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REPORT

Promoting Readiness of Minors in Supplemental Security Income (PROMISE): Maryland PROMISE Process Analysis Report

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ACRONYMS AND ABBREVIATIONS

BHA	Behavioral Health Administration
CSA	Core service agency
DDA	Developmental Disabilities Administration
DHHS	U.S. Department of Health and Human Services
DHMH	Department of Health and Mental Hygiene
DHR	Department of Human Resources
DJS	Department of Juvenile Services
DLLR	Department of Labor, Licensing and Regulation
DOL	U.S. Department of Labor
DORS	Division of Rehabilitation Services
ED	U.S. Department of Education
IEP	Individualized education program
MDOD	Maryland Department of Disabilities
MIS	Management information system
MOED	Mayor's Office of Employment Development (Baltimore)
MSDE	Maryland State Department of Education
Pre-ETS	Pre-employment transition services
PPP	Positive personal profile
PROMISE	Promoting Readiness of Minors in Supplemental Security Income
RAS	Random assignment system
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number
TANF	Temporary Assistance for Needy Families
TTW	Ticket to Work
VR	Vocational rehabilitation
WIOA	Workforce Innovation and Opportunity Act
WIPA	Work Incentives Planning and Assistance

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EXECUTIVE SUMMARY

PROMISE—Promoting Readiness of Minors in Supplemental Security Income (SSI)—was a joint initiative of the U.S. Department of Education (ED), the Social Security Administration (SSA), the U.S. Department of Health and Human Services (DHHS), and the U.S. Department of Labor (DOL) to fund and evaluate programs to promote positive changes in the lives of youth who were receiving SSI and their families. Under cooperative agreements with ED, six entities across 11 states enrolled SSI youth ages 14 through 16 and implemented demonstration programs intended to (1) provide educational, vocational, and other services to youth and their families and (2) make better use of existing resources by improving service coordination among state and local agencies. Under contract to SSA, Mathematica Policy Research is evaluating how the programs were implemented and operated, their impacts on SSI payments and education and employment outcomes for youth and their families (using an experimental design under which we randomly assigned youth to treatment or control groups), and their cost-effectiveness. In this report, we present findings from the process analysis of the first three years of the implementation and operation of the Maryland PROMISE program, known as MD PROMISE. The findings are based on data collected through April 2017 via site visits to MD PROMISE, telephone interviews with and social network surveys of program administrators and staff, and the management information system (MIS) that the program's staff used to record their efforts.

The Maryland Department of Disabilities (MDOD), a distinct cabinet-level state agency created in 2004, was the lead agency for the statewide MD PROMISE program and the recipient of the cooperative agreement with ED. Representatives from six other state agencies participated on a PROMISE steering committee, which supported and worked collaboratively with the program. MDOD contracted with three organizations to provide the following core PROMISE services to treatment group youth and their families: (1) assertive case management and employment-related services; (2) benefits counseling; and (3) financial education services. The MDOD PROMISE project director, the leads from the contracted organizations, and an organization with which MDOD contracted to provide technical assistance to program staff comprised the PROMISE leadership team. In addition to directly providing the core services, the program intended to be a conduit to and coordinator of other existing community services for transition-age youth who were SSI recipients.

In the following sections, we summarize key findings about how MD PROMISE engaged with youth, the services the program provided to them and their families in the first three years of program operations, and the collaborations the program fostered to support its efforts. We also highlight information about the experiences of control group youth that could have implications for the evaluation's impact analysis.

Engaging with youth with disabilities

MD PROMISE enrolled 2,006 youth in the evaluation of the program, 997 of whom were assigned to the treatment group.[1] Three years into program operations, MD PROMISE had

[1] The MD PROMISE MIS showed 996 youth assigned to the treatment group. One youth initially assigned to the control group was later discovered to be a sibling of a youth assigned to the treatment group. Consistent with the

engaged 92 percent of treatment group youth as participants in the program by developing a service plan with them. Hiring specialized staff to focus exclusively on recruitment, retention, and reengagement was a fruitful strategy. MD PROMISE contracted with an organization that had a track record of successfully recruiting individuals into program evaluations; its sole contractual responsibility was to recruit youth and enroll them into the evaluation of MD PROMISE. The efforts of that organization's staff resulted in the achievement of the program's enrollment target substantially ahead of schedule. Similarly, midway through program operations, PROMISE hired specialized case managers whose sole responsibility was to engage treatment group youth who had never participated in the program's services and reengage those who had lost interest in or contact with the program. Over the course of a year, they attempted to contact about one-third of all treatment group youth, one-quarter of whom subsequently engaged or reengaged in program services. Unlike the intervention staff, who juggled multiple responsibilities, the specialized case managers were able to focus their attention on identifying and addressing barriers to engagement.

Services provided to treatment group youth and their families

MD PROMISE delivered assertive case management and employment services to youth, consistent with its program design. Program staff dedicated solely to serving treatment group youth provided them with job search services, conducted outreach to employers on their behalf, and facilitated paid and unpaid work experiences for them. The program met its three-year benchmark of providing unpaid work experiences to 60 percent of treatment group youth, based on a definition of unpaid work experiences that included informational interviews and worksite tours as well as on-the-job experiences. The program almost met its three-year benchmark of providing a paid work experience to half of treatment group youth; 48 percent of the treatment group youth who were actually participating in the program had worked for pay subsequent to their enrollment in the evaluation. Intensive support from a technical assistance contractor was instrumental in ensuring that the staff remained focused on helping youth increase their employability and achieve positive employment outcomes.

MD PROMISE staff also facilitated linkages to adult services, benefits counseling, and financial education. Through the end of February 2017, the program had facilitated linkages to adult service providers for 35 percent of participating youth, surpassing its goal of providing linkages for 20 percent of them. The program was also well on its way to meeting its long-term goal of providing benefits counseling to all treatment group youth. Three years into program operations, at least half (and perhaps as many as four-fifths) of MD PROMISE participants had received some type of benefits counseling, but the intensity of that counseling tended to be low—typically a single in-person or telephone consultation. Between one-quarter and one-third received some form of financial education. The program expected its case managers to make at least 8 to 10 contact attempts per week to youth on their caseloads, their family members, or others to facilitate linkages to community resources or otherwise meet the needs of participants

(continued)

national evaluation's policy, Mathematica changed the status of the control group youth in the evaluation's random assignment system to treatment and flagged the youth as a nonresearch case to exclude the youth from the national evaluation's impact analysis. MD PROMISE did not change the status of this youth in its MIS.

as specified in their service plans. Case managers met this expectation; in a typical month, however, program staff made no contact attempts at all to one-quarter of the youth on their caseloads.

The design for MD PROMISE also called for the program to assist family members of treatment group youth in becoming more self-sufficient, more engaged in their communities and work, and more optimistic about addressing their challenges. MD PROMISE staff provided many case management services to family members; however, they were documented in case notes that Mathematica was unable to analyze. Our analysis of MD PROMISE MIS data revealed that the program provided other services, such as employment and education services, to the parents, guardians, and other family members of very few participating youth.

Program partnerships

Even before MD PROMISE began, MDOD had strong working relationships with the state agencies and contractors that subsequently became partners in the program. Those relationships became stronger and collaboration among the partners increased as PROMISE services rolled out. MDOD's communication with the state agency representatives on the program's steering committee typically occurred as needed rather than in formal meetings. In contrast, MDOD held in-person meetings every other week with managers from each of the contract organizations to discuss operational issues, as well as additional biweekly teleconferences to discuss performance management. This level of coordination and communication among the contracted service providers and between MDOD and its partners helped the program to stay focused on meeting its benchmarks and respond quickly to service delivery issues as they arose.

The relationships that MD PROMISE intervention staff (those providing case management and employment services) had with frontline staff at other service providers were critical to their success in serving treatment group youth and their families. Intervention staff were expected to rely on their own personal and professional networks to link youth and families to community supports, and were encouraged to develop networks and complete an exercise during early program implementation (when caseloads were small) to identify local resources. Initially, the extent of those networks and the ability to leverage them varied considerably across the intervention staff. However, by midway through program operations, most of the intervention staff were relatively well connected with line staff at two of the program's key external partners—the school systems and the state provider of vocational rehabilitation services. Also, by that time, almost every intervention staff member was communicating frequently with frontline staff at the program's contractor for benefits counseling.

Services available to the control group and implications for the impact analysis

The assertive case management and individualized employment services that MD PROMISE intervention staff provided constituted the primary distinction between the services available to the treatment group versus the control group. The case management available to youth with disabilities through other statewide programs was generally of lower intensity. Case management that resembled what PROMISE provided was available only in certain localities through programs that did not explicitly target youth with disabilities. Because PROMISE leveraged existing programs and providers for most of its services, control group youth, in

principle, had access to many of the same services to which the intervention staff referred treatment group youth. Examples of such services include benefits counseling and work experiences and supports arranged through the school systems, the state vocational rehabilitation agency, and American Job Centers. The key distinction was that the control group youth had no single entity funding the provision of these services, facilitating their access to these services, coordinating the efforts of multiple providers, or networking with providers and employers on their behalf. As a result, the availability of these services was often very limited. Control group youth also did not have access to the financial education services developed expressly for the MD PROMISE treatment group; however, as of the end of February 2017, few treatment group youth or families had received this service either.

The process analysis suggests that the conditions were favorable for observing positive impacts of the program on youth. Evidence in three areas implies a marked difference in the service experiences of treatment and control group youth. First, as discussed earlier in this summary, a large share (92 percent) of treatment group youth had actually participated in the program, and most of them had received key services three years into program operations. Second, as discussed in the previous paragraph, control group youth had only limited access to services similar to the assertive case management and employment services that PROMISE provided. Third, there is virtually no risk that control group youth received MD PROMISE services; MD PROMISE staff served treatment group youth exclusively and had no way of identifying control group youth. However, given that the MIS data revealed that the parents, guardians, and other family members of very few treatment group youth received employment services, the prospects for impacts on those individuals are less favorable.

I. INTRODUCTION

PROMISE—Promoting Readiness of Minors in Supplemental Security Income (SSI)—was a joint initiative of the U.S. Department of Education (ED), the Social Security Administration (SSA), the U.S. Department of Health and Human Services (DHHS), and the U.S. Department of Labor (DOL) to fund and evaluate programs to promote positive changes in the lives of youth who were receiving SSI and their families. Under cooperative agreements with ED, six entities across 11 states enrolled SSI youth ages 14 through 16 and implemented PROMISE demonstration programs intended to (1) provide innovative educational, vocational, and other services to youth and their families and (2) make better use of existing resources by improving service coordination among multiple state and local agencies. Under contract to SSA, Mathematica Policy Research is evaluating how the programs were implemented and operated, their impacts on SSI payments and education and employment outcomes for youth and their families (using an experimental design under which we randomly assigned youth to treatment or control groups), and their cost-effectiveness.[2] In this report, we present findings from the process analysis of the first three years of the implementation and operation of the Maryland PROMISE program, known as MD PROMISE.

A. Research objectives, data sources, and methods for the process analysis

Given their substantial investment in PROMISE and the pressing needs of transition-age SSI youth and their families, the federal sponsors of this initiative are keenly interested in whether the PROMISE programs were implemented in ways consistent with their requirements.[3] The sponsors had three key requirements for the programs. First, they required that all programs enroll a minimum of 2,000 youth in the evaluation. Second, they required that all programs include four core services that research suggests are the foundation for good transition programs—case management, benefits counseling, career and work-based learning experiences, and parent training and education. Third, they required that the programs develop partnerships among agencies responsible for providing services to SSI youth and their families. The programs had the liberty to develop their own approaches to implementing these components. This process analysis documents their choices and resultant experiences with respect to enrollment, service delivery, and agency partnerships. Specifically, it addresses the following four broad research objectives and several specific questions within each:

1. **Documenting the PROMISE program—intended design and fidelity to the model.** How did the program conduct outreach to eligible youth and enroll them in the evaluation, and what were the characteristics of enrolled youth and their families? What was the basic structure and logic model for the program? What were its plans for service provision? How closely did the program adhere to its logic model and service plan, and how consistently was the model implemented across local sites?

[2] Each of the PROMISE programs also conducted its own formative evaluation.

[3] These requirements are specified on pages 29735–29737 of the request for applications for PROMISE demonstration programs. Available at https://federalregister.gov/a/2013-12083. Accessed January 7, 2018.

2. **Assessing partner development, maintenance, and roles.** Who were the primary and secondary partners in the program, and what were their roles? What were the contractual or other forms of agreements between the lead agency and its partners? How and how well did the partners communicate, collaborate, and work toward program goals?
3. **Supporting the impact analysis.** To what extent did treatment group members engage in program services, and what might the timing and intensity of services imply for the interpretation of the study's future estimates of program impacts at 18 months and five years after youth enrolled in the evaluation? What was the contrast between the program's services and the counterfactual services (that is, the services available to the control group)? To what extent might the services and partnerships developed through PROMISE have benefited the control group and thus diluted the program's impacts?
4. **Identifying lessons and promising practices.** What lessons can we learn from the process analysis about the factors that facilitate or impede successful implementation of programs for youth with disabilities and their families? What can we learn about the efficacy of certain program components regarding their likely contributions to impacts? What are the lessons about strategies or program components to replicate or avoid in future interventions? What are the lessons for sustaining services once federal funding for the program has ended?

To answer the research questions for the process analysis of MD PROMISE, Mathematica collected and analyzed data from multiple sources, described in the following paragraphs, using protocols that may be found in the *PROMISE National Evaluation Data Collection Plan* (Fraker et al. 2014).

Interviews and site visits. We conducted a one-hour telephone interview with the MD PROMISE program director approximately one month after program implementation. We then conducted visits to MD PROMISE sites 6 and 24 months after program implementation. The visits entailed interviews with administrators and staff of organizations serving treatment and control group youth, a review of program documents and case files, observations of program activities, and focus groups with treatment group youth and their parents or guardians. The focus groups conducted 6 months after program implementation included 10 families (14 youth and 10 parents and guardians); the groups conducted 24 months after program implementation included 13 families (15 youth and 13 parents and guardians). Finally, we conducted telephone interviews with a subset of respondents from the site visits 36 months after program implementation.

Trained Mathematica researchers and analysts facilitated telephone and site visit interviews, as well as focus groups using semi-structured discussion guides that were flexible enough to stimulate free-flowing conversation but structured enough to capture consistent information across respondents. Each interview lasted between 60 and 90 minutes, and each focus group lasted 90 minutes. We used well-established methodologies to analyze the data from these qualitative sources, including preparing narrative descriptions of the interviews and focus groups, and identifying key themes within each; distilling the data into topics bearing on the evaluation's research questions; identifying and interpreting patterns and discrepancies in the data; and triangulating information from different data sources to ensure that the findings from the process analysis were based on mutually confirming lines of evidence.

Social network surveys. We conducted two social network surveys of the administrators and staff of MD PROMISE organizations and partners during the site visits (6 and 24 months after program implementation). Surveys took the form of self-administered hard-copy questionnaires that asked respondents about their relationships with colleagues in other organizations. Using Excel and specialized network analysis software (UCINET 6 and NetDraw), we analyzed data from the social network surveys to document communication and cooperation among organizations involved in MD PROMISE. More details about the surveys are provided in Chapter IV.

The Random Assignment System (RAS). The RAS was a web-based system Mathematica designed and maintained to complete the enrollment of youth in the evaluation of MD PROMISE and assign them either to a treatment or control group. It was accessible to authorized users with personal computers from any location through a high-speed Internet connection. Program staff entered data about an enrolling youth and the enrolling parent or guardian into the RAS. The system first validated the data against lists of eligible youth that SSA provided to Mathematica quarterly to ensure that the fields required for program enrollment and random assignment were complete and that appropriate formats and value ranges for variables such as ZIP codes, dates of birth, and Social Security numbers (SSNs) were used. The RAS then randomly assigned the youth to a study group according to customized algorithms and generated a personalized letter that the program could use as is or customize to notify the applicant of the study group assignment results.

The MD PROMISE management information system (MIS). The MIS contained data on both the program's recruitment and enrollment efforts and its delivery of services to treatment group youth. Data on recruitment and enrollment efforts were maintained in a series of Excel spreadsheets that tracked the communication recruiters had with PROMISE-eligible youth and families. Data on the delivery of program services were maintained in a system MD PROMISE called "Evolv," based on the Netsmart product myEvolv. Program staff entered data into the MIS; the quality and completeness of the data depended on their efforts. They received extensive training on the process for and importance of data entry, and on the program's philosophy that "if it is not recorded in Evolv, it didn't happen." Program staff were required to enter data within 24 hours of an actual or attempted interaction with or on behalf of youth, though staff may not always have adhered to this requirement, making it appear that services occurred later than they actually did. Moreover, program supervisors reviewed Evolv data almost daily and had to approve all data entries. Supervisors also met with staff regularly to discuss cases and ensure that staff were recording all data in Evolv. Thus, although the volume of data entry required was somewhat burdensome, the data on services that the intervention teams provided were likely fairly complete.

Mathematica analyzed data on program services entered through February 2017, approximately three years into program operations. Although the results presented in this report reflect program service delivery as of that time, they captured the experiences of treatment group youth and their families at different stages of their involvement in the program; as of the end of February 2017, the earliest enrollees had been in the program for almost three years, but the latest enrollees had been in the program for just under one year. Using statistical software (Stata), we tabulated data from the MIS and then identified key results pertinent to the research questions.

Monthly calls with ED, SSA, and MD PROMISE program managers. Mathematica participated in monthly calls, during which program managers updated ED and SSA on program activities, progress toward benchmarks, and challenges and plans for addressing them. We considered information obtained from all calls that occurred during the first 36 months of program operations.

B. Overview of MD PROMISE

The Maryland Department of Disabilities (MDOD) was the lead agency for MD PROMISE and the recipient of the cooperative agreement with ED. MDOD is a distinct cabinet-level state agency created in 2004, whose role is to facilitate relationships among and coordinate the efforts of disparate government entities serving individuals with disabilities, and to raise and address issues facing this population. Representatives from the following state agencies participated on a MD PROMISE steering committee, which supported and worked collaboratively with the program:

- Maryland State Department of Education (MSDE) Division of Rehabilitation Services (DORS), which administers the state's vocational rehabilitation (VR) program
- MSDE Division of Special Education/Early Intervention Services, which "provides leadership, support and accountability for results to local school systems, public agencies, and stakeholders in Maryland's comprehensive Birth-21 system of services for students with disabilities and their families" (http://marylandpublicschools.org/programs/pages/special-education/index.aspx, accessed January 7, 2018)
- Department of Health and Mental Hygiene (DHMH) Developmental Disabilities Administration (DDA), which provides services to individuals with developmental disabilities and provides resources to them and their families in five areas—self-determination, self-advocacy, support for families, housing, and employment (https://dda.health.maryland.gov/Pages/home.aspx, accessed January 7, 2018)
- DHMH Behavioral Health Administration (BHA), which provides services and support to promote recovery, resiliency, health, and wellness for individuals who have or are at risk for emotional, substance-related, addictive, and/or psychiatric disorders[4]
- Department of Human Resources (DHR), which administers Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP)[5]
- Department of Labor, Licensing and Regulation (DLLR), which administers the Workforce Innovation and Opportunity Act (WIOA)[6]

[4] In July 2014, the DHMH Mental Hygiene Administration became the Behavioral Health Administration (BHA). In June 2017, DHMH changed its name to the Department of Health.

