



# Lessons from SSA Demonstrations for Disability Policy and Future Research

Edited by

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## Overview

Over the past several decades, the Social Security Administration has tested many new policies and programs to improve work outcomes for Social Security Disability Insurance beneficiaries and Supplemental Security Income recipients. These demonstrations have covered most aspects of the programs and their populations. The demonstrations examined family supports, informational notices, changes to benefit rules, and a variety of employment services and program waivers.

A “State of the Science Meeting,” sponsored by the Social Security Administration and held on June 15, 2021, commissioned papers and discussion by experts to review the findings and implications of those demonstrations.

A subsequent volume—*Lessons from SSA Demonstrations for Disability Policy and Future Research*—collects the papers and discussion from that meeting to synthesize lessons about which policies, programs, and other operational decisions could provide effective supports for disability beneficiaries and recipients who want to work. This PDF is a selection from that published volume. References from the full volume are provided.

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## Chapter 9

# Lessons from Implementation

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The demonstrations conducted by the Social Security Administration (SSA) typically use rigorous impact evaluations to estimate intervention effects and process analyses<sup>2</sup> to examine how interventions are implemented. This chapter considers the second component. The demonstrations' process analyses have focused on (1) describing the implementation (both how the interventions operate and service receipt); (2) assessing fidelity to the intervention model and reasons for deviations; (3) documenting contextual factors such as the labor market, economic conditions, and social service systems; (4) describing the counterfactual condition; and (5) identifying lessons learned and promising practices.

Understanding implementation is vital to interpreting effects; impact analyses alone cannot explain why an intervention does or does not achieve intended results. For example, a demonstration might not produce effects because the intended intervention was poorly implemented (Epstein and Klerman 2012). It is also possible that favorable effects might be found when the intervention implemented differs in important ways from original plans. Research relying on naturally occurring variation in implementation conditions shows that implementation affects outcomes (Bloom, Hill, and Riccio 2003; Durlak and DuPre 2008).

The demonstrations' evaluations are most useful to policymakers if they document how implementation occurred and assess whether the intervention as implemented represents a reliable test of the intended model. If evaluation findings show that an intervention is effective, implementation findings can shed light on how to best replicate and scale it. Even when evaluations do not find favorable effects or interventions are poorly implemented, a careful process analysis can help to identify strategies for strengthening implementation in a future replication or bolstering the program design to increase its effectiveness.

The chapter's first section addresses the implementation mechanics of recruitment and enrollment. Findings about recruitment shed light on likely take-up of different kinds of services and financial incentives and can guide future efforts to conduct

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<sup>1</sup> The views expressed in this chapter are those of the authors and do not necessarily represent the views of the Social Security Administration or the US federal government.

<sup>2</sup> Throughout we use the term *process analysis* to refer to qualitative research that examines the implementation of interventions. A commonly used synonym in the field of program evaluation for this type of research is *implementation analysis*.

outreach and encourage service participation. The second section examines service delivery. It highlights lessons about how services have been delivered, the extent to which participants use the services offered to them, factors that lead to variation in implementation across program locations, and implications for interpreting impacts. The chapter’s third section summarizes the overarching lessons and directions for the future.

**LESSONS ABOUT RECRUITING AND ENROLLING DEMONSTRATION PARTICIPANTS**

To draw lessons about recruitment and enrollment we focus on the 12 demonstrations shown in Exhibit 9.1. The demonstrations vary in whom they tried to reach and what type of assistance they offered. However, all shared the goal of recruiting an appropriate sample sufficient in size to detect meaningful effects or to support other analyses that can inform policy. We begin by examining the results of recruitment. We compare the response to outreach and recruitment efforts across the demonstrations and the methods the demonstrations have used to recruit participants. We then explore findings from the demonstrations about how volunteers compare to non-volunteers.

**Exhibit 9.1. Demonstrations Reviewed to Identify Lessons about Recruitment/Enrollment**

	Target Population and Enrollment Period	Intervention	Data Source(s) for Identifying Population
Early Interventions—Before SSDI/SSI Application			
Demonstration to Maintain Independence and Employment (DMIE) <sup>a</sup>	Working-age adults with chronic conditions who are not SSI/SSDI applicants or recipients/beneficiaries 2006–2008	Health insurance and employment services	Varies by program: employers, state insurance programs, public health systems
Retaining Employment and Talent After Injury/Illness Network (RETAIN)	Working-age adults with illness or injury who are not SSI/SSDI applicants or recipients/beneficiaries <u>Phase 1</u> : 2019–2020 <u>Phase 2</u> : 2021–2022	Return-to-work coordination; occupational health best practices; workplace-based interventions; training and rehabilitation services	Varies by program: employers, state insurance programs, workers’ compensation; health care systems
Supported Employment Demonstration (SED)	Denied SSDI and concurrent applicants who allege mental health condition, with an interest in working, except for those: (1) incarcerated; (2) with cognitive impairments; (3) enrolled in an employment and training program 2018–2019	IPS model of supported employment with integrated medical and behavioral health care and financial assistance for care not covered by individuals’ health insurance plans	SSA administrative data; additional eligibility screening

	Target Population and Enrollment Period	Intervention	Data Source(s) for Identifying Population
<b>Broad Appeals to SSDI Beneficiaries and SSI Recipients</b>			
Benefit Offset National Demonstration (BOND)	Stage 1: SSDI-only and concurrent Stage 2: SSDI-only 2011–2012	\$1 for \$2 benefit offset; benefits counseling	SSA administrative data
Project NetWork	SSDI-only and concurrent; SSI recipients; SSI applicants 1992–1993	Case management	SSA administrative data (SSDI beneficiaries and SSI recipients); SSA claims representatives (SSI applicants)
Promoting Opportunity Demonstration (POD)	SSDI-only and concurrent 2018	\$1 for \$2 benefit offset; benefits counseling	SSA administrative data
<b>Specialized Services for Specific Groups of SSDI Beneficiaries and SSI Recipients</b>			
Accelerated Benefits (AB)	New SSDI beneficiaries in the Medicare waiting period who do not have health insurance 2007–2009	Health insurance or health insurance plus progressive goal attainment; benefits counseling; medical case management	SSA administrative data; additional eligibility screening
Mental Health Treatment Study (MHTS)	SSDI beneficiaries with schizophrenia or affective disorders except for those: (1) in nursing homes; (2) with legal guardian; (3) with life-threatening or terminal illness; (4) receiving supported employment in past 6 months; (5) with a competitive job 30 days before enrollment 2006–2007	IPS model of supported employment; systematic medication management; nurse care coordination	SSA administrative data; additional eligibility screening
Promoting Readiness of Minors in Supplemental Security Income (PROMISE)	Youth receiving SSI, ages 14–16 2014–2016	Case management; benefits counseling and financial literacy training; career and work-based learning for youth and family members; parent training or information	SSA administrative data

	Target Population and Enrollment Period	Intervention	Data Source(s) for Identifying Population
State Partnership Initiative (SPI) New York WORKS project	SSI recipients with psychiatric diagnosis over age 21 2000–2003	Benefits counseling; employment coordination	SSA administrative data
Transitional Employment Training Demonstration (TETD)	SSI recipients with intellectual disability, ages 18–40 1985–1986	Placement in competitive jobs; on-the-job training; postemployment and job retention services	SSA administrative data; additional eligibility screening
Youth Transition Demonstration (YTD)	Youth receiving SSI, ages 14–25 2006–2008	Case management; benefits counseling and financial literacy training for youth and parents; career and work-based learning	SSA administrative data

Key: IPS=Individual Placement and Support. SSDI= Social Security Disability Insurance. SSI= Supplemental Security Income.

Source: Authors' summary of demonstration reports. AB: Michalopoulos et al. (2011). BOND: Gubits et al. (2018a/b). DMIE: Gimm et al. (2009); Whalen et al. (2012). MHTS: Frey et al. (2011). POD: Hock et al. (2020). Project NetWork: Kornfeld and Rupp (2000). PROMISE: Anderson et al. (2018); Honeycutt, Gionfriddo, Kauff, et al. (2018); Kauff et al. (2018); Mamun et al. (2019); Matulewicz, Katz, et al. (2018); McCutcheon et al. (2018); Selekman et al. (2018). SED: Taylor et al. (2020). SPI New York WORKS: Ruiz-Quintanilla et al. (2006). TETD: Thornton and Decker (1989). YTD: Fraker, Mamun, et al. (2014).

<sup>a</sup> Centers for Medicare and Medicaid Services sponsored this demonstration.

Findings about recruitment and enrollment provide direct feedback on the response to the recruitment methods used and demand for the assistance being offered. The findings can also tell us about the potential interest in different interventions among various types of individuals.<sup>3</sup> Findings about which types of outreach strategies did and did not work can hold lessons for designing future demonstrations. Findings about recruitment might also hold lessons for operating SSA's ongoing Ticket to Work (TTW) and Work Incentives Planning and Assistance (WIPA) programs, which also have goals to promote attachment to the labor force. Findings about recruitment and enrollment challenges might suggest ways to focus future outreach efforts or to increase participation among groups with the greatest policy interest.

<sup>3</sup> Recruitment activities end when demonstrations achieve the target sample size; therefore, the enrollment rates might indicate a lower-bound estimate of the level of interest in the interventions. In several demonstrations, enrollment was also time limited. Given this, the proportion of eligible individuals who enroll might not provide evidence about the maximum potential interest in the intervention.

## Recruitment Results

This section compares the results of outreach and recruitment. The comparison yields three principal lessons about (1) the response to outreach and recruitment, (2) the use of various recruitment methods, and (3) special considerations for early interventions.

*SSA demonstrations have successfully recruited both broad and specific target populations; but in most cases, those targeting narrowly defined groups have achieved the strongest response to outreach.*

Overall, new Social Security Disability Insurance (SSDI) beneficiaries, denied SSDI and concurrent applicants, and youth have been more likely to volunteer than existing SSDI beneficiaries and Supplemental Security Income (SSI) recipients. The stronger response may reflect the appeal of the intervention (e.g., health insurance or employment services for denied applicants), as broad appeals offering financial incentives (BOND, POD, Project NetWork) attracted the lowest rates of volunteers, between 2.4 and 5.4 percent of disability beneficiaries (Gubits et al. 2018a/b; Hock et al. 2020; Kornfeld and Rupp 2000). As reported by Thornton and Decker (1989) and Ruiz-Quintanilla et al. (2006), two demonstrations targeting narrowly defined groups of SSI recipients, TETD and the New York WORKS SPI project, also had comparatively low enrollment rates (5.4 percent and 2.2 percent). Exhibit 9.2 below displays the recruitment results, expressed as the proportion enrolled of all eligible individuals recruited. (The summary exhibit at the end of this chapter provides additional detail about recruitment results.)

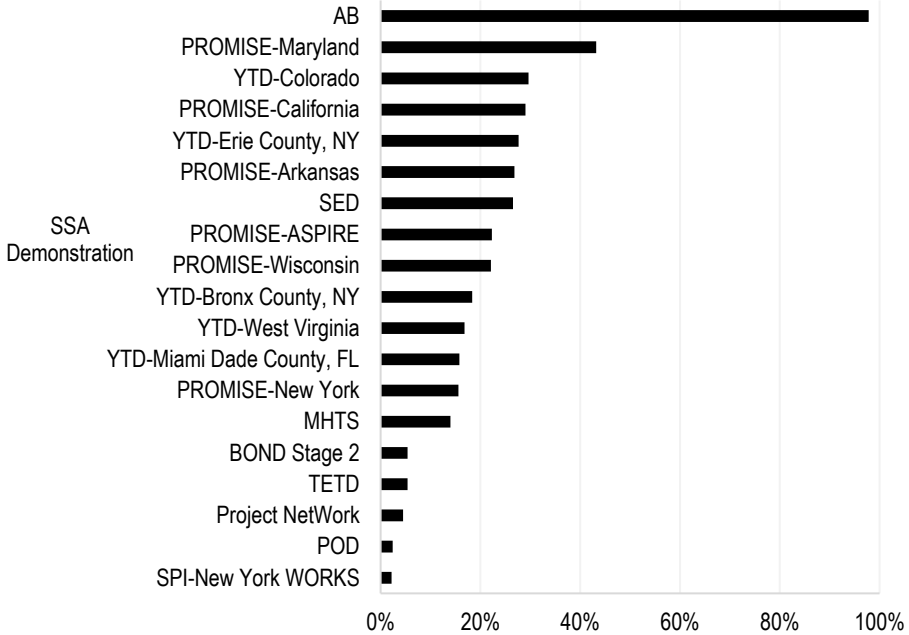
**TETD and Project NetWork.** SSA's early experiences with national demonstrations showed that it is feasible to conduct outreach with large numbers of SSDI beneficiaries and SSI recipients and secure their participation. TETD offered job placement, on-the-job training, job retention, and waivers of SSI rules.<sup>4</sup> SSA sent invitation letters to 13,800 SSI recipients with intellectual disability (Decker and Thornton 1995; Thornton and Decker 1989). Demonstration intake staff in the eight programs that implemented TETD conducted recruitment. These staff made follow-up phone calls, sent reminder letters to potential volunteers, and engaged with community organizations to inform them about the demonstration. Altogether, 2,404

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<sup>4</sup> Thornton, Dunstan, and Schore (1988) describe the waivers that SSA obtained for the TETD project. Three of the waivers allowed demonstration participants to maintain eligibility for SSI benefits while receiving training and working. The first did not count earnings during the demonstration as an indicator of Substantial Gainful Activity (SGA). The second excluded time working from calculations of the Trial Work Period (TWP). The third guaranteed participants a 15-month Extended Period of Eligibility. A fourth waiver excluded earnings that a participant saved from asset limitations in the SSI program. The waivers are documented in *Federal Register* 50, No. 85 (May 2, 1985): 18741-18742.

SSI recipients (17 percent) responded to the initial letter and attended an intake session, and 745 of those solicited (5.4 percent) volunteered.

**Exhibit 9.2. Recruitment Results, Percentage Enrolled of Those Eligible, by Demonstration**



Source: Authors' summary of demonstration reports. AB: Michalopoulos et al. (2011). BOND: Gubits et al. (2018a/b). MHTS: Frey et al. (2011). POD: Hock et al. (2020). Project NetWork: Kornfeld and Rupp (2000). PROMISE: Anderson et al. (2018); Honeycutt, Gionfriddo, Kauff, et al. (2018); Kauff et al. (2018); Mamun et al. (2019); Matulewicz, Katz, et al. (2018); McCutcheon et al. (2018); Selekman et al. (2018). SED: Taylor et al. (2020). SPI New York WORKS: Ruiz-Quintanilla et al. (2006). TETD: Thornton and Decker (1989). YTD: Fraker, Mamun, et al. (2014).

Note: Project NetWork enrolled a total of 8,248 in the evaluation. Of those, 6,527 (4.5 percent) were enrolled through the outreach and recruitment process. The remaining 1,721 were new SSI applicants recruited by SSA claims representatives.

