Supporting Statement Part B for Interventional Cooperative Agreement Program (ICAP)
Vocational Resource Facilitation Demonstration (VRFD)
OMB No. 0960-0829

B. Collections of Information Employing Statistical Methods

SSA contracted with the Kessler Foundation (KF) to conduct a randomized controlled trial of the VFRD intervention. This intervention helps patients with newly sustained spinal cord injuries, spinal cord disease, or brain injuries pursue their employment goals. SSA's contractor, Mathematica, evaluates components of the project for both SSA and KF. Through the VRFD, KF and SSA aim to provide empirical evidence on how the intervention impacts patients in several critical outcome areas, as explained in the Supporting Statement Part A. The VRFD enables SSA and other interested parties to improve employment-related outcomes and decrease benefit receipt.

1. Statistical Methodology

Recruitment materials and baseline survey: KF implemented VRFD at Kessler Institute for Rehabilitation (KIR) inpatient and outpatient facilities in northern New Jersey. KF conducted recruitment for the VRFD evaluation from November 2023 through February 2026. During that time, KF recruited patients who met the study's basic eligibility criteria (described below) into the study. We completed this phase of the evaluation in February 2026.

Selection of eligible patients: The VRFD implementation team recruited up to 226 patients for the VRFD at the KIR inpatient facilities in Chester, Saddle Brook, and West Orange, New Jersey. All three facilities admit patients with brain injuries, and only West Orange admits patients with spinal cord injuries or disease. The demonstration targets the highly diverse population of working-age (18 to 62) New Jersey residents whom KIR admits for inpatient rehabilitation following neurotrauma from a spinal cord injury, spinal cord disease, or brain injury, and who are capable of giving informed consent. Because these patients have experienced significant neurotrauma, they face an increased risk of unemployment, SSI or SSDI benefit receipt, and other adverse outcomes. Although the target population is not statistically representative of all such adults in the United States, New Jersey, or the Newark area, the VRFD evaluation team expects the population to share important similarities. The VRFD evaluation team randomly assigned patients who volunteered for the study to either a treatment group or a control group. Additionally, the evaluation team structured the random assignment process by grouping study subjects over time and then assigning them in blocks. This approach allowed the evaluation team to improve the balance of characteristics across study groups.

Volunteer rate: Each year, the KIR facilities in Chester, Saddle Brook, and West Orange admit about 50 patients with spinal cord injuries or disease and 300 patients with brain injuries who meet the age and residence requirements. Over a 28-month period, from November 2023 to February 2026, the VRFD implementation team approached about 1,000 KIR inpatients who were eligible for the study to solicit their participation in the demonstration. Around 21 percent of these patients volunteered during this period, for a total of 216 patients who enrolled in the demonstration. Because the volunteer pool consists of inpatients who typically stay at KIR for multiple weeks, and because the implementation team used a personal approach to recruitment, the VRFD evaluation team met and exceeded the initial target recruitment of 200 patients. SSA's VRFD evaluation team randomly assigned patients who provided consent and completed the baseline survey to either the treatment or control group. By design, all demonstration enrollees completed the baseline survey, resulting in a 100 percent response rate.

12-month follow-up survey: The 12-month follow-up survey provides information about the outcomes of all enrollees one year after they enroll in the demonstration. The VRFD evaluation team administers the survey and expects to achieve an 80 percent response rate by our end date of February 2027 for the follow-up survey.

Qualitative data from the implementation and operations staff. The VRFD evaluation team completed the first round of site visit interviews in August 2025 and interviewed nine staff members, including RFs, KIR staff, and Division of Vocational Rehabilitation Services (DVRS) staff. The evaluation team will conduct the second round of site visit interviews in the summer of 2026. During these visits, the evaluation team reviews program documentation to collect cost data and conducts semi-structured interviews with RFs, KIR staff, and DVRS staff. The VRFD evaluation team designed the semi-structured interview guide to gather information about staff experiences and the changes made to the intervention during implementation. The interview guide includes questions tailored to the experiences of individual staff members, as well as a set of core questions to enable the evaluation team to systematically collect information across all staff. Although the evaluation team anticipates visiting sites in person to collect data, they will also conduct interviews by telephone to reduce data collection costs if key informants are geographically dispersed or unavailable during in-person visits. The VRFD evaluation team expects to interview up to 12 people during the second site visit. The team selects interview respondents based on their role and knowledge of VRFD at each stage of implementation. The VRFD evaluation team interviews all RFs and selects KIR and DVRS staff who can provide the necessary information. Because the VRFD implementation team

expects KIR and DVRS staff to provide the information needed to assess program implementation and fidelity, the evaluation team expects a 100 percent response rate for the qualitative interviews.