[5] In July 2017, DHR changed its name to the Department of Human Services.

[6] WIOA, which superseded the Workforce Investment Act of 1998, was passed by Congress in July 2014 and began taking effect from 2015 through 2017. WIOA is "designed to help job seekers access employment, education, training, and support services to succeed in the labor market and to match employers with the skilled workers they need to compete in the global economy" (available at https://www.doleta.gov/WIOA/Overview.cfm, accessed

- Department of Juvenile Services (DJS), which manages, supervises, and treats youth involved in the juvenile justice system in Maryland (http://www.djs.maryland.gov/Pages/about-us/About.aspx, accessed January 7, 2018)

MDOD contracted with three organizations to provide MD PROMISE services statewide: (1) Way Station, Inc., to provide case management and employment-related services to youth and families; (2) Full Circle Employment Solutions, to provide benefits counseling; and (3) MD CASH Campaign, to provide financial education services. MDOD also contracted with TransCen, Inc. to provide programmatic technical assistance and ensure fidelity to the program design. The MD PROMISE leadership team, consisting of the MD PROMISE program director at MDOD and management staff at each of the contract organizations, met every other week to discuss operational issues but communicated informally at least every few days. An additional biweekly phone call focused on performance management, using data reports that Way Station created from the MD PROMISE MIS. These reports informed the supervision of and technical assistance to program staff.

In addition to directly providing the services cited above, MD PROMISE intended to be a conduit to and coordinator of existing services for transition-age youth with disabilities. To this end, its cornerstone was assertive case management provided by program staff who served PROMISE treatment group members exclusively.[7] The program's logic model (Figure I.1) illustrates that program designers intended to use PROMISE case management, together with other key resources or inputs (including local education agencies and employment agencies, SSA, and other state agencies) to engage youth and their families in transition services. Technical assistance for program implementation, evaluation, benefits counseling, and financial education supported this work. Program designers anticipated that participation in transition-related activities (the key individual-level program output) would lead to intermediate outcomes and results. These in turn would lead to long-term increases in employment, educational attainment, training, and personal and family income, as well as a decrease in reliance on SSI and other benefits. Other influences on the anticipated outcomes included the resources of key collaborators, comprising state agencies and MD PROMISE partners. Their joint efforts around strategic planning, training, information sharing, program implementation, and evaluation were

(continued)

January 7, 2018). It coordinates and regulates the employment and training services for adults, dislocated workers, and youth administered by DOL and the adult education, literacy, and VR state grant programs administered by ED. During PROMISE implementation, state entities—particularly workforce organizations, VR agencies, and local education agencies—began planning for and implementing practices to address WIOA requirements. By the end of data collection for the MD PROMISE process analysis, state and local agencies were still building capacity to provide the new services the legislation required.

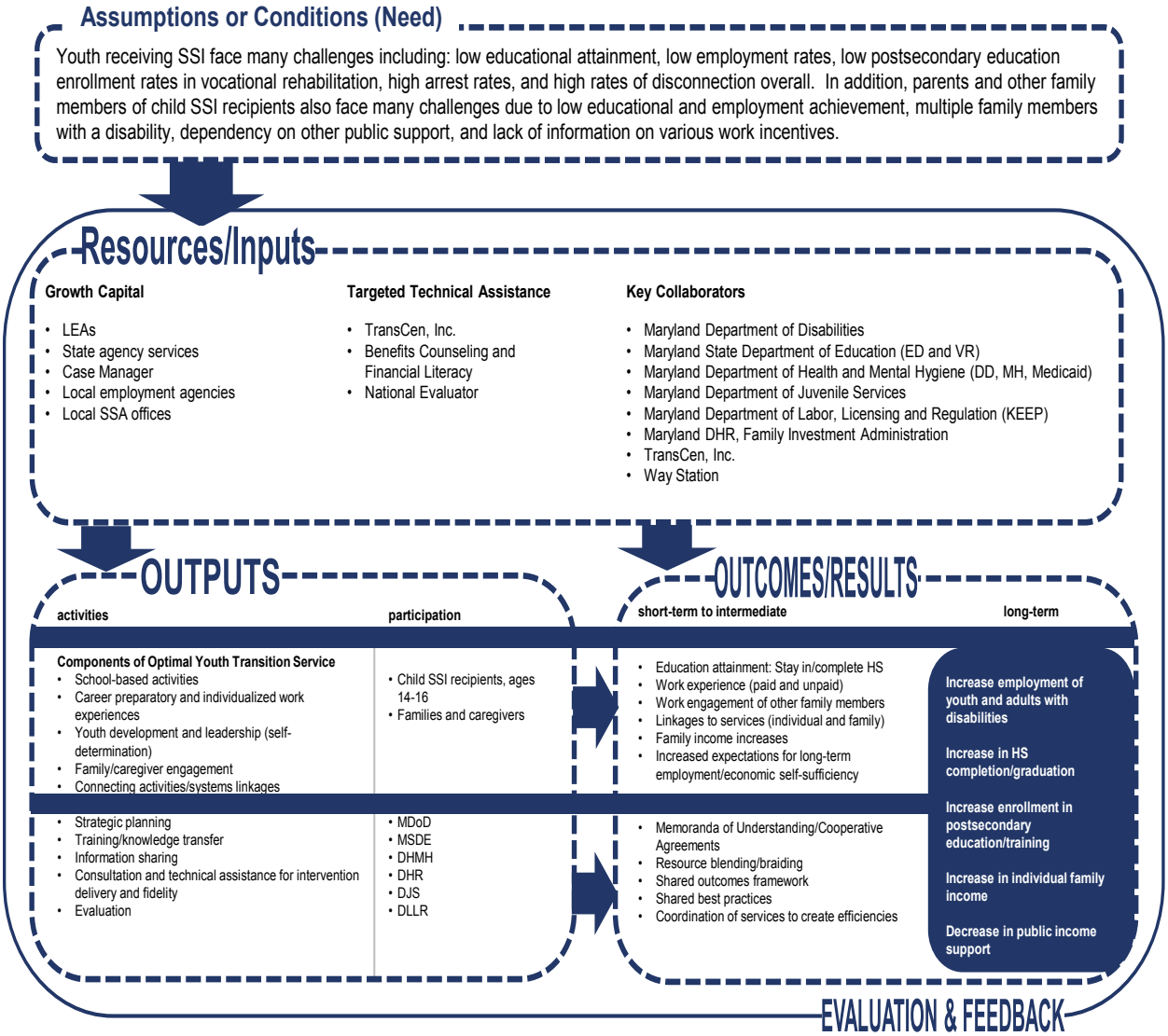
[7] Assertive case management was originally developed in the Program of Assertive Community Treatment as a means of helping adults with psychiatric illnesses remain in the community (Allness and Knoedler 1998). The approach later expanded to other populations, including veterans (Rosenheck et al. 2010) and youth with emotional disabilities (McGrew and Danner 2009), among others. Distinguishing features of assertive case management compared with traditional case management approaches include (1) multidisciplinary case management teams, (2) person- and family-centric service values, and (3) delivering most services in the community—for example, at home or in the workplace.

intended to foster a more collaborative and seamless service environment to facilitate improvements in individual outcomes.

C. Roadmap to the report

The rest of this report presents findings from the process analysis of MD PROMISE. It documents program operations at roughly midway through the five-year PROMISE cooperative agreement period. Five analogous reports will present findings from the process analyses of the other PROMISE programs. This report is organized around the federal sponsors' key requirements of the programs. Chapter II describes MD PROMISE's efforts to enroll youth into the evaluation and the results of those efforts. Chapter III describes the core program services as designed and actually implemented, and how they differed from preexisting services in the community. (Preexisting services are those that were available to both treatment and control group members; we refer to these services throughout the report as counterfactual services.) Chapter IV assesses the quality of the partnerships MD PROMISE facilitated. Chapter V presents lessons learned from the process analysis of MD PROMISE (including promising practices for possible expansion or replication of the PROMISE program) and provides information that will be useful for interpreting findings from the evaluation's impact analysis, to be presented in two future reports.

Figure I.1. MD PROMISE logic model



Source: MDOD application for PROMISE funding.

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II. ENROLLMENT AND PARTICIPATION IN MD PROMISE

Under a subcontract from TransCen, Inc., Westat, an organization that played no role in the delivery of MD PROMISE or counterfactual services, conducted the recruitment of youth and their enrollment in the evaluation from April 2014 through February 2016. In this chapter, we describe the recruitment and enrollment process and summarize the results of Westat's efforts based on data from the PROMISE RAS, SSA lists of PROMISE-eligible youth, and the MIS that Westat used to track its efforts. We also present the number and characteristics of those youth assigned to the treatment group who actually participated in the program.

A. Outreach and recruitment

Westat conducted direct outreach to youth on SSA lists of PROMISE-eligible youth to recruit them into the evaluation. In total 7,828 youth appeared on the lists, which SSA provided quarterly to MD PROMISE; however, the program attempted to recruit only about 59 percent (4,644) of them (Table II.1). Site visit respondents explained that the program prioritized youth who would soon age out of eligibility (that is, those close to their 17th birthday) and then rounded out the sample with youth who lived in the same areas. This strategy stemmed from the recognition that recruiting every youth before they became age ineligible would be necessary to meet the program's target of 2,000 enrolled youth. Westat mailed enrollment packets (containing an introductory letter, enrollment and consent forms, a self-addressed postage-paid envelope for returning the completed enrollment forms, and an MD PROMISE promotional flyer) to each sampled youth's residential address. Recruiters who lived in the communities where they were recruiting (and thus could identify with families and had knowledge of the availability of local services) then conducted follow-up outreach through phone calls, in-person visits, emails, and text messages to encourage enrollment.[8] Westat sent duplicate enrollment packets to families that did not respond to those contacts. The MIS suggests that home visits were an essential component of Westat's recruitment strategy; recruiters conducted home visits to more than 70 percent of the youth they attempted to recruit (Table II.2). On average, it took six actual or attempted contacts, including mailings, to enroll a youth in the evaluation.

MD PROMISE implemented several strategies to maximize the success of Westat's recruitment efforts:

- **Providing incentives.** Westat provided each youth and parent or guardian who completed the enrollment and consent forms with a $50 gift card. Westat advertised the opportunity to receive a gift card in the introductory letter and in subsequent communications with families.
- **Contracting with a third-party locator**. In an effort to improve the accuracy of the contact information provided on the SSA lists, Westat contracted with LexisNexis for locating services. Westat sent 498 cases (just over 10 percent, most of whom never enrolled in the

[8] The SSA lists of eligible youth did not provide email addresses. Recruiters sometimes requested these addresses when they made contact with youth through other methods and then used them for follow-up contacts.

evaluation) to LexisNexis for tracing, resulting in new contact information for 86 percent of them.

- **Collaborating with other agencies**. MDOD worked with DHR to disseminate recruitment information to youth (and associated DHR staff) whose representative payees (as identified on the SSA lists) were social service agencies or institutions. MDOD also worked with select schools, which drafted letters in support of MD PROMISE that the program could include in its recruitment material. Staff in these schools also encouraged youth they knew were eligible to enroll.

Additionally, MD PROMISE began supplementing direct outreach in fall 2014 via marketing through community events, schools, and other state agencies. Specifically, MD PROMISE administrators and Westat recruiters began attending local transition fairs to advertise the program, working with local school districts to promote it to special education students, and meeting with state agency staff to encourage them to disseminate information about it through their networks.

Table II.1. MD PROMISE recruitment efforts over time

	Calendar quarter since program's start of recruitment								
Recruitment effort	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Total
Number of youth									
Newly eligible on the SSA lists	4,365	578	491	497	472	488	474	463	7,828
Targeted for recruitment	434	559	614	697	660	821	642	217	4,644
Number of									
Initial letters mailed to youth	416	550	574	677	673	819	668	214	4,591
Follow-up letters mailed to youth	6	36	51	61	48	19	77	27	325
Telephone calls made to youth	850	1,536	1,775	2,451	1,719	1,770	1,536	822	12,459
Emails sent to youth	10	37	6	13	6	9	1	4	86
Text messages sent to youth	94	667	715	642	582	479	363	131	3,673
In-person visits made to youth	546	1,138	877	1,059	866	1,374	919	443	7,222

Sources: The MD PROMISE MIS and PROMISE RAS.

Notes: The number of youth targeted for recruitment includes one record for each youth recorded as receiving a contact in the MIS data. The table shows all attempted contacts (that is, successful contacts in addition to (1) messages left, no answers, hang-ups, and wrong numbers for telephone attempts; and (2) no answers, wrong addresses, and eligible youth or parents or guardians not at home for in-person attempts) by quarter. All quarters correspond to calendar quarters starting April 1, 2014 and ending March 31, 2016.

Table II.2. MD PROMISE recruitment efforts, by evaluation enrollment status (percentages unless otherwise indicated)

	All	Evaluation enrollees (A)	Evaluation non-enrollees (B)	Difference (A − B)	*p*-value of difference
Private vendor was engaged in locating	10.6	4.0	12.4	-8.4	0.000***
Resulted in new contact information	85.6	86.9	85.9		0.752
Youth sent an initial mailing	95.1	89.4	99.1	-9.7	0.000***
Average number of initial mailings per youth sent mailing	1.0	1.0	1.0	-	-
Youth sent a follow-up mailing	6.4	3.1	8.7	-5.6	0.000***
Average number of follow-up mailings per youth sent mailing	1.1	1.0	1.1	-0.0	0.233
Youth contacted by telephone	84.2	85.8	83.0	2.9	0.006***
Average number of telephone calls per youth called	3.1	3.1	3.0	0.1	0.401
Youth contacted by email	1.2	2.1	0.6	1.5	0.000***
Average number of emails per youth emailed	1.4	1.5	1.3	0.2	0.334
Youth contacted by text	33.4	21.1	42.2	-21.0	0.000***
Average number of texts per youth texted	2.2	2.5	2.2	0.3	0.012**
Youth contacted in person	70.7	62.2	76.7	-14.5	0.000***
Average number in-person contacts per youth contacted	2.1	2.0	2.2	-0.2	0.000***
Number of contacts (including initial mailing):					0.000***
1 contact	4.4	9.8	0.5	9.3	
2–5 contacts	54.1	53.3	54.6	-1.4	
6–10 contacts	29.7	26.7	31.9	-5.2	
11 or more contacts	11.8	10.3	13.0	-2.7	
Average number of contacts (including initial mailing) per youth	5.9	5.5	6.2	-0.8	0.000***
Average time between initial mailing and first contact (days)[a]	14.5	13.4	15.1	-1.7	0.044**
Average time between initial mailing and enrollment (days)[a]	NA	45.0	NA	NA	NA
Number	4,830	2,006	2,824	NA	NA

Sources: The MD PROMISE MIS and PROMISE RAS.

Notes: The universe for this table is youth targeted for recruitment (that is, logged in the MIS as having received a contact) or enrolled in the evaluation without contacts logged in the MIS. The table includes all attempted contacts (that is, successful contacts in addition to (1) messages left, no answers, hang-ups, and wrong numbers for telephone attempts; and (2) no answers, wrong addresses, and eligible youth or parents or guardians not at home for in-person attempts). For a continuous or dichotomous variable, the *p*-value represents a *t*-test. For a polychotomous variable, a single *p*-value is presented that represents a chi-square test for the entire distribution of the variable across the various categories. Numbers in the Difference column may differ from the values calculated as A - B due to rounding.

*/**/*** Statistically significant difference from zero at the 0.10/0.05/0.01 level.

[a] The average time between the initial mailing and first contact excludes individuals who received the mailing after the first contact. The average time between the initial mailing and enrollment excludes individuals who received the mailing after enrolling. Individuals may have received the initial mailing after the first contact or after enrolling if they proactively contacted MD PROMISE before receiving an initial mailing or if the program started other recruitment efforts before sending an initial mailing.

NA = not applicable.

B. Enrollment and random assignment

Enrollment in the PROMISE evaluation and random assignment occurred through the PROMISE RAS. The Westat recruiters had access to the RAS from the field via an Internet connection. If a youth and parent or guardian completed the enrollment and consent forms in the presence of a recruiter, the recruiter could enter the required data from the forms into the RAS, conduct random assignment, and notify the family of the result on the spot. According to the MIS, just under half (48 percent) of enrolled youth were randomly assigned in the field (Table II.3). The others completed the enrollment and consent forms and mailed them to Westat, after which an administrative assistant entered the data into the RAS (typically within one or two days of receiving the forms) and conducted random assignment. Westat mailed all enrollees an official notification letter of their random assignment along with the gift cards; those assigned to the control group also received a document that MD PROMISE developed identifying community resources and support available to them.

MD PROMISE met its enrollment target more than two months ahead of schedule; recruitment efforts ceased on February 16, 2016, when 2,006 youth (26 percent of all eligible youth on the SSA lists and 43 percent of youth MD PROMISE attempted to recruit) had enrolled in the evaluation.[9] Most youth who did not enroll were not recruited before MD PROMISE hit its enrollment target or became ineligible for the program, primarily because they turned 17 during the enrollment period (Table II.3). The pace of enrollment was relatively steady throughout the recruitment period, as shown in Table II.4. MD PROMISE intentionally controlled the pace of recruitment, intending to recruit a similar number of youth each quarter, so that Westat staff would have a relatively even workload over the course of the enrollment period and intervention staff could steadily build their caseloads.

Table II.3. Summary of final recruitment results for MD PROMISE

Recruitment result	Number or percentage
Number of eligible youth on the SSA lists	7,828
Number of eligible youth recruited	4,644
Number of youth enrolled in evaluation	2,006
Percentage of eligible youth enrolled in evaluation	25.6
Percentage of recruited youth enrolled in evaluation	43.2
Mode of enrollment among evaluation enrollees	
Percentage enrolled in the field by a recruiter (using forms completed in the field)	48.3
Percentage enrolled by the central recruitment office (using forms submitted by mail)	51.7
Reasons for non-enrollment among non-enrollees (%)	
Ineligible—aged out	35.1
Ineligible—no longer receiving SSI	6.6
Refused	9.9
Deceased	0.1
Recruitment period ended before enrollment	47.0
Other	1.4

Sources: The MD PROMISE MIS and PROMISE RAS.

[9] The enrollment window for all PROMISE programs was April 2014 through April 2016.

Table II.4. Rate of enrollment in the MD PROMISE evaluation

Quarter	Number of youth enrolled	Cumulative number of youth enrolled	Percentage of enrollment target achieved
Apr–Jun 2014	143	143	7.2
Jul–Sep 2014	209	352	17.6
Oct–Dec 2014	220	572	28.6
Jan–Mar 2015	268	840	42.0
Apr–Jun 2015	269	1,109	55.5
Jul–Sep 2015	359	1,468	73.4
Oct–Dec 2015	358	1,826	91.3
Jan–Feb 2016	180	2,006	100.3

Source: The PROMISE RAS.

