An Unprecedented Crisis:

The WeCARE Program's Experience Serving People with Mental and Physical Health Challenges During a Pandemic

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Overview

This report discusses findings from a descriptive study of the Wellness Comprehensive Assessment Rehabilitation and Employment (WeCARE) program's experience serving clients during the novel coronavirus 2019 (COVID-19) pandemic and the resulting recession.

Introduction

The WeCARE program provides clinical assessment, employment, Social Security application, wellness, and rehabilitation services to tens of thousands of New York City residents who receive public assistance and have physical and/or mental health challenges to employment. These individuals, including single adults who have limited resources and Temporary Assistance for Needy Families (TANF) recipients who struggle to meet work requirements, might typically fall through the cracks of public assistance programs. The WeCARE program aims to fill a critical need by connecting people to disability benefits for which they might qualify and helping those who are able to work with accommodations find placements and training when appropriate.

In March 2020, the COVID-19 pandemic upended the lives of WeCARE clients, staff, and all other New York City residents, affecting their health and job security, and affecting the program's ability to serve clients and clients' ability to receive services in person. This report documents the experiences of WeCARE staff and participants during the first year of the pandemic and shares lessons learned about maintaining services for vulnerable populations in a crisis.

Primary research questions

This report focuses on WeCARE's operations in the first year of the pandemic, from March 2020 to April 2021. It addresses the following research questions:

1. How did the COVID-19 pandemic change the context within which WeCARE operated? How did the pandemic and recession affect who WeCARE serves and the needs of those individuals?
2. How did the pandemic and recession affect the services clients received within and across tracks?
3. How did the pandemic and recession affect the staffing structure, staff roles, and staff engagement with clients?
4. How did the pandemic and recession affect WeCARE's performance?
5. What lessons can policymakers and program administrators learn from WeCARE's response to the pandemic and resulting recession?

Purpose

In March 2020, New York City's Human Resources Administration (HRA)—the administrator of WeCARE—faced an unprecedented challenge to its ability to deliver services to New York City residents. By March 20, 2020, there were more than 5,600 confirmed cases of COVID (New York City Health 2020). At the end of March, WeCARE and its providers had to quickly transition to offering virtual services and working from home. At the direction of the state, WeCARE paused its

enrollment and assessment of new clients and made participation in its services voluntary instead of mandatory for all clients.

What WeCARE learned during this tumultuous time could guide other agencies coping with significant shifts in their environment. To uncover these lessons, the study documents how WeCARE served clients before the pandemic, how the program changed in response to the employment and service needs of its clients during the pandemic and economic recession, and the implications of those changes for long-term modifications to the WeCARE model.

Key takeaways for human services agencies from WeCARE's response to the pandemic

The COVID-19 pandemic was devastating for WeCARE's clients and staff. WeCARE's experience adjusting to a new normal in assessing and providing care for its clients offers useful lessons on maintaining continuity in services during turbulent times, and lessons for new methods of engaging with clients.

- **For WeCARE clients, the pandemic exacerbated already existing disparities and challenges to entering the workforce.** Job opportunities were even more scarce than before for WeCARE clients who faced mental and/or physical challenges to working. With the spread of the pandemic, it became increasingly difficult to sustain employment as clients worried about exposing themselves or their loved ones to COVID-19. Disruptions in school, childcare, and public transportation also made it challenging for some clients to find work.
- **Providing services virtually is feasible and has some benefits, but it also has risks.** Both provider staff and clients found advantages to engaging remotely, including flexibility in attending workshops or appointments, and the ability to offer more one-on-one client support as needed. But staff expressed concerns about not being able to get to know clients in person, and concerns about the clients who are not accustomed to using technology.
- **The lack of mandatory participation requirements revealed the importance of providing client-centered services.** Staff noted they had difficulty getting clients to engage because participation was not mandatory. However, those who did participate appreciated the support they received and found the more individualized attention helpful. In interviews, staff said their experiences during the pandemic reminded them of the importance of connecting clients to a range of services and resources, and the need to adapt to clients' changing needs. However, ongoing challenges in hiring staff and a return to mandatory participation in services may mean that staff caseloads will increase, making it difficult to provide such individualized support.
- **It is important to support both staff and clients.** WeCARE clients highlighted how much they appreciated staff responsiveness during the height of the pandemic. They valued having someone to talk to during lockdown, and WeCARE helped them stay motivated in their job search. HRA and service provider leaders recognized the importance of supporting staff morale and technical capacity so staff could focus on being available to clients. Leaders provided more frequent check-ins and trainings, and reassigned staff instead of letting them go when the needs of the program changed. Staff believed the culture created by leadership also encouraged more collaboration and sharing of lessons across different providers.

Methods

This descriptive study used qualitative and quantitative data to explore themes in the experiences reported by WeCARE staff and clients and trends in the performance data collected by WeCARE providers. The study team conducted interviews and focus groups with 29 staff from HRA and WeCARE providers between April and June 2021. The team also conducted in-depth, one-on-one interviews with 10 WeCARE clients between May and August 2021 who were enrolled in the program before and during the COVID-19 pandemic. Finally, the team analyzed administrative data provided by WeCARE on clients served before and during the pandemic.

The study team used a thematic approach to analyze the qualitative data from the interviews and focus groups, extracting findings related to each of the research questions. To provide more context, they used administrative data to develop descriptive statistics about client characteristics, services, and outcomes.

Executive summary

The Wellness Comprehensive Assessment Rehabilitation and Employment (WeCARE) program provides employment and rehabilitation services to thousands of New York City residents who receive public assistance and have physical and/or mental health challenges to employment. These individuals, including single adults who have limited resources and Temporary Assistance for Needy Families (TANF) recipients who struggle to meet work requirements, might typically fall through the cracks of public assistance programs. The WeCARE program aims to fill a critical need by connecting people to disability benefits for which they might qualify and helping those who are able to work with accommodations find placements and training when appropriate.

WeCARE serves clients who apply for public cash assistance through New York City's Human Resources Administration (HRA; the administrator of WeCARE) and who have mental and/or physical challenges to employment. HRA eligibility workers refer people who receive cash assistance but cannot meet certain work requirements due to mental and/or physical challenges to WeCARE for further evaluation. WeCARE assesses each referred individual and aims to provide a continuum of integrated and tailored services that evaluate and address the needs of clients with mental and physical health challenges. Clients are required to participate in WeCARE to maintain their cash benefits from HRA.

After comprehensively assessing whether the client is able to work, a WeCARE health professional refers clients to one of three tracks to work with a specialized case manager:

1. **Supplemental Security Income (SSI) track.** If a client is unable to work for a likely period of time exceeding 12 months and therefore likely eligible for disability benefits, their case manager will help them with their disability benefits application. If appeals are needed, another program assists clients with this task.
2. **Vocational rehabilitation services (VRS) track.** If a client is deemed able to work, the case manager will connect them to vocational rehabilitation services that will support their short- and long-term career goals.
3. **Wellness track.** If a client's unstable or untreated physical and/or mental health condition(s) makes them currently unable to work, the client will participate in the wellness track for up to 90 days (and possibly longer) to treat and/or stabilize their condition(s) and make a determination regarding the condition's long-term impact on employability.

In March 2020, the COVID-19 pandemic upended the lives of WeCARE clients, staff, and all other New York City residents, affecting their health and job security, and impeding the program's ability to serve clients and clients' ability to receive services in person. This report discusses findings from a descriptive study of the WeCARE program's experience serving clients during the COVID-19 pandemic and the resulting recession. The purpose of the study is to understand how WeCARE pivoted to continue serving clients in this new environment, how clients and staff were affected, and what lessons from this experience can inform other agencies that might face similar shifts in their service environment. Mathematica conducted this study as part of the Next Generation of Enhanced Employment Strategies (NextGen) Project on behalf of the Office of Planning, Research, and Evaluation in the Administration for Children and Families, U.S. Department of Health and Human Services.

Research Questions

The report focuses on WeCARE's operations in the first year of the pandemic, from March 2020 to April 2021. It addresses the following research questions:

1. How did the COVID-19 pandemic change the context within which WeCARE operated? How did the pandemic and recession affect who WeCARE serves and the needs of those individuals?
2. How did the pandemic and recession affect the services clients received within and across tracks?
3. How did the pandemic and recession affect the staffing structure, staff roles, and staff engagement with clients?
4. How did the pandemic and recession affect WeCARE's performance?
5. What lessons can policymakers and program administrators learn from WeCARE's response to the pandemic and resulting recession?

Data Sources

To answer these research questions, the report uses two main data sources:

1. *Staff and client perspectives.* From April to August 2021, the study collected perspectives from WeCARE staff and clients through virtual interviews and focus groups. Twenty-nine staff from HRA and WeCARE providers participated in the interviews and focus groups. The study also conducted in-depth, one-on-one interviews with 10 WeCARE clients across all three tracks who were enrolled in the program before and during the pandemic.
2. *Participant administrative data.* WeCARE provided aggregate program data for WeCARE clients, including data on background characteristics, assessment determinations, participation in services, and some limited outcomes. These are data WeCARE providers collected for performance reporting and not specifically for the study.

WeCARE before the COVID-19 pandemic

WeCARE contracts with three providers to administer services in each of the five boroughs of New York City. Maximus serves clients in Queens; University Behavioral Associates serves clients in the Bronx; and ResCare serves clients in Brooklyn, Manhattan, and Staten Island. All providers use the same assessment process and assign clients to one of the three main WeCARE tracks, though there might be slight differences in how the programs are administered. For example, a service provider in the Bronx might offer different workshops and have different employer relationships and job leads than in Staten Island. Each service provider might also work with different subcontractors and partners. Between March 2019 to February 2020, University Behavioral Associates served the most clients with 10,346 clients, followed by ResCare with 7,831 clients served in Brooklyn and 6,782 served in Manhattan and Staten Island (combined because the programs in these boroughs are operated under one contract), and Maximus with 4,204 clients.

Four in five (62 percent) of the over 29,000 clients served before the pandemic were Blacks/African Americans. The largest age group was between the ages of 45 and 54 (27 percent) and half of WeCARE clients had a high school diploma or equivalent (50 percent). Forty-two percent of WeCARE clients did not have a high school diploma. In addition to the mental and physical challenges they already face, the population served by WeCARE is disproportionately made up of

individuals at highest risk during the COVID-19 pandemic; African Americans were believed to have been the most impacted by the pandemic (Gould and Wilson 2020), and low-skilled workers suffered high rates of job losses during the pandemic (Bateman and Ross 2021).

The COVID-19 pandemic and its impact on WeCARE clients

The COVID-19 pandemic and recession had devastating consequences for WeCARE clients and staff, disrupting the way WeCARE operates. In March 2020, all nonessential businesses were closed and WeCARE had to transition to staff working remotely. As businesses closed and infections rose, unemployment increased, directly impacting WeCARE clients' health and economic wellbeing in a city that had experienced the brunt of the onset of the COVID-19 pandemic. By May of 2020, the unemployment rate in New York City had risen to 20 percent.

The effects of the pandemic exacerbated already existing disparities and challenges for WeCARE clients entering the workforce. Job opportunities were even more scarce than they were before for WeCARE clients who faced mental and/or physical challenges to working. With the spread of the pandemic, it became increasingly difficult to sustain employment as clients were worried about exposing themselves or their loved ones during the pandemic to COVID-19. Disruptions in child care and school made it challenging for some clients to find employment, as they had to look after their kids during the pandemic. Disruptions in public transportation raised more barriers.

Many clients reported increased mental health challenges during the COVID-19 pandemic. The lockdown and resulting city ordinances meant growing isolation and lack of mobility for many clients, worsening their mental health issues. Clients said they were anxious about leaving the house or going to appointments in person. Several clients also reported losing friends and loved ones to COVID-19.

