Improving Employment Outcomes: Collaboration Across the Disability and Workforce Development Systems ▦

A State of the Science Conference ▦

October 31, 2002 & November 1, 2002

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Jurys Washington Hotel
1500 New Hampshire Avenue NW
Washington, D.C.

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Center on State Systems and Employment
A Rehabilitation Research and Training Center
Institute for Community Inclusion
University of Massachusetts Boston

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In collaboration with
National Center on Workforce and Disability/Adult

&

Council of State Administrators of Vocational Rehabilitation

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Acknowledgements

Foreword

Steven James Tingus, M.S., C.Phil.
Director
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Employment remains a central path for both achieving economic self-sufficiency as well as becoming a full and contributing member of society. For many individuals with disabilities the goal of achieving meaningful employment has been elusive. Barriers based on issues of access and technology, perception and expectation, health care and transportation have all contributed to the low levels of labor force participation by individuals with disabilities. Other barriers reflect the complexity of the employment and training system that has been developed over the years. Additionally, some research suggests that fragmented and poorly integrated structures serve as barriers to labor force participation. As we seek to fully implement President George W. Bush's *New Freedom Initiative*, we must consider how we structure our resources such that self-determination, consumer direction and person-centered planning can play a role in ensuring that individual preferences and high quality employment options are a reality for all citizens with disabilities.

The National Summit on Improving Employment Outcomes: Collaboration Across the Disability and Workforce Development System, offers a picture of the current employment and training structures that exist at the state and federal levels, and a vision of an integrated system that provides universal access across any entrance point. The RRTC on State Systems and Employment Outcomes through its research efforts provides state agency administrators and policymakers with a picture of how states are structured and information on emerging practices at the state and local levels. The increasing role of state and local service systems suggests the need to identify and enhance our understanding about federal and state level policies that help to improve employment rates for individuals with disabilities. Research can assist with identifying, evaluating, documenting, and disseminating information about innovations and the most effective practices at the local level. Information dissemination can contribute to efforts to develop and strengthen the role of specialized and generic employment and training systems in serving job seekers who have a disability.

The National Institute on Disability and Rehabilitation Research (NIDRR) supports research activities that inform the development of policies and practices, identify effective strategies that improve employment outcomes, and improves understanding of employment concerns for individuals with disabilities and employers. The mandates of NIDRR are significant and require a rigorous examination of research activities, evaluation of application of research findings, documentation of outcomes and impacts, and the translation of research to practice. Our ongoing effort to illustrate the impact of policy and practices in the state system, including those activities that support employment and training, are presented in the following document. The RRTC on State Systems and Employment Outcomes has identified initial

promising practices as we begin to examine the process of developing a system of services and supports that is comprehensive, coordinated, seamless and universal in its application. The activities of NIDRR will continue to stress the initiation of research that will facilitate both practice and policy formulation addressing employment for individuals with disabilities.

The New Freedom Initiative and the recognition of the role that individuals with disabilities can play in the current economy as contributing members are critical elements in the goals of NIDRR's Long-Range Plan. Our goal of removing barriers, documenting effective practices, disseminating information about these practices and increasing the number of individuals with disabilities in the workforce remains central to the activities of NIDRR now and in the future. State systems are a critical component in the support of individuals with disabilities in entering and remaining in employment. The findings of this summit offer us a place to start as states begin to restructure to address changing values, priorities and practices in serving and supporting individuals with disabilities in employment and other major life areas.

Introduction

William E. Kiernan
Director, Institute for Community Inclusion
University of Massachusetts Boston

The National Summit on Improving Employment Outcomes: Collaboration Across the Disability and Workforce Development Systems is in many ways a reflection of the times. The increased emphasis upon full access to the general curriculum in schools for all students, community inclusion in adult life for individuals with disabilities, and the increased emphasis on self-determination and consumer direction of services and supports, from both a values and a legislative perspective call philosophically for the blending of our many resources into a more comprehensive, coherent, and effective system of services for individuals with disabilities. The research is clear: When individuals with disabilities are included, have a greater say in services and supports, and are perceived as able to be involved, their outcomes will more closely approximate those of individuals without disabilities.

It is no longer unusual to hear stories of the active participation of individuals with disabilities in the development and management of their services, of greater community involvement, or of success in the workplace. The actualization of these beliefs and values for all individuals with disabilities has stressed our complex system of supports and stimulated conversations about mergers, memoranda of understanding, sharing of resources, and development of a seamless method of supporting individuals with disabilities in accessing all levels of community participation. The mission of the Rehabilitation Research and Training Center on State Systems and Employment is to improve the employment outcomes of people with disabilities through the promotion of responsive, effective, and efficient state service delivery systems. It is clear that a comprehensive response to the goal that individuals with disabilities have the same level of labor force participation as the general population requires a comprehensive and integrated approach that involves all stakeholders in state workforce development and disability service systems. This national summit provided an opportunity to merge findings from researchers and practitioners that frame a response to this challenge.

Numerous legislative and judicial mandates are calling for a more integrated service system. The intent of the Workforce Investment Act is clear: our system must be universally accessible, seamless and effective. The principles of "one-stop shopping" are present throughout this legislation and reflect the need for clear methods for bringing together the silos of employment services into a supermarket of resources. The Ticket to Work legislation seeks to develop a system where the consumer has greater say in the allocation of resources, fewer barriers to considering employment, and mechanisms for accessing ongoing supports while working (at least for a limited period of time). The Rehabilitation Act has for more than a decade placed an emphasis upon the consumers being "presumed to benefit" from services leading to employment rather than

the need for individuals to "make the case" for employment-related services. Finally, the issuance of the Olmstead decision has clearly placed the emphasis of supports for individuals with disabilities in inclusive and not segregated settings. These initiatives all stress a change in perception from one of "not able" to "able," in setting from separate to typical, in direction from no work to real work and ongoing supports, and in control from the system to the individual. The goals of this summit reflected the critical issues that the heretofore mutually exclusive and singularly focused array of agencies constituting our current service system must not only embrace but also operationalize: collaboration, quality, access, and information sharing.

The current economic downturn, with unemployment rates averaging from 5.5 to 6% nationally, while reflecting a change in the economy, must not be interpreted to mean that there are no sectors of the employment market or the country where employment is growing. The anticipated exit from the labor force of more than 80 million baby boomers in the next five to ten years will have an impact on many employers. The advances in technology and the recognition of universal design as a way of supporting all employees, including those having a disability, are trends that clearly indicate that the opportunities for employment for individuals with disabilities can and should improve.

Our challenge is one of reducing the complexity of the current system, increasing the quality of the outcomes realized for individual job seekers who have disabilities, and developing a support structure that reinforces remaining engaged in employment through the use of more effective job matching, on-the-job supports, job accommodations, assistive technology, and natural supports in the workplace. This summit offers a view of the current system and its level of interaction from a variety of perspectives, presents promising strategies for increasing collaboration and coordination, and offers some hope for the future for a more seamless, comprehensive, and effective employment and training service for all job seekers, those having a disability as well as those without a disability.

The values and philosophy as well as the mandates are clear. There must be a concerted effort to develop systems that work together, share a common purpose, and interact in the delivery and documentation of outcomes for individuals with disabilities. As federal policies continue to emphasize personal responsibility, increased economic independence, and greater local control, the need for identifying ways to support a comprehensive and coordinated service delivery system that reflects a strong focus on employment is essential. Given the facts regarding our changing demographics, the shifts in the economic engine to a knowledge base, and the recognition that efficiencies are key to the allocation of limited public resources, it is absolutely essential that we develop a system of employment and training such that "no worker be left behind." This mandate is good for the economy as well as the individual. The pathways to reaching this goal necessitate innovations in collaboration, coordination, and resource sharing, and the evolution of our complex system of employment and training such that all job seekers,

those with and without disabilities, are offered a chance to realize their goals of self-determination and economic independence.

Improving Employment Outcomes:
Collaboration Across the Disability and Workforce Development Systems

Purpose

This national forum will address strategies for improving employment outcomes for people with disabilities through effective collaboration across the state disability service systems and state workforce development systems. The conference will center on implementation of the values articulated in the Workforce Investment Act: strategies for facilitating universal access, streamlining of services through interagency collaboration and coordination, performance accountability, and state and local innovations. The overriding goal is to provide concrete and specific guidance about state experiences and emerging practices that have promise to improve employment outcomes for individuals with disabilities through holistic and coordinated service delivery across all components of a state's service delivery systems.

Goals and Objectives

This State of the Science conference will bring together state and national leaders in employment and disability policy, workforce development, disability advocacy, and service delivery. The goals are to:

- Describe promising models for collaboration across both disability and generic service systems that represent comprehensive initiatives to support access to competitive employment.

- Describe state approaches to defining and communicating quality standards and effective approaches to managing performance accountability for employment supports.

- Identify innovations and local variation in welcoming and supporting universal access for customers with disabilities in generic services, including the One-Stop system.

- Identify the impact of universal access initiatives across the full range of customers.

- Disseminate findings through the ICI website, training and outreach activities of the Center for State Systems and Employment, and the National Center on Workforce and Disability. A formal proceedings of the conference, including invited papers, respondent comments, and discussion highlights, will be developed.

Design of the Conference

The conference will use a structure of brief (10 to 20 minute) invited presentations, followed by one to two respondents and general discussion. Each session will end with a summary of action items that relate to research, policy, and practice. Proceedings of the conference will be published, including final versions of the draft papers and a summary of participant comments.

Agenda

Day 1: Effective partnerships and quality outcomes

	Topic	Presenters	Respondents
9:00-9:10	**Welcome**	William Kiernan Institute for Community Inclusion	
9:10-9:40	**Keynote** A changing framework for disability policy: Implications for partnerships at the state and local level	Robert Silverstein Center for the Study and Advancement of Disability Policy	
9:40-10:00	Federal perspectives on employment research, policy, and practice	Steven J. Tingus Director National Institute on Disability and Rehabilitation Research W. Roy Grizzard Assistant Secretary Office of Disability and Employment Policy Department of Labor	
10:15-11:30	**Session 1** Patterns of collaboration in state service systems	Susan Foley Institute for Community Inclusion	John Halliday Connecticut Bureau of Rehabilitation Services
11:45-1:00	**Session 2** Restructuring for partnership between disability and generic service systems (a) Partnership to improve employment outcomes for individuals with mental illness: Collaboration with VR and TANF	Virginia Selleck Adult Mental Health Division Minnesota Department of Human Services Joe Marrone Institute for Community Inclusion	Elizabeth Edgar National Alliance for the Mentally Ill
2:00-3:15	**Session 3** Restructuring for partnership between disability and generic service systems (b) Partnership between VR and workforce development	Sheila Fesko Institute for Community Inclusion Wade Bailey Kentucky Department of Vocational Rehabilitation	Burt Danovitz Resource Center for Independent Living
3:30-4:45	**Session 4** Increasing the participation and quality of employment outcomes of people with disabilities in workforce development services • How can/should states assess outcomes on a global level?	John Butterworth Institute for Community Inclusion Millie Ryan Alaska Governor's Council on Disabilities Catherine Chambless Utah Department of Health	Michael Morris Law, Health Policy and Disability Center University of Iowa
4:45-5:00	**Closing Comments**	John Butterworth Institute for Community Inclusion Carl Suter Council of State Administrators of Vocational Rehabilitation	

Day 2: Promoting universal access and strategies for promoting change

	Topic	Presenters	Respondents
8:30-8:50	Federal perspectives on employment research, policy, and practice	Patricia Morrissey Commissioner Administration on Developmental Disabilities Joanne Wilson Commissioner Rehabilitation Services Administration	
8:50-9:45	**Session 5** Managing funding and resources in a streamlined service delivery system	William Kiernan Institute for Community Inclusion Elizabeth Lopez Oregon Department of Human Services	Cathy Carlson Rehabilitation Services Minnesota Department of Economic Security Michael Cheek National Association of State Medicaid Directors
10:00-11:15	**Session 6** Defining quality: Individual perspectives on quality employment supports	Doris Hamner Institute for Community Inclusion	Evelyn Milorin Haitian American Public Health Initiatives John Burt The Disability Network
11:30-12:45	**Session 7** Integrating work incentives policy across the workforce development system including benefits planning and health care initiatives (Beyond the Ticket)	John Reiser Wisconsin Pathways to Independence Wisconsin Department of Health and Family Services	Melissa Wittman National Consortium for Health Systems Development
12:45-1:00	**Closing remarks**	William Kiernan Institute for Community Inclusion	

Keynote

Using the Emerging Disability Policy Framework to Create a Fully Inclusive Twenty-First Century Workforce Investment System

Robert Silverstein
Center for the Study and Advancement of Disability Policy

On August 7, 1998, President Clinton signed into law the Workforce Investment Act of 1998 (Public Law 105-220). Title I of WIA provides assistance to states interested in establishing statewide and local workforce investment systems. Title IV of WIA sets out a complete rewrite of the Rehabilitation Act of 1973, including the State Vocational Rehabilitation program (State VR program). On August 11, 2000, the Secretary of Labor published in the Federal Register (FR) final regulations implementing Title I of WIA. On November 12, 1999, the Secretary of Labor published interim final regulations implementing Section 188 of WIA pertaining to nondiscrimination and equal opportunity. On January 17, 2001, the Secretary of Education published final regulations implementing the State VR program.

The overall goal of Title I of WIA is to increase employment, retention, and earnings of persons (including persons with disabilities) participating in employment-related activities supported by an integrated workforce investment system. The establishment of a One-Stop service delivery system is the cornerstone of the legislation. The One-Stop service delivery system must be "seamless," i.e., a "one right door and no wrong door approach." [64 FR 18669 (April 15, 1999)] In addition, the One-Stop service delivery system must be designed to address the needs of all individuals, including individuals with disabilities.

In other words, the One-Stop service delivery system must be fully inclusive, incorporating universal design features. Policymakers and other stakeholders at the federal, state, and local levels involved in the design and implementation of a fully inclusive workforce investment system can benefit from an examination of the emerging disability policy framework.[*] The precept, goals, policies, and methods of administration adopted over time for ensuring effective and meaningful opportunity for persons with disabilities to participate in programs, projects, and activities are not limited in their applicability to persons with disabilities; rather, they reflect universal principles that can be the basis for the adoption of a fully inclusive One-Stop service delivery system for all persons eligible to receive assistance.

The purpose of this policy paper is to present the lessons learned (in narrative outline form) from the emerging disability policy framework so that policymakers and others at the federal,

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[*]*Emerging Disability Policy Framework: A Guidepost for Analyzing Public Policy*, Iowa Law Review (August 2000, Volume 85, No. 5). Available at
http://www.communityinclusion.org/publications/policydocs and
http://www.its.uiowa.edu/law.

state, and local levels can design, implement, and evaluate a fully inclusive One-Stop service delivery system. The paper has six sections.

- The Emerging Disability Policy Framework
- The Old and New Paradigm of Disability Policy
- The Goals of Disability Policy
- The Core Policies
- The Methods of Administration Supporting a Fully Inclusive Workforce Investment System
- The Translation from Policy to Practice: Some Next Steps

I. The Emerging Disability Policy Framework

How do policymakers and professionals view and treat people with disabilities?

Over the past two-and-a-half decades, Congress has made a concerted effort to articulate in legislation the precepts, goals, and major policies governing the treatment of people with disabilities (the emerging disability policy framework). In general, this framework can be used as a lens, guidepost, or benchmark to assess social policy from a disability policy perspective. This framework can also be used to design and implement a workforce investment system for all beneficiaries that is fully inclusive and incorporates universal design features.

II. The Old and New Paradigm of Disability Policy.

A. The Old Paradigm

Historically, policymakers and professionals treated people with disabilities as "defective" and in need of "fixing." If a professional couldn't "fix" a person with a disability, policymakers often supported exclusion, segregation, and denial of services and supports. Sometimes the exclusion or isolation was based on malevolent treatment resulting in the exclusion from public education because an individual was "defective" and "produced a nauseating effect" on others. Sometimes exclusion was based on assertions by professionals that persons with disabilities were incapable of working and therefore incapable of benefiting from job training programs, including vocational rehabilitation programs.

Sometimes generic programs used blanket exclusions or automatic referrals to other programs targeted at "the disabled." Sometimes segregation and exclusion were benevolent—persons with disabilities were automatically placed in "sheltered workshops" because of the false assumption that all persons with significant disabilities required segregated placements in "safe and supportive" environments.

Supreme Court Justice Thurgood Marshall characterized our nation's treatment of persons with developmental disabilities as "grotesque."

B. The New Paradigm (Precept of Disability Policy)

The new paradigm of disability policy fundamentally rejects the old paradigm. The new paradigm is based on the precept that diversity is a reality and is good—disability, like race and gender, is a natural and normal part of the human experience that in no way diminishes a person's right to fully participate in all aspects of society. When a system is designed to be accessible by all, "all" truly means "all." The focus of the new paradigm is on fixing the physical and social environment to provide effective and meaningful opportunity for all (not just the average person).

III. The Goals of Disability Policy

- Equality of Opportunity
- Full Participation
- Community/Independent Living
- Economic Self-Sufficiency

IV. The Core Policies

A. Equality of Opportunity

- **Individualization**—Make decisions affecting an individual based on facts, objective evidence, state-of-the-art science, and a person's needs and preferences, not administrative convenience and generalizations, stereotypes, fear, and ignorance.

- **Effective and Meaningful Opportunity**—Focus on meeting the needs of all persons who qualify for services and supports, not just the "average" person, by providing reasonable accommodations and reasonable modifications to policies, practices, and procedures.

- **Inclusion and Integration**—Administer programs in the most integrated setting appropriate for the individual (i.e., the presumption is that a person who qualifies for a public program must receive services in an inclusive setting with necessary support services, and the burden of proof is on the government agency to demonstrate why inclusion is not appropriate to meet the unique needs of the individual), and administer programs to avoid unnecessary and unjustified isolation and segregation (i.e., do not make a person give up his/her right to interact with nondisabled persons in order to receive the services and supports).

B. Full Participation

- Provide for active and meaningful involvement of persons with disabilities and their families in decisions affecting them specifically as well as in the development of policies of general applicability, i.e., at the systems/institutional level. ("Nothing about us without us.")

- This means that policies, practices, and procedures must provide for real, informed choice; self-determination and empowerment; self-advocacy; and person-centered planning and budgeting.

C. Community/Independent Living

- Recognize community/independent living as a legitimate outcome of public policy.

- Provide for community/independent living skills development.

- Provide necessary long-term services and supports such as assistive technology devices and services and personal assistance services and supports.

- Provide cash assistance.

D. Economic Self-Sufficiency

- Recognize economic self-sufficiency as a legitimate outcome of public policy.

- Support systems providing employment-related services and supports.

- Provide cash assistance with work incentives.

V. The Methods of Administration Supporting a Fully Inclusive Workforce Investment System

A. In General

- Public agencies must adopt criteria and methods of administration that facilitate and do not impede accomplishment of the precept, goals, and policies of the government agency's program, consistent with the lessons learned from the emerging disability policy framework.

- Public agencies must establish an infrastructure (that includes elements supporting systems change) that facilitates and does not impede accomplishment of the precept, goals, and policies of the public agency's program, consistent with the lessons learned from the emerging disability policy framework.

B. State and Local Plans, in General

In developing a fully inclusive, comprehensive, person-centered workforce investment system based on universal design features, stakeholders must:

- Review historical context, including the extent to which programs were established based on old paradigms.
- Conduct a needs assessment, including
    - The multiplicity of needs of individuals related to employment, including job training and vocational rehabilitation, health care, personal assistance services and assistive technology, income supports, education, housing, and transportation.
    - The extent to which implementation of current programs is based on the old paradigm.
    - An inventory of existing programs, services, and supports.
    - The prevalence of the population in need and their preferences.
    - The services and supports to address the needs of eligible individuals.
- Articulate the components of a strategic plan, including:
    - The goals (one system with distinct programs that are integral components of the system)
    - The measurable objectives

- The specific action steps (including specific timetables and responsible individuals or agencies)
- The processes for continuous quality performance and improvement, and
- The budgets.
❑ Provide for meaningful, ongoing involvement of stakeholders in the design, implementation, and evaluation of the program.

C. Program Design Elements

Include person-centered planning and budgeting and consumer-controlled, community-based services and supports.

D. Counseling, Including Benefits Counseling

Take steps to provide counseling, including benefits counseling, that focuses on maximizing choice, independent living, and economic self-sufficiency consistent with the interests, preferences, and capabilities of the individual.

E. Outcome Performance Measures

Include outcome performance measures that reflect high expectations and that facilitate and do not impede serving persons with the most significant needs.

F. Financing Systems

Ensure that the system for financing services and supports facilitates the precept, goals, and policies of the emerging disability policy framework. Take advantage of existing funding sources, particularly federal funding sources and waivers.

G. Reimbursement Schemes

Provide for risk adjustment for serving those with significant barriers to employment requiring more intensive, ongoing services and supports (preclude creaming).

H. Interagency Collaboration

Ensure that the system is person-centered and not segmented based on the jurisdiction of various agencies (silos). Establish a seamless system—no wrong door with no buck passing. All partners are at the table. Roles performed include advocacy, sharing of experiences and expertise, and cross training. Systems integration includes memoranda of understanding, including cost sharing and cost allocation, and an effectively functioning information and referral system.

I. Adequacy of the Network of Qualified Providers

Ensure that qualified personnel provide a range of necessary supports and services.

J. Training of Personnel

Ensure that personnel function consistent with the new paradigm (high expectations) and use state-of-the-art promising practices, including knowledge of the range of available services, supports, and technology.

K. Information and Data Collection System

Provide necessary data and information for public agencies to provide for continuous quality improvement and necessary information for the legislative branch to carry out its funding and oversight responsibilities, including disaggregation of data for subgroups, e.g., persons with disabilities.

L. Outreach, Information Dissemination, and Technical Assistance to and Representation of Potential Beneficiaries

Ensure that intended beneficiaries understand their rights and responsibilities and can exercise these rights through the provision of assistance by others.

M. Procedural Safeguards

Provide for, among other things, notice, access to records, and a complaint resolution process (including due process hearing and right to appeal) for individuals to supplement the monitoring and enforcement by government agency personnel.

N. Monitoring and Enforcement

Include a process for government agencies to review policies, practices, and procedures and actual implementation and the ability to respond to findings in a timely and effective manner.

O. Systems Change and Research

Support ongoing systems change and research to ensure that the system is inclusive and based on the principles of universal design, and that services and supports remain state-of-the-art.

VI. The Translation from Policy to Practice: Some Next Steps

The materials presented in the previous sections outline for the reader a rationale for establishing a fully inclusive workforce investment system for the twenty-first century borrowing from the lessons learned from the emerging disability policy framework. The reader is also offered core policies to assist in the shaping of a fully inclusive system. Finally, the creation of any system calls for the monitoring and evaluation of the approaches and outcomes of the system.

In this final section, we offer key stakeholders at the federal, state, and local levels suggestions on how to use the emerging disability policy framework as a tool to help design approaches for translating policy to practice so that workforce investment systems are truly inclusive.

A. Federal Level

Federal agencies play a key role in offering guidance and assistance to state and local stakeholders in the form of policy interpretation of what is meant in legislation and regulations. The need to clarify inconsistencies across the myriad regulations is apparent if we are to develop a workforce investment system that addresses the needs of all job seekers and other stakeholders. Reviews of policies, analysis of model demonstration projects, the sharing of promising practices, and the support of innovation at the state level are all activities that the federal government can embrace in the development of a comprehensive and coordinated, fully inclusive approach to workforce development. Consistency in materials development and dissemination, clear guidance, and technical assistance in program development will facilitate state and local entities' completing their portion of this system. A shared planning effort is an effective way to identify strategies that can support an inclusive workforce investment system.

B. State Level

State agencies can facilitate creation of a fully inclusive workforce investment system through the clear communication of priorities, a consistent message of inclusive planning and program delivery at the service level (regional and local), and the development of reports that support and foster replication of innovation. At the state level, the development of shared policies and practices can greatly enhance the establishment of an inclusive local delivery system. Cross-agency planning around issues of management, cost sharing, eligibility, outcome measures, and monitoring can lead to a more streamlined employment and training system at the local level.

C. Local Level

Local agencies are charged with taking the policies and directives from the federal and state agencies and translating them into practice. The need to ensure that the system responds to all customers as well as to employers is essential. The methods of delivering services should reflect the values and principles articulated in Section IV and the methods of administration outlined in Section V.B above. The translation of policy to practice at the local level is critical. The design of a system that is universal, person-centered, and accountable to the individual requires that there be active planning from the key stakeholders. The impact of the system will be demonstrated by the successes realized by the users of this system, including job seekers with disabilities and employers in need of workers.

Session 1

Patterns of Collaboration in State Service Systems

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Institute for Community Inclusion

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Respondent

John Halliday
Connecticut Bureau of Rehabilitation Services

Patterns of Collaboration Among State Agencies and Employment Outcomes

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Introduction

In the last five years, several policy initiatives have encouraged or mandated collaboration among multiple public social service systems, particularly in the workforce development and poverty arenas. Specific legislative language calls for consolidation, formal interagency agreements, local cost sharing mechanisms, and streamlined service delivery (cf. the Workforce Investment Act of 1999). Several issues arise in the study of state agency collaboration. First, state agencies that offer comprehensive services to a specific population may seek particular services of state agencies that offer specialized services for particular populations. Foley, Marrone, and Simon (2002) discuss the demonstrated demand by welfare agencies for vocational rehabilitation services for women with disabilities in poverty. Mental health and mental retardation agencies routinely collaborate with vocational rehabilitation agencies for employment services (Foley, Butterworth, and Heller, 2000). Second, agencies that offer specialized services to the general population may require intensive services from an agency that targets the needs of a specific population. One Stop Centers provide employment services to the general population and rely upon partners or other agencies to provide targeted services to women in poverty, people with disabilities, youth, and adult learners. Third, state agencies may seek technical advice rather than services to serve specific populations appropriately. For example, One-Stop Centers may seek advice on how to make their services accessible to people with disabilities.

Collaboration is not new, and specific strategies have been in use across systems prior to the recent federal initiatives. In the 1980s and early 1990s, several researchers examined state agency collaboration activities among disability agencies (Rogers, Anthony, and Danley, 1989; Reznicek and Baron, 1991). Rogers et al. reported a lack of consensus on the definition of collaboration and the basic activities measured as evidence of collaboration, although they did report evidence of improved employment outcomes. Reznicek and Baron examined a specified list of collaboration activities and surveyed local and state level vocational rehabilitation and mental health agency administrators for satisfaction and outcome improvement. Administrators reported increased client outcomes (satisfaction, jobs held, and employer acceptance), service integration, development, and increased number served, and increased costs per client (Reznicek and Baron, 1991).

In the mid to late 1990s, increased emphasis was placed on formal interagency activity between disability, poverty, and labor agencies largely due to federal level legislative reforms. The National Institute on Disability and Rehabilitation Research, the Rehabilitation Services Administration, the Administration on Children and Families, and the Department of Labor have all funded major initiatives to examine policy and implementation issues of state agency services, including

consolidation, collaboration, and service integration. Few studies have looked across more than two state agencies, and even fewer have examined interagency activity and employment outcome measures. What is unclear is how the patterns of relationships across state agencies within a state relate to employment outcome data. This paper will describe the patterns of state agency collaboration activities and examine which of these activities are correlated with a proposed measure of state performance.

The Science of It

The Institute for Community Inclusion operates the RRTC on State Systems and Employment Outcomes, which includes multiple research and training efforts to describe the status of state systems delivering employment services to people with disabilities. One of the research studies, the National Survey of State Systems and Employment Outcomes, is a national cross-sectional survey documenting existing structures and functions of seven employment related state services (disability specific and generic). The specific focus of the survey was to address the following research questions:

- How have states chosen to structure their public services?
- What are the mechanisms by which they communicate with each other?
- To what extent do the state agencies share a common goal of competitive employment for people with disabilities?
- What employment services are offered across the dimensions of the system?
- What is the nature of interagency collaborative practice at the state level?
- What is the relationship between collaboration and coordination activities and employment outcomes for people with disabilities?

The sample for this study included 334 representatives from 7 different state agencies that provide employment services specifically to people with disabilities or as a part of their population in all 50 states and D.C. Surveys were sent to commissioners or directors at the following agencies:

- State Vocational Rehabilitation Agency (VR)
- State Commission for the Blind (VRB)
- State Mental Health Agency (MH)
- State Mental Retardation/Developmental Disability Agency (MR/DD)
- State Temporary Assistance for Needy Families Agency (TANF)
- State One-Stop Entity (OS)
- State Medicaid Agency (M/A)

Not all states have a Commission for the Blind (28 out of 51). The response rate for the state agency (non-Medicaid) survey was 82% and for the Medicaid survey was 73%.

Table 1
Response Rate by Agency

Agency	Sample	Returned	Response Rate
VR	51	44	86%
VRB	28	28	100%
MR/DD	51	42	82%
MH	51	39	76%
TANF	51	41	80%
OS	51	37	73%
M/A	51	37	73%

ICI collected information across five specific domains: (a) agency structure; (b) outcome standards; (c) services offered; (d) definition of disability; and (e) coordination with other state agencies. The survey to Medicaid agencies included a section on the Ticket to Work and Medicaid implementation. The specific variables for the survey are listed as Table 2. Additional Medicaid survey variables are available from the first author.

Table 2
Medicaid and Agency Survey Variables

Variables	Agency survey	Medicaid survey
Agency structure		
• Service area jurisdiction	X	X
• Commissioner distance from governor	X	X
• Commissioner tenure	X	X
• Agency movement within state structure	X	X
• Number of organizational layers	X	X
• Central to local relationships	X	X
• Definition of service areas	X	X
• Number of local offices	X	X
Outcome standards		
• Definition of employment outcomes for total population served	X	
• Definition of employment outcomes for people with disabilities	X	
• Outcome data collection efforts	X	X
Service offered		
• Types of employment services offered as a direct service	X	
• Types of employment services offered as vendor contract	X	
• Types of employment services not offered or facilitated	X	
• Types of employment services offered through referral	X	
• State has a Medicaid buy-in	X	
• To whom are employment services offered?	X	
Definition of disability		
• Agency disability determination process	X	
• Service integration of people with disabilities	X	
• Definition of disability	X	
• Top three priority groups for services	X	
• Specialized disability services offered?	X	
Coordination with other agencies		
• Representation on Workforce Investment Board	X	X
• Agency involvement in Workforce Investment Plan	X	X
• Common goals (employment is a priority goal for PWD)	X	X
• Participation in cross-agency awareness training	X	X
• Physical co-location at the agency level	X	X
• Computer networking	X	X
• Shared eligibility information	X	X
• Referral process between agencies	X	X
• Cost-sharing at the client level	X	X
• Participation in multi-agency working groups on disability	X	X
• Use of common client databases	X	X
• Common service delivery areas	X	X

The survey was developed according to a five-step process that included: (a) literature review; (b) identification of salient components; (c) survey draft; (d) expert panel review; and (e) pilot testing. Specific information on survey development is available from the first author. In addition, the Committee on Client Services Through Partnerships (CSTP) at the Council on State Administrators of Vocational Rehabilitation (CSAVR) provided immeasurable support and input in the survey

development process. ICI received approval through the CSAVR Research Committee in late spring 2001 and disseminated the survey in the summer and fall of 2001.

Findings

To summarize the coordination activities, the researchers developed a measure for each activity for each agency. A total coordination score for each of the activities (see Table 2) was calculated by summing the number of state agencies the responding agency reported coordinating with on that specific activity. For example, if the Massachusetts TANF program checked that it shared client tracking data with the MR/DD agency, the MH agency, and VR, it got a total score of 3 on the client tracking data activity. Each of the 265 state agencies received a total score for each of the collaboration measures. Several other measures of coordination are not strictly collaboration activities. These include shared mission, shared service delivery areas, and physical co-location. These measures were included to get a sense of shared mission and structural coordination issues that may explain differences in collaboration activities. For the shared mission item (e.g., employment of people with disabilities is a priority), state agency directors were asked to rate their own agency and the other agencies in their state on what extent competitive employment of people with disabilities was a priority goal for the agency.

