

Executive Summary

Working toward Wellness Telephone Care Management for Medicaid Recipients with Depression, Eighteen Months After Random Assignment

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Overview

Although many public assistance recipients suffer from depression, few receive consistent treatment. This report on a telephonic care management program in Rhode Island that tried to encourage depressed parents who were receiving Medicaid to seek treatment from a mental health professional presents results through 18 months — six months following a one-year intervention. Called “Working toward Wellness,” the program represents one of four strategies being studied in the Enhanced Services for the Hard-to-Employ Demonstration and Evaluation to improve employment for low-income parents who face serious barriers to employment. The project is sponsored by the Administration for Children and Families and the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services, with additional funding from the Department of Labor.

In Working toward Wellness, master’s-level clinicians (“care managers”) telephoned the study participants in the program group to encourage them to seek treatment, to make sure that they were complying with treatment, and to provide telephonic counseling. The effects of the program are being studied by examining 499 depressed Medicaid recipients with children, who were randomly assigned to the program group or the control group from November 2004 to October 2006. Participants were given a list of mental health professionals in the community from whom they could receive treatment.

Key Findings

- **Care managers effectively engaged people with depression via telephone.** Overall, 91 percent of the program group members had at least one discussion with a care manager, and the care managers averaged about nine contacts per client over the yearlong intervention.
- **There were significant barriers to in-person treatment within the target population.** Participants typically faced many ongoing and interrelated life stressors, including multiple health problems and child care and other caregiving responsibilities. The context of poverty shaped their lives in ways that influenced their well-being and ability to seek treatment.
- **The program increased the use of mental health services.** The program group was more likely than the control group to see psychiatrists, psychologists, and primary care physicians. These effects were largest in the program’s first months but faded over time. Program group members made 1.6 times as many visits to mental health professionals, but there was no overall difference between the groups in filling prescriptions for antidepressant medications. However, there was an increase in filling prescriptions for other psychotherapeutic medications, primarily antianxiety medicines.
- **The program did not significantly reduce depression, on average, but it did significantly change the distribution of depression severity, reducing the number of people who suffered from very severe depression.** Program and control group members had similar average depression scores at 18 months following random assignment, but there were shifts in the distribution of depression severity. In particular, individuals in the program group were less likely than those in the control group to be very severely depressed at the 18-month follow-up.

Acknowledgments

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

The Authors

Executive Summary

Although low-income individuals are disproportionately likely to suffer from depression, few receive treatment, and even fewer persist with their treatment. Untreated depression can negatively affect employment, job performance, and worker productivity. This report presents 18-month results of a one-year program that provided telephonic care management to depressed parents receiving Medicaid in Rhode Island to encourage them to seek treatment from a mental health professional. The study, called “Working toward Wellness” (WtW), was conducted as one of four studies in the Enhanced Services for the Hard-to-Employ Demonstration and Evaluation, which is studying strategies to improve employment and other outcomes for low-income parents and others who face serious barriers to employment. The project is sponsored by the Administration for Children and Families and the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services (HHS), with additional funding from the Department of Labor. WtW is being evaluated by MDRC in partnership with United Behavioral Health (UBH) and Group Health Cooperative (GHC). UBH delivered the care management services, and GHC designed the intervention and provided technical assistance and training to UBH staff.

The key findings presented in this report are

- WtW care managers used the telephone to effectively engage people with depression.
- WtW increased the use of mental health services and the likelihood that prescriptions for antianxiety medications would be filled, but it did not have any effect on filling prescriptions for antidepression medicines.
- Although WtW did not have an effect on the average depression level or employment outcomes, it did significantly reduce the number of people who were severely depressed.

Background on the Working toward Wellness Program

Although there is considerable evidence that individuals with depression benefit from psychotherapy and medications, only about one-fifth of depressed individuals currently are in treatment.¹ In low-income communities, there may be less knowledge about depression treat-

¹Kessler, Berglund, Demler, Jin, Koretz, Merikangas, Rush, Walters, and Wang, “The Epidemiology of Major Depressive Disorder: Results from the National Comorbidity Survey Replication (NCS-R),” *Journal of the American Medical Association* 289, 23: 3095-3105 (2003).

ment and lower quality of care than in higher-income communities, and individuals are more likely to be depressed but less likely to receive treatment.