2. Procedures for Collecting Information

As mentioned above ,the VRFD team recruited KIR patients into the demonstration over a 28-month period from November 2023 to February 2026. KIR staff recruited patients on a rolling basis as they admitted new demonstration-eligible patients. KIR and KF staff worked together to identify and enroll eligible patients in the demonstration. The team enrolled 216 patients in the demonstration.

When patients enrolled in the demonstration, the evaluation team randomly assigned them to either the treatment group or the control group. Treatment group members receive the VRF intervention, and control group members receive a referral to DVRS. The evaluation team gives all enrollees an equal probability of assignment to either experimental group. By using random assignments, the evaluation team can attribute any variation in outcomes between the treatment and control groups to the VRF intervention. Because we randomly assigned the enrollees, we anticipated baseline characteristics – both observed and unobserved – would be balanced across experimental groups in expectation. However, since some imbalances in baseline characteristics might still occur in the study sample by chance, even if the evaluation team implements random assignment correctly, the evaluation team used block random assignment to ensure balance across key observable characteristics. Just before random assignment, the evaluation team grouped enrollees into blocks based on observable baseline characteristics that correlated with outcomes of interest to the VRFD. The evaluation team then randomly assigned enrollees within each block equally between the treatment and control groups. This approach helped ensure balance across experimental groups for all the baseline characteristics used to create the blocks. The evaluation team used baseline characteristics related to employment, injury type, and injury severity to create the blocks.

The VRFD evaluation team expects that the analysis type drives more substantive differences in estimation methods than the data collection effort. Therefore, the following subsections describe the methods the evaluation team plans to use for each major analysis component of the VRFD:

Process analysis: As discussed in Part A, the VRFD evaluation team uses site visit and semi-structured interview data to provide a detailed description of the VRFD model, and information on the following; how the VRFD evaluation team implements it; the context in which it operates; and the program operations and their fidelity to design. This detailed description assists in interpreting program impacts; identifying program features; and highlighting necessary conditions for effective program replication or improvement. The VRFD evaluation team

gathers information using a range of data sources to fully describe the programs and activities.

The VRFD evaluation team uses the Consolidated Framework for Implementation Research (Damschroder et al. 2009) to guide the collection, analysis, and interpretation of qualitative data. The Consolidated Framework for Implementation Research guides systematic assessment of the multilevel and diverse contexts in interventions implementation and describes the myriad factors that might influence intervention implementation and effectiveness. Using the framework allows the VRFD evaluation team to structure the analyses of VRFD implementation to produce results based on objective, reliable qualitative data across the key domains related to the program environment; program operations; and strategies to support implementation. For each of these domains, the evaluation team developed measurable constructs that align with research questions for the VRFD process analyses shown in Part A and Appendix C. Based on this framework, the VRFD evaluation team will produce tables that summarize the major process findings in the study's reports. The Consolidated Framework for Implementation Research also allows the evaluation team to make systematic use of qualitative data as part of the impact analysis, enabling the evaluation team to examine how impacts vary with certain implementation constructs.

Impact analysis: The objective of the impact analysis is to provide statistically valid and reliable estimates of the effects of VRFD on the employment and benefit-related outcomes of VRFD enrollees. The VRFD evaluation team relies on a randomized experimental design to estimate the causal impacts of VRF services available to enrollees through the demonstration. Random assignments enable the evaluation team to estimate the net impact of those services through comparing average outcomes across the treatment and control groups. The VRFD evaluation team's analysis focuses on intent-to-treat estimates that measure how the *offer* of VRF services affected outcomes of enrollees after participating in the demonstration.

