Demonstration to Maintain Independence and Employment (DMIE): Preliminary Findings from the National Evaluation

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National DMIE Evaluation Goals

- Address the primary question:
  - Can an early intervention program providing medical and employment assistance prevent or delay the loss of work and independence due to a physical or mental health condition before a person becomes disabled?

- Build on state evaluations in Kansas, Texas, Minnesota, and Hawaii

- Synthesize lessons learned from cross-state comparisons
Research Questions

- Who enrolled in the DMIE across the four states?
- What were the early impacts of the program on disability applications and employment outcomes?
- What lessons were learned from implementing the program?
Preview of Early Impacts

- No difference in the percentage employed or average hours worked 12 months after DMIE enrollment
- Lower percentage of participants applying for disability benefits 12 months after DMIE enrollment
DMIE Eligibility Criteria

- Working at the time of enrollment
- Age 18 to 64
- Not currently applying for or receiving disability benefits at the time of enrollment
DMIE Program Components

- Enhanced medical services
  - Wraparound coverage (dental, vision) beyond existing Medicaid coverage; expedited mental health visits

- Employment supports
  - Peer support; vocational rehabilitation services
DMIE Program Components (cont’d.)

- Intensive, person-centered case management
  - Wellness navigator; life coaching
- Subsidies
  - Coverage of deductibles and co-payments; premium subsidies
DMIE Target Populations by State

- **Kansas**
  - Working adults with physical and mental health conditions in state high-risk insurance pool

- **Minnesota**
  - Working adults with severe mental illness in public programs
DMIE Target Populations by State (cont’d.)

- Texas
  - Working adults with severe mental illness or behavioral health/physical conditions in safety-net program

- Hawaii
  - Privately insured working adults with diabetes
# DMIE Enrollment Total at Baseline (n=4,099)

<table>
<thead>
<tr>
<th>Location</th>
<th>Treatment</th>
<th>Control</th>
<th>Total Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kansas</td>
<td>225</td>
<td>275</td>
<td>500</td>
</tr>
<tr>
<td>Minnesota</td>
<td>1,493</td>
<td>300</td>
<td>1,793</td>
</tr>
<tr>
<td>Texas</td>
<td>904</td>
<td>712</td>
<td>1,616</td>
</tr>
<tr>
<td>Hawaii</td>
<td>128</td>
<td>62</td>
<td>190</td>
</tr>
</tbody>
</table>
Baseline Health Characteristics and Age at Enrollment, by State

<table>
<thead>
<tr>
<th></th>
<th>Mean Age at Enrollment</th>
<th>Mean Mental Health Score</th>
<th>Mean Physical Health Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kansas</td>
<td>50.7 years</td>
<td>50.3</td>
<td>44.8</td>
</tr>
<tr>
<td>Minnesota</td>
<td>38.5 years</td>
<td>35.1</td>
<td>48.1</td>
</tr>
<tr>
<td>Texas</td>
<td>47.0 years</td>
<td>49.6</td>
<td>37.9</td>
</tr>
<tr>
<td>Hawaii</td>
<td>48.4 years</td>
<td>47.4</td>
<td>45.8</td>
</tr>
</tbody>
</table>

Note: SF-12 health scores are norm-based, with 50.0 representing the national average. Lower scores indicate worse health.
## Baseline Employment Characteristics and Education, by State

<table>
<thead>
<tr>
<th>State</th>
<th>Percentage with Four-Year College Degree</th>
<th>Mean Earnings in 2008</th>
<th>Percentage Working Full-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kansas</td>
<td>44.4%</td>
<td>$33,874</td>
<td>49.0%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>18.8%</td>
<td>$17,391</td>
<td>31.9%</td>
</tr>
<tr>
<td>Texas</td>
<td>8.4%</td>
<td>$15,316</td>
<td>35.0%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>50.5%</td>
<td>$49,714</td>
<td>54.9%</td>
</tr>
</tbody>
</table>
Evaluation Design and Analysis

- Randomized design in all four states
  - Control group ("business as usual")
  - Treatment group (offered additional services)
- Intent to treat (ITT) analysis
- Regression-adjusted estimates
  - Accounts for participant age, withdrawals, enrollment year, and prior applications or baseline hours worked
Data Sources

- State-level survey and administrative data
  - Rounds 1 and 2
- SSA 831 file on disability applications
  - Data through fall 2009
- Ticket Research File, Master Earnings File
  - Data through 2008; data to analyze one-year impacts on payments and earnings will be available in fall 2010
- Site visit interviews; descriptive reports
Preliminary Results

- Impact on employment
  - Percentage employed
  - Monthly hours worked

- Impact on disability benefits
  - Percentage applying for SSA disability benefits

- Lessons learned about implementation
Percentage Employed in Texas and Minnesota, 12 Months After Enrollment

Note: p = .55
Average Hours Worked in Last Month in Texas and Minnesota, 12 Months After Enrollment

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours</td>
<td>118</td>
<td>119</td>
</tr>
</tbody>
</table>

Note: p = .76
Percentage Applying for Disability Benefits in Texas and Minnesota, 12 Months After Enrollment

Note: p = .05
Percentage Applying for Disability Benefits in Three States, 12 Months After Enrollment

Note: p = .12, .20, and .47, respectively
Lessons Learned

● DMIE can be implemented in diverse settings to serve various target populations
  - Flexibility for states to design/customize benefits
  - Program diversity strengthens evaluation

● Building DMIE around existing programs makes it easier to identify candidates from a “captive pool”
  - Obtain information to focus recruitment effort
  - Program services build on existing benefits, can be deployed more quickly with existing network
Lessons Learned (cont’d.)

● Participants value person-centered case management
  – Key component of program design in every state (system navigation, life coaching)
  – Helps participants address barriers to employment and obtain services

● Working adults must be recruited at the right point on the disability trajectory
  – Too early: services may not be needed
  – Too late: services may not help prevent disability
Summary

● Early findings on impacts
  – Evidence that early intervention programs can reduce disability applications
  – No short-term impact on employment

● Robust model for early intervention
  – Can be implemented with diverse populations; flexible enough for states to customize benefits

● Implementation findings
  – Provide initial foundation for “best practices” in early intervention
Final Thoughts

- The power of a good idea
- Evidence matters
- Leadership matters, too
Our Partners

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Becky Ozaki, Jean Isip Schneider, Tammy Tom, Denise Uehara (Hawaii)

Jean Hall, Jan Moore, Jenifer Telshaw, Mary Ellen Wright (Kansas)
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