Patterns of Collaboration and Coordination

Table 3 depicts the mean number of state agencies participating in each of the activities with the responding state agency. Most state agencies reported that the collaboration activities most engaged in with other state agencies were (a) multi-agency working groups; and (b) cross-agency awareness training. On average, 4 state agencies shared the mission of employment for people with disabilities. About 2 state agencies shared the same service delivery areas, and few were co-located at the central office level.

Table 3
Mean Number of State Agencies Participating by Collaboration Activity
Total N = 265 State Agencies

Item	Mean
Employment is a priority goal	4.1
Multi-agency working groups	3.4
Cross-agency awareness training	3.3
Same service delivery areas	2.3
Shared costs	2.1
Shared computer network	1.5
Shared intakes	1.5
Physical co-location	1.3
Shared client tracking	0.9

Table 4 provides the agency-specific responses to the coordination measures. Commissions for the Blind report less coordination with other state agencies than the six other agencies. The patterns of coordination activities appear to be similar across the seven state agencies. Most state agencies reported participating in multi-agency working groups and cross-agency awareness training with three to four other agencies. TANF and Medicaid agencies appear to report coordination with more agencies than the other state agencies on most other measures. However, the different state agencies are not necessarily reporting from the same states. The 35 Medicaid respondents may include different states than the 43 MR/DD respondents. One should use caution in comparing the responses.

Table 4
Mean Number of State Agencies Participating by Collaboration
Activity by State Agency
Total N = 265 State Agencies

Item	MR N = 43	MH N = 39	VR N = 44	TANF N = 41	M/A N=35	VRB N=28	OS N=35
Employment priority	3.9	4.2	4.7	4.0	3.7	4.0	4.3
Multi-agency working groups	2.8	3.0	4.5	3.8	3.4	3.1	3.0
Cross-agency awareness training	2.2	3.2	4.6	3.5	3.5	3.0	3.2
Physical co-location	1.7	1.4	.84	1.8	1.5	0.4	1.4
Shared costs	1.7	1.5	2.8	2.7	2.4	1.9	1.5
Shared computer network	1.6	2.1	1.0	2.2	2.0	0.1	1.2
Same service delivery areas	1.6	1.6	2.4	2.9	3.9	2.1	1.7
Shared intakes	1.2	0.9	1.1	2.7	2.0	0.6	1.6
Shared client tracking	0.7	0.7	0.6	1.8	1.2	0.2	1.2

Outcome Measurement

There is a considerable lack of timely outcome measures that can be used to evaluate collaboration activities as they occur. ICI routinely collects or has access to administrative data for the following state agencies: (a) MR/DD; (b) VR; (c) OS; and (d) TANF. Four outcome measures (as defined in Table 5) were used to calculate the mean ranking for each state. States were ranked for each of the four outcome measures and then a mean rank was calculated based upon the four ranks. In several states, MR/DD data was not available. The mean ranking was based upon the available data from the other sources. At present, no employment outcome data is available for state mental health agencies.

Table 5
Data Used for Outcome Measurement

Data Source	Year	Outcome measure
ICI National Ongoing Data Collection for Employment Outcomes for MR/DD Agencies	1999	The measure is the ratio of people receiving integrated employment services to the total number of people receiving day and employment services. Integrated employment is defined in two categories as: 1. Time-limited training/Competitive employment services: Time-limited job-related supports or job placement services are provided to the worker with a disability in order to obtain employment, includes transitional employment. 2. Supported employment services: Ongoing job-related supports are provided to the worker with a disability in order to maintain employment, includes individual jobs and group jobs or enclaves in the community. This data is collected as part of ICI's ongoing national data collection effort for state MR/DD agencies.
Rehabilitation Services Administration Data (RSA911)	1998	Rehabilitation rate. This is calculated as the ratio of all successful (status 26) closures to the sum of successful closures and unsuccessful closures for people whose IPE (Individualized Plan for Employment) has been developed (status 28).
Administration on Children and Families Office of Planning, Research, and Evaluation Data	2000	The measure used is percent distribution of TANF closed cases by reason for closure. The reason used is employment. The data comes from Characteristics and Financial Circumstances of TANF, http://www.acf.dhhs.gov/programs/opre/characteristics/fy2000/.
Workforce Investment Act States Annual Report data	1999	The measure used is entered employment rate for the general adult program. Defined as the ratio of the number of people entering employment to the number of people in the general adult program. The data was taken from the WIA States Annual Report data.

Table 6 provides the ranking of states by the high-performance measure. There is considerable variability in outcome achievement within states. Not all state MR/DD agencies responded to the National Ongoing Data Collection survey and, therefore, those states cannot be ranked by MR/DD data. The mean ranking accounts for missing data.

Table 6
Ranks for MR/DD, VR, OS, and TANF Outcome Data and Mean Rank by State
(Total N = 51)

State	Rank MR/DD	Rank VR	Rank OS	Rank TANF	Mean Rank
Top Ten by Mean Rank					
NH	6	2	9	15	8
OR	16	24	7	4	12.75
MN	5	16	31	1	13.25
MA	18	17	18	3	14
SD	1	27	19	11	14.5
UT	9	1	36	13	14.75
MI	10	38	8	5	15.25
VT	14	9	22	16	15.25
NE	23	31	10	2	16.5
SC	17	23	16	12	17
Second Ten by Mean Rank					
MD	12	8	15	34	17.25
OK	11	22	1	36	17.5
CT	2	12	33	24	17.75
TX	32	20	14	8	18.5
KS	25	19	17	17	19.5
ME	.	43	11	6	20
WA	4	11	26	42	20.75
WI	37	29	3	14	20.75
AZ	3	50	6	25	21
ND	.	6	20	37	21
Third Ten by Mean Rank					
AR	34	5	13	40	23
NJ	29	40	5	18	23
LA	15	7	48	23	23.25
CO	7	21	30	38	24
DC	.	15	51	7	24.33
PA	33	36	21	9	24.75
ID	41	35	4	20	25
WV	.	4	49	22	25
IA	19	48	12	26	26.25
KY	8	13	46	39	26.5

State	Rank MR/DD	Rank VR	Rank OS	Rank TANF	Mean Rank
Fourth Ten by Mean Rank					
RI	.	18	41	21	26.67
IN	31	45	2	29	26.75
NY	30	14	25	41	27.5
AL	35	3	27	46	27.75
VA	24	26	38	27	28.75
IL	42	33	32	10	29.25
NV	22	46	23	33	31
DE	13	30	40	43	31.5
FL	20	37	39	30	31.5
MO	43	10	29	44	31.5
Fifth Ten Plus One by Mean Rank					
GA	27	44	24	35	32.5
OH	26	41	44	19	32.5
WY	28	25	42	47	35.5
NM	21	49	45	28	35.75
NC	38	28	35	45	36.5
AK	.	34	50	32	38.67
TN	40	32	37	50	39.75
CA	39	51	28	48	41.5
HI	.	47	47	31	41.67
MS	36	39	43	49	41.75
MT	.	42	34	51	42.33

Coordination Activities and Mean Ranking of States

Do the coordination activities of state agencies correlate with the mean ranking of the state? In essence, do state agencies in high-performing states act differently than state agencies in other states? Table 7 provides the findings from the correlation analysis. (For the sake of ease, the magnitude of the correlation has been left off of Table 7. Y indicates a significant correlation and N indicates no correlation. As a note, most of the significant correlation statistics were low at about .2 or less.)

Table 7
Correlation of Total Number of State Agencies Coordinating per Activity with Rank on MR/DD Data, VR Data, OS Data, TANF Data, and Mean Ranking
Total N = 265

Item	MR/DD Rank	VR Rank	OS Rank	TANF Rank	Mean Rank
Employment priority	Y	Y	N	Y	Y
Cross-agency awareness training	N	N	Y	N	Y
Physical co-location	N	Y	Y	Y	N
Shared computer network	N	N	N	N	N
Shared client tracking	N	N	N	N	N
Shared intakes	N	N	N	N	N
Shared costs	N	N	N	N	N
Multi-agency working groups	Y	N	N	N	Y
Same service delivery areas	N	N	N	Y	N

States with high performance in MR/DD outcomes have a greater number of state agencies stating that employment is a priority goal for people with disabilities and participating in multi-agency working groups. States with high performance on VR outcomes tend to report a greater number of state agencies stating that employment is a priority goal, and have a greater number of state agencies co-locating physically. States with high performance in OS outcomes tend to have a greater number of state agencies participating in cross-agency awareness training and physical co-location. States with high performance in TANF outcomes tend to have a greater number of state agencies reporting employment as a priority goal for people with disabilities, physical co-location, and similar service delivery areas. States with the best performance across the four outcome measures (mean ranking) tend to have a greater number of agencies stating that employment is a priority goal and participating in cross-agency awareness training and multi-agency working groups. State agencies in high-performance states appear to have a shared mission and working groups at the central office level, and have invested in interagency training.

Item	MR N = 43	VR N = 44	OS N=35	TANF N = 41
Employment priority	N	N	Y	N
Cross-agency awareness training	N	Y	Y	N
Physical co-location	N	Y	N	Y
Shared computer network	N	N	N	N
Shared client tracking	N	N	N	N
Shared intakes	N	N	N	N
Shared costs	N	N	N	N
Multi-agency working groups	N	N	N	N
Same service delivery areas	N	N	N	Y

For the MR/DD agencies, no collaboration activity measure correlates with the state ranking on MR/DD employment outcomes. For the 44 VR agencies, state VR agencies that report a greater number of cross-agency awareness training tend to be in high-performing states. State VR agencies that have high performance rankings tend to have more state agencies physically co-located. State OS entities that are in high-performing states tend to be in states that have a higher number of state agencies responding that employment is a priority and participating in cross-agency awareness training. For TANF agencies, high-performing states tend to have a greater number of agencies physically co-located and report a higher number have the same service delivery areas.

Discussion

State agency collaboration follows a pattern. In 2001, state agency collaboration activities were more often in the form of working groups and cross-agency awareness staff training than in the form of monetary or service delivery exchanges. This may indicate a need or desire to educate staff and form important partnerships through personnel interaction. Service delivery and monetary exchanges may be indications of advanced collaboration activities. In previous research, substantial formal linkages existed among disability agencies (such as vocational rehabilitation, mental retardation, and mental health agencies) (Foley, Butterworth, and Heller, 1999). These linkages appear to be in development across agencies with relatively little collaboration activity previously (such as vocational rehabilitation and welfare). On the other hand, some agencies may not have developed certain collaboration activities because the agencies have been consolidated. Formal written agreements and monetary exchanges may not be necessary but presumed in a consolidated agency.

This pattern of collaboration and the increasing interest in consolidation leads to several research and policy questions.

- How does state agency collaboration grow into a working partnership?
- What types of activities may generate future partnerships?
- How do structural issues (such as consolidation or integration) change the types of collaboration activities necessary for a working partnership?
- What is a mature (i.e., sustainable and effective) working partnership?

States that tend to have consistently high performance across four measures of outcomes tend to participate in different types of collaboration activities. The states with the highest performance rankings were more frequently participating in multi-agency working groups and cross-agency awareness training. States with higher mean rankings tended to have more state agencies reporting that competitive employment for people with disabilities was a priority of the agency. Different collaboration activities are associated with the individual measures of performance. States with higher rankings on welfare data performance reported more frequent collaboration in structural areas such as physical co-location and service delivery areas. Physical co-location was associated with state ranking on outcomes for the vocational rehabilitation agency, One-Stop entity, and the welfare agency. Cross-agency awareness training was associated with state ranking on outcomes for the One-Stop entity.

These findings lead to more questions and potential policy implications. First, what is the legitimacy of this measure of performance (i.e., state rank across four agency outcomes)? What are other options? The above analysis looks at the relationship between past performance and present outcomes. To what extent does present collaboration influence future outcomes? What other variables might explain differences in collaboration or differences in performance? The next set of data analysis will include measures of state structural variables, financial variables, state demographic variables, and implementation variables. The project will focus on available implementation variables that represent possible areas of policy development (such as participation on Workforce Investment Boards, presence of Medicaid waivers, levels of consolidation, and system change grants). The inclusion of these variables may enable policymakers and researchers to determine which aspects of policy implementation may have more relationship to collaboration and/or employment outcomes.

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Session 1

Patterns of Collaboration Among State Agencies and Employment Outcomes

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Discussion Summary

John Halliday: Respondent

- One issue to address is how effective are the collaborations that also are bringing other larger resources to the table? Are we combining public, private, and individual resources in new ways to improve the continuum? What are the roles of private insurance, private organizations, and individuals in collaboration?

- What was the purpose of the collaboration? The definition of both disability and employment is changing. Is the purpose of the collaboration to bring about systems change or to continue to provide the same services?

- The concept of employment is changing. The concept of disability is changing. Which definitions are these programs using and which do they see themselves using in the next five years?

- Consumer impact: What impact are the collaborations having on consumers such as increased choice, satisfaction, experience of the customer?

- Resource impact: What impact are the collaborations having on administrative costs and what are they having upon consumers? What happens to cost savings, and how have they dealt with savings? Savings could be something that you extract from the system or something that you reinvest.

- What is the nature of collaboration at its fundamental level—acquisitions and mergers, or coming together to jointly provide services?

- How does the consistency of leadership affect collaborations and partnerships?

Discussion Points

- Society has low expectations for people. In order for people with disabilities to become part of the fabric of everyday society, then society has to recognize the value of the contribution of people with disabilities. In generic systems, when economies are tight, people with disabilities will get the short end of the service delivery dollar. When generic services have the opportunity to spend, they will not spend it on people with disabilities. Need to ensure that funds are dedicated to support people with disabilities.

- "Make collaboration pay." If we want to move forward with integration and collaboration and to save money, then we must reinvest that money into the services. There is no

incentive for collaboration if we lose those savings. We must have a clear vision of where we are going and how we are going to get there and then use the money that we saved to reinvest and move forward to that mission.

- "When we genericize we minimize the talents of people involved." If collaboration is what we are about, then we need to extend the talents of the players that are involved so that they work at the maximum level to contribute to the system. We are still in an environment in which a person with a disability who shows up at the One-Stop is told "get thee to vocational rehabilitation." But VR is in an order of selection, so we say "get thee to a One-Stop." One idea is to renegotiate our agreements so that they contribute talent in the actual setting that the person is being served. One thing that might make the biggest difference is data sharing and yet that is the thing that people are collaborating on the least. It would be good to know who is spending what on whom and how to coordinate it. It would position each of us to understand our work differently. How many times are dollars spent on the same thing for the same person?

- Legislation can force integration but cannot force collaboration. It is all about people. When the conversation is about employment and how to get people jobs the groups come together. But when you focus on resources, the conversation dissolves. We must keep the conversation on outcomes and not fight about resources.

- One-Stops and outcomes. One-Stops are the only agency in the data that does not focus on employment outcomes, and I think that it is interesting. Most of the other agencies are charged to serve a population, and the outcomes of that population are what is used to document success. The One-Stops are there to provide a service and what they are looking at is finding resources for that population. We are looking at the same populations and ideas from very different perspectives and what you see often depends on where you sit. And that becomes what you stand for, what you are entrenched about, and what you argue for in the resource debate. There is nothing that we have talked about this morning that has not been talked about for different populations, ex-offenders, recovering substance abusers, TANF recipients. I think we have to learn how to share and advocate in a system rather than against the system. We need to start to find out how to get rid of a poor idea or poor practice. We need to find out how to discover the cause of some of the failures.

- Using the business model of developing quality measures. Is coordination a quality measure? Should there be a performance measure related to coordination? There is no common measure of coordination and we do not collect that information. What are the incentives for any of these systems to coordinate? There is no penalty if you don't and no incentive if you do. If coordination is seen as a value-added approach to achieve a common mission, what incentives might be built into the generic workforce system and other systems that would change behavior? What does it mean to coordinate? We need to look at both depth and intensity and how that achieves results.

- When there are serious budget deficits on the horizon, then there are tremendous incentives to collaborate because you can draw on the resources of others and they can draw on yours. The trick is to figure out who and how so that you move forward and get the work done. The incentive is survival just to get things done.

- On the legitimacy of the state mean rank as a performance measure. TANF outcome measures can be misleading in that many people come off TANF for different reasons, including moving on to SSI/SSDI. Then, they have a presumed eligibility for VR. The measures are misleading if you do not get to employment outcomes. We might move down the ranking because we are now left with people who are harder to serve. How do we shift systems to deal with changing populations that are harder to serve? Our systems were designed to do things for people who are very different from the current population. This

is probably true for all of our systems. The labor system was designed for a manufacturing labor economy and it is no longer the economy we have.

- On state structural issues: How do structural issues relate to the ability to collaborate? When we look at numbers are we looking at output or outcomes? The warm fuzzy place to rally is around outcome and you are less likely to get into tenacious defense of resources. Look at how the system is organized—some of them are state-organized, some are county-organized, some are regional centers. Look at how those state pieces intersect with the provider base.

- State resource variables would be interesting to include such as the presence of a Medicaid infrastructure grant.

- Collaboration has become the outcome and the new mantra but it is a bit of a distraction. It suggests to me how unimportant having a strong system is. You would never have the federal agency responsible for all the airports say, "Why don't you folks try to collaborate and organize take-offs and landings?" You have a very fragmented system that some of the players are trying to patch together. Do not be distracted by collaboration, but there is a need to take very seriously how poorly we are doing as a national system.

- The community-based provider system and their role in the system. How do we look at how the provider world is working across systems? Are we looking at how these systems are working together?

Action Items

- The impact on the individual in the system. What is the impact on that individual? Collaboration makes sense if collaboration helps someone get a job. Is it a partnership to get people to work or people out of the system?

- Person-centered planning process. How do we build resources within a person-centered plan?

- Define a state-level approach to measuring employment outcomes for people with disabilities rather than program- or agency-level measurement.

- I'm concerned about using proxies or measures that are not measuring what they are supposed to. For example, is the rehabilitation rate measuring employment outcomes or creaming? Agencies that serve the people with the most significant disabilities may not have the best rehabilitation rate but may be meeting the congressional intent of the law. Where does an agency get credit for participating or assisting in the employment of a person? Part of the issue of collaboration is that you should be rewarded for accomplishing all of the expectations and not just some.

- Identify strategies that focus people on the job at hand and not just collecting data for data's sake.

- Action item on demonstration funds where there are waivers provided from every single federal agency to assist in system redesign and collaboration.

- What are the barriers to sharing data and using that information to plan and deliver services?

- Understand where the money flows and how it is used. Where the money flows is where your values are. Your mission is not a good indicator of that.

- Identify those states in which MIS systems have included vocational rehabilitation systems and addressed confidentiality issues.

Session 2

Restructuring for Partnership Between Disability and Generic Service Systems: Partnership to Improve Employment Outcomes for Individuals with Mental Illness, Collaboration with VR and TANF

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Restructuring for Partnerships Between Disability and Generic Service Systems: Mental Health and Vocational Rehabilitation; Mental Health and TANF

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There is a woman named Heidi living in northeast Minneapolis. Tonight, Tuesday, she is lying on the couch. It is about 9:00 p.m., and the six-pack of Citrona is empty. She is buzzed and wishes the racket from the other room would just <u>stop.</u> She hears her two oldest kids, Jeff, eleven, and Brittany, eight, fighting with each other, louder and louder. One of them must be pounding on the wall behind her, because the couch is vibrating with each thud. Finally, it culminates with a crash; and three year old Bobby tears around the corner, crying, covered with milk and bits of cereal.

She drags herself up and goes to see what's going on, Bobby clinging to her leg as she rounds the corner. Brittany is crying, and Jeff is laughing like a junior hyena, waving a hockey stick around the shattered remnants of the cereal bowl. She yells at them all. Eventually, everyone settles down and she cleans up the mess. She goes to the kitchen and sees the pile of mail she didn't open for the last week—notices from her financial worker at the county, something from her employment counselor too. There is a bill from the car place. That was for a repair that never really fixed the car, but it is now irrelevant because the car was towed last week for being on the wrong side of the snowplow route. It is now at the impound lot and she doesn't have the money to get it out. She already got emergency funds from the county once this year, and that is the limit. She recalls the night of the snowstorm. It was the last time she saw Al, the father of the two youngest kids. They started out having fun that night, had a few beers, and some meth he brought from up north. One thing led to another and they were up till dawn. He left her with a black eye and bruised ribs.

She lies in bed after the kids finally go to sleep. Her mind is racing. There is supposed to be another job interview tomorrow, but she has to go see Jeff's teacher. He fights in school and is in trouble all the time. They said something about maybe he has ADHD, whatever that is. School was always tough for her, too.

And she has to see the welfare lady, but she has to get her story straight about this job thing. She has lost 5 jobs in 4 months, and she figures this new one will be just like the rest. They all start out nice and friendly, wanting to hear about her life and stuff, then when she thinks she can trust them, they change and act all cold and distant, and they end up saying she has an "attitude problem." They just don't understand. Nobody ever cuts her any slack.

She falls asleep, but is wide awake again at 3:00 a.m.—this has been happening for weeks—she lays there, heart pounding, in despair. Sometimes she thinks the kids would be better off without her. It would be so easy to just slip away—a fifth of vodka and a handful of downers. There is nothing left to enjoy, nothing left to hope for. With that thought, she slips back into fitful sleep, and the alarm pierces the room.

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Heidi will go to the employment counselor, who will review her file and the history of all the lost jobs. She has spoken with one or two of her employers and has heard the same story. Heidi starts off with a bang—seems friendly, like she understands things. She tells everybody the story of her life, as though they are all long-lost friends. But she gets upset when break is over and it's time to go back to work. She bothers the other employees, constantly asking for help or instructions, and seems like she has no idea what she is doing. They get frustrated with her, and she gets angry when they don't want to be her friend anymore. And then there are the unexplained absences. She just doesn't show up and then says she had a problem with the kids.

The file reflects some legal issues. She has had custody battles with the father of her oldest son. She has come to the attention of the county social service system several times because the police have been called due to domestic abuse at the hands of her boyfriend. This has put her subsidized housing at considerable risk.

She finally agreed to complete the self-screen for mental health and chemical health issues. It said she should be referred to the health plan to be assessed by a mental heath professional. She missed two appointments (Brittany had ear infections) but finally went. The assessor believes she is clinically depressed, and should see the psychiatrist to be evaluated for medication, but there will be a three-month wait for that.

Heidi was very reluctant to see the counselor, and is even more afraid to see the psychiatrist because her ex always said she was nuts and she fears he will try to take Jack if he finds out.

The employment counselor takes a silent inventory of all of Heidi's issues and sighs, feeling totally overwhelmed and confused by the complexity of it all. And this is the fourth case she has seen like this, and it is only Wednesday. She had to go to training about getting clients to use the screening tool, and she has no doubt that some of her caseload has mental problems and chemical abuse problems. But the aggravation of getting them into the health plan has added a ton of work. And it is clear from the reports she has gotten back that the mental health people are clueless about the TANF requirements. The child welfare person at the training says his department isn't out to take kids from these moms if they admit to mental problems, but she isn't so sure about that.

Maybe it would be the best thing if she just referred Heidi to Social Security. It is hard to see what would help her keep a job—her patterns of job losses just don't make any sense. She has already had 51 months of welfare. Maybe she is just too troubled to work.

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This vignette puts a face on a number of overlapping and complex issues that have emerged and continue to emerge as we attempt to improve employment outcomes in several systems. Heidi is in Minnesota, but the specifics of Heidi's life only scratch the surface of the myriad circumstances that appear all over the country as the tectonic plates of the social service landscape have shifted in the last decade.

The lack of uniformity in organization, funding, and laws across the 50 states is both a curse and a blessing. We have 50 laboratories to test strategies that will result in maximum positive outcomes for people with disabilities, but specific schemes from one state may be hard to transport to another. What *can* be gleaned is evidence of effectiveness in a particular context, and this paper will describe activities in Minnesota.

The strategies for working across the TANF and mental health systems in Minnesota have been under construction for several years. The groundwork for this effort was foreshadowed by the successful collaboration we have achieved between Vocational Rehabilitation and Mental Health, so we look to that experience to guide us through the denser thicket of this newer challenge.

Minnesota is fortunate to have begun MH/VR collaborative work in the context of legislative urging. Advocacy efforts by the League of Women Voters gave impetus to a key piece of the partnership, which resulted in the transfer of funds from the Department of Human Services, Mental Health Division to VR, which enabled VR to draw down more federal resources. These funds were put into the community through RFPs that specifically mandated collaboration between mental health, VR, and the local-level providers. The funds were disbursed under the establishment grant authority, and after the initial four years of funding of each grant cycle, the projects were continued with state funds, allocated by the legislature due to the continued advocacy efforts of the League.

At the outset, these activities were occurring in the context of the Supported Employment movement, which disseminated the vision (substantiated by research) that people with serious mental illness could work in competitive integrated settings. These projects, the Coordinated Employability Projects, grew in number as each round continued to get state continuation funding at the termination of the grant period in order to reuse the establishment grant funds. From 1992 to the present we have increased by 10% the numbers of people with mental illness served by VR, and 76 of our 87 counties now have projects in operation. The outcomes of these projects equal those of model programs around the country.

This foundation led to other collaborative efforts, which included policy changes, fund "braiding," and cross-training events too numerous to mention. The following are illustrative of our activities, though perhaps inscrutable to the reader not familiar with the intricacies of Minnesota government:

- An annually reviewed, formal interagency agreement between the two departments, and quarterly meetings of upper management;
- Permission by the MH Division for counties to use social service dollars to provide the needed match for VR grants;
- Joint MH and VR review of RFPs, joint site visiting, and joint technical assistance to projects;
- MH Division staff assigned as liaison with VR and vice versa;
- Use of a "forced collaboration" model as a condition of funding projects;
- Small federal research grant undertaken to measure the employment outcomes of the projects finding that measurably higher levels of collaboration in local projects resulted in more jobs for consumers;
- MH staff have written the Rehabilitation Option of Medicaid benefit set guidelines to support employment outcomes;
- Efforts at data collection and sharing across departments.

We have been successful in spite of the undeniable issues that could have derailed the collaboration, such as the following (broadly drawn):

- Disparate organizational missions (VR = rehabilitation and work oriented / MH = "treatment and support; symptom reduction");

- Different bureaucratic structures (VR = federal rules / MH = state);

- Different provider array (VR = rehab agencies / MH = mental health centers);

- Different funding methodologies;

- Different approach to the client base (VR = many disability groups, but a single focused mission on employment / MH = more narrow client base—mental health issues, but broader numbers of life domains of interest);

- Stigma about mental illness on the part of VR staff; ignorance of supported work technology plus poor attitudes about the value of work on the part of MH staff.

In Minnesota, these barriers have been substantially overcome over the last decade through the above noted combination of legislative, funding, policy, and collaborative efforts that have been supported, or at least not thwarted, by the prevailing leadership of both agencies. Our respective cultures have changed, to some degree at least, as we have learned each other's languages, and focused on our shared mission, those persons at the intersection of the social service Venn diagram.

A culminating feature of our collaboration is demonstrated by the legislative mandate we were given to write a legislative report outlining and evaluating our mutual activities and indicating unmet need. The initial report was completed in December of 2000. This report will be updated this year, and will be available on the VR website. We welcomed this mandate, as it provided a focal point for demonstrating the effectiveness of the core policy decisions around our interagency collaboration, and it reinforces all parts of the system in these continuing efforts.

In retrospect, the MH/VR effort was easy compared to the issues presented by the TANF/MH overlap. As the Heidi story demonstrated, more systems are involved, and more levels of government, not to mention conflicting agendas between advocacy groups. There is also less clarity about the "right" thing to do for the individuals who are having extraordinarily difficult times meeting TANF work requirements. It is a significant decision to change gears, and instead of urging and mandating work in the TANF program (with its relatively rich resources) to refer a person to Social Security, where the likelihood of ever leaving the rolls is less than 1%.

Just as the first step in the VR/MH collaboration concerned the acknowledgement that we shared a slice of the population, and that people with mental illness are employable, so too must we circumscribe the shape of the overlap with the TANF/MH population.

This issue more properly concerns a broader set of issues than only mental health, of course. Individuals on TANF may have many barriers, including chemical dependency, learning disabilities,

physical challenges, and issues of culture. The children in these families may have a plethora of special needs.

But the impulse to refer the individual to Social Security should be resisted until we have exhausted our capacity to transfer to TANF what we know about what works to assist people with disabilities into employment. A General Accounting Office (GAO) report (2002b) indicated that more than half of those studied with more than two barriers were still able to meet work requirements. It is therefore incumbent on us, as people are daily reaching the 60-month limit, to transfer our knowledge about how to create employment outcomes for people with disabilities to the TANF system, before we resort to transferring the recipients to the disability system.

Some of the steps we have undertaken in Minnesota include the following:

- Statewide introductory training of TANF staff on the subjects of mental illness and chemical dependency.

- The creation of a self-screening tool to identify mental health and chemical health issues in TANF recipients who have failed to make adequate progress in fulfilling work requirements. This tool was created in the context of a broad stakeholder advisory process, and was subject to careful pilot testing. It has been found to accurately identify people who can benefit from professional evaluation.

- Collaborative training between TANF, MH, Chemical Health, and Child Welfare staff to roll out the screening tool illuminated the disconnects present in many areas between local social service entities and the stigma and fear of these issues present in a significant number of employment counselors, while at the same time providing the impetus for future collaboration.

Data sharing across systems has yielded evidence that TANF recipients are seen in the medical system (cross matches with pre-paid plans diagnostic and medication data) for mental health concerns, ranging in frequency by county from 23% to 78% in one sample. This inquiry has been done concurrently with statistical modeling (mental health data was one of many variables) that holds demographic and economic factors constant across counties, permitting comparison of the relative effectiveness of TANF program implementation.

- The Minnesota iteration of the Medicaid Rehabilitation option has sufficiently broad eligibility criteria to permit its use with most TANF recipients with mental illness conditions.

- A broader data sharing project is under discussion to identify that portion of the population served by multiple systems in order to maximize coordination and reduce duplication.

These efforts are a beginning. The challenges to full-fledged collaboration are great, and it remains an open question as to the motivation of the systems to pursue it. Economically, Minnesota is not currently in danger of exceeding the 20% post 60-month cap. Until we are forced to rely on state

funds alone to support these individuals, it may be more palatable and certainly easier to just extend people's benefits rather than rocking the boat by insisting that systems change.

In any case, cross-training efforts will pay off now for social service systems with shrinking resources and multi-tasking workers in all corners. The training agenda needs to include:

- Training TANF staff about other social services and how to access them. This is critical for the TANF worker needing to assist a recipient with a child with disabilities, for example, or dovetailing the supports that can be provided by Medicaid-funded rehabilitation services for TANF recipients, or how VR might appropriately play a role.

- Training TANF staff about disabilities of all kinds in order to reduce stigma and fear, and increasing the organizational capacity to appropriately screen and refer without necessarily letting go;

- Training MH and other social service staff about the rehabilitative value of work, and at least the bare bones outline of the TANF system to enable them to understand the consequences of exemption from work requirements, and the relative benefits offered under the TANF and Social Security systems.

Beyond training, collaboration flourishes when a sense of shared mission emerges, when individual people in each bureaucracy decide that they will not stop pushing their respective systems toward each other as long as such pushing is necessary to serve the needs of recipients. Such collaboration is more successful when staff are rewarded rather than punished for "jumping the fence" to fully understand the other systems.