SSA used the experiences in TETD to inform the design of Project NetWork. Project NetWork offered case management and program waivers<sup>5</sup> to a broad population of SSDI beneficiaries, SSI recipients, and SSI applicants regardless of disabling condition. Project NetWork used similar procedures as TETD to conduct

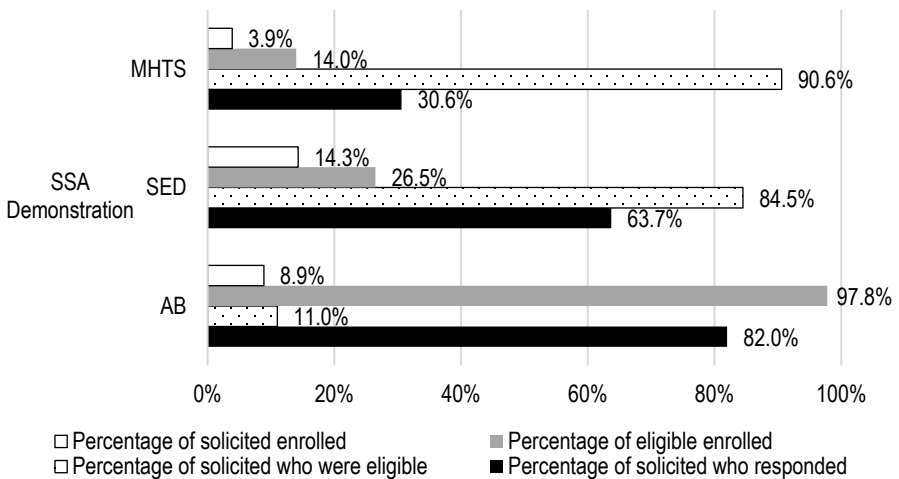
<sup>5</sup> For SSDI beneficiaries, the Project NetWork waivers exempted earnings for a 12-month period when computing TWP months and prevented benefit suspension for those who already had exhausted the TWP. For SSI recipients, the waivers prevented earnings from triggering a medical continuing disability review as would otherwise happen under current-law rules.



outreach to 145,404 SSDI beneficiaries and SSI recipients (Kornfeld and Rupp 2000). SSA sent initial letters to potential volunteers that contained a postcard and instructions that interested individuals return the postcard to complete the enrollment process. Demonstration intake staff conducted in-person information sessions with those who responded, yielding 6,527 enrollees (4.5 percent of those solicited) (Burstein, Roberts, and Wood 1999). Another 1,721 SSI applicants enrolled in Project NetWork in response to outreach conducted by SSA claims representatives, for a total of 8,248 randomly assigned.

**Demonstrations Offering Specialized Services to Specific Groups.** Newly entitled SSDI beneficiaries and denied SSDI and concurrent applicants have proven easier to contact and more responsive than other groups. Factors influencing this could be that contact information for recent awardees and denied applicants is likely more up to date than for longer-duration beneficiaries, the appeal of the intervention offered, or the recruitment methods used. Drawing on findings reported by Michalopoulos et al. (2011) and Frey et al. (2011), we show details about the recruitment results for the AB and MHTS demonstrations in Exhibit 9.3 below. Exhibit 9.3 also shows results reported by Taylor et al. (2020) for SED, which recruited denied SSDI and concurrent applicants.

**Exhibit 9.3. Recruitment Results for Accelerated Benefits (AB), Mental Health Treatment Study (MHTS), and Supported Employment Demonstration (SED)**



Source: Authors' summary of demonstration reports. AB: Michalopoulos et al. (2011). MHTS: Frey et al. (2011). SED: Taylor et al. (2020).

In AB, 82 percent of new SSDI beneficiaries sent a mailing about the demonstration completed the initial interview. The high response rate might indicate strong interest in an easily understood service—health insurance. AB also stands out

for its high rate of enrollment. SSA provided administrative data for newly entitled SSDI-only beneficiaries who were entitled for benefits at the initial level and who had at least 18 months remaining in their Medicare waiting period. The recruitment staff mailed letters to these beneficiaries and then made repeated attempts to contact them by phone to complete eligibility determination, informed consent, baseline interview, and random assignment. Once the recruiting staff confirmed their eligibility,<sup>6</sup> 98 percent of those eligible went on to enroll (Michalopoulos et al. 2011), likely reflecting the appeal of the offer of health insurance.

The AB recruitment process also shed light on an open policy question about the level of unmet health insurance needs among new SSDI beneficiaries (Michalopoulos et al. 2011; Weathers et al. 2010). Of the high proportion (82 percent) who responded to initial outreach in AB, only 11 percent of respondents indicated they did not have health insurance.<sup>7</sup>

Two other demonstrations targeted narrowly defined groups of adults. The currently operating SED offers the Individual Placement and Support (IPS) model of supported employment to denied SSDI and concurrent applicants with mental health conditions<sup>8</sup> in two treatment groups. A “Full-Service” group receives IPS with integrated medical and behavioral health care, systematic medication management and nurse care coordination; a “Basic-Service” group receives IPS and other behavioral health services. MHTS offered IPS, along with systematic medication management and nurse care coordination, to SSDI beneficiaries with schizophrenia or affective disorders.<sup>9</sup>

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<sup>6</sup> To be eligible for the AB demonstration, new SSDI beneficiaries could not be receiving health insurance and could not be institutionalized. Additional screening during recruitment was necessary to confirm eligibility, as SSA administrative data do not provide all the information needed. The recruiting staff asked questions to verify that the beneficiary was not insured, non-institutionalized, and able to answer survey questions. Once staff had confirmed the beneficiary’s eligibility, they obtained informed consent, administered the full baseline survey, and conducted random assignment.

<sup>7</sup> The AB demonstration’s 12-month survey provides even more insights about access to health insurance for new SSDI beneficiaries. Neither the treatment group nor control group had health insurance at random assignment, but after a year, 40 percent of control group members obtained health insurance. This finding is important context for interpreting impact estimates. It also fills a gap in knowledge about the extent to which SSDI beneficiaries without health insurance obtain coverage.

<sup>8</sup> SED eligibility was limited to denied SSDI and concurrent applicants with mental health conditions who were interested in work and not participating in employment services. SSA administrative data do not verify those eligibility criteria; they were confirmed during the recruitment process.

<sup>9</sup> Eligibility for MHTS depended on a diagnosis of schizophrenia or affective disorder, which can be identified in SSA administrative data; but additional eligibility criteria—absence of specific terminal conditions (AIDS, end-stage renal disease, terminal cancer), no receipt of supported employment in the past six months, and no competitive employment 30 days before enrollment—were verified by talking with the potential enrollee.

As in AB, for SED the research contractor conducted outreach and recruitment. Using local interviewers, the contractor sent letters to denied applicants using lists that SSA generated from administrative data. The recruitment staff then made up to five follow-up calls and up to two home visits to attempt to contact the potential volunteers. After contacting potential volunteers, the recruiting staff screened for additional eligibility criteria (i.e., the denied applicants had to be interested in working and not receiving employment services). Unlike in AB, once determined eligible, potential volunteers for SED had to attend an in-person recruitment information meeting to learn more about the demonstration services and to provide informed consent. In MHTS and SED, the IPS model requires in-person recruitment.

Altogether, 64 percent of the denied SSDI applicants who were contacted responded to the initial outreach conducted in SED (Taylor et al. 2020). Of those who responded and were determined eligible, 27 percent enrolled. Both the initial response and enrollment were higher in SED than in MHTS. In MHTS, 31 percent of the SSDI beneficiaries solicited responded to the initial contact; of those determined eligible, 14 percent enrolled (Frey et al. 2011). The stronger response from denied applicants could reflect that this group recognizes employment support can help them secure paying jobs or seeks to meet critical needs for medical or behavioral health care that treatment group membership provides. In addition, denied applicants may have more recent work experience than do beneficiaries and less time away from the workforce, and that may have motivated their participation. Finally, it is possible that some denied applicants may think that responding to outreach could improve the possibility of a positive decision about entitlement in the future.

Differences in the recruitment processes used in SED and MHTS might also have influenced the stronger response to initial outreach in SED compared to MHTS. As discussed by Frey et al. (2011), in MHTS, designated demonstration operations staff (called “research assistants”) conducted outreach and recruitment, using lists of potential volunteers the research contractor developed from SSA administrative data. The research assistants in the sites sent letters and made follow-up calls and visits to contact potential volunteers. Once they contacted a potential enrollee, the research assistant conducted eligibility screening to verify that the beneficiary had not been employed in a competitive job in the past 30 days, did not have a physical health condition that precluded participation,<sup>10</sup> and had not received supported employment in the past six months. Those who passed the eligibility screen then attended two recruitment information group meetings to learn more about the demonstration, provide informed consent, and enroll.

The recruitment results in SED confirmed the feasibility of engaging with individuals before SSDI entitlement and that the level of interest in employment is high among a particular group of denied SSDI and concurrent applicants. However,

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<sup>10</sup> Beneficiaries with AIDS, end-stage renal disease, or terminal cancer were excluded from the demonstration.

SED also points to the difficulties in reaching some denied applicants, mostly because of frequent address changes, unreliable phone numbers, and homelessness.

**Demonstrations Targeting Youth.** To examine recruitment experiences involving youth, we draw on findings from YTD<sup>11</sup> and from PROMISE<sup>12</sup>. YTD and PROMISE offered a variety of case management and career and work-based learning services to youth receiving SSI. Enrollment rates ranged from 16 to 30 percent in YTD and from 16 to 43 percent in PROMISE. These comparatively high enrollment rates for YTD and PROMISE (see Exhibit 9.2 above) are most likely an indicator of the appeal of the specific services (coupled with program waivers in YTD) that were offered and a high level of interest among youth and their families in pursuing employment-enhancing activities.

The response among youth might also reflect interest in employment and perhaps encouragement from families. Responses to the YTD baseline survey, reported by Fraker and colleagues in 2011 and 2012, indicate that enrollees held positive expectations for the future, and these sentiments could have encouraged them to enroll. In all the YTD programs, more than 80 percent of enrollees reported that they expected to work at least part-time in the future. Between 68 and 79 percent in all the YTD sites said they expected to live independently in the future, and between 66 and 97 percent said they expected to continue their education in the future. In YTD, the evaluators concluded that the SSI program waivers—a more generous \$1 for \$4 benefit offset in the earned income exclusion and an extension of the student earned income exclusion to age 21—encouraged participants to enroll.

YTD and PROMISE used different approaches for recruitment. In YTD, the research contractor conducted outreach and recruitment centrally and by phone using interviewer staff. The contractor sent letters to youth whom SSA identified in administrative data and then followed up with reminder letters and phone calls. Response to the initial contact ranged between 29 and 45 percent across the six YTD programs. Once these recruiters spoke to a potential volunteer, they obtained verbal consent and completed the baseline interview. The recruiters instructed the potential volunteer to sign and return the informed consent form. When the research contractor received the signed consent, it proceeded to conduct random assignment.

Given flexibility to develop local approaches, PROMISE projects used a variety of strategies to enroll the required sample size. Local demonstration staff conducted recruitment in all except the Maryland project, where the state engaged a local contractor to conduct recruitment and enrollment. In PROMISE, most projects sent enrollment packets (with information about the services, informed consent, and

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<sup>11</sup> Reported by Fraker, Baird, et al. (2011); Fraker, Black, Broadus, et al. (2011); Fraker, Black, Mamun, et al. (2011); Fraker, Baird, et al. (2012); Fraker, Honeycutt, et al. (2012); Fraker, Mamun, et al. (2012); and Fraker, Mamun, et al. (2014).

<sup>12</sup> Reported by Anderson et al. (2018); Honeycutt, Gionfriddo, Kauff, et al. (2018); Kauff, Honeycutt, et al. (2018); Mamun et al. (2019); Matulewicz, Katz, et al. (2018); McCutcheon et al. (2018); and Selekman et al. (2018).

instructions about how to enroll), followed by phone calls, texts, and follow-up letters, to engage potential participants. One project modified its approach to add an initial postcard prior to the first letter to increase brand recognition. Most projects engaged with community stakeholders such as schools, child welfare agencies, and social workers to inform them about the program. Projects also held community events to publicize their programs and increase awareness. The enrollment results in PROMISE also reflect relatively intense recruitment efforts. The average number of contacts the projects reported making with the enrolled group members ranged from 2.5 to 6.2.

**Demonstrations with Broadly Defined Target Populations.** The BOND<sup>13</sup> and POD projects targeted broad cross sections of the SSDI beneficiary caseload (and in POD, SSDI/SSI concurrent beneficiaries) with offers of alternative SSDI earnings rules intended to encourage work. In BOND, after a letter and up to five follow-up letters, phone contacts, and an in-person enrollment meeting, 5.4 percent of those solicited enrolled in the second (voluntary) stage of the demonstration (Gubits et al. 2013). Because BOND was a test of a national policy, a key objective was to evaluate the results of uniform recruitment procedures applied consistently throughout the BOND sites. The idea was to learn about interest in a benefit offset among a large population of potential participants in a group of large sites.

In POD, the research team mailed enrollment packets to potential participants that contained the informed consent form, baseline survey, and information about current-law rules and the benefit offset being tested (Hock et al. 2020). The enrollment packets instructed beneficiaries who wanted to enroll to return the signed consent form and baseline survey. The demonstration's call center staff were available to answer questions, but no telephone or in-person contact was required to enroll in POD. A total of 6 percent responded to the mailing, by returning the enrollment packet; but 2.5 percent who responded refused consent, and 1 percent did not pass the intake screening or did not provide complete information (Hock et al. 2020). Altogether, 2.4 percent of recruited SSDI/SSI concurrent beneficiaries enrolled in POD.

Several reasons might explain lower enrollment in BOND and POD compared to the youth demonstrations (PROMISE, YTD) and to AB, MHTS, and SED. For BOND, the \$1-for-\$2 benefit offset applied only to earnings that exceed an annualized level of Substantial Gainful Activity (SGA) after completing the Trial Work Period (TWP) and Grace Period. This offer of a financial incentive triggered by future earnings might seem like a more abstract concept than an offer of tangible services such as health insurance or employment services. It seems plausible that for some beneficiaries, uncertainty over whether they would be able to achieve and sustain the level of earnings needed to take advantage of the offset could have dissuaded them from volunteering for the demonstration. In fact, findings from the BOND process analysis reported by Derr et al. (2015) suggest that some of the beneficiaries who did enroll

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<sup>13</sup> We are referring to Stage 2 of BOND, where beneficiaries were recruited to volunteer. In Stage 1, assignment to the treatment group was not voluntary.

expressed some uncertainty about whether they would be able to take advantage of the benefit offset.

The lower enrollment in POD compared to BOND could be influenced by the differences in the earnings rules in the two demonstrations. In POD, monthly earnings exceeding the monthly TWP level triggered the benefit offset, whereas in BOND, benefits were not offset unless earnings exceeded the SGA level. The lower earnings threshold for the POD benefit offset would reduce total income for beneficiaries earning between TWP and SGA compared to current-law rules. In contrast, the benefit offset rules in BOND would not reduce total income for beneficiaries under any earnings scenario. The more appealing earnings rules offered in BOND might have influenced the higher enrollment rates. In addition, it is possible that the differences in recruitment methods might have influenced the higher enrollment in BOND. The follow-up telephone calls, and in-person enrollment sessions used in BOND might have fostered a stronger connection to the demonstration and encouraged higher enrollment.

The enrollment packet mailed to potential participants in POD noted that individuals choosing not to enroll did not need to return the consent form and baseline survey. However, the instructions also noted that all beneficiaries who returned the survey and consent form would receive the \$25 incentive payment. Hock et al. (2019) report that early results from the January 2018 outreach mailing showed the number of beneficiaries who returned the materials but declined to consent exceeded the number who returned the forms and consented to enroll. The POD researchers tested several alternative recruitment procedures in a pilot to identify ways to refine and enhance the recruitment process. One change tested was an insert to the initial enrollment packet with clearer instructions that only those who wished to enroll needed to return the consent materials and baseline survey. After making this change, the research team observed a reduction in the number of letters returned by those who declined to enroll. That is, 5.2 percent of the January 2018 mailing sample returned the materials but declined to consent, whereas only 2.1 percent of those sent a February 2018 enrollment packet (with the insert) returned the materials and declined to consent.

