Executive Summary

Working toward Wellness

Telephone Care Management for Medicaid Recipients with Depression, Thirty-Six Months After Random Assignment

OPRE Report 2011-21

December 2011

Office of Planning, Research and Evaluation (OPRE)
Administration for Children and Families
U.S. Department of Health and Human Services

Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services

Working toward Wellness: Telephone Care Management for Medicaid Recipients with Depression, Thirty-Six Months After Random Assignment

OPRE Report 2011-21

December 2011

Authors: Sue Kim, Allen LeBlanc, Pamela Morris, Greg Simon, and Johanna Walter

Submitted to: Girley Wright, Project Officer
Office of Planning, Research and Evaluation
Administration for Children and Families

Kristen Joyce and Amy Madigan, Project Officers
Assistant Secretary for Planning and Evaluation

U.S. Department of Health and Human Services

Project Director: David Butler
MDRC
16 East 34th Street
New York, NY 10016

Contract Number: HHS-233-01-0012.

Suggested citation: Kim, Sue, Allen LeBlanc, Pamela Morris, Greg Simon, and Johanna Walter. (2011). *Working toward Wellness: Telephone Care Management for Medicaid Recipients with Depression, Thirty-Six Months After Random Assignment.*

OPRE Report 2011-21. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

This report and other reports sponsored by the Office of Planning, Research and Evaluation are available at http://acf.gov.programs/opre/index.html.

MDRC is conducting the Enhanced Services for the Hard-to-Employ Demonstration and Evaluation Project under a contract with the Administration for Children and Families (ACF) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (HHS), funded by HHS under a competitive award, Contract No. HHS-233-01-0012. The project officers are Girley Wright (ACF) and Kristen Joyce and Amy Madigan (ASPE). Additional funding has been provided by the U.S. Department of Labor (DOL). Group Health Cooperative, our partner organization, assisted with site development, implementation research, and cost analysis. HumRRO, a subcontractor, fielded the 36-month client survey and child survey.

The findings and conclusions in this report do not necessarily represent the official positions or policies of HHS.

Dissemination of MDRC publications is supported by the following funders that help finance MDRC's public policy outreach and expanding efforts to communicate the results and implications of our work to policymakers, practitioners, and others: The Ambrose Monell Foundation, The Annie E. Casey Foundation, Carnegie Corporation of New York, The Kresge Foundation, Sandler Foundation, and The Starr Foundation.

In addition, earnings from the MDRC Endowment help sustain our dissemination efforts. Contributors to the MDRC Endowment include Alcoa Foundation, The Ambrose Monell Foundation, Anheuser-Busch Foundation, Bristol-Myers Squibb Foundation, Charles Stewart Mott Foundation, Ford Foundation, The George Gund Foundation, The Grable Foundation, The Lizabeth and Frank Newman Charitable Foundation, The New York Times Company Foundation, Jan Nicholson, Paul H. O'Neill Charitable Foundation, John S. Reed, Sandler Foundation, and The Stupski Family Fund, as well as other individual contributors.

For information about MDRC and copies of our publications, see our Web site: www.mdrc.org.

Overview

Although many public assistance recipients suffer from depression, few receive consistent treatment. This report presents 36-month results from a random assignment evaluation of a one-year program that provided telephonic care management to encourage depressed parents, who were Medicaid recipients in Rhode Island, to seek treatment from mental health professionals. Called "Working toward Wellness" (WtW), the program represents one of four strategies being studied in the Enhanced Services for the Hard-to-Employ Demonstration and Evaluation Project to improve employment for low-income parents who face serious barriers to employment. The project is sponsored by the Administration for Children and Families and the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services, with additional funding from the Department of Labor.

This report focuses on assessing the success of the program's efforts to improve depression symptoms and work-related outcomes, two years after the end of the intervention. In WtW, master's-level clinicians ("care managers") telephoned the study participants in the program group to encourage them to seek treatment, to make sure that they were complying with treatment, and to provide telephonic counseling. The effects of the program are being studied by examining 499 depressed Medicaid recipients with children; these parents were randomly assigned to either the program group or the control group from November 2004 to October 2006.