The economic challenges also worsened housing and financial difficulties, according to staff perceptions. Interviewed staff said there was an increase in housing-related challenges for clients, including fear of losing their housing. Although evictions were temporarily stalled, many clients had problems paying for basic living expenses and utilities. Access to healthy foods and basic resources became limited as a result of the COVID-19 pandemic.

Throughout the pandemic, WeCARE tried to adjust as much as possible to meet clients' needs. In March 2020, a state directive was passed down that meant that clients in all tracks of WeCARE and other workforce development programs were no longer required to participate to maintain their cash assistance benefits. Although WeCARE made services voluntary and ceased intake appointments, many staff stayed in touch with their clients and checked up on them regularly.

With intakes ceased and no new clients to assess, WeCARE caseloads dropped from about 29,000 before the pandemic to about 8,000 in the 10 months since the start of the pandemic. Clients who continued to participate did so virtually. Staff provided enhanced case management for all clients, including those who were referred at the onset of the pandemic and unable to go through the intake process. Case managers called clients weekly to check in and refer them to services that could address their many needs.

Key takeaways for human services agencies from WeCARE's response to the pandemic

WeCARE and its providers adjusted to a new normal during the first year of the pandemic, and their experience in assessing and providing care for clients offers useful lessons on maintaining continuity in services during turbulent times, and insights into new methods of engaging with clients.

- **For WeCARE clients, the pandemic exacerbated already existing disparities and challenges to entering into the workforce.** Job opportunities were even more scarce than before for WeCARE clients who faced mental and/or physical challenges to working. With the spread of the pandemic, it became increasingly difficult to sustain employment as clients worried about exposing themselves or their loved ones to COVID-19. Disruptions in school, childcare, and public transportation also made it challenging for some clients to secure employment.
- **Providing services virtually is feasible and has some benefits, but it also has risks.** Both provider staff and clients found advantages to engaging remotely, including flexibility in attending workshops or appointments, and the ability to offer more one-on-one support as needed by clients. But staff expressed concerns about not being able to get to know clients in person or not being able to build the same type of rapport with clients virtually or over the phone. Staff also reported that some clients are not as accustomed to using technology or had limitations on the technology available to them.
- **The lack of mandatory participation requirements revealed the importance of providing client-centered services.** Staff noted they had difficulty getting clients to engage because it was not mandatory for them to participate. However, those who did participate appreciated the support they received and found the more individualized attention helpful. In interviews, staff said their experiences during the pandemic reminded them of the importance of connecting clients to a range of services and resources, and the need to adapt to clients' changing needs. However, ongoing challenges in hiring staff and a return to mandatory participation in services may mean that staff caseloads will increase, making it difficult to provide such individualized support.
- **It is important to support both staff and clients.** WeCARE clients highlighted how much they appreciated staff responsiveness during the height of the pandemic. They valued having someone to talk to during lockdown, and to help them stay motivated in their job search. HRA and service provider leaders recognized the importance of supporting staff morale and technical capacity so staff could focus on being available to clients. Leaders provided more frequent check-ins and trainings, and reassigned staff to other roles instead of letting them go when the needs of the program changed. Staff believed that the culture created by leaders encouraged more collaboration and sharing of lessons across different providers.

The lessons shared in this report are a useful starting point in understanding how WeCARE services might be evolving from what they looked like before the pandemic. The experiences of staff and participants suggest there may be longer-term changes, but it is unclear how they will manifest because services were still not required for clients as of April 2022, and client participation is relatively low. When HRA makes participation in WeCARE services mandatory for clients again, there may be changes in the composition of WeCARE clients as well as changes in how WeCARE program services are delivered to clients.

1. Introduction

The Wellness Comprehensive Assessment Rehabilitation and Employment (WeCARE) program provides clinical assessment, employment, Social Security application, wellness, and rehabilitation services to tens of thousands of New York City residents who receive public assistance and have physical and/or mental health challenges to employment. These individuals, including single adults who have limited resources and Temporary Assistance for Needy Families (TANF) recipients who struggle to meet work requirements, might typically fall through the cracks of public assistance programs. The WeCARE program aims to fill a critical need by connecting people to disability benefits for which they might qualify and helping those who are able to work with accommodations find placements and training when appropriate. In March 2020, the COVID-19 pandemic upended the lives of WeCARE clients, staff, and all other New York City residents, affecting their health, their ability to serve clients and receive services in person, and their job security.

The NextGen Project

The Office of Planning, Research, and Evaluation in the Administration for Children and Families sponsors the Next Generation of Enhanced Employment Strategies (NextGen) Project in partnership with the Social Security Administration. The goal of the project is to identify and study innovative employment programs for people facing complex employment challenges. The study explores how the programs are designed and operated and for some programs their effectiveness and cost. For more information, visit https://www.acf.hhs.gov/opre/project/next-generation-enhanced-employment-strategies-project-2018-2023.

This report discusses findings from a descriptive study of the WeCARE program's experience serving clients during the COVID-19 pandemic and the resulting recession. The purpose of the study is to understand how WeCARE pivoted to continue serving clients in this new environment, how clients and staff were affected, and what lessons from this experience can inform other agencies that might face similar shifts in their service environment. Mathematica conducted this study as part of the Next Generation of Enhanced Employment Strategies (NextGen) Project on behalf of the Office of Planning, Research, and Evaluation (see sidebar).

Study background and purpose

WeCARE serves clients who apply for public cash assistance from New York City's Human Resources Administration (HRA) and who have physical and/or mental health challenges to employment. HRA eligibility workers refer people who receive cash assistance but cannot meet certain work requirements due to mental and/or physical challenges to WeCARE for further evaluation. WeCARE conducts an assessment and then aims to provide a continuum of integrated and tailored services that evaluate and address the needs of clients, given clients' mental and/or physical health challenges. Clients are required to participate in WeCARE to maintain their cash benefits from HRA.

After comprehensively assessing whether the client is able to work given their challenges, a WeCARE health professional refers clients to one of three tracks to work with a specialized case manager:

1. **Supplemental Security Income (SSI) track:** If a client is unable to work for a likely period of time exceeding 12 months and therefore likely eligible for disability benefits, their case manager will help them with their disability benefits application. If appeals are needed, another program assists clients with this task.
2. **Vocational Rehabilitation Services (VRS) track:** If a client is deemed able to work, the case manager will connect them to vocational rehabilitation services that will support their short- and long-term career goals.
3. **Wellness track:** If a client's unstable or untreated physical and/or mental health condition(s) makes them currently unable to work, the client will participate in the wellness track for up to 90 days (and possibly longer) to treat and/or stabilize their condition(s) and make a determination regarding the condition's long-term impact on employability.

In March 2020, HRA faced an unprecedented challenge to its ability to deliver services to New York City residents. The first case of the COVID-19 virus in New York City was confirmed on March 1, 2020, and by March 20, there were more than 5,600 confirmed cases (New York City Health 2020). The governor of New York issued an executive order on March 20 to close all nonessential businesses in the state, putting many New Yorkers out of work (New York State Governor 2020). At the end of March, WeCARE and its providers had to quickly transition to virtual services and working from home. At the direction of the state, WeCARE paused its enrollment and assessment of new clients at that time and made participation in its services voluntary for all clients instead of requiring participation for continued eligibility for cash assistance.

What WeCARE learned during this tumultuous time could guide other agencies that face significant shifts in their environment. To uncover these lessons, the study documents how WeCARE served clients before the pandemic, how the program changed in response to the employment and service needs of its clients during the COVID-19 pandemic and resulting economic recession, and the implications of those changes for long-term modifications to the WeCARE model.

Research questions, data sources, and analysis

The first phase of the study, captured in this report, focuses on WeCARE's operations in the first year of the pandemic, from March 2020 to April 2021. It addresses the following research questions:

1. How did the COVID-19 pandemic change the context within which WeCARE operated? How did the pandemic and recession affect who WeCARE serves and the needs of those individuals?
2. How did the pandemic and recession affect the services clients received within and across tracks?
3. How did the pandemic and recession affect the staffing structure, staff roles, and staff engagement with clients?
4. How did the pandemic and recession affect WeCARE's performance?
5. What lessons can policymakers and program administrators learn from WeCARE's response to the pandemic and resulting recession?

To answer these research questions, this report uses two main data sources:

1. **Staff and client perspectives.** From April to August 2021, we collected perspectives from WeCARE staff and clients through virtual interviews and focus groups. We conducted interviews and focus groups with 29 staff from HRA and WeCARE providers. We also conducted in-depth,

one-on-one interviews for one to two hours with 10 WeCARE clients across all three tracks who were enrolled in the program before and during the pandemic.

2. **Participant administrative data.** WeCARE provided aggregate program data for WeCARE clients, including background characteristics, assessment determinations, participation in services, and some limited outcomes. WeCARE provider collected these data for performance reporting purposes and not specifically for the study.

The study team analyzed both qualitative data from the interviews and focus groups using a thematic approach and quantitative administrative data on WeCARE clients. More information on the research methods and data sources is available in Appendix A.

Roadmap for report

The remainder of the report provides findings from the first phase of the descriptive study. Chapter II discusses how the WeCARE program was structured before the pandemic and who it served. Chapter III describes the onset of the COVID-19 pandemic and resulting recession in New York City, and the effects of the pandemic and recession on WeCARE clients. Chapter IV discusses how the pandemic changed the way staff delivered WeCARE services and who was served. Chapter V describes how the pandemic affected provider staff, organizations, and performance. Finally, Chapter VI discusses some of the lessons that emerged from the experience of staff and clients during this period.

2. WeCARE Before the COVID-19 Pandemic

New York City's HRA operates WeCARE. HRA is the largest city-level social services agency in the country, serving more than three million New Yorkers each year. HRA refers recipients of cash assistance to WeCARE if they state that they have mental and/or physical health challenges that affect their ability to work and, consequently, their ability to meet the work requirements for cash assistance. WeCARE serves approximately 29,000 clients every year who are receiving cash assistance through the TANF program or the New York State Safety Net Assistance program, which provides cash assistance to individuals or families who are not eligible for TANF because they have reached the time limit of benefit receipt or they do not have children but still meet a certain financial eligibility threshold (Office of Temporary and Disability Assistance n.d.).

WeCARE began in 2005 but evolved from a program called Personal Roads to Individual Development and Employment (PRIDE) that served cash assistance recipients with mental or physical challenges from 1999 to 2005. WeCARE itself has evolved over the years, and HRA considers the current WeCARE program, implemented in 2018, to be the third iteration of the program (see sidebar).

