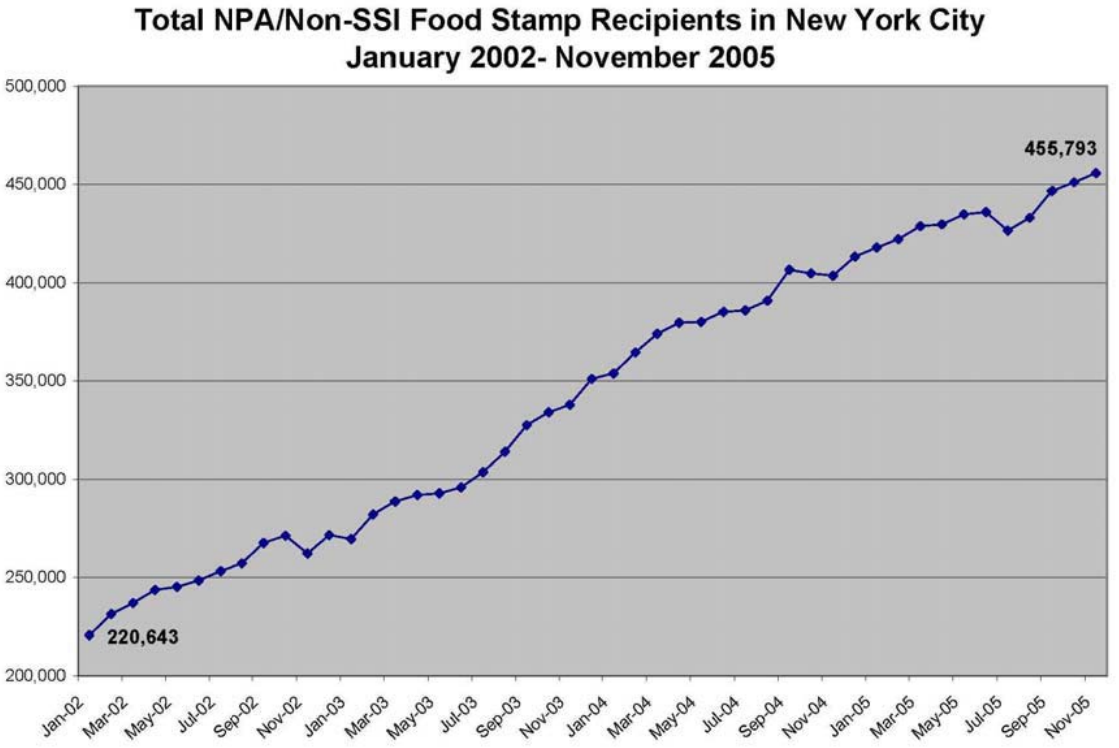
Total NPA/Non-SSI Food Stamp Recipients in New York City
January 2002- November 2005
500,000
450,000
400,000
350,000
300,000
250,000
200,000
455,793
220,643
Jan-02
Mar-02
May-02
Jul-02
Sep-02
Nov-02
Jan-03
Mar-03
May-03
Jul-03
Sep-03
Nov-03
Jan-04
Mar-04
May-04
Jul-04
Sep-04
Nov-04
Jan-05
Mar-05
May-05
Jul-05
Sep-05
Nov-05

Chart 3

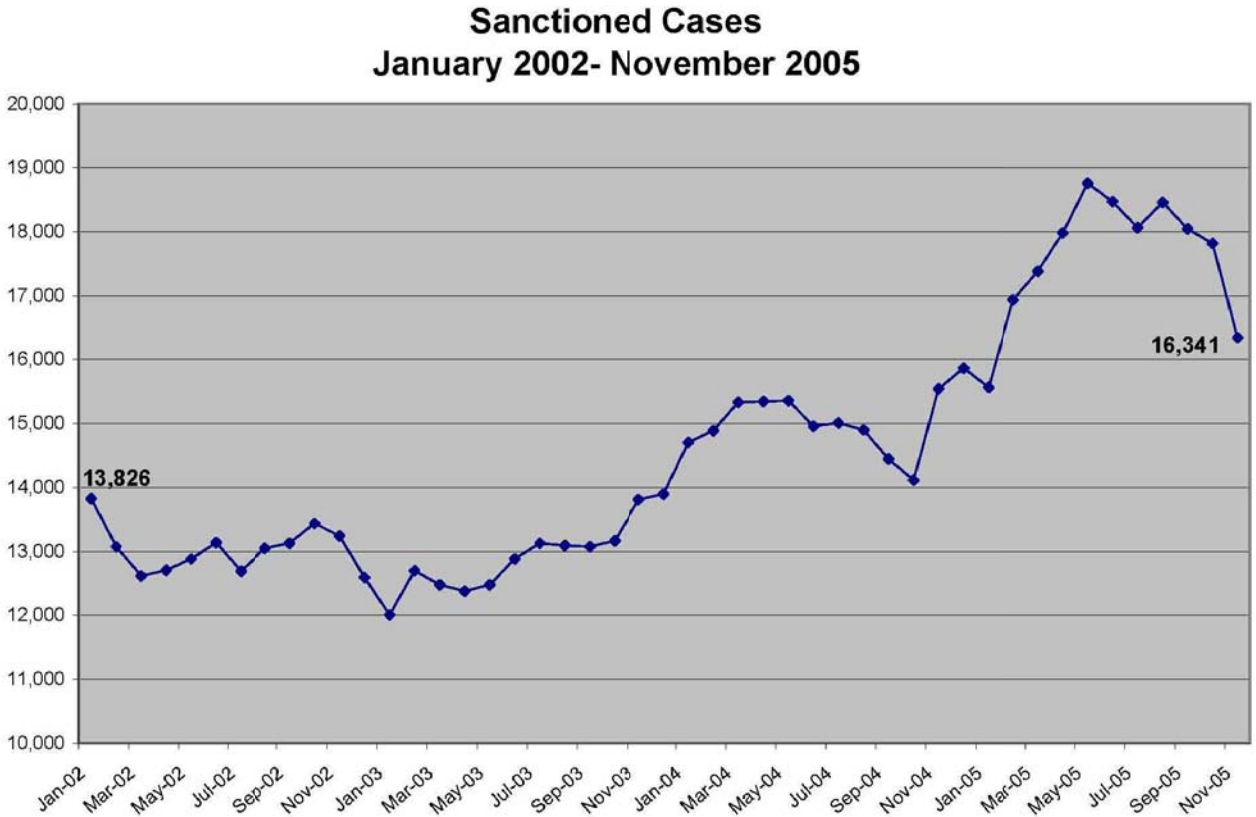
Sanctioned Cases
January 2002- November 2005
20,000
19,000
18,000
17,000
16,000
15,000
14,000
13,000
12,000
11,000
10,000
13,826
16,341
Jan-02
Mar-02
May-02
Jul-02
Sep-02
Nov-02
Jan-03
Mar-03
May-03
Jul-03
Sep-03
Nov-03
Jan-04
Mar-04
May-04
Jul-04
Sep-04
Nov-04
Jan-05
Mar-05
May-05
Jul-05
Sep-05
Nov-05