On most but not all of the characteristics we measured, the enrollees in the evaluation of MD PROMISE were not representative of all eligible youth in the state (Table II.5). Enrollees were one-third of a year older than non-enrollees, likely reflecting the program's strategy of prioritizing older youth for recruitment. Compared with other PROMISE-eligible youth, enrollees more often had intellectual or developmental disabilities or other mental impairments. Fewer were male, and their racial and ethnic composition differed (most notably, a lower proportion of enrollees were Black), though differences in racial and ethnic composition are hard to interpret, given the substantial proportion of youth for whom this information was unknown.[10] Given the self-selection of enrollees into the evaluation, it is likely that they differed from non-enrollees on certain unobserved characteristics not captured in the SSA data, such as youth motivation and resilience; parents' expectations of the youth; or family characteristics, including parents' own employment status or whether the family received other public assistance. Thus, we caution against generalizing the results from the impact evaluation of the program to all PROMISE-eligible youth. However, even though the impact findings may not be strictly generalizable, it is likely that the impact estimates would be broadly applicable to those youth who would choose to participate in a hypothetical voluntary future intervention resembling MD PROMISE.

[10] SSA discourages researchers from using the race variable in its administrative data system for analysis. SSA discontinued the publication of data by race for the SSI program after 2002 in response to changes it made to the process for assigning new SSNs. Most SSNs are now assigned to newborns through a hospital-birth registration process or to lawful permanent residents based on data collected by the Department of State during the immigration visa process. Neither process provides SSA with race and ethnicity data. For the relatively few individuals who apply for an original Social Security card at an agency field office, providing race and ethnicity information is voluntary. "Consequently, the administrative data on race and ethnicity that SSA does collect comes from a self-selecting sample that represents an ever-dwindling proportion of the population" (Martin 2016). Field experience also suggests that many individuals identify as biracial; lack of a biracial category may contribute to the substantial percentage of "other/unknown" responses.

Table II.5. Characteristics of youth eligible for MD PROMISE, by evaluation enrollment status (percentages unless otherwise indicated)

Characteristic	All eligible youth	Enrolled in PROMISE evaluation (A)	Not enrolled in PROMISE evaluation (B)	Difference (A − B)	*p*-value of difference
Average age at end of recruitment period (years)	16.0	16.2	15.9	0.3	0.000***
Male	67.9	65.6	68.7	-3.1	0.011**
Race/ethnicity					0.059*
White (non-Hispanic)	4.0	4.2	3.9	0.3	
Black (non-Hispanic)	27.6	25.1	28.4	-3.3	
Hispanic	1.3	1.6	1.2	0.4	
Asian	0.3	0.2	0.3	-0.1	
American Indian/AK/HI/Pacific Islander	0.0	0.0	0.0	-0.0	
Other/unknown	66.8	68.8	66.1	2.7	
Spoken language					0.240
English	97.2	96.9	97.4	-0.5	
Spanish	2.2	2.7	2.1	0.7	
Other	0.4	0.3	0.4	-0.2	
Missing	0.2	0.2	0.2	0.0	
Primary disabling condition					0.036**
Intellectual or developmental disability	36.3	37.6	35.8	1.8	
Other mental impairment	46.9	47.5	46.7	0.8	
Physical disability	11.7	10.8	12.0	-1.2	
Speech, hearing, or visual impairment	1.6	1.5	1.6	-0.1	
Other	3.6	2.6	3.9	-1.3	
Average age at most recent SSI eligibility determination (years)	7.4	7.4	7.4	0.0	0.844
Number of youth	7,828	2,006	5,822	NA	NA

Sources: The PROMISE RAS and SSA lists of PROMISE-eligible youth.

Notes: The universe for this table is all youth on the SSA lists of PROMISE-eligible youth. For a continuous or dichotomous variable, the *p*-value represents a *t*-test. For a polychotomous variable, a single *p*-value is presented that represents a chi-square test for the entire distribution of the variable across the various categories. Numbers in the Difference column may differ from the values calculated as A - B due to rounding. The primary disabling condition categories correspond to SSA's Listing of Impairments. Other mental impairments include disabilities such as chronic brain syndrome; schizophrenia; borderline intellectual functioning; and affective, anxiety, personality, substance addiction, somatoform, eating, conduct, oppositional/defiant, and attention deficit hyperactivity disorders.

*/**/*** Statistically significant difference from zero at the 0.10/0.05/0.01 level.

NA = not applicable.

Data from the RAS on study group assignment indicate that random assignment worked as intended for MD PROMISE. Of the 2,006 youth MD PROMISE enrolled in the evaluation, 1,866 were classified as research cases and the remaining 140 as nonresearch cases because they were siblings of previously enrolled youth.[11] Among the research cases, 936 youth were assigned to the treatment group and 930 to the control group (Table II.6). This distribution was consistent with the 50/50 random assignment design. Among all youth enrolled in the evaluation (including nonresearch cases), 997 youth were assigned to the treatment group.[12]

Data on the characteristics of treatment and control group youth confirm that random assignment worked as intended. Table II.6 summarizes sample baseline characteristics across treatment and control group youth in the research group, illustrating that overall there were no systematic differences other than what might arise due to chance. Two significant differences existed between the two groups: control group members were about 4 percentage points less likely to be male than treatment group members (64 compared to 68 percent), and the parent or guardian who enrolled the youth was also less likely to be male among the control group members (6 compared to 8 percent). Assuming that all characteristics are independent, we would expect about one of the nine characteristics tested to be statistically significant at the 0.10 level if random assignment worked as intended. Though two of the characteristics were significant, they were significantly correlated, implying a lack of independence.[13] Thus, the number of significant differences between treatment and control group members was about what we would expect when random assignment works as intended. Regression models for the impact analysis will control for baseline characteristics that are significantly different between the treatment and control groups, as well as additional baseline characteristics identified at the time of that analysis.

[11] If data were entered into the RAS for a MD PROMISE applicant who was a sibling of a previously enrolled youth, the system assigned the applicant to the same research group as the previously enrolled sibling. We employed this approach because program services were provided to family members, including siblings, as well as youth. PROMISE programs were also able to assign a maximum of five youth to the treatment group nonrandomly using a wild card system, but MD PROMISE did not exercise this option for any youth. For information on wild cards, see Fraker and McCutcheon (2013).

[12] The MD PROMISE MIS showed 996 youth assigned to the treatment group. One youth initially assigned to the control group was later discovered to be a sibling of a youth assigned to the treatment group. Consistent with the national evaluation's policy, Mathematica changed the status of the control group youth in the RAS to treatment and flagged the youth as a nonresearch case to exclude the youth from the national evaluation's impact analysis. MD PROMISE did not change the status of this youth in its MIS.

[13] The Pearson correlation coefficient is 0.040; the *p*-value is 0.087.

Table II.6. Characteristics of randomly assigned MD PROMISE treatment and control group members (percentages unless otherwise indicated)

Characteristic	All research cases	Assigned to treatment group (A)	Assigned to control group (B)	Difference (A − B)	*p*-value of difference
Youth					
Average age at enrollment (years)	15.2	15.2	15.2	0.0	0.204
Male	65.7	67.6	63.8	3.9	0.079*
Race/ethnicity					0.402
White (non-Hispanic)	4.2	4.3	4.1	0.2	
Black (non-Hispanic)	24.6	25.3	23.9	1.5	
Hispanic	1.5	1.9	1.1	0.8	
Asian	0.2	0.1	0.3	-0.2	
American Indian/AK/HI/Pacific Islander	0.0	0.0	0.0	0.0	
Other/unknown	69.5	68.4	70.7	-2.3	
Spoken language					0.911
English	96.7	96.6	96.9	-0.3	
Spanish	2.8	2.9	2.8	0.1	
Other	0.3	0.3	0.2	0.1	
Missing	0.2	0.2	0.1	0.1	
Primary disabling condition					0.912
Intellectual or developmental disability	37.0	37.3	36.8	0.5	
Other mental impairment	47.7	48.0	47.4	0.5	
Physical disability	11.3	11.0	11.5	-0.5	
Speech, hearing, or visual impairment	1.5	1.5	1.4	0.1	
Other	2.6	2.2	2.9	-0.7	
Average age at most recent SSI eligibility determination (years)	7.5	7.6	7.4	0.3	0.190
Parent or guardian					
Relationship to youth					0.533
Parent or step-parent	87.4	88.0	86.8	1.3	
Grandparent	7.5	6.3	8.6	-2.3	
Brother or sister	0.5	0.4	0.5	-0.1	
Aunt or uncle	2.3	2.7	1.9	0.7	
Other relative	0.5	0.5	0.5	0.0	
Other	1.7	1.9	1.5	0.4	
Missing	0.1	0.1	0.1	0.0	
Average age at enrollment (years)	42.5	42.4	42.6	-0.1	0.748
Male	6.7	7.8	5.6	2.2	0.055**
Number of youth	1,866	936	930	NA	NA

Sources: The PROMISE RAS and SSA lists of PROMISE-eligible youth.

Notes: 140 enrolled cases are excluded from this table because they did not go through random assignment. For a continuous or dichotomous variable, the *p*-value represents a *t*-test. For a polychotomous variable, a single *p*-value is presented that represents a chi-square test for the entire distribution of the variable across the various categories. Numbers in the Difference column may differ from the values calculated as A - B due to rounding. The primary disabling condition categories correspond to SSA's Listing of Impairments. Other mental impairments include disabilities such as chronic brain syndrome; schizophrenia; borderline intellectual functioning; and affective, anxiety, personality, substance addiction, somatoform, eating, conduct, oppositional/defiant, and attention deficit hyperactivity disorders.

*/**/*** Statistically significant difference from zero at the 0.10/0.05/0.01 level.

NA = not applicable.

C. Participation in MD PROMISE

Mathematica advised all of the PROMISE programs about how the rate of participation in the program among members of the treatment group could affect the national evaluation's impact analysis. For evaluation purposes, a treatment group youth was considered to be a participant in PROMISE if he or she had at least one substantive interaction with the program. Based on conversations with MD PROMISE program managers, Mathematica considered a treatment group youth to be a participant in MD PROMISE if he or she either completed an intake interview or developed a family plan. An intake interview, in which program staff assessed youth and family service needs, was generally the first MD PROMISE activity, and program managers expected it to occur within seven days of evaluation enrollment and assignment to the treatment group. On average, it took about two months (61 days) after enrollment in the evaluation to complete the interview, though the median amount of time was under a month (Table II.7). Information from the intake interview was the basis for a form called the family plan, which outlined youth and family goals and plans for achieving them. The program design called for a family plan to be developed for each family in the treatment group—ideally within 14 days of the intake interview—and for program staff to review it with families at least monthly. On average, it took 24 days to develop the family plan after the interview.[14]

Of the 997 youth assigned to the treatment group (including both research and nonresearch cases), 92 percent (920 youth) were classified as participants based on their completion of an intake interview or development of a family plan. About 86 percent completed an intake interview and 91 percent developed a family plan.[15] Generally, the characteristics of participating and nonparticipating treatment group youth were similar (Table II.8). Nonparticipating youth more often enrolled in the evaluation during the last six months of the enrollment window and were more often from the Northern and Southern Maryland regions than were participants. In addition, the race/ethnicity and employment status of the majority of nonparticipants was unknown as of enrollment because program staff had little to no interaction with these families and so could not obtain this information.[16]

[14] Initially, program staff had trouble completing the intake interview (and therefore developing the family plan) in a timely fashion because the interview was based on a lengthy (14-page) questionnaire. Midway through the evaluation enrollment period, MD PROMISE shortened the questionnaire to just one page so that staff could both complete the interview and develop the family plan during the initial visit with a family and thereby more consistently meet deadlines. The median time between completion of an intake interview and development of a family plan over the course of the full enrollment period (0 days) suggests that this strategy may have been successful, though the completed family plans may not have been as meaningful as intended due to the reduced amount of data derived from the shortened intake interview. Mathematica's observations of and interviews with many program staff, however, suggest that over time the staff really got to know the youth and families with whom they worked and constantly engaged them in setting and pursuing goals.

[15] For 13 youth, the MD PROMISE MIS indicated completion of an intake interview but not a family plan. For 57 youth, the MIS indicated development of a family plan without completion of an intake interview.

[16] As described earlier in this chapter, race/ethnicity is coded as unknown for the majority of those on the SSA lists of youth eligible for PROMISE. Data on employment status are not available from these SSA lists.

Table II.7. Efforts to engage treatment group youth as participants in MD PROMISE as of February 2017

	Number or percentage
Number of days from evaluation enrollment to first contact attempt by program staff[a]	
Average per youth	10.4
Median per youth	4.0
Percentage of youth who completed an intake interview[b]	86.4
Number of days from evaluation enrollment to intake interview	
Average per youth	61.3
Median per youth	23.0
Percentage of youth who developed a family plan[c]	91.0
Number of days from completion of intake interview to development of family plan	
Average per youth	24.1
Median per youth	0.0
Percentage of youth who completed an intake interview or developed a family plan	92.3
Number of days from evaluation enrollment to completion of intake interview or development of family plan	
Average	63.9
Median	24.0
Number of youth	997

Sources: The MD PROMISE MIS and PROMISE RAS.

Notes: Contact attempts may have taken any form (that is, telephone, text, email, home visit, and so on) and may or may not have resulted in actual interaction between MD PROMISE and a youth.

[a] MD PROMISE intended the average time between enrollment in the evaluation and the first contact attempt to be three days.

[b] MD PROMISE intended that 100 percent of treatment group youth would complete an intake interview and the average time between enrollment in the evaluation and completion of an intake interview would be seven days.

[c] MD PROMISE intended that 100 percent of treatment group youth would develop a family plan and the average time between completion of an intake interview and development of a family plan would be 14 days. The number of days from completion of intake interview to development of family plan excludes 57 youth who developed a family plan without completing an intake interview and 71 youth who developed a family plan before completing an intake interview. Among youth who developed a family plan first, it took 126 days on average to complete an intake interview; the median number of days was 44.

Table II.8. MD PROMISE participant characteristics at enrollment (percentages unless otherwise indicated)

Characteristic	Assigned to treatment group	Participated in PROMISE services (A)	Did not participate in PROMISE services (B)	Difference (A - B)	*p*-value of difference
Youth					
Average age at enrollment (years)	15.8	15.8	15.7	0.1	0.737
Enrollment timing					0.030**
First 6 months	17.6	18.2	10.4	7.8	
Second 6 months	24.0	24.6	16.9	7.7	
Third 6 months	31.7	31.5	33.8	-2.3	
Fourth 6 months	26.8	25.8	39.0	-13.2	
Male	67.6	67.3	71.4	-4.1	0.456
Race/ethnicity					0.000***
White (non-Hispanic)	19.5	20.9	2.6	18.3	
Black (non-Hispanic)	54.3	57.1	20.8	36.3	
Hispanic	5.2	5.5	1.3	4.2	
Asian	0.3	0.3	0.0	0.3	
American Indian/AK/HI/Pacific Islander	0.2	0.2	0.0	0.2	
Other	20.5	16.0	74.0	-58.0	
Missing	0.1	0.0	1.3	-1.3	
Spoken language					0.414
English	96.7	96.4	100.0	-3.6	
Spanish	2.8	3.0	0.0	3.0	
Other	0.3	0.3	0.0	0.3	
Missing	0.2	0.2	0.0	0.2	
Average age at most recent SSI eligibility determination (years)	7.7	7.6	8.4	-0.8	0.138
Primary disabling condition					0.220
Intellectual or developmental disability	37.6	38.2	31.2	7.0	
Other mental impairment	47.9	47.7	50.6	-2.9	
Physical disability	10.6	10.1	16.9	-6.8	
Speech, hearing, or visual impairment	1.5	1.6	0.0	1.6	
Other	2.3	2.4	1.3	1.1	
Someone in home is working as of enrollment					0.000***
Yes	40.0	42.9	5.2	37.7	
No	28.8	30.8	5.2	25.6	
Unknown	31.1	26.3	88.3	-62.0	
Missing	0.1	0.0	1.3	-1.3	
MD PROMISE region					0.003***
Baltimore	23.5	23.4	24.7	-1.3	
Eastern	15.0	15.3	11.7	3.6	
Northern	19.3	18.7	26.0	-7.3	
Western	26.3	27.1	16.9	10.2	
Southern	15.8	15.5	19.5	-4.0	
Missing	0.1	0.0	1.3	-1.3	

Table II.8. (*continued*)

Characteristic	Assigned to treatment group	Participated in PROMISE services (A)	Did not participate in PROMISE services (B)	Difference (A - B)	*p*-value of difference
Enrolling parent or guardian					
Relationship to youth					0.856
Parent or step-parent	88.2	87.7	93.5	-5.8	
Grandparent	6.2	6.4	3.9	2.5	
Brother or sister	0.5	0.5	0.0	0.5	
Aunt or uncle	2.5	2.6	1.3	1.3	
Other relative	0.5	0.5	0.0	0.5	
Other	2.0	2.1	1.3	0.8	
Missing	0.1	0.1	0.0	0.1	
Average age at enrollment (years)	43.0	43.1	41.2	1.9	0.066*
Male	7.7	7.7	7.8	-0.1	0.981
Number of youth	997	920	77	NA	NA

Sources: Italics signify data elements from the MD PROMISE MIS. Data elements not in italics are from the PROMISE RAS or SSA lists of PROMISE-eligible youth.

Notes: Participation in PROMISE services was defined as having an initial substantive interaction with PROMISE. (In MD PROMISE, an initial substantive interaction was defined as having completed an intake interview or developed a family plan.) For a continuous or dichotomous variable, the *p*-value represents a *t*-test. For a polychotomous variable, a single *p*-value is presented that represents a chi-square test for the entire distribution of the variable across the various categories. Numbers in the Difference column may differ from the values calculated as A - B due to rounding. The primary disabling condition categories correspond to SSA's Listing of Impairments. Other mental impairments include disabilities such as chronic brain syndrome; schizophrenia; borderline intellectual functioning; and affective, anxiety, personality, substance addiction, somatoform, eating, conduct, oppositional/defiant, and attention deficit hyperactivity disorders.

*/**/*** Statistically significant difference from zero at the 0.10/0.05/0.01 level.

NA = not applicable.

III. SERVICES FOR YOUTH WITH DISABILITIES AND THEIR FAMILIES

The actual implementation of program services may or may not conform to their design, and the program resources and inputs identified in the logic model (presented in Figure I.1) may or may not result in the anticipated outputs and, ultimately, outcomes and results. Various contextual factors (such as staff competencies, program management, and the policy environment in which the program operated) may have affected the fidelity of implementation to the program design and mediated the relationships among inputs, outputs, and outcomes. Further, program services could be expected to have yielded outcomes other than those that would have resulted in the absence of the program only if they differed enough from the counterfactual services that were available to control group members. In this chapter, we describe the counterfactual services, how program services were designed, key aspects of how MD PROMISE operationalized the services in practice, utilization of those services, and implications of the program's implementation and utilization for its potential to generate the intended outcomes. Each of sections A through E focuses on a core PROMISE service component. The last section discusses the potential for control group members to receive MD PROMISE services.