Evolution of WeCARE

1999 – Personal Roads to Individual Development and Employment (PRIDE) program begins serving people on cash assistance who have mental or physical challenges

WeCARE 1.0

2002 – New WeCARE program is proposed and request for proposals (RFP) released

2003 – Two providers for WeCARE program selected: Arbor Employment and Training and Federation & Employment Guidance Services (FEGS)

2005 – New WeCARE program officially implemented

WeCARE 2.0

2010 – Second WeCARE RFP released

2012 – Two providers selected for WeCARE 2.0: FEGS and Fedcap Rehabilitation Services

WeCARE 3.0

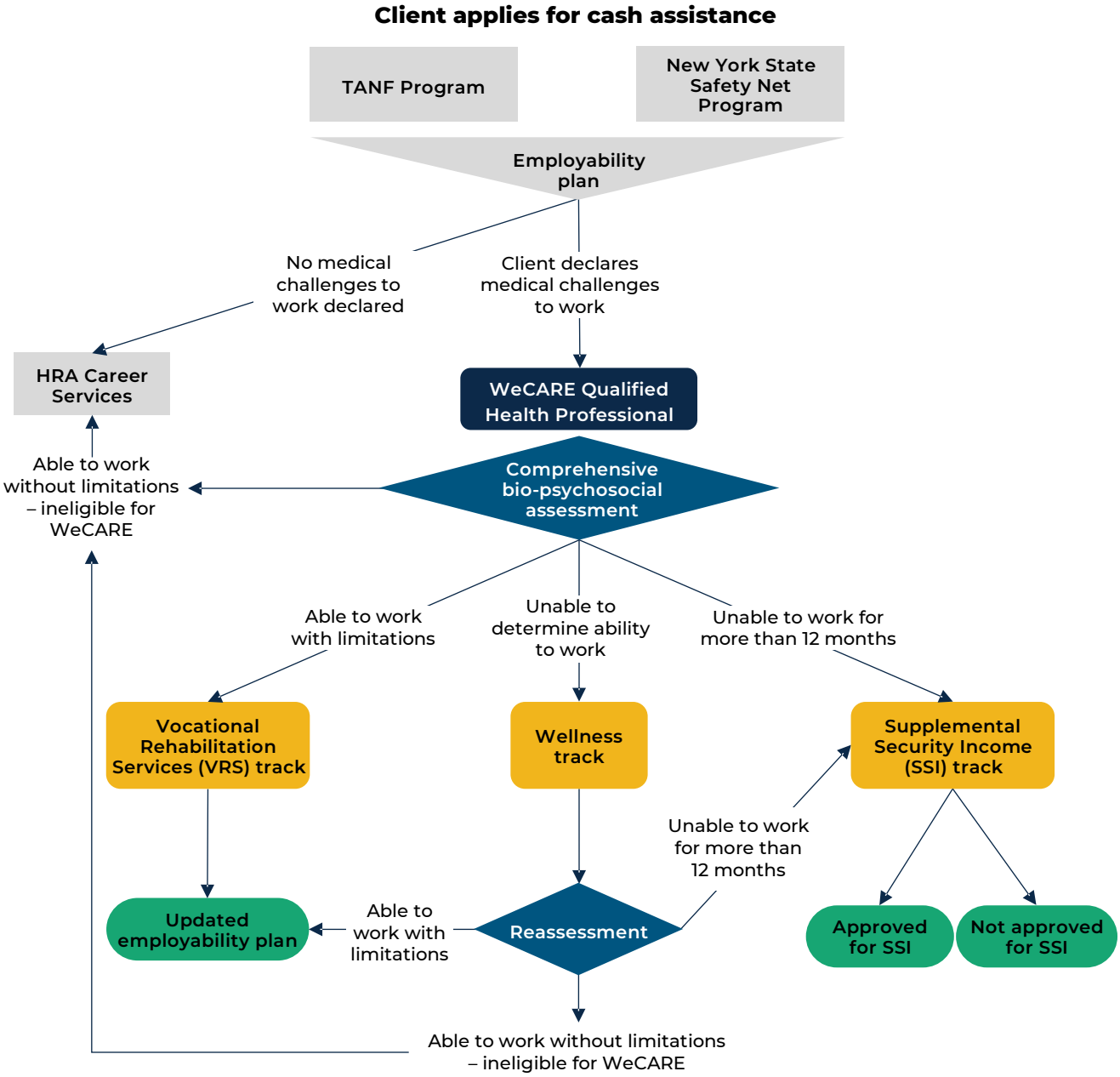
2017 – Third WeCARE RFP released

2018 – Three providers selected for WeCARE 3.0: ResCare, University Behavioral Associates, and Maximus

Initial assessment for WeCARE clients

After HRA makes a referral, potential WeCARE clients visit a WeCARE center (operated by WeCARE's providers) in person to receive a comprehensive clinical assessment from a qualified health professional. This assessment determines the extent of the client's physical or mental health challenges and their ability to work (Figure 2.1).

Figure 2.1. Client flow through HRA and WeCARE



Note: If a client applies for SSI but is not approved, they will be referred to a department within HRA for help with applying for reconsideration.

HRA = Human Resources Administration; SSI = Supplemental Security Income.

If needed, clients can also be referred to a board-certified physician for a medical examination. Before the pandemic, about 25 percent of clients required this medical examination.

The purpose of the clinical assessment is to determine whether the individual (1) is able to work without limitations, (2) is able to work but has limitations that need accommodations, or (3) is unable to work. The clinical assessment examines an individual's physical challenges or other limitations, mental and physical health conditions, housing and family situation, education and work history,

substance use and treatment history, need for reasonable accommodations, and other aspects that would affect their ability to work. WeCARE uses information from the client's own doctor to evaluate physical health, and does additional medical assessments as needed.[1] Based on this information, the qualified health professional would consider ability to work within the framework that is also used by the Social Security Administration (SSA) to determine eligibility for SSI benefits. This framework considers whether the individual would theoretically be able to do any job available in the United States with their condition. They would also determine whether the condition was unlikely to improve in a 12-month period.

After the comprehensive assessment, a client is considered ineligible for WeCARE if a qualified health professional determines they do not have a mental and/or physical condition that affects their ability to work (known as "employable with no functional limitation") or if their condition(s) does not require the supports that WeCARE offers.[2] The client is then referred to a job center to participate in HRA's traditional employment programs. In the year before the pandemic, 18 percent of potential clients were found to be ineligible for WeCARE (Table 2.1). If a qualified health professional determines a client has limitations or is unable to work, the client will be referred to one of the three service tracks to work with a specialized case manager: SSI, VRS, or Wellness.

Table 2.1. Outcomes of initial assessments for WeCARE referrals before the COVID-19 pandemic

Assessment outcomes	March 2019 to February 2020
Received initial assessment	38,146
Ineligible for WeCARE	6,807 (18%)
Eligible for WeCARE	31,339 (82%)
Of those eligible:	
Referred to Supplemental Security Income (SSI) track	7,308 (23%)
Referred to Vocational Rehabilitation Services (VRS) track	6,835 (22%)
Referred to Wellness track	17,196 (55%)

Source: Administrative data provided by WeCARE.

WeCARE's service tracks

Depending on the results of the initial comprehensive assessment, clients eligible for WeCARE are assigned to a case manager in one of three main tracks:

1. **VRS track.** Clients who are employable but have limitations to their ability to work are required to fulfill a certain number of work experience hours (20 to 35 hours per week) to maintain their cash assistance benefits. In the 12 months before the pandemic, 22 percent of those determined eligible for WeCARE were assigned to the VRS track. These clients are assigned to a case manager in the VRS track who will administer additional assessments to help them determine the appropriate activities to fulfill those work experience hours. Allowable activities include an unpaid community service placement at a nonprofit organization, an unsubsidized job placement, job-search and work-readiness workshops, adult basic education, English as a second language classes, short-term vocational training, and other educational activities.

[1] WeCARE 3.0 eliminated automatic medical examinations for clients as part of the initial comprehensive assessment conducted by the qualified health professional, since it did not appear to affect assignments for clients.

[2] A client can ask for a hearing if they disagree with their assessment outcome.

Once clients are in the VRS track, a certified vocational counselor will administer an individual vocational assessment plan (IVAP), which will help them work with the client to determine the client's short- and long-term employment and health goals. The IVAP takes one to two days to administer for most clients and typically consists of taking the Test of Adult Basic Education, an interest inventory like the CareerScope, and a basic computer skills test. Depending on the type of career a client is interested in, a counselor might administer additional assessments to help determine appropriate goals for the client. For example, the counselor might administer an assessment of fine motor skills if those are relevant for the client's chosen career.

2. **Wellness track.** The Wellness track is for individuals who have physical or mental health conditions that make it difficult to make a final determination of their eligibility without further assessment. In the year before the pandemic, more than half (55 percent) of those found eligible for WeCARE were assigned to the Wellness track. Participants in this track receive clinical support and case management services, including monthly check-ins to monitor the progress of their condition for 90 days. Before the client completes 90 days on the Wellness track, the counselor meets with the client again to update their condition and determine if they are still eligible for WeCARE. The counselor then decides whether to refer the client to the SSI or VRS track.

   The case manager can extend the client's time on the Wellness track for another 90 days if the case manager is still unable to determine a client's eligibility; in the year before the pandemic, about 42 percent of clients in the Wellness track had an extension. Clients are temporarily exempt from work requirements while they are in the Wellness track. Before the pandemic, about 70 percent of clients in the Wellness track were referred to the VRS track after reassessment. A small percentage were referred to the SSI track, and the rest were determined ineligible for WeCARE and referred back to HRA's career services program.

3. **SSI track.** Clients who are considered unemployable for more than 12 months are assigned to a case manager in the SSI track to help them apply for SSI or Social Security Disability Income (SSDI) benefits from the Social Security Administration. In the year before the pandemic, 23 percent of those determined eligible for WeCARE were assigned to the SSI track. Clients on this track must meet the preliminary requirements to apply for SSI or SSDI. During this process, the client is exempt from any requirement to participate in services or work. Applying for SSI and SSDI can be a lengthy process, and approval can take as long as two years. If an application is denied, the client will typically be referred to another agency within HRA (outside of WeCARE) that can help them apply for reconsideration of their application. If the appeal is denied, they can be referred to WeCARE again to be reassessed.

WeCARE's contracted service providers

Each of the five boroughs of New York City has a WeCARE center, and each center is run by one of three service providers—Maximus, ResCare, or University Behavioral Associates. Maximus serves clients in Queens; ResCare serves clients in Brooklyn, Manhattan, and Staten Island; and University Behavioral Associates serves clients in the Bronx (Table 2.2).

WeCARE is implemented through a pay-for-performance contracting arrangement with providers. The payments are split into performance-based pay points (30 percent) and line-item pay points based on services provided (70 percent). The performance-based pay points compensate the provider based on their achievement of certain target performance measures, including placement retention for clients in the VRS track, and SSI approval for clients in the SSI track. Line-item pay

points provide compensation based on provider volume and include items such as the number of clients served in the VRS track. Contracts issued before February 2019 had more performance pay points but were reduced for WeCARE 3.0.

All WeCARE providers use the same assessment process and deliver services in the same tracks. In practice, there are differences in the way providers deliver services. For example, the types of workshops offered in the VRS track might differ across providers. Each provider works with employers to develop their own relationships, and each provider develops their own job leads and work experience placements.

Differences also arise from partnerships or subcontracts across providers. For example, Montefiore, part of the Montefiore Medical Center, manages the medical components of WeCARE for University Behavioral Associates and provides treatment for people with medical or psychiatric problems. Fedcap, a nonprofit organization, provides services in the Wellness and VRS tracks as a subcontractor under Maximus's WeCARE contract. Fedcap is also a previous provider for the WeCARE program.

The success of the program relies heavily on service providers' ability to develop partnerships and maintain business and community relationships; these relationships enable them to provide community experiences and placements for participants. According to staff, these relationships are important in meeting the program's goals.

Table 2.2. Active participants by location and track

WeCARE location/track	Mar 2019 to Feb 2020
Bronx (University Behavioral Associates)	
SSI	2,285 (22%)
VRS	2,645 (26%)
Wellness	5,416 (52%)
Total	**10,346**
Brooklyn (ResCare)	
SSI	1,833 (23%)
VRS	1,628 (21%)
Wellness	4,370 (56%)
Total	**7,831**
Manhattan and Staten Island (ResCare)	
SSI	1,531 (23%)
VRS	1,749 (26%)
Wellness	3,502 (52%)
Total	**6,782**
Queens (Maximus)	
SSI	908 (22%)
VRS	669 (16%)
Wellness	2,627 (62%)
Total	**4,204**
Total across providers	
SSI	6,557 (22%)
VRS	6,691 (23%)
Wellness	15,915 (55%)
Total	**29,163**

Source: Administrative data provided by WeCARE. Active participants are those meeting requirements of their assigned track. Manhattan and Staten Island are operated under one contract.