Chart 4

Human Resources Administration

PA - December 4, 2005 - Weekly Report

PA - Weekly Caseload Engagement Status

	A	B	C	D	E	F	G	H	I
		December 4, 2005		7 Days Change	November 27, 2005		35 Days Change	October 30, 2005	
		#	%		#	%		#	%
1	*Total ACTIVE CASES - NYCWAY*	207,238		(704)	207,942		(679)	207,917	
2	*Active Single Issue Cases*	6,657		105	6,552		52	6,605	
3	*Total UNDERCARE CASES*	200,581	100.0%	(809)	201,390	100.0%	(731)	201,312	100.0%
4	*INDEFINITELY UNENGAGEABLE*	68,383	34.1%	(133)	68,516	34.0%	(65)	68,448	34.0%
5	*Case Head on SSI*	1,520	0.8%	3	1,517	0.8%	(75)	1,595	0.8%
6	*HASA Case*	20,834	10.4%	(24)	20,858	10.4%	36	20,818	10.3%
7	*Child Only Cases (ages 15 and under)*	35,125	17.5%	(66)	35,191	17.5%	(54)	35,179	17.5%
8	*Case Head Age 60 or Over*	10,884	5.4%	(46)	10,930	5.4%	28	10,856	5.4%
9	*TEMPORARILY UNENGAGEABLE*	14,584	7.2%	(281)	14,665	7.3%	(921)	15,505	7.6%
10	*Temporarily Incapacitated - Health*	871	0.4%	19	852	0.4%	107	764	0.4%
11	*Child Under 3 Months*	1,752	0.9%	(39)	1,791	0.9%	(25)	1,777	0.9%
12	*SSI Pending/Appealing*	4,651	2.3%	17	4,634	2.3%	(27)	4,678	2.3%
13	*Temporarily Exempt*	1,888	0.9%	(26)	1,914	1.0%	(71)	1,959	1.0%
14	*Pending WeCARE Scheduling/Outcome*	5,222	2.6%	(252)	5,474	2.7%	(905)	6,127	3.0%
15	*TOTAL UNENGAGEABLE CASES*	82,767	41.3%	(414)	83,181	41.3%	(986)	83,753	41.6%
16	*TOTAL ENGAGEABLE CASES*	117,814	58.7%	(395)	118,209	58.7%	255	117,559	58.4%
17	ENGAGED	73,833	62.7%	(343)	74,176	62.7%	120	73,713	62.7%
18	*WORK*	42,488	36.1%	105	42,383	35.9%	728	41,760	35.5%
19	*Employment*	25,670	21.8%	18	25,660	21.7%	325	25,345	21.6%
20	*-Budgeted*	21,617	18.3%	54	21,563	18.2%	321	21,296	18.1%
21	*->20 hours/week*	7,669	6.5%	(24)	7,693	6.5%	(165)	7,834	6.7%
22	*-20-30 hours/week*	3,295	2.8%	(3)	3,298	2.8%	97	3,198	2.7%
23	*->30 hours/week*	10,653	9.0%	81	10,572	8.9%	389	10,264	8.7%
24	*-Not Budgeted: No Aid to Continue*	2,148	1.8%	(30)	2,178	1.8%	(59)	2,207	1.9%
25	*-Grant Diversion*	1,902	1.6%	(14)	1,916	1.6%	64	1,838	1.6%
26	*Wage Subsidy*	3	0.0%	0	3	0.0%	(1)	4	0.0%
27	*WEP*	11,656	9.9%	129	11,527	9.8%	496	11,160	9.5%
28	*-WEP Basic*	1,548	1.3%	48	1,500	1.3%	(9)	1,557	1.3%
29	*-WEP Medical Limitations/WeCARE*	422	0.4%	(3)	425	0.4%	(2)	424	0.4%
30	*-WEP & BEGIN Managed Activities*	2,077	1.8%	4	2,073	1.8%	104	1,973	1.7%
31	*-WEP Special*	670	0.6%	(23)	693	0.6%	(37)	707	0.6%
32	*-WEP & Job Search*	5,384	4.6%	61	5,323	4.5%	288	5,096	4.3%
33	*-WEP & Substance Abuse Treatment*	124	0.1%	(19)	143	0.1%	(17)	141	0.1%
34	*-WEP/Substance Abuse/Job Search*	283	0.2%	3	280	0.2%	28	255	0.2%
35	*-WEP/Substance Abuse/Training*	0	0.0%	0	0	0.0%	(3)	3	0.0%
36	*-WEP/WECARE Concurrent Activity*	565	0.5%	41	524	0.4%	149	416	0.4%
37	*-WEP & Training*	583	0.5%	17	566	0.5%	(5)	588	0.5%
38	*Other Work Activity*	449	0.4%	(10)	459	0.4%	1	448	0.4%
39	*Substance Abuse Residential Treatment*	4,713	4.0%	(24)	4,737	4.0%	(94)	4,807	4.1%
40	*OTHER PARTICIPATION*	31,345	26.6%	(448)	31,793	26.9%	(608)	31,953	27.2%
41	*Education/Training*	3,968	3.4%	57	3,911	3.3%	317	3,651	3.1%
42	*Job Search*	1,799	1.5%	(358)	2,157	1.8%	(198)	1,997	1.7%
43	*Student over age 15*	1,341	1.1%	(10)	1,351	1.1%	(34)	1,375	1.2%
44	*Substance Abuse Treatment*	6,923	5.9%	(56)	6,979	5.9%	(180)	7,103	6.0%
45	*Substance Abuse/Job Search*	63	0.1%	1	62	0.1%	2	61	0.1%
46	*Substance Abuse/Training*	45	0.0%	0	45	0.0%	7	38	0.0%
47	*Wellness/Rehab/WeCARE*	7,689	6.5%	(229)	7,918	6.7%	(266)	7,955	6.8%
48	*WeCARE & Substance Abuse*	7	0.0%	(4)	11	0.0%	3	4	0.0%
49	*WeCARE Vocational Rehabilitation*	2,860	2.4%	205	2,655	2.2%	(697)	3,557	3.0%
50	*WeCARE Concurrent Activity*	2,615	2.2%	41	2,574	2.2%	512	2,103	1.8%
51	*Needed at Home*	4,035	3.4%	(95)	4,130	3.5%	(74)	4,109	3.5%
52	IN ENGAGEMENT PROCESS	14,148	12.0%	266	13,882	11.7%	894	13,254	11.3%
53	*Call-in Appointment Scheduled*	8,952	7.6%	142	8,810	7.5%	211	8,741	7.4%
54	*Eligibility Call-In Appointment Scheduled*	66	0.1%	(21)	87	0.1%	(119)	185	0.2%
55	*WeCARE Assessment Scheduled*	4,430	3.8%	328	4,118	3.5%	594	3,836	3.3%
56	*In Review Process*	700	0.6%	(175)	875	0.7%	208	492	0.4%
57	IN SANCTION PROCESS	13,492	11.5%	(584)	14,076	11.9%	(760)	14,252	12.1%
58	*Conciliation/Conference/NOI*	10,162	8.6%	(711)	10,873	9.2%	(810)	10,980	9.3%
59	*Awaiting Conciliation Scheduling*	814	0.7%	84	730	0.6%	(175)	989	0.8%
60	*Fair Hearing*	2,516	2.1%	43	2,473	2.1%	233	2,283	1.9%
61	*-Contesting*	1,481	1.3%	24	1,457	1.2%	(40)	1,521	1.3%
62	*-Not Contesting*	1,035	0.9%	19	1,016	0.9%	273	762	0.6%
63	SANCTION IN EFFECT	16,341	13.9%	266	16,075	13.6%	1	16,340	13.9%
64	UNENGAGED	0	0.0%	0	0	0.0%	0	0	0.0%

* Indicator includes WeCARE Cases

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Human Resources Administration
12/29/2005

Report 1

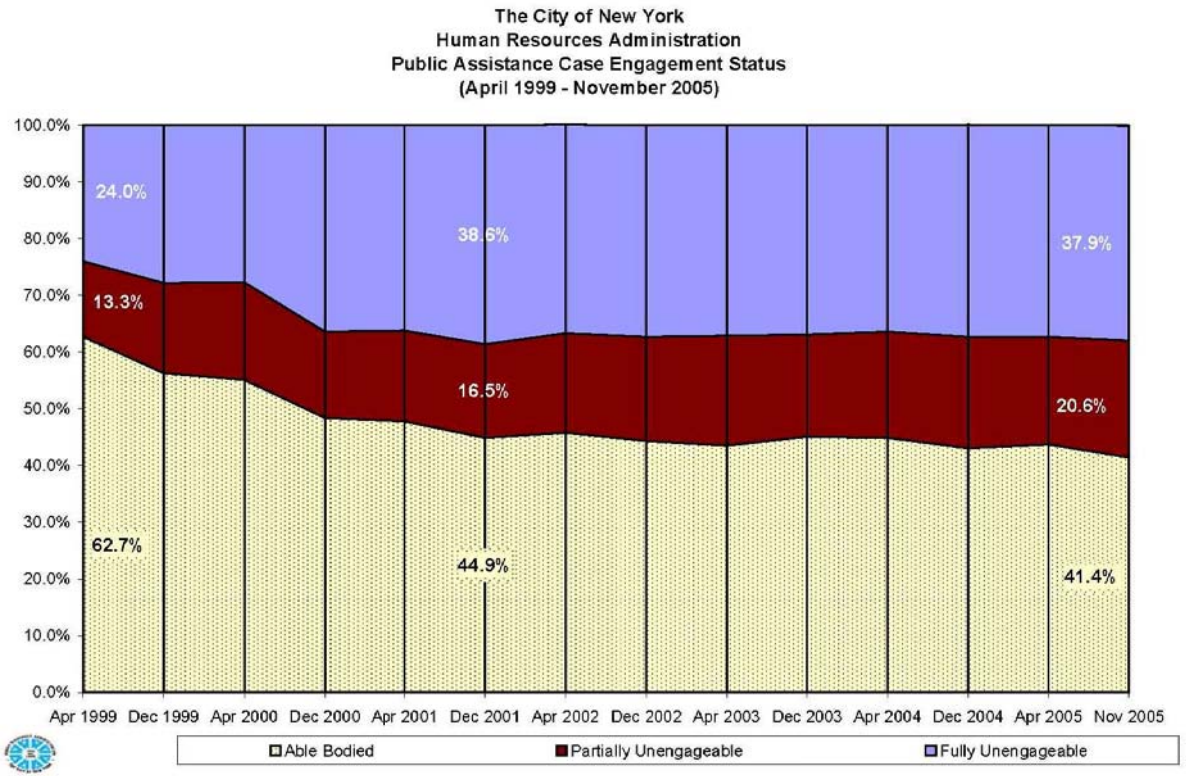
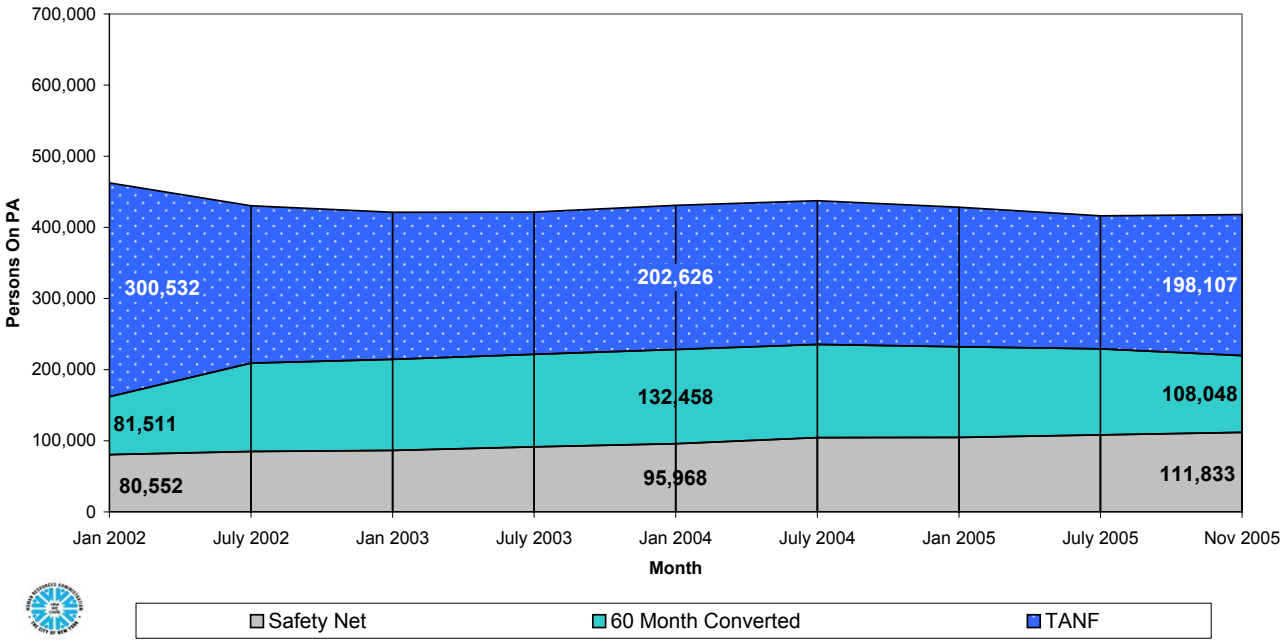


Chart 5

Office of Program Reporting, Analysis & Accountability
12/29/2005
JD

NYC Human Resources Administration
Persons On Public Assistance (PA) By Category
(January 2002 - November 2005)



Office of Program Reporting, Analysis & Accountability
4/13/2006

Chart 6

Human Resources Administration
Caseload Information
November 1, 2005 Total Cases = 211,923

Partially Unengageable				***Able Bodied***			
Temporarily Unengageable				Employed		23,503	
Temp. Incapacitated-Health	764			Employed with Wage Subsidy		1,842	
SSI Pending/Appealing	4,678			**WEP**			
WeCARE Scheduling	6,127			WEP-Basic	1,557		
WEP/WeCARE	424			WEP-BEGIN	1,973		
WEP/WeCARE Concurrent Activity	416			WEP-Special	707		
Wellness/Rehab/WeCARE	7,955			WEP/ESP	5,096		
Medical Assessment	3,836			WEP/Training	588		
Temporarily Exempt	1,959					9,921	
WeCARE Vocational Rehab	3,557						
WeCARE Concurrent Activity	2,103						
		31,819		Other Work Activity	448		
				Education /Training	3,651		
Substance Abuse				Job Search	1,997		
WEP/Substance Abuse	399			Student over age 15	1,375		
Substance Abuse Residential	4,807			Needed at Home	4,109		
Substance Abuse Treatment	7,202			Engagement Process	9,418		
WeCARE & Substance Abuse	4			Sanction Process	14,252		
		12,412		Sanction in Effect	16,340		
						51,590	
Total Partially Unengageable		**44,231**	**20.9%**	**Total Able Bodied**		**86,856**	**41.0%**

Fully Unengageable		
Case Head on SSI	1,595	
HASA	20,818	
Case Head Age 60 or over	10,856	
Other	10,611	
State/City Fully Unengageable	**43,880**	**20.7%**
Child Only	35,179	
Child Under 3 months	1,777	
Federal Fully Unegageable	**36,956**	**17.4%**

Glossary:

WEP - Work Experience Program
PRIDE - Personal Roads for Individual Development and Employment
BEGIN - For clients with Literacy and language Issues

Engagement Process - Clients waiting to be assigned to an activity or awaiting a return appointment.
Sanction Process - Clients who have failed to cooperate with a work activity or are appealing their assignment.