Key Findings

- WtW care managers used the telephone effectively to initiate engagement with people with depression to consider treatment. They contacted 91 percent of those assigned to the program group, and they averaged about nine contacts per client over the yearlong intervention.

- WtW increased the use of mental health services while the intervention was running, but it did not help individuals sustain treatment after the intervention ended. Although the program group members were more likely to receive mental health treatment and to fill prescription medications for depression in the early phase of WtW, this effect disappeared after the one-year intervention ended.

- Authorization procedures limited the capacity of WtW care managers to function as liaisons between clients and clinicians; care managers could not provide direct feedback to clinicians regarding WtW clients as they progressed in treatment. Such a collaborative approach was difficult to orchestrate in the case of WtW because the care managers worked for UBH while the community clinicians worked in a variety of settings outside UBH.

- WtW did not have an effect on depression or employment outcomes at 36 months after the end of the intervention. At that point, despite some modest impacts on depression for subgroups in earlier follow-up periods, the overall distributions of depression levels between the program and the control groups are not significantly different. Since the 36-month impact on depression was minimal, it is not surprising that there were no differences in employment outcomes for the two groups.

Acknowledgments

The evaluation of the Working toward Wellness project in Rhode Island would not have been possible without the cooperation and hard work of many individuals from United Behavioral Health (UBH) and Group Health Cooperative (GHC). Funding from the U.S. Department of Health and Human Services — specifically, the Administration for Children and Families and the Office of the Assistant Secretary for Planning and Evaluation — with additional funding from the Department of Labor made the evaluation of this project possible.

We are grateful to Dr. Greg Simon at GHC for sharing his expertise and for providing guidance about depression treatment. We are thankful to Dr. Evette Ludman at GHC for her support and for providing valuable insight about the program. Also to thank at GHC are James Savarino and Chester Pabiniak, computer programmers who were responsible for the development of the management information system used to support the intervention program. We also acknowledge Belinda Operskalski for her help on this project.

At UBH, Dr. Francisca Azocar took the lead to ensure program operations at UBH, and we thank her and the care managers Maria Sekac, Thalia Genes, Susan Epstein, Curtis Wilkins, Kathleen Sweet, and Stephanie Ridgeway, who worked closely with program participants. We are thankful to Robert Branstrom for providing the data, to Gregory Greenwood for preliminary analytics, and to Patrice Cooper from AmeriChoice for helping connect us with the State of Rhode Island's Rite Aid account.

We are also grateful to Dr. Phil Wang and Dr. Ron Kessler for first suggesting that we use the Harvard study as a model for this evaluation.

At MDRC, we thank David Butler for serving as the project director for the evaluation. We are grateful to Charles Michalopoulos and Ginger Knox for reviewing early drafts of the report and providing valuable comments and guidance on how best to interpret the findings. We also thank Lauren Cates for being part of the Hard-to-Employ Demonstration and Evaluation team. Special thanks go to Christopher Leake and Johanna Walter for processing and analyzing the claims and survey data and to Julianna Alson for coordinating the report.

The Authors

Executive Summary

Although low-income individuals are disproportionately likely to suffer from depression, few receive treatment, and even fewer persist with their treatment. Randomized controlled trials have demonstrated that telephone care management interventions can successfully encourage primary care patients and employed workers to talk with mental health specialists, increase their use of antidepressants, reduce their depression, and even improve their work performance and job retention.[1]

This report presents the 36-month results from a program called "Working toward Wellness" (WtW) that provided telephone care management to a low-income population — depressed parents receiving Medicaid in Rhode Island — to encourage them to seek treatment from a mental health professional. The project was conducted as one of four studies in the Enhanced Services for the Hard-to-Employ Demonstration and Evaluation Project, which was sponsored by the Administration for Children and Families and the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services (HHS), with additional funding from the Department of Labor. WtW is being evaluated by MDRC in partnership with United Behavioral Health (UBH) and Group Health Cooperative (GHC). UBH delivered the care management services, and GHC designed the intervention and provided technical assistance and training to UBH staff.