One promising way to help people receive effective depression treatment is through care management. In WtW, master's-level clinicians — “care managers” — call individuals who are suffering from depression to encourage them to seek treatment, help them find and make appointments with mental health professionals, make sure that they are keeping appointments and taking prescribed medications, educate them about how depression will affect them and how treatment can help them, and provide support and counseling by telephone to individuals who are reluctant to seek treatment in the community. It was hoped that encouraging people to seek treatment and alleviate their depression would help more of them return to work or become more productive at jobs they already held. Although telephonic care management has been shown to be effective in treating depression with some populations,² this is the first study of the approach with low-income Medicaid recipients who have children. Moreover, because WtW is provided telephonically, it could represent a relatively inexpensive way for social service agencies to aid individuals with depression. It was also hoped that the program might improve work productivity and increase employment if short-term improvements in depression subsequently led to a greater interest and capacity to seek and retain employment.

The Working toward Wellness Evaluation

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

²Simon, Ludman, Tutty, Operskalski, and Von Korff, “Telephone Psychotherapy and Telephone Care Management for Primary Care Patients Starting Antidepressant Treatment: A Randomized Controlled Trial,” *Journal of the American Medical Association* 292, 8: 935-942 (2004); Wang, Simon, Avorn, Azocar, Ludman, McCulloch, Petukhova, and Kessler, “Telephone Screening, Outreach, and Care Management for Depressed Workers and Impact on Clinical and Work Productivity Outcomes: A Randomized Controlled Trial,” *Journal of the American Medical Association* 298, 12: 1401-1411 (2007).

assignment ensures that all characteristics are similar for the two groups at baseline so that any substantial differences that later emerge can be attributed to the program with some confidence.

Of the 499 individuals in the study, 245 were randomly assigned to the program group, and 254 were assigned to the control group. The average age of the participants at baseline was 35, and 90 percent are women. About half the participants had a General Educational Development (GED) certificate or a high school diploma, and a quarter had some education beyond high school. A little less than half of the participants are white; approximately one-third are Hispanic; and 12 percent are African-American. The study includes individuals who are comparable demographically to previous studies of care management for people suffering from depression. However, the participants in the current study were more severely depressed than participants in studies that have focused on employed populations.³ In this study, less than half the participants (44 percent) were employed at the time of random assignment.

The random assignment of study participants occurred from November 17, 2004, to October 20, 2006. This report presents results through 18 months following random assignment, or from May 2005 (for the first clients assigned) to April 2007 (for the last clients assigned). The two main purposes of the study are to determine (1) whether a telephone care management model that is focused on low-income parents can successfully help participants get treatment and, if so, (2) whether the model is effective at alleviating depression and increasing employment and earnings.

Key Findings on Program Implementation

The first question addressed by the study is whether care managers were able to engage members of the program group and what challenges they faced in helping individuals seek treatment. To address these issues, data were drawn from multiple sources, including a management information system (MIS) that created a record of all care manager-client “contacts” and qualitative data from care manager case notes entered into the MIS. Key findings on the implementation of the program are presented below.

- **Care managers effectively engaged people with depression via telephone.**

Care managers successfully contacted 91 percent of those assigned to the program group, and they averaged about nine contacts (8.82 contacts) per client over the yearlong intervention. This took considerable effort, as the contact-to-attempt ratio was about 30 percent — meaning that the care managers made about 3.5 attempts for each contact. Making contacts also required time. After the initial contact, which typically occurred within just a few days after

³Wang et al. (2007).

random assignment, the median period that elapsed between contacts was about three weeks through the fifth contact and from three to four weeks through the ninth contact.

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

The “phone program” became a useful tool for engaging those who were not yet willing or able to begin in-person treatment. The phone program was a structured psychoeducational program based on a workbook that clients worked through under a care manager’s telephone guidance. The workbook was designed to help people who are experiencing stress and depression to better recognize and manage their symptoms. The phone program was initially envisioned only as a temporary or “fallback” alternative to in-person treatment, but over time it also was seen as a valuable way to capture a client’s attention early on. Therefore, it became standard practice to mail the workbook to all individuals who were assigned to the program group as they began WtW in September 2005, at which point about 40 percent of the study sample had been recruited. With clients in the phone program, the care managers continued to encourage in-person care for those who remained depressed, although for many who used it, the phone program became an end in itself. According to the case note data, it does not appear that the phone program typically led to in-person treatment.

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

It was originally expected that the care managers would provide feedback to clinicians in the community regarding WtW clients as they progressed in treatment. Such a collaborative approach — whereby care managers and clinicians work together — has been shown to have benefits for depression patients in settings where both care managers and clinicians work for a single organization (such as the U.S. Department of Veterans Affairs [VA] and staff model Health Maintenance Organizations, which employ the clinical staff who serve their memberships). This type of collaboration was difficult in the case of WtW, however, because the care managers worked for UBH and the community clinicians worked in a variety of settings outside UBH, contracting to offer care not only with UBH but also with a number of other health organizations. To be sensitive to any client concerns about contact between the care managers and the clinicians, it was a requirement that the care managers obtain written permission from both the clients and the providers before performing the liaison function. Unfortunately, this requirement also became an administrative barrier, and consequently the care managers did not perform this role. Instead, they demonstrated ingenuity by acting as coaches, advising or guiding clients on ways to better navigate care and to advocate for themselves. In short, they worked to empower clients to be more proactive in accessing and managing their care.