Report 2

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Human Resources Administration

Human Resources Administration
Safety Net Caseload Information
November 1, 2005 Total Cases = 82,880

Partially Unengageable				*Able Bodied*			
Temporarily Unengageable				Employed		3,432	
Temp. Incapacitated-Health	44			Employed with Wage Subsidy		734	
SSI Pending/Appealing	3,170			**WEP**			
WeCARE Scheduling	3,338			WEP-Basic	545		
WEP/WeCARE	284			WEP-BEGIN	457		
WEP/WeCARE Concurrent Activity	283			WEP-Special	85		
Wellness/Rehab/WeCARE	4,665			WEP/ESP	2,046		
Medical Assessment	2,244			WEP/Training	122		
Temporarily Exempt	1,232					3,255	
WeCARE Vocational Rehab	2,070						
WeCARE Concurrent Activity	1,462						
		18,792		Other Work Activity	424		
				Education /Training	580		
Substance Abuse				Job Search	822		
WEP/Substance Abuse	343			Student over age 15	189		
Substance Abuse Residential	4,543			Needed at Home	727		
Substance Abuse Treatment	5,927			Engagement Process	2,940		
WeCARE & Substance Abuse	4			Sanction Process	5,597		
		10,817		Sanction in Effect	1,260		
						12,539	
Total Partially Unengageable		**29,609**	**35.7%**	**Total Able Bodied**		**19,960**	**24.1%**

Fully Unengageable			
Case Head on SSI	1,158		
HASA	17,086		
Case Head Age 60 or over	10,135		
Other	4,319		
State/City Fully Unengageable	**32,698**	**39.5%**	
Child Only	500		
Child Under 3 months	113		
Federal Fully Unegageable	**613**	**0.7%**	

Glossary:

WEP - Work Experience Program
PRIDE - Personal Roads for Individual Development and Employment
BEGIN - For clients with Literacy and language Issues

Engagement Process - Clients waiting to be assigned to an activity or awaiting a return appointment.
Sanction Process - Clients who have failed to cooperate with a work activity or are appealing their assignment.

Report 3

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Human Resources Administration

Human Resources Administration
TANF Caseload Information
November 1, 2005 Total Cases = 87,233

Partially Unengageable				***Able Bodied***			
Temporarily Unengageable				Employed		9,117	
Temp. Incapacitated-Health	592			Employed with Wage Subsidy		603	
SSI Pending/Appealing	1,027			**WEP**			
WeCARE Scheduling	1,630			WEP-Basic	532		
WEP/WeCARE	29			WEP-BEGIN	935		
WEP/WeCARE Concurrent Activity	45			WEP-Special	424		
Wellness/Rehab/WeCARE	2,492			WEP/ESP	1,646		
Medical Assessment	893			WEP/Training	353		
Temporarily Exempt	469					3,890	
WeCARE Vocational Rehab	590						
WeCARE Concurrent Activity	222						
		7,989		Other Work Activity	7		
				Education /Training	2,179		
Substance Abuse				Job Search	720		
WEP/Substance Abuse	13			Student over age 15	1,059		
Substance Abuse Residential	240			Needed at Home	2,646		
Substance Abuse Treatment	443			Engagement Process	4,380		
WeCARE & Substance Abuse	0			Sanction Process	5,343		
		696		Sanction in Effect	7,590		
						23,924	
Total Partially Unengageable		**8,685**	**10.0%**	**Total Able Bodied**		**37,534**	**43.0%**

Fully Unengageable			
Case Head on SSI	287		
HASA	2,684		
Case Head Age 60 or over	200		
Other	2,037		
State/City Fully Unengageable	**5,208**	**6.0%**	
Child Only	34,482		
Child Under 3 months	1,324		
Federal Fully Unegageable	**35,806**	**41.0%**	

Glossary:

WEP - Work Experience Program
PRIDE - Personal Roads for Individual Development and Employment
BEGIN - For clients with Literacy and language Issues

Engagement Process - Clients waiting to be assigned to an activity or awaiting a return appointment.
Sanction Process - Clients who have failed to cooperate with a work activity or are appealing their assignment.

Report 4

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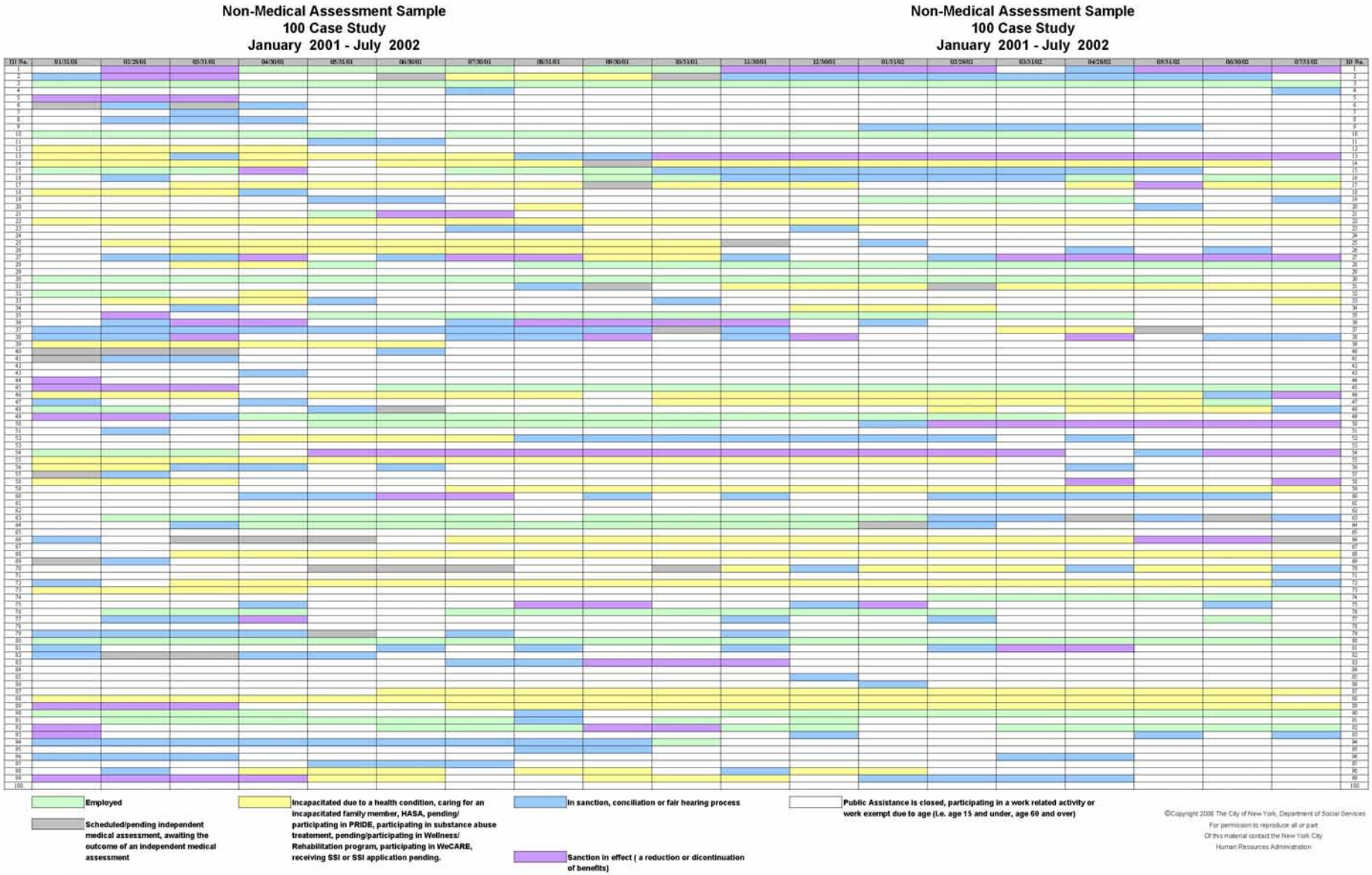

Non-Medical Assessment Sample
100 Case Study
January 2001 - July 2002

Report 5

Medical Assessment Sample
100 Case Study
January 2000 - July 2002

Medical Assessment Sample
100 Case Study
January 2000 - July 2002

Employed

Scheduled/pending independent medical assessment, awaiting the outcome of an independent medical assessment

Incapacitated due to a health condition, caring for an incapacitated family member, HASA, pending/ participating in PRIDE, participating in substance abuse treatement, pending/participating in Wellness/ Rehabilitation program, participating in WeCARE, receiving SSI or SSI application pending

In sanction, conciliation or fair hearing process

Sanction in effect (a reduction or discontinuation of benefits)

Public assistance is closed, participating in a work related activity or work exempt due to age (i.e. age 15 and under, age 60 and over)