The pilot also found that follow-up postcards were as effective at boosting enrollment as follow-up phone calls, and less costly. A postcard sent ahead of the enrollment packet, and a last chance reminder postcard also increased response (Hock et al. 2019; Hock, Wittenburg, et al. 2020). The pilot results provided immediate evidence about ways to tailor the POD recruitment process. In addition, the researchers noted that the insights from the pilot might also have other applications relevant to SSA. In particular, the finding that postcards were as effective as phone calls in spurring response to outreach is potentially useful for other SSA administrative procedures such as letters about TTW and notifications about continuing disability reviews, where phone calls would likely be infeasible or costly.

In collaboration with the Office of Evaluation Sciences (OES) at the General Services Administration, SSA has conducted several experimental impact studies to evaluate alternative messages. Informed by behavioral insights, a recent study evaluated four variations in reminder letters intended to encourage SSI recipients to report changes in earnings (GSA/OES 2019b). The study found that receiving any one of the letters increased earnings reporting and the amount of countable earnings reported, potentially reducing overpayments. Hemmeter et al. (2020) reported the results of another study aimed at improving participation in SSI among individuals over age 65. The researchers found that receiving any one of four letters informing potential applicants about their likely eligibility for the program, emphasizing the simplicity of the application process, or noting the maximum monthly benefit increased SSI applications and awards. SSA also collaborated with OES to evaluate the effect of providing information about employment assistance available at American Job Centers or state Vocational Rehabilitation (VR) agencies to denied applicants (GSA/OES 2019a). The impact analysis found that providing such information had no effect on appeals. SSA is collaborating with OES to design a new study to examine alternative information intended to increase participation in the TTW program.

***Using dedicated recruitment staff who do not also have responsibility for service delivery has shown advantages for achieving enrollment results and service delivery goals.***

In the previous section we describe the various approaches used in the demonstrations for recruitment; key features of outreach and recruitment in the demonstrations are shown in Exhibit 9.4. Our comparison of recruitment strategies shows several advantages of using dedicated recruiters rather than having the same staff conduct recruitment and service delivery.

The PROMISE projects adopted a customized process for recruitment, modifying the number and type of contacts. Projects sent initial letters and then used texts, calls, email, and in-person visits to encourage enrollment. As reported by McCutcheon et al. (2018), in the New York project, recruitment took extensive effort—with 41 percent of enrollees receiving between 6 and 10 contacts before enrolling, and another 12 percent receiving 11 or more contacts. Local project staff in five of the six PROMISE projects conducted the outreach and recruitment. The Maryland project used a local contractor, dedicated solely to recruitment. It achieved the target sample ahead of schedule and the highest enrollment rate (43 percent) of all the PROMISE projects (Kauff et al. 2018).

**Exhibit 9.4. Key Features of Demonstration Outreach and Recruitment**

	Uniform Recruitment Procedures Used in All Sites	Research Contractor Conducted Recruitment	Enrollment Required In-Person Meeting	Enrollment Required Additional Eligibility Screening beyond SSA Data	Same Staff Conducted Recruitment and Delivered Services
AB	✓	✓		✓	
BOND	✓	✓	✓		
MHTS		Contractor and demonstration staff		✓	
POD	✓	✓			
Project NetWork			✓		✓
PROMISE <sup>a</sup>			Varied		In three programs (CA, NY, WI)
SED	✓	✓	✓	✓	
TETD			✓	✓	✓
YTD	✓	✓			

Source: Authors' summary of demonstration reports. AB: Michalopoulos et al. (2011). BOND: Gubits et al. (2018a/b). MHTS: Frey et al. (2011). POD: Hock et al. (2020). Project NetWork: Kornfeld and Rupp (2000). PROMISE: Anderson et al. (2018); Honeycutt, Gionfriddo, Kauff, et al. (2018); Kauff et al. (2018); Mamun et al. (2019); Matulewicz, Katz, et al. (2018); McCutcheon et al. (2018); Selekman et al. (2018). SED: Taylor et al. (2020). TETD: Thornton and Decker (1989). YTD: Fraker, Mamun, et al. (2014).

<sup>a</sup> The Maryland PROMISE project engaged with a local contractor to conduct recruitment and enrollment.

In AB, BOND, POD, SED, and YTD, the research contractor conducted outreach and recruitment. It sent initial mailings, made follow-up phone calls, and conducted informed consent and random assignment. To reinforce the legitimacy of the outreach and promote trust, the contractor worked closely with SSA to develop outreach materials and messages and to format letters to make it clear that the contractor was contacting the individual on behalf of SSA.

Focusing exclusively on recruitment (rather than balancing recruitment with service delivery) and applying techniques used in survey data collection—tracking all contacts, calling at different times of day, obtaining additional contact information—to maximize response rates could have contributed to the results for AB, BOND, SED, and YTD. Where the project staff were responsible for both recruitment and service provision—in Project NetWork and two of the PROMISE projects (CA, NY), the process analyses reported challenges in balancing the two functions, with delays in service provision during peak recruitment times (see Leiter, Wood, and Bell 1997; Matulewicz, Katz, et al. 2018; McCutcheon et al. 2018).

Furthermore, the PROMISE projects in which the same staff were responsible for recruitment and for service delivery also had some advantages. This approach helped staff build rapport and trust with the youth during recruitment, which helped to encourage the youth to participate in services after enrollment. The process analysis



also found that the continuity in staffing avoided disruption that could come with a handoff to a different staff person after enrollment. In New York, this staffing arrangement impeded service delivery. Early on it was necessary to focus intensively on achieving enrollment targets, making it challenging to give the attention needed to engage enrolled youth in case management at the same time. This staffing arrangement could have led to delays in beginning case management with enrolled youth in New York, where the average time from enrollment to first contact was reportedly 220 days (McCutcheon et al. 2018).

The sites that had staff focused solely on recruitment appear to have completed recruitment more quickly. They also used similar approaches—mailings, with follow-up calls and postcards, and in-person meetings.

Additionally, the individual approach to recruitment seems to have yielded better results than conducting group sessions. As reported by Honeycutt, Gionfriddo, Kauff, et al. (2018) and Matulewicz, Katz, et al. (2018), the Arkansas and New York projects initially tried group sessions as the first step in recruitment (initial letters invited youth to a group meeting), then changed to individual contacts when they were unable to recruit enough youth using only the group sessions.

***Early interventions face tradeoffs between achieving the target sample size and conducting adequate screening to identify the intended target population.***

Early interventions such as DMIE, sponsored by the Centers for Medicare and Medicaid Services, and RETAIN, sponsored by SSA and the US Department of Labor (DOL), seek to provide services to workers at risk of leaving employment because of illness or injury. Intervening early, before workers separate from the labor force and before they apply for disability benefits is an important policy priority. Services provided soon after an onset of illness or injury might be more effective at preserving employment than interventions that begin later (Ben-Shalom, Christian, and Stapleton 2018). Recruitment and enrollment for these interventions can be challenging because of a lack of information about which workers are at risk of leaving the labor force and of applying for disability benefits and which of them could benefit from an early intervention. Identifying the desired population is essential to target resources efficiently. Another challenge is determining how and where to identify such workers.

As Anderson et al. 2020 point out, to maximize the likelihood of detecting effects of an early intervention such as RETAIN, it is crucial for programs to consider the tradeoffs between achieving the target sample size and adequate screening to identify the appropriate target group. The ideal target group is workers who would leave the labor force and enter SSDI or SSI in the absence of an intervention. This group is difficult to identify—many workers who experience an illness or injury will remain in the labor force even if they do not receive any assistance other than health care.

Unless the demonstration offers the intervention to a target population who would be likely to be eligible for SSDI, without enrolling a large sample it will be difficult to detect effects of the intervention on SSDI, if such effects exist. Imagine if the AB

recruitment process had not screened on health insurance, and instead randomly assigned all new SSDI beneficiaries to receive its health insurance and employment services. That only 11 percent were uninsured would have created treatment and control groups consisting largely of beneficiaries who had health insurance, potentially jeopardizing the ability to evaluate the effects of removing the 24-month waiting period. The additional screening of the new SSDI beneficiaries was crucial to identifying the desired target group for the evaluation and to establishing the extent to which newly entitled SSDI beneficiaries had unmet health needs during the 24-month waiting period.

Anderson et al. (2020) point to the experience in DMIE and data on the geographic variation in SSDI application and awards as a lesson for RETAIN. In DMIE, the impact analysis did not detect impacts of the health care and employment services on SSDI application and found that only a small proportion of the control group lost a job or applied for disability benefits. This indicates that recruitment and enrollment in DMIE might not have recruited a sample of the workers most likely to benefit from its interventions. Given the finding in DMIE, Anderson et al. suggest that for RETAIN, a customized recruitment approach in each state will likely be more successful than attempts for federal sponsors to standardize recruitment. The states could need to use large catchment areas and solicit workers from the entire state to achieve the desired sample size after applying the screening needed to identify the ideal target population.

### **Comparing Volunteers to Non-Volunteers**

Even if the sample is large enough to support analyses, it is also crucial to examine who enrolls and how closely the sample compares to the target population of interest. The composition of the group of volunteers determines whether the findings from the sample would be applicable if the policy were offered more broadly. The composition of the volunteers can also affect the likelihood that an evaluation can detect intervention impacts. This section highlights two lessons that arise from the analyses of volunteers versus non-volunteers reported in the demonstrations' evaluations.

***Outreach to a broad group of disability beneficiaries produced volunteers who are distinct from the general caseload in their orientation toward work.***

The broad target groups for BOND, POD, and Project NetWork, which were unconditioned on type of disability or other factors, could be readily identified in SSA administrative data without additional eligibility screening. Researchers and policymakers expected that the financial incentives offered in the demonstrations would attract beneficiaries with an interest in work. The benefit offset offered in BOND and POD and the Project NetWork waiver that stopped the TWP for a period of 12 months would only be advantageous to beneficiaries who expected to earn at a level where the incentive would take effect.

In all three demonstrations, the analyses showed that the beneficiaries who volunteered appeared more inclined to work than did non-volunteers. For example, Project NetWork found that volunteers were more likely than non-volunteers to have worked 30 hours per week in the past year, and volunteers reported more positive attitudes and commitment to work than non-volunteers did. Volunteers also were less likely to report poor health and less likely than non-volunteers to report a limitation that prevented work.

The BOND Stage 2 volunteers had higher rates of employment at baseline compared to the nationally representative Stage 1 group, with 36 percent of the Stage 2 control group working in the year prior to random assignment, compared with 14 percent of the Stage 1 control group (Gubits et al. 2018a/b). The BOND evaluation found that Stage 2 volunteers were more likely to be women, were younger, and more likely to have a mental health disorder than were non-volunteers (Gubits et al. 2013). Beneficiaries who received SSDI benefits for 36 months or less volunteered at higher rates than those with longer SSDI receipt, and disabled adult children were less likely to volunteer, as were those who had a representative payee appointed to help manage benefits.<sup>14</sup> As Livermore (2011) found in an analysis of 2004 National Beneficiary Survey data, work-oriented beneficiaries were more likely to be younger and shorter-duration beneficiaries.

The POD evaluation also found that compared to non-volunteers, a higher proportion of volunteers had a history of substantial earnings, including a higher proportion with recent history of earnings at the TWP level, at the SGA level, or between TWP and SGA. In addition, compared to non-volunteers, a higher proportion of POD volunteers had engaged with a TTW Employment Network (Hock et al. 2020). Overall, the POD researchers concluded that patterns of differences between volunteers and non-volunteers are consistent with past research about factors that differentiate work-oriented beneficiaries in the SSDI caseload. This suggests that like Project NetWork's and BOND's processes, the POD recruitment process produced a sample of beneficiaries with greater orientation toward work than in the full caseload.

In YTD, the researchers concluded that the enrollment process yielded a broad group of youth SSI recipients who were like non-enrollees. As expected for the youth target population, the volunteers were not more likely than non-volunteers to have had recent work experience or higher earnings in the previous year. In PROMISE, the projects found that volunteers were slightly younger than non-volunteers. Like all the demonstrations, in both YTD and PROMISE, that the group of volunteers are self-selected likely means that volunteers differ from non-volunteers in unobservable characteristics such as motivation or interest. In the process analyses for PROMISE, authors (Anderson et al. 2018; Honeycutt, Gionfriddo, Kauff, et al. 2018; Kauff,

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<sup>14</sup> The Social Security Act authorizes SSA to appoint representative payees if it determines that program beneficiaries/recipients are unable to manage their own benefit payments. Beneficiaries with a representative payee were less likely to volunteer for BOND and POD compared to beneficiaries without a representative payee.

Honeycutt, Katz, et al. 2018; Mamun et al. 2019; Matulewicz, Katz, et al. 2018; McCutcheon et al. 2018; Selekman et al. 2018) caution policymakers that impact results are not likely generalizable to the full sample of youth SSI recipients but are indicative of results for a group who would volunteer for the package of services offered.

***Findings about which beneficiary characteristics are associated with enrollment could help SSA target recruitment efforts in the future.***

In addition to reporting the proportion of those eligible who enroll and comparing the characteristics of volunteers to non-volunteers, several demonstrations conducted more rigorous analyses of participation patterns (see Burstein, Roberts, and Wood [1999] and a summary by Ruiz-Quintanilla et al. [2006]). Project NetWork examined participation rates among subgroups defined by program and personal characteristics. Its analysis found the highest participation (12.2 percent, compared to the overall 4.5 percent enrollment rate) among those who had worked more than 30 hours per week in a job in the 12 months prior to enrollment, who did not report severe limitations in activities of daily living, and who reported they were able to work.

Heckman and Smith (2004) decomposed participation in DOL's Job Training Partnership Act experiment into stages: eligibility, awareness, application, acceptance, and enrollment, modeling characteristics associated with each stage. Using a similar approach for one of the SPI demonstration projects, Ruiz-Quintanilla et al. (2006) examined four stages of participation in the New York WORKS project: (1) information delivery; (2) response; (3) interest; and (4) enrollment. At the first stage, delivery refers to an informational letter not being returned as undeliverable because the person no longer lived at that address. The researchers examined the relationship between individual characteristics and the outcomes at each stage in the recruitment process. For example, at the last stage, the researchers analyzed the effect of individual characteristics on enrollment given that the person was eligible, the letter was not returned, the person responded, and expressed interest in their response. The results showed that younger SSI recipients were more likely to not participate, because they did not respond to the letter. The results also showed that SSI recipients with anxiety disorders who expressed an interest in the project were more likely to drop out at the enrollment stage than were SSI recipients with other psychiatric disorders.

Building off this approach, both MHTS and SED also conducted analysis to predict the factors related to enrollment (see Frey et al. [2011] and Taylor et al. [2020]). In addition to showing the potential for engaging with individuals before SSDI entitlement, the results from SED (reported in Taylor et al. [2020]) indicate that certain characteristics affect enrollment. Compared to non-enrollees, they found that men, those with less prior work experience, and those with higher educational attainment were more likely to enroll. Local context also influenced enrollment, with those living in areas with higher unemployment and in counties where average wages were rising more likely to enroll. Another predictor of enrollment was denial at step 5

in the disability determination process,<sup>15</sup> indicating a decision by disability adjudicators that the individual was unable to perform the same work as in the past (“past relevant work”) but could perform alternative work in the national economy. This finding might suggest a potential target population for future policy tests. The recruitment analysis also examined reasons for not enrolling and found that concerns about the legitimacy of the demonstration offer was a common concern, both among enrollees and non-enrollees. Other reasons for not enrolling included the perception that the potential volunteers could not work or improve their health.

