Good afternoon my name is Michelle Wood and I'm from Abt Associates. My co-author for this chapter is Debra Goetz Engler from the Social Security Administration.

I just want to start by noting that our chapter and today's presentation do not reflect the opinions, or policy of the SSA. The presentation is based on our own analysis of the SSA's demonstrations.

So, what I'd like to do today is walk through the headlines from our summary of implementation lessons.

I'll start with some context, followed by lessons about recruiting and enrolling participants, and also implementing interventions.

Because impact analysis alone isn't enough to explain why a particular intervention does or does not have the effects that we observe. It is really important to study implementation.

The implementation analyses describe the processes and operations of the intervention, and they answer a variety of questions.

Things like, how did the intervention operate in practice?

Was it implemented as intended? What were the economic conditions in place at the time?

What services are typically available?

Policy makers can use answers to these questions to interpret impact findings and also to draw lessons about how to enhance future demonstration design.

For the chapter, we found it really helpful to group the demonstrations into categories based on the kinds of implementation lessons that we saw.

The first group are the earliest demonstrations that took place in the 1980s and 1990s these demonstrations highlighted the feasibility of recruiting and delivering services to the SSA population.

Next are the demonstrations that test alternative earnings rules for calculating SSDI benefits in the form of benefit offsets.

The third group are demonstrations that offered specialized services: things that are outside of SSA's normal operations, like case management,

health insurance and supported employment. And the last group are the early interventions, and they take place before receipt SSDI & SSI benefits.

So now we'll take a look at some lessons from recruiting and enrolling demonstration participants.

So when we look across demonstrations, we see that enrollment varies. And what this slide shows is, the proportion of eligible individuals who enrolled.

We think that a combination of factors explain differential enrollment: differences in the target population, the nature of the intervention and recruitment methods that each demonstration used. I'll just point out a couple of things on this chart.

At the top, you'll see Accelerated Benefits and for that demonstration of very high proportion.

98% of the eligible individuals volunteered.

Now, this is a very specific target population. These are new SSDI beneficiaries who do not have health insurance. And what they were offered is health insurance during the 24 month Medicare waiting period.

The recruitment process involved, a good deal of eligibility screening, and once the researchers narrowed it down to this very specific target group, a very high proportion volunteered and they've volunteered to receive an intervention that's very concrete.

And also likely very valuable to them.

The youth demonstrations--and you see those on the chart they're labeled as PROMISE and YTD for youth transition--also have higher enrollment than other demonstrations.

And we think that youth might be really motivated to pursue employment and also get encouragement from their families.

Outreach to broader cross sections of the SSDI & SSI populations--And you see those on the chart as Project NetWork, BOND and POD have attained lower enrollment.

Between 2.4% and 5.5% of eligibles enrolled, and we think that these interventions offered in these cases might seem more abstract to potential volunteers. In the case of BOND and POD,

People are offered a financial incentive that might potentially increase total income when earnings increase.

It might seem less certain to beneficiaries, and also potentially less valuable than other services.

In the chapter, we compare recruitment methods. I'll just highlight a couple of things here.

First, we found differences in the use of in person processes in recruitment, the mental health treatment study and said, required in person components to recruitment because of the intervention.

The BOND program, and the PROMISE programs also used in-person meetings as part of recruitment.

But Accelerated Benefits, Youth Transition and POD did all of the recruitment by mail or phone.

Second, we also found, particularly as we reviewed the PROMISE program implementation studies, that there seemed to be advantages to assigning dedicated staff to conduct recruitment, rather than having the same staff do recruitment and service delivery.

In the chapter, we summarize a lot of demonstration findings that compare volunteers to non-volunteers.

One key example is the volunteers in the offset demonstrations, are more work oriented than non-volunteers.

Four of the demonstrations: Project NetWork, The New York Work State Partnership Initiative, the Mental Health Treatment Study, and the Supported Employment Demonstration, conducted additional analysis of recruitment to examine the characteristics that predict enrollment.

And one example is the New York WORKS SPI project.

The researchers for that project broke out the enrollment process into 4 stages.

And they examined outcomes of enrollment at each of those stages.

And what they found was that younger SSI recipients were more likely to decline to participate, because they did not respond to the initial stage to the very first outreach letter.

They also found that SSI recipients with anxiety disorders who expressed an initial interest in the project were more likely to drop out at the enrollment stage than were SSI recipients who have other types of psychiatric disorders.

So we think that this type of assessment of participation, particularly if it examines a wide range of characteristics, like education, race, and ethnicity, could be very helpful to explore possible disparities in enrollment and to understand whether some steps in the enrollment process are less accessible than others for particular groups.

So now we'll turn and look at some lessons about delivering services and other types of interventions.