How Mental Health and Welfare Reform Interact in the Context of Welfare-to-Work: The Need for Hope, Hassling, Systems, and Support

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Abstract

This article describes some of the lessons learned in the implementation of the Personal Responsibility and Work Opportunity Reconciliation Act (**PRWORA**), as it relates to people with mental illness. Issues include how this learning has given efforts at implementing mental health evidence-based practices some guidance and, concurrently, welfare policies have been informed by the widening knowledge base generated within the field of employment services and people with mental illness. Specific policy and program innovations at both a local (county) level and statewide are highlighted to demonstrate these issues. Finally, areas for further inquiry and reflection are raised in the conclusion.

How Mental Health and Welfare Reform Interact in the Context of Welfare-to-Work: The Need for Hope, Hassling, Systems, and Support

During the past five years, several major federal legislative reforms have sought to restructure the state systems responsible for services to people living in poverty and dependent upon government income supports or users of public employment services. The most publicized and dramatic change occurred in social welfare, as efforts sought to reduce the welfare rolls dramatically and overhaul the welfare system. Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act (**PRWORA**) was the legislation that launched this effort. It has been viewed both as a success for sweeping social and economic change over its five years of operation and as failing to address the true factors of poverty as well as for eliminating the federal "floor" supporting TANF nationally. Yet it created a platform that encouraged policymakers, researchers, advocates and TANF agencies to reconfigure their state welfare programs. The systemic change both in philosophy and results achieved in less than 5 years of welfare implementation hold many lessons for those in the mental health and rehabilitation employment policy fields and a concomitant change in direction for some efforts. These lessons include both funding mechanisms that allow states to design their systems flexibly and adding clear measurable outcomes for individuals receiving benefits. In simplified terms, the emphasis in PRWORA is on outcomes with varying processes to achieve them, based on the assumption that strategies prior to 1996 have proven ineffective. Welfare policy changes have created fifty-one laboratories as each state determines how to structure welfare programs to reduce the rolls and increase the number of people returning to or entering work. Concurrently, the public mental health system is increasingly charged with implementing evidence based practices into its service delivery paradigm (Carpinello, Rosenberg, Stone, Schwager, & Felton, 2002; Corrigan, Steiner, McCracken, Blaser, & Barr, 2001) and is being asked to include employment outcomes within the panoply of service outcomes for which it takes some responsibility (Drake, Goldman, Leff, Lehman, Dixon, Mueser, & Torrey, 2001). Shrinking resources at the state level have created further incentives to support demonstrably effective service methods. Indeed, this is one of the few paths open to policymakers that has broad appeal philosophically and to legislators eyeing the bottom line.

While there are many examples that illustrate that people with significant psychiatric disabilities can work (Becker, Bond, McCarthy, Thompson, Xie, McHugo, & Drake, 2001; Bond, Becker, Drake, Rapp, Meisler, Lehman, Bell, & Blyler, 2001), employment as a mandated outcome within mental health systems of care remains controversial, despite the fact that the technology exists within an evidence-based practice approach to achieve this goal (Marrone & Golowka, 2000). Disability advocacy for employment has repeatedly emphasized the untapped capacity of people with disabilities to make a contribution to our society as citizens through working. However, few if any mental health systems espouse the unalloyed view that people with mental illness do, in fact, have to accept personal responsibility to choose employment as part of the social contract of citizenship—a view that PRWORA unequivocally supports for TANF recipients. Another difference in these recent social policies in mental health vis-à-vis welfare is more subtle, but nonetheless major. The focus on

evidence-based *practice* has concentrated on proven strategies, i.e., processes to implement, rather than encouraging an improvement in employment *outcomes* within mental health systems of care, and encouraging the creation of new technologies or interventions.

The National Perspective: Policies, Populations, and Problems

As these parallel systems have developed and successes noted, many are recognizing the overlap in populations, the limitations of each system's resources, and the potential to achieve their own independent outcomes through collaborative initiatives (Foley, 2002). Despite this recognition, the systems tend to have different views on the goal of services. The origins of the mental health and poverty systems may explain some of this difference. The poverty system grew out of an effort to assist families headed by a single parent (almost always assumed to be the mother) survive, and has changed into a transitional program that offers services to assist families achieve self-sufficiency. This transition was sponsored through a series of federal reforms that emphasize the importance of work and see public welfare as a short-term, time-limited program, not a permanent source of ongoing financial support (Nightingale, Pindus, & Trutko, 2002). These reforms culminated in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).

The mental health system is the public system principally responsible for social and clinical services for people with serious psychiatric disability. Some mental health agencies offer vocational services; others refer people to the state vocational rehabilitation agency. Many mental health programs (especially over the last 5 years) provide some employment services for a portion of their clients, who may or may not be concurrently served by the VR system. These vocational services tend to be a subset of an array of services. Mental health systems have focused more recently on expanding their vocational activities to provide, fund, or regulate employment services for their service recipients and, as one activity under this rubric, coordinate more closely with the state-federal VR system. Both agencies continue to debate the employability of people with significant mental health disabilities and, in the case of public mental health systems of care, whether work as an outcome is even desirable. Part of the emerging collaborations between welfare and disability services staff have led to internal confusion about the roles of each.

The following quotes illustrate this point:

- *"Well, if they're disabled, why don't we just help them get on SSA?" – state-level welfare staff*
  "SSA!! If we send them there, we're dooming them to a life of poverty and unemployment!" – state-level disability policy staff
- *"What's the problem with just writing an exemption from the work requirements? Work is too stressful for people with mental illness." – community mental health counselor*
- *"You want me to ask people about their mental health problems?! What if they break down in my office?" – TANF provider*
- *"These mental health screening questions are too personal—their mental health isn't my business, getting them a job is my business." – TANF provider*
- *"You have to be **very** careful when you do anything that might imply that someone has a mental health problem!" – an advocate*
- *"If her ex-husband finds out she has mental illness, he'll get the kids!" – TANF provider*

These are real-life statements from some of the people who are trying to help the remaining individuals on welfare get to work. There is a chasm between the culture of the public mental health system of care and state TANF systems trying to implement the mandates of PRWORA. Legal advocates often try to secure welfare exemption status or Social Security eligibility for people with psychiatric disabilities in the welfare system. Disability advocates try to secure services, equipment, and rights to work. TANF agencies seek to encourage work, triage to an exemption status, or to Social Security (SSA), even though SSA benefits are hardly a vehicle to self-sufficiency but rather continued subsistence below the poverty level—subsistence, however, that is subsidized more heavily than TANF by federal, as opposed to state, resources. An interesting observation on this cost-shifting social policy is that more recent SSA policy is moving toward a return or enter work philosophy and the message from TANF to people with disabilities runs counter to the SSA recent policy message.

As the 60-month timeline approaches or has expired for many TANF recipients, it is clear that there has been a dramatic reduction in TANF participation and an increase in current or former recipients' earning income in the competitive labor market and for some (but not many) a movement out of poverty. There has been much national debate and analysis about whether these successes can be attributed primarily to PRWORA, the national economy, or local policy implementation factors within state TANF agencies. The changing economy of late 2001 and 2002 as well as the continuing national security crisis will provide some comparative data. Whatever the merits of the debate over the reasons for these impressive results ("all of the above" appears as the most prevalent answer advanced in voluminous policy reports over the 5 years), there are two facts on which no debate exists:

1. The pool of TANF recipients who can be discouraged from long-term dependence through their self-directed efforts has largely been fully tapped. While caseloads still include some short-term users who pass through the system relatively quickly, those long-term TANF participants who have not been successful in moving off public assistance to date require some exceptional strategies beyond those already implemented.

2. This cadre of current long-term TANF participants is disproportionately composed of people with many problems that can be attributed to a variety of disabilities, especially mental illness and/or emotional/behavioral problems.

Ample data to support both postulates exist from numerous reports from national groups and local state reports such as the 1998 report from the Washington Department of Social and Health Services, *A Baseline Analysis of TANF One-Parent Families: Findings from the 1997 Client Survey*. Nearly one-quarter of men and one-third of women with disabilities live in poverty (LaPlante, Kennedy, & Trupin, 1997). Excluding Supplemental Security Income (SSI), women with disabilities are more likely to receive income supports and food stamps from welfare programs while men with disabilities are more likely to receive Social Security Disability Insurance (SSDI), veterans' benefits, workers' compensation, and pensions (LaPlante, Kennedy, & Trupin, 1997). The United States General Accounting Office (GAO) estimates that about half of the people currently receiving welfare are people with disabilities (GAO, 2001). In a subsequent report, nearly 25% of the 700,000 child-only welfare cases were families headed by an adult receiving SSI or SSDI (GAO, 2002a). Reports from the Center on Budget and Policy Priorities

and the Urban Institute estimate the number of people receiving welfare who have a serious mental health problem to be between one-fourth and one-third of the population (Sweeney, 2000; Zedlewski 1999). Approximately one-fifth of those who have left TANF and are not working have mental impairments, and almost half of parents in this group either said that they were in poor general health or scored low on a standard mental health scale (Sweeney, 2000). Zedlewski (1999), using the National Survey of American Families, found that one-fifth of non-working former recipients scored very poorly (in the bottom 10%) on the mental health scale. As many as one-fourth to one-half of the parents no longer receiving TANF due to a sanction indicated an inability to comply because of a disability, health condition, or illness (Zedlewski, 1999).

Two studies, in Michigan and Utah, did in-depth diagnostic questioning of TANF recipients. The Michigan study focused on a sample of all TANF recipients in one urban county, while the Utah study looked at those who had received welfare for at least 3 years. They found:

- **Major or clinical depression**: In Michigan, one-quarter suffered from major or clinical depression, while in Utah over two-fifths did.
- **Post-traumatic stress disorder**: In both states, about one-seventh of the recipients had post-traumatic stress disorder.
- **General anxiety disorder**: About 7% of recipients in both studies had general anxiety disorder (Barusch & Taylor, 1999; Danziger, Corcoran, & Danziger, 1999).

In the Michigan sample, 36% of respondents met the criteria for at least one of five key psychiatric disorders: major depression, post-traumatic stress disorder, generalized anxiety disorder, alcohol dependence, and drug dependence. This same study concluded that being depressed, drug-dependent, or in poor health significantly reduces the chances of working at least 20 hours per week. The 1998 Washington state TANF agency's report found that more than 25% of TANF recipients experienced some form of diagnosable mental illness for which they had sought treatment in the previous year (Washington Department of Social and Health Services, 1998). The Minnesota TANF agency through its own analyses since the inception of welfare reform in that state mirrors this finding (MN DHS, 1999).

The magnitude of the problems facing these recipients is clear. Solutions are less inherently obvious as they involve the interplay of clinical, socio-economic, demographic, political, and systemic factors. Yet some programmatic guideposts do exist for remedies, based on social science and psychiatric rehabilitation research conducted over 20-plus years, that support people with major mental illness in surviving and thriving in the community. As indicated above, many of the current long-term welfare recipients are, in fact, people with mental illness. Furthermore, apart from clinical similarities, there is a long-standing correlational, but not necessarily causative, link between poverty and mental illness and indeed, poverty and overall health status. The U.S. Centers for Disease Control in Atlanta, Georgia, estimates that 8% of the U.S. adult population experience "frequent mental distress" (defined as being in poor mental health for more than 14 days out of the previous 30) at any point in time. Such

individuals are more likely to possess one or more of the following characteristics: unemployed, poor, female, separated, or poorly educated (CDC, 1998), all factors that are intrinsically tied in with being on TANF for long periods of time. The Urban Institute has reported in 1999 that "while there appears to be a general consensus that the most job-ready recipients have left welfare and those remaining are more likely to experience disabilities and other barriers to employment, states and localities are still in the early stages of developing and implementing practices which identify and respond to the needs of these recipients in a proactive and systematic fashion." (Zedlewski, 1999). The process cannot still be described as "in the early stages." Nonetheless, the attempts of the U.S. Department of Labor to target those TANF recipients with the most disadvantages under the rubric of Welfare to Work (WTW) no longer are funded, having foundered on the shoals of overly complex eligibility category definitions. Concurrently, the current fiscal realities of budget cuts and increasing TANF caseloads have led to decreased experimentation. Finally, PRWORA reauthorization on the legislative horizon shows little in the way of similar targeted initiatives. In sum, it appears that despite the fact that this social revolution is 3 years farther along than when the 1999 report appeared, identifying and responding to the needs of those with multiple disadvantages still remains a social policy conundrum.

Those employed as helpers in all the systems where welfare recipients get services are being obliged to cross the great divide in the social service system and work together. Untreated conditions are presenting a serious barrier to employment. There are concerns that people may "run out of time," depending on how states handle funding, and have less support to deal with these issues. Anybody focused on helping people with mental illness to work knows about the barriers, and anyone who has a family member with mental illness knows about them too. Unfortunately, some of the barriers, at least in the past, have come from fellow professionals who fear that work is too stressful— this in spite of the fact that no research finding substantiates the idea that work leads to relapse. In fact, some studies find an association between work and improved mental health (Drake, Becker, Biesanz, Wyzik, & Torrey, 1996; Drake, Becker, Clark, & Mueser, 1999).

Barriers caused by differing missions, cultures, funding streams, and structures among parts of the public social services system are not news. These rifts are exacerbated when it comes to mental health and welfare systems interacting. Recipients of services, and their families, are routinely forced to be unwilling emissaries across the abyss between the many parts of the social service system. People are often motivated to navigate the process to get resources and help; but in the case of mental health assessment and treatment, they often don't want to go, and parts of the system are afraid to send them. As noted above, mental health issues are far more common than the general public tends to acknowledge, though people with the most serious mental illnesses comprise a smaller group. Not all people with mental health issues need special help to get to work. It is likely, however, that many individuals who remain on the welfare rolls are having their efforts toward self-sufficiency complicated by a mental health barrier. This article describes the experiences in two widely divergent places: Washington state (local-level program implementation) and Minnesota (state-level intervention) and tries to identify policy lessons that may be gleaned from these disparate efforts. In Minnesota,

significant effort is under way to screen TANF recipients for psychiatric disability. Many states are developing their own screening tools, borrowing from other states, or evaluating the benefit of screening. The effort is time-consuming, complex, and politically charged. In Washington, a community mental health provider seeks to offer employment services to people with psychiatric disabilities served by the welfare and mental health systems. Mental health providers offering vocational services to people receiving welfare become critically aware of the implementation obstacles created by two distinct policies. Both states are similar in many respects: population, booming economies around their two major urban centers (Seattle and Minneapolis respectively) until 2002 with major recession since mid-2001, urban-rural disparities across very large states with a large concentration of agriculture-related work in the rural areas, state TANF policies that have been very successful in reducing the welfare rolls (until the trend was reversed in 2002), and a system of specialized third-party-contracted, intensive services to TANF recipients seen as facing multiple barriers to working, including mental illness. One additional administrative complexity that both states face in coordinating services across MH and TANF systems is that each state TANF system is run centrally through a series of local service offices throughout the state while their state MH systems are administered through a set of central policies but are administered, funded, and operationally controlled by local county or regional authorities.

The Minnesota Experience

Efforts at cross-divisional/cross-departmental collaboration in Minnesota have focused on finding the people with mental health and chemical dependency (CD) barriers so they can be helped to use the welfare supports to self-sufficiency while they still have time. Minnesota has implemented the use of a screening tool after an extensive pilot phase to help the welfare employment counselors identify those in need of a professional mental health or CD assessment. The screening tool is used only after a person has been in the system for a period of time and is not making progress in their employment plan. In the pilot phase, over 800 people were screened, 63% of whom scored in the range indicating need for a professional assessment. Actually obtaining the assessment, though it is a covered service in the recipient's Medicaid plan, was quite difficult due to resistance on the part of the recipient and system linkage problems. Of the 148 people who have so far been professionally assessed, nearly 100% have been diagnosed with a disorder. Minnesota historically has been one of the most enlightened states in the country in social policy, and still, in the screening tool pilot sites:

- Employment counselors were often reluctant to use the screen because of fear and stigma;
- Recipients often didn't want to acknowledge these mental health issues. If they did acknowledge them, they often refused professional mental health assessment (even knowing they could have their grant reduced if they did not have it);
- Persons were even less likely to endorse items directly acknowledging a chemical dependency issue, but subsequent professional assessment revealed its presence;
- The advocacy community was very concerned about labeling an individual "mentally ill," and was very watchful of the screening process. One of the authors routinely asks

in training sessions with employment counselors working with TANF recipients, "What would you do if a client in your office complained of chest pain and shortness of breath?" Of course, there is universal endorsement about getting medical assessment at once. But when a person acknowledges feelings of hopelessness, thoughts of self-destruction, sleep and appetite disturbance, well, we don't want to offend them by suggesting they might have a mental health problem.

There is a web of misperception that confuses so many well-meaning efforts. Stigma about mental illness is a piece of this Gordian knot, but there are others too. Welfare staff are fearful that child protection staff, who necessarily see the child as their client, will take drastic measures against mothers if they reveal things like mental illness and substance abuse. The child welfare system is itself fighting an uphill battle to encourage people into treatment. Questions about the appropriateness of work for people with mental illness are another strand in the knot that tangles up large swathes of the system. This may not even be due to stigma, but more likely, widespread unawareness of the empirical evidence that work has **not** been shown to cause relapse or symptom exacerbation. Minnesota, as elsewhere, continues to struggle with the results of the historical separation of social service systems, divorcing the efforts of professionals who are trying to help clients get healthy (mental health system), from the efforts of those who are trying to help them get work (vocational rehabilitation). The child welfare system may present inadvertent barriers to service by some eligibility requirements. The resulting bi- and trifurcation of efforts on behalf of a single client on welfare can be dizzying, and cause wasted and misdirected activity. One of the huge problems in social policy is that services are labor-intensive. Redundancy is not just a waste of resources, it is a colossal waste of precious and scarce resources.

Efforts to quantify the problem of people with mental health and chemical health barriers continue. Minnesota has begun to use administrative data to match the overlap of TANF recipients using mental health services or psychotropic medications. During one of the time frames studied, 58% of the sample had received either a Medicaid-funded mental health service or psychotropic medication.

Another background factor is the deep personal ambivalence about work, welfare, poverty, and disability among staff. Approaches vary from "tough love," i.e., force them to work, versus a softer "social service" approach. Many long-time staff who view themselves as "supporters" do not like the shift to a "disciplinary" role. When a recipient has mental health issues, helpers often feel they are being "punishing" rather than supportive by insisting on work. And on the mental health side, deep divisions exist around the fundamental question of whether work is therapeutic or, conversely, is too stressful. The latter group is strongly inclined to write letters exempting people from work requirements, often unaware that the 60-month clock is still ticking. Further, many mental health staff have no clear idea of how to support a person who wants to return to work. The mental health system has not traditionally been expected to deal with work issues; indeed, it has been discouraged from doing so. Fee-for-service Medicaid regulations create great caution about how to include employment supports in the benefit. Welfare staff, struggling to help a financially impoverished single mother with

several children improve parenting and home management skills, feel overwhelmed by the added demands to help support employment goals as well.

Current PRWORA policy/practice interventions acknowledge both explicitly (through specialized funding and programs) and implicitly that the TANF clientele requires broader based interventions than merely financial assistance. A similar situation confronts employment specialists performing U.S. Department of Labor-funded state labor exchange activities that historically have been designed to deal with long-time workers confronting relatively short periods of unemployment. With the population remaining on TANF whom these workers have to assist in job finding, this structure appears inadequate.

The Washington Experience

Clearview Employment Services is a program of Columbia River Mental Health Services, providing clinically integrated employment services as part of the overall system of care in Clark County (Vancouver), Washington, which lies across the Columbia River from Portland, Oregon. This program is focused on helping all clients build hope, [re]discover their strengths, and [re]develop faith in their own abilities. Services through Clearview include career counseling, vocationally related case management, support, job coaching, vocational assessment, and job development. In fiscal year 2002, Clearview helped over 129 people served through the mental health system to obtain employment (including 70-plus people served through its specialized projects for welfare recipients with mental health barriers, many of whom are also enrolled in the MH system of care).

Clearview's service design:
- Uses a person-centered career planning approach in the assessment of interests and abilities and the design of service delivery.

- Emphasizes rapid job entry and wraparound planning and supports.

- Provides intensive on- and off-the-job supports by use of "vocational specialists" for personal support, advocacy, community, and personal resource linking, including an initial "rally" to build momentum in this direction.

- Provides community-based vocational assessments through selected employers.

- Uses peer and natural supports, such as peer support groups, personal networking for job acquisition, and worksite mentors.

Using this formula, Clearview planned to assist people who were long-term welfare recipients and had barriers to employment related to mental illness and/or substance abuse through a local Welfare-to-Work (WTW) contract. The original design called for serving 80 of the "hardest to serve" (by federal definition, those on TANF at least 30 months and facing multiple barriers to self-sufficiency) recipients and helping at least 40 get jobs. After 2 years of operation the program served well over 100 people, and helped over 70 get permanent employment. A screening tool developed by local mental health agency staff was provided to TANF personnel. The purpose was to allow them to identify people who might benefit from referral to the program, not necessarily to initiate a thorough diagnostic mental

health assessment, though clients were offered this as a service if they were so identified. Initially it was assumed those individuals who fit the WTW criteria were similar to those individuals served in the mental health system. Those individuals may have experienced depression, anxiety and other such symptoms. When Clearview first received the funding, it wanted to target individuals within its parent community mental health agency. This proved much more problematic than initially thought for a variety of reasons. A significant one was the fact that Clearview staff, because of their outreach to and interest in serving TANF clients, were not ready for the naïveté and lack of knowledge of mental health system clinical personnel on the issues of welfare reform. The majority of the MH staff was not aware of clients' financial issues/funding, the guidelines of welfare reform, or PRWORA. Over 50% of the clients served were already involved at time of referral, either as primary or secondary (i.e., their children were receiving services) consumers of the mental health system of care.

Initially the belief that Clearview employment staff held—that individuals had the inherent desire to work—was quickly challenged as individuals engaged in power struggles with financial workers to keep their TANF checks. It seemed as though people consistently gave excuses, related to medical and psychological reasons, saying that they were unable to work, which raised the issue of whether or not the welfare exemption from work activity due to disability was causing inadvertent inducements to claim disability status regardless of the person's ability to get work. While this exemption was intended to provide people in truly difficult circumstances a cushion, it was based upon a flawed theory about who could work and what services were available to support people looking for work. This was in contrast to individuals who came to the program voluntarily through the mental health center, wanting any kind of employment. Whereas moving towards employment was an explicit expectation of WTW funding and indeed, within PRWORA generally, work wasn't (and still isn't) a clear *expectation* of clinical intervention within a mental health system of care but rather an *opportunity* for those who chose to seek it out.

Clearview staff spent much time with clients identifying their strengths, establishing what conditions and environment a person with active psychiatric symptoms would need to be successful. Often, people would come to the program with an unrealistic vocational goal. This goal was not confronted as unrealistic but rather seen as a part of the vocational development process, and the strategy used was to identify threads from that goal that could be woven into transferable steps and goals. With WTW clients, excuses and often outright refusal dashed most of the possible lines of vocational inquiry tried. What seemed to be unrealistic short-term vocational goals were cited as expectations and jobs were turned down because they didn't meet the exact conditions. The power struggle between the individual and the TANF agency was also apparent, most clearly manifested in clients being sent to Clearview involuntarily, quite different than the core mental health program design.

The TANF recipient identified and mutually agreed to concrete steps with the TANF case manager, but as the local TANF office became more focused on measurable and accountable activities, power struggles increased. Clients had to provide documentation or prove that they had accomplished the steps. Failure to do so would result in sanctions. This accountability was in clear contrast to the mental

health system, which is largely based in voluntary treatment and participation. If an individual claimed that they were unable to participate in the activities identified on the plan, they would need to provide the documentation of such issues such as medical or psychological conditions. Some individuals did get jobs just to get "off" the system rather than getting into struggles with TANF staff over whether their conditions were trivial or they were malingering.

In a more clinical vein, Clearview employment staff often were concerned about clients seeming to display paranoia that the TANF agency was against them, problematic traits manifested in causing friction between mental health and TANF staff. This behavior is often referred to in therapeutic terms as "splitting," that is, one staff feeling the need to "rescue" the client from problems caused by another staff or system, with the assumption that the client was using this as a strategy to cause confusion and thus enable him/her to avoid needed change. An interesting observation in the Washington demonstration was that in some ways, the tension was caused by some role reversals between the MH and TANF staff. Unlike many states or even other parts of Washington, the Clearview Employment staff held unequivocally to the belief that all people can and should work, while some TANF staff were looking to Clearview to provide them data justifying that the particular family member should be exempted from work activity.

The more agencies involved with a family, the more opportunities there were for a client to engage in what professional staff described as "manipulative" or more accurately "dysfunctional" behavior and become overwhelmed by the responsibilities indicated on the plan. Frequently, each agency had a separate direction or tasks for the client to complete. Anxiety and emotional dysregulation were evident through many of the interactions that were observed with clients in the Washington project. What these staff observations were not able to discern, however, was cause-and-effect relationships between the difficult and complex situations TANF clients found themselves in and the occurrence of these behaviors. More simply put, it is unclear from the Clearview experience in Washington whether such conduct was a logical response to a dysfunctional human service system or whether the people referred tended to fall into these clinical categories. Part of the virtue of Clearview's position as part of a comprehensive mental health center was easy access to mental health diagnostic assessment. However, most clients, if they were not already engaged in treatment, did not choose to avail themselves of this option and, where it was rendered, diagnosis often led to the clash in cultures between the mental health tendency to try to "exempt" and "protect" and the TANF "mandatory work activity" formulation.

Clearview had the opportunity to walk on both sides of the fence. To the TANF agency, it was providing a service and had to become acquainted quickly with the guidelines of welfare reform. To the mental health center, Clearview was a part of their agency, staffed by mental health workers. As the two worlds collided, Clearview staff observed quite a few differing perceptions between the agencies. Originally, the local TANF agency was hesitant to refer people to the program, as its staff perceived the mental health system as enabling and protecting clients. Conversely, the many clinical personnel within the mental health agency felt that people were being forced back to work who were

not yet ready or prepared. Clearview often felt caught "in the middle." The first several months of this project was spent overcoming the TANF agency's perception that Clearview was going to help individuals with a therapeutic (i.e., overly protective), approach rather than a work search orientation and that the program wouldn't communicate fully with TANF. The mental health center was viewed as a "black hole" where clients were referred and never heard from again. Communication about a person's treatment progress, participation, or even whether they were accepted into services was rare in the eyes of most TANF agency staff. TANF social workers would identify an individual they felt might have symptoms of mental illness and they would refer that individual to the mental health center. They perceived that this person was accepted for services, would receive intensive treatment, and become cured, and would return to the work search. During this time of treatment, the client would be deferred from a countable work search activity. As the project progressed, local TANF caseloads came under increasing scrutiny from state administrators, which translated into increasing "pressure" for local staff moving more of their clientele into countable work search activities.

Even though the welfare system and the mental health system collided on several levels, through this project Clearview was able to assist in the communication process between the agencies. It was able to help some clients gain access to, and others use more effectively, needed mental health services, and facilitated a communication system from the point of entry into the local mental health system of care. Regular dialogue was established through reporting and frequent meetings at both the direct service and supervisory levels of both agencies in order to facilitate information flow. Clearview staff acted as liaisons to both systems, which allowed them to complete case staffings, report on a person's progress, and describe a person's environmental issues of which therapists might not be aware.

Policy Implications and Recommendations

It is possible to create a philosophical fusion of all of these apparent contradictions, albeit with difficulty. Work, carefully found and supported, is health-enhancing and also part of the social responsibility we all bear as citizens. There are a number of strategies that can be used to help staff to surmount barriers that exist. Some may include:

1. While major systemic reforms, training, and interagency linkages are crucial pieces of the change strategy required, the need to assist individuals to reframe their personal view of the world cannot be ignored. Because work historically has not been a major focus of mental health outcomes, adding this factor to the barriers that have led to long-term welfare dependency for those without mental health issues affecting their lives complicates the personal change process in which recipients must engage. As one recipient with mental health problems stated at a national meeting on helping people with disabilities move off public assistance attended by one of the authors: "By the time I applied for public assistance I already decided I was a self-identified failure, so I needed to and wanted others to help me deal with that self-image at the same time they were asking me to get a job and leave public assistance behind." Lower standards of achievement in many life areas for staff assisting people with mental illness, whether on public assistance or not, have been ascribed to factors such as "severity of the disability" or "system disincentives." It is now time for personnel in the mental health, TANF, and WTW systems to consider the possibility that in addition to these well established stumbling blocks, other obstacles exist in the nature of

minimal expectations for achievement, diminished capacity for hope and positiveness, and lack of systemic accountability for poor performance of staff members and programs. Before hope can be instilled in program recipients, it must first be instilled in the staff. Program supervisors must ensure that staff has an awareness of the Recovery approach, including systematic exposure to people who have actually recovered. The GAO report (GAO, 2002b) describes the work outcomes across a broad population with many barriers. As barriers go up in number, work outcomes diminish; however, more than 50% of those studied with two or more barriers were meeting work expectations. A corollary to the need to create a greater sense of "hope" in recipients is the concurrent obligation to help people move out of what seems an inevitable status quo of economic stagnation by a strategy that includes "hassling." By this term, we don't mean using power and authority to force people into untenable positions or to mandate behavior change while ignoring the multiple systemic, socio-environmental barriers that recipients face. Rather, we are speaking of the reality that all people and systems require some internal and external motivators to move off stasis in their situations. In more traditional welfare reform literature, this synergy between "hope" and "hassling" is discussed in terms of the relative weight that sanctions and supports have within program and policy design.

2. The knowledge base within the research literature on employment of people with mental illness must be brought into the efforts to support recipients with mental illness off TANF. The project in Washington state mirrored some of the problems involved in the issue of welfare reform as a whole vis-à-vis the balance between support and sanctions as a way of effecting individual change. One interesting dilemma that Clearview Employment Services faced in implementing its program was trying to use best practice findings from mental health employment research. Consistent findings in this arena stress the utility of active job search in the community (i.e., getting people to contact many employers and solicit many job interviews) over the teaching of job readiness or job seeking skills in classes. This approach was sorely tested in that the local TANF agency was quite concerned initially that clients' 20-hour work activity requirement was not as well monitored through this technique as through daily on-site classes where people could be counted. Clearview managed to navigate these perceptual impediments through a multi-pronged strategy that involved modifying some of its procedures to include daily group check-ins, a point-of-entry job seeking skills group, buying clients diaries to record their job search, and ultimately proving by its success with a population labeled "hard to serve" by the local TANF staff that their methodology, in fact, served the larger purposes of PRWORA and achieved the desired outcomes. In sum, TANF should be able to support universal work requirements, even for those facing barriers due to mental illness, as long as the concept of adequate, intensive supports is concomitantly recognized.

3. The analog to #2 above, in terms of what the mental health system can draw from a policy perspective from the implementation of PRWORA, has to do with what is the most effective strategy for implementing broad system change initiatives that require system clients, system staff, and the community at large to reframe their world views. Much has been written within the organizational literature from business about the importance of changing behavior as a precursor and a stimulus to changing values rather than vice versa. (Beer, Eisenstat, & Spector, 1990; Marrone, Hoff, & Gold, 1999). It is practically a tautology to state that welfare reform, in its short history since 1996, has had a more drastic effect on how welfare (especially TANF) services are delivered than evidence-based practice in mental health (Sanderson, 2002) or supported employment generally in the disability world (Mank, 1994) has had on their respective service systems. The reasons for this are speculative at this stage but it is the authors' contention that two key reasons are that (a) PRWORA has unequivocally made employment an explicit outcome for services in a way that mental health has not (as noted in #1 above); and (b) the focus of the reform has been

less on "practice" and more on a clear policy statement of expected outcomes and emphasis on flexible funding and experimentation not on fidelity scales related to the process of implementation. Many advocates argue that if the sequelae of mental illness result in limitations that require remediation to obtain functioning, then rehabilitation services focused on employment are medically necessary and should not be prohibited by Medicaid. If this reasoning is accurate, then the time may have come for a federal mandate for state MH systems of care to incorporate employment as an expected, reportable outcome. This expectation is complicated due to the localized nature of most MH funding and the complexities of Medicaid funding mechanisms and waivers but nonetheless needs to be explored more fully. However, another argument that has been made (though often derided as "unrealistic" in the vein of the "perfect being the enemy of the good" aphorism) is that the rubric of medical services does not provide the ideal construct under which to fund employment services (Hagner & Marrone, 1993). The support for this latter argument is that continuing to fund employment services as a "waiver" of existing authority, rather than as a focused funding stream, inherently devalues them and, in terms of broader social implications, dilutes an already underfunded, fragile safety net in health care in the U.S.