As reported by Frey et al. (2011), the MHTS found that several items available in SSA administrative data predicted enrollment: having a representative payee, distance from the study site, months receiving SSDI, and recent TTW activity. The researchers concluded that enrollment might exceed 25 percent in a demonstration if SSA were to target SSDI beneficiaries with recent TTW activity. This suggests that offering a specialized, intensive service like what was offered in MHTS might be particularly attractive to beneficiaries who have shown an interest in employment services. The main reasons for declining to participate in MHTS included general lack of interest, concerns about not being able to work, and concerns about physical health.

In the next section we explore what happens after recruiting the demonstration sample to identify lessons about implementing the various types of interventions SSA has tested in its demonstrations.

## **LESSONS ABOUT IMPLEMENTING AN INTERVENTION**

To identify lessons about implementing interventions, we limited our review to demonstrations where process analysis findings are available. We include lessons from experimental and non-experimental designs, from implementing services in the local and state demonstrations Benefit Offset Pilot Demonstration (BOPD); Homeless Outreach Projects and Evaluation (HOPE); Homeless with Schizophrenia Presumptive Disability (HSPD) Pilot; SSI/SSDI Outreach, Access, and Recovery (SOAR); and SPI, as well as in the large national experiments AB, BOND, MHTS, POD, Project

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<sup>15</sup> SSA evaluates disability applications in a five-step determination process: (1) The SSA field office determines whether an applicant is financially eligible for SSDI or SSI. (2) If so, a Disability Determination Services (DDS) examiner evaluates whether the applicant has a severe impairment; those without a severe impairment are denied benefits. (3) DDS examiners determine whether the applicant’s mental or physical impairment meets or medically equals an impairment in the Listing of Impairments; those that do, result in an award. (4) For those that do not, the DDS evaluates whether the applicant’s residual functional capacity is sufficient to perform past relevant work or (5) whether the applicant can perform other work in the national economy. For more detail see the publicly available Program Operations Manual System: <https://secure.ssa.gov/poms.nsf/lnx/0422001001>. POMS DI220001.001 discusses sequential evaluation of Title II and Title XVI adult disability claims.

NetWork, PROMISE, Structured Training and Employment Transitional Services (STETS), TETD, and YTD.

We first highlight the contributions of SSA's earliest demonstrations in showing the feasibility of recruiting applicants and beneficiaries and delivering interventions that promote employment. We then organize the discussion into two groups: (1) lessons from demonstrations that evaluate changes to SSDI program rules in the form of benefit offsets; and (2) lessons from demonstrations that evaluate specialized services outside of SSA operations.

SSA's earliest demonstrations laid the groundwork for future research and contributed to the body of evidence about supported employment. SSA's TETD followed the DOL's STETS conducted in the early 1980s; both showed that it was feasible to recruit participants with intellectual disability and to deliver employment services involving direct placement in competitive jobs (Kerachsky et al. 1985; Thornton and Decker 1989). The STETS demonstration was one of the first evaluations of transitional employment for youth with disabilities. SSA subsequently began TETD in 1985 to evaluate transitional employment services for youth and adult SSI recipients with intellectual disability. SSA awarded grants to eight private, non-profit, and university-based organizations to provide services in 13 sites, including job development and placement, on-the-job training, and short-term follow-up support. Some of the organizations had experience providing these services; others created new programs for TETD.

TETD placed two-thirds of the treatment group members in jobs, and half of them were stabilized in permanent jobs. As reported by Thornton and Decker (1988) and Decker and Thornton (1995), the basic program elements in TETD were implemented as planned, with some variation across sites, but all sites delivered the essential components. The implementation findings showed that 12 months seemed to be an adequate amount of time to find and place participants in permanent jobs, and that a wide variety of supportive services (e.g., job search assistance, soft skills training, housing, and budgeting assistance) were necessary to respond to the diverse needs of the target population. It also showed the critical nature of transportation assistance for employment support and the extensive efforts needed to assist participants.

Project NetWork showed that it was possible to recruit a broad cross section of the SSDI beneficiary, SSI recipient, and applicant populations. In the mid-1990s when it began, Project NetWork was the largest demonstration SSA had conducted, with outreach to 145,404 potential volunteers. Project NetWork tested the effects of case management provision on employment. In one model, SSA field office staff delivered the case management; in another, SSA field office staff implemented the less intensive referral management. Private rehabilitation organizations delivered case management in the private contractor model, and state VR agencies implemented a model where state VR counselors provided case management from an SSA field office. The case managers coordinated the rehabilitation process; obtained medical, psychological, and

vocational assessments; established vocational goals and plans; and monitored participants' progress.

The process study showed that 60 percent of participants completed assessment and employment planning, and 45 percent received purchased employment-related services across all four of the case management models (Leiter, Wood, and Bell 1997). Kornfeld and Rupp (2000) concluded that broad-based return-to-work services can be implemented on a large scale in a variety of institutional arrangements. Project NetWork was an immediate precursor to the TTW program, authorized in the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act).

SPI showed it was feasible to support states to implement innovative strategies to promote employment for SSI recipients and SSDI beneficiaries. In 1998, SSA funded 12 of the state projects and the US Department of Education's Rehabilitation Services Agency (RSA) funded six. Specific components varied, but the projects provided services in these general areas: (1) improving information about the effect of work on benefit receipt (benefits counseling), (2) encouraging the use of available work incentives, (3) testing modifications to program rules to allow SSI recipients to earn and save more, and (4) providing better access to vocational supports.

Despite mixed results from the impact analyses conducted in four of the SPI projects, the conclusions report discusses several ways that SPI informed future program design (Kregel 2006a, 31–32):

- The SPI projects led the way to establish a nationwide system of Benefits Planning, Assistance, and Outreach (BPAO) projects, with many staff involved in the ongoing training provided to these BPAO projects. The BPAO projects became the WIPA program that currently provides benefits counseling through SSA.
- Several SPI projects were instrumental in facilitating the development and/or implementation of Medicaid buy-ins in state projects, at first through the Balanced Budget Act of 1997 and later through the Ticket Act.
- The model for the Disability Navigators initiative within the One-Stop Career Center system that is currently under DOL's Employment and Training Administration was initially developed through the RSA-funded Colorado SPI project.
- In several SPI projects, the use of benefits planning and assistance services by the state VR became a "routine" component of service delivery for SSA beneficiaries.

These early demonstrations highlighted the array of services that can be offered and the range of organizations that could collaborate to offer employment services to SSDI beneficiaries and SSI recipients. They also contributed to the landscape of disability research and helped set the stage for SSA's ongoing TTW program.

## Lessons from Implementing Benefit Offsets

### *Implementing interventions that change SSDI earnings rules have posed unique implementation challenges.*

In BOPD, BOND, and POD, SSA evaluated earnings rules that adjust SSDI benefits through a benefit offset in place of the current law's "cash cliff."<sup>16</sup> These demonstrations have evaluated changes to the SSDI program rules, as well as changes to the processes for beneficiaries to report earnings and for SSA to adjust benefits. Implementing these changes has posed challenges and offers some lessons.

**Benefit Offset Pilot Demonstration (BOPD).** SSA conducted BOPD to generate lessons for implementing the national offset demonstration in BOND. (The pilot also produced initial estimates of the likely impact of the benefit offset for volunteers.) As reported by Chambless et al. (2011) and Tremblay et al. (2011), one of the most important lessons from BOPD had to do with administering the benefit offset. In BOPD, SSA used a manual process to calculate benefit payments according to the demonstration rules. SSA customized this process for each of the four participating states. Though this manual process minimized disruption to SSA's current-law operations for processing earnings and calculating benefits, it created delays in adjusting benefits. Also, some beneficiaries received notices with incorrect information about their SSDI benefits; and in some cases, errors applying the offset rules led to under- and overpayments to beneficiaries. To handle the much larger size of the national demonstration and improve on the implementation experience in the pilot, BOPD recommended that for BOND, SSA automate and centralize the administrative procedures used to adjust benefits.

**Benefit Offset National Demonstration (BOND).** Drawing on lessons from BOPD, SSA developed an automated benefit processing data system to calculate benefits in BOND (Gubits et al. 2013; Gubits et al. 2018a/b; Stapleton et al. 2010). This system operated separately from SSA's regular administrative data systems to avoid disruptions to current-law operations. In another step to avoid disrupting regular operations, SSA attempted to approximate the benefit offset implementation that would occur in an ongoing program, but without involving the SSA field office structure. Therefore, it established a centralized team at SSA to assist with the administration of the BOND case processing and contractor staff to obtain earnings estimates, document earnings deductions, and assist with SSA notices and appeals.

Even with the automated benefit adjustment system and centralized SSA operations team, Gubits et al. (2018a/b) report that timely benefit adjustment was

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<sup>16</sup> Under current-law program rules, SSDI beneficiaries lose all SSDI benefits after substantial earnings. This complete loss of benefits is referred to as the "cash cliff." Specifically, SSDI benefits are suspended or terminated if, after completing a nine-month TWP and a three-month Grace Period, a beneficiary's countable monthly earnings exceed the monthly SGA amount.



challenging in BOND. Median duration from first month of offset use (defined as the first month when a beneficiary's earnings triggered the benefit offset) to the time that SSA first adjusted SSDI benefits was 22 months for Stage 1 and 15 months for Stage 2. For Stage 2, enhanced counseling led to shorter times to first benefit adjustment compared to standard work incentives counseling, most likely because of the proactive outreach of enhanced work incentives counseling staff, which in turn might have improved beneficiary reporting.

Delayed first adjustments meant that beneficiaries continued to receive full SSDI benefits after the time that benefits should have been reduced by the benefit offset. Delays in benefit adjustment could have diminished beneficiary understanding of and confidence in the offset rules. As Gubits et al. (2018a/b) report, factors that contributed to delayed benefit adjustment included backlogs in conducting the work continuing disability reviews necessary to determine when the TWP had been completed and when benefit offset should be applied and that some beneficiaries were not timely in reporting earnings.

As discussed by Derr et al. (2015), the initial notifications to the Stage 1 treatment group explained the benefit offset and provided contact information for the demonstration's call center and website, but the notifications did not direct beneficiaries to contact the demonstration staff. Information provided to the Stage 2 volunteers during recruitment and after assignment to the treatment group (Gubits et al. 2013) provided instructions for reporting earnings and a message about the importance of timely reporting of earnings. More consistent and clearer messages about the requirement to report earnings and procedures for doing so might have improved earnings reporting.

Another lesson from BOND relates to challenges in replicating the level of knowledge of new earnings rules as would occur in a national program. The levels of understanding of BOND rules in the Stage 1 and Stage 2 research samples (Gubits et al. 2018a/b) suggest that outreach and information were not sufficient for the treatment group to understand the offset rules as well as the control group understood the current-law rules. (That knowledge of current-law earnings rules is itself low; in BOND, 54 percent of the nationally representative Stage 1 control group seemed to understand them.)

Outreach to the national sample assigned to the Stage 1 treatment group (the mandatory sample) consisted of two letters and two phone contact attempts from the contractor and a notice from SSA. These efforts led to 29 percent of the Stage 1 treatment group, three years after random assignment, knowing correctly how earnings affect benefits under the offset rules (Gubits et al. 2018a/b). The volunteers in the Stage 2 treatment group received outreach and recruitment materials about the benefit offset and completed an informed consent and enrollment process. These extra efforts in Stage 2 produced wider, though still limited, understanding of offset rules among the Stage 2 treatment group compared to Stage 1. About half of the members in each of the two Stage 2 treatment groups correctly understood the offset. Enhancements to

work incentives counseling evaluated in one of the Stage 2 treatment groups increased the level of understanding compared with the other treatment group's understanding (52 percent in the enhanced work incentives group understood the BOND rules correctly, compared to 48 percent in the standard work incentives group; Gubits et al. 2018a/b).

The evaluators concluded that (1) implementation challenges could have been one of four factors that kept those offered the offset from using it.<sup>17</sup> The other three factors were (2) limited work capacity among beneficiaries; (3) insufficient increase in the incentive to earn more; and (4) complexity of the intervention and of the current-law rules, making it difficult for beneficiaries to understand the change in incentive.

The BOND evaluators noted that it is possible that the impact on the proportion of beneficiaries earning more than the BOND threshold might have been somewhat larger in the nationally representative Stage 1 had outreach to Stage 1 treatment group members been more robust and benefit adjustments quicker. Nothing in the evidence, however, suggested to evaluators that the overall finding for BOND would have changed if these implementation challenges had been avoided.

**Promoting Opportunity Demonstration (POD).** One year after volunteering to enroll in the demonstration, compared to the BOND Stage 2 voluntary treatment group, three times as many POD treatment group members had used its benefit offset (Levere, Mann, and Wittenburg 2020). Compared to BOND, the lower earnings threshold for the benefit offset in POD, different earnings rules, and the lower volunteer rate likely contributed to higher rates of offset use in POD sooner after random assignment. In addition to the benefit offset, POD evaluated alternative rules for several work incentives—eliminating SGA, the TWP, and Extended Period of Eligibility. Another change compared to BOND is that SSA adjusted benefits using monthly earnings rather than annual earnings estimates. These changes reduced SSA's administrative burden for adjusting benefits, relative to BOND where a work continuing disability review was required to determine when the benefit offset should be applied.

In another contrast to BOND, POD distributed benefits processing throughout seven of SSA's payment centers, creating small workgroups in each payment center responsible for any manual workloads necessary to implement the POD rules. POD also offered beneficiaries an online option for reporting earnings that was not available in BOND. Beneficiaries could mail pay stubs, enter the information into the online tool, or report earnings by phone to their POD counselor. This online tool simplified earnings reporting for some beneficiaries. Mamun et al. (2021) report that in the first two years of implementation, 24 percent of POD treatment group subjects had used

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<sup>17</sup> In Stage 1 of BOND, 3.6 percent of the treatment group used the offset in any of the first five years after enrollment. As expected, given that a higher proportion of Stage 2 volunteers were working at enrollment, Stage 2 offset use was higher than in Stage 1, with about 15 percent of treatment group members using the offset in any year during the first five years (Gubits et al. 2018a/b).

the benefit offset. Altogether, 22 percent of POD treatment group subjects reported earnings, and the online portal was the most frequent method used (46 percent of those who reported earnings used the online portal).

***Work incentives counseling was important for explaining the benefit offset, and findings from BOND showed it was feasible to implement changes in the current counseling model.***

The results of BOPD (see Chambless et al. 2011; Tremblay et al. 2011) showed the importance of work incentives counseling, and both BOND and POD included such counseling. BOND also implemented an enhanced form of work incentives counseling that featured increased outreach and intensity of services such as proactive, regular outreach from the counselor, structured vocational assessments, and an employment support plan. BOND assigned smaller caseloads per counselor for enhanced work incentives counseling, and it used performance benchmarks for participant engagement to communicate expectations and monitor progress. The BOND process analysis (see Derr et al. 2015) found that the enhanced counseling was implemented according to design.