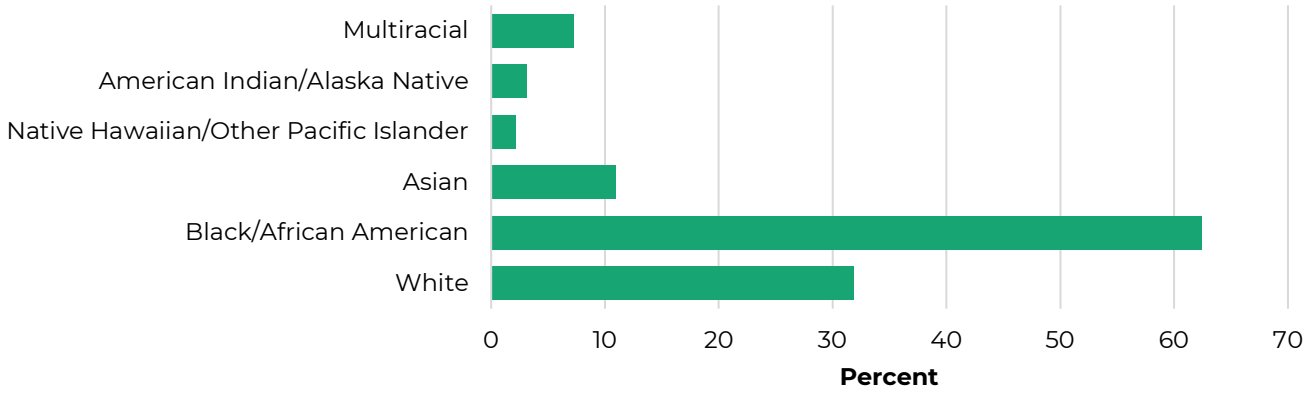
SSI = Supplemental Security Income; VRS = Vocational Rehabilitation Services.

Characteristics of participants served by WeCARE before the COVID-19 pandemic

Data from WeCARE's administrative data system provides a glimpse into the characteristics of clients served by WeCARE before the pandemic. In the year before the pandemic, WeCARE served approximately 29,000 people (Table 2.2). Among the providers, United Behavioral Associates (UBA) served the most clients in the Bronx, followed by ResCare in Brooklyn and ResCare in Manhattan and Staten Island, followed by Maximus which served clients in Queens. The distribution of clients across the three tracks is fairly similar across WeCARE locations, although the percentage of clients in the Wellness track is slightly higher and the percentage in the VRS track slightly lower in Queens than in other locations.

Before the pandemic, people who were Black/African American represented the largest racial group of WeCARE clients (Figure 2.2). Sixty-two percent of WeCARE clients were Black/African American, compared with 32 percent who were White, 11 percent who were Asian, 7 percent who were multiracial, 3 percent American Indian, and 2 percent Native Hawaiian. In addition, 37 percent of clients were Hispanic.

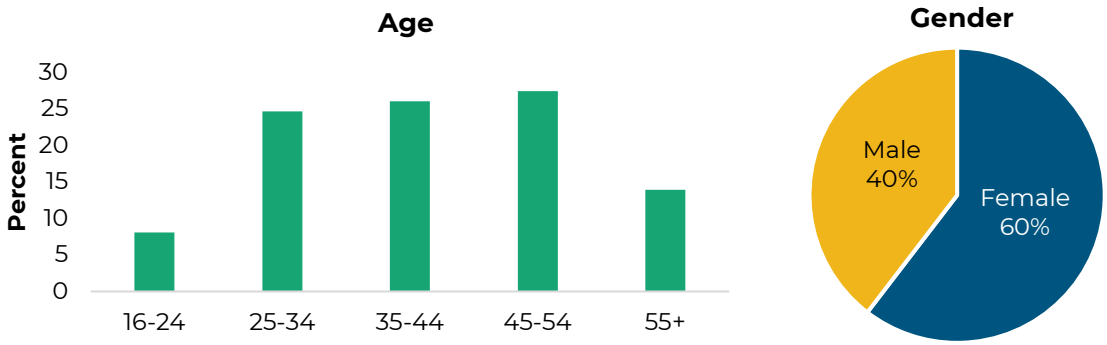
Figure 2.2. Race of WeCARE clients served between March 2019 and February 2020



Source: WeCARE administrative data.

The largest age group of WeCARE clients before the pandemic was the 45–54 age group, at 27 percent of those served (Figure 2.3). There were slightly smaller groups in the 35–44 age range (26 percent) and 25–34 age range (25 percent). Women represented 60 percent of enrolled clients, according to the data.

Figure 2.3. Age and gender of WeCARE clients served between March 2019 and February 2020



Source: WeCARE administrative data.

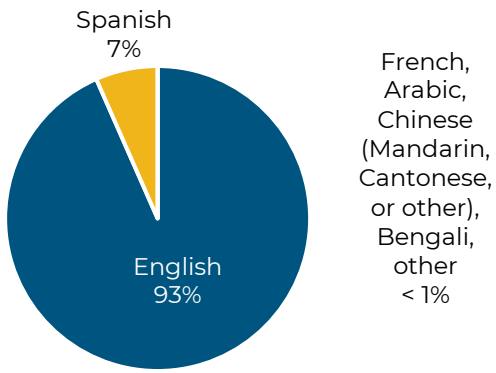
English was the predominant primary language among WeCARE clients before the pandemic, and Spanish was the second most common primary language spoken by clients (Figure 2.4). Ninety-three percent of clients listed English as their primary language, whereas 7 percent listed Spanish as their primary language. Several other languages are represented in smaller numbers, including Bengali, Arabic, and Chinese.

About half of WeCARE clients before the pandemic had a high school diploma or equivalent, representing the most common education level for clients (Figure 2.5). Forty-two percent of the

clients who enrolled in WeCARE did not have a high school degree. Small numbers of clients had more than a high school diploma, including 4 percent with an associate's degree and 3 percent with a bachelor's degree.

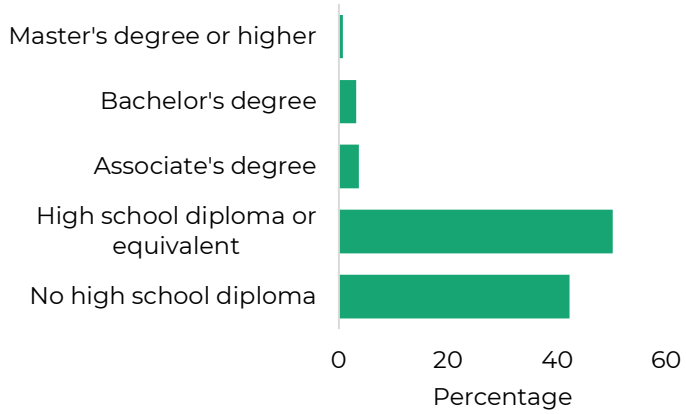
From this data we can see that the WeCARE client population represents individuals that were at high risk during the pandemic. Blacks/African Americans make up the largest racial group among WeCARE clients, and Blacks/African Americans are believed to have been one of the racial/ethnic groups most impacted by the adverse economic and health effects of the pandemic (Gould and Wilson 2020). Few clients have postsecondary education experience, which makes it more difficult to find work outside of low-wage sectors heavily impacted by the pandemic (Bateman and Ross 2021). In addition, the majority of WeCARE clients are women, who have faced great challenges staying at work during the pandemic because of child care responsibilities and other issues (McKinsey and Company 2021). With this context in mind, we discuss in the next few chapters how the COVID-19 pandemic affected the city of New York and WeCARE services, staff, and clients.

Figure 2.4. Primary language spoken by WeCARE clients served between March 2019 and February 2020



Source: WeCARE administrative data.

Figure 2.5. Education level of WeCARE clients served between March 2019 and February 2020



Source: WeCARE administrative data.

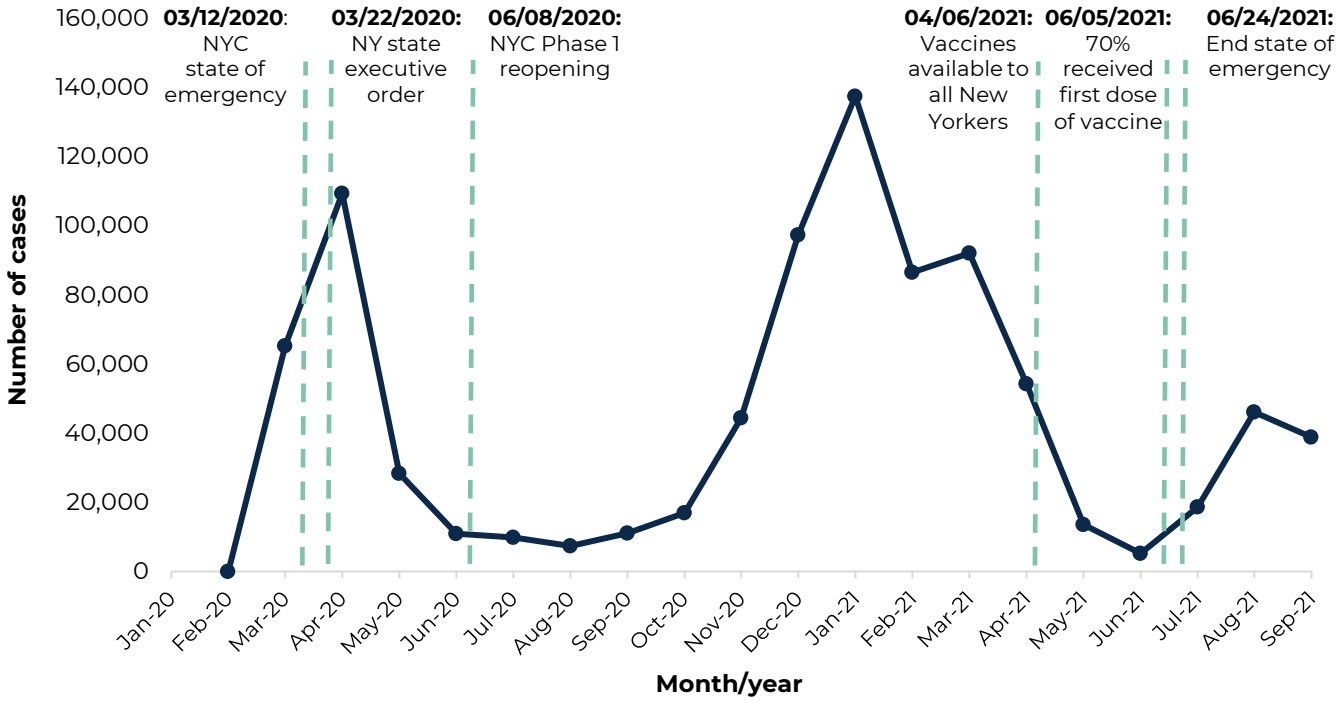
3. The Pandemic and Recession in New York City and Its Impacts on WeCARE Clients

The COVID-19 pandemic and resulting recession disrupted life for WeCARE staff and clients and changed the environment within which WeCARE operated. In March 2020, businesses and nonessential organizations like WeCARE were asked to close in-person operations and have staff work from home. As COVID-19 cases rose and unemployment increased, WeCARE's clients were directly impacted. In this chapter, we discuss the timeline of the pandemic and how it affected the needs of those WeCARE served.