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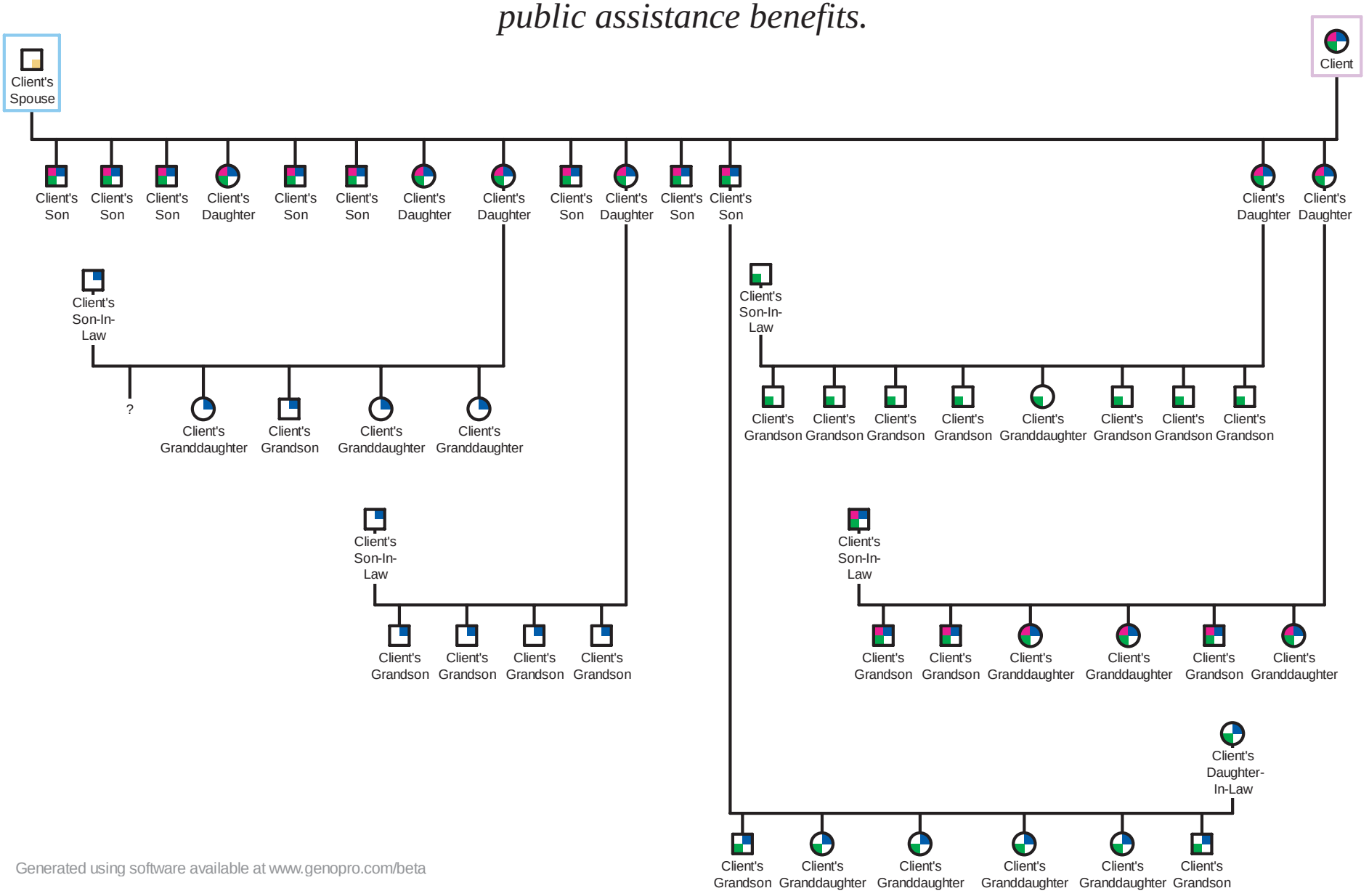
Report 6

Case A

The following genogram is an example of a sizable family with intergenerational receipt of public assistance benefits.



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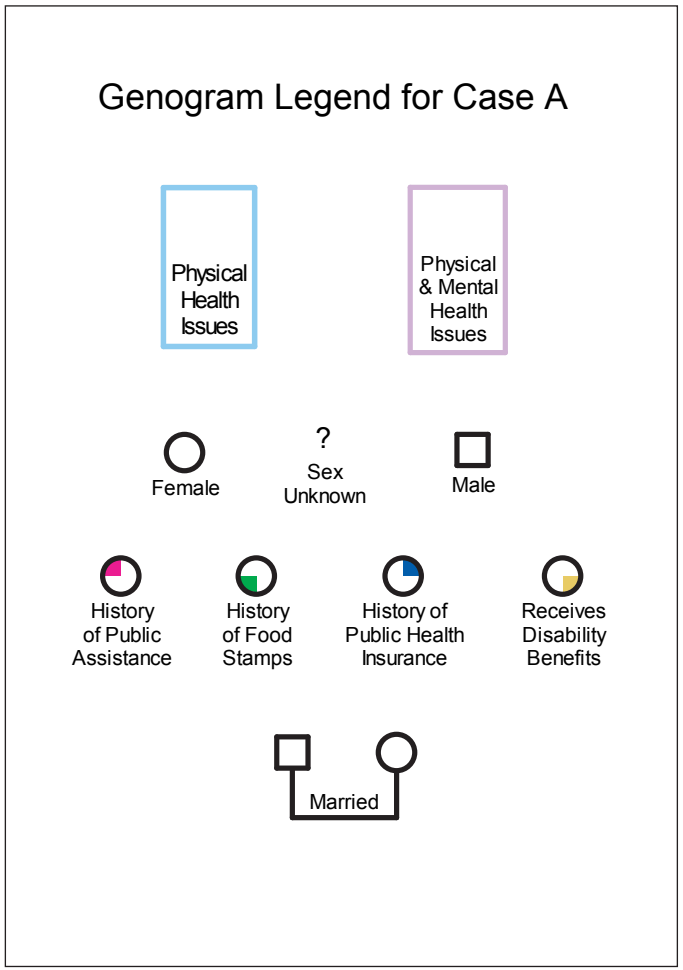
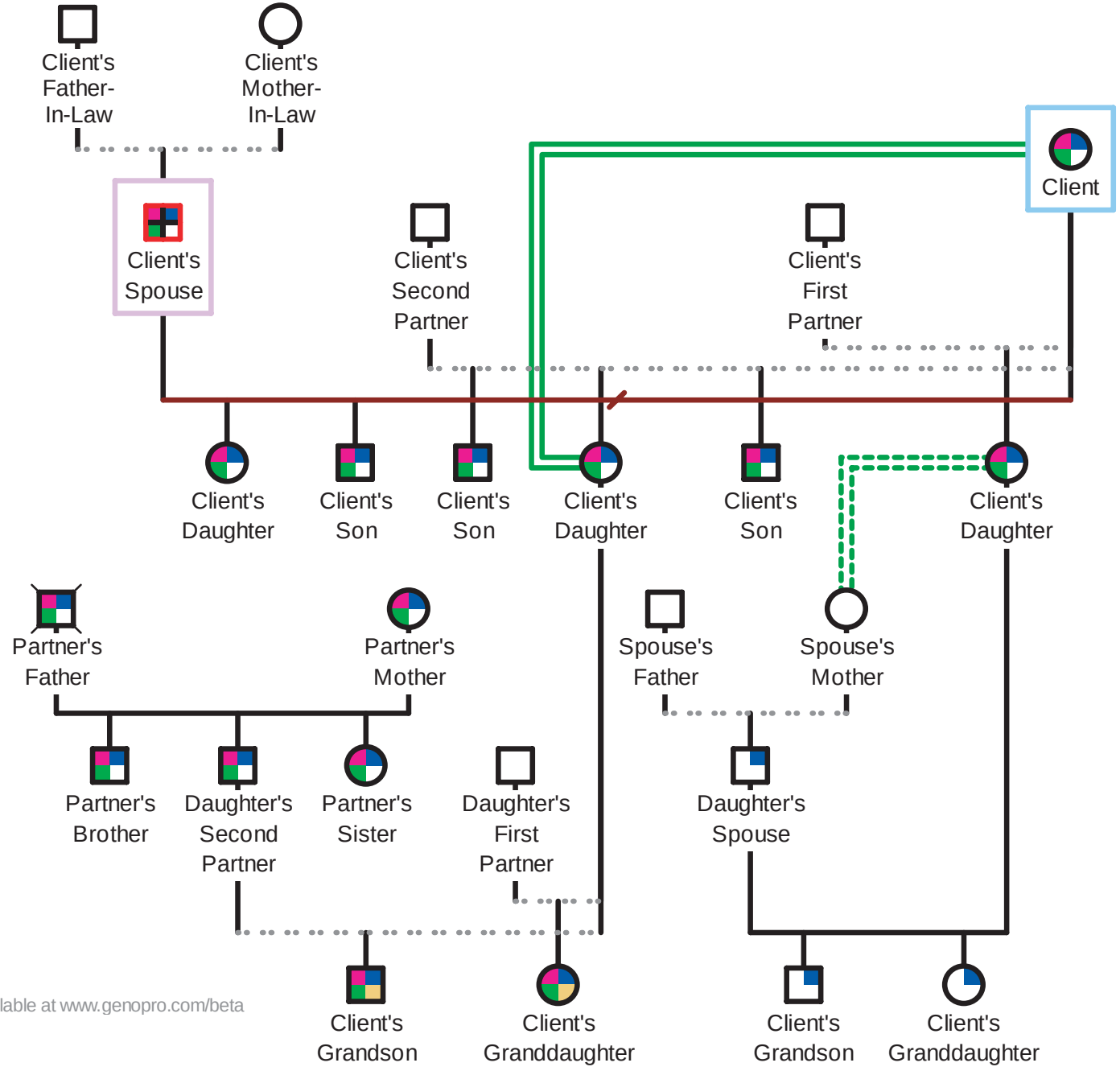
Genogram A


Genogram Legend for Case A
Physical Health Issues
Physical & Mental Health Issues
Female
?
Sex Unknown
Male
History of Public Assistance
History of Food Stamps
History of Public Health Insurance
Receives Disability Benefits
Married

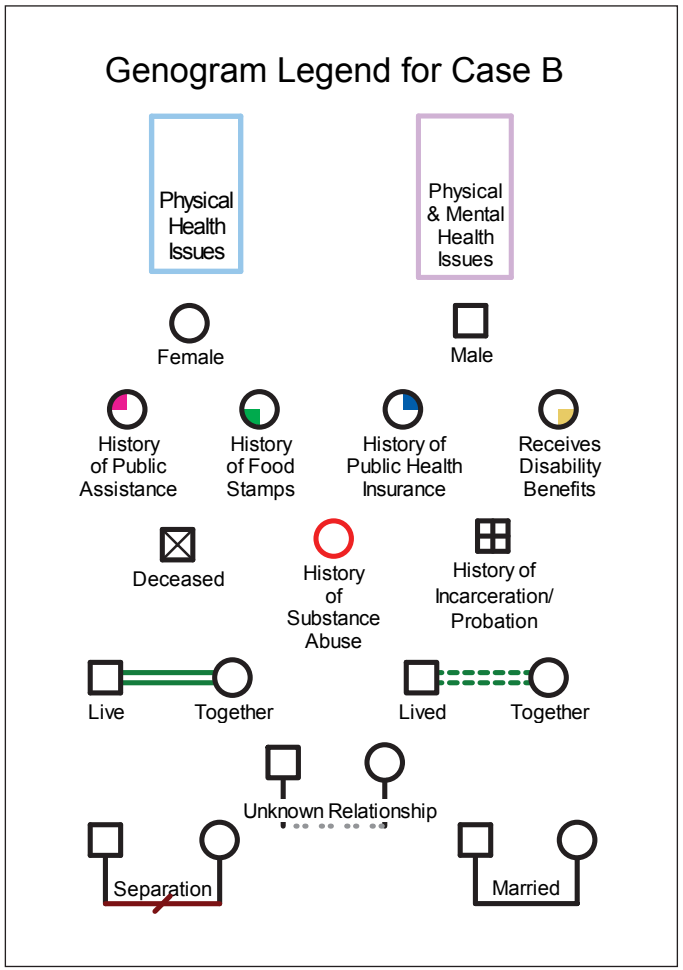
Case B

The following genogram is an example of a client who has been scheduled for WeCARE services.