Primary outcomes. To avoid concerns about multiple comparisons and to reduce the extent of false positives, the VFRD evaluation team prespecified a parsimonious set of primary outcomes. The list of those outcomes includes the following: employment status; earnings above a substantive threshold; enrollment in school or job training programs; and applications for or receipt of SSI or SSDI benefits. The VFRD evaluation includes results for secondary outcomes related to employment, earnings; DVRS services; education; receipt of benefits; expectations; satisfaction; and health. However, we consider these results exploratory. This approach strikes a balance between addressing the multiple comparisons problem and maintaining the evaluation's ability to detect

policy-relevant impacts. By limiting the number of primary outcomes tested in the impact analysis, this approach reduces the likelihood of false positives without undermining the evaluation's statistical power to detect true impacts on any single outcome.

Model. The main impact model is a weighted linear regression model as follows:

$$(1)\ y_i = \alpha + \beta X_i^{'} + \gamma T_i + \varepsilon_i,$$

where *i* is an index for demonstration enrollees; *y* is an outcome measure; *X* is a vector of baseline or pre-baseline enrollee characteristics such as injury profile and employment status; *T* is an indicator of treatment group membership (1 for treatment and 0 for control); we estimate α, β, and γ e parameters and ε is a random error term. The value of the coefficient γ indicates the impact of the VRF intervention on the outcome. The regression models incorporate elements, such as inpatient facility indicators and nonresponse weights (for survey-based outcomes), that add precision to the impact estimates and minimize the chance of bias because of survey nonresponse.

The evaluation team uses a model similar to equation (1) to estimate impacts for select subgroups defined by baseline characteristics and compare impacts across these subgroups.

Benefit-cost analysis: The VRFD evaluation team conducts the benefit-cost analysis for the VRFD by using an approach successfully adopted in other evaluations, including the Benefit Offset National Demonstration (BOND) (Bell et al. 2011), the Youth Transition Demonstration (Fraker et al. 2014), and the Promoting Opportunity Demonstration (POD) (Wittenburg et al. 2021). To accomplish this approach, the VRFD evaluation team develops a comprehensive accounting framework that incorporates a range of perspectives to guide benefit-cost data collection, analysis, and reporting. These perspectives include those of the treatment group members, KIR, DVRS, SSA, and other government entities.

The accounting analysis focuses on monetized impacts. It is not feasible to monetize the value of some benefits and costs, such as quality of life or social integration stemming from greater employment. Most inputs to the benefit-cost analyses come directly from the impact estimates, such as the estimated effects on earnings and benefit amounts. The VRFD evaluation team supplements the impact estimates in the benefit-cost analysis with other sources of data, including program cost information collected during site visits to KIR.

The expected sample size of eligible enrollees supports an analysis that can reliably distinguish the impact of VRF on outcomes from other factors shaping the outcomes of enrollees. Calculating minimum detectable impacts (MDIs) is a

standard way to characterize the expected precision of the evaluation's results given the sample sizes and research design. MDIs quantify the smallest true impact that is likely found to be significantly different from zero, based on one and two-sided statistical tests of differences.

MDIs for outcomes measured in administrative data for all subjects. The VRFD evaluation team expects that impact estimates have sufficient precision to reliably assess policy-relevant impacts of VRF on outcomes. Table 1 summarizes MDIs for the binary employment status outcome over a range of sample sizes. With 216 enrollees, we expect the impact analysis detects an employment rate increase of at least 10.6 percentage points. This MDI is substantively smaller than the 21-percentage point increase in employment observed in the VRF pilot (O'Neill and Dyson-Hudson, 2020).

MDIs for outcomes measured using survey data for subsets of subjects. The VRFD evaluation team expects to detect modest-sized impacts overall and for all but the smallest subgroups. Because of survey nonresponse, the evaluation team expects less precision for survey-based outcome measures than for outcomes measured in administrative data. Based on a study sample of 216 expected response rate of 80 percent, the evaluation team expects a respondent sample size of 173 for the follow-up survey. The MDI for employment with a sample of 173 is 14.0 percentage points.

Table 1. Minimum detectable impacts for VRFD evaluation

Sample size			Minimum detectable impact (percentage points)	
Treatment	Control	Total	Two-sided test	One-sided test
108	108	216	0.129	0.109
83	90	173	0.140	0.124

Note: This assumes an employment rate in the control group of 21 percent and requires at least an 80 percent chance of correctly identifying true impacts as statistically significant using statistical tests with a 10 percent significance level. The evaluation team assumes estimates impact using regression models that include baseline covariates explaining 15 percent of the variation in employment outcomes (that is, has an R-squared of 0.15).