COVID-19 infections and unemployment in 2020 and 2021

After COVID-19 cases hit in March 2020, the city experienced three waves of high infection rates through September 2021, with the last wave in that time period ending in August 2021 (Figure 3.1). On March 12, 2020, New York City declared a state of emergency, and the state barred gatherings of 500 or more people (Adcroft and Toor 2021). On March 22, 2020, the state then announced that all nonessential businesses statewide must close in-office functions for staff and clients (New York State Governor 2020). After the rate of new cases fell in May 2020, the city began limited reopening, referred to as "Phase 1" in the figure below, in early June 2020 (Gold and Stevens 2021). More reopenings occurred as vaccinations became available to all New Yorkers in April 2021, and the state of emergency was lifted on June 24, 2021 (New York State Governor 2021a, 2021b).

Figure 3.1. Confirmed COVID-19 cases in New York City by month

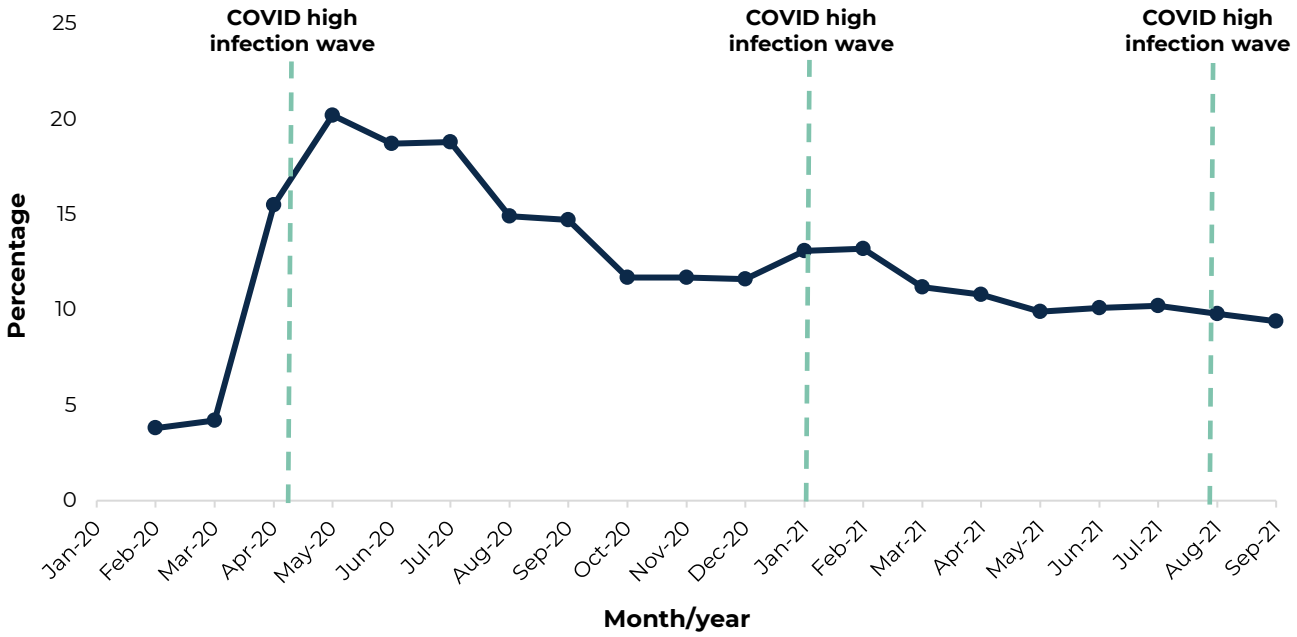


Source: New York City Open Data. n.d.

NYC = New York City.

Unemployment jumped dramatically as COVID-19 infections rose, soaring to a high of 20 percent in May 2020 (Figure 3.2). Although the unemployment rate has since decreased, in September 2021, it was still close to 10 percent in New York City, more than two times higher than before the pandemic began in February 2020.

Figure 3.2. Unemployment rate in New York City by month



Source: U.S. Bureau of Labor Statistics. n.d.

Effects of the pandemic and recession on WeCARE clients

WeCARE clients were highly exposed to the effects of the COVID-19 pandemic and recession. When the economy "came to a screeching halt" in March 2020, as one service provider leader noted, it exacerbated existing economic challenges and barriers to entering the job market for WeCARE clients.

Employment access and job loss

Staff emphasized that WeCARE clients are often last on the list of people to be hired because of public perceptions about hiring employees with disabilities. The pandemic worsened this challenge. During the first year of the pandemic, job opportunities were scarce, and the ones that did exist were more competitive because the pool of available workers was much larger than it was pre-pandemic. For example, one client mentioned that they had been looking for work as a home health aide during the pandemic, but that it was challenging to find opportunities.

Many clients were anxious about working or interviewing for jobs in person. WeCARE staff noted that clients who were placed in restaurant and retail jobs had to stop working when the pandemic hit and establishments were forced to close, and many clients were laid off. A total of 533 clients across all providers were reported to have lost their jobs between mid-March 2020 and the end of 2020, according to HRA staff (this may be an underreport if clients do not report jobs or job losses to their case managers). Two clients interviewed for the study reported that they had to stop working at the beginning of the pandemic. One of these clients was working at a school that closed, and the other stopped working to stay home with their children who were no longer attending school in

person. Staff mentioned that when they were able to arrange job interviews for clients, many of the interviews were still in person. In addition to concerns about COVID-19 exposure, it was challenging for many clients to access transportation to get to these interviews because of disruptions in public transport, such as transit closures and delays due to decreased schedules and fear of using public transportation.

Staff reported maintaining their relationships with employers throughout the pandemic through ongoing communication and collaboration. Although many employers were closed or not hiring throughout the height of the pandemic, staff said they maintained contact so that when employers wanted to hire again, it would be easier to get in touch and recommend WeCARE clients to fill positions. As employers gradually started reopening in 2021, staff started to see more opportunities for WeCARE clients, though staff reported less traditional engagement from employers such as onsite interviews and employer presentations

Lack of child care

Staff and clients mentioned loss of access to child care as a major challenge when it came to looking for work. Over three quarters of WeCARE clients are in the 25-55-year-old age group, which is the group likely to have school-aged children. Many clients who are parents lost access to child care centers and schools during the pandemic because centers were no longer operating in person, so they became 24-hour child care providers—and often teachers—for their children. Three clients interviewed pointed to their lack of child care as the main factor keeping them from looking for work. Without someone to watch their children at home, these clients knew they would not be able to manage employment. Clients have tried to address this challenge by working while their children were in school or on weekends when other adults could care for their children, but this was not always possible.

Of the 10 WeCARE clients we interviewed, six were women and all had children. Based on pre-pandemic numbers, women were also 60 percent of the enrolled clients in WeCARE. The women interviewed for the study were more likely than the men to identify a lack of child care as a challenge. Three women discussed a lack of child care as a barrier to finding or looking for employment. Two others said they were stay-at-home parents, and both expressed a desire to look for part-time or remote work. Two of the four men that we interviewed were parents with children at home, but none of them mentioned child care as a barrier to employment. WeCARE staff also mentioned that clients who had children at home and enrolled in virtual school did not have as much time or bandwidth to participate in services.

Increased mental health challenges

The most common personal challenges to employment that staff and clients described were related to mental health. Mental health issues arose as clients dealt with illness in their close family and social circles, limited mobility during the lockdown, and isolation from support systems. Service provider staff confirmed that this population was especially vulnerable because the pandemic exacerbated existing mental health issues or triggered new issues. Some clients have struggled with accessing treatment for these mental health challenges during the pandemic because of increased anxiety about leaving the house and not being able to see doctors in person.

Most of the clients interviewed said the pandemic negatively affected their mental health, especially during periods of isolation from their social and emotional support systems. Although many

described feeling bored or restless with kids in the house all the time, others detailed more serious effects, including drug addiction, depression, and anxiety. One client said, "When it first started it wasn't too bad for me, but as we got into it, really into it, I started to get a little depressed … I wasn't used to being home all the time, and then the kids are home talking with me." Staff confirmed that many clients were overwhelmed by having their children home all day, which, in some cases, increased their food insecurity because they had to provide their children with meals during the day. Another client said that "COVID-19 [made] our life [a] disaster … everything stopped, I [couldn't] go outside." This client also became a full-time caregiver for their spouse recovering from major surgery because there was no room to recover in the hospital as a result of COVID-19 patients.

Several clients and staff lost friends and family members to COVID-19. One client lost nearly 30 family members and friends, and as a result is "petrified of [COVID-19]" and extremely anxious about going outside. This client also said that "a lot of people in between [have] passed, and now it's to the point where I hate to say it, I'm numb to it." Another client described frustration with feeling confined and said their "children lost two uncles in the pandemic, and they were very sad."

> **"When it first started it wasn't too bad for me, but as we got into it, really into it, I started to get a little depressed … I wasn't used to being home all the time, and then the kids are home talking with me."**
>
> **WeCARE client**

Despite the serious challenges clients have faced, one staff member highlighted a bright spot. She pointed out that because the pandemic is negatively affecting so many people's mental health, talking about mental illness has become much less stigmatized. She has noticed that WeCARE clients, and society in general, have been more willing to address mental health disorders. Staff noted that they continued to make referrals to mental health services during the pandemic.

Increased homelessness, financial difficulties, and domestic violence

Clients and staff interviewed for the study described housing and financial difficulties among WeCARE clients that were worsened by the effects of the pandemic. Staff pointed to an increase in housing-related challenges for clients, which exacerbated existing mental health issues for some clients. One staff member said they wished WeCARE could provide more housing supports to clients because referrals are sometimes unsuccessful, and many clients "don't want to go into shelters." Although a moratorium on evictions was temporarily stayed in the city, many clients reported challenges with paying utilities and other everyday living expenses. One client mentioned that it was difficult to afford and access healthy foods because of a lack of resources and time.

One staff member also noted that having more people at home has increased domestic violence incidents with clients. WeCARE staff are trained on these issues and worked to support clients experiencing these challenges. For example, a staff member described a situation in which a client emailed a WeCARE case manager about experiencing domestic violence, and the case manager worked to help them get out of the house.

4. The Effects of the Pandemic on WeCARE Services and Who Was Served

The pandemic and recession affected how WeCARE served clients within and across tracks. In March 2020, HRA made participation in all WeCARE services voluntary and ceased intake appointments for new clients at that time, and then resumed them in January 2021. This changed the nature and frequency of services, such as offering more services in a virtual format, and changed how clients engaged with the program including more one-on-one services than group-based services. In general, clients interviewed for the study expressed appreciation for WeCARE's assistance during this time, but some clients faced challenges participating in services virtually. Although administrative data show some differences in the outcomes of client assessments starting in January 2021 compared with before the pandemic, the characteristics of the client population did not change significantly during the pandemic. This chapter discusses changes to the program and how they affected services across the tracks from staff and client perspectives.

Major changes to WeCARE services in March 2020 and January 2021

In response to the pandemic, HRA made four major changes to the program across service providers:

1. **Making receipt of WeCARE services voluntary.** As directed by the state, HRA made WeCARE services voluntary, so clients no longer were required to participate in WeCARE to maintain their cash assistance benefits from HRA. This change pertained to clients in all tracks—for example, clients in the VRS track did not have to participate in the typically required 20–35 hours of work experience or related activities to receive cash assistance. As of December 2021, services were still voluntary.
2. **Shifting from in-person to virtual services.** In compliance with the city's requirements, in mid-March 2020, HRA asked all service providers to close their offices and for staff to shift to serving clients virtually from their homes. Service providers maintained a limited physical presence at their service locations in case clients visited in person seeking services or to drop off paperwork (such as wet signatures for SSI applications). When necessary, staff conducted home visits to homebound clients to get paperwork. For clients in the VRS track, service providers also

A hybrid event for employers and WeCARE clients organized by WeCARE provider ResCare

organized virtual workshops on topics such as job search, résumé development, and interviewing.

In January 2021, service providers reopened their service locations to WeCARE clients. Staff resumed working on-site on a rotational basis during normal business hours, though assessments were done virtually, and some services, such as VRS workshops, were still held mostly virtually.