The national evaluation's process analysis relied on MD PROMISE MIS data to describe program service utilization among youth in the treatment group who participated in the program. Our main aim was to document the services MD PROMISE provided. Thus, to fully document the program's efforts, we included in the service utilization analysis those nonresearch cases who participated in the program, even though they will not be included in the impact analysis. The statistics presented in this chapter were computed for the participant sample (that is, the youth and other household members in the 92 percent of treatment group families who completed an intake interview or developed a family plan) and reflect service utilization through roughly the third year of program operations (April 2014 through February 2017).

A. Case management

The federal PROMISE program sponsors required that each program provide case management to ensure that PROMISE services for participants were appropriately planned and coordinated, and to assist participants in navigating the broader service delivery system. They expected that case management would also include transition planning to assist participating youth in setting post-school goals and facilitate their transition to appropriate post-school services. In this section, we describe counterfactual services with respect to service coordination and transition planning in Maryland and the services MD PROMISE provided in this area.

1. Counterfactual services

In Maryland, case management for youth with disabilities was available through the DHMH DDA and BHA, though these programs had limited capacity. DDA provided family and individual services to people with physical or mental impairments who were unable to live independently without supports. DDA could identify transition-age youth potentially eligible for its services as early as age 15 and provide them with limited resource support coordination (called targeted case management). Once youth reached age 18, DDA support coordinators helped them apply for home- and community-based waiver services, and provided a somewhat increased level of targeted case management. Youth became eligible for the waiver services at age 21 (though typically a waiting list existed). Those services included assistive technology,

supported employment, community-supported living, and other more intensive services, along with ongoing targeted case management.

BHA funded community behavioral health services for individuals who have emotional, substance use, addictive, or psychiatric disorders and were eligible for Medicaid. Each county had a mental health authority that oversaw BHA-funded mental health service providers (called core service agencies, or CSAs). During the evaluation period, the CSAs may have offered targeted case management, which included assessment, development of a care plan, referrals to services and supports, and follow-up.[17] BHA also had several grant programs for CSAs, under which they provided case management and linkages to entitlements and support services; these programs were small, however.[18]

Case management was also available in some areas of the state through local programs. The Baltimore Mayor's Office of Employment Development (MOED), for example, operated two Youth Opportunity Centers, where out-of-school and unemployed youth ages 16 to 25 could access a full range of educational, occupational, and personal support services in a "one-stop" environment.[19] Enrollees at the centers received case management, mentoring, advocacy, educational support, and substance abuse counseling. They also received referrals for mental health assessments and treatment, housing, child care assistance, occupational training, and career readiness services. In 2014, the centers enrolled more than 800 young people, encompassing individuals both with and without disabilities.

2. MD PROMISE services

The case management services that MD PROMISE offered were much more intensive than the preexisting services offered by DDA and BHA and, unlike other local programs, were targeted to the needs of SSI youth and their families. MD PROMISE implemented a team approach to providing the interventions, including case management. The program assigned each youth in the treatment group to an intervention team, consisting of a case manager and family employment specialist employed by Way Station, a private nonprofit behavioral health organization. The team members worked exclusively as well as cooperatively and intensively with participants, and were trained to provide individualized, or person-centered, services. Family employment specialists focused specifically on setting and achieving employment goals; case managers addressed all other issues.

[17] Way Station was a CSA in Carroll, Frederick, and Howard counties, but the staff providing BHA services were distinct from the Way Station staff who provided MD PROMISE services.

[18] One example is the Healthy Transitions Initiative, which provided services for transition-age youth with mental health and co-occurring disorders with funding from the federal Substance Abuse and Mental Health Services Administration. The program served youth ages 16–25 and their families in Frederick and Washington counties, but was small, serving 139 youth and their families in 2013. Originally scheduled to end in September 2014, the program was extended and continued delivering services through 2015. Maryland was also awarded a grant from the same agency to implement similar programs that serve transition-age youth in Howard County and the Southern Maryland Tri-County region going forward. Training of service providers began in state fiscal year 2015.

[19] Funding for Youth Opportunity came from DOL and Baltimore general funds.

The design for MD PROMISE specified an average caseload for an intervention team of 35 total youth (in addition to their family members) at any given time. Actual caseloads averaged 28 total youth (in addition to their family members) (Table III.1). Intervention teams reported during site visits that, typically, about 50 to 75 percent of their caseloads were active at any given time. They also suggested that caseloads were higher in densely populated areas and lower in rural areas, where program staff had to spend more time traveling to meet with families.

Table III.1. Case management: Communication with MD PROMISE participants as of February 2017 (percentages unless otherwise indicated)

	Number or percentage
Average number of participating youth per intervention team[a]	27.5
Average number of weekly contact attempts to participating youth in a typical month[b]	
By case manager	7.9
By family employment specialist	9.0
Average number of weekly contact attempts family employment specialists made to employers in a typical month	1.6
Percentage of engaged youth participants to whom case managers or family employment specialists made contact attempts in a typical month:	
0 contacts	27.3
1 or 2 contacts	31.4
3 to 7 contacts	34.4
8 or more contacts	6.9
Number of participating youth	920

Source: The MD PROMISE MIS.

Notes: Contact attempts may have taken any form (that is, telephone, text, email, home visit, and so on) and may or may not have resulted in actual interaction between MD PROMISE and an intended respondent.

[a] MD PROMISE intended that intervention teams carry caseloads of 35 youth, on average.

[b] Analysis was based on contact attempts in February 2017. MD PROMISE intended case managers to make 8 to 10 contact attempts per week to youth on their caseloads, their family members, or others to facilitate linkages to community resources or otherwise meet the needs of participants specified in their family plans. The program intended family employment specialists to make 8 to 10 contact attempts per week to employers.

[b] Analysis was based on contact attempts in February 2017 to the 698 participating youth (75.8 percent) currently engaged in MD PROMISE (see Table III.4).

The intervention teams were located in five regions in the state: the City of Baltimore; the Eastern Shore; and the Northern, Southern, and Western regions.[20] Initial program staffing in the Western Region was insufficient due to the unanticipated high number of enrollments in the evaluation there, resulting in caseloads that averaged 44 total treatment group youth (see Table A.1 in Appendix A) and in one instance was as high as 75 youth for a period of time, according to the intervention teams and their supervisors. Toward the end of the recruitment and enrollment period, MD PROMISE reallocated staff to reduce caseloads in that region, but comments from program participants and Mathematica's observations suggested that in the interim, the high

[20] The City of Baltimore and Baltimore County are distinct political jurisdictions, independent of each other. To distinguish these two jurisdictions in the remainder of this report, we use "Baltimore" to refer to the city and "Baltimore County" to refer to the county.

caseloads resulted in lapses in service delivery and frustration among participants.[21] Mathematica's focus groups with program participants occurred in the Western Region. The parents and guardians who participated in the first group all were optimistic about the program and hopeful about the opportunities it might provide; however, half of the parents and guardians who participated in the second focus group were disheartened by the program and uncertain about whether they and their youth would continue to participate. They indicated that changes in the intervention teams to which they were assigned were key to their ambivalence. 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. Some of the parents and guardians knew the identity of their youth's case manager or family employment specialist, whereas others were uncertain.

The primary role of the intervention teams was to work with participating treatment group youth and their family members to develop plans for their education, employment, and related activities, and assist them in implementing those plans. In carrying out that role, the intervention teams spent their time on the following activities: communication with and on behalf of participants, linkages to community supports, career planning, and ongoing program engagement.

Communication. MD PROMISE expected its case managers to make at least 8 to 10 contact attempts per week youth on their caseloads, their family members, or others to facilitate linkages to community resources or otherwise meet the needs of participants specified in their family plans. Similarly, the program expected family employment specialists to make at least 8 to 10 contact attempts youth and family members per week, as well as 8 to 10 contact attempts employers per week regarding youth on their caseloads. Case managers reported during site visits that they typically spent up to half of their time seeking out additional resources for youth on their caseloads. The MD PROMISE MIS captured these efforts in case notes (that is, text fields), which we were unable to analyze for this report. The data we analyzed reflected only contact attempts case managers made directly to youth and family members.[22] The data likely do not accurately reflect the frequency of interactions that intervention teams had with family members, however, because these interactions were often documented within case notes as well. Reports from intervention team members during the site visits suggest that the extent to which they interacted with family members of participating youth varied considerably and was strongly influenced by the interests and needs of those individuals.

The MIS data suggest that, as they were expected to do, in a typical month case managers made an average of eight contact attempts per week to youth and family members on their caseloads. Family employment specialists made an average of two contact attempts per week to

[21] Because Way Station staff live in the same areas as youth on their caseloads, staff serving youth in other regions could not easily shift to serve youth in the Western Region. Rather, Way Station had to hire new staff, and supervisors told us it took time in that higher-cost area of the state to find individuals with the required skill set willing to accept the salary the program offered, even though the salary was equivalent to or higher than commensurate positions in the region.

[22] MD PROMISE MIS data cannot support an analysis of the percentage of successful contact attempts.

employers—short of expectations. In line with expectations, they made nine contact attempts per week directly to youth and family members (Table III.1). When contact attempts by case managers and family employment specialists are combined, however, in a typical month the intervention teams did not attempt to contact one-quarter of active youth on their caseloads at all (the MIS uses the term "engaged" to refer to active youth). As the program design required, all in-person interactions with participants occurred in participants' homes or community locations outside of MD PROMISE offices. The intervention team members had virtual offices (laptops and other mobile equipment) that facilitated this strategy.

The program trained the intervention teams to use two tools in their communications with participants. The first, a form called "learning independent steps toward success" was intended to identify specific steps the participant would take to reach an established goal and support the development of action plans for achieving intermediate milestones. Case managers and family employment specialists told us they found this tool very useful and, based on Mathematica's observations of and interviews with several intervention teams, they appeared to use it consistently. The second tool was motivational interviewing, a goal-oriented counseling style that affects behavior change by helping participants explore thoughts and behaviors that impact their ability to pursue stated goals. Staff focused more on motivational interviewing once caseloads grew to capacity, but some told us they used it selectively rather than consistently as originally designed because the lives of some participants were so chaotic and stressful they thought motivational interviewing (particularly regarding employment) did not work well. Among the youth in the focus groups who had consistent interactions with their case managers, most found them helpful.

Linkages to community supports. To facilitate linkages to community resources and work experiences, both case managers and family employment specialists connected participants to and coordinated with other service providers. Our interviews with program staff suggest that the extent to which these connections occurred depended on the intervention team members' familiarity with the resources in their local areas, which varied.[23] Nonetheless, MD PROMISE MIS data indicate that three years into program operations, intervention teams had made connections to other service providers (by discussing the availability of such services, providing referrals, or providing support in completing applications for enrollment in the services) for approximately 35 percent of participating youth, surpassing its goal of making these connections for 20 percent of them (Table III.2). Most of those connections were to one of three key adult service providers: about 23 percent of participants were connected to DORS, 11 percent to DLLR American Job Centers, and 4 percent to DDA.[24] The intervention teams had connected slightly more than 6 percent or fewer participants to each of the following: BHA, DJS, DHR, local departments of social services, and local housing authorities. The teams had access to a

[23] MDOD, Way Station, and TransCen staff told us that during early program implementation, intervention teams engaged in a resource mapping exercise intended to identify local services providers that could support MD PROMISE treatment group youth. All of the intervention teams we interviewed, however, said they rarely used the findings from this effort in practice, though they did not elaborate on why.

[24] Staff in the Western Region connected a higher percentage of youth to adult service providers relative to staff in the other regions (See Table A.1 in Appendix A). Staff in the Baltimore Region connected few youth to DORS, particularly relative to staff in the other regions.

flexible case service fund to cover emergency services and supports or minor employment-related expenses for families on their caseloads. Three years into program operations, they had tapped these funds for about one-third of participating families, providing an average of $386 to each. Program managers reported that as a condition of receipt, families were required to engage in activities that would mitigate the need for future funds, but program staff seemed unaware of this requirement during site visit interviews.

Table III.2. Case management: Connections to adult service providers for MD PROMISE participants as of February 2017 (percentages unless otherwise indicated)

	Number or percentage
Participating youth connected to adult service providers[a]	35.4
Department of Rehabilitation Services (DORS)	23.2
Developmental Disabilities Administration (DDA)	3.5
One-stop center/American Job Center (DLLR)	11.2
Behavioral Health Administration (BHA)	1.4
Department of Human Resources (DHR)	0.4
Department of Social Services (DSS)	6.3
Housing and Urban Development (HUD)	2.9
Criminal justice system	0.8
Home- and community-based health services	0.2
Academic and career support (including Job Corps)	2.4
DORS, DDA, or DLLR (required for successful case closure)	30.0
Participating youth provided with flexible case service funds	32.4
Average dollar amount among those receiving funds	386.2
Number of participating youth	920

Source: The MD PROMISE MIS.

Note: We do not include connections to transportation services or SSA as connections to adult service providers.

[a] MD PROMISE intended that 20 percent of youth would be connected with adult services providers by the end of program operations.

Career planning. As noted earlier, family employment specialists were primarily responsible for working with youth and family members to develop and pursue employment goals and opportunities. They relied on several documents to facilitate this work:

- The ***positive personal profile (PPP)*** identified participants' interests, experiences, skills, resources, and needs for success in the workplace. The program design called for 75 percent of treatment group youth to have a PPP completed by the third year of program operations (mid-2017) and 100 percent by the fourth year (mid-2018); the program had no expectations for the number of parents, guardians, or other household members that would complete a PPP. MIS data indicate that as of February 2017, 86 percent of participating youth but hardly any parents, guardians, or other household members had a PPP (Table III.3).

- The ***individual job development plan*** (also known as an individual plan for employment) used information from the PPP to identify desired jobs and potential employers to contact about them. Based on the program design and mirroring the PPP benchmarks, by the third year of program operations, 75 percent of treatment group youth should have had these plans in place, and 100 percent by the fourth year; the program had no expectations for the number of parents, guardians, or other household members who would have a job development plan. MIS data indicate that as of February 2017, 85 percent of participating youth but hardly any parents, guardians, or other household members had an individual job development plan (Table III.3).
- Finally, for all parties involved in an employment placement (discussed in Section C of this chapter), the ***workplace supports plan*** identified the supports needed for the participant to succeed in the workplace and a plan for ensuring those supports actually would be available. The MD PROMISE MIS did not provide data on the percentage of participants for whom a workplace supports plan had been developed because the plan was not required, but rather suggested as a best practice.

Table III.3. Case management: Career planning services to MD PROMISE participants as of February 2017

	Percentage
Participating youth with a PPP[a]	85.7
Participating youth with parents or guardians with a PPP	0.3
Participating youth with other household members with a PPP	0.0
Participating youth with an individual plan for employment[a]	84.5
Participating youth with parents or guardians with an individual plan for employment	1.0
Participating youth with other household members with an individual plan for employment	0.1
Number of participating youth	920

Source: The MD PROMISE MIS.

[a] MD PROMISE intended that 75 percent of youth would have a PPP and an individual plan for employment by the end of program operations.

Ongoing program engagement. As noted earlier, not all treatment group youth were actively engaged in the program at all times. The case managers and family employment specialists with whom we spoke told us that, typically, 25 to 50 percent of youth on their caseloads were "disengaged" at any point in time—a status that MD PROMISE used to identify youth and families who were unresponsive to program contact attempts for at least 60 days or expressed disinterest in the program. At the time we collected MD PROMISE MIS data in February 2017, 29 percent of all treatment group youth (24 percent of participants and 90 percent of nonparticipants) were classified in the system as disengaged (Table III.4).

During the first two years of program operations, the intervention teams were responsible for continuing to reach out to disengaged youth and encourage their participation in services; in practice, however, they focused the majority of their attention on active cases, defined as those working toward program benchmarks and those in maintenance status (those who had met at

least two program benchmarks and so required less intensive case management). Program benchmarks included the following:

- Completed a PPP
- Completed an individual job development plan
- Completed one or more goals in the family plan
- Completed an unpaid work experience
- Completed a paid work experience
- Received benefits counseling (either a phone consultation, initial assessment, or continuing counseling)
- Had enrolled in adult services, if eligible, or been determined to be eligible (through DORS, DDA, or a DLLR American Job Center)

MD PROMISE considered participants to have completed the intervention if they had completed each benchmark (though it was designed to enable participants to receive services for as long as necessary while the program was in operation). Way Station managers told us that as of February 2017, no cases had been closed.

Table III.4. Ongoing program engagement in MD PROMISE (percentages unless otherwise indicated)

	Assigned to treatment group	Participated in PROMISE services	Did not participate in PROMISE services
Engagement status			
Youth currently disengaged[a]	29.3	24.2	89.6
Youth currently disengaged	70.7	75.8	10.4
Youth ever sent to specialized case manager through February 2017	31.7	27.5	81.8
Average number of contacts per youth among those sent to specialized case manager[b]	5.2	5.1	5.5
Number of youth	997	920	77

Source: The MD PROMISE MIS.

[a] Disengaged youth were those who were unresponsive to program contacts for 60 days or expressed disinterest in the program. "Currently" represents a youth's status from the February 2017 MD PROMISE MIS extract.

[b] Contact attempts may have taken any form (that is, telephone, text, email, home visit, and so on) and may or may not have resulted in actual interaction between MD PROMISE and a youth.

To ease the burden on intervention teams, MD PROMISE used some of the supplemental funding it received from ED in 2015 for hiring staff to conduct outreach to disengaged youth and families. Way Station managers told us they planned to hire seven specialized case managers (two for Baltimore, one for each of the other regions, and one floater) who would be dedicated solely to engaging treatment group youth and families who had not participated in program services at all (that is, had not completed the intake interview or developed a family plan), and reengaging those who had participated at some point but had disengaged before achieving at

least one of the goals in their family plans. As of the end of the third year of program operations, five specialized case managers had been hired, but one had left the program due to performance issues. During telephone interviews, those staff reported using outreach strategies similar to those used by the Westat recruiters to locate families, including phone calls, text messages, emails, home and school visits, and use of LexisNexis to obtain updated contact information. MIS data indicate that as of February 2017, the families of 317 treatment group youth (32 percent) had been referred to the specialized case managers (Table III.4). The outcomes of those referrals were not tracked in the MD PROMISE MIS; however, the specialized case managers we interviewed reported varying degrees of success. One case manager reported having engaged or reengaged 9 of 54 families on her caseload, another 15 of about 105, and yet another 50 of about 116.[25] Upon engagement or reengagement, responsibility for the youth and families shifted to the intervention teams; however, the specialized case managers sometimes supported their efforts.