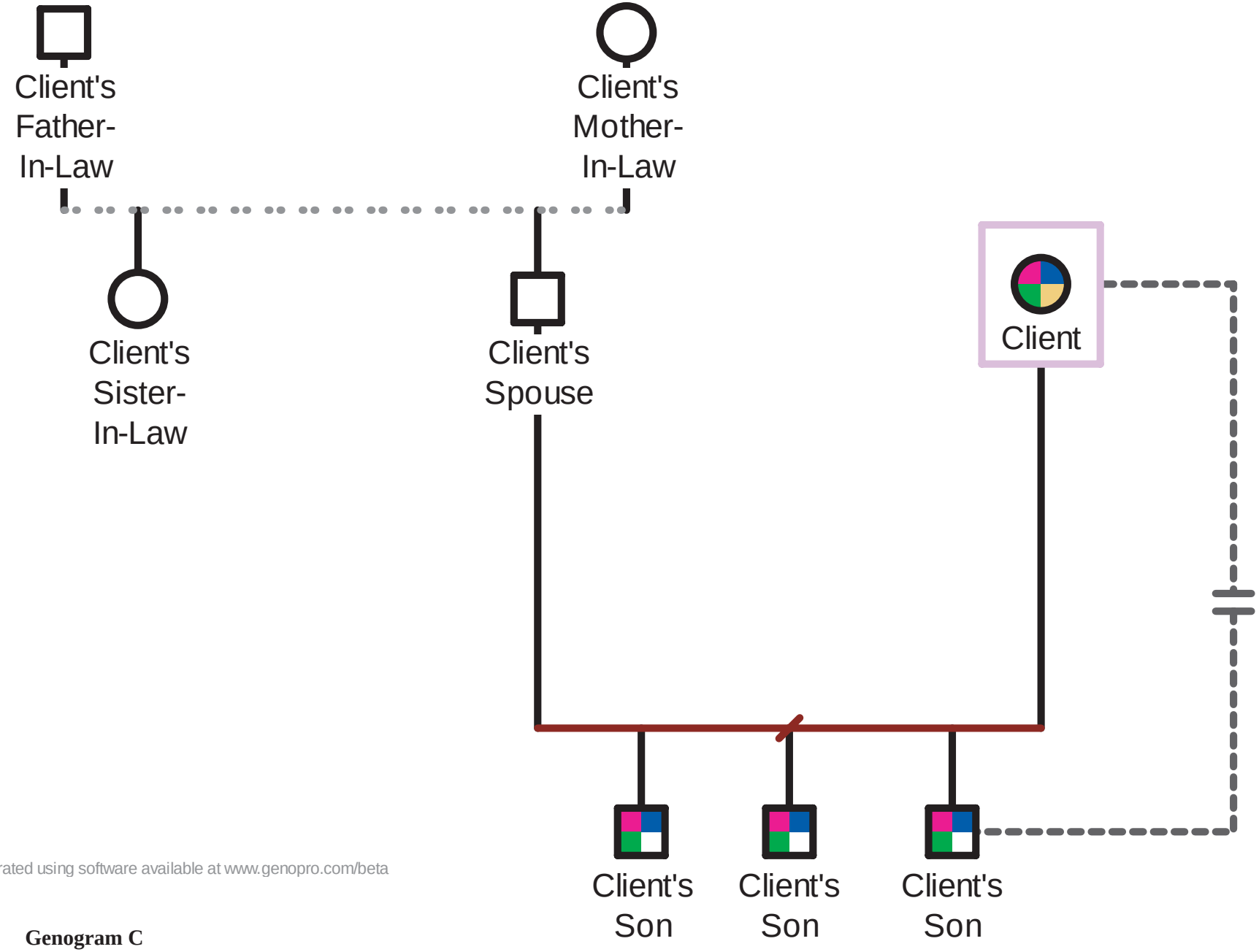
Generated using software available at www.genopro.com/beta

Genogram B


Genogram Legend for Case B
Physical Health Issues
Physical & Mental Health Issues
Female
Male
History of Public Assistance
History of Food Stamps
History of Public Health Insurance
Receives Disability Benefits
Deceased
History of Substance Abuse
History of Incarceration/ Probation
Live
Together
Lived
Together
Unknown Relationship
Separation
Married

Case C

The following genogram is an example of a case that has been assigned to the Intensive Services Center. The clientís son has been assigned to Intensive Services.



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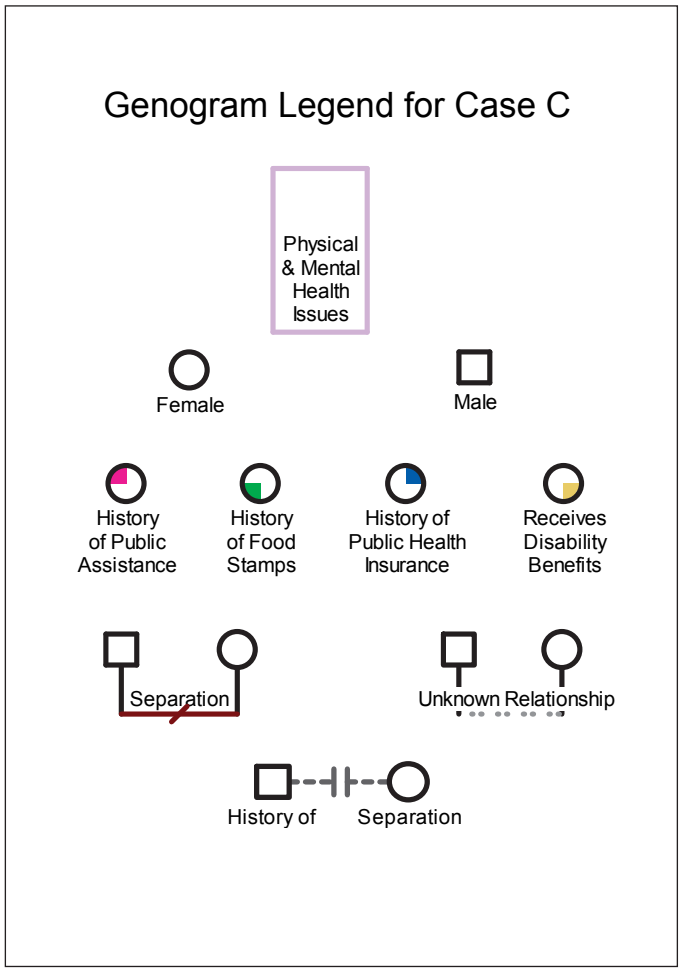
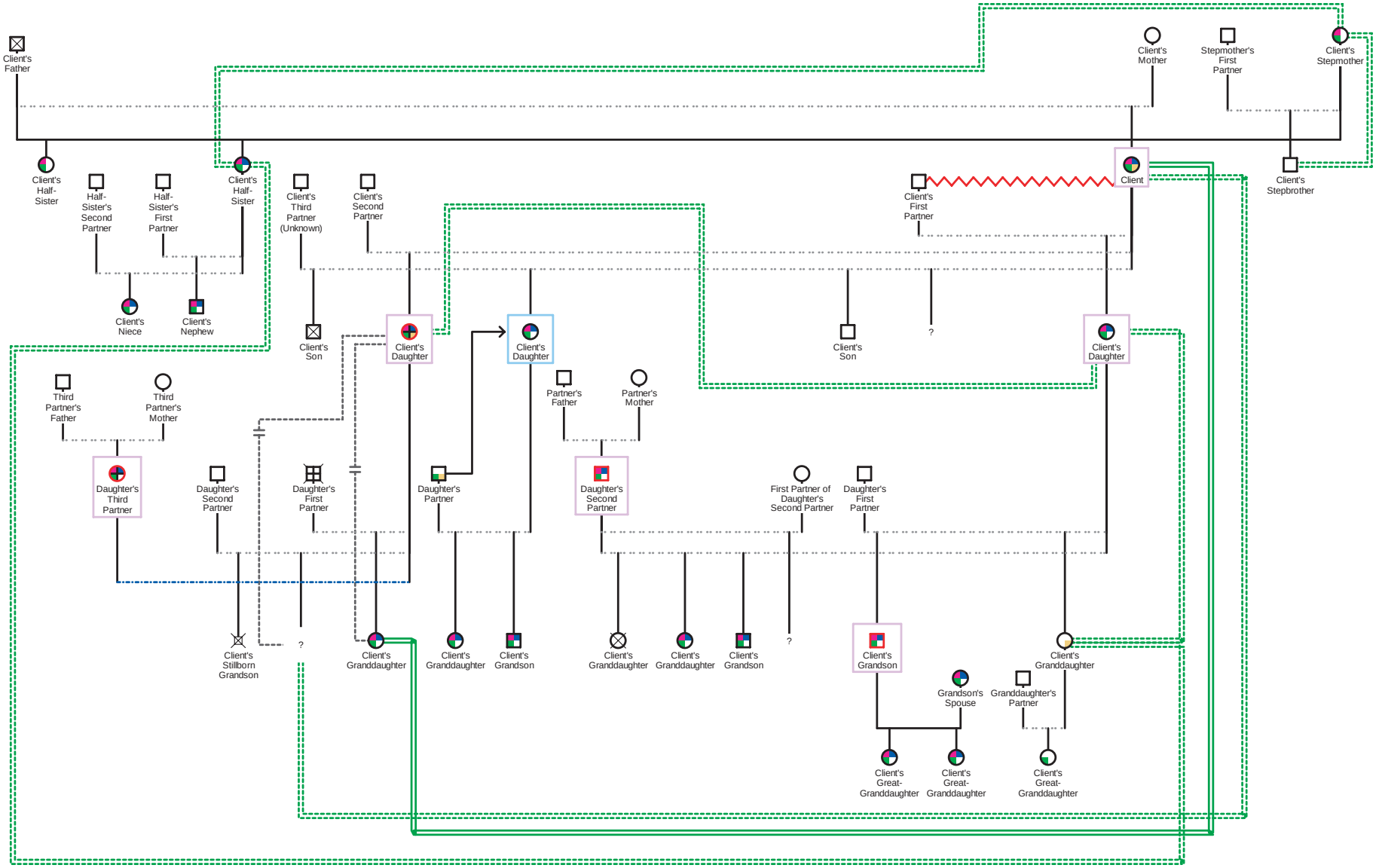
Genogram C