4. Co-locating mental health, chemical health, and welfare in the same office as has been done in several states. This strategy reduces the complexity of making referrals, and is less intimidating for recipients. Even in the absence of formal co-location, the Washington project spent much time in creating interactional opportunities for staff from different systems, including scheduled staff tours of the agencies, joint periodic informational meetings with both direct service and supervisory personnel, regular weekly case staffings involving MH Center and TANF staff, and consistent communication disseminating system, as well as specific client, information. But proximity, in and of itself, does not cross the philosophical and service intervention divide (or more appropriately, chasm) that separates staff steeped in a mental health culture from those inculcated within a TANF system. The leadership in all systems must reward, rather than discourage, collaboration among staff.

5. Intensive cross-training of staff in all areas is essential. This must be an ongoing process due to both staff turnover and the complexity of the issues involved. The scope of this training must include information about the respective systems' values and practices, overview of clinical and functional characteristics associated with relevant mental illness diagnoses (e.g., clinical depression, post-traumatic stress disorder), basic knowledge of PRWORA philosophy with opportunities for discussion about the underpinnings of this major paradigmatic shift, information about the prevalence and incidence of mental health problems within the TANF population, information about best practices in recovery, rehabilitation, and employment for people with mental illness for both TANF and mental health professionals, and innovative collaborative activities among TANF, mental health, rehabilitation, and workforce staff nationally.

6. The goal of assessment should be to determine the concrete supports that will assist the person, as they present, to become employed. Many states are focusing more heavily on "screening tools." Screening is of limited utility, particularly with psychiatric disability, in that it identifies problems without concomitant strategies related to overcoming them in the context of work and self-sufficiency. Recent assessment efforts in welfare have been to assess for barriers and deficiencies and to look at what further training is needed to make people job ready. Considerable interest, particularly in the form of research initiatives, has focused on identifying the number of barriers and their relationship to employability. While this defines the particular characteristics of a sub-sample of a large population, it does not instruct a caseworker on how to work with the individual person of concern. The discussion on disability in an environmental context has application, and rehabilitation approaches to assessment have potential for both mental health and welfare agencies, i.e., looking at

capacities, skills, and interests and finding out what type of work the person is ready for now. It also may prove to be an area for collaboration among mental health, welfare, vocational rehabilitation, and workforce development programs in obtaining non-traditional employment for people with atypical skills.

7. Federal and state policies should be developed to support integrated funding. Clients with multiple needs draw from many funding sources, and the challenge of putting together services is great. The desirable outcome is seamless (from the client's view) service delivery.

8. Analyzing whether the number of hours of work required for people with mental health disabilities should be modified. The issue of whether people with significant mental health problems can move as readily into full-time employment as those without such problems is open to much debate. Historically, it appears that people with mental illness have difficulty working full-time; what is not as clear is whether this is a characteristic of the illness itself or of the inadequacy of services and supports targeted to achieve this end. The advantage to people with disabilities is that there is a clear message that work is an expectation in terms of PRWORA's requiring minimum number of hours worked. One strategy may be to offer states the opportunity to receive credit for reducing exemptions and increasing an individual's vocational activity engagement gradually to 40 hours at some point in the welfare tenure. Protecting states that increase the number of work activity hours required for people and have the requisite percent of people engaged but do not meet the weekly 40-hour requirement may have longer range benefits for the welfare population, people with disabilities, and states. It would be fair to say that the disability community might be divided on whether or not therapy and related activities should be counted as meeting work requirements. The authors would say no, because it confounds goals to define therapy as work. As it relates to education, many people with psychiatric disabilities require longer periods of time to learn. Allowing states to extend the time an individual is allowed to count education toward a work requirement could be understood as an accommodation. This would be supported by the American with Disabilities Act of 1990 and be in compliance with the Office on Civil Rights mandate to provide accessible services to people with disabilities in the welfare system (U.S. Office on Civil Rights, 2001).

9. Supported employment techniques as developed through early iterations of welfare and adapted through VR may have significant implications for post-employment supports (Foley, Marrone, & Simon, 2002). Job supports that include a coach, mentoring, natural supports, and career development may help a newly-hired person find stability on the job. Other areas to explore are creative problem solving and self-monitoring of mental health issues or symptomatology. If people do not have more influence and involvement in the development of supports, they will not learn how to manage the bumps in the road later. Individuals should acquire the resources to seek services from their employer, community, and other private individuals prior to welfare. People should not be dissuaded from seeking mental health system help, but once having done so, should be encouraged to see themselves as competent beings who can mobilize a range of professional and personal supports. Adopting a Recovery approach supports growth and competence.

10. Rehabilitation philosophy regarding choice and self-determination ties engagement, motivation, and individual change to the involvement of the person in question. Welfare reform initiatives have clearly articulated the value of work for women and men in poverty. Policies and practices at federal, state, and local levels have transferred this mission to the people receiving welfare. If this mission includes people with disabilities, it does much to reduce societal bias toward people with disabilities and their employment potential.

Advocates would be doing a great service to inquire how systems are collaborating to support work efforts of people with mental illness in the welfare system. It cannot be said too often: People with mental illness can and should work. But the system, all of it, must learn to provide the needed supports to permit success. This must include the acceptance of mental health problems as part of many people's lives, problems that can be helped, not fearsome secrets. Furthermore, the system must be willing to accept not merely the presence of mental illness as a reality in the lives of many long-term TANF recipients but also the responsibility to use proven systemic and clinical strategies that help such clients move from welfare dependency to individual financial, career, and personally fulfilling success.

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Session 2

Restructuring for Partnership Between Disability and Generic Service Systems: Partnership to Improve Employment Outcomes for Individuals with Mental Illness: Collaboration with VR and TANF

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Discussion Summary

Joseph Marrone

While we value personal choice, there is a role for social policy in determining "acceptable" social outcomes, i.e., outcomes that we expect public money to produce. In the case of work, it is a reasonable expectation that people with disabilities should work as part of their social responsibility, and not just have the option to choose work. Are people who are currently involved in multiple systems in fact "more difficult to serve," and thus should the system not be expected to achieve many successful employment outcomes? While there are clearly people with multiple barriers, the data are unclear as to whether they present less chance of employment success. Also, all change is difficult no matter how well planned for, as it is often easier to envision changes other systems and people need to make rather than those we can see possible for ourselves or within our own spheres of influence.

Issues in VR - MH collaboration:

Overall Philosophical Issues Between the Systems Are:
1. How to reconcile VR and MH worldviews.
2. How to ensure collaboration as a systemic, not just individual, activity.
3. Success in collaboration is measured by results for clients, not staff satisfaction.

Structural Administrative Issues in Links Between the Two Systems:
1. Major systemic reforms, training, and interagency linkages are crucial pieces of change strategy, but the need to assist individuals to reframe their personal view of the world should not be ignored. Work has not been a major focus of MH outcomes.

2. The knowledge base within the research literature on employment of people with MI must be brought into the efforts to support clients of VR with MI.

3. Intensive cross-training of staff in all areas and co-locating MH and VR staff are necessary but not sufficient conditions of improved collaboration.

4. The goal of assessment should be to determine the concrete supports that will assist the person to become employed, not to screen for potential success.

5. Integrated funding and the use of MH funds to match and draw down federal VR dollars: Is this strategy a policy success or failure? What else besides joint funding works?

6. How can we use outcomes management as guidance for staff improvement, not as screening tests for clients?

7. How should we define "work"? There is no consistent definition across systems.

Virginia Selleck: Collaboration Between VR and MH and VR and TANF—
The Minnesota Experience

Specific Activities Undertaken in Minnesota:

1. An annually reviewed, formal interagency agreement between the two departments, and quarterly meetings of upper management.

2. Permission from the MH Division for counties to use social service dollars to provide needed match for VR grants.

3. Joint MH and VR review of RFPs, joint site visiting, and joint technical assistance to projects.

4. MH division staff assigned as liaison with VR and vice versa.

5. Use of a "forced collaboration" model as a condition of funding local projects.

6. Small federal research grant undertaken to measure the employment outcomes of the projects finding that measurably higher levels of collaboration in local projects resulted in more jobs for consumers.

7. MH staff has written the Rehabilitation Option of Medicaid benefit and set guidelines to support employment outcomes.

8. Efforts at data collection and sharing across departments.

Issues Im peding Effective Collaboration in Minnesota:

1. Disparate organizational missions (VR = rehabilitation and work oriented / MH = "treatment and support; symptom reduction").

2. Different bureaucratic structures (VR= federal rules / MH = state).

3. Different provider array (VR = rehab agencies / MH = mental health centers).

4. Different funding methodologies.

5. Different approach to the client base (VR = many disability groups, but a single focused mission on employment / MH= more narrow client base—mental health issues, but broader number of life domains of interest).

6. Stigma about mental illness on the part of VR staff; ignorance of supported work technology plus poor attitudes about the value of work on the part of MH staff.

Steps Taken in Minnesota Include:

1. Statewide introductory training of TANF staff on the subjects of mental illness and chemical dependency.

2. The creation of a self-screening tool to identify mental health and chemical health issues in TANF recipients who have failed to make adequate progress in fulfilling work requirements. This tool was created in the context of a broad stakeholder advisory process, and was subject to careful pilot testing. It has been found to accurately identify people who can benefit from professional evaluation.

3. Collaborative training between TANF, MH, Chemical Health, and Child Welfare staff to roll out the screening tool illuminated the disconnects present in many areas between local social service entities. The stigma and fear attendant to these issues were present in a significant number of employment counselors; at the same time, this level of discomfort often provides the impetus for future collaboration

4. Data sharing across systems has yielded evidence that TANF recipients are seen in the medical system (cross matches with pre-paid plans diagnostic and medication data) for mental health concerns at a high level, variable by county from 23% to 78% in one sample. This has been done concurrently with statistical modeling that holds demographic and economic factors constant across counties, permitting comparison of the relative effectiveness of TANF program implementation.

5. The Minnesota iteration of the Medicaid Rehabilitation option has sufficiently broad eligibility criteria to permit its use with most TANF recipients with mental illness conditions.

6. A broader data sharing project is under discussion to identify that portion of the population served by multiple systems in order to maximize coordination and reduce duplication.

7. These efforts are a beginning. The challenges to full-fledged collaboration are great, and the motivation of the systems to pursue it remains an open question. Economically, MN is not currently in danger of exceeding the 20% post 60-month cap (i.e., the federal mandate requiring that no more than 20% of a state's TANF caseload be receiving welfare funding for over 60 months). Until we are forced to rely on state funds alone to support these individuals, it may be more palatable and certainly easier to just extend people's benefits rather than rocking the boat by insisting that systems change.

8. In any case, cross-training efforts will pay off now for social service systems with shrinking resources and multi-tasking workers in all corners. The training agenda needs to include:

   • Training TANF staff about other social services and how to access them. This is critical for the TANF worker needing to assist a recipient with a child with disabilities, for example, or dovetailing the supports that can be provided by Medicaid-funded rehabilitation services for TANF recipients, or how VR might appropriately play a role.

   • Training TANF staff about disabilities of all kinds in order to reduce stigma and fear, and increasing the organizational capacity to appropriately screen and refer without necessarily letting go.

- Training MH and other social service staff about the rehabilitative value of work and at least the bare-bones outline of the TANF system to enable them to understand the consequences of exemption from work requirements and the relative benefits offered under the TANF and Social Security systems.

Elizabeth Edgar: Respondent

1. This information validates the importance of requiring MH systems to publicly report employment data.

2. Collaboration and resource sharing between VR and MH has been a positive experience in other states.

3. The effectiveness of joint training programs involving a residential, immersion experience funded through an RSA grant and involving VR and MH staff over a several week period stressed to me the importance of ongoing training and support, not just a conferencing experience.

4. Changes in Social Security and Medicaid rules are needed to make it financially feasible to work for people with mental illness.

5. Housing subsidies and supports are a concurrent issue to be attended to if employment efforts are to succeed.

6. MH providers and systems need to hire more people with mental illness in a variety of jobs to role model the belief that people with mental illness can work.

Discussion Points
- It is important to do third-party match arrangements to draw down maximum federal dollars, but two dangers are that you have a bunch of uncoordinated projects primarily to "chase dollars" and also you "rob Peter to pay Paul."

- Minnesota projects worked because VR and MH central office staff had worked together on VR- MH issues for over 15 years and shared a vision and mission. Also, the League of Women Voters was a strong advocate for legislative support. Furthermore, these start-up funds created a demand for state-sponsored employment support to avoid a "crisis" of people's losing jobs due to initial funds running out without long-term support.

- The point of collaboration is not to collaborate better—but to get good outcomes.

- Differences in the length of time in which agencies provide services need to be resolved. VR runs into problems when it tries to coordinate better with more time-limited service streams (e.g., TANF services) and so if VR believes a 4-year college program is the best option for a client, VR then might run the risk of working at cross-purposes with the welfare system goal of terminating welfare benefits sooner rather than later.

Session 3

Restructuring for Partnership Between Disability and Generic Service Systems: Partnership Between VR and Workforce Development

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Note: Discussion for this session was incorporated into the final manuscript.

Partnership Between Vocational Rehabilitation and the Workforce System

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The ability of individuals with disabilities to work is clear, but the capacity of the system to support individuals in finding employment and moving out of poverty has not resulted in success for all the individuals who want to work. The 27th Institute on Rehabilitation Issues (2001) identified the challenge of the high unemployment rate for people with disabilities and the demand for skilled labor as indicators that "state vocational rehabilitation [VR] agencies cannot go it alone" (p.xv). While they emphasize the unique and important role of Vocational Rehabilitation (VR) in serving customers, there is an additional call for VR to expand its capacity through new partnerships and collaboration with the rest of the workforce system.

The central goal of the Workforce Investment Act (WIA) is to bring together various employment and training entities into an integrated workforce system to meet the needs of all individuals, including people with disabilities. Previous research has indicated that individuals greatly benefit when service providers work in coordination with one another. It also shows that interagency linkages can increase the probability of successful rehabilitation outcomes. Dellario (1985) found that individuals who used agencies with highly functioning interagency linkages had increased probabilities of a successful vocational rehabilitation outcome. Rogers, Anthony, and Danley (1989) also found that interagency collaboration between state VR and other systems resulted in improved consumer outcomes.

Although a goal for each agency is to provide job seeker assistance, each system has its own service delivery model, traditions, and experiences (Cohen, Fesko, & Timmons, 2002). For instance, the rehabilitation model (which focuses on the functional abilities of individuals and how to use them to increase independence) is vastly different than the medical model (operating under the supposition that there is something inherently "wrong" with a person with a disability) that guides many systems. Central tenets of the VR system, such as the importance of individual choice as well as the empowerment of individuals to take control of their job search, are not the focus of other agencies that have a "work first" orientation.

Under WIA, agencies with different roles, histories, cultures, authorities, and priorities are expected to collaborate for one common mission. Expectations about accountability, supervision, and responsibility for decision-making are vastly different across agencies. Although multi-agency coordination is a desirable objective, due to a combination of structural, philosophical, cultural, and financial blocks that arise in practice, the process has proved difficult to achieve (Perry-Varner, 1998). Mazzella (2000) described many of the systemic barriers to interagency collaboration. These

obstacles included: differences in organizational culture and procedures, which often lead to an unwillingness to take risks or compromise; funding sources, which may limit flexibility in the sharing of resources; turf issues, in which one or more of the organizations do not want to relinquish power and responsibility for the services of the individual; and the misperception by stakeholders that regulations will not permit collaboration.

As states begin to identify and work through these barriers, they are learning to appreciate the expertise of their partners, and beginning to see that they are stronger through collaboration than they were as individual agencies (Fesko, Timmons, & Cohen, 2002). As the partners define these relationships, there are essential components that must be present while undertaking a collaborative effort. Research shows that collaborations are more successful when they are focused, such as on a particular group or community, and when members work towards a mutual goal (Elder, 1980). Findings also indicate that the most successful collaborators share a common perspective with regard to their responsibilities and have a mutual respect for their counterpart agencies (Dellario, 1985). Additional elements that have contributed to success include staff training on the scope and type of services each partner provides, as well as formative, or process, evaluations that help to chart the course of a collaboration and provide a valuable record for lessons learned throughout the process (Bruner, Kunesh, & Knuth, 1992). Finally, the purpose of the collaboration must be clear, ownership of the process understood, allies identified, and an agreement to act in place (Butterworth, Foley, & Metzel, 2001).

Collaborative efforts between VR and the workforce system began in some places prior to WIA, but for the majority of states, the newly mandated partnerships were unexpected and not always welcome. To some extent, this sense of forced collaboration has contributed to anxiety about, and resistance towards, these developing relationships. It has also caused some in VR to question whether they will continue to have a role in this new workforce system, as the emphasis moves towards job seekers with disabilities having access to typical One-Stop services. In addition, the level of funding being provided to states under WIA has decreased by 20% since implementation and has contributed to the challenges facing the workforce system.

Considering these pressures, it is not surprising that collaboration between VR and the workforce system has taken on a variety of forms across states. Some states have made the co-location of VR staff in all One-Stops a priority, while others have staffing on an itinerant basis or a combination of full co-location and itinerant staffing based on local needs. The predominant model in Kentucky, for example, is three agencies, typically VR, Employment Services, and the Title I provider, serving as the operator. In this model, three managers are empowered to sit down and negotiate the day-to-day operations of the One-Stop. In contrast to Kentucky, there are states that have limited interaction between VR and the workforce system, and their connectivity is primarily through referral and electronic information exchange.

Multiple factors have impacted how states have embraced the principles of a seamless service delivery system. Despite accepting the concept of partnership, some states face challenges in actualizing this

goal because of limited resources and the complexities of operating within a bureaucratic system. There are other states, however, that remain unconvinced that collaboration best serves their customers. Their limits in partnering are the result of philosophical differences rather than practical ones. This stems from the concern that individuals with disabilities may not receive the services they need in an integrated system because One-Stops may not be adequately prepared to work with this population.

Although partnerships between VR and workforce development agencies may look different across the country, there are common themes or challenges across all designs as states and local entities are implementing WIA. Some information for this paper is based on case studies completed as part of the NIDDR-funded Rehabilitation Research and Training Center that were conducted in Kentucky, Maine and Minnesota by research staff at the Institute for Community Inclusion (ICI). These states were selected based on a national nomination process, review of nominees by an expert panel, and information from a screening interview. The studies described how states have begun to collaborate under WIA, how they have included individuals with disabilities in the planning process, and how they have supported access to One-Stops for individuals with disabilities. Interviews were conducted with key players at the state and local level. Qualitative data analysis was conducted using interview transcripts. State-specific summaries were developed that described the themes of how states have incorporated this new mandate in their operations.

The following paper is presented in two parts. The first section identifies three primary challenges as described in the case study research conducted at ICI. These challenges were prepared for, and presented at the State of the Science conference. They include: (a) resource sharing; (b) the evolving role of vocational rehabilitation staff; and (c) respecting and maintaining client confidentiality in a merged system. This paper will discuss how each of these challenges has affected the nature of collaboration and partnership between VR and the workforce system. It will also offer suggestions on how these issues can be addressed to better meet the employment needs of individuals with disabilities.

The second section raises additional challenges, strategies and recommendations that were generated by State of the Science attendees in response to the presentation. Issues discussed in this paper are intended to inform research, policy development, and practice.

Resource Sharing

In many states, partnering agencies initially experienced difficulty agreeing on guidelines for cost allocation within One-Stops. The Department of Labor has issued directives concerning how to calculate shared costs. In addition, the Rehabilitation Services Administration (RSA) has cautioned states about the need for VR to closely follow RSA guidelines and their obligation to direct funds to client services. These federal policies then must be interpreted locally. Most states developed cost allocation guidelines to assist local boards in developing a plan that delineated each local partner's financial commitment to sustain the One-Stops.

Many partners felt that creating an effective plan for cost allocation was one of the biggest challenges associated with implementing WIA. For states committed to collaboration and partnership, the logistics

of sharing costs while staying within the limits of their program guidelines was difficult. In many states, cost allocation guidelines were developed at the state level, but applied flexibly within local areas. Challenges related to resource sharing included: (a) shared office space; (b) shared staffing; (c) marketing; and (d) fiscal silos, and (e) complexity of guidelines.

Shared Office Space

When initially addressing shared office space, the Portland, Maine Career Center shared rent based on a 40/40/20 split, where VR was responsible for 20% of the cost since 20% of the customers were VR clients. In July 2001, the RSA mandated that VR funding could not be used to pay for the Information Center/Resource Room because it was not specifically focused on serving VR clients. RSA clarified this mandate, noting that rehabilitation funds can only be used for rehabilitative services. This meant that the partners needed to work creatively and collaboratively to find a solution that did not violate the federal directives. As a result, VR acquired a greater share of the reception and switchboard to offset the expense the other partners needed to absorb.

Costs were also allocated by type of space. In Minnesota, space was categorized as: dedicated space, common space, and shared space. Dedicated space was used and paid for exclusively by one program. Space like the conference room or the reception area was common space, used by all partners. Calculation for common space was based on either the amount of time (in number of days) a program used the space, or the bill was simply divided among partners. Shared space was different than common space because it was used by many partners but not all. An example of shared space is a training room that VR did not use but was widely used by others, such as Title I and Title III programs

Shared Staffing

Many agencies struggled with an inadequate fleet of staff members to co-locate within One-Stops. In Kentucky for instance, the Department for the Blind did not have enough staff members to have their agency co-located on a full-time basis. Staffing cutbacks at some agencies because of economic downturns exacerbated this issue. A lack of adequate staffing also deterred staff that from attending trainings because there was insufficient staff to cover the operation of agency services.

Agencies dealt with this problem in a number of ways. Staff were co-located on an itinerant basis, and rotated among One-Stops in the area. Staffing constraints such as these often resulted in creative management. In the Portland, Maine Career Center, the partners came together and reached a consensus that involved all four agencies sharing responsibility for the reception/switchboard areas and the Information Center. In addition, the switchboard was moved from a back room up to the reception area so that reception staff could operate it without the presence of a separate operator.

Marketing

Marketing the One-Stops was also a difficult issue. Many agencies wanted "their" funding to go directly towards helping people find jobs. The concern was that if too much of the budget was spent on marketing costs, funding would be scarce for the provision of actual services. It was also important

to consider that marketing of One-Stops will bring in more customers, allowing partners to provide more services. Despite this, many agencies were reluctant to dedicate too much funding to administrative costs.

An additional concern raised in regard to shared marketing efforts is whether to focus on the combined resources of the One-Stop or to promote the individual service providers. In Kentucky's Bluegrass area, the Title I program has shouldered the costs of marketing material. This material broadly depicts One-Stop services and does not focus on specific agencies or programs. For states where VR has shared the cost of the marketing material, they have typically wanted materials to focus on the needs of their customers, not the broader One-Stop customer base.

Fiscal Silos

One of the most significant challenges faced in WIA implementation related to cost allocation is the fiscal silos, mandating that agency funds can only be used for specific purposes. While WIA "mandates" a cohesive system, it is left up to the local areas to figure out how to implement the directive. Conflict exists at a local level because although they have been given this responsibility, they see their federal mandates as interfering. The federal mandate issued can be particularly challenging for VR since WIA is U.S. Department of Labor legislation that is instructing an agency that is accountable to the U.S. Department of Education.

Complexity of Guidelines

Another challenge that hinders more effective sharing of resources is the complexity of the current guidelines. Federal guidelines issued for state agencies that are accountable to different entities have been cumbersome for local administrators. Partners who seek to cost-share with other agencies may be stymied by the bureaucratic obstacles encountered when establishing collaborative financial agreements. Many partners felt that the lack of an effective cost allocation formula prohibited agencies from working together. The complexity of the current formula prevented people who are interested in collaborative work from taking on this challenge.

Discussion

The benefits of relationship building and trust that result from resource sharing may outweigh the challenges. Anecdotally, staff reported that being part of an integrated workforce system was beneficial to their job performance since it broadened the range of resources available. In addition, secondary data analysis conducted at ICI on the Heldrich survey of One-Stops suggests the importance of the contribution of VR on site. One-Stop managers and operators reported a significant, positive relationship between VR presence and satisfaction with their partnership with VR (ICI, 2002). The more time VR spent at the One-Stop, the more satisfied respondents reported they were with their relationship with VR. Therefore, creating opportunities for resource sharing can help build these relationships and benefit the staff as well as the customers.

The Evolving Role of Vocational Rehabilitation Staff

VR has experienced much turbulence since the passage of WIA. There have been (a) concerns regarding job security and (b) challenges around merging organizational cultures.

Concerns

As staff from partner agencies began to meet and discuss areas of collaboration and crossover, a primary concern expressed by staff from all agencies was how these changes would affect their personal job security. When cross-training was suggested to familiarize staff with one another's agencies, it was assumed that the intention was to prepare staff to perform the functions of the partner agencies in order for staffing to be reduced. Over time, staff realized that there was substantial work for everyone, but expressed concern about the implications of agency collaboration for professional identity. For VR counselors who had specialized training and advanced degrees, the prospect of individuals with disabilities being served in One-Stop Centers suggested that their skills were no longer needed. VR staff were concerned both for their professional status and their clients and the level of specialization in service delivery that they may require.

Merging Organizational Cultures

VR and other agency staff who have begun to share office space and resources are also working through the challenge of merging organizational cultures. Differences as basic as the hours staff work and the amount of time spent out of the office seeing customers must be negotiated. A more significant consideration is the different type of staff working side-by-side. Some staff are union members, some work for the state, and others work for private providers. This results in a range of salaries and titles used for staff providing similar functions. Together, all of these differences can undermine the fabric of the collaboration.

Discussion

Rather than threaten VR, the changes mandated under WIA should be seen as creating opportunities. With approximately 36 states in an order of selection status, VR is no longer able to serve all eligible clients and can serve only those who have the most significant disabilities. In the past, VR had limited resources to offer individuals who were eligible but could not be served due to order of selection. Individuals with disabilities that are eligible for VR services but do not meet the state's order of selection must be referred to One-Stops for employment-related services.

While a strength of the VR system is its ability to provide extensive career planning and development services, securing these services can be a lengthy process. Some individuals may begin this process with VR but become frustrated because they are financially insecure and need immediate income from a job. One-Stop services can help address the short-term employment needs of the individual, while the VR counselor can continue to aid in career development.

For many reasons, such as stigma or frustration with the system, some individuals with disabilities will choose not to enroll with VR. One-Stops can provide a reasonable alternative. Rehabilitation staff is committed to the importance of work and economic independence for individuals with disabilities. Where the individual receives these supports is less critical than the achievement of these goals.

Although professional identity challenges were reported by VR staff, the new opportunities created under WIA allowed VR to reevaluate its role in the workforce system and renegotiate how it serves the needs of its clients as well as those of the larger community of individuals with disabilities. The knowledge and expertise VR staff brings to supporting people with disabilities is critical, but the mechanism by which this service is provided may need to evolve over the upcoming years.

In Kentucky, VR has taken on the role of consultant as the staff prepared the range of One-Stop partners to effectively serve people with disabilities. Rather than operating under the assumption that VR staff will serve all customers with disabilities, VR is building the capacity of partner agencies and providing them with resources. This consultant role can be labor-intensive, but over time One-Stop staff have been able to handle these issues independently. From the workforce perspective, the time VR staff has committed to this consultation has been extremely helpful. Workforce staff in Minnesota identified the strong ties VR staff had in communities and schools as assets that have strengthened the entire One-Stop system.

VR consultation is also being sought from secondary schools for students transitioning into adult services. Recommendations for revisions of the Individuals with Disabilities Education Act (IDEA) have included a VR staff member to become a member of the educational planning team for students as young as 14 years of age. The expertise VR could bring to this planning process would be valuable in helping to ensure that students have vocational opportunities while they are preparing for life after graduation. While the advantages to providing these services are clear, there are practical considerations related to expanding counselor workload to support these students. In addition, students that young would typically not have a case opened since they still receive services from the school system, so there is not a mechanism to acknowledge the work put into this effort. This proposal is in line with current VR regulations that require VR to provide outreach and identification of students with disabilities who are in need of transition services.

This consultation model creates an opportunity for individuals with disabilities to receive services in the most integrated setting while still ensuring that disability-specific issues are addressed. This approach capitalizes on the expertise of VR staff and expands the scope of a counselor's impact. However, the current administrative structure of VR makes it challenging to implement a system where staff spend time consulting with other professionals rather than providing direct services. Staff caseloads and expectations around time in status (length of time it takes a client to move through the system) will need to be considered in evaluating counselors' new roles. Instead of eliminating VR staff positions, the new collaborations may require some additional staff to either serve as consultants or to help to ease existing staff's caseloads so that consultation is shared across all staff. Currently, VR

federal regulations do not lend themselves to fully supporting staff time dedicated to consulting services.

Client Confidentiality

As a system, VR seems to place a different type of emphasis on maintaining the privacy of its customers as compared to other partner agencies. VR's commitment to confidentiality has been an inviolable philosophical underpinning of its service delivery for many years. Although this has historically been to the benefit of its customers, maintaining that emphasis on confidentiality can have an effect on collaboration. The differences are most striking in two arenas. Specifically, confidentiality issues come to the forefront when negotiating (a) private office space and (b) data sharing.

Private Office Space

For agencies that have begun to co-locate, assignment of private offices was a contentious issue. As negotiation of space was undertaken, VR has frequently required that their staff have private offices. VR counselors required private offices to see their clients (as had been their previous agency norm), but other agencies perceived this request as elitist. One compromise that has been used in some One-Stops is to group all staff within open spaces but have private counseling space available when necessary. In Kentucky, VR has insisted on private offices. This also has cost implications because more square footage is necessary for VR staff than for staff from partnering agencies.

VR staff was adamant about private offices because they felt that they discussed confidential issues that are protected by current VR regulations. While other agency staff also discuss private issues (particularly welfare agencies) there seemed to be a different emphasis on maintaining confidentiality. Although this created some tensions among agencies, VR counselors wanted to stay true to the culture and confidentiality regulations of their agency and protect the privacy rights of their customers.

Data Sharing

Not only do confidentiality concerns affect co-location among agencies, they also affect how agencies share information with one another. The reporting of performance measures for all One-Stop customers is required, yet there is no systematic way in which to collect or share this information. ICI conducted a National Survey of State Systems to study how state agencies involved in the workforce system collaborate and share information. In questions concerning common databases and data sharing, VR was significantly less likely to share data with other workforce partners (ICI, 2002). States have begun to develop data collection and operating systems, but these have typically focused on the needs of the workforce agency, with less consideration of the needs of VR. Of particular concern to VR is how their clients' confidentiality will be respected in this larger system. VR agencies are also demanding that all operating systems be accessible. Another practical concern raised is the reporting requirements of agencies. It has been challenging to find sets of data that are needed across multiple agencies.

There are both benefits and drawbacks of information sharing among agencies. One of the greatest benefits of data sharing is that it can facilitate seamless service delivery for job seekers. When agencies share data, assessment information can immediately be shared to ensure that customers do not have to undergo a battery of evaluations at each agency. Customers benefit by not having to repeat the same information to staff from multiple agencies. Front-line workers from different agencies can also work together to comprehensively serve the customer, instead of offering more fragmented services.

While the benefits of data sharing are potentially great, so too are the drawbacks if the information is mishandled or shared cavalierly. When personal information is shared among agencies, there is the potential for it to be used to discriminate against the individual. Also, individual privacy is a universally shared norm, and one that should not necessarily be sacrificed in the name of better service delivery. Therefore, a balance must be struck that keeps the integrity of the information, but shares enough with relevant parties to enable agencies to most effectively serve job seekers.