3. **Ceasing referrals and assessments.** Following guidance from the state, HRA stopped referring potential clients to WeCARE in mid-March 2020. WeCARE staff ceased assessments for any potential clients who had already been referred, and did not enroll any new clients into the program. Some clients stopped engaging in program activities because engagement was no longer mandatory. This resulted in a decrease in the WeCARE active caseload over time from about 29,000 in the year before the onset of the pandemic to about 8,000 in the 10 months after the onset of the pandemic (Table 4.1). The caseloads in all tracks declined, but the decline was most pronounced in the VRS track and least pronounced in the Wellness track. Clients were most likely to disengage from the VRS track because the work requirements were no longer mandatory, and services temporarily ceased. Clients stayed in the Wellness track longer because of difficulties obtaining medical assessments to determine their status (as discussed later in this report).

Table 4.1. Engaged clients by track

WeCARE track	Mar 2019 to Feb 2020 # (%)	Mar to Dec 2020 # (%)	Jan to May 2021 # (%)
SSI	6,557 (22%)	1,558 (19%)	897 (34%)
VRS	6,691 (23%)	650 (8%)	26 (1%)
Wellness	15,915 (55%)	5,886 (73%)	1,718 (65%)
Total	**29,163**	**8,094**	**2,641**

Source: Administrative data provided by WeCARE.

Notes: Engaged clients are those actively participating in activities in their track. Staff did not begin referring any new clients to the VRS track until July 2021.

SSI = Supplemental Security Income; VRS = Vocational Rehabilitation Services.

Voluntary referrals to WeCARE began again in January 2021, but assessments occurred at a much lower rate—at a rate of about 1,200 per month, compared with nearly 3,200 per month before the pandemic (Table 4.2). WeCARE staff started scheduling assessments with the clients who had been referred before the pandemic and who were on a waitlist for assessment. They reported that many clients either declined the assessment or agreed to be assessed but then did not show up for appointments. Because high no-show rates were not an issue before the pandemic, staff speculated (and inferred from comments made by clients) that dropping the requirement to participate to receive cash assistance was a key reason for clients not wanting to engage.

Table 4.2. Assessments, all service providers

Number of clients who received initial assessment	Mar 2019 to Feb 2020	Mar to Dec 2020	Jan to May 2021
Total	38,146	0	6,028
Per month	3,179	0	1,206

Source: Administrative data provided by WeCARE.

Note: WeCARE stopped assessing new clients in March 2020 and restarted assessments in January 2021.

4. **Enhancing the case management approach.** WeCARE service providers also shifted to implementing an enhanced case management approach for all clients, including those who were referred to tracks at the pandemic's onset but were waiting for an intake appointment when intakes stopped. In mid-March 2020, service providers reached out to all clients to let them know services were voluntary and any scheduled appointments would be held virtually. When communicating the changes to WeCARE clients, provider staff observed that clients had a variety of questions and unmet needs related to the pandemic. In May 2020, WeCARE instructed service providers to reach out to individuals who were referred to WeCARE but had not had an intake appointment to engage them in weekly check-in calls to answer questions and refer them to services to help meet their needs. WeCARE provider staff then suggested extending these enhanced case management services to all clients.

   Enhanced case management consisted of at least weekly phone calls to all WeCARE clients. During these calls, staff asked clients about their general health and wellness and asked whether they wanted any referrals to resources, such as access to food, shelter, domestic violence resources, medical supports, or other needs. Each staff had a list of resources to pull from, which was not provided previously. By making these phone calls, service provider staff increased the frequency of contact to once or twice a week, a boost from the pre-pandemic frequency of about once every three weeks. They typically had to make several calls to get in touch with a client.

Characteristics of WeCARE clients during the pandemic

Administrative data from the WeCARE program suggest there was little change in the client population from the period before the pandemic to the first few months of 2021 when new clients started enrolling again. WeCARE staff interviewed for the study did not perceive a change in the composition of the clients they worked with. In this section, we look at how HRA data on assessments and client characteristics demonstrate changes in client distribution across tracks but not in client demographics.

Data on the outcomes of initial assessments show that the rate at which people were referred to tracks changed in the early months of 2021 compared with the year before the pandemic (Table 4.3). The proportion of clients deemed ineligible for WeCARE was higher in January to May 2021 than in the pre-pandemic period. Service providers deemed almost 50 percent of clients referred by HRA as ineligible during the later period, compared with less than 20 percent in the pre-pandemic period. Staff attributed this to a change in the HRA staff responsible for referring clients to WeCARE. Because of HRA staffing changes during the pandemic, new staff were deployed from elsewhere in the agency to conduct interviews for cash assistance application and recertification. These staff might have deemed more clients appropriate for WeCARE than would have typically been referred by more experienced staff.

Table 4.3. Assessment outcomes, all service providers

Assessment outcomes	Mar 2019 to Feb 2020	Jan to May 2021
Received initial assessment	38,146	6,028
Ineligible for WeCARE	6,807 (18%)	2,874 (48%)
Eligible for WeCARE	31,339 (82%)	3,154 (52%)
Referred to SSI track (of those eligible)	7,308 (23%)	1,087 (34%)

Assessment outcomes	Mar 2019 to Feb 2020	Jan to May 2021
Referred to VRS track (of those eligible)	6,835 (22%)	100 (3%)
Referred to Wellness track (of those eligible)	17,196 (55%)	1,967 (62%)

Source: Administrative data provided by WeCARE.

Notes: WeCARE stopped assessing new clients in mid-March 2020 and restarted assessments in January 2021.

SSI = Supplemental Security Income; VRS = Vocational Rehabilitation Services.

The data also show an increase in the proportion of SSI and Wellness track referrals (of those who were eligible for WeCARE) and a decrease in referrals to the VRS track. Of the clients assigned to tracks from January to May 2021, service providers placed the majority (more than 60 percent) in the Wellness track, about one-third in the SSI track, and only 3 percent in the VRS track. WeCARE continued to keep the VRS track limited because of a continuing lack of opportunities for work experience and low participation among clients. Staff explained that only clients who were already enrolled in some type of education or training program when they were assessed were referred to VRS before July 2021. This would explain the low number of clients referred to VRS.

Data on the characteristics of WeCARE clients before the pandemic and in the early months of 2021 suggest a small increase in the share of women enrolled in the program in the latter period, but few changes in other characteristics (Table 4.4). There was a 4 percent increase in the share of clients who are female, and a corresponding decrease in males.

Table 4.4. Characteristics of clients enrolled during time period

	Mar 2019 to Feb 2020 % by category	Jan to May 2021 % by category
Ethnicity		
Hispanic	37.4	37.8
Race		
White	31.8	29.1
Black/African American	62.4	60.3
Asian	10.9	10.7
Native Hawaiian/Other Pacific Islander	2.1	4.0
American Indian/Alaska Native	3.1	5.2
Multiracial	7.3	8.3
No response	0.0	2.6
Age (as of beginning of time period)		
16–24	8.1	5.3
25–34	24.6	23.4
35–44	26.0	28.7
45–54	27.4	28.7
55+	13.9	13.9
Gender		
Female	60.4	64.4
Male	39.6	35.6

	Mar 2019 to Feb 2020 % by category	Jan to May 2021 % by category
Primary language spoken		
Arabic	0.2	0.2
Bengali	0.6	0.3
Chinese Mandarin	0.1	0.0
English	91.9	93.8
French	0.0	0.0
Spanish	6.5	5.4
Other	0.7	0.4
Education level		
Associate's degree	3.7	2.4
Bachelor's degree	3.1	1.8
High school diploma or equivalent	50.2	51.8
Master's degree or higher	0.7	0.4
No high school diploma	42.2	43.5

Source: Administrative data provided by WeCARE; sample sizes vary by characteristics because of missing data but include all clients in the database during that period, whether active or not active.

Effects of the pandemic on services

Although the client population remained unchanged, the pandemic did introduce new challenges to operations within each of the three tracks in the WeCARE program.

SSI track. During the pandemic, service providers continued to work with clients to complete SSI applications but faced challenges. Service providers still had to submit SSI applications with a wet signature from clients, a SSI requirement not waived during the pandemic, which required them to conduct home visits to get the client's signature or go back and forth over mail, email, and phone several times to get all the signatures needed. Service provider staff said they observed delays in the processing of SSI applications because of delays in mail delivery and SSA office closures. Some service providers also reported challenges communicating with SSA about applications, which they attributed to SSA office closures.

VRS track. At the onset of the pandemic, service providers paused offering VRS services. In summer and fall 2020, they started offering virtual VRS and personal wellness training to all WeCARE clients in response to clients' interests and feedback. For clients who expressed interest in working, service provider staff helped them find and apply for jobs in individual virtual sessions. One staff respondent said: "[We] help[ed] them improve their skills and maybe investigate some things that they've always been interested in. I think that was powerful for us because [it] enabled us to really engage more people."

Staff reported maintaining engagement with employers throughout the pandemic. Even for those employers that were closed or not hiring, staff said they maintained contact so they knew when employers wanted to hire again and participate in recruitment events. Service providers also held virtual job fairs and open houses with employers. Staff received positive feedback on these events from those who attended, but they said many clients did not have the technology to access online trainings and events. Clients that did have access to technology also had to get trained on how to

use the technology to communicate with employers. According to one staff member, it was also challenging for staff to identify community service placements for clients as part of their VRS work experience activities because most community service organizations remained closed during the pandemic. Although community service placements were not available, staff did continue to place clients in jobs.

Wellness track. Service providers continued to follow up with clients already in the track at the beginning of the pandemic to have them provide information and attend physician appointments so staff could make determinations to assign those clients to the other tracks. Staff said they found it sometimes difficult to make determinations because of challenges working with physicians during the pandemic. At the beginning of the pandemic, physicians closed their offices or were overwhelmed with COVID-19 patients. Service providers found that physicians sometimes took new jobs or moved out of the city, which meant that service providers lost relationships with some of the physicians they typically worked with pre-pandemic. As a result, clients stayed in the Wellness track longer, on average, than they did pre-pandemic. Staff also said that finding new physicians that accepted Medicaid was challenging. As the pandemic continued, more widespread use of telehealth platforms did reportedly ease some of the challenges with finding physicians to see WeCARE clients.

Staff perspectives on services during the pandemic

Service provider staff experienced challenges and opportunities with delivering services remotely. Staff mentioned the following four challenges:

1. **Higher no-show rates for assessments.** When assessments restarted in January 2021, service providers found that clients missed appointments more frequently than they did before the pandemic, likely due to participation in services being voluntary. Given high no-show rates, staff said they spent more time tracking down clients and rescheduling appointments than they did pre-pandemic.
2. **Lengthier assessments.** Service provider staff noted that assessments took longer, on average, when offered virtually. Clients appeared to be more distracted over the telephone because of children in their vicinity or other distractions, which usually were not an issue pre-pandemic when clients came to a WeCARE office in person for their assessments.
3. **Limited ability to observe clients.** Not meeting with clients in person also affected how service provider staff could become familiar with clients' ability to work in some instances. Staff said they were accustomed to gathering information about clients as part of meeting them in person. For example, pre-pandemic, a client might have reported a mobility challenge, and staff could corroborate that in an assessment by seeing that the client had trouble walking. One staff respondent said, "I would say the biggest challenge doing this type of work telephonically [is that] you lose that human presence. I believe in having that person in front of you, looking at their body language, really understanding what might be going on with them based on those nonverbal cues. [We have] to be a little more creative, maybe ask more in-depth questions."
4. **Technological challenges.** Service provider staff experienced technological challenges doing their work and working with clients.
    a. Staff noted challenges in shifting nearly everyone to work from home—for example, in getting computers to staff members' homes and making sure they had reliable Internet and could connect to their service provider organization's private network. Staff respondents said

they also had to coordinate equipment delivery to the homes of older and less mobile staff; other staff got the equipment to their homes themselves.

b. Service providers blocked, or anonymized, staff members' personal phone numbers when they made calls to clients to give staff privacy, but staff found that clients would not pick up calls from blocked numbers. Also, some clients figured out a workaround to call back blocked numbers, and some staff expressed discomfort that clients could reach their personal cell phones. Some frontline staff respondents mentioned that they would have preferred to use smartphones issued by their employer, rather than using their personal phones, for work calls.

c. In addition, staff reported that many clients lacked Internet access, experienced intermittent connectivity issues, or had general difficulties using new technologies, which hindered their ability to access online services, such as VRS workshops, early in the pandemic. Staff reported that these issues were exacerbated when clients needed to share paperwork with them because most clients do not use email or do not respond reliably over email. Service provider staff reported that clients who have literacy challenges had to rely on family members or friends to help them complete WeCARE paperwork at home, whereas pre-pandemic, they would have had help from staff to complete such paperwork in person at a service location.