First, we found the interventions that changed the earnings rules that determine SSDI benefit calculations in the form of the benefit offset, pose some unique implementation challenges.

One challenge is in making timely adjustments to benefits.

Beneficiaries earnings reporting and operational backlogs can make it difficult to make timely benefit adjustments and that in turn might diminish the behavioral response to the benefit offset.

Another area of challenge is the complexity of both current law earnings rules and the benefit offset rules.

Both the BOND and POD demonstrations found low understanding of current earnings rules in the control groups as well as low understanding of the benefit offset rules in the treatment groups.

Now I'll turn to some lessons about offering specialized services that are outside of SSA's normal operations.

One approach that SSA has tried is to deliver highly structured evidence based services.

Like, the Individual Placement and Support intervention. This was analyzed in the Mental Health Treatment Study, and is in the field right now with the Supported Employment Demonstration.

The Mental Health Treatment Study was the first time that IPS was tested with SSDI beneficiaries on a large scale across the U. S. in community based mental health centers.

The study showed that it is possible to deliver IPS with high fidelity in these settings and to these participants, and the key to doing so was careful site selection and rigorous monitoring.

But an area where we think additional research could be useful is about whether it's possible to alter any of the requirements of IPS and still achieve participant outcomes.

In the Mental Health Treatment Study, the site level fidelity wasn't associated with participant outcomes as had been shown in other studies.

It might be because there wasn't enough variation, in site-level fidelity to detect any effects.

But we think that research that intentionally tests, whether less stringent application of IPS could produce outcomes might also be useful, especially as IPS is expanded to other areas.

So in contrast to the highly structured evidence based services, SSA has also used demonstrations to build evidence about new approaches, requiring core program requirements, but offering local flexibility to customize design and implementation.

The two main examples of this are the youth demonstrations. YTD and PROMISE, but RETAIN also uses this approach.

So, on the one hand, this kind of local discretion promotes innovation and flexibility.

For example, the arrangement allows programs to take advantage of local strengths--services that are already in place and existing relationships, which can make it possible to get services and in place more quickly.

The arrangement can also offer flexibility to tailor services.

We noted that in several of the PROMISE programs, the programs were able to hire additional staff or modify a component of service or a mode of service delivery in order to respond to unanticipated developments or to increase take-up.

However, on the other hand, this flexibility can also make it complicated to compare results across programs or to pinpoint what exactly achieves the results.

So, this type of arrangement puts a real premium on conducting a rigorous process analysis that documents the variation across sites and collects uniform data.

In the chapter, we discuss factors that hinder and enhance service delivery. Something that we read over and over again in the implementation analyses was that service providers frequently found the participants faced crises, or had basic needs.

For example, they might have faced housing crises or needed basic services like food, transportation or healthcare and that these crises and service needs made it difficult for participants to engage with the demonstration services.

A couple of things--The programs also found some tension between meeting the requirement of the... the requirement of the intervention and meeting these needs for basic services.

A couple of things could really seem worth considering.

First: building in flexibility for service providers can help.

And it also helps when addressing these kinds of basic needs are included in the design of the intervention, as is the case in the Supported Employment Demonstration and Mental Health Treatment Study.

Other factors that enhance service delivery had to do with communication and leadership.

These two things really stood out in demonstrations that evaluated 3rd party assistance to help people experiencing homelessness to navigate the SSI application process.

Investment from organization leaders and a really structured contact and communication process among the third-party organization, the SSA field office,

and the disability determination service seem to have been essential to the success of these demonstrations.

Clear roles and expectations among all of the partners also helped.

The demonstrations found that assisting underserved populations increased approval rates at the initial level and reduced the time for benefit award.

We think this lesson is especially relevant today as SSA responds to the decrease in applications, resulting from the COVID-19 pandemic, and the need to reach underserved populations.

We think SSA can build off lessons from the SSI Outreach Demonstration, HOPE, HSPD, and the SOAR projects in these efforts.

So finally to summarize: taken together, we think that there are a lot of successes in implementation. The SSA has had success recruiting different groups, delivering services using a variety of arrangements,

and in some cases, partnering with state and other federal agencies.

There have also been some challenges, particularly related to the earnings reporting and benefit adjustment operations that are needed for benefit offset demonstrations.

Overall, our review of the demonstrations implementation studies shows a lot of success in conducting credible tests of a wide range of interventions.

We think that any absence of intervention effects does not appear to stem from implementation challenges.

And finally, we think the implementation analyses are a crucial part of these projects.

I haven't had time to go through all of them here today, but our chapter contains many other examples of lessons that we think can be applied to future demonstrations and to policy.

A couple that we've highlighted are about analyzing factors that project enrollment at different stages, and taking account of the basic needs of participants in intervention design stage.

Thank you very much.