Genogram Legend for Case C
Physical & Mental Health Issues
Female
Male
History of Public Assistance
History of Food Stamps
History of Public Health Insurance
Receives Disability Benefits
Separation
Unknown Relationship
History of
Separation

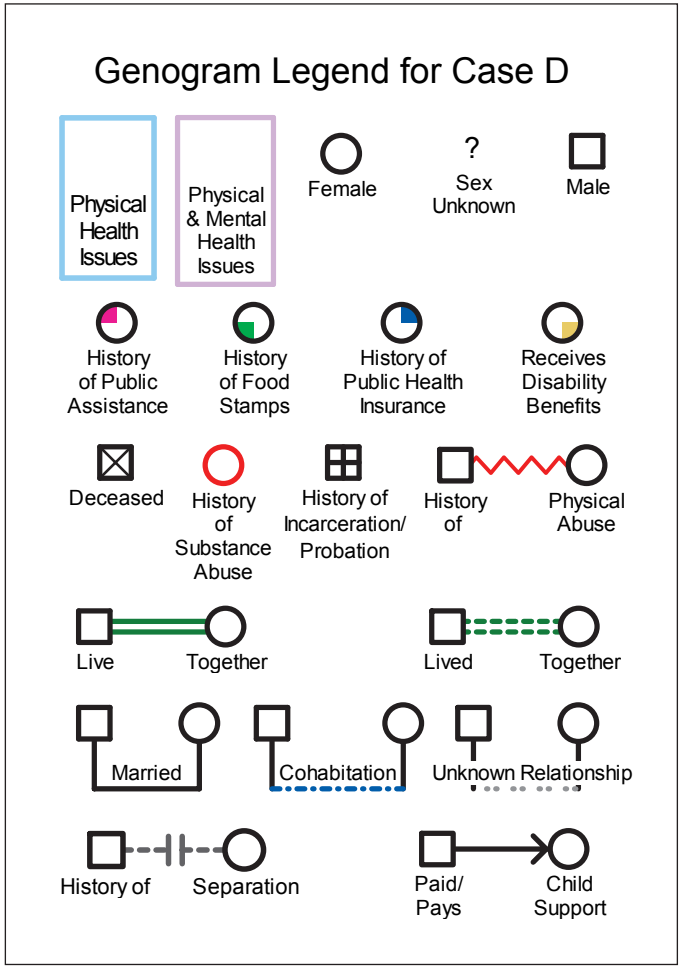
Case D

The following genogram is an example of a family with many needs and issues that have been addressed under HRA's "umbrella" model of seamless client services.



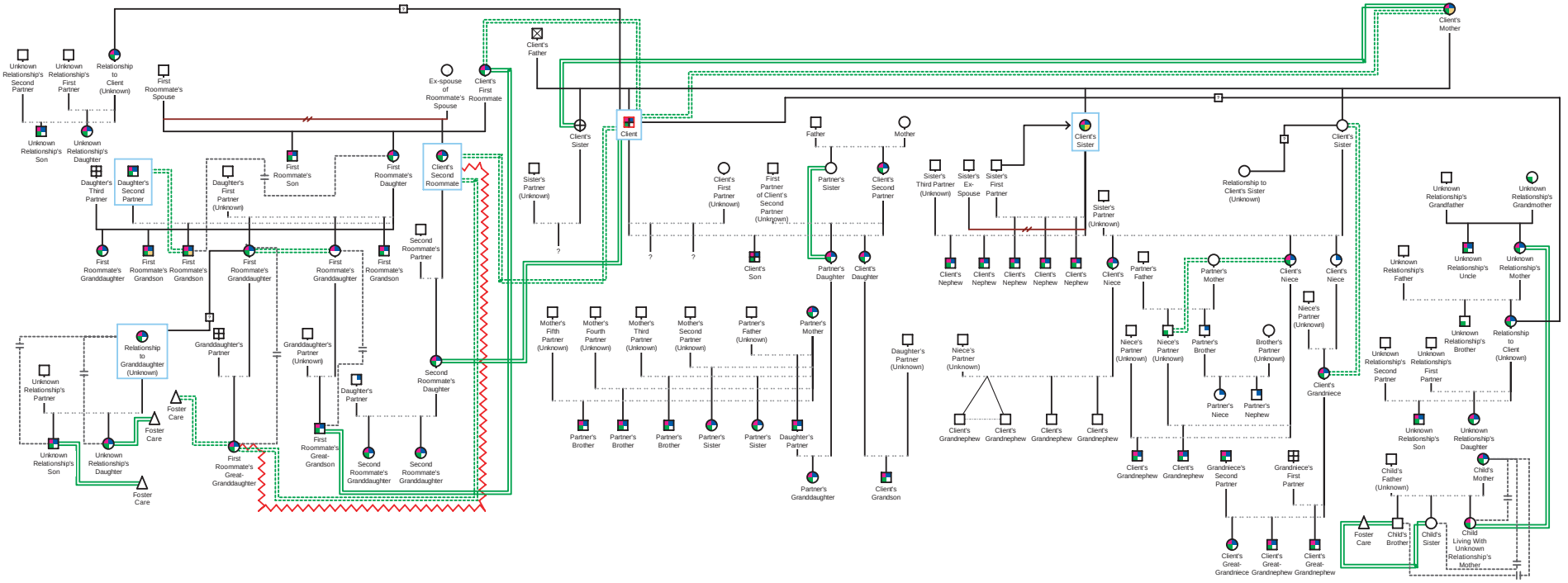
Generated using software available at www.genopro.com/beta

Genogram D


Genogram Legend for Case D
Physical Health Issues
Physical & Mental Health Issues
Female
?
Sex Unknown
Male
History of Public Assistance
History of Food Stamps
History of Public Health Insurance
Receives Disability Benefits
Deceased
History of Substance Abuse
History of Incarceration/ Probation
History of
Physical Abuse
Live
Together
Lived
Together
Married
Cohabitation
Unknown Relationship
History of
Separation
Paid/ Pays
Child Support

Case E

The following genogram is an example of a client with a history of receiving public assistance benefits. Over time he has lived in the households of several women who also have a history of receiving public assistance benefits.



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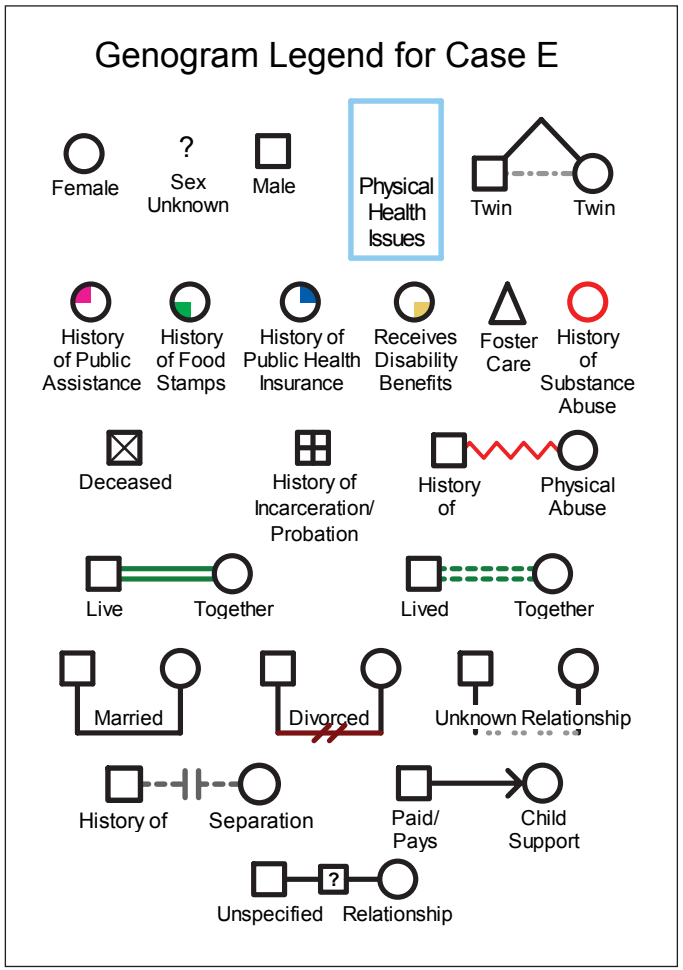
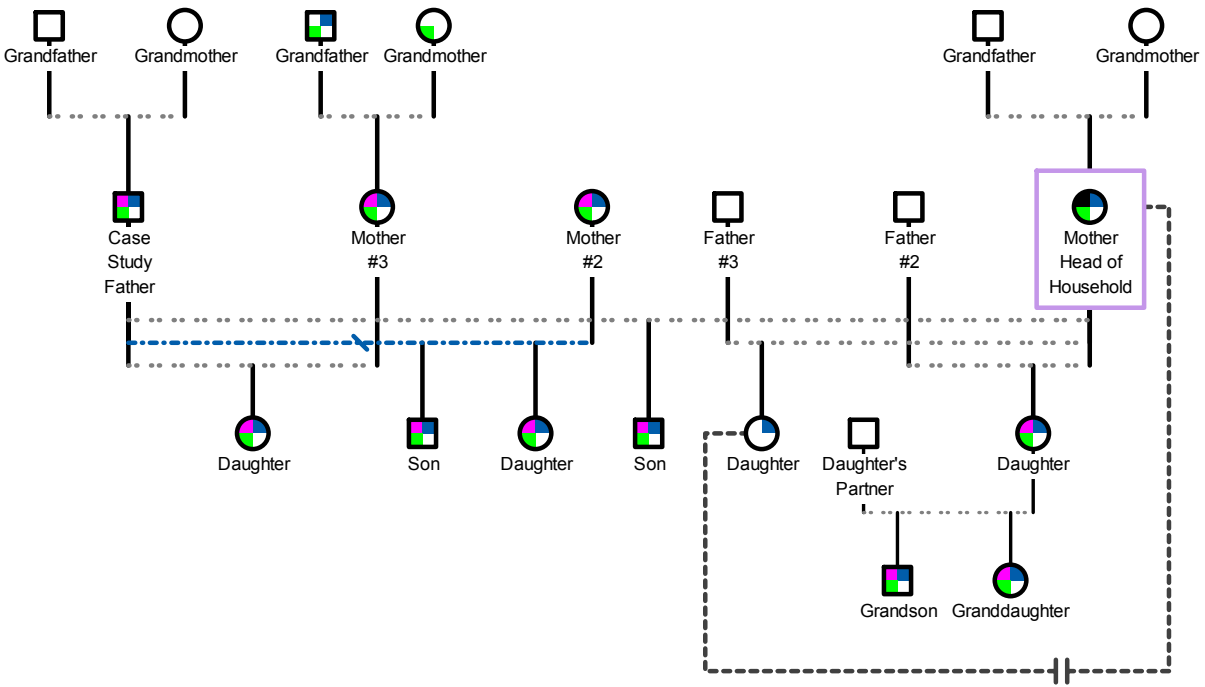
Genogram E