Relative to the regular work incentives counseling, Gubits et al. (2018a/b) report that the enhancements yielded positive effects on some important outcomes: improvements in beneficiaries' understanding of the benefit offset rules; shorter average duration from first offset use to benefit adjustment; and lower average overpayments. However, the counseling enhancements did not increase use of the offset; generate higher earnings; or reduce SSDI benefits. Nor did the evaluation find any evidence that the enhancements improved beneficiaries' lives in other areas such as health status, health insurance coverage, participation in other income assistance programs, or household income.

## **Lessons about Service Delivery**

SSA has also evaluated a variety of specialized services that are not part of SSA's regular operations. In this section we explore lessons about implementing these types of services. Drawing on findings reported by Frey et al. (2011), Michalopoulos et al. (2011), Fraker, Mamun, et al. (2014), and Mamun et al. (2019), we found three general approaches to implementing services. First is the approach used in MHTS and SED. These demonstrations evaluated a highly structured intervention implemented in multiple, local program settings. Second is the approach used in AB, in which a single, centralized provider delivered a uniform set of services to demonstration participants in multiple locations. Third is the approach used in PROMISE, RETAIN, and YTD, in which SSA (and its federal partners in PROMISE and RETAIN) established guidelines but gave flexibility to local projects to develop specific service delivery approaches. The lessons highlight factors that contribute to successful implementation and factors that make it challenging to deliver services in each of these arrangements.

***When the objective is to produce evidence about the effects of a highly structured, specialized service delivered by local programs, careful attention to site selection and rigorous fidelity monitoring can help ensure the intervention is implemented according to the intended design.***

MHTS, conducted from 2006 to 2010, was the first time the IPS form of supported employment was evaluated with SSDI beneficiaries in community-based mental health systems. SED is also evaluating IPS, for denied SSDI and concurrent applicants with mental health conditions. The process study for MHTS showed that the intervention can be delivered with high fidelity to the evidence-based IPS model on a large scale in real-world health care settings. As noted by Bond, Drake, and Becker (2012):

Individual Placement and Support (IPS) is a systematic approach to helping people with severe mental illness achieve competitive employment. It is based on eight principles: eligibility based on client choice, focus on competitive employment, integration of mental health and employment services, attention to client preferences, work incentives planning, rapid job search, systematic job development, and individualized job supports. Systematic reviews have concluded that IPS is an evidence-based practice. (32)

To avoid uncertainty about the findings—Would a lack of effects indicate that the service does not work, or would poor implementation mean that the demonstration did not perform a reliable test of the intervention?—the research team opted to select a purposive sample of community mental health centers with experience operating the IPS model. They recommended 20 sites of 50 in operation in 2006 when the demonstration began (Frey et al. 2011). SSA also sought to ensure adequate representation of the Hispanic population, and the research team added two additional sites that had experience serving that subgroup. Because the study covered a wide range of geographic areas and included sites that served high proportions of Hispanic beneficiaries, it provided support for the hypothesis that these kinds of services could be replicated in other regions of the United States.

The researchers examined program-level fidelity, the extent to which the programs adhered to IPS standards, using a validated 15-point Fidelity Scale that rates each program on staffing, organization, and service requirements. Researchers conducted annual site visits and rated each program according to the scale (see Frey et al. 2011, Appendix 5A). The study found that 77 percent of the MHTS program sites achieved high fidelity to the IPS model in the first year of the program and even more (86 percent of programs) in the second and third years.

The investigators concluded that this sustained, high level of fidelity was unusual, better than that attained in the National Implementing Evidence-Based Practices Project, which set out to use a comprehensive and standardized training strategy for IPS (McHugo et al. 2007). They attributed the high level of program-level fidelity to

Careful site selection and rigorous monitoring. The researchers selected sites purposively to maximize the potential for high fidelity to and consistent implementation of the service model. The result is that the study provides strong evidence about the feasibility of implementing IPS and the impacts of the IPS intervention but less information about whether the findings are generalizable to a national policy. As Barnow and Greenberg note in Chapter 2 in this volume, MHTS is an example of an efficacy trial, providing insight about the optimum implementation of a given intervention.

As reported by Frey et al. (2011), the researchers also examined individual-level service utilization data to determine the extent to which treatment group members engaged with IPS. They found low rates of employer contact by beneficiaries who were not employed, and relatively low rates of receipt of mental health case management services. The demonstration showed low job-seeking rates among the treatment group members who were not employed, and the study was not able to isolate the precise barriers to employment for this population.

The investigators also assigned global ratings of IPS fidelity to each site based on annual assessments derived from a structured checklist that supplemented information from the IPS Fidelity Scale with information about site-level activities and specific requirements for the MHTS implementation. These results showed that 86 percent of the sites had adequate to very strong implementation in the first year and 74 percent in the second year. The most frequently cited barriers to implementation were unresponsive leadership, finances, mental health services not available, and staff turnover.

The authors note that previous research has shown program-level fidelity to be a strong and consistent predictor of participant outcomes (Bond, Becker, and Drake 2011). However, the investigators found no association in the MHTS between program-level IPS fidelity measures and site-level employment rates. It might not have been possible to detect variation in impacts correlated with fidelity simply because there was insufficient variation in fidelity among programs (Frey et al. 2011). The MHTS findings of a lack of correlation between program-level fidelity and treatment group outcomes suggest a need for further research, perhaps even formal evaluations that systematically vary aspects of the implementation, to better understand the extent to which program-level fidelity influences outcomes.

Given policy interest in whether IPS can be an effective intervention for individuals with other types of health conditions, it is important to know whether strict fidelity to the IPS model leads to better outcomes and whether positive outcomes are possible even with less stringent implementation of the model's components.

***The AB demonstration showed that when the goal is to provide a limited set of uniform services in numerous locations, a centralized service provider can be a practical solution to promote consistency and efficiency.***

The AB demonstration evaluated whether providing health insurance and employment supports to new SSDI beneficiaries in the Medicare waiting period would improve health and employment outcomes. AB operated in the 53 metropolitan statistical areas in the United States that had the largest populations of new SSDI beneficiaries. The demonstration targeted new SSDI beneficiaries in the Medicare waiting period who did not have health insurance. One treatment group received health insurance; a second treatment group received health insurance plus services intended to promote employment.

The AB Plus treatment group received the health plan and three other voluntary services: (1) Progressive Goal Attainment Program (PGAP), (2) employment and benefits counseling, and (3) medical case management. PGAP is a behavioral modification program intended to incrementally increase activity levels and change daily routines to be consistent with employment. PGAP had not been evaluated in randomized clinical trials prior to AB, but evidence from non-experimental research supported its potential effectiveness for SSDI beneficiaries (Michalopoulos et al. 2011). The demonstration implemented the AB Plus services in a centralized manner, by in which a single service provider organization conducted intake and PGAP, another provider offered employment and benefits counseling, and a third performed medical case management. This approach minimized concerns about variation in service delivery across sites and provided an efficient solution to deliver services across many widely dispersed locations.

***PROMISE, RETAIN, and YTD feature federal guidelines for services but offer local programs flexibility to customize intervention design. This approach offers insights about the use of existing services to evaluate a new program design.***

In contrast to AB and MHTS, where the services evaluated were precisely specified, the federal sponsors of PROMISE<sup>18</sup> and YTD established guidelines about required services but gave the programs flexibility to design and deliver services. Both demonstrations are based on effective youth transition practices documented in the National Collaborative on Workforce and Disability for Youth's *Guideposts for Success* and the National Technical Assistance Center on Transition's Effective

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<sup>18</sup> SSA and its partners (US Departments of Education, Health and Human Services, and Labor) set requirements for core components of the PROMISE projects: (1) formal partnerships with state social service agencies; (2) case management; (3) benefits counseling and financial education; (4) career and work-based learning experiences; and (5) parent training and education. Each project also had to enroll 2,000 participants.

Practices and Predictors Matrix (Fraker, Mamun, et al. 2014). Both demonstrations intended to deliver intensive case management, benefits counseling, financial literacy training, and career and work-based learning experiences.

For RETAIN, DOL established seven core service components,<sup>19</sup> but the states that implement RETAIN have considerable flexibility to design and implement interventions. Each state will develop an approach to identify and recruit its target population and to determine the role of health care providers, employers, and the return-to-work coordinator. As with YTD and PROMISE, process analyses for RETAIN that describe the services delivered in detail, roles of service providers, and implementation results will be essential to understanding the intervention delivered and to interpreting impact estimates.

For YTD, SSA selected universities and private non-profit agencies to deliver the intervention.<sup>20</sup> Except for West Virginia, YTD projects were already serving youth, and some had to modify their focus to deliver the employment-focused services called for in the demonstration. Changing existing program operations and philosophy can be a challenge and required extensive technical assistance in some cases. For example, the Erie County (NY) project adapted its original program model, which used a classroom-based self-determination curriculum along with basic education and career exploration but no direct employment services. To adapt its program to the YTD logic model, the project replaced the classroom-based structure with individualized case management and employment services. The process analysis found that the project delivered a structured set of services that conformed closely to the updated logic model. Alternatively, adapting a prior program model proved more challenging in the Colorado YTD project. As discussed by Fraker et al. (2014) and Fraker, Baird, et al. (2011), a strong commitment to the project's original focus on case management posed a barrier to developing an emphasis on employment services and individualized work-

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<sup>19</sup> RETAIN's core components are (1) return-to-work coordinators to coordinate health and employment service delivery; (2) training for participating health providers in occupational health best practices and alternatives to opioids for pain management; (3) incentives for participating health care providers to use best practices; (4) early communication to all stakeholders to return the worker to the workplace as soon as possible; (5) workplace-based interventions, including accommodations such as lighter and/or modified duties and adjustments to work schedules, tasks, and the physical worksite, if necessary; (6) training/rehabilitation for workers who can no longer perform their prior job or other available suitable alternate work; and (7) tracking and monitoring the medical and employment progress of participating workers.

<sup>20</sup> As detailed by Fraker, Mamun, et al. (2014), the experimental evaluation included six YTD projects that entered the evaluation in two phases. SSA selected three Phase 1 projects from a group of seven projects SSA had been funding through cooperative agreements, and three Phase 2 projects from a group of five pilot projects that it had been funding through a contract. Phase 1 projects had been operating for several years before the evaluation began, which affected their receptivity to technical assistance. The evaluation found systematic differences between the phases in how the projects were implemented and their impacts on youth outcomes.

based experiences. This strong commitment to the original program model also led to resistance on the part of project managers to technical assistance designed to help staff develop skills to provide job development and job placement services (Fraker, Baird, et al. 2011).

Lessons from YTD influenced the design of the PROMISE demonstration. To improve the study's potential to detect impacts, the PROMISE project sponsors adopted a larger sample size (2,000 per project, compared to 800 per project in YTD). PROMISE also focuses on younger individuals (ages 14–16, compared to 14–25 in YTD) and on serving the entire family. Based on lessons from YTD about the need for coordination across multiple touchpoints—school, health care, Vocational Rehabilitation—PROMISE aimed to secure buy-in and cooperation from all relevant state agencies. One of the YTD lessons, the importance of partnerships for effectively serving youth in transition, became a foundation for PROMISE as it sought to improve the coordination of services.

Examples from PROMISE show that programs that rely on existing relationships might be able to establish partnerships quickly and might have existing services in place that can be tapped for the demonstration. But in some cases, relying on existing service providers taxed their capacity, made it hard for them to commit resources and staff to the new program, and made it difficult to engage in a timely way with program participants (McCutcheon et al. 2018). The ASPIRE (consortium) project provided case management as a new service and then referred participants to existing programs for benefits counseling, financial literacy training, and employment-related services. This proved to be an efficient way to deliver services for this site. The Arkansas project found that developing a new program can be challenging and time-consuming, particularly the work needed to educate community partners. Relying on service providers in different organizations also presented a management challenge for Arkansas.

Relying on existing service providers can also raise concerns for preserving the experimental contrast. Using existing providers to provide demonstration services to the treatment group means that demonstration staff need to ensure that those providers do not also provide demonstration services to the control group. When coupled with low take-up of services by treatment group members, this might make it harder to establish a sufficient treatment/control differential to detect the effects of the PROMISE intended services. Some PROMISE projects, for example, generated greater treatment/control contrast than others and produced a greater chance of detecting impacts. The New York project assigned control group members to receive some contact with case managers who also served the treatment group (McCutcheon et al. 2018). In projects where recruitment staff also provided case management, it was more possible to introduce opportunities for contact with controls. In the Maryland project, a robust existing service delivery system meant that control group members had access to many of the services offered to the treatment group (Kauff, Honeycutt, et al. 2018).



***It is important to consider tradeoffs regarding data systems and monitoring for designs that are centralized or locally developed.***

As noted in the process analysis reports, each PROMISE project developed its own management information system (MIS) to record information about service delivery, although each PROMISE project was required to use an MIS to record data on recruitment and its efforts with treatment group youth and families. Project differences made it difficult to compare projects on some measures, though that was not an objective for the PROMISE evaluation.

Locally developed systems allow programs to build on existing systems that staff are familiar with, which can be less costly than developing a new MIS and training staff on it. Limitations in some of these systems for measuring service receipt can make it difficult to monitor service receipt in detail, and different MISs might not capture uniform data, which makes it difficult to measure service receipt in the same way across all programs. The PROMISE process reports document some complications with data entry that hindered the ability to measure service take-up. For example, Matulewicz, Katz, et al. (2018) note that in the California project, the staff did not consistently enter data about the enrollment interview, because if a participant enrolled, the interview would be assumed to have occurred. In other cases, some interactions were recorded only in client case notes, making it difficult to identify the service provided. Also, the timing of some events was not recorded, making it difficult to determine whether the project met its benchmark.

The approach taken in other demonstrations to develop a single data system (e.g., BOND, POD, and YTD) was more practical because the organizations that operated the demonstrations were required to build systems under their contracts to SSA. In contrast, the PROMISE projects, as Department of Education grantees, were not required to build data systems. If it were possible, setting uniform content and data entry requirements might have made projects easier to compare. Weighing tradeoffs in costs, deciding on minimum data collection requirements up front, and staff training can help to maximize the value of data systems used to monitor service provision.

### **Lessons about What Helps or Hinders Service Delivery and Participation**

***Leadership, mode of delivery, and adjustments during implementation affected service delivery.***

The demonstration implementation studies report on several factors that influence service delivery. Here we summarize factors that arose in several demonstrations, affecting participation and engagement.

**Leadership.** Several factors related to leadership have contributed to successful service delivery: (1) a strong management structure, (2) setting clear expectations and roles across partners for collaboration and communication, and (3) obtaining high-level buy-in for support. PROMISE required grantees to form partnerships among state

departments of education, Vocational Rehabilitation, Medicaid, and other agencies to deliver services. Obtaining high-level buy-in within the state governments in the sites helped to coordinate across the various agencies and to achieve the strong partnerships that were essential to implementing the programs.

The Wisconsin PROMISE project formed an executive committee with top state government officials and a steering committee with agency and provider leaders as part of the management structure to cultivate the partnerships. The committee was important for ongoing communication, coordination of multiple partners, and meeting enrollment targets (Selekman et al. 2018). The Maryland project built on its existing relationships with the state agencies that participated in the project, finding that creating a small leadership team was effective for project operations and communication between partners. The smaller team allowed for clearer messaging to providers and quicker responses for guidance when needed (Kauff, Honeycutt, et al. 2018).