Staff also found that virtual and voluntary service delivery had some advantages.

1. **More positive dynamic between staff and client.** Some staff said that their rapport with clients improved during the pandemic, which they presumed was because clients knew that their public benefits could not be sanctioned or closed. Given that participation was not mandatory during the pandemic, those clients who did volunteer to participate could have been more motivated. One staff member also noted that the assessments are now more client-led than in the past because staff could no longer meet clients in person to judge clients' ability to work and instead had to rely on clients' own reports in the virtual setting. The staff member said, "The client-led piece has been a shift for us. It's not that we didn't believe the clients before, but [we will be] taking [clients' perspectives] into account a little bit more when we're making our determinations … in the future."
2. **More flexible workplace.** Staff also reported some positive aspects of working remotely. Many staff mentioned that attending and fully engaging in staff trainings has been easier in a virtual environment. Staff also said they found it easier to schedule times to talk to clients and other staff because they were interrupted less frequently than in the in-person environment (for example, by other staff stopping by to chat or ask a question).

Clients' perspectives on WeCARE services during the pandemic

Despite the challenges they faced, clients across all tracks described overall positive experiences interacting with virtual WeCARE services and with WeCARE staff during the pandemic.

Support from staff and other clients. Several clients emphasized the importance of being able to keep in touch with WeCARE staff throughout the pandemic. One client said, "There's always someone you can contact. If you can't get them on Zoom, you can call them, they're going to answer you right away. You can email, and they're going to answer you right away." Another said that staying in touch with her employment coach was helpful for her. Two clients expressed appreciation for the care and support of WeCARE staff whenever they needed help. For clients engaging in VRS services, Zoom workshops reportedly functioned like support groups. One client mentioned that

they "keep people on a positive note and…. You see what other people are going through and then you give each other advice." Another said that during the workshops, they talked with the group about what they were experiencing during the pandemic and discussed job-related advice.

Ease and challenges in accessing online workshops. Two VRS clients mentioned that the number of Zoom workshops offered throughout the day made it easier for them to participate when their schedules allowed. Other clients mentioned how online workshops and services helped alleviate transportation issues.

Although most clients appreciated online services, some clients noted initial and ongoing challenges with virtual services. Clients mentioned early problems with a lack of Internet access and difficulties using technology, although most clients noted that they solved those issues with the support of staff and other clients. Staff mentioned a city grant to help families access the internet for education purposes which they referred clients to. And although the increased flexibility of online workshops helped some parents access services on their own schedule, others said they did not have time to engage with workshops at all on top of child care responsibilities. In addition, one Spanish-speaking client expressed the desire for WeCARE to offer more virtual activities in Spanish.

5. Implications of the Pandemic for WeCARE Staff, Service Providers, and Performance

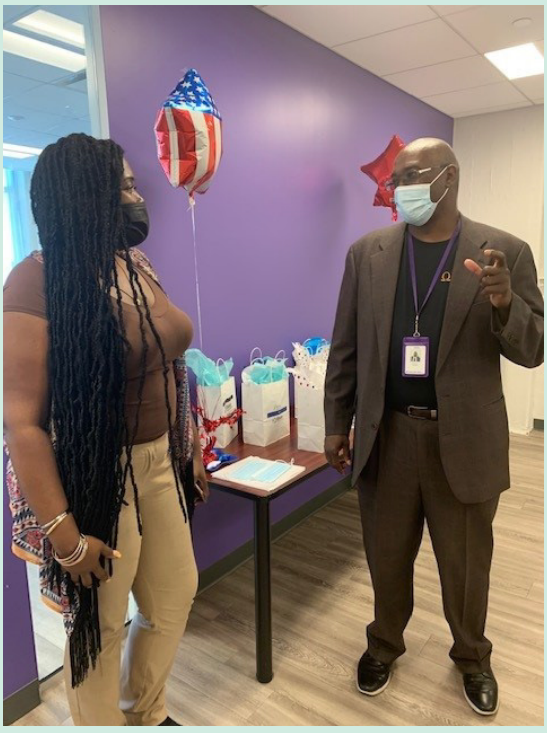
The pandemic and recession affected WeCARE service providers in many ways. Staff roles and responsibilities changed, especially for those staff whose function had temporarily ceased (such as assessment staff). To address these challenges, HRA and the service provider organizations offered new types of support for staff during the pandemic. HRA also suspended all paid performance targets during the pandemic while continuing to monitor performance across service tracks. Still, staff voiced concerns about their capacity to resume normal operations post-pandemic because of perceived hiring challenges for WeCARE staff and the impacts of the pandemic on their personal lives and well-being, including grieving the loss of loved ones to COVID-19 and mental health challenges. In this chapter, we discuss how the pandemic affected staff roles and performance accountability for service providers, and how providers and HRA supported staff through this time.

Changes in staff roles during the pandemic

At the beginning of the pandemic, HRA instituted a hiring freeze, which meant service providers could not fill positions when staff left. But no staff were furloughed or laid off by any of the service providers. As one staff member noted "We're really lucky we didn't have to go down that path as far as laying staff off. We had a hiring freeze, so many positions that were unfilled at that point or any staff that we lost throughout that time, we weren't allowed to refill those positions. But we didn't have one layoff, we didn't have one furlough."

HRA eased this freeze as the pandemic went on, but in the meantime, some staff took on new responsibilities or more than their usual share of responsibilities. For example, because HRA stopped making referrals for new clients, service providers no longer had new clinical assessments to conduct. Qualified health professionals that typically conducted these assessments shifted to making check-in calls as part of the enhanced case management approach. In addition, one organization subcontracted to a service provider had to reassign some WeCARE staff to other roles in the organization because it did not have enough work for those staff under WeCARE.

For those whose workloads decreased substantially, service provider leaders and staff took advantage of the time to focus on program improvement. For example, assessment staff at one service provider took steps to improve their processes by conducting quality reviews, in which they reviewed previous assessment results and discussed whether those results were accurate. Assessment staff at that service provider also developed a guidebook that recommends next steps



WeCARE staff employed by ResCare in conversation at an event hosted for employers and clients.

based on specific diagnoses clients might have. Staff also reported taking advantage of online trainings when no referrals or calls were assigned to them. "I do my online trainings that we have access to.... We have the LinkedIn learning, [and] we have ResCare Academy. We have different training sites that we can still engage to fill in the hours that we're scheduled to work so there is no real downtime."

Staff capacity challenges

After HRA eased the hiring freeze, service providers still found it difficult to fill open positions. One staff respondent speculated that, given the circumstances that people experienced during the pandemic, high quality job candidates wanted to work from home full time or had left the city and did not want to return. Staff also anticipated that client volume would be even higher after the pandemic and questioned whether there would be enough qualified staff to work with clients. One staff member reported that difficulty filling positions and high staff turnover were issues before the COVID-19 pandemic began and were exacerbated by the pandemic labor market.

Other staff noted challenges with finding qualified individuals for specific roles. For example, one staff member reported difficulties finding qualified staff to conduct clinical assessments. Staff respondents shared similar concerns about the certified rehabilitation counselors, who administer vocational assessments to clients entering the VRS track. Certified rehabilitation counselor positions are typically hard to fill, even pre-pandemic, because the position requires a master's degree and a certification from New York City. Staff noted that there might be a need to increase the number of certified rehabilitation counselor positions after the pandemic if the number of clients increases.

Some staff also struggled to meet their work responsibilities because of the impacts of the pandemic on their lives. Staff respondents said they and other staff faced personal challenges during the pandemic that sometimes affected their ability to work. For example, some staff we interviewed reported grieving losses that resulted from COVID-19, experiencing mental health challenges, and needing flexibility in their work schedules to care for their children at home. Some staff reported feeling anxious about returning to work in person and potentially contracting COVID-19.

Support for staff from HRA and service providers

Staff received additional support during the pandemic, including training, technical assistance, and more frequent check-ins from HRA leaders to help deliver services virtually. This support involved increasing standing meetings between HRA and service provider leaders from monthly or biweekly to weekly for most of the pandemic (meeting frequency scaled back down in April 2021). HRA staff also provided one-on-one technical assistance to service provider staff on its management information system and any technological challenges related to working virtually. To encourage and celebrate service providers, HRA started publishing and disseminating a newsletter during the pandemic in which it shared information and success stories.

Service provider staff also received support from their parent organizations, including access to training on use of technology and equipment, and regular communication and information sharing. Service provider leaders reported investing deeply in technology training for staff at the beginning of the pandemic to address some of the technological challenges they faced.

In addition to training on technology and equipment, service providers offered trainings to support mental health and wellness for staff; updates on guidance from the U.S. Centers for Disease Control

and Prevention; and guidance on how to keep clients engaged, improve customer service, and manage working from home while caring for children. Service providers also offered mental health counseling under Employee Assistance Programs and flexibility in work schedules for staff who needed to care for children at home. For employees whose families experienced financial hardship during the pandemic, one parent organization offered an employee emergency fund.

Service providers also devised new procedures to monitor the performance of staff working off-site. For example, service providers required that staff check in by a certain time each morning to certify that they were online and working and required them to log their activities each day. Service provider leaders also checked in daily to address and troubleshoot any technical issues that staff had. Service provider leaders noted that with staff working from home, fewer staff called out sick than before the pandemic.

Adjustments to performance accountability for service providers

Before the COVID-19 pandemic, HRA required WeCARE service providers to report on their progress toward meeting specific performance outcomes as part of their pay-for-performance contracts, as Chapter II describes. During the pandemic, because services were not mandatory, the service providers still reported on these outcomes, but HRA did not hold them to meeting most of their existing targets and paid them as if they met the targets. For example, providers had an outcome related to how many VRS clients enrolled in and completed education and training. The service providers still reported this data during the pandemic, but many of the education providers in the city had shut down, so HRA did not hold service providers to meeting the usual target for this outcome. Another staff member said it was difficult to interpret the outcomes during the pandemic: "You can't compare outcomes when services are voluntary to outcomes when services were mandatory.... If you tell somebody they don't have to do anything, it's much harder to get them to do it."

HRA still required service providers to complete Wellness plans within the 90-day time frame for any clients already in the Wellness track when the pandemic began. HRA also required service providers to complete SSI applications for any clients already in the SSI track.