- **There were significant barriers to in-person treatment within the WtW target population.**

WtW participants typically faced a proliferation of ongoing stressors — both eventful and chronic — in multiple life domains. While no one event, demand, or strain in particular may have reached a state of crisis — although they sometimes did — their cumulative impact greatly limited or overwhelmed clients’ efforts to seek or maintain in-person care, despite engaging with a care manager for support via telephone. Indeed, the circumstances of many of the WtW participants reflect typical situations of “stress proliferation,” wherein stressors rooted in the basic conditions of daily life or social roles (such as being a single parent) lead to an array of stressors in other life domains (for example, employment). Stressors relating to comorbidities, child care, and other caregiving appear to be especially challenging. Moreover, the context of poverty shaped participants’ lives in ways that fundamentally influenced their well-being and ability to seek treatment.

Key Findings on Program Impacts

This report presents results through the 18 months following random assignment, using information from Medicaid claims data and a survey conducted with about 86 percent of study participants. At this 18-month follow-up point — six months after the end of the one-year program — the focus of the study has been to assess whether WtW improved depression symptoms and work-related outcomes if short-term improvements in depression subsequently led to a greater interest and capacity to seek and retain employment. In addition, the study was also designed to examine effects on participants’ children. The key impact findings are presented below.

- **More program group members than control group members received treatment for depression.**

As shown in Table ES.1, at the 18-month point, WtW increased the use of any mental health service by about 8 percentage points. About 46 percent of the program group received a mental health service during the 18 months following random assignment, compared with 38 percent of the control group. Program group members were more likely than control group members to see a psychiatrist, primary care physician, or psychologist about a mental health issue. For example, participants in the program group had, on average, about 1.6 times more mental health visits than those in the control group.

In addition, although there was no overall difference in filling prescriptions for antidepressant medications, program group members were more likely to fill prescriptions for other psychotherapeutic drugs, especially antianxiety medications, which are often prescribed along

The Enhanced Services for the Hard-to-Employ Demonstration

Table ES.1

**Estimated Impacts on Use of Mental Health Services, Prescription Medications Filled,
and Depression Outcomes in Eighteen Months Following Random Assignment**

Rhode Island: Working toward Wellness

Outcome	Program Group	Control Group	Difference (Impact)	P-Value
<u>Use of mental health services, by type (%)</u>				
Received mental health services	45.8	38.1	7.8 *	0.072
Psychiatrist	21.6	15.4	6.2 *	0.078
Primary care physician	20.5	14.1	6.3 *	0.057
Psychologist	6.6	1.9	4.6 **	0.012
Clinical social worker/counselor ^a	29.2	26.1	3.1	0.439
Visited emergency department for mental health services	4.6	1.0	3.6 **	0.018
Hospitalized for mental health services	5.6	1.7	4.0 **	0.020
Received chemical dependency services	8	7.7	0.3	0.911
<u>Prescriptions filled, by type (%)</u>				
Filled a prescription for psychotherapeutic drugs	60.0	54.4	5.6	0.160
Antidepressant drugs	52.8	49.5	3.3	0.418
Other psychotherapeutic drugs	34.4	23.6	10.8 ***	0.005
Filled a prescription for adequate therapeutic dosage of antidepressant medication	36.7	33.9	2.7	0.506
Filled a prescription for nonpsychotherapeutic drugs	89.7	89.4	0.3	0.917
Sample size (total = 499)	245	254		
<u>Depression outcomes: QIDS-SR^b depression scale^c</u>				
Mean depression score at 18 months	11.5	12.1	-0.7	0.203
Depression level 18 months following random assignment (%)				
Out of depression	17.4	14.9	2.4	0.490
Mildly depressed	26.6	23.5	3.1	0.469
Moderately depressed	29.0	33.1	-4.2	0.361
Severely depressed	23.0	18.2	4.8	0.222
Very severely depressed	4.1	10.3	-6.2 **	0.015
Sample size (total = 428)	211	217		

(continued)

Table ES.1 (continued)

SOURCES: Measures of health service utilization are based on MDRC calculations using United Behavioral Health medical and prescription claims data. Measures of depression are based on MDRC calculations using data from respondents to the 18-month survey.