In multiple PROMISE sites, evaluators identified the importance of clear roles and expectations among partners for achieving more effective collaboration at the local level. In the ASPIRE project, which consisted of a consortium of states, the process analysis report notes that a centralized management structure and advisory committee, such as those described above, might have been helpful in facilitating linkages, consistency, and communication across partners (Anderson et al. 2018). To maintain these local collaborations, the California project found that management monitoring progress was a key factor for these ongoing relationships (Matulewicz, Katz, et al. 2018). In the Arkansas site, where multiple organizations provided services, managers faced difficulties setting the expectations and clarifying roles among partners. The site overcame these issues through joint trainings and meetings, including joint management team meetings (Honeycutt, Gionfriddo, Kauff, et al. 2018).

Four other projects are examples where effective leadership has produced collaboration with third parties to improve the disability application process for underserved groups. This lesson is particularly relevant now as SSA responds to growing concerns about the effects of the COVID-19 pandemic on disability applications.

In the early 1990s, SSA conducted the SSI Outreach Demonstration, providing cooperative agreements to outside organizations to conduct outreach and application assistance. Building from lessons from that effort, the HOPE demonstration engaged programs to conduct outreach to individuals experiencing chronic homelessness to help them file disability applications, along with assistance accessing other treatment and services. SSA provided the organizations with trainings and information about the agency's application process. Participants in HOPE who received application assistance received determinations more quickly and had improved housing situations 12 months after enrollment (McCoy et al. 2007). The evaluators identified two important factors for implementation: (1) coordinated collaboration among HOPE

staff, Disability Determination Services (DDS) liaisons, and SSA regional office or field office liaisons; and (2) clear and open communication among these parties, with all invested in problem-solving.

The Substance Abuse and Mental Health Services Administration's SOAR program built off HOPE and was designed to help individuals at risk of or experiencing homelessness to access disability benefits. A SOAR Technical Assistance Center provides ongoing trainings and coordination for state and local initiatives. A central component of the SOAR model is the collaboration among the SOAR sites, SSA, and DDS, as SOAR staff help eligible individuals navigate the disability application process. In an evaluation of SOAR in six states, Kauff et al. (2009) identified strong leadership to facilitate coordination and communication among partners; agency-level buy-in and support; active collaboration; engagement from SSA and DDS; and strong, ongoing, and structured communication among partners as keys to successful implementation. Kauff, Clary, and Lyskawa (2014) found that using core components of the SOAR process for filing SSDI and SSI applications was predictive of higher approval rates at the initial application level. They found the rate was almost double the rate for all applicants experiencing homelessness in Fiscal Year 2010. The authors also found that the collaboration among SOAR programs, SSA, and DDS was crucial.

SSA also conducted the HSPD Pilot to address barriers to receiving SSI benefits for individuals with schizophrenia or schizoaffective disorders. The intervention was based on a structured collaboration among community health agencies, SSA, and DDS. Bailey, Goetz Engler, and Hemmeter (2016) found favorable outcomes for individuals who received assistance, such as higher approval rates at initial application and reduced time to award. The SSA regional office championed this pilot and was invested in the effective collaboration and communication with the community partners.

**Mode of Delivery.** Demonstrations have provided lessons about the advantages and disadvantages of delivering services in new ways—telephone versus in person, group versus individual benefits counseling. In AB, the demonstration provided the AB Plus services—PGAP, benefits and employment counseling, and medical case management—by telephone because the number of participants in each location was too small to deliver in-person services.

The AB process study found that it was possible to deliver services by telephone but with some limitations. For example, some employment counselors reported challenges in ascertaining a beneficiary's work limitations and work readiness. One counselor helped a participant explore the physical demands of jobs requiring standing or lifting by explaining on-the-job activities. Because the remote counselors could not have direct experience with the labor markets in 53 different metropolitan areas, they would encourage participants to explore their neighborhoods to identify businesses and potential employers. Counselors also developed resource lists with employment services in each area and contacted service providers to collect information on procedures for serving SSDI beneficiaries.

PGAP, one of the services offered to the AB Plus treatment group, was originally designed as a face-to-face intervention for Canadian workers' compensation claimants, delivered by occupational and physical therapists. In AB, social workers provided PGAP, and the demonstration participants had a wider range of diagnoses and functional limitations than previous service recipients. This was also the first time that PGAP was delivered by telephone; before AB, it had been provided only in person. Michalopoulos et al. (2011) reported that overall, PGAP was delivered as intended, but noted that other studies of PGAP that provided this service in person had larger effects than in AB. Moreover, participant take-up was low, with about one-third of the AB Plus treatment group engaged in this service, and low literacy was a barrier that made participating in PGAP more difficult.

We also note the importance of remote services, as many providers have had to pivot to provide various modes of delivery because of the pandemic, which raises additional questions. Is service provision that is local and in person more effective than service provision that is local and remote? Furthermore, is it possible for a non-local provider to approximate the local context given appropriate training and technical assistance? Along with the examples from AB, SSA's operations of the WIPA program provide important insights on these questions.

The WIPA service model emphasizes remote service delivery, and its community work incentives counselors have developed strategies for interacting with beneficiaries via telephone and video conferencing to develop individualized plans and to counsel them on a range of benefits. Some counselors use screen sharing to review documents with beneficiaries. The WIPA program also uses a database that compiles information on the rules of individual state benefits, making it possible for counselors to advise beneficiaries on a wide range of state benefit programs.

For services in group versus individual settings, PROMISE offers lessons about providing benefits counseling in groups. The Arkansas project provided benefits counseling primarily in monthly group training sessions, with individualized benefits counseling reserved for individuals who had questions about their SSI benefits (Honeycutt, Gionfriddo, Kauff, et al. 2018). The Arkansas staff reported that group sessions worked smoothly and were well received by participants, with about half (55 percent) receiving benefits counseling in the group format. However, in the New York PROMISE project, group benefits counseling was not well received, as youth and families did not want to discuss personal financial information in a group. In that project, low take-up of the group benefits counseling prompted the project to move to individual counseling (McCutcheon et al 2018).

**Adjustments during Implementation.** The process analyses highlight factors that make it difficult to deliver services as planned and opportunities to adjust service delivery to achieve intended goals. MHTS is an example where ethical and practical considerations made it impossible to achieve uniform service implementation for one of the project components, systematic medication management (SMM). Two issues affected implementation of the SMM. First, the demonstration designed an approach

for this service, but it was not practical to expect the providers to change their regular operations. Therefore, some staff began providing SMM according to the demonstration design but also continued serving other individuals as before. In addition, if treatment group members already had an ongoing relationship with a mental health provider who assisted with medication management, they were not required to change providers, and these outside providers were not required to adopt MHTS's practices. It was not considered reasonable or ethical to ask treatment group members to discontinue relationships with existing providers.

In other demonstrations, early assessments identified the need to re-focus services on employment to improve delivery of the intervention as intended. Modifying service approaches and technical assistance made it possible to make these course corrections. For example, in the AB demonstration, as reported by Michalopoulos et al. (2011), early information showed the need for adjustments to ensure services promoted a rehabilitation model rather than a medical model. The process analysis identified adaptations to services that helped to encourage participants to re-orient their health care and daily routines toward returning to work. One change was to remove questions from the AB Plus intake instrument about the individual's medical condition and medications, and instead emphasize preparation for employment-oriented activities. This change came about when, early in the demonstration, the design team became concerned that the original instrument focused too much on medical providers and medications and that this distracted participants from engaging with employment and benefits counseling and PGAP. After the change, most of the intake time focused on introducing PGAP. Another adaptation was to restrict referrals to medical case management to specific short-term medical issues that were limiting a beneficiary's ability to initiate PGAP.

Course corrections and technical assistance in one of the YTD projects also helped to maintain a focus on employment. The projects had been operating prior to YTD and sometimes had to alter prior practices. As discussed by Fraker, Mamun, et al. (2012), the Miami-Dade County project, previously focused on serving in-school youth with case management and pre-employment services, needed to broaden its focus to deliver the YTD services. In the first year, the process analysis found that participants were spending relatively few hours on employment and paid work experiences. Technical assistance helped the project make changes to put greater emphasis on job placement, which increased participation in employment.

The New York PROMISE project experienced a similar issue. The project staff found that they had not clearly communicated expectations about employment-related services. McCutcheon et al. (2018) found that most referrals for employment services were for pre-employment activities—assessments, career planning and preparation activities. Referrals to paid and unpaid employment were much lower and well below benchmarks the project had set. This occurred because the project wanted to tailor services to youth's needs and did not prescribe benchmarks for types of employment

services. When staff realized that paid employment lagged expectations, they developed increasingly detailed benchmarks and began monitoring more closely.

***Local resources and appropriate staffing facilitated, whereas emergency and basic needs impeded, participation and engagement.***

Our review of process analysis reports found that local resources and appropriate staffing levels can provide advantages for participant engagement. We also found in many demonstrations that participants experienced emergency needs for housing and food assistance and faced crises that interfered with program participation.

**Local Resources.** Local resources can be beneficial for service delivery and addressing barriers to participation and engagement. PROMISE required a core package of services but allowed each project flexibility to customize specific approaches to delivering services. Honeycutt and Livermore (2018) highlight that state and federal collaboration is not sufficient for these cross-cutting services, that local agencies must also be engaged. Mamun et al. (2019) discuss the variation in PROMISE local environments and implementation, and how that can influence the impacts of the intervention. In addition, local barriers such as transportation, labor market conditions, and service availability also influenced implementation of PROMISE projects.

Importantly, local resources helped projects meet the need for cultural awareness and sensitivity in PROMISE sites. The California project hired staff who reflected the diversity of the local communities, who could speak in participants' preferred languages, and who understood cultural sensitivities. These resources were also valuable in the ASPIRE project engaging with and providing services to American Indian populations. Another example is the YTD project in Bronx County (NY) that hired bilingual parents of youth to serve as liaisons for other program participants. These liaisons met with youth and their families in their homes and provided encouragement to participate in college workshops.

In the Maryland PROMISE project, staff engaged participants in urban areas differently from participants in rural areas. As Kauff, Honeycutt, et al. (2018) note in the process analysis report for that project,

In communities where other service options are plentiful, as is often the case in cities, program staff must make the case for why the new services are unique and better than existing ones. In rural communities, where existing services may be limited, families may be more receptive to new services, but their geographic dispersion may make service provision challenging. (57)

Projects in rural areas encountered challenges with distance. The ASPIRE PROMISE project began to allow case managers to travel to more remote areas and developed options for families to receive services online and in other remote modes (Anderson et al. 2018). The Wisconsin project provided tablets to youth to make it

easier to stay in touch, but spotty cell coverage sometimes interfered. Because of geographic dispersion, the Wisconsin project helped participants address transportation needs, varying access to services, and other unique needs (Selekman et al. 2018). Staff in the Maryland project also noted that service coordination could occur based on a staff member's familiarity with local resources (Kauff, Honeycutt, et al. 2018).

Another example is SED, where the local project operators are drawing on local resources to help participants address crucial food and housing needs and to obtain legal assistance. The projects have compiled contact information for legal assistance providers who can help formerly incarcerated participants expunge or correct criminal system records or obtain assistance with custody arrangements or other legal matters. To address major, ongoing medical and behavioral health care needs (particularly for individuals living in non-Medicaid-expansion states), each SED site compiled an inventory of local low- or no-cost health clinics, including dental and vision sources, where participants could find needed care.

In the projects focused on assisting individuals experiencing homelessness to apply for benefits, awareness of the local environment and meeting the needs of the participants within the local context were also key factors. In HSPD, staff in the community centers were familiar with the target population, knew how to find individuals in need of assistance, and knew ways to maintain contact during service provision. Moreover, the local partners were invested in the project, including the community centers, DDS, and the SSA regional offices and local field offices, all of which were also important in HOPE and SOAR.

**Appropriate Caseloads.** Appropriate caseload assignment contributes to effective service delivery and participant engagement. For many of the services provided across the demonstrations, caseload size and resource allocation are key factors in service delivery. If caseloads are too high, service intensity, quality, and accessibility can suffer and can lead to reallocation of staff. In PROMISE, the Wisconsin project counselors found it difficult to serve both youth and families, because the family members essentially increased their caseloads (Selekman et al. 2018). In the New York site, the project tasked case managers and family coaches with recruitment, which took time away from their duties to provide services (McCutcheon et al. 2018). After the California project hired additional staff to balance workloads better, managers noted that the quality of services improved (Matulewicz, Katz, et al. 2018).

Not only do these issues affect the provision and quality of services, but they also affect participant engagement. Participants in the Maryland PROMISE project commented on staffing changes (Kauff, Honeycutt, et al. 2018):

When changes occurred, these parents and guardians felt that they and their youth had to start 'all over' because it did not seem to them that previous staff had shared case notes, resulting in the new staff lacking critical information about the youth and families. (24)

In the New York project, when caseloads were too high or staff changes delayed services, participants became frustrated with waiting, which could affect their engagement. These delays also frustrated staff who referred participants to providers that lacked capacity, only to have their participants wait (McCutcheon et al. 2018).

These issues occurred in other demonstrations, too, including BOND and Project NetWork. Benefits counselors in BOND were tasked with collecting earnings information and documenting earnings deductions for the offset, a duty different from their usual workload to counsel beneficiaries, which they reported competed with the counseling (Derr et al. 2015). In Project NetWork, when there were delays in obtaining the initial assessments of participants, which also affected other services, participants disengaged during these waiting periods (Leiter, Wood, and Bell 1997).

**Emergency and Basic Needs.** Participants' emergency and basic needs can hinder program participation across demonstrations. In multiple demonstrations, process analyses found that immediate needs of individuals and families—food, health, housing—had to be resolved before they could engage with employment-related services. Family crises and challenges made it difficult to remain in contact with some families—contact information changed frequently—and crises made it difficult for some families to engage. For projects generally focused on employment outcomes, first addressing basic needs was viewed as conflicting with pursuit of employment goals. Before they could focus on program goals, providers needed flexibility to help address these immediate needs, and participants needed flexibility to increase stability. SED provides an example where addressing these critical needs was included as part of the model (Marrow et al. 2020).

Alternatively, staff in multiple PROMISE projects reported that instability, crises, and basic needs hindered contact with participants and participants' engagement in services. The Wisconsin project reported that working with the entire family unit rather than just an individual also revealed the needs and complexities (Selekman et al. 2018). In that project, the service provider addressed basic needs throughout the program as they would develop. The provider continued to reach out to engage these participants, as well, even after participants had temporarily disengaged from services. In contrast, some service providers might have policies to discontinue outreach to disengaged participants, rather focusing only on engaged participants. Selekman et al. (2018) note that the service model allowed providers flexibility and promoted engagement in services.

The Maryland PROMISE project hired staff whose sole responsibility was to reach out to participants who had never engaged or who disengaged. Of those contacted through these efforts, one-quarter of the participants began to engage or re-engaged (Kauff, Honeycutt, et al. 2018). In the ASPIRE project, when transportation posed challenges to participating in in-person events, project staff began allowing families to view recorded or live trainings online to make their participation more convenient (Anderson et al. 2018).



The service team in the AB demonstration reported that AB Plus participants typically needed to address other basic needs before they could move on to the PGAP and other service components. Michalopoulos et al. (2011) also found that AB participants had high rates of unmet medical needs and had gone without treatment or care. The health coverage provided in AB reduced these unmet medical needs, and participants were less likely than the control group to opt not to seek medical care for financial reasons and less likely to forgo a needed prescription.