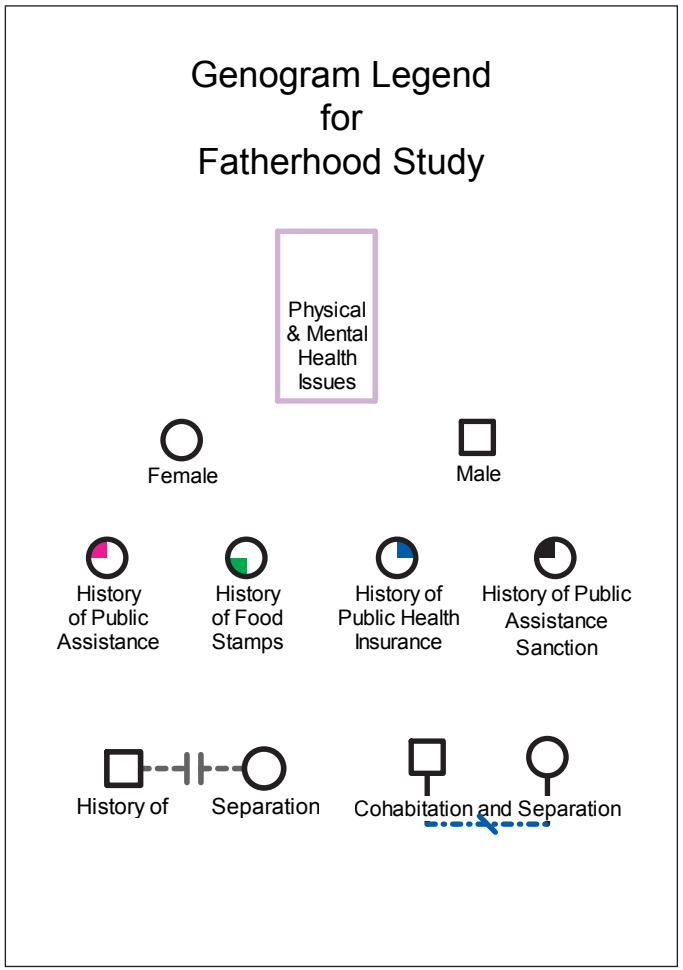

Genogram Legend for Case E
Female
Sex Unknown
Male
Physical Health Issues
Twin
Twin
History of Public Assistance
History of Food Stamps
History of Public Health Insurance
Receives Disability Benefits
Foster Care
History of Substance Abuse
Deceased
History of Incarceration/ Probation
History of
Physical Abuse
Live
Together
Lived
Together
Married
Divorced
Unknown Relationship
History of
Separation
Paid/ Pays
Child Support
Unspecified
Relationship

Fatherhood Study Genogram

The following genogram is an example of a father on public assistance who has children with three different partners. One of the mothers has also had children with two additional partners.



Fatherhood Study Genogram


Genogram Legend
for
Fatherhood Study
Physical & Mental Health Issues
Female
Male
History of Public Assistance
History of Food Stamps
History of Public Health Insurance
History of Public Assistance Sanction
History of
Separation
Cohabitation and Separation

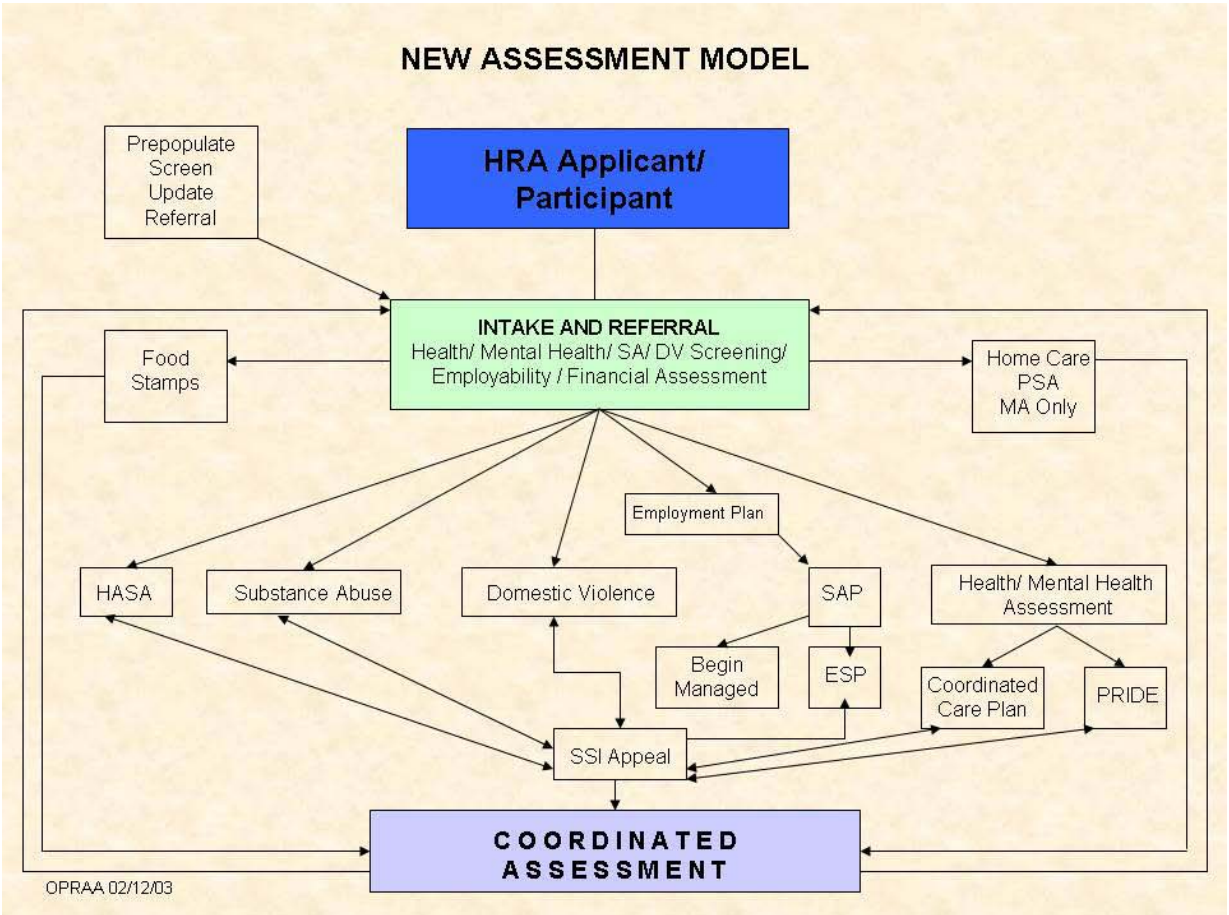

NEW ASSESSMENT MODEL
Prepopulate
Screen
Update
Referral
HRA Applicant/
Participant
INTAKE AND REFERRAL
Health/ Mental Health/ SA/ DV Screening/
Employability / Financial Assessment
Food
Stamps
Home Care
PSA
MA Only
Employment Plan
HASA
Substance Abuse
Domestic Violence
SAP
Health/ Mental Health
Assessment
Begin
Managed
ESP
Coordinated
Care Plan
PRIDE
SSI Appeal
COORDINATED
ASSESSMENT
OPRAA 02/12/03

Chart 8

Endnotes

[1] Grinker, W. and Smith, D. (2005). *The Transformation of Social Services Management in New York City: "CompStating Welfare"*. New York: Structured Employment/Economic Development Corporation (SEEDCO: 35-36.
[2] Lombardi, Frank. "O*utreach Time at the HRA: Advocates Find Open Arms Instead of Cold Shoulder,"* Daily News, February 4, 2002.
[3] U.S. Census Bureau, *Statistical Abstract of the United States: 2004-2005* (124th Edition) Washington, DC, 2004P: 371, 427.
[4] Formerly known as Eligibility Verification Review (EVR).
[5] Testimony before the House of Representatives Ways and Means Committee Hearing on Welfare Reform Reauthorization, February 10, 2005.
[6] Dr. Swati Desai, Executive Deputy Commissioner, Office of Program Reporting, Analysis, and Accountability, HRA/DSS.
[7] The Nelson A. Rockefeller Institute of Government, "Performance Management in State and Local Government," June 2005.
[8] Grinker, W. and Smith, D. (2005): 24.
[9] HRA/DSS Retention Work Group, 2003.
[10] HRA/DSS Prevention Workgroup, 2003.
[11] This model was developed as the foundation for the current WeCARE program.
[12] HRA/DSS CTC Workgroup, 2003.
[13] Eggleston, V. "Look at the People, Not the Numbers," *Gotham Gazette*. March 17, 2002.
[14] See note 2.
[15] Steinhauer, Jennifer. "Bloomberg Aims to Move Many Infirm Welfare Recipients into Work Force." *The New York Times,* May 10, 2003.
[16] See HRA/DSS *HIV/AIDS Services Administration Initiatives and Achievements: August 2003-August 2005.*
[17] See HRA/DSS "Recommendations on Public Health Insurance Reform." January 2004
[18] Birnbaum, M. and Haslanger, K. (2004). *Bringing Information Technology Innovation to New York's Public Health Insurance Programs.* New York: United Hospital Fund: 2.
[19] IREA Position Paper "Plan to Combat Medicaid Fraud." 2005.
[20] The Model Center initiative was profiled in a 2005 "Promising Practices" report by the USDA.
[21] Birnbaum, M. and Haslanger, K. (2004): 11.
[22] Mike Forte, Director of Training, Citywide Training Center.
[23] At the time of this writing, TANF is extended to March 31, 2006 by the passage of the TANF and Child Care Continuation Act of 2005. The Deficit Reduction Act (DRA) of 2005 was signed into law (PL 109-171) by President Bush on February 8, 2006. This contains the reauthorization of TANF and related programs through September 30, 2010. A number of HRA/ DSS's recommendations are reflected, such as maintaining the 50% work participation rate and the current work participation requirements of 20 core and 30 total hours (see Appendix).
[24] See note 23.

Appendix

New York City
TANF Block Grant Recommendations
September 2003

When dealing with a diverse population and wide-ranging state and regional economies, "one size doesn't fit all." States and localities must be allowed the necessary flexibility to best serve individuals with a myriad of health or other issues that create barriers to self-sufficiency. Congress should continue TANF's success by maintaining it as a program in which states and localities are given maximum flexibility in designing programs to meet federal goals.