When data sharing does not occur, it can be to the detriment of both the customer and the system. For instance, in Maine, because the rehabilitation system had recently invested considerable resources in its own data system, administrators were reluctant to spend additional money and energy changing to a newer system created in response to WIA. This resulted in challenges completing daily, core administrative functions within the agencies. Additionally, they experienced substantial limitations in data sharing and the inability to capture use of multiple services.

Data sharing and performance measure tracking problems are compounded by the self-service nature of One-Stops. For all the partners, identifying the customers served, the services provided, and outcomes achieved has been an ongoing challenge. The use of the system by individuals with disabilities is potentially underestimated since it relies on self-identification and presumes the One-Stop has been able to collect the appropriate information.

Many states are currently experimenting with security tabs to create seamless service delivery without compromising confidentiality. Even without sharing referral or diagnostic information, a referral from VR automatically implies disability, which can be stigmatizing. The operating system Kentucky has been wrestling with involves a series of tabs with security clearances. Some basic demographic tabs would be available to anyone using the system, but more confidential information could be accessed only by a limited number of individuals. One challenge that arose in creating these tabs was the difficulty of communicating the importance of confidentiality to the technical staff who developed the system. Kentucky tried to ameliorate this problem by ensuring that front-line staff who will be using the system were involved in the development process.

Discussion

VR's steadfast commitment to maintaining the integrity of its clients' information has had both positive and negative implications for collaboration and service delivery. In one sense, VR is keeping a primary focus on the needs of the job seeker with disabilities, but alternatively, collaboration among

partnering agencies can be hindered when the practices of some agencies violate the norms of another. Ineffective collaboration serves neither the clients' needs nor those of the system.

State of the Science Response

Attendees to the State of the Science conference identified the following challenges and strategies in dealing with issues concerning partnership of VR and the workforce systems. Following this discussion, recommendations for policy, practice, and research are presented.

Challenges

In addition to some of the challenges discussed in the first section of this paper, conference attendees identified additional barriers to One-Stop service delivery for job seekers with disabilities. These challenges are based on their experiences implementing WIA in their own communities. Challenges identified included: (a) funding reductions; (b) determining performance measures; (c) the increased pressure for collaboration at the local level; and (d) the capacity to serve customers with disabilities.

Funding Reductions

A challenge that has faced most state agencies is collaborating when all agencies are experiencing significant reductions in funding. Directors in agencies are trying to continue to provide services and expand the range of customers served, but are being asked to do so with less funds.

Some attendees felt that VR is viewed as an agency with considerable funding and that other agencies look to them to for assistance in replacing the funding they have lost. Since most states are in an order of selection, VR lacks the funds to serve its own clients, much less share with other agencies.

Another consideration around funding is related to communication. Since many agencies are not familiar with working in partnership, they do not always clearly share information about anticipated costs. An example was given concerning an assumption that VR was going to contribute funds for a marketing brochure that had been developed without the input of VR staff.

Determining Performance Measures

The evaluation of services for customers who are served in the generic system as well as VR's role and time in supporting that system was raised as a concern. Obtaining an accurate picture of the number of individuals with disabilities who are served through the generic system is not possible since many individuals choose not to disclose that information.

One mechanism that has been considered for evaluating the workforce system is a cost-benefit analysis. In other words, comparing the amount of resources spent helping an individual find a job with the benefits obtained by the individual who receives the job. Using this mechanism could create a disincentive for One-Stops to serve customers with barriers to employment, since the time and expense of helping the individual get a job may not reflect well on paper.

VR is currently evaluated based on measures such as the length of time a client spends "from application to active status" and the number of clients who are successfully closed in employment. Time that VR staff spend with One-Stop staff or supporting customers with disabilities who may not be eligible for VR services is not captured by those measurement standards. A concern was raised about the potential for VR to appear less efficient by these measures when in reality, their partnership activities are helping a greater number of individuals find work.

The satisfaction measures currently being used must be more thoroughly evaluated to ensure that customers with disabilities are adequately represented in the customer satisfaction rate. If the overall satisfaction rating for a One-Stop is positive, but the majority of people with disabilities are not satisfied with their services, there must be a mechanism to capture this concern.

Increased Pressure for Collaboration at the Local Level

The nature of WIA has mandated that entities at the local level bear the pressure of increased collaboration with less of an emphasis on this need at the federal level. There are positive examples of collaboration that have been occurring locally but attendees advocated for greater state and federal level efforts that could foster even greater collaboration at the local level.

The regulatory standard that Memorandums of Understanding (MOUs) define the collaborative effort established at the local level has not been successful in application. Most attendees reported that MOUs are "boilerplate" and do not address the substance of how partnerships work. Those details are negotiated through personal relationships and informal communication. One director indicated a preference for not documenting details in writing since this makes it more difficult to be flexible or to respond to changes that arise.

The Capacity to Serve Individuals with Disabilities

While there were pockets of activity where people felt positively about the changes that have resulted from WIA, there is still overall concern about how this new system is meeting the needs of the individual with disabilities. Supporting people in their decision to work after experiencing long-term unemployment, and addressing the concerns that those returning to work have regarding benefits, are critical needs for this system.

The workforce system as it currently exists tends to focus on certain types of jobs that may not be consistent with the needs or interests of all individuals with disabilities.

Other agencies in a local One-Stop may have more emphasis on job attainment rather than job satisfaction or may not share the view of employment as a means to increasing community participation. Gaining a broader spectrum of employment opportunities will be necessary to serve individuals effectively. Finally, the concept of a seamless system where a primary person is coordinating services for individuals and specialized services (such as VR or apprenticeship programs) are brought in if necessary has not been actualized.

Strategies

While attendees spoke broadly about the challenges that they faced in the current workforce system, they were also eager to suggest specific strategies that have addressed some of these concerns. Strategies discussed included: (a) creating successful partnerships; (b) using joint funding; and (c) using neutral space when co-locating.

Creating Successful Partnerships

In some local areas, success has occurred through partnerships among school personnel, VR staff, and workforce staff. This has been beneficial in several ways: students feel more supported because they have more resources available to them, and staff feel a sense of accomplishment because they are providing services that eventually will have a positive impact on the employment outcomes of the transitioning students. Further, supporting students and helping them prepare for employment is usually less time-intensive than their usual work of helping adults find and retain jobs because VR is not the sole service provider. One drawback to this strategy is that VR cannot get "credit" for helping youth prepare for employment because actual job attainment is many years in the future.

Using Joint Funding

Another successful strategy cited during the forum is the use of VR funding to pay the salary of a One-Stop staff person. This staff person provides job development services for customers with disabilities. In this way, customers are served in the integrated environment of the One-Stop, with the availability of specialized services to meet the unique employment needs of job seekers with disabilities.

Using a Neutral Space

When discussing strategies that help to alleviate the tensions that may arise when agencies physically share space, it was clear that partners who move into a completely new center typically experience fewer turf issues than those who move into space that has been previously occupied by one or more of the partners. When partners move into neutral office space, this ensures that all agencies are on equal footing and that one agency does not feel more "ownership" of the space than others. This finding was also confirmed through ICI case study research with state One-Stop systems.

Recommendations

One purpose of the State of the Science conference was to generate research, policy, and practice recommendations that can be useful to the VR and workforce development communities. Recommendations from the session participants included: (a) reevaluating measurement and outcomes data; (b) focusing on the customer, (c) expanding VR's potential for influence and leadership; and (d) influencing policy at multiple levels.

Reevaluate Measurement and Outcomes Data

One challenge that was identified was how the changing role of VR (including spending time on staff training and technical assistance for partnering agencies who also serve customers with disabilities) is reflected in outcomes data. Spending time training One-Stop staff inevitably means that time spent interacting one-on-one with job seekers is diminished, resulting in a lower number of successful closures for VR staff. The way the data are currently reported suggests that the VR system is becoming less effective because of a smaller number of successful closures. In reality, through training and technical assistance, VR staff is contributing to the effectiveness of the entire One-Stop system. RSA outcome measures should be modified to reflect the dual roles of VR staff (as service provider, consultant, and trainer) and give credit for outcomes in both of these areas.

Many participants agreed that staff spend the most time and energy achieving the outcomes by which they are formally measured. If collaboration were a variable upon which agencies and staff were formally evaluated by their federal oversight agencies, agencies might spend more time working together. Coordinated guidance from federal oversight agencies regarding outcomes should reflect the goal of collaboration among the partners. With a joint collection of systemic outcome measures, each agency would receive credit for the role it played in helping a customer find employment.

Focus on the Customer

It is important for all partnering agencies to always keep their focus on the customer. One way to accomplish this is to consistently seek customer input throughout all steps in the process, beginning from when the customer enters the One-Stop. Input should be solicited at the onset regarding what the customer needs, and then how they perceived their needs were met by the One-Stop service providers.

Partners need to come together and emphasize what they can offer in terms of meeting the needs of both their agencies and their customers. Often agencies approach collaboration with the intention of filling gaps that have resulted from financial cutbacks and budget deficits. Agency collaborations should emphasize how to most effectively serve their customers and not how to secure extra funding from partnering agencies to make up for budget shortfalls.

Expand VR's Potential for Influence and Leadership

Session participants noted that at times it could feel like the VR system was somewhat isolated and focused solely on its own customers. Participants emphasized the need to send the message to VR that it is "OK to get out of their bunker." This is especially important because VR has the potential to be a driving force in the collaboration process. As an agency, VR is particularly experienced in providing case management and coordinating services for customers. Their expertise in providing services to customers with disabilities makes VR staff ideal in their role as consultants in the One-Stops, and could also enable them to be facilitators in the collaboration process.

Influence Policy at Multiple Levels

Although many participants focused on the changes that need to occur at the federal level, local and state government play an important role in the implementation of workforce legislation. Key players such as the governor and local and state legislators can take an active role in facilitating these collaborations and should be considered integral to this process.

Conclusion

Collaborative efforts between VR and the workforce system create challenges that have been worked through with creativity and ingenuity. The two parties have been working hard to best respond to the needs of their customers while tackling such obstacles as resource sharing, maintaining client confidentiality, and dealing with funding reductions. In addition to these challenges, VR staff have experienced changes in expectations related to their role in conjunction with workforce partners, major shifts in their work environment, and struggle with the One-Stop's capacity to adequately support individuals with disabilities. What remains promising is the eagerness of both parties to develop solutions that facilitate strong relationships, improve service quality and accountability, and allow them to move forward with a focus on serving their diverse customers.

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Session 4

Increasing the Participation and Quality of Employment Outcomes of People with Disabilities in Workforce Development Services: How Can/Should States Assess Outcomes on a Global Level?

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Assessing Outcomes on a Global Level

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Summary

This paper discusses selective measurement issues related to assessing the participation and quality of employment outcomes of people with disabilities in workforce development services. Issues discussed include: (a) defining target populations; (b) defining and measuring quality/success from individual, program, and One-Stop system perspectives; and (c) securing frequent customer feedback to improve systems. The aim of the discussion is to improve accountability in workforce systems that are required to include individuals with disabilities.

Define Target Populations

Who are people with disabilities to be served in the workforce development system? Clarity concerning the target populations is very important. There are many definitions of disability arising from federal legislation – some functional and some categorical. Disability is defined differently in the Americans with Disabilities Act, the Rehabilitation Act, the Individuals with Disabilities Education Act (IDEA), and the Developmental Disabilities Act. The Social Security Administration uses a different definition for adults than it does for youth. A state or region may use its own definition of disability. Some One-Stop Centers in our experience use a "disadvantaged" criterion, or even a customer self-report of disability. A target population must be clearly defined in order to be able to know who was served.

The characteristics of a program's customers need to be identifiable in order to determine if the interventions used are effective in addressing particular barriers. State VR programs are typically organized to address different needs of various populations; for example, specially trained counselors for individuals who are deaf. If individuals with disabilities are served in a non-specialized One-Stop system, it is important to know if particular programs or interventions are effective (or not) with individuals who have particular characteristics.

How will these characteristics be measured and recorded? And how can the program or system know if individuals with disabilities have been served adequately and appropriately across the system? These are the challenges in measuring outcomes across a workforce system. Programs can and will specialize

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and serve different target populations, but the measurement system should be clear about who is being served.

Consequences of not defining disability. This issue can best be illustrated with an example. Four years ago a state VR agency, through a cooperative agreement with a state Workforce Services agency, created a specialized job placement service for people with disabilities. Several new positions were created with approximately one-half of them being located in One-Stop Employment Centers, the other in VR offices. The program was intended to serve "people with disabilities who were hard to place." The notion of who was a "person with disability who was hard to place" was not defined clearly. Some workers assumed every person from VR who was seeking a job was a candidate for the service. Other offices limited the program to people who needed careful job matching or intervention with an employer. And some Workforce Services employment counselors referred people with self-reported disabilities who would not have been considered to have a disability by VR.

An external project evaluation was unable to conclude that the program was beneficial, since it could not discern who the population was that received the service. Did the program provide valuable services to some? The services may have been very critical and needed, but because the target population was not defined clearly, it was impossible to say whether the participants received a service not available to them elsewhere. It is difficult to justify continuation of an expensive or value-added service if you cannot show it is reaching the intended population. Moreover, it is impossible to prove you've reached a target if the target is not clearly defined in the first place.

If workforce systems are to demonstrate meaningful progress in serving customers with disabilities, program administrators need to identify target populations and describe characteristics of customers who are intended to be served by particular programs. The performance of these programs must be monitored to determine if the interventions actually work for the intended target groups. If desired outcomes are not achieved for the target populations, changes should be made.

Define and Measure Quality/Success from Individual, Program, and One-Stop System Level Perspectives

When assessing global outcomes of any cross-agency system like the One-Stop system, it is important to keep in mind that there are actually three levels of outcomes to assess (individual, program, and system). Each level references varying perspectives as to what constitutes quality and success. If global outcomes are to be truly assessed, it is essential that these perspectives be incorporated into a comprehensive assessment process.

There are a number of "bottom line" elements that cross all three levels. They include wages, hours worked, retention, types of jobs, opportunities for career advancement, and satisfaction compared to persons without disabilities. They also include the cost of services and budget neutrality (long-term

savings compared to short-term costs) across all public programs used by people with disabilities (e.g., food stamps, housing benefits, cash benefits).

The goal of improving employment outcomes for people with disabilities requires complex interventions, and thus requires complex performance indicators. In order for people with disabilities to work, they often need supports or accommodations, health care assistance, transportation, income assistance – either temporarily or ongoing. These supports must be coordinated and integrated in a timely way to support the person while also fitting the needs of the employer. Many factors go into identifying performance measures for employing people with disabilities.

Individual Level

The notion of what constitutes "quality employment" needs to be evaluated in light of how it impacts the individual. The definition of quality should consider an individual's abilities, needs, and goals. This individualized approach challenges traditional measures of successful employment. Measurement of quality cannot be satisfied solely with objective, quantitative measures such as earnings, hours worked, or job retention time. Indicators of success need to be more multi-dimensional – both quantitative and qualitative. Since people with disabilities vary so much in their needs for support and effectiveness of support, additional measures are needed to explain outcomes. These additional measures should look at the nature and quantity of supports provided and satisfaction with supports on the part of the customer and the employer. The definition of "quality employment" on the individual level should be more comprehensive than traditional quantitative measures. Accountability demands a more comprehensive approach to quality measurement than our programs have heretofore been expected to deliver.

Program Level

The Disability Policy Framework developed by Bobby Silverstein provides a starting point for determining quality and success at the program level. Some elements that could be assessed include the extent to which (a) program implementation is based on the old paradigm of disability (that the individual is defective, needs "fixing," and is incapable of working); (b) services and supports meet the preferences of eligible individuals; (c) individuals are afforded choice and control; and (d) person-centered planning and budgeting is provided. Other elements include ease of access, timely access to services, and customer-responsiveness. Assessment of many of these components requires asking the customer's opinion of the effectiveness of both processes and outcomes.

System Level

The Disability Policy Framework also provides a starting point for determining quality and success at the One-Stop system level. Some elements that could be assessed include the extent to which (a) implementation of the current system is based on the old paradigm of disability; (b) there is meaningful involvement of individuals with disabilities in the design, implementation, and evaluation of the system; (c) there is an adequate network of qualified providers offering a range of necessary services and

supports; and (d) there is a seamless system (no wrong door, no buck passing) and an effectively functioning information & referral system.

Other elements include the extent to which (a) reimbursement and personnel evaluation mechanisms provide risk adjustment for serving those with significant disabilities requiring more intensive, ongoing services and supports; (b) financing systems facilitate the principles, goals, and policy of the disability policy framework (i.e., person-centered planning and budgeting, customer choice and control); (c) financing systems take advantage of existing funding sources, including federal funding sources and waivers; (d) personnel are trained in the new disability paradigm and state-of-the-art promising practices; and (e) outreach, information dissemination, and technical assistance are provided to potential customers of the One-Stop system.

Secure Frequent Customer Feedback to Improve Systems

There are a number of ways in which quality and success can be ascertained, including the use of an integrated, cross-agency database system, self-assessments, special studies, surveys, focus groups, and field research or pilots. What each state uses depends upon the extent to which existing data is accessible, the availability of resources for conducting additional assessments, and the extent of interagency collaboration by One-Stop partners. Whatever methods are used, it is important to keep in mind that the ultimate goal of data collection is to provide accountability for system effectiveness.

States and regions must determine ways to collect consistent and ongoing user-friendly data. Data collection needs to be simple and easy for the user who gathers and records the information. Whenever possible, data collection should be built into the tasks that people already do or into existing reporting and program evaluation systems. Technology is available and should be utilized to automate, mechanize, prompt, or trigger timely data collection activities.

Gather Baseline Data

It is of course essential to gather baseline data if global outcomes are to be assessed over time. There are a variety of ways to gather baseline data. What each state or region gathers depends upon the availability of existing data, the definition of the target populations, and whether a state has systems change staff to compile a baseline profile. Some important baseline measures for a system might be:

- Definition and characteristics of the target population(s), the specific array of services and supports they use now and may require when they go to work, and the cost of those services and supports;
- Barriers to the employment of people with severe disabilities, both at local and state levels;
- Description of the political, economic, and social environment within which existing systems operate and their interrelationship;
- Perceptions of barriers to employment by persons with severe disabilities and their specific needs—across disability groups;
- Employers' perceptions of barriers to employment—across large, medium, and small employers;

- Outcome data on the types of interventions that result in long-term employment for individuals with severe disabilities.

Example of gathering baseline data. The Alaska Works Initiative contracted with Dr. Pam Hanes at the Oregon Health Policy Institute to survey Alaskans with disabilities to determine the percent and profile of individuals who want to work, the specific barriers to their employment, their experiences using work incentives, and the types of services and support they need to maintain their employment. Of the 1,000 Medicaid recipients who represented the geographic and ethnic dispersion of the state's population, 337 or 34% completed the survey. Survey data were separated into 5 distinct categories (chronic mental illness, physical disability, developmental disability, sensory disability, and traumatic brain injury) and cross-tabbed to reveal group differences.

This same survey will be used in the spring of 2003 to assess the extent of systems change in Alaska. Baseline data will be compared to the findings in the second survey to determine what, if anything, has changed over the past 5 years. Respondents will also be asked about their awareness and use of the specific interventions the Alaska Works Initiative has implemented (i.e., holistic vocational rehabilitation services that include benefits counseling, Medicaid , One-Stop services).

Build a Cross-Agency Data System

Independent and autonomous state agencies are not accustomed to sharing databases. Most state and local service agencies have multiple databases that are incompatible, and data is not easily shared for program planning or evaluation purposes. Demands for data come from many different sources, and legal requirements for limiting data access are becoming stricter.

Failure to build a cross-agency data system can result in duplicating services to individuals or customers falling through the cracks. It also makes it difficult for agencies to be held accountable for providing the appropriate services needed by individuals or not providing more services than are needed.

Example of cross-agency data system. The Utah Department of Workforce Services (DWS) has been developing a "data warehouse" that coordinates all the electronic databases that existed from several separate agencies (Wagner-Peyser programs, unemployment compensation, TANF, Medicaid, food stamps, WIA programs) before it was consolidated into a single agency in 1997. DWS is also developing a newer case management database. VR is a separate state agency with its own case management and fiscal management databases. Both agencies are working together to identify certain data fields (data elements, such as vocational goal, or program status) that can be shared across agencies if the individual has signed a consent form.

The DWS data warehouse will provide VR counselors limited access (i.e., password-protected) to certain data elements that are authorized and built into the database. This is a web-based system that can be accessed from any location with Internet access. While this system is months if not years from

completion, this limited data sharing holds promise for increased accountability and better access for customers to services that will best meet their needs.

While a shared data warehouse system may address cross-agency data needs, it may not be feasible or practicable in many regions or states. Alternative data sources to fill the need for cross-agency outcomes may be special data requests from administrative databases in each agency, intermittent surveys, or focus groups. Whatever the approach, agencies must keep in mind the goal of accountability for achieving individual outcomes across the workforce system.

Include Customer Feedback That Impacts the Individual, Program, and System Levels

Customer feedback must be collected on a routine basis and fed back at all levels. As mentioned earlier, if workers, programs, and systems are to become "customer-responsive," methods must be instituted to measure and provide a feedback loop to the appropriate levels for response. Individuals with disabilities who access services should be asked for their assessment of the processes and outcomes, and these measures should be combined with objective measures of employment outcomes. Employers are considered customers of the workforce system as well, and should be included in any assessment process to improve the system. Customer satisfaction with supports is an important component of success or quality measurement. Objective, quantitative measures of employment outcomes (e.g., wages, hours, retention) must be combined with subjective, qualitative measures (e.g., individual and employer satisfaction) for adjusting and improving supports for maximum effectiveness.

Program funding decisions should be based on both the objective employment outcomes and the subjective customer satisfaction data of both individuals with disabilities and employers. Customer satisfaction must not only be systematically measured but also the results must be fed back into the system for change and improvement. No longer should programs justify their funding based only on number of job placements, wage levels, and job retention time. Customer satisfaction must be measured and used to make decisions about resource allocation—which interventions achieve outcomes desired by customers, which staff deserve raises, and which programs are worthy of continuation. Customer satisfaction should drive what happens to an individual, a program, and a system. It is the critical link in assessing accountability.

Systemically Identify and Remedy Problems at the Individual, Program and System Levels

Each state should use the data it has to identify and improve areas where changes in policy and/or procedure are needed. Systems change projects (e.g., State Partnership Initiatives, Medicaid Infrastructure Grants, or Department of Labor Workforce Coordinating grants) can bring additional resources to states to conduct barriers and needs assessments and develop partnerships for policy and/or procedure change.

Example of systemically identifying and remedying problems. The Alaska Works Initiative convened a policy summit to discuss policy issues and make policy recommendations for creating lasting change that increases the employment rate of Alaskans with disabilities. The findings from Alaska data and

research along with a discussion of policy issues from a national perspective were used to frame the discussions and resulting policy recommendations in the following areas: services for people from different disability populations, Medicaid , One-Stop services, and Personal Assistance Services. A wide variety of data and research were used, including: (a) studies of Alaska-specific work disincentives and work incentives design; (b) surveys of Medicaid recipients, employers, and individuals with chronic mental illness; (c) focus groups with people representing a cross-disability and disability-specific perspective and with employers; (d) self-assessment by One-Stop system staff; and (e) field research, i.e., holistic vocational rehabilitation services that included benefits counseling. The policy summit developed short- and long-range recommendations for systems change that are being implemented through various agencies. Outcome data will be monitored to assess progress in achieving the changes recommended by the summit.

In summary, we have described some challenges of developing accountability in workforce systems that serve individuals with disabilities. Identifying target populations of people with disabilities, defining quality employment outcomes from three different perspectives, and developing performance indicators that include measures of customer satisfaction are key focus areas in this paper. The challenge today is trying to make a comprehensive workforce system responsive to all its customers, many of whom have very complex needs and demands. Our workforce systems are expected to have expertise to address a myriad of barriers for people with widely varying needs. The system is expected to customize supports for job seekers to fill labor needs in an exponentially fast changing labor market. It is no surprise that measurement and monitoring systems must become both more global (i.e., comprehensive across agencies), and multidimensional (i.e., include both quantitative and qualitative measures) in order to adequately serve accountability demands. The old, traditional "silo" approach of evaluating categorical programs is anachronistic because customers and funding sources are demanding more "seamless" and accountable systems to meet the labor and human resource requirements of the twenty-first century for *all* Americans.

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Session 4

Increasing the Participation and Quality of Employment Outcomes of People with Disabilities in Workforce Development Services: How Can/Should States Assess Outcomes on a Global Level?

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Discussion Summary

John Butterworth

Agencies vary in what outcomes they report measuring. VR, TANF, and Workforce Development (WD) all report measuring entry into competitive employment. Only VR and WD consistently report measuring customer satisfaction, and only VR consistently reports measuring earnings. State MR/DD and MH agencies are much less likely to report measuring any of these outcomes.

Wide variation in reported success in achieving employment outcomes. The rate of entering employment for customers with disabilities from WD agencies ranges from 35% to 88%. The percent of individuals supported in integrated employment by state MR/DD agencies ranges from 10% to 60%.

Annualized wages for individuals closed into competitive employment by the VR system was $13,699 in FY1998, slightly below the poverty line for a family of four ($16,450) and slightly above the poverty line for a family of one ($8,050).

Survey of state benefits planning projects: Is employment an explicit goal of your benefits planning project? Only 6 of 11 responded yes.

Discussion: Should Employment Be the Primary Outcome of Benefits Planning Initiatives?

Catherine Chambless

Agencies should figure out how to measure successes in a way that extends beyond their silos.

Important question to begin: Who are the people we are serving? How do we define that?

- Utah State Partnership Initiative project—VR and One-Stop Centers collaborated to develop intensive job placement services. Able to create 17 new FTEs in One-Stop Centers and VR offices to take referrals from both agencies. VR referred "VR eligible individuals with disabilities" while One-Stops referred individuals with "multiple barriers to employment."

- Program had problem demonstrating effectiveness because it was not clear who had been served.

What methods would work for states to define target populations? States should develop their own guidelines because we cannot afford to wait for this to come from the federal level.

Millie Ryan

Three Perspectives on Outcomes:

- Individual
- Program
- System

Some outcomes are relevant at all levels (wages, hours worked, types of jobs, opportunities for career advancement).

Individual

- Hours worked and wages are not sufficient as outcome measures

- Need to address the full range of support needs (outside of employment)

- Need to address the nature and quality of supports available

- Individual and employer satisfaction with supports. Are we helping individuals get and keep the job they want?

Program Level

- Bobby's disability policy framework a good starting point

- Meaningful involvement of persons with disabilities

- Are services and supports meeting customer preferences?

- Choice and control

- Person-centered planning and budgeting

System Level

- Bobby's framework applies here

- Build outcome measures around an adequate network of qualified providers, a seamless system (no wrong doors), and reimbursing/rewarding staff for serving people with more intensive support needs. Without incentives for supporting difficult-to-serve individuals it is unlikely people will take that chance and try something that may be held against them

Securing and using customer feedback?

- Build data collection systems into things people already do. Make it easy to collect the data.

- Establish baseline data on the target population, supports they use now, barriers to employment, the environment in which the state functions, and perceptions of barriers by persons with disabilities and employers.

    - Example: Alaska contracted with Pam Haynes to survey 1,000 people on Medicaid. The state will use the same survey in 2003 to see what has changed in the system, including perceptions about employment and consumer awareness of specific interventions including benefits counseling and the Medicaid .

Catherine Chambless

Building a cross-agency data system is the best way to make agencies accountable for global outcomes.

- It is difficult, and as a result agencies are not doing it.

- Barriers include incompatible databases that people have built up over many years. There is considerable personal and organizational investment in these existing systems.

- Barriers include increasing legal requirements about sharing information, e.g., HIPAA law.

Example: Utah is investing in a cross-agency data warehouse software system. Any worker or manager can ask questions of it and find out information. VR and WD agencies have developed a plan for how to share a limited number of data elements across the system for purposes of planning at the individual worker/client level and to see at aggregate levels how outcomes are being addressed by the two agencies.

- They are not coming to the table saying the laws say they can't do it. They see it as a way to show that agency services are efficient.

- In order to show things like disability they need informed consent. Consent will have an expiration date (timeline).

- There is technology (i.e., data warehouse software) to do these kinds of things. It takes the will of administrators to do it.

Millie Ryan

Important to look at how you use the information you have. May be soft data. But helps target resources and make decisions.

- Example: Alaska held a policy summit to discuss policy issues and make recommendations that would lead to lasting change in the employment rate for Alaskans with disabilities.

- The summit used information from a study of Alaska-specific work disincentives.

- We surveyed employers.
- A specific survey targeted people with mental illness. Findings from focus groups of people with disabilities and employers and field research provided data to the summit.
- A policy person is being hired to work on getting policies in place.
- The work of the summit leads to another round of outcome data: Do we make these policy changes? Are they making a difference?
- The summit discussion considered whether policy recommendations were doable. Recommendations were rated them based on politics and money.

Catherine Chambless

In addition to quantitative, "hard numbers" data, some agencies are developing feedback systems where they ask customers what they want.

- Use this feedback to make decisions and changes at the counselor/worker level, at the program level (what services should we continue), and at the systems level.
- Qualitative data has been criticized as more subjective and not as valid. But in order to have a system that responds to a wide variety of needs, including people with significant disabilities and on TANF, agencies need to use measures of *both* qualitative and quantitative data.

Michael Morris: Respondent

There are three kinds of questions that relate to measuring outcomes in the Workforce Development system:

- When we count
- How we count
- What we count

When We Count

- There is no standard method for counting people who come in for services.
- There are wide differences within a state in things like when a person is registered and becomes part of who is counted.
- The workforce development system is really built on short-term goals. It does not address job retention and support over time.

How We Count

- Person with disability doesn't care how we count who provided a critical service and gets credit for it.
- Issues of double and triple counting—which system, service intervention, or funding source made the difference? How can we move from counting closures to having all who contributed to an outcome get credit?

- How we count is especially important for persons with significant disabilities. There are lots of incentives to not work with people with more intense needs. Could lead to sanctions for not meeting performance measures.

What We Count

- Need to consider what we count not just on individual level, but at the program and systems level.

- We need to count more than wages and hours worked per week.

- We need to establish common service definitions. What is service coordination?

- Outcome measures should take us into new areas beyond employment to areas of wealth creation. We need to tackle barriers that prevent individuals from not just entering employment but from having assets and resources.

- There is a need for significant discussion that involves more than the workforce development system, but various other systems.

Discussion Points

- How do we move the entire system of counting outcomes to a more global level that nurtures the kind of collaborative work that we are talking about?

- How do we balance the focus on process versus outcome kinds of measures?

- How do we effectively address both systems-level and individual-level outcome measures?

- The notion of 70% of people with disabilities being unemployed is wrong. It may be accurate that 70% of people with disabilities are not working, but the definition of "unemployed" requires that an individual be actively looking for work.

- We create a trap of saying to ourselves that we have not made progress. I think that is wrong. We are categorizing all people with disabilities as a homogeneous group, but it is a heterogeneous group. If we asked the right questions we may find that those with mild moderate disabilities have had significant improvement. People with the most significant disabilities, especially those on cash benefits, are a different problem.

- *Definition of disability*: As long as we say the definition of disability is that a person is "unable to work," and then ask a person who is working "do you have a disability," then they will say "no." We need to be much more sophisticated in identifying our target population. Something simple like "do you have a physical or mental impairment that limits an activity such as breathing and walking and talking and seeing and hearing, with or without mitigating factors like technology."

- Need to focus not just on collecting information, but on publishing the information and making it accessible. Outcomes data can be a powerful tool for assisting individuals to make program choices

- *Systems capacity*: VR serves 1.2 million people a year, only a very small percentage of individuals with disabilities. Gets to an issue of resources and an issue of severity of disability.