## CONCLUSION

This chapter examined findings about demonstration implementation to understand successes and challenges in recruiting and enrolling participants and in delivering services. Our analysis produced a set of lessons and observations about the factors that hindered and supported implementation, considerations for replicating interventions, and the way implementation influences how policymakers interpret impacts. In some cases, even when demonstrations have not produced evidence of impacts on earnings and employment, lessons about operations and service delivery emerge that can inform policy.

Looking across these lessons, we draw seven conclusions that we believe are especially important for policymakers. They constitute valuable contributions to the body of knowledge about disability policy and research and help set the stage for future demonstrations.

- ***Response to recruitment varies among a targeted population and by intervention.*** Variation in recruitment and enrollment underscores the diversity in the SSDI and SSI caseloads. Though SSA's demonstrations have successfully recruited both broad and specific target populations, those targeting narrowly defined groups and offering specialized services have achieved the strongest response to outreach. Overall, newly entitled SSDI beneficiaries, denied applicants, and youth have been more likely to volunteer than existing SSDI beneficiaries and SSI recipients. Broad appeals offering financial incentives yielded the lowest enrollment rates of the group solicited. More rigorous analysis of patterns of enrollment like the analysis conducted by Ruiz-Quintanilla et al. (2006) could help SSA better understand the characteristics that affect program participation at the various stages in the recruitment process. This type of analysis, with greater focus on patterns of participation by characteristics such as education, race, and ethnicity, could help to enhance program outreach and to ensure that all subgroups have access to programs. In general, we think a greater emphasis on equity would strengthen future implementation studies.

- ***Beneficiaries who volunteer for offers of financial incentives are more work oriented than non-volunteers.*** Offering a broad group of beneficiaries a change in benefit rules or a program waiver that made higher earnings more attractive yielded volunteers distinct among the general caseload in their orientation toward work. Volunteers for these demonstrations were more likely than non-volunteers to have had recent work experience. This suggests that for policies offering financial incentives, targeting recruitment to individuals with recent work history might be more efficient than broader outreach.
- ***Administrative challenges can diminish the behavioral response.*** In BOND, administrative burden and operational challenges in implementing a benefit offset delayed benefit adjustments for participating beneficiaries. These time lags could have made beneficiaries less likely to respond to the intervention. As POD is testing changes that reduce some of the administrative burden that occurred in BOND, we look forward to the final results to determine whether these changes were effective.
- ***SSA can use its experience evaluating third-party assistance for underserved disability applicants to respond to an immediate policy concern.*** SSA can build from lessons learned in the SSI Outreach Demonstration, HOPE, HSPD, and SOAR projects to address concerns during the COVID pandemic about access to disability benefits for underserved populations. Those projects showed that strong leadership and effective communication foster the kind of structured collaboration needed to help individuals navigate the application process. SSA has responded to the current crisis by launching a national outreach campaign and designating new positions to serve as liaisons to work directly with third parties. It can apply the principles used to engage with third parties on those projects to develop guidance for SSA's regional offices, field offices, and state DDS to engage with third-party providers to assist applicants. SSA could also conduct rigorous evaluations of these efforts to continue to build evidence about how best to engage with and assist these underserved populations.
- ***Participants may have basic needs that must be addressed if they are to engage in services promoting employment.*** Across multiple demonstrations, participants faced immediate needs—housing, food, health, transportation—that needed to be met before they were able to fully engage with employment-related services. For example, several of the PROMISE projects found that youth and their families could not engage in benefits counseling or career and work-based learning until their immediate crises were resolved. This suggests that addressing basic needs should be factored into demonstration design in the future where appropriate, possibly as a necessary service or by allowing service providers the flexibility to focus on critical needs. It is also important

to consider how providers can successfully continue to engage participants during these crises.

- ***It is possible to implement highly structured, evidence-based services with fidelity, but more research is needed on whether adaptations to a highly structured model could also achieve outcomes.*** MHTS provides strong evidence that it is feasible to implement the specialized IPS model of supported employment with strong fidelity. Key to the success was careful site selection and rigorous fidelity monitoring. However, underpowered to detect such findings, the study found no association between program-level fidelity and treatment group employment rates. This suggests that more research might be needed to understand whether less stringent application of IPS (or other interventions) might also achieve desired outcomes.
- ***It is possible to implement a more flexible service design, providing guidelines for service components but allowing local innovation.*** PROMISE and YTD offered projects flexibility to design services, allowing policymakers to build evidence for what services and arrangements are most effective. Local flexibility promotes innovation and takes advantage of local system strengths; but without a strong data system and fidelity measures, it is more challenging to determine exactly which service/arrangement influences effects and how to replicate it. A model offering local flexibility puts a premium on rigorous process analysis to document exactly what is delivered and how. One important lesson is that within the constraints posed by the type of project or contractual vehicle (cooperative agreements versus contracts), policymakers should set requirements for the data elements to be collected in a program's data system to ensure the system records all the data needed to document in detail the services provided and to compare implementation and outcomes across sites.

Taken together, the evidence about SSA's demonstration implementation underscores a high level of success in carrying out credible tests of a wide range of interventions. Overall, process analyses indicate that interventions have been implemented largely according to intended design. Robust process analyses have allowed for adjustments when needed to improve implementation, and the absence of intervention effects in several demonstrations does not appear to stem from implementation challenges. However, more rigorous evaluation designs that evaluate alternative implementation conditions are needed in the future to understand definitively the role of implementation in participant outcomes.

**Exhibit 9.5. Summary of Recruitment Results**

Enrollment Target	Solicited in Initial Outreach	Responded to Initial Outreach		Eligible for Demonstration		Enrolled in Demonstration			
		Number	Percentage of Solicited	Number	Percentage of Responded	Number	Percentage of Eligible	Percentage of Solicited	
<b>Early Experiences with National Demonstrations</b>									
TETD	13,800	2,404	17.4	N/A	N/A	745	5.4	5.4	
Project NetWork <sup>a</sup>	145,404	11,838	8.1	N/A	N/A	6,527	4.5	4.5	
New York WORKS	41,431	17,275	41.6	N/A	N/A	900	2.2	2.2	
<b>Broad Appeals Offering Financial Incentives</b>									
BOND	12,650	238,070	9,047	3.8	N/A	N/A	12,954	5.4	5.4
POD	10,000	419,481	24,910	5.9	N/A	N/A	10,070	2.4	2.4
<b>Specialized Services Offered to Specific Groups</b>									
AB	2,000	22,612	18,545	82.0	2,049	11.0	2,004	97.8	8.9
SED	3,000	21,003	13,375	63.7	11,307	84.5	3,000	26.5	14.3
MHTS	2,000	57,634	17,642	30.6	15,982	90.6	2,238	14.0	3.9
<b>Interventions for Youth: YTD</b>									
Bronx County, NY	880	4,843	1,412	29.2	N/A	N/A	889	18.4	18.4
Colorado (4 counties)	880	2,968	1,332	44.9	N/A	N/A	880	29.6	29.6
Erie County, NY	880	3,183	1,296	40.7	N/A	N/A	880	27.6	27.6
Miami-Dade County, FL	880	5,573	1,955	35.1	N/A	N/A	880	15.8	15.8
Montgomery County, MD	880	N/A	N/A	N/A	N/A	N/A	840	N/A	N/A
West Virginia (19 counties)	880	5,207	1,930	37.1	N/A	N/A	875	16.8	16.8
<b>Interventions for Youth: PROMISE</b>									
Arkansas	2,000	7,459	N/A	N/A	N/A	N/A	2,000	26.8	26.8
ASPIRE	2,000	9,196	N/A	N/A	N/A	N/A	2,051	22.3	22.3
California	2,000	11,271	N/A	N/A	N/A	N/A	3,273	29.0	29.0
Maryland	2,000	4,644	N/A	N/A	N/A	N/A	2,006	43.2	43.2
New York	2,000	13,393	N/A	N/A	N/A	N/A	2,090	15.6	15.6
Wisconsin	2,000	9,150	N/A	N/A	N/A	N/A	2,024	22.1	22.1

Source: Authors' summary of demonstration final reports. AB: Michalopoulos et al. (2011). BOND: Gubits et al. (2018a/b). MHTS: Frey et al. (2011). POD: Hock et al. (2020). Project NetWork: Kornfeld and Rupp (2000). PROMISE: Anderson et al. (2018); Honeycutt, Gionfriddo, Kauff, et al. (2018); Kauff et al. (2018); Mamun et al. (2019); Matulewicz, Katz, et al. (2018); McCutcheon et al. (2018); Selekman et al. (2018). SED: Taylor et al. (2020). SPI New York WORKS: Ruiz-Quintanilla et al. (2006). TETD: Thornton and Decker (1989). YTD: Fraker, Mamun, et al. (2014).

<sup>a</sup> Project NetWork enrolled a total of 8,248 in the evaluation. Of those, 6,527 were enrolled through the outreach and recruitment process. The remaining 1,721 were new SSI applicants recruited by SSA's claims representatives.

## Contributors

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Chapter 9

## Comment

David Stapleton

*Tree House Economics*

Wood and Goetz Engler (in “Lessons from Implementation”) deserve a great deal of credit for drafting an extensive and valuable review of implementation experiences from several decades of SSA demonstration projects. They have drawn some valuable lessons, with which I largely agree. I consider the implications of their findings and lessons for strategies designed to optimize the value of Social Security Administration (SSA) demonstrations going forward.

### FOCUS ON EARLY INTERVENTIONS

The authors’ findings reinforce a view I have held for some time: that SSA employment demonstrations should focus exclusively on testing relatively “early interventions”—that is, interventions designed for people at risk for application, applicants, and new beneficiaries or recipients, rather than those designed specifically for long-term beneficiaries or recipients. As others have suggested, there are important reasons unrelated to implementation to do so: the bulk of post-award work activity starts in the first few years after award (Liu and Stapleton 2011; Ben-Shalom and Stapleton 2015), and return to work becomes more challenging the longer an individual is out of the workforce (e.g., separation from past employers and skill deterioration). The authors’ comparison of recruitment yields (Exhibit 9.2) adds a practical argument: it is easier to recruit youth with disabilities, applicants, and new beneficiaries or recipients to participate in rigorous demonstrations than it is to recruit from the broad adult beneficiary/recipient population. Other things equal, this means that the task of evaluating a meritorious early intervention will be less difficult than the task of evaluating an equally meritorious intervention targeted at long-term beneficiaries or recipients.

### INITIALLY TARGET THOSE MOST LIKELY TO USE THE INTERVENTION AS INTENDED

As other authors in this volume have pointed out (Gregory and Moffitt in Chapter 4; von Wachter and Goldman in Chapter 7 and its Comment, respectively), until we know that an intervention works well for a group for which we expect it to work well, it makes little sense to test it on others. The recruitment findings reported by Wood and Goetz Engler reinforce this view. They point to evidence that it is easier to recruit from target populations that are likely to use an intervention—assuming it is possible to make meaningful distinctions in advance. Accelerated Benefits (AB) and the Promoting Opportunity Demonstration (POD) are polar opposites in this regard.

AB offered health insurance to uninsured Social Security Disability Insurance (SSDI) awardees—individuals expected to need financing for health care—and 98 percent volunteered. In contrast, POD recruited volunteers from the full SSDI beneficiary population for the test of a change in the earnings rules that, based on evidence from the Benefit Offset National Demonstration (BOND) and other past research, was likely to be attractive to a small minority. Only 2.4 percent volunteered.

### ***Build on Initial Success***

SSA demonstrations have already shown the value of this lesson. The authors point to a string of demonstrations that follow this approach to testing interventions that reduce barriers to Supplemental Security Income (SSI) and SSDI entry to people with disabilities in exceptionally vulnerable subgroups. Similarly, Wittenburg and Livermore (Chapter 6) point to SSA interventions for youth that gradually build on initial success; and Goldman points to the value of expanding tests of the Individual Placement and Support (IPS) model of supported employment, which have been found to be successful for individuals with serious mental illness, to other disability populations.

BOND illustrates why SSA *should not* test an intervention on a broad population until favorable results have been found for a narrowly targeted population. SSA did, in fact, test the BOND benefit offset on four target populations for which the offset was expected to have substantial impacts, under the Benefit Offset Pilot Demonstration (BOPD). BOPD was a proof-of-concept test, designed to help SSA learn about operational issues prior to BOND. Although BOPD was not intended to provide preliminary evidence on impacts for target populations likely to use the intervention, it provided the opportunity to do so. Each of its four randomized control trials recruited beneficiaries who had signaled an interest in work via an interaction with a specific state agency. One of the two unfavorable results from BOPD was in the implementation domain, as Wood and Goetz Engler point out: major problems in processing of benefit adjustments that led to mistakes and long delays in the adjustment of benefits. The other unfavorable BOPD findings are based on the impact analysis completed by Weathers and Hemmeter (2011): there was no detectable impact on earnings whereas mean benefits increased. SSA, which was legislatively required to conduct a national study, moved forward with BOND before the BOPD impact findings were available.

The BOND evaluation findings are unfavorable in the same ways that the BOPD findings were: problems with the implementation of the benefit offset, despite efforts to fix the issues identified in BOPD; and, as Gregory and Moffitt (Chapter 4 in this volume) point out, impacts on mean earnings and mean benefits were unfavorable in the same way. Thus, despite an enormous investment, we cannot confidently rule out the possibility that better implementation of the BOND benefit offset would result in much more favorable impacts. It is at least arguable that SSA would have learned more, and saved time and valuable resources, if policymakers had not required the

agency to conduct a national demonstration before having completed more-targeted tests designed to verify that the impact results would be more favorable once the implementation problems were well addressed.

### ***Find High-Quality Implementation Partners***

Although obvious, this point is so important that it deserves explicit attention. Other authors in this volume have written about the value of SSA collaboration with other federal agencies, state agencies, and private organizations. Wood and Goetz Engler point to attributes of partners that are important to success, including leadership, strong working relationships among partner organizations, ability to innovate, ability to implement an intervention with fidelity, ability to make midcourse corrections, and ability to support recruitment. SSA's experience provides many examples of the importance of these attributes. It is important for SSA to draw on lessons from the many different approaches that it has taken to engagement with partners over many demonstrations.

### ***Implement AND Test Innovations That Improve Access to the Main Intervention***

Wood and Goetz Engler identify two important challenges that may make it difficult for demonstration participants to access the intervention being tested: limits on their ability to access information technology and unmet needs for basic necessities.

The COVID pandemic both accelerated the use of virtual services and heightened awareness of the need to increase access to information technology for the most vulnerable populations. Virtual services have both benefits and costs, as illustrated by the authors' discussion of remote counseling services. One cost is limitations on access for some individuals. SSA demonstrations provide an opportunity to develop and test approaches to improving access. The Promoting Readiness of Minors in SSI demonstration in Wisconsin offers an example: it provided tablet computers and data plans to students in rural areas. As SSA starts to address the advantages and challenges of expanding virtual services in the SSDI and SSI application process, its demonstrations could test various ways of delivering services virtually in the application of earnings rules, benefits counseling, delivery of early employment interventions, and other services.

Wood and Goetz Engler point to several demonstrations in which treatment participants with high unmet needs for housing, food, clothing, transportation, child care, and other necessities did not have the capacity to take advantage of the intervention. Unmet needs are also an impediment to recruitment. Interventions that are designed to help participants temporarily meet their basic needs, so that they can take advantage of the intervention and get to the point where they can take care of basic needs on their own, seem more likely to succeed than those that leave such needs unmet.