This report presents the following key findings:

- WtW care managers used the telephone effectively to initiate engagement with people with depression to consider treatment.
- WtW increased the use of mental health services while the intervention was running, but it did not help individuals sustain treatment after the intervention ended.
- Authorization procedures limited the capacity of WtW care managers to function as liaisons between clients and clinicians; care managers could not provide direct feedback to the clinicians regarding WtW clients as they progressed in treatment.
- WtW did not have an effect on depression or employment outcomes at 36 months after the end of the intervention.

[1]Katzelnick et al. (2000); Wang et al. (2004); Simon et al. (2004).

Background on the WtW Program

Although there is considerable evidence that individuals with depression benefit from psychotherapy and medications, only about one-fifth of depressed individuals currently are in treatment.[2] In low-income communities, there may be less knowledge about depression treatment and lower quality of care than in higher-income communities, and individuals are more likely to be depressed but less likely to receive treatment.

One promising way to help people receive effective depression treatment is through care management. In WtW, master's-level clinicians — "care managers" — call individuals who were suffering from depression to encourage them to seek treatment, help them find and make appointments with mental health professionals, make sure that they were keeping appointments and taking prescribed medications, educate them about how depression would affect them and how treatment can help them, and provide support and counseling by telephone to individuals who were reluctant to seek treatment in the community. It was hypothesized that encouraging people to seek treatment and alleviate their depression would help more of them return to work or become more productive at jobs they already held.

Although telephone care management has helped reduce depression among populations of relatively high socioeconomic status, its effects for low-income populations were unknown. It was unclear whether telephone care management would be effective in providing Medicaid patients with depression the education, support, and motivation that they need to enter and engage with treatment over time. The evaluation of WtW begins to fill this gap by reporting the results of a randomized controlled trial of a telephone care management intervention for Medicaid recipients who have children.

The WtW Evaluation

To study WtW, individuals who had children and who were receiving Medicaid in Rhode Island and were eligible for mental health services through United Behavioral Health were screened by telephone for depression. Those who were found to have depressive symptoms as defined by a clinical assessment using the Quick Inventory of Depressive Symptomatology-Self Report (QIDS-SR) questionnaire and who agreed to participate were assigned to the study. Individuals scoring 6 or higher on the QIDS-SR questionnaire — which is defined as a mild or higher level of depression — were included in the study. The evaluation used a random assignment design, meaning that each study participant was randomly assigned to either a program group, which received the intervention's mental health services, or a control group, which did not. Participants in the program group were eligible to receive telephone care management from master's-level clinicians employed by UBH. The control group received usual care that includ-

[2]Kessler et al. (2003).

ed referrals to mental health treatment providers in the community. Random assignment ensures that, on average, all characteristics are similar for the two groups at baseline so that any substantial differences that later emerge can be attributed to the program with confidence.

Of the 499 individuals in the study, 245 were randomly assigned to the program group, and 254 were assigned to the control group. The study includes participants who were more severely depressed than those in studies that have focused on employed populations.[3] The average age of the participants at baseline was 35, and 90 percent are women. About half of them had a General Educational Development (GED) certificate or a high school diploma when they entered the study, and a quarter had some education beyond high school. A little less than half the participants are white; approximately 33 percent are Hispanic; and 12 percent are African-American. Less than half the participants (44 percent) were employed at the time of random assignment.

The random assignment of study participants occurred from November 17, 2004, to October 20, 2006. This report presents results through 36 months following random assignment, or from November 2007 (for the first clients assigned) to October 2009 (for the last clients assigned). The two main purposes of the study are to determine (1) whether a telephone care management model that is focused on low-income parents can successfully help participants get treatment and, if so, (2) whether the model is effective at alleviating depression and increasing employment and earnings.

Key Findings on Program Implementation

As stated in the 18-month report, the first question addressed by the study is whether care managers were able to engage members of the program group and what challenges they faced in helping individuals seek treatment. Key findings on the implementation of the program are presented below.