Disengagement was particularly problematic in Baltimore. More than 40 percent of treatment group youth in Baltimore had been referred to a specialized case manager as of February 2017, compared to no more than 28 percent of treatment group youth in the other regions (see Table A.2 in Appendix A). The members of the local intervention teams attributed this finding to two factors: (1) many families in the inner city faced substantial hardships and ongoing crises that interfered with their ability to consider employment possibilities and participate in the program; and (2) families more able to participate in MD PROMISE may have been receiving services from other providers, as Baltimore is relatively resource rich.

B. Benefits counseling and financial education services

ED and its federal partners required that each PROMISE program provide counseling for treatment group youth and their families on SSA work incentives; eligibility requirements of various other assistance programs; as well as rules governing earnings and assets and their implications for benefit levels. They also required that the programs provide financial education. Education may cover a range of topics related to promoting families' financial stability, such as budgeting, saving and asset building, tax preparation, consumer credit, and debt management. In this section, we describe counterfactual services in these areas for youth with disabilities and their families in Maryland and the services MD PROMISE provided.

1. Counterfactual services

Benefits counseling. Benefits counseling for all youth in Maryland who receive SSI was available through two SSA-funded programs. First, youth age 14 or older could receive counseling through Maryland's Work Incentives Planning and Assistance (WIPA) project. Funding for WIPA benefits counseling in Maryland was limited, however, so the likelihood that control group youth and families received counseling through WIPA was relatively low. Second, youth age 18 or older could receive counseling through the Ticket to Work (TTW) program. Few youth were likely to receive counseling through TTW, however, because of their limited short-

[25] MD PROMISE's own data collection outside of its MIS suggested that a total of 77 families had been reengaged as of the end of February 2017.

term earning potential (due to their school obligations). TTW did not reimburse employment networks for counseling until a participant was engaged in substantial gainful activity (that is, earning more than $1,820 per month for blind individuals and $1,130 for non-blind individuals, net of impairment-related work expenses, in 2016).[26] Consequently, the employment networks offered employment and benefits counseling selectively to those individuals they assessed to be capable of engaging in substantial gainful activity.

Benefits counseling was also available to youth with open DORS cases. High schools may have referred youth with individualized education programs (IEPs) to DORS, but youth with disabilities who did not have IEPs may have been referred by their parents, therapists, doctors, community agencies, DLLR, and other organizations.[27] Before the implementation of WIOA, DORS did not engage with youth until one to two years before high school exit, typically at age 16 or 17. However, a new provision under WIOA prompted DORS to create a pre-employment transition services (Pre-ETS) program, through which it planned to engage with youth throughout their entire high school careers. Services provided to youth through Pre-ETS fell into five categories: (1) job exploration counseling, (2) work-based learning (such as an internship or summer employment experience), (3) counseling on opportunities for postsecondary education or comprehensive transition programs, (4) workplace readiness activities (such as work etiquette or social skills needed in the workplace), and (5) self-advocacy instruction. Although benefits counseling was not an explicit Pre-ETS service category, it was available to DORS participants; thus, as of 2016, when the WIOA provisions were beginning to take effect in Maryland, Pre-ETS was an avenue through which control group youth could have accessed counseling. Other programs that serve individuals with disabilities in Maryland may have provided benefits counseling as a complement to their core services, but it was likely to be of low intensity.

Financial education. The availability of financial education services for Maryland youth with disabilities was more limited than benefits counseling. MD CASH Campaign, a statewide nonprofit organization, offered financial education classes to the public directly or through local affiliates, but those classes were geared to adults, did not explicitly include content relevant to individuals with disabilities, and were not well advertised or well known. About 25 community-based organizations around the state used an online budget coaching tool that MD CASH Campaign had recently developed.

Financial education occurred in some schools. Each year between 2014 and 2016, the Maryland legislature attempted but failed to pass legislation that would have mandated a financial education course as a high school graduation requirement. In response, the State Board of Education issued guidance encouraging districts to include financial education in their curricula. Each district, however, had jurisdiction over whether and how to implement this guidance.

[26] An employment network is an entity that enters into an agreement with SSA either to provide or coordinate the delivery of services to Social Security disability beneficiaries.

[27] An IEP specifies the goals a student with disabilities intends to accomplish during the school year, based on his or her identified strengths and needs.

2. MD PROMISE services

Benefits counseling. Benefits counseling through MD PROMISE was provided by federal- and state-certified counselors employed by Full Circle Employment Solutions, a for-profit corporation that provides employment and benefits counseling for people with disabilities in eight states and the District of Columbia.[28] Full Circle provides most WIPA benefits counseling in Maryland under contract to the Center for Independent Living, which operates the state's WIPA project. It is also one of several contracted DORS providers that offer this service and is an employment network in the TTW program, providing both employment and benefits counseling. According to both MDOD and Full Circle leadership, however, unlike the counseling it provides through other programs, the benefits counseling Full Circle provided under MD PROMISE was focused on the family unit rather than the individual SSI recipient.

Full Circle offered two levels of benefits counseling to MD PROMISE participants. The first level was a benefits assessment for families in which no one was working. The assessment focused on the opportunities that various work incentives offered through SSI and other programs, and options for combining earnings and public benefits to maximize financial security. According to Full Circle staff we interviewed, it entailed one in-person meeting, but the benefits counselors encouraged participating families to follow up with questions. They provided the families with a two- to three-page summary of key points discussed. The second level was continuing counseling for families in which at least one person was working. It focused on assessing the impact on benefits of increased earnings and ensuring that appropriate work incentives were in place. Continuing counseling consisted of an initial assessment plus periodic follow-up meetings. Families participating in MD PROMISE received one or both levels of benefits counseling, depending on their specific situations and how those changed over time.

MD PROMISE anticipated that each family in the treatment group would receive at least one of the two levels of benefits counseling; however, during Mathematica's site visits, leadership within MDOD, Way Station, and Full Circle shared with us that the take-up rates were low during most of the first two years of program operations. They explained that intervention teams did not initially appreciate the importance of or fully understand benefits counseling and, though it was a core intervention in the MD PROMISE model, presented it as an optional program service. Early on, Full Circle staff did not participate in PROMISE intervention team staff meetings, which would have bridged this gap. Furthermore, many families declined to participate in the counseling because they were not otherwise engaged in program services, did not see the need for the counseling, or were reluctant to share their personal financial information. Program managers also explained that the benefits counseling model MD PROMISE used was developed to meet the needs of individuals with disabilities who wanted to work and learn how they could do so. Their perception was that the model was not as well suited to the PROMISE population, which often distrusted programs and systems and had fears about working.

[28] In addition to obtaining work incentive counselor certification through Virginia Commonwealth University, all Full Circle staff working in Maryland must obtain state certification by completing a training developed by MDOD that addresses state-specific benefit issues.

In response to low take-up rates during the first two years of MD PROMISE, the program leadership reinforced the message to the intervention teams that all youth and families should be referred for benefits counseling, and made a more concerted effort to integrate the Full Circle benefits counselors into PROMISE. Program leaders and benefits counselors subsequently noticed an increase in the take-up rates for the two levels of benefits counseling. MIS data indicate that by February 2017, the families of 47 percent of participating youth had received an initial assessment and 18 percent had received ongoing counseling (Table III.5).

Table III.5. Take-up of benefits counseling and financial education services among MD PROMISE participants as of February 2017

Service	Percentage of participating youth whose family received service
Referred for benefits/work incentives counseling by an intervention team	69.7
Received benefits/work incentives counseling[a]	49.3
Initial face-to-face benefits/work incentives assessment	46.6
Ongoing benefits/work incentives counseling	17.5
Received benefits/work incentives phone call	32.7
Sought Section 301 waiver	9.9
Received financial education class	25.7
Received 1 financial education class	70.8
Received 2 financial education classes	14.4
Received 3 or more financial education classes	14.8
Average number of classes	1.7
Received financial coaching	4.5
Received 1 financial coaching session	78.0
Received 2 financial coaching sessions	19.5
Received 3 or more financial coaching sessions	2.4
Average number of sessions	1.2
Received financial counseling	3.2
Received 1 financial counseling session	89.7
Received 2 financial counseling sessions	3.4
Received 3 or more financial counseling sessions	6.9
Average number of sessions	1.4
Received any financial education, coaching, or counseling	28.6
Number of participating youth	920

Source: The MD PROMISE MIS.

[a] Participants could have received benefits/work incentives counseling without being referred by an intervention team because of outreach the MD PROMISE benefits counseling and financial services lead conducted beginning in summer 2016. The types of benefits counseling presented are not mutually exclusive; the same youth may have received an assessment and ongoing counseling. MD PROMISE intended that 100 percent of families would receive some type of benefits counseling by the end of program operations.

To further increase the take-up of benefits counseling, in summer 2016, the MD PROMISE benefits counseling and financial services lead (who was also MDOD's work incentives project director and himself a certified benefits counselor) began calling treatment group families not yet participating in benefits counseling to consult with them about their financial situation and engage them in this service component. His goal was to refer the families to Full Circle for a benefits assessment or continuing counseling. If families remained uninterested in working with

Full Circle, the financial services lead would provide as much substantive information to them as possible over the phone and then send a letter documenting the consultation. The program counted this type of substantive interaction toward its benchmark of engaging each family in the treatment group in benefits counseling. As a last resort, the financial services lead sent a letter describing available work incentives to families he was unable to reach by phone or did not engage in a substantive discussion over the phone. This letter did not count toward the program's benchmark. The MD PROMISE MIS data we analyzed documented benefits counseling phone calls but did not distinguish between substantive and nonsubstantive calls. Overall, the data indicate that as of February 2017, one-third of participating youth had received a phone call (Table III.5). Assuming all calls were substantive would increase the total percentage of participating youth who received any benefits counseling from a lowerbound estimate of 49 to an upperbound estimate of 82. It is likely that the true percentage is somewhere in between; in fact, MD PROMISE's own records suggest that 539 families (59 percent) had received counseling.

Three years into program operations, MD PROMISE was well on its way to meeting its goal of providing benefits counseling to all treatment group youth, but the intensity of that counseling was generally low (Table III.5).[29] As of February 2017, more than three-quarters of those who had any contact with a benefits counselor had only a single encounter, either in person or by telephone. Perhaps as a result of the benefits counseling received, however, the families of 10 percent of participating youth sought a Section 301 waiver. For a youth who does not meet the adult definition of disability at the age-18 medical redetermination for SSI benefits, this waiver allows the benefits to continue for as long as the youth participates in an approved vocational program or SSA demonstration project, conditional on SSA's determination that continued participation will make the youth less likely to need benefits in the future.

Financial education. Unlike benefits counseling, the program persisted throughout the duration of operations in presenting financial education services as optional for families in the treatment group as it was not a core component of the MD PROMISE model. It did, however, significantly modify the format for those services. Initially, MD PROMISE contracted with MD CASH Campaign to provide group classes in financial education that used existing curricula and materials tailored to the needs of families with transition-age youth with disabilities, and to provide treatment group families with free tax preparation services. No financial education services were provided during the first few months of MD PROMISE program operations while MD Cash Campaign determined how to change its typical classes in ways that best supported program participants. During Mathematica's site visits, leadership within MDOD, Way Station, and MD Cash Campaign said that even once MD Cash Campaign began offering classes, the take-up rate was extremely low, in part because youth and families found it difficult to travel to the venues where the classes were offered, the intervention teams varied in how they promoted financial education services, and MD PROMISE participants were uninterested in group

[29] The service goals that MD PROMISE set were based on 1,000 treatment group youth. In reporting the program's progress toward meeting its goals both here and elsewhere, we compare the percentage of program participants (920 youth) who received a specified service with the percentage benchmark based on 1,000 youth. MD PROMISE's progress toward meeting its goals would appear somewhat less if we included nonparticipants in the analysis.

classes.[30] In response, the program modified its contract with MD CASH Campaign in 2016 to provide two additional financial education services—financial counseling and financial coaching—delivered on an individual basis rather than in group classes.

- **Financial counseling** was provided by certified financial counselors to address specific financial issues or crises that youth or families faced, such as whether to file for bankruptcy, how to deal with consumer fraud or identity theft, and managing the foreclosure of one's home or an increase in rent. This counseling occurred by telephone and entailed either one or several sessions.
- **Financial coaching** was provided by trained volunteers and typically occurred via the Internet or face to face but was also available by telephone. It could entail just one session or as many as 12. Using the organization's online budgeting tool, the financial coaches worked with youth and/or their families to identify personal financial goals and provide ongoing support to achieve them.

Despite the new service offerings, the take-up rate for financial education remained much lower than for benefits counseling (Table III.5). As of February 2017, for 29 percent of participating youth, a family member or members received one or more of the three types of financial education services offered by the program. Despite the challenges program staff observed, most often those services took the form of financial education classes (26 percent of participants). Far less often, the financial education services consisted of either coaching (5 percent of participants) or counseling (3 percent), perhaps reflecting the relatively recent addition of those services. As with benefits counseling, the intensity of financial education services was low. Those who received any such services participated in just one or two sessions of classes, coaching, or counseling.

C. Career exploration and work-based learning experiences

The federal sponsors stipulated that each PROMISE program was to ensure that participating youth had at least one paid work experience in an integrated setting while they were in high school. They also required that other work-based experiences be provided in integrated settings, such as volunteer activities, internships, workplace tours, and on-the-job training. In this section, we describe counterfactual services with respect to career exploration and work-based learning experiences for youth with disabilities and their families in Maryland and the services MD PROMISE provided in this area.

1. Counterfactual services

Special education teachers and MSDE transition coordinators could arrange employment opportunities for transition-age youth with IEPs and sometimes did so in coordination with DORS. Those youth, as well as others who had disabilities but no IEPs, could also access

[30] MD PROMISE could not provide us with reliable data on take-up of tax preparation services because MD CASH Campaign referred participants to partner agencies for these services and, per Internal Revenue Service rules aimed at protecting confidentiality, partners cannot disclose any information about their clients. MD CASH Campaign did not maintain data on families referred to partner agencies.

employment services directly through three statewide programs in Maryland. First, in addition to the employment services that DORS historically began offering to students one to two years before high school exit and later to younger students under Pre-ETS, the agency offered job development, placement, coaching, and retention services to youth after they exited from high school.[31] Second, DLLR served transition-age youth with barriers to employment that may have included, but were not limited to, disabilities.[32] Each DLLR American Job Center in the state had a specialist who worked with youth to prepare them for employment through internships and other volunteer work opportunities, job shadowing opportunities, on-the-job training, and similar services. DLLR's summer jobs program, available statewide, provided youth with six weeks of subsidized employment at the minimum wage for up to 30 hours per week. Third, CSAs in 12 of the state's 23 counties and its only independent city (Baltimore) provided youth with supported employment opportunities. Five of these programs were for youth age 16 or older, one was for youth age 17 or older, and the remaining seven programs were for youth age 18 or older.

Examples of employment services available to transition-age youth with disabilities in selected Maryland localities, using funding from the agencies mentioned above or through privately or locally funded programs, included the following:

- The Youth Works Summer Jobs Program and the two previously mentioned Youth Opportunity Centers that MOED operated in Baltimore. The former provided summer employment opportunities to youth ages 16–21 with and without disabilities. The latter offered transition-age youth with and without disabilities an array of employment services, including occupational training and career readiness support.
- The Marriott Foundation's Bridges from School to Work program, which provided skills assessment; career planning; and job development, placement, and retention services to youth with disabilities ages 17–22 in Baltimore and Montgomery County.
- Project Search, which combined job-readiness training with employment in an integrated setting for at least 16 hours per week during the academic year at the minimum wage or higher for transition-age youth with developmental disabilities in Baltimore and Montgomery, Howard, and Anne Arundel counties.
- The Community Employment Program that Way Station operated in Frederick, Howard, and Washington counties. This program assisted individuals with disabilities in developing and

[31] In all counties, community rehabilitation providers provided VR services on a fee-for-service basis. Way Station was a DORS service provider. About half of the youth on the DORS caseload in Frederick County who received job development, placement, and retention services did so through Way Station (through different staff than MD PROMISE staff, whose time was 100 percent dedicated to the program).

[32] DLLR programs historically served youth ages 16–21, but WIOA extended eligibility to age 24 and required DLLR to target a higher percentage of out-of-school youth (which may have drawn resources away from younger populations). In addition to services offered statewide, local American Job Centers may have offered their own programs. For instance, the center in Frederick County operated (1) the Frederick County Public Schools Success program, which served youth ages 18–21 with significant disabilities and provided internships after they successfully completed a two-week career readiness training program (offered in the schools a few times per year); and (2) the Work to Learn program, a partnership with DORS to provide subsidized internships to about 30 deaf youth.

realizing employment plans through assessment, training, job development, coaching, and supports. Eligible individuals must have been at least 16 years old with a physical, psychiatric, or developmental disability.[33]

With some exceptions, these programs tended to serve small numbers of participants. Some employment services for transition-age youth with disabilities existed in other localities, though many of them were not focused explicitly on low-income youth.

2. MD PROMISE services

Family employment specialists at Way Station led the facilitation of employment-related services and activities for MD PROMISE participants.[34] These activities fell into the following categories:

- **Unpaid work experience.** These activities included informational or job interviews; worksite tours; job shadowing; work sampling (work by a youth that did not materially benefit the employer but allowed the youth to spend meaningful time in a work environment to learn aspects of potential jobs and soft skills required in the workplace); service learning (volunteer service in the community consistent with the objectives of classes the youth was taking in school); unpaid internships; and apprenticeships.
- **Paid work experience.** These activities included self-employment; paid summer workplace learning; temporary jobs; standard jobs; and customized jobs (new positions the employer created in which the relationship between the employer and the employee was negotiated and personalized in a way that met the needs of both).
- **Job search services.** These services included assessing the employment strengths, needs, interests, and preferences of youth participants; training youth on soft skills and appropriate workplace behavior; working with youth to complete job applications, resumes, or other work experience paperwork; and providing job coaching and post-employment follow-up support for youth and employers.
- **Employer outreach services.** These services included contacting employers through telephone calls, in-person visits, or emails to introduce MD PROMISE; conducting workplace assessments to identify potential employment opportunities; meeting with employers to discuss their staffing needs and youth seeking jobs or work experiences; and following up with employers to maintain and strengthen existing relationships.

[33] As with VR services, Community Employment Program services were provided by different staff than MD PROMISE staff, whose time was 100 percent dedicated to PROMISE.

[34] As noted previously, family employment specialists worked exclusively with MD PROMISE participants. It is possible, however, that as an organization, Way Station applied some of the approaches and lessons learned under PROMISE to the employment services it provided to other youth (including, potentially, control group youth) through its role as a DORS service provider or through the Community Employment Program in select counties.

Although the program administrators hoped that each youth in the treatment group would have at least one unpaid and one paid work experience in an integrated setting before leaving high school, the program set benchmarks of 80 and 70 percent of youth having each experience, respectively, by the end of program operations (60 and 50 percent, respectively, by the end of the third year of operations). MDOD, TransCen, and Way Station staff told us that in the first two years of the program, youth had paid and unpaid work experiences primarily during the summer, when they were out of school and had more time, though they were available to youth at any time. Program managers encouraged the family employment specialists to facilitate work opportunities throughout the year for students who wanted and were able to work during the academic year. TransCen supported them in doing so by establishing informal relationships with large employers (such as CVS, UPS, Johns Hopkins Medicine, Aetna, Best Buy's Geek Squad, Food Lion, Crowne Sports Center, and the Pyramid Arts Program) to secure their commitment to employ or provide unpaid work experiences to multiple MD PROMISE youth based on the youths' interests and skills.