3. Methods to Maximize Response Rates

The VRFD evaluation team employed several approaches to enhance response rates at enrollment, as well as during the 12-month follow-up survey, and in qualitative data collection. In the section below, we outline the steps to increase response rates across all data collection activities. We also describe how we assess and address nonresponse bias if the 12-month follow-up survey does not reach an 80 percent response rate.

Designing an informative recruitment process. Informed consent from VRFD enrollees helped the evaluation team produce more reliable estimates of VRFD's impacts on a study population for whom the treatment is salient. Consequently, the recruitment plan centered around providing demonstration-eligible KIR patients with the information they needed to make informed choices. The recruitment strategy relied on research coordinators to identify and approach eligible patients for enrollment in the demonstration. Recruitment had several steps. First, staff at KIR reviewed the medical charts of all newly admitted patients every other week to determine which patients met key eligibility criteria. Second, staff at KIR sent the names of potentially eligible patients to research coordinators at KF. Third, the research coordinators at KF contacted the patients' clinical staff at KIR to determine which patients were medically stable and could provide informed consent. Fourth, the research coordinators at KF met individually with patients who met all eligibility criteria to determine whether the patients wanted to participate. During each meeting, the research coordinators at KF explained the demonstration and answered any questions. Research coordinators asked patients who wanted to participate in VRFD to provide informed consent and complete the baseline survey before randomly assigning them into the treatment or control group. Each week, research coordinators at KF recontacted patients who did not initially enroll until the patients were discharged from KIR or definitively indicated no interest in participating. We completed this phase of the evaluation in February 2026.

Balance of study sample and integrity of random assignment: The VRFD evaluation team used a management information system to maintain balanced study groups and minimize on-site contamination risks. Built-in eligibility and duplication checks prevented staff from enrolling patients who had not completed a baseline survey and provided written consent or who might have previously enrolled. The VRFD evaluation team used block random assignment to improve the extent to which the distribution of baseline characteristics was similar in each experimental group. The procedure created a series of blocks based on important baseline characteristics. The evaluation team assigned enrollees equally (randomly) within each block into treatment and control groups. Block random assignment helped ensure that all the baseline characteristics used to create the blocks are balanced across experimental groups. The VRFD evaluation team monitored the random assignment process and checked the balance of study groups using data on subjects recorded in the baseline survey. The evaluation team did not see substantial or statistically significant differences (based on t-tests and chi-square tests, as appropriate) in characteristics across subgroups, and assignment status.

Response rates

The VRFD evaluation team's approach to the follow-up survey addresses several challenges that can depress response rates. The evaluation team offers follow-up survey in several modes (web and telephone) to encourage response. Enrollees receive an advance letter by mail and via email with a link to the web survey and their unique survey login information so they can easily access the web survey. The VRFD evaluation team designed the survey interview to be brief to encourage response and full completion. As discussed in greater detail in Part A, the evaluation team offers a $25 response incentive to encourage participation. The evaluation team approved this token of appreciation and are currently using it; this extension request does not propose any changes.

The evaluation team takes several actions to help enrollees complete the follow-up survey. If necessary, the evaluation team has available bilingual (English- and Spanish-speaking) telephone interviewers to address enrollee questions clearly and effectively and to gain enrollees' cooperation and to avoid refusals. The evaluation team trained interviewers to work with enrollees who need accommodations such as Text Telephone Relay to complete surveys. Finally, the evaluation team trained staff (also bilingual) on techniques for locating subjects who are no longer at the address and telephone number provided at enrollment.

Item nonresponse

Although the VRFD evaluation team's rates of item nonresponse on the follow-up survey are very low, some item nonresponse is inevitable. In reviewing the follow-up survey data to date, the evaluation team did not identify any survey questions with a nonresponse rate greater than 10 percent. The follow-up survey primarily collects data on outcome measures for use in the impact analysis. Depending on the pattern of missing data observed, the evaluation team considers alternative multivariate imputation techniques or omits subjects with missing data on a given outcome when analyzing that outcome.