NYC TANF Program Facts

- **Reduced caseload from over 900,000 in 1995 to less than 329,609 by August 2003.**
- **In April 1999, 23.1% of the caseload was fully or partially unengageable in work activities. By August 2003, that proportion had grown to 57% of the caseload.**
- **Clients with significant barriers require a range of services and adequate time to achieve and maintain self-sufficiency.**
- **NYC's current work participation rate is 36.4%, and as the proportion of clients with employability barriers has increased, the participation rate has decreased accordingly.**

Work Participation Rate and Activities

- **Maintain the current 50% work participation rate and have the same rate apply for all TANF families.**
- **If the mandatory work participation rate is increased for all TANF families, allow states to:**
- **Define allowable work and work related core activities to include wellness and barrier removal activities.**
- **Determine client service participation timelines based on the client's needs.**
- **Provide a caseload reduction credit, or an employment credit that reflects all job placements (documented through client report or data match), including diversion from TANF and non-custodial parents.**
- **Continue to include job search, job readiness and vocational educational training (increase threshold for the latter from 30% to 40% of participants).**
- **Allow programs to meet core and supplementary work-related activity**

requirements by averaging over a longer time period such as 3-weeks of full-time work and 1-week of other activities in a month.

- **Maintain the current 20 core and 30 total work hours.**
- **If core requirements increase to 24 hours, recognize that TANF employees are allowed an hour per day for lunch.**
- **Give states additional participation rate credit for engagement above these hours.**
- **Do not penalize states that are making progress toward meeting participation requirements.**

Child Care

- **Increase child care funding by a minimum of $5.5 billion over the next five years to continue supporting working families that have left TANF and engage those families still receiving assistance.**
- **Deem child care as non-assistance for TANF clients.**

Legal Immigrants

Restore TANF, Medicaid and SCHIP health insurance eligibility for all legal immigrants.

- **Improve Transitional and Retention Support Grant greater flexibility to use TANF funds to support working families who have left welfare, and extend transitional medical assistance. Deem housing subsidies for these families non-assistance for TANF purposes.**
- **Permit subsidized housing beyond 4-month limit, at least until a family is eligible for Section 8 assistance.**
- **Treat child care and transportation as non-assistance for both working and non-working families.**
- **Allow non-custodial working parents with a child on TANF to be included in TANF work activities and eligible for TANF services.**
- **Suspend time limits for families on TANF when an adult is working full-time and participating in time-limited, goal-directed education and training activities.**

Programmatic Simplification

Grant state flexibility to simplify and align various program requirements and to implement uniform rules for means-tested benefit programs.

- **Streamline data collection requirements.**

TANF Emergency Homeless Assistance

- **Consider emergency shelter provided for homeless families, for any duration, as emergency assistance.**
- **Allow states to extend emergency assistance related to homelessness beyond 4 months.**

Funding For Related Services

Maintain the 10% transfer of TANF to Title XX.

A mandated increase in the work participation rate will impose greater demands on states and localities and should include substantial and proportionate increases in:

- **TANF funding for education, training, job placement, and barrier removal programs.**
- **The Child Care and Development Block Grant.**
- **The Title XX Social Services Block Grant.**

Glossary of Terms and Abbreviations

Able-bodied client: An adult client who is fulfilling or in the process of being assigned to work activity requirements; an engageable client

ACCIS: Automated Child Care Information System

ACCO: Agency Chief Contracting Officer

AFDC: Aid for Families With Dependent Children; replaced by TANF under the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)

ALERTS: Automated Listing of Eligibility Requirements Tracking System

APS: Adult Protective Services

BEGIN: Begin Employment, Gain Independence Now

CASAC: Credentialed Alcohol Substance Abuse Counselor

CHP: Child Health Plus , New York State's health insurance program for children under the age of 19

CHP A: Child Health Plus A; formerly Children's Medicaid

CHP B: Child Health Plus B; Children who are not eligible for Child Health Plus A can enroll in Child Health Plus B if they do not already have health insurance and are not eligible for coverage under the public employees' state health benefits plan.

COBRA: Consolidated Omnibus Budget Reconciliation Act

CRB: Contract Review Board

DRM: Disaster Relief Medicaid

DAU: Disability Application/Appeals Unit

EDITS: Eligibility Data and Image Transfer System

EDW: Electronic Data Warehouse

Engageable: An adult client who is fulfilling or in the process of being assigned to work activity requirements; an able-bodied client

Engagement Report: Statistical compilation of the public assistance caseload by location and case types

ESP: Employment Services Plan

FACTORS: Family Care Tracking System

FE: Facilitated Enrollment

FFFS: Flexible Fund for Family Services

FHP: Family Health Plus

FIA: Family Independence Administration

Full engagement: Occurs when all clients of HRA/DSS are accounted for, and are either engaged in employment or work activities, in the assignment or assessment process, sanctioned for noncompliance or appropriately classified as exempt from work activity

Fully unengageable: Clients that are indefinitely unengageable in work activities due to various reasons, including child-only cases, state exemptions for recipients over the age of 60, or recipients of SSI Disability benefits

Genogram: A graphic organizer used to depict familial and social relationships among clients

HASA: HIV/AIDS Services Administration

HHC: The New York City Health and Hospitals Corporation

HRA/DSS: Human Resources Administration/Department of Social Services. HRA is a New York City agency. DSS is the local district of the New York State Department of Social Services. HRA/DSS encompasses both responsibilities.

IREA: Investigation and Revenue Enforcement Administration; formerly ORI

ISC: Intensive Services Center

IVR: Interactive Voice Recognition

LDSS: Local Department of Social Services

LL 49: New York City Local Law 49; establishes and governs HASA

LL 73: New York City Local Law 73; requires City agencies to provide meaningful access to benefits and services for all individuals, regardless of English language proficiency

MA: Medical Assistance

MAP: Medical Assistance Program

MICSA: Medical Insurance and Community Services Administration

MIS: Management Information Systems

Model Office/Model Center: A client service center that combines improved infrastructure with technological innovation to provide superior customer service

NYCWAY: New York City: Work, Accountability, and You

OCSE: Office of Child Support Enforcement

OLA: Office of Legal Affairs

ORI: Office of Revenue and Investigation; currently known as IREA

OSR: Office of Staff Resources

PA: Public Assistance

PaCS: Payment and Claiming System

Partially Unengageable: A client who is temporarily unable to participate in work activities due to various reasons, including temporarily irresolvable medical or mental health issues

PCAP: Prenatal Care Assistance Program

RFP: Request for Proposals

SAP: Skills Assessment Placement

Safety Net Converted: Clients who have reached their five-year TANF lifetime limits and have enrolled in Safety Net Assistance

SNA: Safety Net Assistance

SSDI: Social Security Disability Insurance

SSI: Supplemental Security Income

STARS: Substance Abuse Tracking and Reporting System

TANF: Temporary Assistance for Needy Families; replaced AFDC under the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)

TANF I: The first phase of welfare reform (1996-2001), characterized by a focus on "welfare to work" and a sharp reduction in public assistance rolls

TANF II: The second phase of welfare reform (2002-present)

WeCARE: Wellness, Comprehensive Assistance, Rehabilitation, and Employment

Welfare: Cash assistance

References

Birnbaum, M. and Haslanger, K. 2004. *Bringing Information Technology Innovation to New York's Public Health Insurance Programs.* New York: United Hospital Fund.

Bloomberg, M.R. "Address on Welfare Reform". May 15, 2002.

Eggleston, V. "Look at the People, Not the Numbers." *Gotham Gazette.* March 17, 2002.

Grinker, W. and Smith, D. 2005. *`The Transformation of Social Services Management in New York City: 'CompStating' Welfare*. New York: Structured Employment/Economic Development Corporation (SEEDCO).

Lombardi, Frank. "Outreach Time at the HRA: Advocates Find Open Arms Instead of Cold Shoulder," *Daily News*, February 4, 2002

New York City Human Resources Administration/Department of Social Services. 2005. *HIV/AIDS Services Administration Initiatives and Achievements August 2003-August 2005*.

_____. 2005. *Investigation and Revenue Enforcement Administration Position Paper: Plan to Combat Medicaid Fraud.*

_____. 2004. *Office of Legal Affairs Restructuring Workgroup Report*.

_____. 2003. *Culture, Teambuilding, Customer Service Workgroup Report.*

_____. 2003. *Prevention Workgroup Report.*

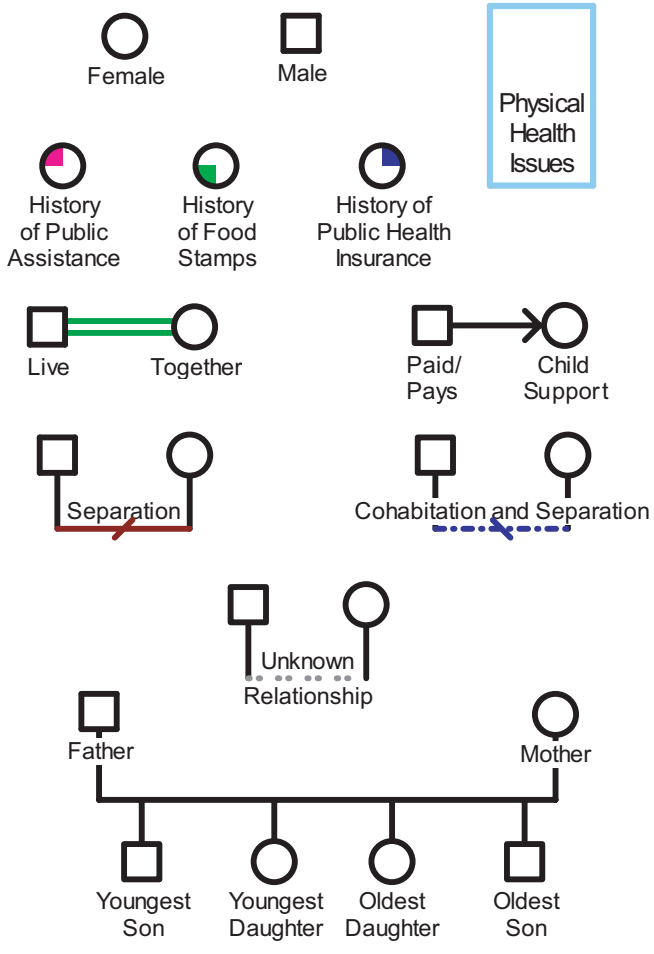
_____. 2003. *Recommendations on Public Health Insurance Reform*.

Nelson A. Rockefeller Institute of Government. 2005. *Performance Management in State and Local Government.* New York.

Steinhaur, Jennifer. 2003. "Bloomberg Aims to Move Many Infirm Welfare Recipients Into Work Force," *New York Times*, October 23, 2003.

U.S. Census Bureau. 2004. *Statistical Abstract of the United States: 2004−2005* (124th Edition), Washington, DC.

Legend


Female
Male
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History of Food Stamps
History of Public Health Insurance
Live
Together
Paid/ Pays
Child Support
Separation
Cohabitation and Separation
Unknown Relationship
Father
Mother
Youngest Son
Youngest Daughter
Oldest Daughter
Oldest Son