A recent randomized control trial of “self-directed” mental health services illustrates this point. Cook et al. (2019) found that over two years, providing young adults with major mental illnesses considerable discretion in the expenditure of funds available for their mental health services resulted in a considerable improvement in mental health (the objective of the intervention), employment and educational attainment when compared to use of the same funds for mental health services only. The self-directed design is a less extreme version of the intervention that Liebman (in his comment on Chapter 5) suggests as a control arm for all SSA demonstrations: a cash stipend equivalent to the cost of the main intervention. It is more akin to the self-directed delivery of personal assistance services that most state Medicaid programs have adopted following the successful Cash and Counseling demonstration (Foster et al. 2003). High unmet needs in a demonstration’s target population is an important reason to build self-directed services into the intervention itself.

The impact findings from rigorous tests of social program innovations always grab the headlines. If impact findings are favorable from the perspective of stakeholders, the test is likely to be deemed a “success”; but if not, it may be deemed “a failure.” The review and comparative analysis of many decades of SSA demonstrations offered by Wood and Goetz Engler illustrates that this dichotomous assessment ignores the knowledge that can be gained from rigorous implementation evaluations. The lessons learned go beyond implications for the conduct of individual tests to include implications for the design of interventions to be tested and the approach to testing. That is what makes this chapter such an important contribution to this volume.

**David Stapleton**, Independent Consultant, Tree House Economics—Retired from Mathematica in 2018, Dr. Stapleton continues to conduct disability policy research on a part-time basis. Much of his work has focused on how the Social Security Administration’s disability programs affect the employment and income of people with disabilities, and the potential of policy reforms to improve income and employment.

Chapter 9

## Comment

Calvin Johnson

*US Department of Housing and Urban Development*<sup>21</sup>

Woods and Goetz Engler (in “Lessons from Implementation”) present two sets of lessons learned from Social Security Administration (SSA) demonstrations—(1) recruiting and enrolling participants and (2) implementing an intervention. Discussion of these lessons focuses on 12 demonstrations with rigorous evaluation designs and complementary process evaluations. The following sections highlight key lessons presented by the authors in each section, as well as additional consideration for future SSA demonstrations.

### RECRUITING AND ENROLLING PARTICIPANTS

The implementation of demonstrations as a tool for evidence building is challenging. Getting enough people to respond to a notification announcing the demonstration is a great challenge. Without sufficient response to a notification, there is no demonstration to implement. This challenge requires us to assess how much we know about the ways in which potential participants for a demonstration understand and perceive the services being offered. Services that are easier to understand may result in higher response than those that are not. And services that are perceived as more desirable will present fewer recruitment challenges than those perceived as less desirable.

The authors describe Accelerated Benefits (AB) as a demonstration with services that are easy to understand and highly desirable among targeted participants. AB recruitment efforts presented the offer of health insurance benefits and health benefits with support services among Social Security Disability Insurance (SSDI) beneficiaries who are otherwise required to wait 24 months for Medicare coverage. Eighty-two (82) percent of SSDI beneficiaries targeted for the AB demonstration responded. Among those who responded, 11 percent reported not having health insurance. The offer of health insurance is easy to grasp, and waiving the health insurance waiting period has plenty of appeal. The combination of easy to understand and a desirable benefit undoubtedly contributed to the high-response/high-enrollment pattern among eligible SSDI beneficiaries. Further, as the authors pointed out, the high initial response rate even among the already insured is perhaps an indication of unmet health care needs among SSDI beneficiaries overall.

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<sup>21</sup> The views expressed in this chapter are those of the author and do not necessarily represent the views of the Department of Housing and Urban Development or the US federal government.

The authors provide additional discussion about how assumptions about perceived desirability of services might be used to inform future demonstrations. Specifically, the assumed desirability of supportive employment among SSDI and concurrent applicants and beneficiaries enables us to refine our understanding of service desirability on demonstration recruitment efforts. The response and enrollment rates for the Supported Employment Demonstration (SED) and the Mental Health Treatment Study (MHTS) provide some insight to the possible motivation for demonstration participation among those already enrolled for services and those denied for services. The targets for MHTS were existing SSDI beneficiaries with schizophrenia or affective disorders. These beneficiaries were assumed to have lower levels of motivation to participate in a supportive employment demonstration. The working assumption was that SSDI beneficiaries had limited recent workforce experience and were therefore less motivated to participate in a supportive employment program. Conversely, targets for SED were denied SSDI and Supplemental Security Income (SSI) applicants assumed to have more recent workforce exposure and for whom access to supportive employment services is extremely desirable. Unlike AB, roughly 85 percent of SED solicited applicants and 91 percent of solicited MHTS beneficiaries were eligible for their respective demonstration. Compared to AB, a much smaller percentage of SED and MHTS solicited who were eligible enrolled in the demonstration. The rate of enrollment among SED solicited (denied SSDI and SSI applicants) was nearly twice that of MHTS (SSDI beneficiaries) for similar supportive employment services.

These three studies highlight the impact that the desirability of an offer has on response to a solicitation and subsequent recruitment. First, demonstrations that tap into unmet needs might be more desirable and result in high-response/high-enrollment patterns. The response will be high even among persons ineligible for service. SSA might engage ineligible responders to understand the motivation behind their response.

Second, narrowly focused demonstrations targeting existing beneficiaries will likely have a lower response rate than demonstrations targeting denied applicants. Current beneficiaries might be less motivated to respond and enroll in demonstrations for which the services have little appeal; whereas demonstrations targeting denied applicants might have greater appeal, resulting in higher response and enrollment rates. With data from both the SED and MHTS, SSA has sufficient information to estimate predictive models to identify the characteristics of denied applicants and SSDI beneficiaries with severe mental impairments who enroll in a supported employment program. This information will be extremely useful in developing targeted outreach materials designed to increase enrollment among applicants and beneficiaries in these two distinct groups.

The Promoting Readiness of Minors in Supplemental Security Income demonstration (PROMISE) and the Youth Transition Demonstration (YTD) provide insight to the use of target outreach materials designed to increase enrollment. Specifically, recruitment staff used mail correspondence followed by phone call and

intense follow-up engagement to consent participants and assign them to intervention groups. Given the high level of motivation among youth toward employment, independent living, and education, the use of mail correspondence followed by phone call, text, and additional mail correspondence proved sufficient to achieve acceptable levels of enrollment. The addition of stakeholder engagement among community groups working with youth likely enhanced the outreach effort and provided additional supports in recruiting targeted youth.

POD illustrated the importance of testing outreach materials to increase response and enrollment. Specifically, providing clearer instructions and follow-up by postcard appeared to have resulted in increased response and consent to enroll. In fact, the use of “last chance” postcards was equally effective as a follow-up phone call in boosting enrollment. SSA has conducted messaging experiments with the General Services Administration’s Office of Evaluation Science that demonstrate the utility of using behavioral-informed messages to modify behavior. Continuing to work with the Office of Evaluation Science in the design and testing of messages illustrating the benefit(s) to demonstration enrollment will provide additional options for packaging outreach materials. Additionally, developing follow-up messages focusing on intentional next steps and testing their effectiveness in moving potential participants through the enrollment process might offer additional insight into ways to improve outreach materials as well as make enrollment procedures more efficient.

Finally, projects that use the same team members to perform recruitment and service delivery are challenging. The authors suggest that programs with dedicated staff for each of the two roles have higher response and enrollment rates. Although dual-role staff might do a better job building rapport and trust, staff conducting recruitment and service delivery run the risk of sharing information with control group participants that would be unavailable absent the demonstration. Further, sites with separate recruitment and service delivery staff appear to have more efficient recruitment processes and uniform recruitment efforts across sites. SSA might consider including language requiring separate staff to perform recruitment and service delivery in future solicitations.

## IMPLEMENTING AN INTERVENTION

For the “Lessons about Implementing an Intervention” section of the chapter, the authors limited their review to demonstrations with process evaluation findings. Below are comments on a selection from each of the section’s three subsections (1) “Lessons from Implementing Benefit Offsets”; (2) “Lessons about Service Delivery”; and (3) “Lessons about What Helps or Hinders Service Delivery and Participation.”

### *Lessons from Implementing Benefit Offsets*

Whenever there is a rule change for a demonstration that affects benefit amounts, systems designed to compute the benefit must be updated for participants of the

demonstration. Unfortunately, systems designed to calculate benefits are designed on legacy platforms that do not easily accommodate the application of benefit rule changes for the small number of beneficiaries enrolled in demonstrations. Therefore, SSA has either performed these benefit calculations manually across sites or centralized the function to support larger-scale national demonstrations. Regardless of the approach, demonstrations requiring recalculation of benefits often experience delays in benefit adjustment. These delays also contribute to beneficiaries not fully understanding their new benefit rules, and this in turn can erode their confidence in the new benefit rule.

Lessons learned from the Benefit Offset National Demonstration (BOND) provide examples of the challenges associated with demonstrations that affect benefit amounts. Specifically, BOND established a standalone system to make benefit adjustment calculations without interfering with the existing systems used for benefit calculation. SSA established a centralized team that would implement the benefit offset without burdening SSA field office staff who would otherwise have benefit offset case processing responsibilities. SSA hired contractors to estimate earnings, document earnings deductions, and assist SSA staff with appeals. Finally, SSA provided enhanced counseling to ensure that beneficiaries received clear instructions on the importance of timely earnings reporting.

Despite the creation of a standalone system, the parallel implementation process, and enhanced counseling, long delays persisted for the period from the first month a beneficiary's benefit made them eligible for the benefit offset to the time SSA first adjusted their SSDI benefits.

Like other federal agencies that adjust benefit rules for demonstrations, SSA will need to assess the tradeoff of new systems designs for benefit calculation and parallel implementation of benefits programs. If a benefit rule change is a key feature of a demonstration, it is imperative that beneficiaries understand the rule change and have confidence that the calculations are being performed properly. The first step to ensuring an understanding of and building confidence in the new benefit rule is to calculate the new benefit rule promptly, accurately, and consistently. Additional steps taken by SSA to ensure that outreach and counseling staff were delivering the new benefit rules in a clear and concise manner and that beneficiaries understood the importance of timely earnings reporting and the impact for not doing so were important implementation features that netted noticeable results in the average length of time for SSDI benefit adjustments.

### *Lessons about Service Delivery*

Data collection is such an integral part of any demonstration. SSA demonstrations are no exception. When a demonstration relies on a single data system for tracking recruitment and service delivery activities as well as monitoring program activities, the implementers have a better chance at consistent data collection across sites, than if each site had its own system. A single data system ensures uniformity in data fields

viewable across sites. Despite uniformity in data entry fields across sites, there will undoubtedly be variation in the use of these field and the quality of information entered in them. Nonetheless, with a single data system, SSA and its contractor will have access to demonstration data that in theory should be consistent across sites. Using this single data source, SSA and its contractor can establish quality control routines for ensuring data quality standards across all points of data entry. The execution of quality control routines will enable SSA and its contractor to assess data quality standards and use information from their assessment to improve data quality. Data quality improvement efforts may include training and technical assistance on data entry, data standards, and data validation. The objective is to minimize variation in data quality across sites and address quality concerns as they emerge. Demonstrations relying on a single data collection system built by the implementers of the demonstration provide more flexibility in implementing quality control routines and follow-on data quality improvement activities.

The Department of Education required PROMISE programs to use an information system to collect program data. Perhaps not surprisingly, programs such as PROMISE typically collect information within existing systems that are familiar to staff. Because implementation also varies across programs, PROMISE experienced challenges compiling comparable data across programs. As such, PROMISE lacked comparable data across programs. Unlike for PROMISE, SSA required implementers of BOND, POD, and YTD to build an information system to capture key program data. In doing so, SSA positioned itself to capture consistent program data, ensure data quality monitoring, and respond to data quality issues with staff training. SSA must consider the tradeoffs of each approach in future demonstrations.

### *Lessons about What Helps or Hinders Service Delivery and Participation*

Many demonstrations are implemented locally. Successful implementation of local demonstrations requires an understanding of the local service delivery ecosystem. Implementers of these demonstrations must be willing to collaborate with local partners to ensure placement of demonstrations within that ecosystem. As the authors point out, local resources include service providers with an understanding of the cultural context within which service provision occurs. These service providers typically understand nuances of service engagement that program participants have with institutions across their local community. As such, local providers are often poised to incorporate their understanding of the local cultural context in ways that might otherwise impede the ability of demonstration implementers to effectively recruit and enroll participants as well as deliver services sensitive to this context.

Lessons learned from SED highlight the value of local services in addressing the needs of beneficiaries in their local environments. In that demonstration, the implementers required access to local resources to ensure appropriate variation in service delivery. This included working with local legal aid groups to remove criminal

records that served as a barrier to program participation. SED implementers also worked to ensure that sites had access to affordable health, vision, and dental care.

Additional lessons learned from PROMISE and YTD showed an intentionality of service delivery within local cultural contexts. Specifically, these programs hired diverse staff or bilingual parents to address language barriers as well as to engage beneficiaries in their preferred language. ASPIRE gave particular attention to the cultural context of service delivery among American Indians. The Tribal Councils and numerous Tribes informed the cultural context of service delivery and ensured the cultural competence of program staff.

SSA has sufficient information from its process evaluations that highlight the importance of local resources and local cultural context in implementing its demonstrations. To ensure that all organizations implementing demonstrations are equipped to draw on their local resources and understand local cultural context, SSA might consider including in its solicitation for demonstrations a requirement to have partners that understand and have a successful track record navigating local service delivery ecosystems. The solicitation should require a declaration of how local cultural context will be addressed by demonstration implementers. Further, demonstration implementers should be required to provide examples of similar efforts implemented during prior demonstrations.

## IN CLOSING

The authors present lessons learned from SSA demonstrations with a focus on recruiting and enrolling volunteers and implementing an intervention. Both components are necessary for the successful implementation of a demonstration. Effective recruitment and enrollment of demonstration targets require an offer of services that is easy to understand. Offering desirable services that also tap into unmet needs among targets of a demonstration might also increase enrollment. And demonstrations targeting denied applicants might result in higher enrollment, especially given the potential lack of appeal that an offer of service(s) may have among existing beneficiaries.

Focusing on a few of the lessons learned from implementing an intervention, implementing an intervention that affects the amount of the benefit requires additional consideration for calculating the new benefit rules promptly, consistently, and accurately. Otherwise, beneficiaries might not understand the new benefit rule and/or lose confidence in the new rule. Although designing a standalone system for new benefit calculations and hiring or assigning staff to replicate benefit processing procedures for a demonstration might be appealing, there are tradeoffs to consider mostly associated with costs and additional staff burden.

Somewhat related is the need to ensure the collection of comparable data across sites. Because demonstrations are about comparisons, the collection of comparable data across sites is important. Local systems for data collection often exist but lack design comparability to facilitate uniform data collection. These data comparability

issues present additional tradeoffs that will affect a demonstration's ability to make meaningful comparisons.

Finally, implementing an intervention requires an understanding of the local cultural context within which services will be delivered. The authors highlight relevant examples of how attention to local cultural context and intentionality with respect to staffing and partners for service delivery are important considerations for implementing interventions. To ensure that demonstrations are respectful to local cultural contexts, it is critical that local partners are engaged to inform the design and implementation of service delivery models.

Implementing a demonstration is challenging, but attending to these and other lessons in this chapter will improve the implementation of SSA's future demonstrations. For sure, other federal agencies will benefit from these implementation lessons, too.

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