- **Care managers effectively contacted people with depression via telephone, but it was difficult to maintain engagement with them.**

Care managers successfully contacted 91 percent of those assigned to the program group, and they averaged about nine contacts (8.8 contacts) per client over the yearlong intervention. This took considerable effort. The contact-to-attempt ratio is about 30 percent — meaning that the care managers made about 3.5 attempts for each contact. Making contacts also required time. After the initial contact, which typically occurred within just a few days after random assignment, the median period that elapsed between contacts was about three weeks through the fifth contact and from three to four weeks through the ninth contact.

[3] Wang et al. (2007).

- **The "phone program" was a useful alternative for clients but typically did not lead to in-person treatment.**

The "phone program" became a useful tool for engaging those who were not yet willing or able to begin in-person treatment. The phone program was a structured psychoeducational program based on a workbook that clients worked through under a care manager's telephone guidance. The workbook was designed to help people who are experiencing stress and depression to better recognize and manage their symptoms. With clients in the phone program, the care managers continued to encourage in-person care for those who remained depressed, although, for many who used it, the phone program became an end in itself. According to the case note data, it does not appear that the phone program typically led to in-person treatment.

- **The care managers were rarely able to function as liaisons between clients and clinicians in the community.**

It was originally expected that the care managers would provide feedback to clinicians in the community regarding WtW clients as they progressed in treatment. Such a collaborative approach — whereby care managers and clinicians work together — was difficult to orchestrate in the case of WtW because the care managers worked for UBH while the community clinicians worked in a variety of settings outside UBH. The community clinicians were contracting to offer care not only with UBH but also with a number of other health care organizations. To be sensitive to participants' concerns about contact between the care managers and the clinicians, the care managers were required to obtain written permission from both the participants and the providers before performing the liaison function. Unfortunately, it was very difficult for the care managers to obtain this written permission from either party, and consequently the care managers could not perform this role. As a result, care managers could only advise or guide the participants on ways to better navigate health care and how to advocate for themselves.

Key Findings on Program Impacts

This report presents results through the 36 months following random assignment, using information from Medicaid claims data and a survey conducted with about 86 percent of study participants. Depression and employment outcomes were assessed at the time of the 36-month follow-up survey. UBH provided claims data on the use of behavioral and physical health care services and prescription drugs. These data cover only through 24 months following random assignment because medical claims data were incomplete beyond that point. The focus of the study has been to assess whether WtW improved depression symptoms and work-related outcomes after the end of the intervention.

The key impact findings are presented below.

- **More program group members than control group members received treatment for depression, but that effect did not last past the one-year intervention period.**

In the early phase of the intervention, program group members were more likely than control group members to receive mental health treatment and to fill prescription medication for depression. As shown in Figure ES.1, higher percentages of the program group received mental health services on a monthly basis in the first six months of the intervention. Program group members were more likely than control group members to see a psychiatrist, primary care physician, or psychologist about a mental health issue. This impact on the use of mental health services is slightly higher than was found in a study of a similar intervention serving a non-Medicaid population.[4] The line graph also shows that the difference between the program and the control groups started to decline after about Month 7 of the intervention and that there were no differences by the end of the intervention and beyond Month 12. This graph supports the finding that WtW had a positive impact on the use of mental health services during the one-year intervention but not after the end of the intervention.

Similarly, Figure ES.2 shows the percentages of program and control group members who filled prescriptions for psychotherapeutic drugs, by month. Except for at Month 3, there was no significant difference in filling prescriptions for psychotherapeutic drugs overall, although program group members were more likely than control group members to fill prescriptions for psychotherapeutic drugs other than antidepressants during the 24-month follow-up period. Often, other psychotherapeutic drugs, such as antianxiety medications, are prescribed along with antidepressants for people suffering from depression.

- **Although earlier results suggested that there may have been some modest impacts on depression, the program did not significantly reduce depression at 36 months.**

At the 6-month follow-up point, no overall difference in depression levels was observed between the program group and the control group. For a subgroup of Hispanic sample members, there was an effect on treatment, and the program group had reduced depression severity at 6 months, but this subgroup effect was no longer detectable at 18 months or 36 months following random assignment. Although no significant effect on average depression severity was found for the full sample, there was a significant change in the distribution of depression severity at the 18-month follow-up. Specifically, there was a reduction in the number of people who suffered from very severe depression at 6 months and at 18 months, although that effect did not persist through 36 months.