MD PROMISE's efforts to facilitate work experiences seemed fruitful. As of February 2017, 61 percent of MD PROMISE participants had an unpaid work experience (broadly defined) subsequent to their enrollment in the evaluation (Table III.6). Thus, the program met its target rate of youth engagement in unpaid work experiences by the end of the third year of operations. When the definition of an unpaid work experience is narrowed by excluding informational interviews and worksite tours (which do not involve performance of job tasks), 42 percent of participating youth had an unpaid work experience by the end of the third program year; the average number of experiences among them was two. The program nearly met its target of a 50 percent rate of youth engagement in paid work experiences by the end of the third year of operations; MIS data indicate that, as of February 2017, 48 percent of participating youth had worked for pay at a standard job, a customized work assignment, a temporary or summer job, or were self-employed. Among the youth in the focus groups who discussed having had paid work experiences, some had obtained those experiences with the direct help of their intervention teams but more had obtained them through other channels (such as their schools or personal connections)—some before PROMISE began and some afterward, perhaps using skills they learned through PROMISE.

According to the program design, the ideal paid work experience, and the one a family employment specialist was expected to attempt to facilitate first, was a job in which an employer paid a youth's wages. If a family employment specialist was unable to help a youth secure this type of job, the next course of action was to refer the youth to an existing program (for instance, through WIOA) that would place the youth in a job and pay the wages. As a last resort, a family employment specialist could directly arrange a job placement with wages paid using MD PROMISE funds. Work experiences supported by PROMISE funds were available only in the summer. MDOD and TransCen staff estimated that the paid work experiences of youth were split roughly evenly among these three types; the MD PROMISE MIS did not capture the source of wages for those in paid work experiences.

Table III.6. Take-up of career exploration and work-based learning experiences among MD PROMISE participants as of February 2017 (percentages unless otherwise indicated)

Service	Participating youth who received service	Participating youth with parents or guardians who received service	Participating youth with other household members who received service
Unpaid work experiences			
Informational interview	35.2	1.0	0.9
Worksite tour	31.6	1.0	1.0
Job shadowing	10.9	0.2	0.1
Work sampling	26.3	0.1	0.3
Service learning	20.7	0.0	0.4
Internship	4.0	0.0	0.1
Apprenticeship	1.4	0.0	0.0
All	0.2	0.0	0.0
Any[a]	61.2	1.2	1.5
Average number per participant with any experiences	3.3	2.1	2.4
Any, excluding informational interviews and worksite tours	42.2	0.2	0.8
Average number per participant with any—excluding informational interviews and worksite tours	2.0	1.5	1.3
Paid employment[b]			
Standard job	21.3	4.2	2.9
Customized work assignment	5.3	0.0	0.0
Temporary job	13.2	0.3	0.3
Summer workplace learning experience	17.1	0.0	0.0
Self-employment	4.6	0.0	0.2
Any	48.3	4.6	3.2
Average number per participant with any paid jobs	1.5	1.3	1.3
Job search services			
Discovery of vocational interests and aptitudes	75.9	3.9	3.6
Soft-skills or pre-employment training	49.2	2.6	1.7
Job application and resume assistance	50.7	2.8	2.6
Job development tools	17.9	1.0	0.5
Assistance with employment-related paperwork	81.4	5.2	4.3
Post-employment follow-up	7.5	0.2	0.2
All	2.3	0.0	0.0
Any	82.3	5.3	4.5
Employer outreach services			
Direct contact and employer introduction	67.9	2.6	2.3
Informational interview or job analysis	39.7	0.3	0.5
Employer consultation to strengthen relationships	27.3	1.3	0.9
Follow-up with/proposals to employers	16.7	0.0	0.0
All	6.8	0.0	0.0
Any	70.7	3.0	2.5
Number of participating youth	920	920	920

Source: The MD PROMISE MIS.

[a] MD PROMISE intended that 60 percent of youth would have an unpaid work experience by the end of the third year of program operations and 80 percent by the end of program operations.

[b] MD PROMISE intended that 50 percent of youth would have a paid work experience by the end of the third year of program operations and 70 percent by the end of program operations.

MD PROMISE provided job search services to prepare youth for successful work experiences. Three years into program operations, intervention teams had provided these services to more than 80 percent of participating youth (Table III.6). In addition, the intervention teams had conducted outreach to employers on behalf of 71 percent of participating youth. The parents or guardians and other household members of participating youth were also eligible for employment-related services from MD PROMISE, though the program had no expectations for the percentage who would receive these services. MIS data indicate that few of them had received any such services as of February 2017. The program had provided job search services to and conducted employer outreach on behalf of the parents or guardians and other household members of about 5 percent and 3 percent of youth, respectively. Virtually none of the youth had parents, guardians, and other household members with an unpaid work experience. The percentage of youth with parents or guardians and other household members who had paid employment experiences was only slightly higher.

During site visits, TransCen staff shared with Mathematica that their technical assistance on the delivery of employment services was much more intensive than anticipated at the program's outset. Furthermore, TransCen delivered that assistance to the intervention staff primarily on an individualized basis rather than through group workshops, as originally planned, to provide support that was customized to each staff member's strengths and weaknesses. TransCen made these adjustments because, as TransCen staff and Way Station managers both acknowledged, many of the staff had come to MD PROMISE with social service backgrounds and lacked the focus on employment so central to the program's design. To reinforce messages around employment, two years into program operations, TransCen recommended that all family employment specialists go through Association of Community Rehabilitation Educators training, which is designed to raise service delivery standards among professionals working in the field of employment for people with disabilities. Way Station held the first training in spring 2016.

TransCen's technical assistance helped the PROMISE managers focus more keenly on attaining the program's benchmarks for unpaid and paid work experiences, but elicited mixed reactions from the case managers and family employment specialists. Several of them suggested to us that the focus on the employment benchmarks may have been to the detriment of needed case management and possibly reduced attention to youth who already had work experiences but still needed services. Some of the intervention team staff said, "It shouldn't all be about quantity, but quality," and, "We need to do more than just check the [employment] boxes." These sentiments reflect the challenge program managers described as shifting the field away from a social service philosophy in which staff manage youths' crises and services to one in which they focus on youths' abilities and facilitating and supporting their work efforts.

D. Parent training and information

The federal sponsors specified two areas in which they expected PROMISE programs to provide training and information to the families of youth participants: (1) the parents' or guardians' role in supporting and advocating for their youth to help them achieve their education and employment goals; and (2) resources for improving the education and employment outcomes of the parents or guardians, and the economic self-sufficiency of the family. In this section, we describe counterfactual services in this area for families of youth with disabilities in Maryland and the services MD PROMISE provided.

1. Counterfactual services

Although some training for the family members of youth with disabilities may have occurred through other programs mentioned in the previous sections of this chapter, none of the site visit respondents in the evaluation of MD PROMISE was aware of any such efforts. A search of resources provided by MDOD revealed that The Parents' Place of Maryland, the state's only Parent Training and Information Center, provided individual consultation; information dissemination through workshops, webinars, conferences, and print materials; parent mentoring; and parent leadership trainings to parents of children with disabilities.[35]

2. MD PROMISE services

MD PROMISE intended for the intervention teams to provide employment and other services to family members in addition to participating youth, with the expectation that those services would improve parents' and guardians' self-efficacy and raise their expectations about their own futures and those of their children. Although the program offered the career exploration and work-based learning experiences described previously to family members, the initial program design did not include specific trainings or group activities (for instance, workshops on navigating medical and social services for youth with disabilities, increasing engagement in children's education, or learning how to empower oneself or one's child) for parents and guardians or other family members, and none occurred during the first three years of program operations. Rather, MD PROMISE intended that case managers would provide information and support to parents during individual meetings and connect them to existing resources and trainings in the community. MDOD staff talked during site visits about hoping to use some of the supplemental funding MD PROMISE received from ED in 2015 to provide more formalized parent training, but, as of the end of the third year of program operations, the program had been unable to identify an existing curriculum that was culturally sensitive and targeted to low-income parents of youth with disabilities.

E. Education services

The federal PROMISE program sponsors did not specify education services as a core program component, but programs were free to implement them in the context of or separate and apart from other program services. Examples include activities to expose participating youth to postsecondary education and assistance with individual transition planning in schools. In this section, we describe counterfactual education-related services for youth with disabilities in Maryland and the services MD PROMISE provided in this area.

1. Counterfactual services

Most education services available to transition-age youth with disabilities in Maryland were provided either by the schools themselves or in the schools by other organizations or programs. Each school district in the state had a school system transition facilitator, and each high school had at least one special education teacher. By law, at age 14, students with IEPs must have at

[35] Supported by the U.S. Department of Education, Office of Special Education Programs, Parent Training and Information Centers are charged with providing training and information to parents of children with disabilities from birth through age 26.

least one postsecondary education transition goal in their programs. In addition to providing other supports to students, transition facilitators and special education teachers participated in IEP meetings to facilitate and monitor progress toward those goals. Regardless of whether they had IEPs, students with disabilities, if they were known to school or DORS staff, might have received services from DORS transition counselors in high schools, including counseling on opportunities for postsecondary education. DORS assigned a transition coordinator to each school district and a transition counselor to each high school (although some high schools shared a transition counselor). Before the implementation of the Pre-ETS provision in WIOA in 2016, these services were more limited and focused on students who were one to two years away from exiting high school.

Several CSAs received BHA grants to provide services to transition-age youth with disabilities that were not billable under BHA's fee-for-service system; one such service was supported education. Supported education is defined as "education in integrated settings for people with severe psychiatric disabilities for whom postsecondary education has not traditionally occurred or for people for whom postsecondary education has been interrupted or intermittent as a result of severe psychiatric disability, and who, because of their handicap, need ongoing support services to be successful in the educational environment."[36] Such services were available in Howard and Montgomery counties, and the southern Maryland tri-county region (Calvert, Charles, and St. Mary's counties).

Finally, DLLR youth specialists worked with youth ages 16–21 not only to prepare them for careers, as discussed in Section C of this chapter, but also to meet their educational goals. These services were not limited to youth with disabilities.

2. MD PROMISE services

Depending on the needs and interests of the youth they served, the MD PROMISE intervention teams engaged with school special education staff and DORS transition counselors. A key way in which the intervention teams described interacting with those professionals was by attending (and preparing for and following up on) IEP meetings. MIS data indicate that as of February 2017, team members attended IEP or other school meetings on behalf of 24 percent of participating youth (Table III.7). Although every child who receives special education services must have an IEP, not all MD PROMISE youth received such services or were enrolled in school.[37] The program also provided the following types of education services to treatment group youth with or without an IEP (Table III.7):

- **Communication with school personnel.** This communication included face-to-face, telephone, and email contact with special education teachers, transition counselors, transition coordinators, and other school personnel regarding a youth's education and transition needs. As of February 2017, intervention teams provided this service for 57 percent of participating youth.

[36] Available at http://cafetacenter.net/wp-content/uploads/2011/05/SUPPORTED-EDUCATION-white-paper-5-27-11.pdf. Accessed January 7, 2018.

[37] MD PROMISE did not maintain data on and could not estimate the number of treatment group youth who had an IEP.

- **Student support services.** These services entailed working with a youth to identify and facilitate education supports, such as tutoring, transportation to school, financial assistance with school-based expenses, and other education-related services. As of February 2017, intervention teams provided this service for 40 percent of participating youth.
- **Postsecondary education linkages.** These services entailed supporting or facilitating a youth's participation in programs for youth with disabilities on college campuses, college fairs, college campus tours, and college entrance exams. Additional services in this category included assistance with research on postsecondary education options, postsecondary education applications, financial aid applications, accessing disability support services offices at postsecondary institutions, and pursuing coursework at these institutions. MD PROMISE anticipated that by the end of program operations, 25 percent of youth would have received postsecondary education linkages (15 percent by the end of the third year of operations). As of the end of the third year of program operations, MD PROMISE had significantly exceeded its end goal, having provided such linkages to nearly one-third of participating youth. For almost all of those youth, the linkages had included assistance in conducting research on options for postsecondary education; for about half of them, the linkages included college campus tours.

Table III.7. Take-up of education services among MD PROMISE participants as of February 2017 (percentages unless otherwise indicated)

Service	Participating youth who received service	Participating youth with parents or guardians who received service	Participating youth with other household members who received service
Education-related services			
Preparing for or attending IEP or other school meetings	23.7	0.3	0.3
Communication with school personnel	57.4	0.8	1.2
Student support services	40.4	0.7	1.3
All	12.2	0.0	0.1
Any	69.8	1.3	2.1
Postsecondary education linkages[a]			
Dual enrollment program	0.9	0.0	0.0
College fair	2.3	0.1	0.0
College campus tour	14.3	0.5	0.8
College entrance exam	1.3	0.1	0.2
Postsecondary education options research	27.7	0.8	1.0
Postsecondary education application	3.3	0.0	0.2
Financial aid application	2.7	0.1	0.2
Disability support services	3.8	0.2	0.2
Course enrollment	1.8	0.0	0.1
All	0.0	0.0	0.0
Any	32.6	1.2	1.5
Number of participating youth	920	920	920

Source: The MD PROMISE MIS.

[a] MD PROMISE intended that 15 percent of youth would have postsecondary education linkages by the end of the third year of program operations and 25 percent by the end of program operations.

Site visit interviewees from MDOD, Way Station, and TransCen indicated that the degree to which the MD PROMISE intervention teams were involved with schools initially varied substantially across the school districts. These interviewees reported and MSDE administrators confirmed that although the districts were required to comply with MSDE policy, they had considerable discretion in how to do so and were receptive to MD PROMISE to varying degrees at the program's outset. Initially, MD PROMISE fostered collaboration with education authorities at the state level and encouraged intervention staff to develop relationships with district and individual school staff. Districts were receptive to different levels and types of collaboration with MD PROMISE staff.[38] Midway through program operations (in September 2016), PROMISE invited staff from each school district to a meeting about the program and how it could work collaboratively with schools to better serve participating youth. Site visit interviewees described that effort as successful and resulting in most districts developing communication and service coordination protocols vis-à-vis PROMISE. These protocols allowed the intervention teams greater access to school personnel and regular participation in IEP meetings. At the end of the third year of program operations, site visit interviewees pointed to only one large school district that had been unwilling to provide MD PROMISE with information about youth without going through a lengthy institutional review board and approval process. However, MD PROMISE staff did provide information to the school on youth in that district and participated in IEP meetings when they obtained parental permission.

MD PROMISE did not set any benchmarks for the provision of education services to the parents, guardians, or other family members of participating youth, and very few received them. The parents or guardians of only about 1 percent of participants received secondary education support services or the provision of postsecondary education linkages. Rates of receipt of those services by other family members were only slightly higher, not exceeding 2 percent (Table III.7).

F. The possibility that control group members received MD PROMISE services

Adherence to a study design that maintains and maximizes a distinction between the treatment and control groups throughout program operations is critical for an evaluation to be able to detect program impacts (that is, statistically significant differences in outcomes between the treatment and control groups). The more a program inadvertently provides services to control group members, the less likely average outcomes will differ between the treatment and control groups.

MD PROMISE's approach to engagement in program services ensured that youth assigned to the control group could not access services from PROMISE. The evaluation recruitment team at Westat was distinct from the intervention teams at Way Station, and they rarely interacted. Westat provided information to Way Station on treatment cases only; Way Station staff did not have access to Westat's recruitment data or the RAS, and throughout program operations had no way of identifying youth assigned to the control group. MD PROMISE case managers and

[38] Examples of concerns among some local school administrators included issues related to the Family Educational Rights and Privacy Act, staff impact, and institutional review boards and research.

family employment specialists worked exclusively on PROMISE and served only youth who had been referred to them by Westat; they accepted no referrals from other entities or walk-ins.

A program model that intends to create lasting change in the service environment can also be challenging for an experimental impact evaluation. Sustaining improvements in the service delivery environment, as expected by federal PROMISE partners, and certain components of MD PROMISE may become the program's greatest legacy if the results are more effective services for future cohorts of transition-age youth with disabilities and their families. As those outside of the treatment group begin to benefit from such enhancements, however, the impacts of the program within the context of the random assignment evaluation may diminish. Consequently, any sustainment of MD PROMISE could have problematic implications for the evaluation's five-year impact analysis and any longer-term impact analyses that SSA or other organizations might choose to undertake.

As of the end of the third year of program operations, MD PROMISE itself had no specific plans for sustaining discrete aspects of the program's service model beyond the end of the cooperative agreement. Way Station hired case managers and family employment specialists specifically for the program; their positions will be eliminated when Way Station's contract with MDOD for PROMISE ends. Likewise, MD PROMISE (and MDOD) had no plans to continue or replicate the benefits counseling and financial education services provided through the program. As the state's coordinator of efforts to serve individuals with disabilities, MDOD (and its project partners) is well positioned to disseminate lessons learned and best practices from the implementation and operation of MD PROMISE. Whether they will actually facilitate the sustainment of components of MD PROMISE, and what components those might be, remains to be seen.

Finally, systems-level changes that MD PROMISE facilitated or that occurred apart from but concurrently with it may dilute the impacts of the program if they result in enhanced services for members of the control group similar to those provided by MD PROMISE. Several initiatives that included systems-change elements and were implemented while PROMISE was operational could have implications for the program's impacts. These include WIOA, a grant that Maryland received to address the needs of youth with disabilities, and an MSDE initiative focused on transition.

WIOA. WIOA required that DORS spend 15 percent of its funding on transition services for youth with disabilities. In 2016, Maryland operationalized this requirement by creating the Pre-ETS program for youth in 9th or 10th grades and youth in higher grades on the waiting list for traditional VR services.[39] We learned during site visit interviews that although DORS was in the process of hiring Pre-ETS staff and contracting with community rehabilitation providers to provide services, it did not want to accumulate a Pre-ETS caseload too quickly (the agency estimated that 33,000 youth might be eligible for Pre-ETS statewide), so it accepted referrals of youth to the Pre-ETS program only from parents, not from school staff. Thus, the extent to which

[39] For years, DORS has been operating under an order of selection, with a waiting list for Category 2 individuals—those with significant disabilities—of up to 22 months. Category 3 individuals—those with the least significant disabilities—have never been served.

MD PROMISE treatment group youth benefitted from Pre-ETS during its early implementation likely depended on how proactive the program staff were in promoting Pre-ETS to parents and guardians. The extent to which control group youth benefited from Pre-ETS during its early implementation likely depended on how savvy their parents or guardians were in learning about such opportunities, or on information they may have obtained about Pre-ETS from other service providers.