- We need to know more about who is working, and who wants to work.

- We have not talked much about other customer – the employer. There is a critical tension between serving the customer with the most intensive needs and the customer who is the employer. Are the right performance measures being collected to inform their perspective on whether the workforce development system is working for them?

- Workforce boards present an interesting opportunity to address what we count. Boards are not that interested in the standard required reporting. It's not what we talk about, particularly with employer members of the board. They ask me a different set of questions and work from different criteria for success. Boards provide an opportunity to try out different ways of counting.

- Collaboration: Maybe we should start identifying those customers who are using multiple systems. Maybe we can demonstrate that we are more successful when we collaborate.

- Self-disclosure: If doing a particular intervention or approach you need to be absolutely sure who your target population is. This is much harder at a more generic level because of customer concerns about disclosure.

- I have no idea how the workforce system knows whether someone has a disability or not. They don't ask that question.

- The workforce development system relies on self-report. I don't know how we would get beyond that without violating individual's civil rights.

- In Vermont I had identified that we could work together on customer satisfaction, but I couldn't get anyone else to want to play. They didn't want to do that.

- I went to my state Department of Labor and volunteered to be a partner to create a shared database. We are working on that. The major issue is confidentiality. One solution is to create a single giant agency and make it everyone's business.

- If we can work out shared information with a database some of these issues would be answered. It's going to take some time to work out.

- I am encouraged because 5 years ago I was told we would have to throw out our system and start over. Now technology has advanced and that's not an issue.

- The data issue is going to go away. There are two issues. One is the cloak of confidentiality. The other is technology investment, and that is less and less of a concern.

- I wonder… our fear of data is that it has been used in ways we are uncomfortable with. One use is improving services. Some of our New England agencies use great satisfaction surveys. Businesses tell us we have great outcomes in that data.

- In NAMI…. I think many local chapters have no idea what One-Stops are. It could be really useful for One-Stop folk to go and speak to a NAMI chapter.

- One stops and VR have totally different set of issues: VR has eligibility criteria, One-Stops do not. This presents a different type of challenges.

- It does come down to how you set your performance measures. How you define them drives your system. We haven't done well at bringing people across systems.

- We collect information on whether people have disabilities or not in the Wagner-Peyser program (Title I dislocated worker adult and youth programs). How good the data is is another story altogether.

- What are the incentives for a customer of a One-Stop to identify himself or herself as a person with a disability or, for that matter, a person who speaks a different language? Is there a reward? Not that I know of, but there is a lot of fear that it will differentiate me in a negative way.

- What is the system's reward for capturing more accurate information about persons with disabilities?

- I have found that you can include outcome measures for serving people with disabilities in any state system that address employment. We have the flexibility to do that, and VR is in a position to influence this at a state level.

- Section 188 of the Workforce Investment Act addresses requirements for equal opportunity and nondiscrimination. Section 188 requires that records be kept for participants, registrants, eligible applicants, and terminees, by race, gender, and disability status. There is a civil rights obligation to determine disability for everyone who walks in the door

- How do we ensure that agencies, particularly VR, get credit for expanding role as advocates and as a source of technical assistance rather than direct service?

- How do we think globally about "is the state doing well?" Do we need to focus on the labor force participation rate? Are the number of youth with disabilities leaving school and entering workforce improving?

- WIA allows for negotiation between governors and federal officials regarding performance levels. There is a statement in the analysis accompanying the regulations that say specifically that negotiations can take into account differences in participant characteristics that might include indicators of disability. Advocates in states have the ability to influence the outcome measures used by the state.

Action Items

- We need to establish a structure for dual credit. With 300 people on the wait list [in our state], we're in every One-Stop. We do have a common customer. We have a mechanism for providing services to groups. Once put on a wait list an individual is a future customer, and we can serve them as a future customer under that "services to groups" category. Perhaps we can creatively use that mechanism. Talk to RSA and keep track of how we jointly serve customers. Work with RSA to establish some legitimate credit for the service. Provide disability as a missing link for individuals who don't qualify or are put on a wait list. Figure out the nooks and crannies that allow us to get it done *and* count it, measure it.

- Identify a set of alternative or additional or complementary performance measures at the individual, program, and systems level.

- State MH authorities need to collect and share information on employment of people who use their services. Not just VR or One-Stops, but the whole service population. We need to get everyone on the charts.

- Our state has been warned that they need to collect that data [on employment outcomes for people with mental illness], and we are rolling out an expansion to capture all of them. Part of the big performance indicator plan nationally. The next step is sorting out, nationally, "what do we mean by work?" We have been doing that locally within the state, but we have not addressed the definition of work nationally.

- Locally we are able to determine how to count and weight outcomes. We need to ensure that it is a positive thing to serve people with disabilities in the system.

- We should consider some concept of weighting to distinguish VR work outcomes from One-Stop counselor outcomes.

- We should set standards that ensure the population served in One-Stops reflects the local population. Maybe as a minimum standard about 18% of people served at a One-Stop should be persons with disabilities.

Session 5

Managing Funding and Resources in a Streamlined Service Delivery System

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Managing Funding and Resources in a Streamlined Service Delivery System

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Background

The Oregon Department of Human Services (DHS) is Oregon's largest state agency. Consisting of approximately 9,700 employees, DHS has a two-year budget of almost $8 billion, which represents nearly a quarter of the state government's overall expenditures. The agency is responsible for assisting Oregon's most vulnerable citizens in overcoming the challenges associated with disability, aging, child abuse or neglect, poverty, mental illness, and abuse of alcohol or other drugs.

In all of its work, DHS strives to assist Oregonians to become independent, healthy, and safe. Achieving better outcomes in this endeavor requires an integrated, collaborative approach to human services.

DHS has learned that in any given calendar year it serves nearly one million unduplicated Oregonians. DHS has also learned that about 46% of these one million users have multiple needs requiring services from three or more DHS programs. In the past DHS system, it was the burden of the client to navigate the system and obtain the services they needed. Many clients had to travel to various locations, visit several DHS offices, and complete several different sets of duplicative forms to apply for inclusion in the many programs offered through DHS. Some of those services include vocational training and placement, public assistance funding, drug and/or alcohol treatment, support in caring for an aging parent, support for a child with disabilities, and access to medical care.

Yet we know from experience and research that clients who receive integrated services are more satisfied with the services they receive and the outcomes they achieve.

It is for these reasons that DHS has replaced this complex system, which did not maximize its potential, with an integrated one that provides a single, coordinated case plan and integrated supports tailored to meet the needs of each client and family.

Creating a New Department

In early 1990 the Department began its journey down the path of change in a series of pilot projects in 40 communities across the state. In each of these projects partners at the local level discovered new ways to achieve outcomes for the clients served through collaborative partnerships. Based on the success and promise of this work, in 1995 the Department began the creation of a new social services system. This work led to the 1999 passage, with only two dissenting votes, of legislation that created one Department of Human Services.

Throughout this entire process the Department has worked closely with federal, state, and local governments, private non-profits, clients, advocates, and citizen representatives in shaping the new

social service delivery system in the state of Oregon. Countless opinions and voices have been heard. Some voices expressed concerns that their individual program would get lost in the shuffle while others voiced concerns about efficiency. Understanding that the rebuilding of Oregon's social service delivery system is one of the most complex undertakings in the public sector, the Department responded to these differences by simply engaging everyone in the process of building the new DHS. However, it goes without saying that there continue to be significant discussion and debate as the new department emerges.

Additionally, all of this change has been accomplished in an environment in which economic uncertainty has been growing. Reduced resources make change, integration, and reorganization more difficult to achieve. On the other hand for many, in particular our governor and legislature, reduced resources have made integration and reorganization even more urgent.

Funding Streams

One of the Department's first steps in the endeavor to provide integrated services was to consolidate the administration, funding, and resources that support individuals with disabilities who are seeking employment. DHS was the recipient of four separate grants, all focused on issues surrounding the employment of people with disabilities.

1. The Robert Wood Johnson Foundation (RWJ) grant was awarded to DHS in an effort to evaluate the effectiveness of policies and programs and provide recommendations regarding the state's Medicaid employment supports for persons with disabilities.

2. The Rehabilitation Services Administration (RSA) grant project identifies strategies, develops and recommends policies, and provides direct supports to strengthen the employment infrastructure for persons with disabilities.

3. The U.S. Department of Labor (DOL) grant is a Work Incentives grant. The activities of this project are to identify strategies, develop and recommend policies, and provide direct supports to local One-Stops and workforce partners for the purpose of providing access to employment services for persons with disabilities.

4. The Center for Medicare and Medicaid (CMS) Infrastructure Grant identifies strategies, develops and recommends policies, and provides direct supports to Medicaid and other related programs for the purpose of supporting employment for persons with disabilities.

Each of the four grants provided for separate staff to complete the individual grant activities. The DHS found that these activities were often duplicative and overlapping. By consolidating the administrative structure supporting these grants, the DHS greatly enhanced its ability to manage the programs, funds, and services for people with disabilities. It was determined that by coordinating these four funding streams, as well as the activities connected to them, within one unit of the DHS, the work could be organized and completed in a more efficient and effective manner.

Although the various funding agencies understood the significant benefits of the Department's reorganization, there were significant differences of opinion on how DHS should reorganize to be most effective. The biggest concerns centered on the absolute priority of participation from the

mandatory partners. Some believed that the new structure did not lend itself to equal involvement of these key participants. It was only after an immense education effort that these benefits and the expansive participation were ultimately communicated.

Operational Structure

The Oregon Employment Initiative (OEI) Consortium, comprised of representatives from all facets of Oregon's workforce system, collaborates to guide the activities of these grants. The OEI Consortium currently includes representation from the Department of Human Services, Department of Education, Department of Community Colleges and Workforce Development, Oregon Employment Department, Social Security Administration, Oregon Workforce Investment Board, Oregon Business Leadership Network, Oregon Disabilities Commission, State Rehabilitation Council, Oregon Commission for the Blind, Lane County Law and Advocacy Center, Oregon Developmental Disabilities Council, State Independent Living Council, individual Centers for Independent Living, and individual consumers with disabilities and their advocates.

The Disability Employment Policy Unit (DEPU), located in the Office of Employment and Financial Benefits, provides leadership, facilitation, accountability, and technical support to the OEI Consortium and the multiple funders.

Oregon's Experience

In the first year, the integration of these grants and the central coordination of the many activities have greatly increased the employment support system capacity in many areas. This report will share specific Oregon experiences that demonstrate the benefits that DHS and its workforce partners have seen in several key areas.

- Greater involvement of key partners
- Greater coordination of activities
- Elimination of duplicate efforts
- Strategic and focused outcomes
- Increased collaborative funding
- Shared ownership of products

Mentoring

Coordinating the administration of these grants has greatly enhanced mentoring services in Oregon. In one instance, RSA grant funds were obligated to implement a peer mentoring project with 3 Oregon Centers for Independent Living (CILs). The project was designed to capitalize on the expertise of SPOKES Unlimited, a CIL with a well-established and successful peer mentoring program. DHS had initially contracted with SPOKES to create a mentoring manual to be distributed and used as a resource for peer mentors. SPOKES was awarded a contract to provide a comprehensive training

program for representatives from two emerging CILs—the Umpqua Valley disAbilities Network and the Eastern Oregon Center for Independent Living.

Subsequent to the funding of this project, two additional mentor programs were selected for funding by the OEI Consortium Evaluation Committee as Innovative Solutions projects under the DOL Work Incentives Grant. These projects included mentoring design, training and implementation.

To maximize outcomes, funding and eliminate duplication of effort, the OEI Consortium requested that the mentors from the DOL-funded peer mentor programs be invited to attend the planned RSA peer mentor training. That in turn sparked the director of SPOKES to then extend the invitation to other workforce partners who were also interested in providing peer mentoring services. The resultant collaboration has been very successful and has sparked the discussion for development of a statewide mentor network.

Anticipated benefits include the provision of consistent mentor training and technical assistance, a central collection site for mentoring outcomes data, a computerized listserv for mentors to interact with and support each other, quarterly conference calls to share best practices, and an annual peer mentor educational retreat.

The individuals and programs affiliated with the development of the Statewide Mentor Network share some common features.

1. Training for mentors. Each of the mentors is provided with comprehensive training that covers such topics as developing effective mentoring skills, mapping resource systems within the community, ADA employment law, disability language and etiquette, and most importantly, an overview of Independent Living philosophy. Incorporating Independent Living philosophy into these mentoring programs is critical in empowering the mentored individuals and offering them tools to control their own lives.

2. Person-to-person mentoring. A person with a disability is mentored by a person with a disability who is trained in the Independent Living philosophy. The mentor relationship is enhanced when the mentor shares a common life experience with the mentee. Individuals who receive mentor services support the benefit of this practice.

3. Payment for mentors. The vast majority of peer mentors are currently paid for their services as employees or consultants of a CIL. However, in the statewide network there may be a few mentors that have and interest in providing services as a component of their own employment or outside interest. Providing payment eliminates some of the challenges in recruiting and retaining skilled mentors, offers additional employment options for people with disabilities as they are trained to provide mentor services, and validates mentoring as a component of an overall career plan for the mentor.

4. Marketing. Services are marketed as a benefit to both employers and service providers. Thus, representatives from Oregon's private employers and public agencies such as the Oregon Commission for the Blind, the DHS Office of Vocational Rehabilitation Services, and the DHS Seniors and People with Disabilities programs have all found value in the purchase of peer mentoring services. Counselors report that peer mentored clients are better able to set and achieve their employment-related goals.

Benefits Planning

Through the Benefits Planning and Outreach Workgroup, OAC, DHS and other key OEI Consortium partners have collaborated in developing a functional statewide Benefits Planning and Outreach Network. The Benefits Planning and Outreach Network refers to the delivery system for benefits planning and outreach services.

The workgroup that provides guidance for further development of the network is co-chaired by staff from DHS and OAC with consultation from representatives of the OEI Consortium. Although DHS and OAC each receive separate federal funding streams to provide benefits planning services for people with disabilities and outreach to consumers and community partners, collaboration through the OEI Consortium has made it possible to maximize resources and provide consistent benefits planning services statewide. A continued focused effort is being made to enhance the program of benefits planning and outreach services, with a common goal of promoting employment opportunities for people with disabilities.

Training

An example of a collaborative training project that is currently in process is one that is occurring in collaboration with the Oregon Department of Education (DOE). DOE, linked by participation on the OEI Consortium to key individuals with specialized expertise, is developing a training curriculum for transition specialists and special education teachers in the public school system. The participants in this youth transition training will take part in a series of five Netcast sessions, each session developed by individuals with extensive knowledge of a particular subject. Anticipated topics for the transition training include developing quality IEP's and transition plans, teaching self-advocacy skills to youth, identifying resources and navigating community systems, and building skills to assist in the development of mentoring, internship, and work experience opportunities in the community.

Through this project, the educators that are working directly with youth will better meet the needs of youth with disabilities at an earlier age by preparing them for post-secondary education or employment. Knowledge and resources gained through the training will provide the necessary tools for these educators to feel confident in their ability to empower their students in accessing the services of One-Stop Career Centers, Vocational Rehabilitation, Centers for Independent Living, and college advisors.

An interesting aspect of this youth transition training project that should not be overlooked is how the entire plan came to be. In fact, the DOL-funded benefits planning training was instrumental in paving the road to implement this training statewide for minimal cost.

Youth Transition

The delivery systems for youth in Oregon are complex, and services are offered by a collection of organizations that typically operate independently of each other. In an effort to bring these supports in alignment, the OEI Consortium has contributed to the development of a comprehensive mapping of

systems within DHS and undertaken the much larger task of developing a comprehensive map of services for youth across delivery systems and organizations statewide.

Collaboration is underway with Oregon Community Colleges and Workforce Development to identify services for youth being conducted in regions throughout the state. Through the Oregon Workforce Investment Board, youth summits are being held with 10-plus representatives from a variety of organizations each interested in serving their region's youth.

Statewide, individuals are coming together to identify existing youth services and develop new services to meet the needs of all youth in their community. Through these collaborations, the OEI Consortium uses information gained to link partners across the state to develop strategic, focused outcomes that enhance existing programs and services, which include self-advocacy skills, job development, and developing resources.

Partnership Expansion

Expansion of the mandatory partnership and formation of the OEI Consortium is probably the most significant achievement of the resource integration. The many benefits of the communication that occurs on a regular basis among the project staff, OEI Consortium members, workforce partners, and disability advocates cannot be stressed enough.

This expansive interaction with workforce partners promotes a system of coordinated services and allows many of Oregon's workforce partners to collaborate on projects. As a result of these relationships, the needs of people with disabilities are incorporated into new programs. These collaborations will continue long after the projects of the various grants are completed. The workforce partner's overall future ability to meet the needs of people with disabilities has been permanently enhanced by a wealth of information and the connection to both local and national resources. It is a high priority for OEI Consortium partners to continue this statewide collaboration after these grant projects conclude.

Lessons Learned

- Connectivity between programs and services is essential to effective collaboration and coordination of services.

- Ongoing staff and partner education of programs and services are critical to developing successful collaborations.

- Funding requirements often interrupt strategic planning and organizational development.

- Outcomes related to training are maximized through collaboration with workforce partners.

- Duplication of effort is eliminated when resources and funds are effectively integrated.

- Disability awareness and knowledge of available services and community resources are greatly enhanced through collaboration and integration.

- The establishment of an equal partnership that includes a shared vision is key to the successful integration of funds and resources.

- Implementation strategies and program reviews must focus on outcomes as opposed to process.

- A strong organizational foundation is necessary to implement an integrated service delivery system.

- Communication, one of the most difficult challenges for expanded partnerships, is a key to success.

Conclusion

As states consider how they will comply with federal mandates (uch as those included in the Ticket to Work and Work Incentives Improvement Act and the Personal Responsibilities and Work Opportunities Act, there must be an understanding that these standards cannot be met if programs continue to operate separately. However, when successfully collaboration does occur, better outcomes are achieved.

Larry remained ambitious even though a diving accident left him quadriplegic at 21 years old. Today he owns and manages two fast foods franchises—a Blimpies and a TCBY Treats.

Georgena is living her passion. She is working as a peer counselor for Independent Living Resources in Portland, helping other people with disabilities to become and remain independent.

Andrew is getting a start on his adult life. He is independent of his parents and proud of his own apartment. In his new job he works in the mailroom at a local newspaper.

Janell, a person with quadriplegia, is employed at Crisis Hotline, a nonprofit that serves people from across the country. Janell responds to an 800 hotline. She counsels on issues ranging from suicide calls to moms needing diapers or formula for their newborns.

Response to "Managing Funding and Resources in a Streamlined Service Delivery System"

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Today, many states are interested in providing a more cohesive array of services and reshaping policies to guide a more congruent employment supports system. Facts driving these changes, as noted by Ms. Lopez, include:

- Most users of health and human services programs are enrolled in multiple programs; better integration improves the effectiveness of services and reduces replication of efforts (i.e., case management, benefits planning, etc.);

- Consolidation and improved coordination reduces the burden on the consumers; in the past support systems have been so difficult to navigate, consumers simply gave up; and

- The dire fiscal situation faced by virtually every state has made streamlining of resources and integration an imperative. For more information on state Medicaid fiscal issues, go to www.kff.org/content/2002/4064/.

Oregon and other states that have undertaken service integration initiatives also have emphasized that it is critical that such an initiative be developed and implemented with full stakeholder involvement to ensure a useable system that takes into consideration the needs of consumers and provides the resources state staff will need to provide high quality services.

Possible Drawbacks. While combining programs, collapsing responsibilities, and gearing staff development towards being "generalists" with a working knowledge of many programs and services sounds very appealing, a few issues have arisen. Some cautions for states interested in following this model include the following.

First, consolidating program operations will likely entail collapsing workloads into a smaller group of responsible staff – especially in the current state budgetary environment. With increased workloads, many staff may find themselves with more work, more responsibilities and less time. Consequently, states beginning such initiatives should carefully weigh responsibilities, workloads, and operational requirements.

Secondly, where states are combining an array of state and federal funds, either programmatic or grant, special steps will need to maintain appropriate record keeping. Many state legislatures and federal agencies are highly sensitive to "combining" dollars in ways that make it difficult to track outcomes.

Finally, the "glue" of Oregon's employment supports initiative (OEI) is an array of staff and community members whose jobs or roles are technically part of a grant funded project (i.e., MIG, WIG, RSA grant, etc.). Oregon and states with similar consolidation initiatives will need to think carefully about how they will fund and operate such projects once grant funding ceases. In the coming year, Oregon's RSA and WIG grants both end.

Session 5

Managing Funding and Resources in a Streamlined Service Delivery System

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Discussion Summary

William E. Kiernan: Highlights of Elizabeth Lopez's manuscript

Benefits that Oregon DHS and its workforce partners have seen in several key areas

- Greater involvement of key partners
- Greater coordination of activities
- Elimination of duplicate efforts
- Strategic and focused outcomes
- Increased collaborative funding
- Shared ownership of products

Lessons Learned at Organizational and Individual Levels in Oregon

- Connectivity between programs and services is essential to effective collaboration and coordination of services.
- Ongoing staff and partner education of programs and services are critical to developing successful collaborations.
- Funding requirements often interrupt strategic planning and organizational development.
- Outcomes related to training are maximized through collaboration with workforce partners.
- Duplication of effort is eliminated when resources and funds are effectively integrated.
- Disability awareness and knowledge of available services and community resources are greatly enhanced through collaboration and integration.

- The establishment of an equal partnership that includes a shared vision is key to the successful integration of funds and resources.

- Implementation strategies and program reviews must focus on outcomes as opposed to process.

- A strong organizational foundation is necessary to implement an integrated service delivery system.

- Communication, one of the most difficult challenges to expanded partnerships, is a key to success.

Soccer team analogy: Everyone plays different positions and has an individual role, but success depends on everyone moving towards the goal and working from the same playbook. Everyone gets equal access to the ball, and communication is essential to the success of the team. Finally, outcomes (getting more goals) are important, not just how you play.

Cathy Carlson: Respondent

Soccer analogy: A youth team that I know knew the rules, played as a team, and were well coordinated, but nonetheless lost to a bigger team that didn't seem to play by the rules. When we look at streamlining systems:

1. How many duplicative forms were eliminated? What were they?
2. What is included in coordinated case plans? How is it working? Are more people satisfied?
3. Are needs being met better?
4. Who is represented on the Oregon Employment Consortium, and what is the Consortium's function? Who sets the agenda? Who chairs the meetings?
5. Is it having an impact on systems and clients?

Leveraging resources is not a substitute for inadequate funding. We can't sell collaboration as a cost savings. Collaboration can reduce the complexity of navigating the system but does not make things simpler. The purpose of a shared mission, shared vision, and using mutual resources is to produce better results for clients.

Discussion Points
- Discussion of the Oregon initiative as described in Elizabeth Lopez's paper.

  - Varied level of interest, commitment, and involvement in the operations of the Oregon Employment Initiative. A concern was voices that systems people involved in the coordinating committee often lacked formal authority.
  - Oregon system had two distinct projects: One was the restructuring of the human services structure highlighted in the paper and the other was the Oregon Employment Initiative, which was an attempt to consolidate and coordinate the four federal system change grants that Oregon has received. VR was consulted very little in the human service reorganization but was actively involved in the Employment Initiative. Three of the four system change grants came about through VR initiatives but were then moved up into the new centralized human services structure.
  - Reorganization was driven by a gubernatorial initiative and a centralized state policy.
  - Will VR lose its employment focus in becoming part of a more generic human services system and more specifically subject to the "siphoning" of resources to non-VR purposes?

- Concerns were raised about the emphasis on local control and local partnerships. How does this relate to broader federal policy on inclusion and workforce accessibility?

- The fact that collaboration and consolidation haven't worked well yet does not mean they can't. Collaboration and consolidation haven't necessarily been given a chance. Remember, the needs of staff are not necessarily the needs of clients.

- VR has the opportunity to be a leader in the areas of customer service strategies and issues like consumer choice.

- How much should a "one-stop human service" concept be stressed? "Navigating the system is America" and having a somewhat confusing array of choices is a side effect of having choices and control. There was debate about whether people with significant disabilities, by definition, need some sort of help using the system or whether this is the price paid for more choice and control.

- Multiple agencies should experiment with pooling funds for maximum benefit. It would be important for RSA to develop some different measures of success to reflect these sorts of joint services to VR clients on a wait list.

- There were three options under WIA for VR when Congress was debating the law: (a) one generic system; (b) two totally separate systems; and (c) one system with distinct programs. Congress chose (c). So there is a need to see VR having a service role for people with disabilities.

Session 6

Defining Quality: Individual Perspectives on Quality Employment Supports

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A Continuum of Services: Guided and Self-Directed Approaches to Service Delivery*

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This article focuses on the characteristics of effective employment services at the system level and is based on the experiences of individuals with disabilities who were successful in finding employment. We conducted interviews with 17 adults with disabilities who used a state agency to find employment and examined experiences with employment services, including job search and job entry experiences, strategies that facilitated involvement, supports provided, and barriers experienced. Findings showed that agency services varied from providing a guided approach to requiring a high level of self-direction. Job seekers shaped their experiences with agencies to find an effective place on the continuum between the 2 approaches. Findings also showed the advantages and limitations of each approach. This article also presents strategies for tailoring supports to meet the unique needs of each consumer along this spectrum.

Recent focus in disability policy has been on the involvement of the consumer in state agencies. In particular, research has been done in the areas of consumer empowerment, self-determination, and improving the level of control individuals have over the services they receive (Stancliffe, Abery, Springborg, & Elkin, 2000; Whitney-Thomas & Moloney, 2001). At the same time, there are policy initiatives such as the Workforce Investment Act that encourage consolidating and streamlining services.

In order to clearly understand recent changes in focus and legislative policy, it is helpful to comprehend the growing trend toward improving service options for people with disabilities. Recent research findings have uncovered factors that improve employment outcomes, including giving the system an important role in the employment process, working with quality personnel, maintaining consumer directedness, as supports are provided, coordinating services, having easy access to resources, and maintaining positive environment at the agency location (Timmons, Schuster, Hamner, & Bose, 2001). The combination of these factors makes a system in which consumers feel comfortable.

Other research has identified other characteristics of effective direct support strategies from the perspective of the job seeker. Patterson and Marks (1992) identified determinants of service quality that could be applied to rehabilitation services to promote consumer satisfaction with services. These determinants included reliability, responsiveness to the needs of the consumer, good communication between counselors and consumers, competent staff, and consumer involvement throughout the process. Consumer education was also important in encouraging consumer involvement.

In addition to characteristics of direct support strategies, the personal qualities of the individuals who use these service systems also play a role in the service delivery experience. In a study of adults with learning disabilities who had attained vocational success, Gerber, Ginsberg, and Reiff (1992) examined relevant personal factors that may contribute to high achievement. The results showed that the notion of control is an important contributor to success. Successful individuals make conscious decisions to take charge of their lives and adapt and shape themselves in order to move ahead. These individuals display characteristics such as a strong desire for success, goal-oriented thinking, persistence, a good fit with chosen environments, learned creativity, and the ability to develop strong support networks.

Another study with a comparable population uncovered similar characteristics. Individuals who displayed high levels of self-awareness and acceptance of their disability were able to recognize their strengths and limitations and accommodate goals and activities accordingly to ensure a manageable environment. They were proactive in setting appropriate goals and were self-directed in identifying means to reach these goals (Spekman, Goldberg, & Herman, 1992). Another study by Timmons, Schuster, Hamner, and Bose (2001) illustrated the importance consumers attributed to taking control of their own job search. This concept of "taking control" meant leading the job finding process, not allowing oneself to rely solely on the support of the system, and not allowing the many facets of the job search to be done by someone else. The importance the respondents placed on control and self-directedness was immense because it increased the likelihood that the services they received would be tailored and individualized.

Several studies have examined consumer and counselor satisfaction with the vocational rehabilitation system in terms of consumer choice and involvement. Through a series of focus groups with vocational rehabilitation counselors and consumers, Thomas and Whitney-Thomas (1996) identified elements necessary for consumers and counselors to be satisfied with the service delivery process. One important element was the presence of a positive working relationship that involved free exchange of knowledge about services, needs, and expectations between counselors and consumers. A true positive working relationship went beyond mere coordination of tasks and included emotional support and shared responsibilities. Communication breakdowns were often identified as the greatest barrier to a positive working relationship.

A key finding from Thomas and Whitney-Thomas's (1996) study was that as the consumers become more involved and assertive in the search for suitable employment, their services improved. It is important to build the competence of job seekers so that the search for work becomes a practiced skill that is developed over time. One way that consumers can build their own competence is to find jobs or explore career options by using informal supports or social networks such as family, friends, co-workers, and neighbors (Timmons, Schuster, & Moloney, 2001).

As consumers exercise their choice-making skills, they are also building their competence as job seekers. Fry (1995) discussed informed choice as encouraging consumers to make their own choices to

find suitable employment. As consumers explore their options, they can more readily identify the opportunities that are available and the positive and negative implications of those different choices.

Typically, persons with disabilities have limited opportunities to exercise their decision-making skills, not because of their own limitations but because of the negative attitudes and practices of some caregivers, service providers, and social institutions. When consumers are given the opportunity to obtain information that helps them make good decisions for their own purposes, they are learning valuable job seeking tools that will guide their job searches and that may help them in the future. When consumers control the values and input into the services they procure, they are more likely to obtain the goals they desire (West & Parent, 1992).

As services become more consolidated, more opportunities are arising for consumers to guide their own job searches. Historically, there have been separate service delivery systems specifically for persons with disabilities. Services were compartmentalized; they offered persons with disabilities different answers, were conducted in various languages, and were based on different funding sources. In the past, each different agency also had its own rules for eligibility.

There are several disability-specific agencies that serve only people with disabilities: state mental retardation/developmental disabilities agencies (MR/DD), state mental health agencies (MH), and state vocational rehabilitation agencies (VR). MR/ DD services may include help with job placement, transportation, and personal and living supports for people with mental retardation or other developmental disabilities. Similar to MR/DD agencies, MH agencies provide help with job placement, transportation, and personal and living supports. However, these MH agencies focus their services on people with mental illness and substance abuse. Typically, MH agencies also provide emergency services, out-patient, and hospital-based treatment services. In general, employment is only a very small focus in most MH agencies. Whereas MR/DD and MH agencies deliver employment supports as part of a range of services to individuals with disabilities, the primary emphasis of VR is on employment-related support. Individualized employment counseling and job development for individuals with disabilities are among its primary services. VR also provides a range of independent living services.

In recent years, the U.S. employment service paradigm has shifted toward the One-Stop Career Center (OSCC) as a way to offer consolidation in services. With this move toward consolidated services, the state offers job seekers one delivery system with a variety of employment options and training programs. The foundation of this system is to provide a common source of information and services; the goals are to provide convenience and to cut the number of locations used to one (Perry-Varner, 1998).

The establishment of the OSCC as part of an employment and training service delivery mechanism has been expanded since the Workforce Investment Act was signed in 1998. The OSCC has features that allow for the consolidation of services to become a reality, such as universal access, streamlined services, increased accountability, a focus on the empowerment of individuals, and state and local

flexibility. OSCCs are working to achieve these goals as part of the emerging paradigm of collaboration and coordination. The ultimate goal is to develop a new service system that will help people with and without disabilities succeed in finding employment (Fesko, Hoff, Jordan, Phaneuf, & Thomas, 1999).

As we move from systems that focus on a disability-specific service to a consolidated system that offers services to all job seekers, different agencies are working together to accomplish common goals with an increasing emphasis placed on collaboration and coordination between the agencies. As a result, new links are being formed and infrastructures that transform a fragmented structure into a streamlined service system are being constructed. Links are being built in different ways that combine planning, information, referrals, and service delivery (Grubb et al., 1999).