Although HRA made participation in services voluntary for clients and thus loosened most of its expectations related to performance targets, staff respondents said HRA still expected them to offer all WeCARE services and maintain a high level of service quality during the pandemic. HRA asked service providers to report on two things in particular:

- **Service provision.** Providers were asked to report weekly on outcomes for clients in service tracks, including the number of enrollments in online workshops in VRS and the number of Wellness calls made and clients reached, as well as determinations for Wellness clients. For the Wellness calls, service providers were expected to call and reach a certain number of clients each week.
- **The effects of COVID-19 on clients.** Providers were required to report each week how many clients said they had tested positive for COVID-19 and any COVID-19-related client deaths that staff learned about. In addition, staff reported how many clients experienced job loss and other employment changes as a result of the pandemic and recession. HRA also asked service providers to report qualitative information on client needs that they heard about during the enhanced case management calls, as well as ideas for meeting those needs. For example, one staff respondent said that many of their WeCARE clients needed help obtaining Internet access

for their children to attend online school. Staff at that service provider told those clients about a city grant to help families access the Internet for education purposes and reported to HRA how many clients it informed about the grant as well as how many applied and got the grant.

Performance of WeCARE providers during the pandemic

Although HRA did not hold service providers to most of their usual performance targets, HRA and service providers reported that providers demonstrated an impressive level of performance during the pandemic. Staff reported being pleased with their performance on outcomes such as the number of job placements for clients and the number of resources shared with clients, considering the immense employment and personal challenges faced by clients and staff during the pandemic and recession.

Although one of the research questions for this study asked how the pandemic affected outcomes for WeCARE clients, it is difficult to compare the pre-pandemic period with the 15 months that followed because client participation dropped significantly, and no new clients were enrolled for a significant period of time. The clients who engaged in the program when services were mandatory are likely different than the subset of clients who engaged when services were no longer mandatory.

6. Lessons Learned

WeCARE's experience adjusting to a new normal in assessing and providing care for its clients offers useful lessons on maintaining continuity in services during turbulent times, and lessons for new methods of engaging with clients.

Providing services virtually is feasible and has some benefits, but it also has risks

The ways staff adjusted during the COVID-19 pandemic demonstrated that it is possible to offer both remote and in-person services. Although staff reported challenges working and serving clients remotely, and although participants reported challenges receiving remote services, providing services remotely had some advantages. Staff and clients appreciated the added flexibility for clients to attend virtual workshops based on their availability, and the option to conduct virtual sessions on a voluntary basis with clients interested in receiving one-on-one training with their job search. Staff and clients also appreciated the increased accessibility for clients in attending appointments by phone when they were unable to reach a WeCARE office.

Staff reported that they expected there to be a new normal post-pandemic in which clients regularly engage remotely. As one staff member mentioned, "We are far away from things going back to pre-pandemic days when there were a gazillion employees and participants all over. The future of WeCARE will likely be a hybrid model." Staff envisioned a hybrid model in which clients receive remote or in-person services based on their needs, and staff are flexible in their approach to delivering those services. Staff reported that they sensed that many people have become accustomed to doing things virtually and will not be "rushing through the doors" when services are mandatory again. According to staff, some clients might even prefer to engage remotely; a few WeCARE clients have had challenges getting to a physical WeCARE center in person.

Offering multiple options for accessing services could enable clients to choose the engagement method that best suits their circumstances. Before the pandemic, WeCARE already provided some form of client flexibility; the Wellness unit offered clients phone appointments and case manager home visits for people who were homebound or might have had medical issues that prevented them from traveling to a WeCARE location. During the pandemic, WeCARE evaluated which services could be offered virtually and provided many workaround solutions to customize services based on individual needs and preferences. For example, staff reported many clients lost loved ones during the pandemic, and they and others are still nervous about the risks of going to WeCARE locations in person. Offering virtual clinical assessments on a Zoom call or over the phone is one way that WeCARE responded to clients' needs.

A notable challenge that emerged from staff and client experiences is that not all clients can access technology. Staff reported that many WeCARE clients have difficulty interpreting paperwork over the phone or submitting paperwork electronically, and many have trouble accessing devices to engage in virtual services that might require special software. While most staff reported using phones to engage in virtual services, staff noted difficulty with clients who did not have smart phones or had limited minutes in their phone's calling plan. Any shift to virtual or remote services will have to consider the variation across WeCARE clients in their access to and literacy with technology.

Staff also reported that another challenge with working with clients remotely is that it affects their ability to fully understand client situations. Meeting with clients in-person can offer visual cues that are hard to gather in a remote meeting.

The lack of mandatory participation requirements revealed the importance of client-centric services

Staff noted they had difficulty getting clients to engage because it was not mandatory for them to participate. However, those who did participate appreciated the support they received and found the more individualized attention helpful. Staff found many clients to be especially appreciative of efforts to check in on their well-being during the pandemic, which underscored the importance of staff efforts to offer client-centric services. Most of the staff interviewed felt their experiences during the pandemic reminded them of the importance of connecting clients to a range of services and resources, and the need to adapt to clients' changing needs. Staff reported referring clients more often to mental health services and organizations to help address their substance abuse issues, compared to before the pandemic. They recognized that when program operation returns to normal, they will likely see more clients who have developed mental health issues such as anxiety and depression, and clients who are at risk of homelessness.

Staff also found it helpful to have time to provide more individualized support to clients. Because individual staff caseloads were lower during the pandemic, and communication with clients was largely virtual, staff were often able to work with clients one-on-one in more depth than was possible before the pandemic. In particular, VRS staff were able to provide more online, individualized support to some clients to help them explore potential careers or to aid them in their job search, and this might not have been possible had caseloads been larger and the focus been more on in-person group workshops. This lesson may be difficult to apply for WeCARE in the near future, as a return to mandatory services and staff hiring challenges will likely mean larger caseloads.

Supporting staff is as important as supporting clients

Staff and clients highlighted the important role that case managers and other frontline staff play in any program. Clients felt that staff showing concern for them and being accessible when needed helped them stay motivated in a challenging and stressful time. Staff reported that clients appreciated having someone to talk to during lockdown at the height of the COVID-19 pandemic.

Staff also needed their own support system in order to be available to clients. The COVID-19 pandemic created challenges in the personal lives of staff, and these challenges directly affected their ability to work, especially for staff who were parents or caregivers. HRA and service provider leaders recognized the importance of supporting staff morale and technical capacity in order for the program to sustain itself through the pandemic. Leaders provided more frequent check-ins and trainings, and reassigned staff to other roles rather than letting them go when the needs of the program changed. One staff member mentioned that there were calls with different groups of staff during lunchtime to check in and keep staff supported and engaged. Staff reported that this created a sense of camaraderie and highlighted the importance of being more connected and tuned in to employee needs moving forward.

The camaraderie and culture of staff support might have also encouraged more collaboration among staff within and across service providers. Staff at one service provider mentioned their organization creating a "fresh ideas" email address for staff to email ideas about improving day-to-

day operations. Staff also described opportunities to collaborate more with staff at other service providers during the pandemic and felt that their shared challenges made them more open to learning how other service providers operated their programs.

The WeCARE program in the long term

The lessons learned from this phase of the study will provide a useful starting point to understand how WeCARE might be evolving from what it looked like before the pandemic. The experiences of staff and participants suggest that there may be longer-term changes, but it is unclear how they will manifest since services are not expected to be mandatory for clients before early 2023 and participation is relatively low. When HRA makes participation in WeCARE services mandatory for clients again, there may be changes in the composition of WeCARE clients, as well as changes in how WeCARE adapts the delivery of program services based on what they learned from the first years of the pandemic. There may also be changes to the trends in performance outcomes in the longer term for WeCARE service providers, which could be affected by larger trends in the labor market.

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Appendix A. Data Sources and Research Methodology

Data sources

Several sources of data informed the report:

Interviews and focus groups with HRA and WeCARE provider staff. The study used a purposive sampling strategy to select respondents for interviews and focus groups based on the roles of staff members in delivering the WeCARE program. The research team selected the sample of staff after reviewing organization charts for each of WeCARE's three providers (across four contracts) and confirming roles and responsibilities with WeCARE administrators. The goal of the selection was to identify staff who interacted with clients during intake or when the clients participated in each of the three service tracks in the program, and managers who supervised staff in the tracks and oversaw the assessment process and WeCARE as a whole. Of the 35 managers and staff selected for interviews, 29 participated in interviews and focus groups (Table A.1) between April and June 2021. Interviews and focus groups used a semi-structured discussion guide, were held over the phone, and lasted one hour, on average. The interviews were audio recorded and transcribed for analysis.

Table A.1. Number of staff respondents by provider and position

Provider	Number of respondents
ResCare (Manhattan, Staten Island, and Brooklyn)	
Manager	5
Frontline staff	7
Queens Maximus	
Manager	2
Frontline staff	3
UBA Bronx	
Manager	6
Frontline staff	4
HRA	
Manager	2
Total	
Manager	15
Frontline staff	14

HRA = Human Resources Administration; UBA = University Behavioral Associates.

Interviews with WeCARE participants. The study used a combination of purposive and voluntary response sampling to identify participants for one-on-one, in-depth interviews. Program staff from each of the providers were asked to identify 10 participants who were in the program both before and after March 2020 (the beginning of the COVID-19 pandemic in New York City) and to include participants across a mix of ages, genders, and service tracks (Table A.2). The research team contacted each of those participants directly to obtain their interest and availability to participate in a study interview. In addition, the research team asked program staff from each of the providers to refer participants who staff had informed of the study and who had expressed interest in participating. The team interviewed 10 consenting program participants between May and August 2021, maintaining a mix of participants across tracks and providers in the sample. The interviews were conducted over the phone in English or Spanish and were recorded and transcribed. The interviews lasted up to two hours each, and interviewees received a $60 incentive in the form of an electronic or physical gift card after the interview.

Administrative program data. WeCARE provided aggregate program data for WeCARE participants served across three time periods: (1) in the year preceding the pandemic (March 2019 to February 2020), (2) the first 10 months of the pandemic when WeCARE did not assess new clients (March 2020 to December 2020), and (3) the months since WeCARE began assessing new clients

(January to May 2021). The data includes background characteristics, assessment determinations, participation and services, and outcomes. This is data collected by WeCARE providers for performance reporting purposes and not for the study. WeCARE was able to provide administrative data on outcomes for most clients during the first year of the pandemic, but the sample size for the pandemic period is much smaller than the sample size before the pandemic, primarily because services became voluntary.

The interviews and focus groups conducted for this study were approved by the Office of Management and Budget (OMB), under the collection called "OPRE Data Collection for the Next Generation of Enhanced Employment Strategies Project (New Collection)", OMB #0970-0545.

Methodology

The study used descriptive methods to explore the research questions, using a thematic analysis approach (Braun and Clarke 2012) to analyze qualitative and quantitative data sources. The study team analyzed the qualitative data using a thematic framework and multiple levels of coding: (1) a first-level sorting of the data by relevant research questions and topics, and (2) a second-level coding based on themes that emerged from the data. The analysis of quantitative data supplemented the discussion of themes in the qualitative data. The research team used descriptive statistics to describe the trends in participant characteristics, services received, and program outcomes. The team used these statistics to present the pre-pandemic caseload and changes in the caseload over time.

After the second-level coding of the qualitative data, we combined the analysis of qualitative data with the analysis of quantitative data to produce the report. This involved refining the themes that emerged to capture a meaningful story that answers the research questions and reflects findings from the qualitative and quantitative data.

Table A.2. Characteristics of WeCARE participant interview respondents

Characteristics	Number of respondents
Gender	
Male	4
Female	6
Age[a]	
25–34	1
35–44	2
45–54	5
Language	
English	8
Spanish	2
Track	
SSI	3
VRS	2
Wellness	5
Provider	
Maximus	3
ResCare	5
UBA	2

a Age for two respondents was not available.

SSI = Supplemental Security Income; UBA = University Behavioral Associates; VRS = Vocational Rehabilitation Services.

To learn more, please visit

https://www.acf.hhs.gov/opre/project/next-generation-enhanced-employment-strategies-project-2018-2023

Questions? NextGenProject@mathematica-mpr.com