MD PROMISE began providing its staff with information about Pre-ETS and how to refer treatment group youth to the program in spring 2016. Site visit interviewees revealed that by the end of the third year of program operations, Pre-ETS service providers were operating in all areas of the state and accepting referrals from all sources (including school and other programs), but not all services were available in all areas. In addition, the Pre-ETS program was serving any in-school youth with disabilities regardless of age or DORS application status. (To ensure that it met its 15 percent funding requirement, DORS made the strategic choice to serve all in-school youth through the Pre-ETS program rather than its traditional VR offerings.) DORS staff shared with us that in the first quarter of 2017, the Pre-ETS caseload consisted of 1,294 youth.

National Technical Assistance Center on Transition grant. In January 2016, the National Technical Assistance Center on Transition awarded Maryland a grant to promote collaboration between state and local education agencies and DORS and its service providers to improve postsecondary outcomes for students with disabilities. To further foster collaboration, MSDE formed a state-level workgroup through the grant, consisting of MSDE, MDOD, and other state entities serving transition-age youth.

MSDE's online portfolios for students. In 2016, MSDE developed and piloted online portfolios in four school districts designed to (1) facilitate the sharing of information about individual students with disabilities across agencies and (2) promote smoother transitions from school-based to adult services. All of the services provided to a student with disabilities, as well as the student's connections with adult service providers, are recorded in his or her online portfolio. While a youth is in school, MSDE has unlimited access to the portfolio; when a youth exits school, he or she controls access and can share it with providers of adult services.

Concurrently, MD PROMISE developed and piloted a hard-copy form in several counties that allowed for coordination and communication regarding youth. The form facilitated information sharing between PROMISE, schools, and DORS. Over time, MD PROMISE expanded its use of this form to most of the counties in the state. MDOD and MSDE are working in partnership to refine this tool to improve information sharing between schools and adult service agencies.

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IV. PROGRAM PARTNERSHIPS

As noted in Chapter I, a key objective of the PROMISE programs was to improve service coordination among multiple state and local agencies. The federal sponsors required recipients of PROMISE cooperative agreements to establish formal partnerships among state agencies responsible for programs that serve the target population, encouraging them to cultivate new partnerships and expand existing ones with community-based disability providers. At a minimum, these partnerships needed to include the agencies responsible for programs that provide VR, special education, workforce development, Medicaid, TANF, services for those with developmental or intellectual disabilities, and mental health services. MD PROMISE established partnerships with each of these agencies, as well as the state agency that provides juvenile justice services (DJS) and community-based organizations that provide direct services. In this chapter, we describe the quality of these partnerships and changes in communication and collaboration among the partners over time.

Data from two social network surveys of administrators and frontline staff of MD PROMISE partners provided an opportunity to quantify and graphically depict their partnerships before PROMISE and how those partnerships changed as they implemented the program. The surveys were grounded in network theory, which focuses on the ties among individuals or organizational entities (Wasserman and Faust 1994). Survey data from administrators (who did not provide services directly to participants) provided insight into system changes that supported service delivery and might extend beyond the end of the cooperative agreement for MD PROMISE. Survey data from frontline staff (who provided services directly to participants) illuminated the service networks that may have facilitated or impeded program implementation and operations. Changes in relationships that occurred concurrently with program implementation and operations cannot necessarily be attributed entirely to PROMISE, as other initiatives (such as WIOA) and environmental factors may have been driving or contributing forces.

The social network surveys asked respondents to report their involvement with 10 MD PROMISE partner organizations.[40] They included the lead agency (MDOD), the lead service provider (Way Station), and other organizations on the steering committee, including state-level partners that may have provided services to youth in the treatment or control groups (BHA, DDA, DLLR, DORS, and MSDE) and state-level partners that did not provide such services because they do not specifically offer direct services targeted to youth with disabilities (DHR, DJS, and other offices within DHMH).[41] Respondents to the survey of administrators included

[40] Because these surveys differ from typical surveys (they ask about relationships between the respondent and all other MD PROMISE partner agencies), we used network analysis computations to quantify the results. Network analysis is an approach to examine relationships among a set of actors. In the network analysis computations, we excluded the respondent's own organization. For the administrative network analysis, when more than one person from an organization responded, we used the highest value across respondents to represent the organization's response. In these instances, the analysis reflects the "best" relationship reported. We then computed the average percentage across all organizational respondents. The average percentage is reported in the tables and figures.

[41] We excluded TransCen from the network analysis because its only role in MD PROMISE was to provide technical assistance. Also, one potential partner was noticeably absent from the MD PROMISE steering committee. Intervention team staff and supervisors told us during site visits that inadequate housing was one of the primary

staff from five partners (MDOD, Way Station, DLLR, DORS, and MSDE). Respondents to the survey of frontline staff included Way Station case managers and family employment specialists; the analysis excluded their involvement with DHMH and MDOD, as those organizations lacked corresponding frontline staff with whom the intervention teams could connect.[42] We captured information about the MD PROMISE networks during the following periods:

- Before MD PROMISE services began (about 6 months before enrollment in the evaluation began, which was 12 months before we conducted the first round of the survey)
- Early implementation (about 6 months after enrollment in the evaluation began, which was when we conducted the first round of the survey)
- Late implementation (about 24 months after enrollment in the evaluation began, which was when we conducted the second round of the survey)

The findings we present below suggest increasing involvement of state-level administrators during MD PROMISE implementation and varied connections among frontline staff, even during late implementation. Even though state-level administrators had effective working relationships before the program started, their communication frequency increased during early program implementation and remained at that level through late implementation. Furthermore, as MD PROMISE progressed, administrators collaborated on program-related activities more frequently. In contrast, frontline staff had varied levels of communication and collaborative activities, even during late implementation, and more frequently reported involvement with benefits counselors, MSDE staff, and DORS staff than with other partner organizations.

A. Administrative partnership networks

When the program rolled out, communication and effective working relationships increased among MD PROMISE partners at the administrative level about issues pertaining to youth with disabilities. These increases were largely sustained as the program matured. Table IV.1 shows the relationships reported by the five MD PROMISE administrative partner organization respondents with the other nine partner organizations. The first column identifies the question asked, the second column indicates the level at which we assessed the responses, and the percentages represent the share of partner organization relationships at the level indicated for each period. For example, before PROMISE services began, each of the five respondents reported on their communication with each of the other nine partner organizations, for a total of 45 reported relationships. 26 of the 45 reports (58 percent) indicated the communication occurred at least monthly.

(continued)

issues that kept treatment group families in crisis. Many of those families were eligible for housing assistance, but the Maryland Department of Housing and Community Development was not one of MD PROMISE's state agency partners. The federal sponsors of PROMISE did not require programs to establish formal partnerships with housing agencies.

[42] Although we surveyed staff from Full Circle Employment Solutions and MD CASH Campaign, we excluded those responses from this analysis to focus on the primary MD PROMISE service delivery staff.

Table IV.1. Communication and effective working relationships among MD PROMISE partners, by implementation period

Relationship question	Response assessed	Share of partner organization relationships		
		Before PROMISE services	Early implementation	Late implementation
How frequently did administrative staff from your organization communicate with administrative staff in the following organizations about issues pertaining to youth with disabilities and their families?	Communication at least monthly	58%	82%	76%
To what extent did your organization have an effective working relationship with each of the following organizations on issues related to youth with disabilities and their families?	Effective working relationship to a considerable extent	51%	73%	60%
	Effective working relationship to some or a considerable extent	91%	100%	96%

Notes: Respondents for five MD PROMISE administrative partners (MDOD, Way Station, DLLR, DORS, and MSDE) completed interviews in the early and late implementation periods (the early interview also covered the period before PROMISE services began) to describe their relationships with each of the other nine MD PROMISE partner organizations. More than one person from Way Station responded regarding all periods, and more than one person from MDOD responded regarding the late implementation period; however, in each instance we used the highest value reported to represent the organization's response. Thus, it was as if there was one respondent for each organization.

Generally, partners built on preexisting relationships; most of the respondents' communication with other partners was at least monthly before the implementation of MD PROMISE services (58 percent of partner organization relationships) and the quality of most of the relationships was positive, whether measured as effective to a considerable extent (the highest response option, representing 51 percent of partner organization relationships) or to some or a considerable extent (91 percent of partner organization relationships). Site visit interviews with MDOD and its key partners confirmed the existence and strength of these previously established relationships. MDOD officials felt it was not necessary to formalize agreements (through contracts or memoranda of understanding) for MD PROMISE with its state agency partners for the following reasons: their history of working together successfully on other efforts; because the legislation that created MDOD required that it facilitate relationships among and coordinate the efforts of government entities serving individuals with disabilities; and because the partners were not receiving funding from PROMISE for their efforts. MDOD's PROMISE partners had laid some of the groundwork for partnership development under MD PROMISE through their work on the Maryland Seamless Transition Collaborative, a five-year initiative that ended in September 2012 and, like MD PROMISE, relied on TransCen for technical assistance and program support. This initiative connected school districts with adult service providers in 11 jurisdictions across the state to improve postsecondary outcomes for youth with disabilities.

Survey data indicated that, as the program was implemented, the share of partner organization relationships with at least monthly communication or a positive working relationship increased, though these levels subsided slightly during late implementation.[43] As noted previously, the primary role of the state agency partners was to provide guidance and support to MD PROMISE through their participation in its steering committee. They provided support largely by promoting the program to regional and local affiliates, and disseminating communications from the program to the agencies' staff. MDOD also facilitated several workshops to bring the partners together to educate them about MD PROMISE. The MDOD and partner organization administrators we interviewed during site visits all concurred that though they communicated with each other regularly, the steering committee did not meet as a group as frequently as anticipated, in part because of changes in state agency personnel (an issue also salient at the local level). Rather, communication between program senior management and the steering committee typically occurred as needed and outside of the context of formal meetings.

MDOD and Way Station became more prominent among partner organizations over time. Throughout early and late program implementation, all partners reported at least monthly communication and effective working relationships with MDOD (up from half and three-quarters, respectively, before program services began) (Table IV.2). In addition, only one-quarter of the partners communicated at least monthly with Way Station before PROMISE services began, and half reported an effective working relationship with them. During both early and late program implementation, half or more of PROMISE partners reported at least monthly communication with Way Station; all reported effective working relationships to some or a considerable extent.

[43] This pattern was consistent when we restricted the analysis to reciprocal relationships among the organizational respondents (that is, those relationships in which the respondents were in agreement). For example, pairs of organizations reported at least monthly communication with each other 40 percent of the time before PROMISE services began, 80 percent of the time during early implementation, and 85 percent of the time during late implementation.

Table IV.2. Communication at least monthly and effective working relationships among MD PROMISE partners, by implementation period

	Share of partner organizations with which respondents reported relationship				
Implementation period	All PROMISE partners (10)	MDOD (1)	Way Station (1)	State-level PROMISE partners providing counterfactual services (5)	State-level PROMISE partners not providing counterfactual services (3)
Communication at least monthly					
Before PROMISE services	58%	50%	25%	73%	47%
Early implementation	82%	100%	75%	91%	67%
Late implementation	76%	100%	50%	91%	53%
Effective working relationship to some or considerable extent					
Before PROMISE services	91%	75%	50%	100%	93%
Early implementation	100%	100%	100%	100%	100%
Late implementation	94%	100%	100%	100%	87%

Notes: Respondents for five MD PROMISE administrative partners (MDOD, Way Station, DLLR, DORS, and MSDE) completed interviews in the early and late implementation periods (the early interview also covered the period before PROMISE services began) to describe their relationships with each of the other nine MD PROMISE partner organizations. They responded to the questions, "How frequently did administrative staff from your organization communicate with administrative staff in the following organizations about issues pertaining to youth with disabilities and their families?" and "To what extent did your organization have an effective working relationship with each of the following organizations on issues related to youth with disabilities and their families?" For each group of MD PROMISE partner organizations, we computed the percentage of those organizations with which each administrative partner reported communication "at least every month" or effective working relationships "to some or a considerable extent." More than one person from Way Station responded regarding all periods, and more than one person from MDOD responded regarding the late implementation period; however, in each instance we used the highest value reported to represent the organization's response. Thus, it was as if there was one respondent for each organization. Responses are shown for all MD PROMISE partners as well as by four mutually exclusive partner types (lead agency, lead service provider, partners providing counterfactual services, and partners not providing counterfactual services).

As MD PROMISE matured, the administrative partners increasingly collaborated with each other on program-specific activities related to client referrals, service delivery, and data sharing. Table IV.3 shows the share of partner organization relationships in which the respondents reported working on four specific activities (shared resources, service delivery, data sharing, and client referrals) both related to and outside of PROMISE during early and late implementation.[44] During early program implementation, partners collaborated more often outside of the context of the program than within, likely reflecting the relationships that already existed before PROMISE began regarding their work with youth. During late implementation, collaboration was about as frequent within and outside of the program. The exception was service delivery, which continued to occur much more frequently outside of PROMISE (again reflecting the fact that these agencies worked with youth other than those involved with the program). Sharing resources was the one area in which collaboration related to PROMISE did not increase; at the same time, collaboration

[44] For survey brevity, we did not assess the extent of collaborative activities before PROMISE services began.

outside of the program on this activity decreased substantially. By design, MD PROMISE never intended to share resources with other entities. The partners reported working less frequently with Way Station on non-PROMISE activities than with other organizations, which might have been expected, given that Way Station was the only organization in the network that was not a state agency (data not shown).

Table IV.3. Activities on which MD PROMISE partners collaborated related to and outside of the program, by implementation period

		Share of partner organization relationships	
Relationship question	Collaborative activity	Early implementation	Late implementation
In the past year, and related to your work on PROMISE, with which of the following organizations has your organization [conducted the activity]?	Shared resources	27%	27%
	Service delivery	16%	40%
	Data sharing	13%	29%
	Client referrals	4%	31%
In the past year, and outside of your work on PROMISE, with which of the following organizations has your organization [conducted the activity]?	Shared resources	69%	27%
	Service delivery	40%	69%
	Data sharing	29%	36%
	Client referrals	31%	24%

Notes: Respondents for five MD PROMISE administrative partners (MDOD, Way Station, DLLR, DORS, and MSDE) completed interviews in the early and late implementation periods to describe their collaborative activities with each of the other nine MD PROMISE partner organizations. We computed the percentage of those organizations with which each organizational respondent reported conducting the specified activity. More than one person from Way Station responded regarding both periods, and more than one person from MDOD responded regarding the late implementation period; however, in each instance we used the highest value reported to represent the organization's response. Thus, it was as if there was one respondent for each organization.

B. Service partnership networks

The relationships that individual Way Station intervention team staff had with MD PROMISE partners varied. We asked about their relationships with eight partners that employed frontline staff who worked directly with clients. 17 staff members responded to the questions about early implementation and 9 about late implementation; 8 of the respondents provided information about both periods. In Table IV.4, we show the share of frontline partner organization relationships in which Way Station frontline staff reported communicating at least monthly or conducting collaborative activities during early or late implementation.[45] For

[45] We did not assess Way Station staff relationships before PROMISE services began because these staff had not yet begun working for the program.

example, during early implementation, 17 staff members reported on their communication with each of 8 partner organizations, for a total of 136 reported relationships. 19 of the 136 reports (14 percent) indicated that communication occurred at least monthly.

In 14 percent of their relationships during early implementation and 25 percent during late implementation, Way Station case managers and family employment specialists reported communicating at least monthly with the frontline staff of other organizations. During early implementation, Way Station intervention team staff collaborated with MD PROMISE partners most often to refer youth and families to their services and to conduct joint training. As the program matured, intervention staff increasingly collaborated with partners' frontline staff with respect to these and all other activities we assessed: discussing clients' needs, goals, and services; transition planning; data sharing; and receipt of referrals from the partner organizations.[46]

Table IV.4. Activities among MD PROMISE Way Station frontline staff and MD PROMISE partners, by implementation period

		Share of partner organization relationships	
Relationship question	Response assessed/collaborative activity	Early implementation	Late implementation
How frequently did you communicate with frontline staff (who work directly with clients) in the following organizations about client issues?	Communication at least monthly	14%	25%
Related to your work with youth or adults with disabilities, how often did you do the following with each organization?	Refer clients to partner organization	15%	31%
	Conduct joint training	13%	19%
	Discuss clients' needs, goals, and services	11%	27%
	Meet for transition planning	9%	22%
	Share client data	7%	22%
	Receive referrals from partner organization	2%	14%

Notes: A total of 17 intervention team respondents completed interviews during early implementation and 9 during late implementation to describe their activities with eight MD PROMISE partner organizations. We omitted one staff member's responses about collaborative activities due to incomplete data.

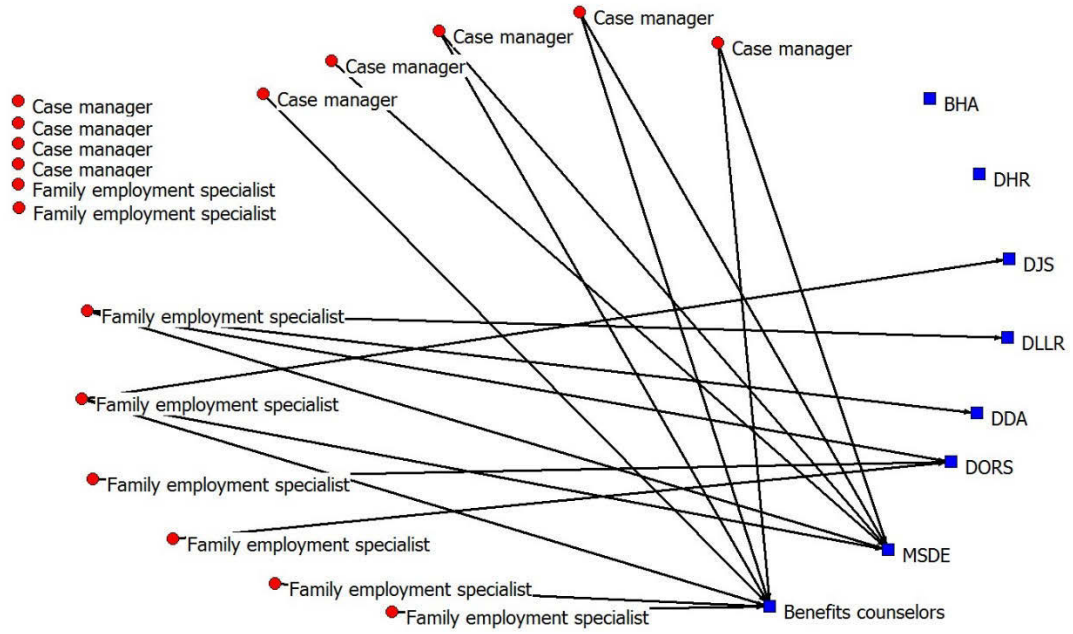
[46] These patterns are similar when examining the responses for the eight staff respondents who provided information during both early and late implementation. For example, these respondents reported communication at least monthly with 17 percent of the frontline staff of MD PROMISE partner organizations during early implementation and 27 percent during late implementation.