As this consolidation develops, state agencies often experience changing roles. They may find themselves both playing a critical role in the consumer decision to seek employment and directing consumers to the most appropriate sources of support. Also, as streamlining takes place, individuals with disabilities who have traditionally received support from disability-specific state agencies are now more likely to get support from generic sources such as OSCC or the welfare system.

As this change becomes a reality, it is essential to discuss the ways services are being revised. Although we know a fair amount about direct employment support strategies for people with disabilities, it is time to discuss the impact of state agency collaboration on the individual with a disability, particularly in regard to the streamlining of disability-specific and generic agencies. Also, it is informative to investigate the impact of consumer directedness and self-determination as they relate to employment supports and service delivery. To fill the gap in existing disability research, this article addresses the following research questions: ï

- How do the experiences and supports received by individuals differ between disability-specific and generic agencies?
- What is the impact of these differences on the job seeker?
- What are the implications for the newly consolidated workforce system?
- What are the different ways support is given to individuals according to the principles of selfdetermination in generic and disability-specific agencies or services?

Method

This research was conducted using a qualitative methodology to allow for a more detailed picture of consumer experiences (Bogdan & Biklen, 1992). In-depth, semistructured interviews were carried out with adults with disabilities who had successfully become employed with the help of a state service system. This approach enabled the researchers to understand pertinent issues regarding service delivery and consumers' perceptions of the systems they used. The following section will address (a) the sample, (b) data collection methods, and (c) data analysis.

Sample

Recruitment. The sample of individuals with disabilities was recruited through a variety of disability advocacy groups including Centers for Independent Living and the Massachusetts ARC. In addition, state agency personnel were asked to recruit potential consumers using a packet of information and eligibility criteria provided to them by the research team. Once agency staff had identified eligible consumers, names and contact information were forwarded to the research team.

Description. We interviewed a total of 17 adults with disabilities. Eight were women and nine were men, and they ranged in age from 20 to 49 years. These individuals represented a wide range of disabilities, with eight reporting their primary disability as psychiatric; five, as cognitive; three, as physical; three, as a sensory impairment; and one, as a learning disability. Ten respondents defined their racial/ethnic background as Caucasian; four defined themselves as African American; two, as "other"; and one, as Latino/Hispanic. Educational backgrounds also represented the full spectrum, from college and postcollege degrees to one individual who did not receive any education because she had been institutionalized. Agencies used included VR (10), MR/DD (3), MH (3), OSCC (7), and Commission for the Blind (1). It is important to note that several of the participants described themselves as having multiple disabilities and also had used multiple systems; thus, the numbers do not add up to 17.

At the time of the interviews, the 17 participants were employed in a variety of positions ranging from supervisory and administrative work to janitorial, kitchen, and clerical work. Some had started working right out of high school, whereas others had earned advanced degrees. The job seekers were also at different stages in their careers. For example, one individual had extensive experience in a highly specialized field. In contrast, another had spent most of her adult years in a sheltered workshop and was working in a competitively paid retail position in the community for the first time. Others also had very limited employment histories with little to no job skills.

Data Collection

Screening for Eligibility. Each participant was asked to complete a demographics form. This form was used to compile individual profiles and served as a screening tool. Participants were screened for eligibility based on the following criteria: (a) they were 21 years of age or older, (b) they described themselves as having a disability, (c) they were currently employed, and (d) they had found their most recent job through the assistance of any of the following state agencies: VR, MR/DD, MH, or OSCC. In addition, the researchers required that services were used in a variety of locations, including urban, suburban, and rural, and ensured statewide representation.

Interviews. Once the referral was made from the recruitment source, the project staff contacted each individual and explained the purpose of the research, acquired a signed consent form, and scheduled an interview. Interviews were indepth, semistructured, conducted in person, and lasted approximately 45 minutes to an hour. If a face-to-face meeting could not be arranged, interviews conducted over the

telephone at a prearranged time most convenient for the participants. Two phone interviews were conducted in total.

A protocol of questions was constructed to guide the interview process. However, interviewers encouraged open discussion and, in keeping with the qualitative framework, did not adhere strictly to a specific set of questions or topics (Bogdan & Biklen, 1992). This allowed for a free flow of conversation that encouraged a comprehensive collection of the interviewee's experience. Interview questions focused on individuals' perspectives on receiving support from state service systems. More specifically, participants were asked to expand on their reasons for wanting to work; why and how they sought assistance from an agency; their experiences as recipients of agency support, including helpful aspects and barriers, and a description of their current employment situation. Each participant was offered a stipend as compensation for his or her time. All interviews were tape-recorded with the consent of the participant. Tapes were then sent to an independent agency to be transcribed.

Proxies

Proxies were used in two instances in this study. In both cases, the sample members were individuals with cognitive disabilities who had attempted the interview but were unable to participate because they had difficulty with the interview format. They were asked to nominate a collateral source (or proxy) to speak on their behalf (Ferraro, Overvedal, & Plaud, 1998). The researchers asked permission to contact the nominee. In both cases, the study participant nominated a parent as a proxy, and researchers requested the consent of the parent to be interviewed. Each proxy was instructed to answer protocol questions from the perspective of the individual with the cognitive impairment, rather than from his or her own point of view.

Data Analysis

After transcription, the researchers undertook analysis of the data. QSR NUD*IST 4.0 (1997) for the Macintosh was used to facilitate conceptualization of themes and coding and sorting of data. This software was designed specifically to facilitate qualitative analysis and had been used successfully on previous qualitative projects by these researchers. The specific data analysis techniques used by the researchers were coding and memo writing.

Coding. The analytic process by which a researcher begins organizing data into themes or categories related to both original and project-inspired research questions is known as coding (Strauss, 1987). These codes become meaningful labels that denote concepts, actions, or recurrent themes. Once data is coded, the researcher can see relationships between pieces of data.

The authors developed codes by reading through the transcripts and assessing appropriate labels and themes that recurred in the data. The authors then met as a group to assess the codes they had constructed individually and to create a master list of codes and definitions. Consensus on coding was reached by having more than one author code a particular transcript and then meeting to achieve

reconciliation of codes. As new data were collected, the process of conceiving and reconciling codes was repeated and additional codes were added to the master list as appropriate.

Memo Writing. Memos are systematic writing and musings of the researchers that occur during the coding process. Memos focus the emerging themes and concepts into a discussion that emphasizes responses to the research questions. Memos are often used to generate organizational schemes and further conceptualization or sorting of data. While conducting analysis, the researchers met on a regular basis to discuss the emerging data and the memos generated by this process.
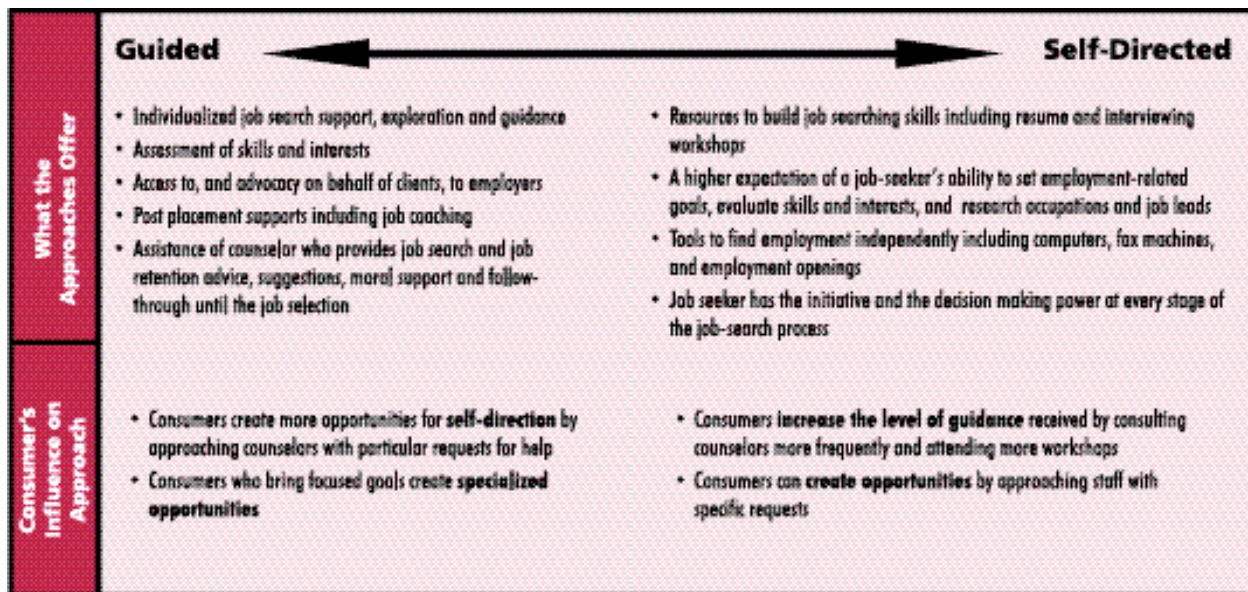
The researchers were also careful to ensure consistency of data analysis by using the reconciliation and cross-check method of independently coded data previously mentioned. The validity of the findings was verified by several participants, who were invited to confirm interpretations presented in publishable products or summaries of data analysis.

Findings

This section is organized according to descriptions of the agency's overall approach to providing assistance to consumers. Individuals in this study received employment supports from state service systems including both disability-specific agencies, such as the state vocational rehabilitation agency, mental health agency, and mental retardation or developmental disability agency, and generic agencies that provide employment supports to all job seekers. The consumers encountered differences in the types of approach depending on whether they used a generic or a disability-specific agency. The type of approach found most frequently at disability-specific agencies was described by the researchers as guided; at generic agencies the approach was defined as self-directed. Although these approaches differed, the consumers found that their self-directedness made a difference in terms of tailoring the services to fit their needs. We discuss the impact of the different approaches and examine both the positive and negative aspects. The different sections feature quotes that highlight the experiences of the consumers.

Definition of Approaches: Guided and Self-Directed

Consumers encountered distinct differences in agencies' overall approaches to providing support. Consumers who sought help from VR, MH, and MR/DD experienced a guided approach. In the guided approach, consumers were assigned counselors who worked one-on-one with the consumer through the entire job search process, from initial orientation/ assessment meetings to consumers' being placed in jobs and receiving postplacement support. Consumers who received services from one-stop centers were helped in a more self-directed manner; they were briefly oriented to the centers by staff members, provided a short appointment with a counselor, and then presented with an array of resources. Their time at the one-stop centers was their own to plan, with very little direction from staff members.

	Guided ←——————————————————→ Self-Directed
What the Approaches Offer	• Individualized job search support, exploration and guidance • Assessment of skills and interests • Access to, and advocacy on behalf of clients, to employers • Post placement supports including job coaching • Assistance of counselor who provides job search and job retention advice, suggestions, moral support and follow-through until the job selection	• Resources to build job searching skills including resume and interviewing workshops • A higher expectation of a job-seeker's ability to set employment-related goals, evaluate skills and interests, and research occupations and job leads • Tools to find employment independently including computers, fax machines, and employment openings • Job seeker has the initiative and the decision making power at every stage of the job-search process
Consumer's Influence on Approach	• Consumers create more opportunities for **self-direction** by approaching counselors with particular requests for help • Consumers who bring focused goals create **specialized opportunities**	• Consumers **increase the level of guidance** received by consulting counselors more frequently and attending more workshops • Consumers can **create opportunities** by approaching staff with specific requests

Our findings indicate that although there were two types of approaches to system delivery available, it was the consumers who tailored the service to fit their needs. This characteristics each consumer brought to the job search. If the consumer had a clear idea of the type of job she or he wanted, she or he could use the services of a one-stop more effectively than a job seeker without clear goals. Also, consumers who felt they could communicate comfortably with the staff could influence their helpers' approaches. At the disability-related agencies, consumers created more opportunities for self-direction by approaching counselors with particular requests for help. In the generic agencies, consumers increased the level of guidance by consulting counselors more frequently and attending more workshops. This meant that rather than receiving one of two distinct approaches to service delivery— either self-directed or guided—each consumer experienced a form of help that resembled one approach more closely than the other. The guided and self-directed approaches existed on either end of a continuum with the agency's approaches to service delivery falling somewhere in between (see Figure 1).

Impact of the Approaches: Positive and Negative Aspects

Study participants experiencing help from agencies that emphasized either guidance or self-direction described both positive and negative aspects of each approach. The following are their descriptions and comments, along with the possible effects of these approaches on job seekers with disabilities, as our findings indicate.

Guided Approach: Advantages. The guided approach presented important advantages for job seekers. Consumers who were unclear about their job search goals, skills, or interests could benefit from a counselor's assistance. This assistance could lead to more promising job matches. Some consumers were helped by individualized services, such as a discussion of disclosure or other sensitive issues with the counselor and being individually shown how to use resources and adaptive equipment at the agency in a job search. One-on-one assistance in writing résumés and mock interview sessions taught

consumers how to present themselves to a potential employer. These consumers were more likely to succeed at eventually finding employment when they organized their thoughts and practiced presentation skills with specific guidance.

Another advantage of the guided approach is that it gave consumers motivation, emotional support, and momentum when the job search was tough. Consumers reported that they were motivated by counselors who were willing to be present during the challenging and stressful times. For example, one participant reported, "It was good because . . . they would come with you on an interview for moral support or they just take you around to different places to fill out applications." The right kind of support gave the consumers good momentum to keep the search moving through challenges. When consumers were given assistance during crucial times, they were ultimately able to pursue their goals with enduring persistence. One consumer explained, "[I] desperately needed someone to hold my hand and get me through it and that's what happened. [My counselor] did it and now I can get through the rest of it pretty much with more confidence." Good counselors also gave consumers kind words and encouragement, which, when received at the right time, helped consumers continue after they had realized their goals. One study consumer indicated, "They gave me a lot of support . . . compliments and motivation just to help me out. I just liked the way they handled things." Another said of her counselor, "She gave me a lot of confidence. She gave me extra boost so I can feel comfortable at the next job I go to."

Another advantage of the guided approach was that consumers who were not clear about their job search goals and had not examined their skills and interests benefited from the opportunity to articulate these with the counselors' help. Having done so, they could direct their time and energy toward more interesting job matches in more appropriate work environments, rather than following less promising job leads. One consumer found this experience particularly valuable:

> Nobody ever touched base on my being an artist all my life. . . . [The counselor] touched base on it
> very quickly. As soon as I told her I had been doing it for that long, she made the call right away and
> we made interviews. . . . Right away I knew it was going to be exciting for me.

Guided Approach: Disadvantages. Although consumers received crucial help from systems that provided guided supports, the disadvantage is that they ran the risk of the counselors taking control of the job search. The counselor's taking control could prevent the consumer from learning valuable lessons and skills useful for a future job search. Therefore, heavy-handed use of the guided approach had a significant negative impact on job seekers because it provided them with too much direction and left them expecting very little in return:

> I would look up the leads for my jobs, and I would send the leads to my counselor, and my counselor
> would basically set up the cover letter and send the résumé and so forth, and I think that sometimes
> when you are not as involved in the process in the event that something happens and your counselor is
> not there then you have to try to get the rustiness out of your brains and say, "Okay, now I need a cover
> letter, I got to do this and that." It can be difficult sometimes.

As this study participant stated, when job seekers had limited involvement in the job search, they had little opportunity to prepare to conduct a future job search more independently. Although counselors could offer practical help to job seekers by providing oral and written communication to employers, consumers ran the risk of becoming disconnected from the job search process if their counselors moved from providing help with communication to handling all contact with employers. In fact, with excessive guidance, the job seeker ran the risk of choosing positions that were unsuitable and thereby having to repeat the job search process.

Self-Directed Approach: Advantages. The positive impact of the self-directed approach was that the individual had access to a variety of tools and resources and could take initiative and be involved in the job search at every stage. Helpful aspects of the self-directed approach included access to job search techniques and strategies and access to the tools for conducting an independent job search, including copy machines, faxes, word processors, the Internet, and printers. The self-directed approach to job service delivery could be very powerful because of the level of initiative job seekers could exercise. On their own initiative, the job seekers researched career fields and open positions and followed up on job leads.

Self-Directed Approach: Disadvantages. Although a self-directed approach allowed the job seeker maximum control during the job search, the disadvantage was that the client who did not have the proper orientation or experience with job seeking would be lost and not able to fully access the resources offered. In addition, he or she would not learn the skills needed to successfully find and maintain employment. Many consumers indicated that they were unable to take full advantage of the resources available because of their inexperience with the job search process, and/or the need for more job exploration:

> I was really impressed that there was this place you could go to and use for free that had all these very important tools for the job search available. . . . However, I didn't really know how to use the Web, the Internet, for a job search. I never did find out . . . you almost had to know what you were looking for before you went in there.

As this job seeker reported, a limited understanding of computers and the Internet frustrated her job seeking experience. Although agencies offered technological tools, the job seeker was responsible for figuring out how to use them.

Whereas many job seekers preferred to be completely self-directed, others had questions about resources and workshops available to them through the agency. If they had questions or requested assistance and were met with staff members who seemed preoccupied or uninterested in helping them, there was a risk of consumers' becoming unimpressed with the agencies' services and leaving without taking advantage of the resources the agency had to offer.

> [The agency] did provide a lot of different workshops but . . . you have to make the decision to do whatever you are going to. [Their attitude] was basically, "We will give you some tools and you have to find your own way through."

Similar to the negative impact of the guided approach, job seekers who were self-directed but would have appreciated assistance from agency staff would not learn valuable skills related to seeking and maintaining employment.

As reported by job seekers in the study, the second risk of the self-directed approach is that consumers will not receive adequate orientation to the range of agency services and procedures. Although these agencies stored a large amount of important information, consumers were likely to be lost and confused when their orientation to agency resources was too cursory. As a result, one consumer offered the following recommendations about agency orientations:

> [I wish I had received] not just an orientation as to "this is what we provide" but an orientation of the agency to you. What are your needs and can we meet them here, and if we can't meet them here where else could we direct you [to]? . . . It doesn't even have to be an in-depth one, just something so that they would get an idea of what you were looking for and if they have those resources or services available [so] that they could just make the connection for you.

Discussion

Implications

Consumers' experiences of service delivery systems reflect a range of agency techniques and ideas about the best ways to help job seekers. Disability-related agencies provided a guided approach that involved one-on-one counselor assistance from assessment to postplacement, whereas the generic agencies offered a self-directed approach to the consumer. They provided a variety of resources for the consumer to access and to adapt according to his or her own individual needs. Service delivery was not solely defined by the provider, but also by the consumer, who experienced a form of help that he or she could tailor to suit his or her own needs.

As our findings and the consumers' comments indicate, both approaches have aspects that help the consumer and aspects that impede the job search process. Advantages of the guided approach included receiving one-on-one emotional support, motivation, and momentum from one's counselor. The negative dimension of the guided approach was that the job seekers risked becoming disconnected from the job search, because he or she received too much direction. Although the self-directed approach offered the job seeker access to a variety of resources, without proper agency orientation or experience with job searching, the participants often did not fully use them. In this section, we will use these findings to suggest ways to best provide support to persons with disabilities.

Focus on flexibility in service delivery to make sure that services are tailored to meet people's needs. All agencies, regardless of whether they are disability-specific or generic, should focus on flexibility in service delivery to make sure that services are tailored to meet people's needs. Agencies need to recognize the level of support an individual wants and needs in the job search and adapt service options accordingly. Agencies can train staff members to explore the needs of all consumers regardless of disability. Both disability-specific and generic agencies can work to incorporate an initial consumer assessment during the mandatory orientation to the agencies' services. Finally, both types of agencies

should offer a job skills workshop on discussing job accommodations with employers for people with and without disabilities.

As disability-related agencies and the one-stop system begin to collaborate, they have an opportunity to bring the best aspects of both approaches together to use as best practices in supporting people with disabilities. These practices from each approach often complement one another; for example, the detailed assessment from the guided approach could lead a consumer to elect to attend particular workshops and initiate more of the job search independently, as is done in the self-directed approach. A consolidated job service delivery system that offers such a range of beneficial options has room to develop enough flexibility to ensure that when visiting each agency, individual consumers, both with and without disabilities, find the amount and type of help best suited to their successful acquisition of meaningful employment. Agencies need to identify strategies that find the correct balance of guidance and self-direction for each individual.

Provide a clear path to services so consumers can feel comfortable asking for additional help. Access to such services can produce what Zimmerman and Warchausky (1998) described as critical awareness, which refers to one's knowledge of how to acquire resources and the skills that are necessary to manage resources once they are obtained. This knowledge can be gained through empowering processes provided by the agency, such as training programs that provide opportunities to develop and improve skills and knowledge, learn leadership, and facilitate goal setting. These programs help consumers become more self-reliant and self-governing (Zimmerman & Warchausky, 1998). Access to job finding resources can create a solid knowledge of the necessary skills to achieve one's job search goals while empowering the job seekers in the process.

Ensuring that there is a clear path to resources, especially if the job seeker needs more intensive training and/or services, requires strong communication and assessment skills and the creation of an environment where consumers feel comfortable asking for additional help. The types of services that individuals can expect to receive at the various agencies should be clarified. Agencies should consider instructing job seekers on available services as part of an orientation process.

Providing a clear path to services can also be achieved through considering the agency's social and physical environment. A constructive social environment includes the generally positive demeanor of all staff members, which creates a welcoming agency. Agencies should also maintain a constructive physical environment, which includes signage that conveys a positive and safe tone. Attention to accommodations such as ramps, doors, and accessible bathrooms allows the facility to be useful to all job seekers. Furthermore, the accessibility of resources should be ensured through the use of adapted formats, including large print and Braille, along with adapted and accessible computer equipment. The combination of a positive social and physical environment allows consumers to feel safe advocating for their unique needs if they choose. It ensures that consumers are welcome to bring up special needs related to learning style, physical accessibility, mental health concerns, or other issues.

Build job seeker competence and self-determination. Consumers who benefit from guided supports should be better able to manage their own job search and career decisions in the future. Collaborators can work to build job seeker competence and self-determination by teaching them job search techniques, rather than simply showing them or doing it for them.

One such technique already proven successful is networking. Previous research on this employment strategy showed that individuals who used a networking approach found jobs with better pay and more hours in less time than those who used other approaches (Temelini & Fesko, 1996). It is important to develop job seekers' networking skills so that they can use natural supports for job finding and career exploration in the future. This can be done by supporting individuals' close personal relationships, mapping out their personal resources, and helping them develop action plans for job finding and follow-up. Linking individuals with mentorship opportunities and peer supports is another valuable method for building networking resources. Finally, agency personnel can become familiar with person-centered planning processes, such as Personal Futures Planning, Planning Alternative Tomorrows with Hope (PATH), or Whole Life Planning (Butterworth et al., 1993), which encourage individuals to call upon their networks to assist them in developing goals and implementing a plan for achieving them.

In addition to strengthening job seekers' ability to independently search for employment in the future, it is important to foster self-determination in a more general sense. The findings show that as job seekers' self-directedness increased, so did the likelihood that the services they received would be tailored and individualized. One way to foster self-determination is through encouraging informed choice. This is a process that occurs within a partnership in which options at each decision point in the rehabilitation are identified and explored together. The consumer identifies positive and negative implications, and the counselor provides the support he or she needs to make informed choices and ultimately find a satisfactory employment outcome (Fry, 1995). Informed choice is a key aspect of a consumer-directed system. Unfortunately, individuals with disabilities often have limited opportunities to learn and practice decision making and self-direction, not necessarily because of their limitations or impairments but because of the attitudes and practices of caregivers, service providers, and social institutions. Individuals may not be given the opportunity to make choices or to obtain information or experience that would allow for good decision making (West & Parent, 1992). The use of informed choice throughout the rehabilitation process is necessary in order for agencies to be effective service delivery programs, and consumers must be given opportunities to exercise this skill.

Through workshops and the resource lists, agencies can educate consumers about the needs they can meet and the best ways to communicate with agency personnel about problems, questions, changes, and goals in service delivery. Workshops can also be used to build job seeker communication skills that will inevitably assist them in requesting accommodations or addressing disclosure either during the job search or at the workplace. Finally, education about employment rights under the Americans with Disabilities Act (ADA) of 1990 is valuable in order to build the job seeker's ability to make his or her own decisions concerning disclosure. Fear of discrimination, a legitimate concern affecting

decisions about disclosure, creates barriers throughout the job search process, and education about one's protections can help. Familiarity with ADA will also build the capacity of the job seeker to request accommodations.

Conclusions

As the examination of collaboration and consolidation continues and policy shifts, research can help to determine how best to prepare consumers and state agencies for the teamwork ahead. As with all new beginnings, the challenges can lead to better solutions as disability-specific and generic agencies continueto learn, work, and grow together.

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Session 6

Defining Quality: Individual Perspectives on Quality Employment Supports

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Respondents:

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Haitian American Public Health Initiatives

John Burt
The Disability Network

Discussion Summary

Doris Hamner

Studied those who were successful in their job search. Discovered what was helpful in job search, barriers, and strategies consumers used to shape the supports they received from agencies. In general, participants described:

- A continuum of services—participants described a continuum of supports that varied from a predominantly guided approach to service delivery to a predominantly self-directed approach to service delivery. Services were guided on the one hand, self-directed on the other.

- The guided approach is primarily offered by disability-specific agencies and the self-directed approach is offered by generic agencies such as One-Stop Centers.

Guided Approach

- Offers individualized job search supports, exploration, and guidance

- Wide array of skills and supports

- Provides access to direct advocacy on behalf of consumers with employers

- Positive aspects of a guided approach: one-on-one emotional support, momentum, and motivation

- Negative aspects of a guided approach: job seekers risk becoming disconnected from their job search

Self-Directed Approach

- Provides general skill-building resources, including workshops on interviewing skills and how to write resumes

- Has a higher expectation for person to identify own needs, set employment-related goals, evaluate skills and interests, and research occupations and job leads

- Job seekers needed to have the initiative to direct each stage of the job search. Without the proper orientation or experience, participants may not know how to utilize services available

- Positive aspects of the self-directed approach: flexible supports for individual styles and needs, access to a variety of resources

- Negative aspects of a self-directed approach: without proper orientation or experience, job seekers did not fully utilize the available resources

Job seekers need to find the correct balance between the guided and self-directed approach that meets their own needs and preferences. Sometimes the complexity of the options made self-determination difficult when they entered an agency.

Evelyn Milorin: Respondent

The experience of Haitian young adults who have cognitive and developmental disabilities: What do I define as the worse disability? Language. Some can speak, but cannot speak English. Some can't speak and can't speak English. The experiences of young adults who tried to find employment in 1996 offer concrete examples. First my son, after 6 years working at a dry cleaners. He worked 2 hours a day. The employer would not hire him for a full-time job. He can travel on his own, became a homeowner, lives on his own. As a parent, not many people with disabilities can achieve this.

Took young people from Haitian Public Health initiative to look for work, and one employer said, "if you can not fill out this application, you cannot have a job." Then he pats me on the back, and said, "Go teach that child English." Reality for people with disabilities: If English is your second language you have an additional barrier to employment.

We need to identify strategies for change, and identify areas of need. It has been years that people with disabilities are unemployed. Can you tell me how people with disabilities can get jobs? Face the reality: This is what we face in Boston with Haitian young Americans living with disabilities.

John Burt: Respondent

One of the models we are using in Michigan is a cash match between our mental health system and our VR system. Pay the network to work with people with disabilities, things they may not normally address—this may be housing or transportation. Make the program open so that people can have cash direction, from where they are to where they want to be.

Community organizations provide what the state organizations do not. Benefits analysis to see what is happening to your benefits if you work so many hours a week. Housing, transportation, and benefits are major issues.

Job choices change over time, and you may change your mind on a job. With a "cash match" program you can stay outside of VR, so VR isn't under pressure to close your case. VR can offer assistance here and there. In urban areas, cash match offers more chances for self-directed supports. In rural areas

supports are mostly guided—a lot of the guided approach that is transportation and computer access. Geographical issues affect the cash match program and the southern areas. It makes a lot of difference to do some work with microenterprises in the rural areas. A woman has a fabric business using eBay. Another started a car wash. The microenterprise and the cash match have been very successful.

Discussion Points

- Access for information and resources: Consumers do want to have choices, and need information. Even when we go through competitive bidding, consumers often want choices that are the second or third bidder for a variety of good reasons. They may also want to add specifications to a bid and pay for them directly. We have negotiated successfully with our state to allow consumers to make that choice. One of the changes is the mix of government and private resources, as in the case of the microenterprises.

- Program income is also a possibility that we need to talk about more with our partners, particularly with Labor. We talk about "shuffling the deck of government resources" between systems. One alternative is to create more resources together. There are a couple of regional workforce boards that have done this, and at one up to 40% of their resources does not come from government but from private companies, private resources, and other things. The New Freedom Initiative talks about loans, grants, technologies, individual development accounts, hiring your own case managers.

- Systems are already set up in a certain way. There are alternative, grassroots models that don't get a lot of press. Cash match is not that difficult to set up—only takes 18 months. I have yet to get a call from a state asking for help setting up a cash match.

- Parents of young people from diverse cultures don't speak any better English, so the language barrier is real. ICI came to our rescue—we had a focus group with local employers. We had employers who got together and discuss why the community needs to accept people with disabilities. They want to see what young adults can do, and it is a first step toward making changes. They realize that the language obstacle is a big barrier to them.

- One opportunity for addressing this is a One-Stop that has been doing some collaboration successfully. There are examples in a One-Stop in which collaboration is person-centered and brings together the needs of individual. One-Stops try to find out where a customer needs services from different types of collaboration and plan effectively for someone to receive what they need. Sharing resources is a priority, but we have 100-plus people coming through so it is not really practical in that kind of setting.

- Two questions for someone who walks in the door: How do we set up strategies for someone who just walks in the door, how do we know where they are on the continuum? Also, how do we help people to set up strategies to deal with the guided systems that let them be more self-directed in the future—so the last time they walk in the door they can be clearer about what they want? How do we fit that into the more generic systems?

- We are not exactly where we should be: When VR is in a One-Stop, people with disabilities are referred right to VR. Evolutionary process, and we co-locate and people are learning to ask people with disabilities what they are there for first.

- Centers need to see people in different kinds of roles; a lot of our staff members have a disability. And when co-located, people from other systems have a different view of the role of people with disabilities.

- Rural areas have VR and One-Stops but do not have enough VR staff. Two people cannot be in every One-Stop. It is an evolutionary process, but it has a very long way to go.

- Just to give another point of view, though I don't disagree—there is uneven progress, and some places are just better than others at this. Good service does begin with that one question: "What can I do for you today?" or "How can I help you today?" But that is only one part of it. In terms of guided versus self-directed services, that is a more incremental learning process. Someone will come in and ask for a job. As we work with them, as they begin their own search and aren't making progress, we ask more questions. As we ask more questions, we might move toward a more guided process and ask other people to come in. This is not a single-point decision. It is an incremental information-gathering and decision-making process, and we have to stay in contact with each other throughout it.

Action Steps

- At reception, how do we respond to people directly who communicate differently? It's ASL, Japanese, Korean, Hispanic, eight or nine dialects of Chinese…. How do we communicate when we receive people; how they are greeted and what written materials do we provide (language, large print, Braille)? We have many different languages from people who come here. Do we have the text and resources that people need in order to meet their needs? And are there available electronic resources that they can use when home? Can electronic access help deal with these issues?

- Is there a difference between variance in customer service and customer communication and who the prime contractor is at the One-Stop? Who is it that sets the tone at the One-Stop? What is the relationship in terms of what consumers deem as appropriate customer service?

- A lot of it has to do with size, and the service differs depending on the size of the operation. Smaller and medium-size centers are more consumer-directed than larger operations. How does size affect structure and service?

- How effectively is DOL supporting the mandate that One-Stop Centers serve individuals with disabilities? What other supports and resources are needed?

- The Department of Labor has $2.5 million to help One-Stops serve people with disabilities better. I think the resources are there, they are just not being used, and the question is: why? How do we make this a stronger focus for line staff in centers?