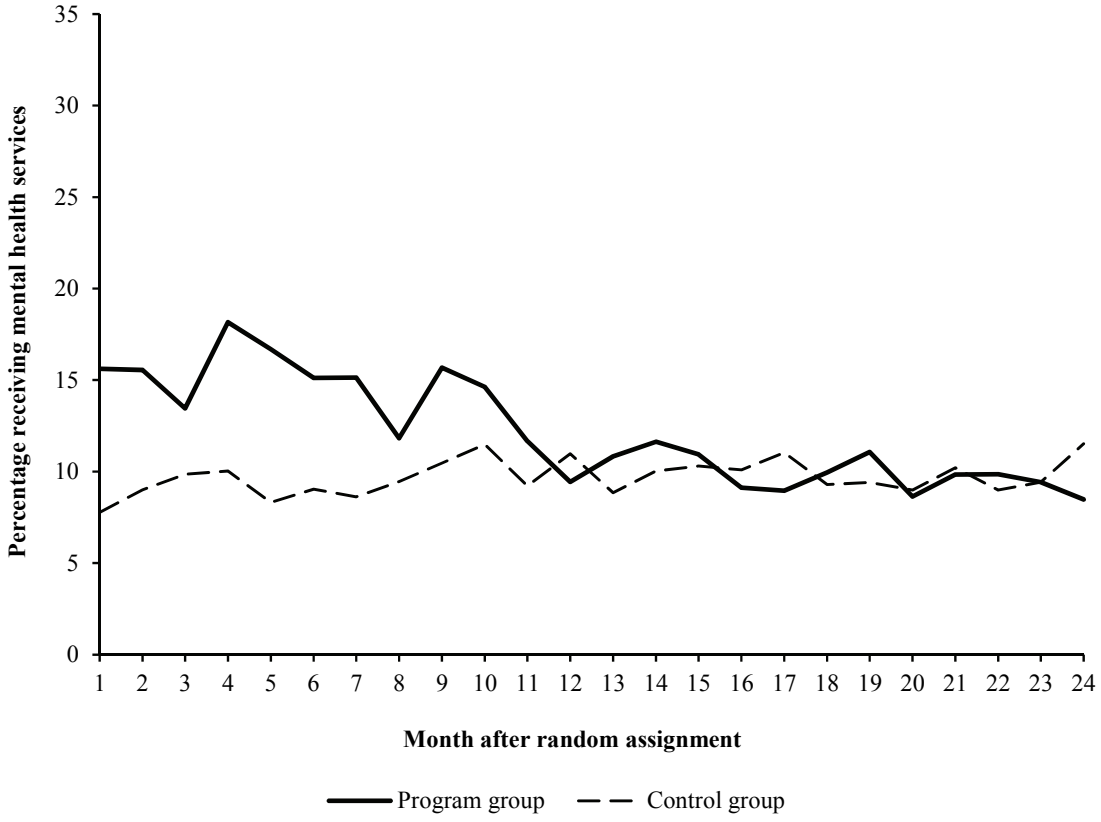
[4]Wang et al. (2007).

The Enhanced Services for the Hard-to-Employ Demonstration

Figure ES.1

Percentage Receiving Mental Health Services, by Month

Rhode Island: Working toward Wellness



SOURCE: Measures of health service utilization are based on MDRC calculations using United Behavioral Health medical claims data.