The percentages shown in Table IV.4 offer summary information about relationships but do not reflect the variations between individual Way Station intervention team staff and MD PROMISE partner organizations. Figure IV.1 uses graphical representations of relationships (sociograms) to depict at least monthly communication (shown as lines) that Way Station case managers and family employment specialists (shown as red circles) reported having with MD PROMISE partner organizations (shown as blue squares). Figure IV.1a shows the relationships reported during early implementation; Figure IV.1b shows them during late implementation. In both figures, the staff members who reported less than monthly communication with all partners are shown in the upper left. Four patterns emerge from these figures:

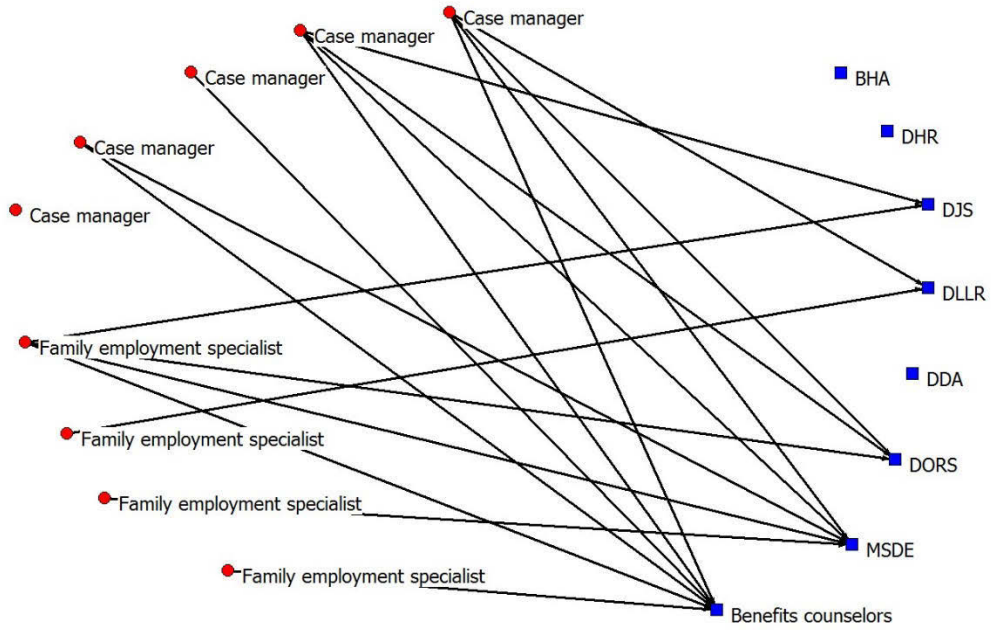
1. During both periods, some intervention team staff communicated at least monthly with three or more partners, whereas others communicated with no partners or only one or two. This finding mirrors observations from our site visits indicating that program frontline staff were expected to develop their own networks for their work on PROMISE, and that the extent of those networks and the abilities of staff members to leverage them both varied. As noted above, MD PROMISE made efforts to facilitate relationships with some partners at the local level, but some of those efforts occurred after we conducted the second social network survey.
2. By late implementation, almost every member of the Way Station intervention teams (that is, the case managers and family employment specialists) communicated at least monthly with the benefit counselors at Full Circle Employment Solutions. These strong ties provide evidence that benefits counseling was in fact an integral component of MD PROMISE, as specified in the program design.
3. By late implementation, Way Station intervention team staff were relatively well connected with MSDE special education staff, although some had no relationships with this partner. It is possible that this pattern reflected the inconsistency with which school districts collaborated with MD PROMISE during the first half of program operations, and that the pattern changed in response to enhanced efforts the program made in 2016 to facilitate and expand local-level collaboration with school system staff. Connections between Way Station intervention team staff and DORS staff were less frequent at that time.
4. No Way Station intervention team staff had monthly or more contact with DDA, BHA, or DHR staff during late implementation. Intervention teams may not have had contacts to tap at DHR. MDOD administrators told us that, although MD PROMISE did forge relationships with DHR at the state and regional levels to identify case managers within the foster care system with whom PROMISE intervention teams could connect, they expected intervention staff to develop their own local-level relationships. None of the intervention staff with whom we spoke during site visits discussed developing such relationships with foster care, TANF, or SNAP staff. Intervention staff may not have felt the need to collaborate with DHR because that agency does not provide services specifically targeted to the families of youth with disabilities or because they perceived the services DHR provides as easy for families to access on their own. On the other hand, DDA and BHA do provide service coordination and other supports for youth with disabilities, which intervention staff in principle could have leveraged in serving MD PROMISE youth and families. Although DDA services are typically targeted to older youth, establishing relationships with staff at this agency early on could have facilitated future transitions for PROMISE youth. BHA services are available to youth of all ages. Intervention staff may not have perceived DDA or BHA services as relevant to enough youth on their caseloads to warrant at least monthly contact with them, however.

Figure IV.1. Communication at least monthly among MD PROMISE Way Station staff and MD PROMISE partners, by implementation period

a. Early implementation



b. Late implementation



Notes: A total of 17 respondents completed interviews during early implementation and 9 during late implementation. The figures show responses of "at least every month" from the intervention team members at Way Station to the question, "How frequently did you communicate with frontline staff (who work directly with clients) in the following organizations about client issues?" Red circles represent intervention team members at Way Station; blue squares represent PROMISE partners, including Full Circle Employment Solutions (specifically, the benefits counselors). Respondents who did not report any communication at least monthly are shown in the upper left-hand corner of the figures.

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V. LESSONS AND IMPLICATIONS FOR THE IMPACT ANALYSIS

In the absence of findings from the evaluation's ongoing impact analysis, it is premature to assess whether MD PROMISE was successful in reducing SSI payments and improving education and employment outcomes among transition-age youth with disabilities. Nonetheless, the process analysis revealed several lessons on the benefits and challenges of the program's approach to engaging youth with disabilities, delivering services to them and their families, and facilitating partnerships to improve service coordination. It also identified important considerations about how administrators and staff implemented the program in practice that may have implications for its ability to generate impacts.

A. Lessons about engaging youth with disabilities and their families

Hiring experienced local staff whose only responsibility is recruitment is a good strategy for achieving enrollment goals. MD PROMISE's approach to recruitment was very successful, as evidenced by its attainment of its evaluation enrollment target several months ahead of schedule. Three elements of the program's staffing of the recruitment process contributed to its success:

1. MD PROMISE engaged an organization (Westat, under a subcontract from TransCen) with experience in recruitment for program evaluations.
2. Westat hired staff who resided in the areas where they would be recruiting and conducted door-to-door outreach to eligible youth. This approach enabled the recruiters to connect meaningfully with the youth and their families.
3. The recruitment staff had no responsibilities for providing program services, which enabled them to focus exclusively on conducting outreach to youth and enrolling them in the evaluation.

Engaging youth with disabilities and their families in program services may require different approaches in different community contexts. 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. Smaller caseloads can help ensure that staff who must travel long distances to deliver services in rural areas can devote sufficient time to maintaining families' program engagement. In areas of dense poverty, families often face crises that may limit their ability to engage in programs focused on increasing human capital. Supporting those families through such crises may be an important step toward engaging them in a program's core education and employment services while maintaining a focus on employment as the ultimate outcome.

Getting youth who are not participating in program services to do so can be expensive, but may be worth the investment. MD PROMISE used a substantial portion of its supplemental funding from ED to hire seven specialized case managers whose sole role was to engage treatment group youth who had never participated in the program or had done so briefly and then lost interest in or contact with it. Their efforts met with some success. Within the short

period between when MD PROMISE hired the specialized case managers in 2016 and Mathematica's last qualitative data collection in 2017, about one-third of all treatment group youth were referred to the specialized case managers, one-quarter of whom either became engaged in program services for the first time or became reengaged. Unlike the intervention team staff (case managers and family employment specialists), who had to juggle multiple responsibilities, the specialized case managers were able to focus their attention on identifying and addressing barriers to engagement.

B. Lessons about delivering program services and facilitating partnerships to improve service coordination

A compact leadership team can respond nimbly to program issues as they arise. The MD PROMISE leadership team consisted of the program director from MDOD and the MD PROMISE directors at Way Station, and TransCen. Being small, this team was able to meet biweekly to review program operations and communicate informally as needed between meetings, which facilitated efficiency in decision making. The small size of the team also fostered cohesion among the program leaders that was palpable to all program staff and partners, and set a tone of collegiality within the program. Although the leaders said they might have benefited from a somewhat larger team, that cohesion enabled the leadership team to deliver clear and consistent messages to the staff and partners about program expectations.

Intensive support from a technical assistance provider can maintain a program's focus on critical benchmarks. A key challenge that MD PROMISE faced was moving staff beyond case management and crisis intervention, and getting them to embrace an employment-first philosophy (which program managers agreed is critical to obtaining meaningful employment outcomes) while still providing other supports. At times, some of the staff felt that requirements to meet benchmarks for employment outcomes were at odds with the program's person-centered approach, which was intended to empower youth and families to identify their own goals, and then offer the services and supports needed to achieve them. Reconciling this issue required substantial communication among program administrators, supervisors, staff, and the technical assistance provider. TransCen played a key role in supporting the MD PROMISE intervention teams at Way Station in pursuing and achieving employment-related benchmarks for treatment group youth. TransCen provided training to staff in groups and individually, provided intense supervision of staff activities and management practices, reviewed performance management data to identify challenges in service delivery and customize technical assistance to address them, and created an agreement structure that the intervention teams used with employers to facilitate work experiences for youth. Most Way Station staff had social service backgrounds and lacked the employment focus needed to achieve the program's employment benchmarks without such support. Supporting staff in the field was critical to TransCen's success, suggesting that technical assistance staff must be willing to accompany program staff on visits to participants' communities.

Data-driven reports on services delivered are powerful tools for program improvement. Alternating with general operational meetings, the MD PROMISE leadership team met biweekly to review reports on service provision based on data in the MD PROMISE MIS. The purpose of the meetings was to assess the program's performance relative to its benchmarks. The reports provided statistics on services at the program, regional, and

intervention team levels. These statistics informed the supervision of and technical assistance to the program's intervention teams and ensured that everyone involved remained focused on its key objectives. MD PROMISE also revised several of its services in response to the reports. For instance, the program changed its approach to benefits counseling (first by requiring families to opt out rather than in to the counseling and then by adding telephone consultations to the service mix) and to the provision of financial education services (by supplementing group classes in financial education with individualized financial coaching and counseling) in response to the low referrals and low take-up rates documented in the reports.

Existing and newly formed relationships of intervention staff are key to comprehensive service delivery. Relationships between intervention staff and service providers at the local level are key in a program model that relies heavily on referrals to existing services. The intervention staff were expected to develop their own personal and professional networks to facilitate linkages to community resources for youth and families on their caseloads. The extent of those networks and staff's ability to leverage them varied, however. It would behoove future similar programs to develop processes based on early or past successes for connecting local-level program staff with staff at other local service providers. Relationships between intervention staff and targeted youth are also key in a model in which case management is the core component. Trusting relationships are foundational to engaging youth and their parents or guardians in a program, and tend to dictate their satisfaction with it.

Engaging directly with district-level education authorities may be necessary for programs implemented outside of the school system to overcome challenges in engaging with school staff around IEPs and supporting youth in pursuit of their educational goals. Early on, MD PROMISE leadership reached out to state education authorities at MSDE to inform them about the program and encourage them to talk to their district-level counterparts about facilitating access to schools for program staff. Despite that effort, the program's intervention teams often experienced difficulty in making connections with schools' staff during the first half of program operations. After MD PROMISE leadership made a concerted effort to facilitate collaboration between local school districts and PROMISE staff, program access to local schools improved and solid partnerships were forged. It would behoove future similar programs to develop strategies for engaging education staff at all levels during the program design phase and early implementation.

Tailoring service delivery to participants' needs can increase service take-up rates. MD PROMISE expected that the families of all treatment group youth would receive benefits counseling, but during the first half of program operations, few of them actually received this service. Many families did not see the need for counseling or were reluctant to share their personal financial information. At the same time, intervention staff lacked the skills to address their concerns and effectively promote benefits counseling to families; also, Full Circle staff were not integrated into MD PROMISE sufficiently to assist them in developing these skills. In response to the low take-up rate, the program implemented several mid-course corrections, including ensuring that benefits counselors met more consistently with the intervention teams and offering the option of a phone consultation for those families not interested in an in-person benefits assessment. Subsequently, take-up of benefits counseling increased dramatically. MD PROMISE's experience also suggests that developing a counseling model that addresses the specific needs and concerns of youth receiving SSI and their families may produce better results

than a model developed for populations that expect to work and are motivated to obtain benefits counseling.

C. Considerations for interpreting findings in the impact analysis

The key interventions that the impact analysis will assess are assertive case management and employment services. The case management that MD PROMISE provided to treatment group youth was unusual; other programs in the state rarely served youth as young as those in MD PROMISE or provided case management with the same level of intensity. Also, whereas some other programs in the state offered employment services to youth with disabilities, none provided the individualized support offered by MD PROMISE. Although work opportunities, benefits counseling, and transition services were available to control group youth through other programs, their take-up of those services may have been low in the absence of the dedicated structure and funding for assertive case management and individualized support that MD PROMISE provided to treatment group youth. Thus, any impacts of the program with respect to youth employment (which will be discussed in forthcoming reports) may be the result of assertive case management and individualized employment services that facilitated work opportunities, benefits counseling, and transition services.

MD PROMISE satisfied conditions that maximized the likelihood the evaluation could detect impacts. The sharp distinction between MD PROMISE recruitment staff and service staff, along with the restriction of program services to treatment group youth only, meant there was virtually no risk that control group youth would have received program services. Also, data from the MD PROMISE MIS show that, as of February 2017, a large share (92 percent) of treatment group youth actually had participated in the program, and most of them had received key services. When considered along with evidence suggesting that control group youth had only limited access to alternative sources of assertive case management and employment services, these findings from the process analysis suggest a marked difference in the service experiences of treatment and control group youth. In addition to PROMISE, however, other initiatives also were occurring in Maryland that could promote long-term systems-level changes that may benefit all youth with disabilities and their families, including those in the control group. These initiatives could have implications for the evaluation's five-year impact analysis.

The take-up of career exploration and work-based learning experiences offered by MD PROMISE was high among treatment group youth. Three years into program operations, almost half of participating treatment group youth had worked at paid jobs, and more than half had participated in unpaid work experiences. With a year and a half of its operational period remaining, MD PROMISE continued to work toward its ultimate employment goals of providing 80 percent of treatment group youth with unpaid work experiences and 70 percent with paid work experiences. As of February 2017, the program's family employment specialists had provided job search services for and conducted outreach to employers on behalf of the vast majority of participating youth.

MD PROMISE facilitated linkages to adult service providers and benefits counseling for many treatment group youth; however, those linkages did not guarantee the receipt of meaningful services. Three years into program operations, the intervention teams had connected 30 percent of participating youth with at least one of three key entities providing employment

services to adults with disabilities. Those connections, however, entailed discussions about the availability of such services, referrals to them, or support in completing applications for enrollment in them. The extent to which the connections resulted or eventually will result in the actual receipt of services from those entities is unclear. MD PROMISE anticipates that more youth will receive connections to adult service providers as program operations draw to a close in September 2018 and staff attempt to facilitate alternative services for cases they close. Also, although the intervention teams had linked the families of at least half of participating youth to the provider of MD PROMISE benefits counseling, as of February 2017, the majority of those families had experienced only one interaction with a benefits counselor through an initial face-to-face or telephone consultation.

The family members of treatment group youth rarely received MD PROMISE employment services. The program's MIS primarily captured case management services provided to the family members of participating youth in case notes, which we were unable to analyze for this report. The data we analyzed do capture employment services provided to family members, but indicated that few had received them as of February 2017. The program had provided job search services to and conducted employer outreach on behalf of the parents or guardians and other household members of about 5 percent and 3 percent of youth, respectively. Virtually none of the youth had parents, guardians, and other household members with an unpaid work experience, and the percentage of youth with parents or guardians and other household members who had paid employment experiences was only slightly higher. The level of service observed suggests that the prospects for employment impacts on parents and guardians are less favorable than for youth.

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APPENDIX A

SUPPLEMENTARY ANALYSES OF PROGRAM SERVICE DATA

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Table A.1. Case management service delivery to MD PROMISE participants as of February 2017, by region (percentages unless otherwise indicated)

	Baltimore	Eastern Shore	Northern	Southern	Western
Average number of participating youth per case management team	22.4	20.2	27.3	26.3	43.7
Participating youth with a positive personal profile (PPP)	81.9	89.4	91.3	81.1	85.5
Participating youth with an individual plan for employment	73.0	92.2	92.4	79.7	87.1
Participating youth provided flexible case service funds	40.9	28.4	44.8	27.3	21.7
Average dollar amount among those receiving funds	278.2	394.9	456.5	633.2	277.2
Participating youth connected to adult service providers[a]	27.0	29.1	34.9	19.6	55.8
Department of Rehabilitation Services (DORS)	4.2	15.6	27.9	16.1	44.6
Developmental Disabilities Administration (DDA)	2.8	5.0	4.1	1.4	4.0
One-stop center/American Job Center (DLLR)	7.9	6.4	7.0	0.7	25.7
Behavioral Health Administration (BHA)	1.9	0.0	1.7	0.0	2.4
Department of Human Resources (DHR)	0.0	0.0	1.2	0.0	0.8
Department of Social Services (DSS)	10.7	9.2	2.3	0.0	7.2
Housing and Urban Development (HUD)	8.8	2.1	0.6	0.0	1.6
Criminal justice system	0.9	2.1	1.2	0.0	0.0
Home- and community-based health services	0.0	0.7	0.6	0.0	0.0
Academic and career support (including Job Corps)	4.7	2.1	1.7	2.1	1.2
DORS, DDA, or DLLR (required for successful case closure)	14.4	22.7	31.4	18.2	53.4
Number of participating youth	215	141	172	143	249

Source: The MD PROMISE MIS.

Notes: In practice, Baltimore was divided into two regions. In this table, we present combined statistics for both regions.

[a] We do not include connections to transportation services or SSA as connections to adult service providers.

Table A.2. Ongoing program engagement in MD PROMISE among treatment group youth, by region (percentages unless otherwise indicated)

	Baltimore	Eastern Shore	Northern	Southern	Western
Percentage of youth currently disengaged[a]	25.6	18.4	18.0	22.4	31.7
Percentage of youth ever sent to specialized case manager through February 2017	41.4	22.0	23.3	16.1	28.1
Average number of contact attempts per youth	6.0	9.4	4.0	2.5	3.6
Number of youth	215	141	172	143	249

Source: The MD PROMISE MIS.

Notes: In practice, Baltimore was divided into two regions. In this table, we present combined statistics for both regions. Contact attempts may have taken any form (that is, telephone, text, email, home visit, and so on) and may or may not have resulted in actual interaction between MD PROMISE and a youth.

[a] Disengaged youth are those who were unresponsive to program contacts for 60 days or expressed disinterest in the program. "Currently" represents a youth's status from the February 2017 MD PROMISE MIS extract.

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