- Are training and TA dollars effective ways to promote systems change? The Department of Labor does not control One-Stops or WIBS. There **is** a tension between what DOL says and what the WIBs do. In some states they are powerful, sometimes they are the state employment agencies, some places just like PICs. Also, it seems every single constituency group approaches the One-Stops and requests specialized training and TA. It is really a dilemma for centers to get their work done and meet these diverse demands. (It is hard to cater to all.)

- There are a lot of groups that are more than willing to tell One-Stops what to do. It is a mosaic within a mosaic and we need to deal with it that way. Increased awareness and sensitivity are incredibly important. We have tried to build a capacity, but every office has unique strengths. One-Stops want to know, "What is in it for me?" So anybody that can tell me what they can do for me moves up in the list. Everyone else, it is—"who is going to pay for this?" I will always engage in that conversation.

- A study of those centers or One-Stop systems that are successes. What impact is the disability community having on the Boards at the policy level? Is that a factor in changing the system?

- Good to look at success but a slightly different look will look to where is the innovation, was it worth innovating, and why is it there? What I learn from working with VR should

be applicable to many other populations with special needs. That gets it out of the turf issue.

Session 7

Integrating Work Incentives Policy Across the Workforce Development System Including Benefits Planning and Health Care Initiatives (Beyond the Ticket)

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Respondent

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Using the "Emerging Disability Policy Framework" to Review Post-Implementation Issues Arising in the Ticket to Work—Work Incentives Improvement Act and the Workforce Investment Act

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It is well established that persons with severe disabilities are not employed to the extent they wish to be or to the level of the general population. Youths with disabilities are less likely to graduate from high school, get a post-secondary education, or secure employment than their non-disabled peers. Beneficiaries of the nation's two largest disability income support programs, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), leave the rolls due to paid employment at dishearteningly low rates.

We live in an aging society where degenerative diseases, both physical and mental, increasingly lead to disability before age 60. This will soon put immense pressure on publicly funded disability and retirement programs. The call for improvements in employment services and employment outcomes is loud and clear.

At the close of the twentieth century two major pieces of legislation promised to improve employment opportunities and service outcomes for workers with disabilities. The Ticket to Work—Work Incentives Improvement Act (P.L. 106-170 or TWWIIA) is devoted to facilitating employment for those who work under a disability (as defined by Social Security[1]) through program development and systems change demonstrations. The Workforce Investment Act (PL 105-220 or WIA), with its cornerstone system of collaborative One-Stop Job Centers and Workforce Investment Boards, provides a framework for "generic" workforce preparation and an employment system serving people who have disabilities as well as those who do not.

TWWIIA and WIA are two components of a matrix of federal legislative and executive activity (e.g. the New Freedom Initiative) that has its origin in policies developed in the last quarter-century. This matrix prompts the view that disabilities are not something to be "fixed," but natural and expected consequences of the human condition. It is the employment and health care systems (and their supporting policies) that need to adapt to this new view of social reality, not the "disabled" population. Emerging systems changes at the state level flow from this matrix and reflect this new paradigm. Programs need to be directed at eliminating the societal and systemic barriers that limit full participation of people in their communities.

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[1] 20 CFR Subpart 404.1505(a)

Robert Silverstein, in "Emerging Disability Policy Framework: A Guidepost for Analyzing Public Policy,"[2] suggests that the framework of this new paradigm follows from the precept that the presence of disability in no way diminishes the right of a person with a disability to take full advantage of that which society offers. Silverstein and others[3] have applied the framework to analyze the extent to which public policy, in WIA and TWWIIA, finds expression in state-level implementation activities, and the extent to which these activities adhere to the new disability paradigm.

Elements of this framework, for purposes of this paper and the conference for which it has been prepared, will be similarly employed as a means of examining emerging issues and themes as TWWIIA and WIA are being developed and implemented.[4] These examinations are here kept to a minimum and offered with the intention of spurring thought and discussion.

The Framework

Silverstein defines the *goals* and supporting "core policies" of the new paradigm as including:

- **Goal: Equality of Opportunity**, expressed in policies that create "Individualization," "Effective and Meaningful Opportunity," and "Inclusion and Integration." In sum, these policies require that people be treated in the system of services and supports as individuals, and not as a generic class. One size will not fit all, and what is provided should be based on individual data and considered in the context of the mainstream, without segregating services, supports, or environments.

- **Goal: Full Participation,** with core policies that support the means (information, self-determination, and advocacy) and authority for direct involvement of persons with disabilities in decision-making at all levels.

- **Goal: Community/Independent Living**, ensured by consumer skill development mechanisms and appropriate and sufficient services and supports.

- **Goal: Economic Self-Sufficiency**, guaranteed through employment and access to cash assistance.

The new paradigm is all about "inclusion," and workforce inclusion, along with the broader goal of community inclusion, resonates throughout the legislation and the reflecting framework. Each of these policy goals clearly links the paradigm to new workforce development components of service and support through physical and programmatic access to WIA "One-Stops" and guarantees of health care coverage benefits.

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[2] Robert Silverstein, Center for the Study and Advancement of Disability Policy (CSADP); 85 Iowa Law Review, 1691 (2000).
[3] Morris, Farah and Silverstein "Review of State Plans for the Workforce Investment Act from a Disability Policy Framework" National Center on Workforce and Disability, Institute for Community Inclusion, April 2002.
[4] Conference, "Improving Employment Outcomes Collaboration Across the Disability and Workforce Development Systems." Center for State Systems and Employment, October 2002.

A fully accessible system based on the new paradigm can be evaluated in terms of these goals and core policies. The new policies, programs, and practices arising in TWWIIA and WIA reflect the new paradigm and can be seen as well in issues emerging from activities at the state level.

Access to Health Insurance

Fear of losing the health care insurance associated with SSI and SSDI due to earned income or the acquisition of wealth is commonly cited as limiting employment and long-term savings among persons with disabilities. The Balanced Budget Act of 1997 and TWWIIA provide means of addressing this barrier to employment through provisions that reflect the framework core policies of Community Inclusion/Independent Living and Economic Self-Sufficiency.

To date, 26 states have enacted legislation providing access to Medicaid for workers with severe disabilities, with other states developing legislation or stakeholder support for such access. TWWIIA also provides states with access to Medicaid for those no longer found to be disabled under Social Security law, as well as Medicare for 8.5 years after the Trial Work Period has been exhausted.

States have developed and are using new analytical methods and evaluative practices to ensure their participation is consistent with their own unique workforce goals, fiscal environment, and the context of other Medicaid programs. As a result we now see developing a robust array of health insurance program features, including savings, income assessment, and premium or cost-share structures to target workers who earn at certain levels and/or reduce their dependence on unearned income from public cash support programs.

At the same time, the variety of buy-in programs developing creates a complex policy landscape. Means of evaluating Medicaid buy-in outcomes within and across states requires expertise and collaborative structures for sharing information. The Centers for Medicare and Medicaid Services (CMS) and the several national consortia working with state programs supported through TWWIIA-based Medicaid Infrastructure Grants (MIGs) have begun development of common performance measures with the intent of assessing the impact of buy-in programs. This collaborative activity promises to generate data-based improvements to buy-in programs across the nation.

The new paradigm and framework implicitly value a person-centered perspective with regard to program development, implementation, and evaluation. Traditional outcome measures included changes in earnings and the impact of supports on program costs. While earning increases and cost reductions remain critical yardsticks of performance, the new paradigm reflects the public's right to responsive and individualized public programs, with performance measures reflecting individual values and desired outcomes whenever possible. Along this line, state buy-in programs under evaluation seek to assess consumer "advancements in self-sufficiency, independence, inclusion and integration" as

outcome variables.[5] As an example, the evaluation of the Wisconsin buy-in surveys participants annually to measure consumer changes in perception of issues such as work capacity and health status, adequacy of program outreach, and ease of program access. Although increased employment should lead directly to these less tangible outcomes, the new paradigm views these as distinct and worthy goals in and of themselves.

Guaranteed health care is the initial step in supporting employment for persons with significant health care needs. Now that the connection between health care access and employment has been firmly established, a new avenue of investigation centers on the relationship between the manner in which health care is provided and employment outcomes. How does the employment-focused service system communicate and work with the health care system supported by Medicaid? How can the employment service and support system work collaboratively with the health care system to identify and meet the unique needs of persons with disabilities? How should health care be structured for workers with disabilities to ensure employment goals are achieved? How might the infrastructure around Medicaid, specifically the buy-in programs, influence primary and long-term health care services? How can we help shift from the "severely disabled and medically needy" to a "disabled and in need of employment health insurance" paradigm for Medicaid services delivered to those who work and pay premiums? How can the employer become more actively engaged in the Medicaid health care delivery system for their employee with a disability? How can we expand health care access to employees with severe disabilities while dealing with the challenge of controlling costs?

Comprehensive, Integrated Service Systems

"If we agree that the individual in need is at the center of our work, [we] must be guided more by the construct of stewardship and less than by that of ownership."[6]

The new paradigm is about inclusion: workforce inclusion and the broader goal of community inclusion. Each policy goal links the paradigm to new workforce development components of service and support through physical and programmatic access to WIA "One-Stops" to guarantees of health care coverage.

The emerging disability policy framework contemplates "a fully inclusive, comprehensive, person-centered workforce investment system based on universal design features."[7] This requires that the system reflect an understanding of, and accommodation for, the multiple needs of workers with

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[5] Peter Blanck and Helen Schartz, "Toward Researching a National Policy for Persons with Disabilities", in 22nd Mary E. Switzer Memorial Seminar: Emerging Workforce Issues" WIA, Ticket to Work and Partnerships, National Rehabilitation Association, July 2001.

[6] John Dorrer, "Workforce Development Program Consolidation and Service Integration—Ensuring Consistent Service Quality and High Professional Standards for Persons with Disabilities" in Emerging Workforce Issues: W.I.A, Ticket to Work and Partnerships," A Report on the 22nd Annual Mary E. Switzer Memorial Seminar. National Rehabilitation Association, July 2001.

[7] Robert Silverstein, "Using the Emerging Disability Policy Framework to Create a Fully Inclusive Twenty-First Century Workforce Investment System." Iowa Law Review, May 2002.

disabilities, including job training, health care, income supports, education, housing, and transportation. It also requires that programs be administered through interagency collaboration, with qualified and technically supported providers, including benefits counselors. These programs must be accompanied by research and evaluation components that encourage continuous quality improvement and facilitate data-based decision-making by federal and state administrative and legislative decision-makers.

The paradigm requires that rehabilitation and employment professionals adopt a perspective of stewardship that accepts responsibility and accountability for the system's performance in providing services, and rejects the "silo" mentality that fostered paternalistic control over consumer choice. States are developing person-centered planning and team-based delivery models that pull together and integrate otherwise distinct programs. This requires sharing resources and expertise across the system

The growing commitment to person-centered service provides an excellent opportunity to craft comprehensive and integrated systems at the state level. Team-based service patterns and policy demonstrations are developing under the several federal grants now underway. Several states are taking advantage of this opportunity to design, develop, and implement cutting-edge programs reflecting the emerging framework.

The Wisconsin Pathways to Independence project is, in reality, a series of interrelated initiatives centered on improving broad employment outcomes:

- Pathways to Independence is an Social Security Administration (SSA), Rehabilitation Services Administration, state of Wisconsin, and Robert Wood Johnson Foundation-supported research and demonstration project providing integrated, comprehensive, team-based vocational and employment services to over 700 SSI/SSDI participants to date, with the program featuring benefits counseling and Social Security disability waiver elements.

- The Wisconsin Medicaid Purchase Plan (MAPP) is a "buy-in" crafted under the Balanced Budget Act currently supporting the health care interests of over 3,000 participants and including the previously referenced comprehensive evaluation.

- A CMS Medicaid Infrastructure Grant (MIG) program supports systems change and policy research around health care for workers with disabilities.

Each program is distinct, using a different combination of funding streams, but is administered, managed and evaluated by the same state agency based team. An executive team and an advisory council provide guidance to Pathways. Decisions regarding each program are made in the context of their impact on the others. Services and service coordination appear seamless to the consumer, being facilitated by a single team composed of both permanent and as-needed members that cross agency boundaries. Nearly all elements of the Pathways initiatives are subject to comprehensive research and evaluation. Participant satisfaction and perceptions, changes in employment rates, earnings, support program expenditures, and evaluations of process implementation activities are all areas of research interest. Data is collected, stored, and analyzed by Pathways research staff and partners, including

Innovative Resource Group, Virginia Commonwealth University, and the Oregon Health Policy Institute.

Connecting Pathways programs to other national initiatives are activities with SSA, CMS, and the several technical assistance consortia. Wisconsin is a member of the National Consortium of Health Systems Development. Participation in the consortium has provided a means of sharing lessons learned across all Pathways programs with federal partners as well as other states. The consortium serves as a forum for emerging issues and promising practices, and facilitates development of Medicaid- and employment-related data sources accessible for decision-makers at both the state and federal level.

Comprehensive and integrated service programs are designed to simplify system access for consumers, but they are organizationally complex, requiring coordination between federal and state bureaucracies. Balancing system priorities and resources requires more coordination between federal, state, and local stakeholders. New program policies and practices are being developed, implemented, and managed in a turbulent environment. Federal political and economic priorities change at a different pace than state and consumer priorities. Since the events of September 11, 2001, there has been an understandable shift in congressional and federal activity, as well as public interest, to the war on terrorism. Yet states continue to administer new programs initiated prior to the tragedy, struggling with decreasing federal support and their own slowing economies, with resulting revenue shortfalls. Predictably, states are increasingly restricting, if not eliminating, consideration of new programs. Policymakers are, in effect, aiming at a retreating target.

"Aligning federal priorities with consumer and employer needs at the local level is the promise of the last century and the challenge of the new. Committed leadership and interagency coordination at the federal level is needed to keep the targets clearly in view. Beyond that, an increased willingness from federal partners to delegate systems change authority to state and local stakeholders offers the most assurance that the target will be reached. Waiver authority granted from a silo is a partially failed systems change strategy of the past. Comprehensive waiver authority, across silos, is the systems change strategy needed for the future. The recent federal rhetoric and HHS Olmstead and WIA activity around 'interagency coordination' and 'multiple waiver authority' hold great promise for achieving significant systems change. The challenge now is how to advance the rhetoric into action during times of such great distraction."[8]

Benefits Counseling

The framework rooted in the legislative matrix defines the policy goal of full participation in activities and decisions affecting the lives of people with disabilities. The foundation of full participation consists of informed choice, empowerment, self-advocacy, and self-determination.

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[8] Personal correspondence, Charlene Dwyer, Administrator, Wisconsin Division of Vocational Rehabilitation.

It is well understood that a single "extra" dollar in earnings can jeopardize critical access to thousands of dollars in healthcare services and cash supports as an SSDI beneficiary approaches the so-called "cash cliff." Thousands of people have lost access to critical benefits due to misunderstanding complex program eligibility rules and inconsistent administrative interpretations of those rules.

Along with the development of Medicaid buy-in programs, perhaps no emerging activity arising from the recent legislation has been as favorably received as benefits counseling, also called benefits advisement and benefits management counseling. Benefits counseling explains to consumers the effect of earnings and asset acquisition on eligibility for the many service and support programs to which they are entitled and upon which they may depend.

Benefits counseling training, along with technical assistance for practitioners, has been implemented nationally since TWWIIA was enacted. Benefits advisement programs are proliferating, thanks to increasing demand and the availability of federal/state funding. Practitioner capacity is growing, and VR programs are underwriting service expenses. A number of MIG and Workforce Investment Grant projects provide consumers with benefits counseling services in a wide variety of settings, including One-Stop Job Centers. The SSA Benefits Planning, Assistance and Outreach initiatives employ over 400 benefits planners through 117 grants nationwide, providing benefits advisement and work incentives counseling to SSI recipients and SSDI beneficiaries.

 "Benefits planning" is rapidly becoming a generic term that encompasses at least five distinct types of service:

- Information and referral
- Long-term benefits management
- Work incentives counseling
- Problem solving, advocacy, and representation
- Follow-up services

Benefits counseling has become widely accepted to the point where professionalization, including certification, standards of practice, and required preparation, are commonly discussed by practitioners.[9]

Despite the rapid growth and acceptance of benefits counseling in its many forms, issues and questions remain. What is the role of the benefits counselor in relation to workers with disability entitlements—to inform them how to decrease dependence on benefits, to be neutral providers of factual information, to assist in the acquisition and maintenance of eligibility for benefits, including advocacy and assistance with administrative actions? Furthermore, what public agency should fund this activity, particularly around advocacy and representation? These difficult questions highlight the need for

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[9] Kregel, John and O'Mara, Susan, Virginia Commonwealth University, "Current Efforts by State Projects to Design and Deliver Benefits Planning and Assistance Services." SPI Courier Express, May 2000. http://www.spiconnect.org/downloads/benefits%20assistance2.pdf.

agencies at all levels to work together to establish common vision, goals, and methods of working seamlessly together.

Definition of Disability

"To a remarkable degree, contemporary employment and rehabilitation programs for persons with disabilities are modeled on outmoded and medicalized stereotypes about disabilities. These longstanding views date back to the birth of the Civil War pension systems, which linked the definition of disability to an inability to work."[10]

The old disability paradigm supported exclusion of persons with disabilities based on "assertions by professionals that persons with disabilities were incapable of working."[11] To ensure its pervasive application and maximal effect, the old paradigm needed little more in the way of support than could be found in arguably the most important definition of "disability" on the policy landscape—that employed by Social Security.

Disability for Social Security purposes, and effectively for purposes of Medicaid eligibility, including state buy-in programs, is defined as "the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months" (20 CFR Subpart 404.1505[a]).

On its face, this definition is inconsistent with all four goals of the new framework, and arguably, in practice, it is. There is no doubt that the disconnect between the definition of disability and the message underlying the SSA "work incentives" that TWWIIA aims to improve is obvious and disquieting for disability recipients and beneficiaries. Given the difficulty persons with disabilities experience in initially proving they cannot work, there is little wonder the traditional work incentives are grossly underutilized. Further, there is reason to believe many people limit their work activity to avoid providing the Continuing Disability Review (CDR) adjudicator with evidence of "medical improvement." This is particularly true where work-related functioning, based on evidence collected from employers and co-workers, is frequently determinative (e.g., psychiatric impairments).

CMS uses the SSA disability definition and adjudication process in establishing medical eligibility for buy-in claims. The one alteration eliminates the automatic denial should the claimant be earning at the Substantial Gainful Activity (SGA, presently $780/month) level. Nevertheless, potential buy-in participants need to be both working and medically unable "to do any substantial gainful activity" as a condition of eligibility.

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[10]Peter Blanck and Helen Schartz, "Toward Researching a National Policy for Persons with Disabilities", in 22nd Mary E. Switzer Memorial Seminar: Emerging Workforce Issues" WIA, Ticket to Work and Partnerships, National Rehabilitation Association, July 2001.
[11] Robert Silverstein. "Using the Emerging Disability Policy Framework to Create a Fully Inclusive Twenty-First Century Workforce Investment System." Iowa Law Review, May 2002

As the basic policy goal of a Medicaid buy-in is to support people with disabilities who wish to work, thus decreasing dependence on public supports, a determinative process that emphasizes inability to work seems ill suited to the purpose. Possible alternative determination processes could include broad-based reviews of function that place no greater weight on work-related activities than on any other area. SSA already uses such a process in determining eligibility for the Disabled Child program. "Domains" of functioning are used to evaluate impairment. These domains include cognitive, social, motor, and others, depending on the child's age. No one domain takes precedence over the others in terms of decisional weight.

Another determination alternative is an evaluation of functioning in terms of the need for supports typically associated with Medicaid. For example, the documented and medically determinable need for a wheelchair, cueing, or personal assistance services in the workplace would provide eligibility evidence.

At present, two related activities are underway with CMS grant support that are intended to develop an understanding of the impact of the definition of "disability" in the context of Medicaid buy-in programs.

The Wisconsin Disability Determination Service and the state MIG project under Pathways are collaborating in a review and analysis of the buy-in eligibility determination process. The primary goal of the initiative is simply to assess the effect on decisional outcomes of the process. However, this assessment skirts the edge of the broader issue around the meaning of disability.

The National Consortium of Health Systems Development is supporting the Wisconsin initiative by surveying other state determination services and seeking to develop context and background to aid in determining the extent of the understanding of these issues among claim decision-makers.

Should these and subsequent investigations support a need to review the definition of disability, SSA would suffer great difficulty in moving the massive determination structure in response. However, there is optimism, given the more limited size and newness of the Medicaid buy-in eligibility determination process, that CMS will be able to adjust policy to reflect the new disability paradigm and "adopt criteria and methods of administration that facilitate and do not impede accomplishment of the... goals and policies… consistent with the lessons learned from the emerging disability policy framework."[12]

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[12] Silverstein, ibid.

Session 7

Integrating Work Incentives Policy Across the Workforce Development System Including Benefits Planning and Health Care Initiatives (Beyond the Ticket)

John Reiser
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Respondent:

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National Consortium for Health Systems Development

Discussion Summary

John Reiser

The Medicaid Infrastructure Grants (MIGs) provide an opportunity for states to develop and enhance their Medicaid programs. These are very flexible funds, and we have some fourteen separate initiatives under this project. The MIGs provide an opportunity to form strategic alliances with the generic workforce system, VR, the private sector, and others.

WIA and TWWIIA offer tools to achieve improvements in the workforce development system. TWWIIA provides demonstration authority for innovation, so that Social Security and CMS develop policy that enhances employment for persons with disabilities. This provides an unprecedented scope of demonstration.

In Wisconsin we have worked with SSA to develop an "early intervention" model that works with people who have not yet been found disabled, have shown up at the Social Security office to file a disability claim and are likely to be entitled to SSDI, and are good job placement candidates. The idea is to get people jobs quickly before they become dependent on the public support system. We will connect them to private service vendors to get and keep jobs, and there is significant incentive for both the vendors and the individual to get a job. Participants will get immediate access to Medicare, immediate access to our Medicaid buy-in without going through disability determination, and a short-term cash stipend that mimics their disability entitlement. What is particularly interesting is how we are working with SSA. They have a model, and we are developing operational details.

TWWIIA also mandates testing a gradual rather than precipitous loss of benefits (the "cash cliff") as a person earns beyond the SGA level. The complexities of conducting a demonstration of a two-for-one model are becoming legendary. In our Pathways to Independence project we have some SSI waivers already in place. A plug-in component has always been an SSDI two-to-one demonstration study to look at the impact on the participant, the trust fund, and the public supports system. We have not been able to implement this yet, but still hope to do so. This would leave us with a comprehensive and integrated package including the health care assurance of a Medicaid buy-in and DVR services

including benefits counseling, etc. We are able to pull in much of the generic system as part of the package.

In other states: CMS has a few states that are providing Medicaid for people not yet at an allowable level of disability, someone with a progressive disorder such as MS. They can access Medicaid with the idea that with health insurance and treatment they won't reach that level, or will prolong the time before they reach that level, thereby prolonging their vocationally productive time. Also people who have medically recovered and are no longer at the requisite level of impairment for the disability program can access Medicaid under a similar program—states can run demonstrations for people who have medically improved and would not otherwise be eligible for insurance coverage. These individuals will retain access to Medicaid and treatment that will reduce the likelihood of medical relapses

Another byproduct that allows us to cross arising in the MIGs is the Technical Assistance Consortia attached to the MIGs—grantees being required to participate in a consortium that provides TA to other states, and eligible to receive TA from other states to enhance their own programs. I have come to think a great deal about the requirement of participation in a TA consortium. We provide TA around evaluation of buy-ins, and come back with more expertise about how other states are their programs. This opportunity to observe others has been a great benefit for Wisconsin's program.

Policy changes being discussed and implemented allow us to see potential for informing policy. Continued access to health insurance is critical. As an early implementing state for the Ticket we are in a good position to see how the current system changes when you put one of these initiatives into it. The truth is it hasn't changed very much. I don't find that discouraging. It takes a long time for major changes like this to have an impact. We are beginning to observe small changes at the local level in new strategic alliances among private and public agencies that make a great deal of sense.

The high level of discussion and thinking about disability policy and employment policy and programs raises new and fundamental questions. For example, how applicable are the Social Security standards being applied to Medicaid cases where a basic component of eligibility is that you have to be both disabled and unable to work, yet be working? Medicaid buy-in applicants in Wisconsin have two eligibility processes applied to them simultaneously, one for the buy-in and one for standard Title XIX. Does a person who is working find himself or herself disadvantaged when that system is applied to them—one where you need to be both working yet unable to work; the other where you just need to show you cannot work?

We have developed a broad focus on service improvements that are consumer-centric, based on person-centered planning. We try to bring everything that a person needs to achieve their employment outcomes to the table at once, so all the professionals are brought to the table in one place with the consumer directing activities. It is very expensive, very comprehensive, but we feel for people with multiple barriers it is going to turn out to be cost-effective in the long haul. Our benefits

counselors are an integral part of this process. Every meeting with a consumer includes a benefits counselor, an employment specialist, and a VR counselor.

We have about 40 benefits counselor practitioners tied to our SPI project, but we also have 70 or so other benefits counselors tied to the long-term care system that does not focus activities solely on employment issues. Each category of benefits counselor has a slightly different focus, but the basic training for both of them are identical. The point of divergence is goal focus, yet they understand the issues specific to the others work environment. The curriculum, training, and TA are identical. There has been a lot of advantage to merging training for those programs.

Finally, the rich policy environment supporting discussions such as we are holding today encourages exploration and innovation. We clearly recognize the value of straightforward, simple questions relating to accepted practice. For example, what is the relationship between how medical services are provided in the long-term care system and employment outcomes? Do you provide services differently if a person has employment as their primary outcome? There is broad interest in this issue from potential grant funders given its connection to the disability, employment, and healthcare systems.

Melissa Whitman: Respondent

Key points to consider from a Medicaid Infrastructure Grant (MIG) perspective:

1. The Ticket legislation makes concrete the recognition that health care is one of the critical components of going back to work.

2. The Ticket legislation, via the MIGs, made Medicaid agencies the "change agent." These infrastructure grants offer a minimum of $500,000/year to the Medicaid agency in states that successfully apply for the grants to build infrastructure that supports competitive employment in partnership with other stakeholders. In essence, these grants are offering money to the medical system to fix the employment problem. It's an interesting shift within those states to collaborate on a systems change level.

3. MIG dollars are flexible dollars for broad systems change initiatives. The states are using the funding to accomplish many different improvements to their infrastructure, including: (a) expanding personal assistance into workplace; (b) establishing cross-agency collaborations and linkages across existing funding initiatives; (c) implementing strategies for meaningful consumer and stakeholder involvement; and (d) developing monitoring systems that can measure and track improvements. Bobby Silverstein asked earlier, "Can we design performance measures that have employment as an outcome?" and our state partners are working on that.

4. All of these activities through the MIGs are key elements of developing a seamless system with a "one person, one application" approach to employment services. The dollars encourage states that are farther ahead to think critically about health systems development, and provide those not so far ahead the basic funding to start thinking about what is needed. Of particular interest are states that focus on issues related to the appropriateness and design of health care services to optimize *function* and the return to work, instead of primary care that uses an "acute" or a onetime approach.

5. The experiences of the Medicaid Infrastructure grantee states lead us toward thinking about the necessary components for systems change as being a "three-legged stool"— one leg is "people," one leg is "politics," and one leg is "programs." By thinking about

how these three legs interrelate and push each other, states are uncovering focus areas to successfully implement overarching systems change. While we are experiencing additional challenges during the current fiscal crisis, states are considering how these different "legs" are important (e.g., using the MIG to explore questions like, "Where is the leadership to maintain and continue this energy and momentum while dollars are drying up and priorities shifting?" and "How do we keep it moving?").

6. The infrastructure grantees that did not receive full funding in their first year grant awards must meet CMS-approved benchmarks to receive additional funding. More specifically, many states must make changes to personal assistance services (e.g., they may be expected to change state plans, change their home- and community-based waiver programs, and/or develop planning to otherwise expand personal assistance services). These benchmarks require that the states continue to look for opportunities to be creative and try to move forward. Oftentimes, this is most successfully achieved by developing partnerships and collaborations across existing programs and efforts to develop an inclusive workforce and achieve full community integration for persons with disabilities.

General Discussion

- VR wrote the Medicaid Infrastructure Grant for the Department of Human Services. We feel strongly it will benefit VR. A lot of creative power out of VR—so counselors integrate it into daily work.

- Potential fantastic and terrific—26 closure and successes, people in Medicaid buy-in but working below SGA level—parked below because rules of SSA—until get gestalt of pictures. Rehab. will have success, but still be limited.

- We need to address the impact of the definition of disability. The definition says "can't work," but incentives programs encourage work. Disability is not about the inability to work. It is counterproductive to have a system based on the inability to work and then have programs that encourage work.

- What does disability mean, and what is the role of government in relation to that definition?

    - Template—the SSI program for children looks at a number of different levels and domains of functioning.

- Definition for retired persons. Workforce issues change because of changing population demographics and the economy. We will not have enough workers, and will need the elderly in workforce, so we need to eliminate disincentives.

- We do have a window of opportunity here. Congress has given us resources. We have to show some results or there is not going to be a next step. If the demonstrations don't go well it will beg the question of whether people will go to work.

- The opportunities are good. The risk to lose them is considerable if we don't show results.

- Of the people in Medicaid buy-in programs, 86% are working at a level that is lower than SGA

- We need to get the word out to the community, because they don't believe that work incentives can be trusted.

- We need to invest enough resources to get information out with the need for benefit counselors.

- Benefits counseling is essential. A fee-for-services will need to cover this service. Wisconsin has had benefits counseling for the elderly, so we are piggybacking on this service.

- What role will benefit counselors play in redefining the role of case manager for state MR/DD and MH agencies?

- Case managers are not well trained in benefits counseling. Benefits counseling will/should find its way in mainstream and allow case managers to do their jobs because now they are not doing benefits counseling effectively.

- The case manager needs to be able to ask questions to direct customers correctly to benefits counseling. We have a system for quality control of benefits counseling services in Alaska.

- How do we best address people who park below SGA? A benefits counselor's ethical response is that you do no harm, so don't make people take a position that is less than where they began. If the intent is to counsel, we need clarity around the message.

- The counselor's approach should be, "Here are the facts of your situation. What more information do you need?" Help customers go to work as much as they want to work.

- The Ticket to Work is causing people to talk who would not talk under WIA. Each model will serve some people: Vocational Rehabilitation, rehabilitation employment networks, employment networks.

- There is a sense of urgency, but we need action on two-for-one demonstrations particularly. Do people work below SGA? Do Medicaid buy-in premium structures discourage unearned income?

- Why do we focus on benefits counseling? Benefits counseling is not consistent with the new paradigm. Benefits counseling suggests that you are trying to keep them on the benefit. The goal is employment—employment should be the focus and in the name of the service.

- Employment is the primary goal, definition/eligibility needs to be changed.

- Benefits counseling has been the best result of the SPI projects. We have less success at getting people to work. We need to collect information on the issues.

- A philosophical question needs to be addressed when we look at the success of these projects: Are you talking reduction of benefits or elimination of benefits? As long as the focus is on elimination it is not going to work, but if the focus is on reduction there will be savings.

Appendix A

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Brief Reports

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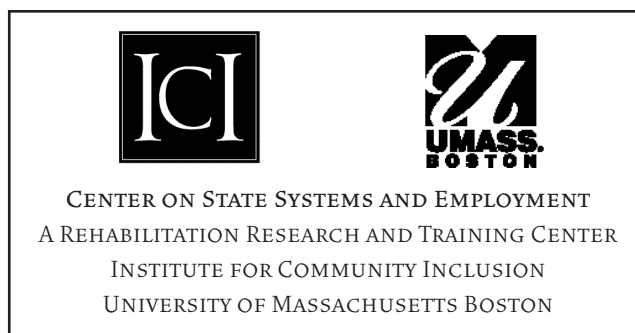
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