- **There was no difference in employment between the program and the control groups.**

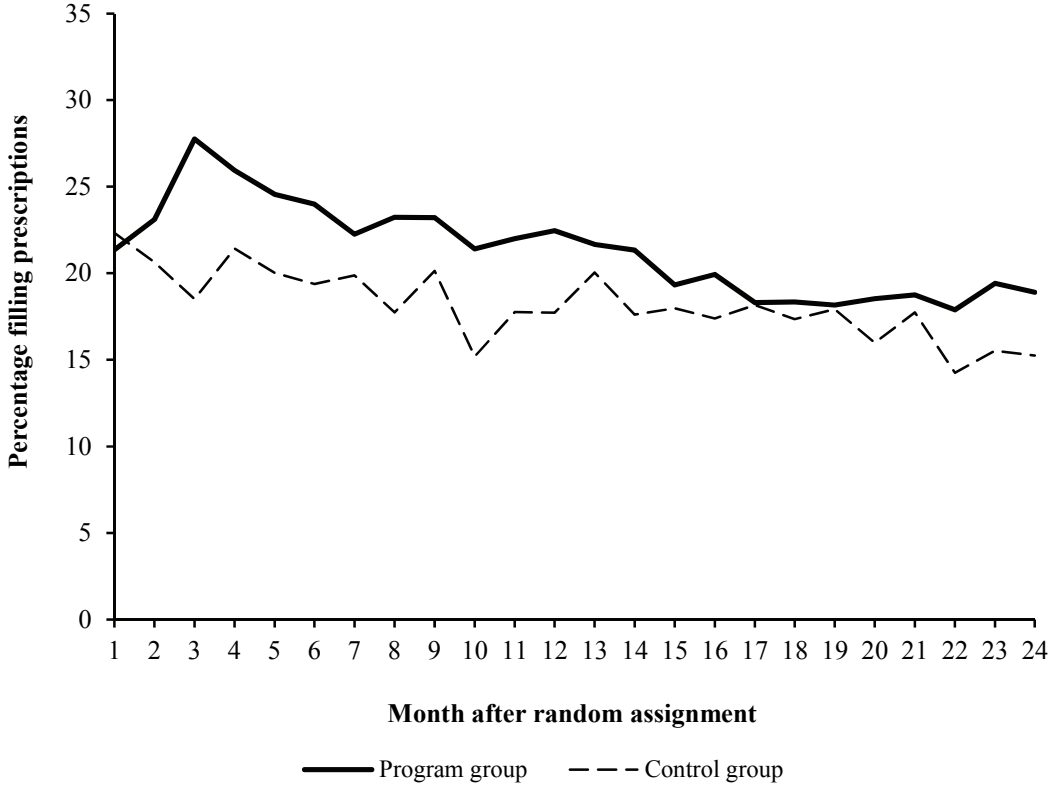
There were no differences in the number of days of missed work or in hourly wages between the two research groups. Since the 36-month impact on depression was minimal, it is not surprising that there were no differences in employment outcomes for the two groups.

The Enhanced Services for the Hard-to-Employ Demonstration

Figure ES.2

Percentage Filling Prescriptions for Psychotherapeutic Drugs, by Month

Rhode Island: Working toward Wellness



SOURCE: Measures of health service utilization are based on MDRC calculations using United Behavioral Health prescription claims data.

NOTES: Percentages shown are adjusted for pre-random assignment characteristics.

- **WtW had few effects on parenting and outcomes for children.**

Besides examining the effects of WtW on adults' depression, this study also examines how the program affected participants' children. The "child add-on study" allowed the research team to collect in-depth information on older children of study participants — children at the transition to early and late adolescence — for whom the effects of parents' depression might be particularly salient. Research has found that maternal depression contributes to difficult adjust-

ment during adolescence in low-income families,[5] as well as to depression among the adolescents themselves, particularly among girls after puberty.[6] Based on parental reports of their children and on youth reports of their own mental health, social skills, and self-esteem, effects of the WtW program are extremely rare. While a few significant differences were found between the program and control groups on the youths' use of medical services, there is no consistent pattern of benefits for children as a result of their parents' assignment to the WtW program.

Implications of the Findings

The WtW study found that care managers were able to engage the participants by telephone and encourage them to seek in-person treatment for depression. Nearly everyone in the program group was successfully contacted at least once, but it was difficult to maintain engagement with them. The WtW intervention had a modest impact on the use of mental health treatment services overall. The high rate of successful telephone contacts in the early phase of the intervention suggests that care managers were able to engage the participants and had at least begun building telephone relationships with them. However, the challenge appears to be in encouraging individuals beyond initial engagement and sustaining them in treatment.