NOTES: Results in this table are adjusted for pre-random assignment characteristics.

Two-tailed t-tests were conducted to determine statistical significance. Statistical significance levels are indicated as: * = 10 percent; ** = 5 percent; and *** = 1 percent. The significance level indicates the probability that the impact estimated would be this large if the program had zero true effect.

^aThis item includes claims for one program group member who received services at a behavioral health clinic.

^bQuick Inventory of Depressive Symptomatology-Self Report (QIDS-SR), which determines whether the person meets criteria for being diagnosed with major depression over the past seven days.

^cA chi-square test was used to test the difference in distribution between the program and control groups (p-value = 0.1368).

^dScores on the QIDS-SR depression scale fall into the following categories: very severe depression, severe depression, moderate depression, mild depression, no depression.

with antidepressants for people suffering from depression. While this impact on the use of mental health services is slightly higher than that found in a study of a similar intervention serving a non-Medicaid population,⁴ it is smaller than the impacts found in studies that were conducted in health care systems where care managers had direct access to health care providers, facilitating easier communication with the providers.⁵

Also, it is important to note that although impacts are reported for the 18-month period, the higher likelihood of the program group members' receiving mental health services is the cumulative effect that is mostly attributed to the difference during the first 12 months of the intervention (Figure ES.1). There were only minor differences in the use of mental health services between the program and the control group after the end of the program.

- **After 18 months, the program did not significantly reduce depression, on average, but it did significantly change the distribution of depression severity, reducing the number of people who suffered from very severe depression.**

Program and control group members had similar average depression scores 18 months following random assignment, but there were shifts in the distribution of depression severity. In particular, individuals in the program group were less likely than those in the control group to

⁴Wang et al. (2007).

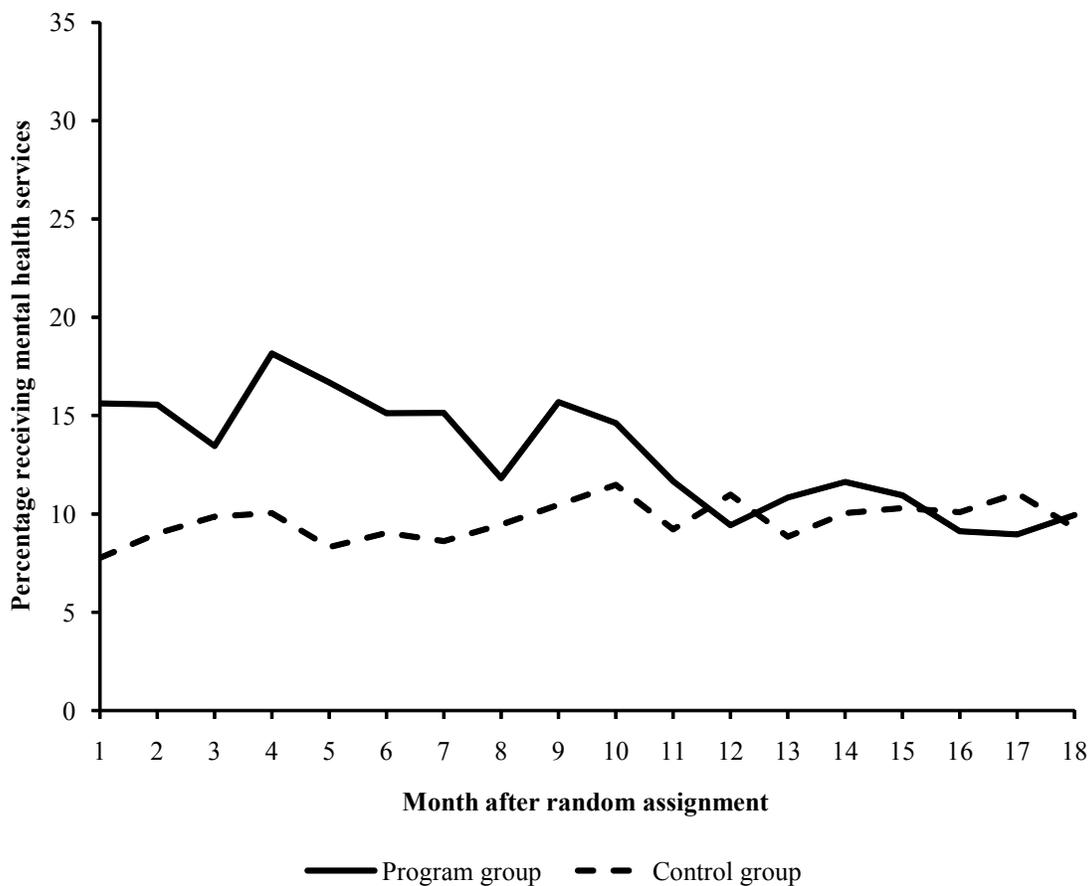
⁵Wells, Sherbourne, Schoenbaum, Duan, Meredith, Unützer, Miranda, Carney, and Rubenstein, "Impact of Disseminating Quality Improvement Programs for Depression in Managed Primary Care: A Randomized Controlled Trial," *Journal of the American Medical Association* 283, 2: 212-220 (2000); Simon et al. (2004).

The Enhanced Services for the Hard-to-Employ Demonstration

Figure ES.1

Percentage Receiving Mental Health Services, by Month

Rhode Island: Working toward Wellness



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

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

be very severely depressed at the 18-month follow-up. There may have been shifts at other depression levels, but the differences between the program and the control groups are not significant at other levels. Also, the overall distribution of depression levels between the program and the control groups are not significantly different.

- **There was no difference in employment between the program and the control groups, including those who were employed.**

There were no differences in the number of days of missed work or in hourly wages between the two research groups (not shown). Since there was minimal impact on depression at the 18-month follow-up, it is not surprising that there were no differences in employment outcomes.

- **Not surprisingly, given the limited effects of the WtW program on adults' depression, there were few effects of this program on parenting and outcomes for children.**

In addition to examining the effects of the WtW program on adults' depression, this study also examined how the program affected participants' children. Referred to as the "child add-on study," this allowed the research team to collect in-depth information on older children of study participants — children at the transition to early and late adolescence — for whom the effects of parents' depression might be particularly salient. Based on parental and youth reports of their mental health, social skills, and self esteem, effects of the WtW program are extremely rare. While there are a few effects on youth use of medical services, there is no consistent pattern of benefits for children as a result of their parents' assignment to the WtW program.

- **The WtW program had net costs of \$774 per program group member, largely reflecting the added cost of care management services. Given the small effects of WtW on the overall usage of mental health services and the lack of effects on the usage of other health services, not surprisingly, no differences were found in the costs for these services.**

The gross costs for health services were \$5,496 per program group member. The gross costs for health services for the control group were substantially the same: \$5,348 per control group member. Therefore, the net cost of WtW of \$774 per program group member largely reflects the cost of the care management services, which were \$625 per program group member.

Implications

High rates of depression combined with low rates of treatment among public assistance recipients present a compelling picture of unmet need. These facts also present a vexing

problem for state administrators seeking to help recipients become self-sufficient, because individuals suffering from depression are less likely to work. The results from the Working toward Wellness study provide some important lessons to consider before implementing such programs as care management of depression. Although such programs have been successful in improving depression among individuals in other settings, future interventions for public assistance recipients should consider other social and financial barriers that discourage disadvantaged populations from engaging in treatment. Results indicate that telephonic care management can increase the use of mental health services, but the impacts on treatment were modest, and there was no effect on depression. The results, however, also suggest some ways in which programs like this could be strengthened.

The modest effects of WtW do not reflect a failure of care managers to reach participants. Indeed, almost every client talked with a care manager at least once, and care managers talked with each person once a month, on average. Rather, many participants faced barriers to seeking treatment, including their own health, having to care for other family members, and work. The study also highlights the difficulty of engaging the participants in treatment for a prolonged period. Although the program group members were more likely to receive mental health services than the control group in the first six months of the WtW intervention, the numbers drop in the last six months of the intervention and decrease further after it ended. Thus, programs like this might be strengthened by having care managers devote additional resources to helping parents overcome the barriers they face. Although care managers used more telephone counseling than expected, even earlier and greater reliance on telephone counseling might also have produced larger effects on depression symptoms because it would have provided a form of treatment that did not require individuals to leave their homes.

At the six-month follow-up period, it appeared possible — since many participants were still in early stages of treatment — that the program's effects on depression and employment might grow over time. However, this does not seem to have occurred. Treatment participation actually dropped in the last six months of the program. For future interventions, it would be important to consider what factors contributed to receiving treatment and improving depression for some participants. If research can identify groups or characteristics that were less likely to receive treatment, that might suggest approaches that could be used in the future to encourage treatment.

Finally, future interventions might be more effective if they could establish ongoing processes of information sharing, communication, and coordination between care managers and doctors, a relationship WtW was unable to establish.

About MDRC

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

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

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- Improving Public Education
- Raising Academic Achievement and Persistence in College
- Supporting Low-Wage Workers and Communities
- Overcoming Barriers to Employment

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