The results from this study provide some important lessons to consider before implementing telephone care management of depression for the Medicaid population. One factor contributing to the lack of impact on depression may be that the study sample was already a highly served population. It turned out that many participants had received depression treatment prior to enrolling in the WtW intervention. This may be a function of the way in which the original sample was selected. Medicaid recipients received letters asking them to complete a depression screener and mail it back. Very depressed, untreated people may have been less likely to return the letter to begin with. In fact, only about 10 percent of people who were mailed this letter ever returned the depression screener. It is possible that individuals who had been treated for depression in the past were more likely to respond to the recruitment letter and to agree to participate in the study. About 73 percent of the participants reported ever having received treatment for depression, and 40 percent of them had the treatment in the prior year. The program may not have succeeded in reaching people who were less inclined to get treatment (but who might have benefited more from it) because the outreach to recruit participants was conducted only by mail. Recruitment methods such as in-person screenings at social service agencies might have discovered more individuals with untreated depression and might have resulted in a more representative sample. This is a speculation, however, and there are no data to directly assess these assumptions.

[5]McLoyd, Jayaratne, Ceballo, and Borquez (1994).

[6]For a review, see Beardslee et al. (1998); also see Angold, Costello, and Worthman (1998).

On the other hand, given that WtW participants experienced life stressors that often prevented them from receiving continuous treatment, recruiting individuals without prior depression treatment might have resulted in a group who had even greater barriers to treatment. The relatively modest effect on the use of mental health services may be highlighting the multiple challenges to treatment and the competing demands faced by low-income parents. According to extensive case notes compiled by the care managers,[7] study participants faced many stressors that may have limited or overwhelmed their efforts to seek or maintain in-person care. Moreover, a portion of the participants appear to have had personal crises that caused them to lose all contact with their care managers for extended periods of time.

Another way to strengthen the program might be to have care managers devote additional resources to helping individuals overcome the barriers to receiving depression treatment. Perhaps earlier and greater reliance on telephone counseling (rather than just care management) might also have produced larger effects on depression symptoms, because it would have provided a form of treatment that did not require individuals to leave their homes. Future interventions should also consider a system whereby care managers are able to directly coordinate the patients' care with the health care providers. Past studies within the Group Health Cooperative system have found larger effects and have shown benefits for depressed patients participating in telephone care management — although primarily within a non-Medicaid population.[8] In these studies, care managers were able to work within a single health care system with the mental health providers and could directly communicate with them to coordinate care. Because such a collaborative approach was not possible for WtW, care managers could only advise or guide the participants on ways to better navigate health care and how to advocate for themselves.

Finally, although there is evidence that telephone care management is a relatively inexpensive means of reducing depression for more affluent populations, existing telephone care management models may not be intensive or comprehensive enough for low-income populations — in particular, Medicaid participants with children. For future interventions, it would be important to consider whether Medicaid and other low-income populations require more intensive interventions that extend beyond telephone care management, possibly including in-person components that address critical barriers to in-person treatment. If researchers can identify groups that are less likely to receive treatment, that might suggest approaches that could be used to encourage treatment.

[7]Kim et al. (2010).

[8]Simon, Ludman, and Rutter (2009); Simon et al. (2004).

References for the Executive Summary

Angold, Adrian, E. Jane Costello, and Carol Worthman. 1998. "Puberty and Depression: The Roles of Age, Pubertal Status, and Pubertal Timing." *Psychological Medicine* 28: 51-61.

Beardslee, William Rigby, Eve M. Versage, and Tracy R. G. Gladstone. 1998. "Children of Affectively Ill Parents: A Review of the Past 10 Years." *Journal of the American Academy of Child and Adolescent Psychiatry* 37: 1134-1141.

Katzelnick, David J., Gregory E. Simon, Steven D. Pearson, Willard G. Manning, Cindy P. Helstad, Henry J. Henk, Stanley M. Cole, Elizabeth H. B. Lin, Leslie H. Taylor, and Kenneth A. Kobak. 2000. "Randomized Trial of a Depression Management Program in High Utilizers of Medical Care." *Archives of Family Medicine* 9, 4: 345-351.

Kessler, Ronald C., Patricia Berglund, Olga Demler, Robert Jin, Doreen Koretz, Kathleen R. Merikangas, A. John Rush, Ellen E. Walters, and Philip S. Wang. 2003. "The Epidemiology of Major Depressive Disorder: Results from the National Comorbidity Survey Replication (NCS-R)." *Journal of the American Medical Association* 289, 23: 3095-3105.

Kim, Sue E, Allen J LeBlanc, Pamela Morris, Greg. E. Simon, and Johanna Walter. 2010. *Working toward Wellness Telephone Care Management for Medicaid Recipients with Depression, Eighteen Months After Random Assignment*. New York: MDRC.

McLoyd, Vonnie C., Toby Epstein Jayaratne, Rosario Ceballo, and Julio Borquez. 1994. "Unemployment and Work Interruption Among African-American Single Mothers: Effects on Parenting and Adolescent Socioemotional Functioning." *Child Development* 65: 562-589.

Simon, Gregory E., Evette J. Ludman, and Carolyn M. Rutter. 2009. "Incremental Benefit and Cost of Telephone Care Management and Telephone Psychotherapy for Depression in Primary Care." *Archives of General Psychiatry* 66, 10: 1081-1089.

Simon, Gregory E., Evette J. Ludman, Steve Tutty, Belinda Operskalski, and Michael Von Korff. 2004. "Telephone Psychotherapy and Telephone Care Management for Primary Care Patients Starting Antidepressant Treatment: A Randomized Controlled Trial." *Journal of the American Medical Association* 292, 8: 935-942.

Wang, Philip S., Arne L. Beck, Pat Berglund, David K. McKenas, Nicolaas P. Pronk, Gregory E. Simon, and Ronald C. Kessler. 2004. "Effects of Major Depression on Moment-in-Time Work Performance." *American Journal of Psychiatry* 161, 10: 1885-1891.

Wang, Philip S., Gregory E. Simon, Jerry Avorn, Francisca Azocar, Evette J. Ludman, Joyce McCulloch, Maria Z. Petukhova, and Ronald C. Kessler. 2007. "Telephone Screening, Outreach, and Care Management for Depressed Workers and Impact on Clinical and Work Productivity Outcomes: A Randomized Controlled Trial." *Journal of the American Medical Association* 298, 12: 1401-1411.

About MDRC

MDRC is a nonprofit, nonpartisan social and education policy research organization dedicated to learning what works to improve the well-being of low-income people. Through its research and the active communication of its findings, MDRC seeks to enhance the effectiveness of social and education policies and programs.

Founded in 1974 and located in New York City and Oakland, California, MDRC is best known for mounting rigorous, large-scale, real-world tests of new and existing policies and programs. Its projects are a mix of demonstrations (field tests of promising new program approaches) and evaluations of ongoing government and community initiatives. MDRC's staff bring an unusual combination of research and organizational experience to their work, providing expertise on the latest in qualitative and quantitative methods and on program design, development, implementation, and management. MDRC seeks to learn not just whether a program is effective but also how and why the program's effects occur. In addition, it tries to place each project's findings in the broader context of related research — in order to build knowledge about what works across the social and education policy fields. MDRC's findings, lessons, and best practices are proactively shared with a broad audience in the policy and practitioner community as well as with the general public and the media.

Over the years, MDRC has brought its unique approach to an ever-growing range of policy areas and target populations. Once known primarily for evaluations of state welfare-to-work programs, today MDRC is also studying public school reforms, employment programs for ex-offenders and people with disabilities, and programs to help low-income students succeed in college. MDRC's projects are organized into five areas:

- Promoting Family Well-Being and Children's Development
- Improving Public Education
- Raising Academic Achievement and Persistence in College
- Supporting Low-Wage Workers and Communities
- Overcoming Barriers to Employment

Working in almost every state, all of the nation's largest cities, and Canada and the United Kingdom, MDRC conducts its projects in partnership with national, state, and local governments, public school systems, community organizations, and numerous private philanthropies.