Individual-level nonresponse

As mentioned above, with almost any survey, some nonresponse in the follow-up survey is inevitable. It is possible that the VRFD evaluation team may not be able to located some sample members, and others may not able or willing to respond to the survey. The VRFD evaluation team expects to attain a response rate of at least 80 percent based on the evaluation team's experience with prior SSA demonstrations. In the event that response rates are lower, the team analyzes nonresponse using various data items from administrative data records and baseline survey. The nonresponse bias analysis consists of the following steps:

Compute response rates for key subgroups. The VRFD evaluation team computes the response rate for the subgroups using the American Association for Public

Opinion Research definition of the participation rate for a nonprobability sample: the number of respondents who provided a usable response divided by the total number of people from whom the evaluation team requests participation in the survey (American Association for Public Opinion Research 2016). The VRFD evaluation team compares the response rate across key subgroups, including most notably the treatment group and the control group, as well as subgroups they used for block random assignment (the evaluation team defines the latter set of subgroups using pre-enrollment characteristics from KIR medical records, the baseline survey, or both). The goal of this analysis is to determine whether response rates in specific subgroups differ systematically from that of other subgroups or from the overall response rate. This could inform the evaluation team's development of nonresponse weights for use in the analysis.

Compare the distributions of respondents' and nonrespondents' characteristics. Again, using data from program records and the baseline survey, the evaluation team compares the characteristics of respondents and nonrespondents. The evaluation team assesses the statistical significance of the difference between these groups using *t*-tests. This type of analysis can help identify patterns of differences in observable characteristics that might suggest nonresponse bias. This approach, however, has low power to detect substantive differences when sample sizes are small, and the large number of statistical tests conducted can also result in high rates of Type I error. Consequently, we interpret the results of this item-by-item analysis cautiously.

Identify the characteristics that best predict nonresponse and use this information to generate nonresponse weights. This is a multivariate generalization of the subgroup analysis described previously. The evaluation team uses logistic regression models to assess the partial associations between each characteristic and response status; propensity scores obtained from such models provide a concise way to summarize and correct for initial imbalances (Särndal et al. 1992). Because of the rich set of program and baseline survey data available for this analysis, the evaluation team uses a mixture of substantive knowledge and automated machine learning methods to identify covariates to include in the final weights. Examples of automated procedures they could use to produce these weights efficiently include (1) using prespecified decision rules, such as those described by Imbens and Rubin (2015) and Biggs et al. (1991) to select covariates and interactions between them; and (2) identifying and addressing outliers by, for example, trimming weights in a way that minimizes the mean-square error of the estimates (Potter 1990).

Compare the nonresponse-weighted distribution of respondent characteristics with the distribution for the full random assignment sample. In this last step, the evaluation team compares the weighted distribution of respondents' baseline

characteristics with the unweighted distribution of the full set of study subjects that went through random assignment. The evaluation team makes these comparisons for the whole sample and for subgroups, as described earlier in this subsection. This step includes validation of the nonresponse weights using outcomes measured in the program data for the full sample (but not used in the construction of the weights). This analysis can highlight the measures with the greatest potential for nonresponse bias, even after weighting, in which case greater caution should be exercised in interpreting the observed findings.

Qualitative data from the implementation and operations staff: The VRFD evaluation team will conduct in-person site visits in the summer of 2026. During the visit, the evaluation team will conduct semi structured interviews with program staff and other key groups to collect information about their experiences and any changes made to the program during implementation.

Response rates

The VRFD evaluation team expects that KIR and DVRS provide the information required to assess program implementation. KIR and Mathematica collaborated on the proposal plan for site visits, and KIR and DVRS have a history of close collaboration, so the evaluation team anticipated high levels of cooperation for the qualitative interviews. The evaluation team held a phone call with the KIR project director to describe the information gathered from KIR staff and partners during site visits and in-person interviews. To minimize burden on site staff and maximize staff availability, the evaluation team worked with the KIR project director to determine the most convenient times to convene the interviews. The evaluation team limited the interviews to about one hour so that the data collection imposes only a modest burden on respondents.

To facilitate a smooth interview process and improve the completeness of the data collected, the VRFD evaluation team emails an information packet to the KIR project director and the DVRS contact containing the final site visit and interview schedule. The evaluation team sends out the packet about two weeks before the site visit. The packet contains the lead site visitor's contact information so the respondents can reach the visitors in case the schedule changes or other issues arise before the interviews. The evaluation team also sends email reminders to the KIR project director and the DVRS contact several days before the site visit confirming their arrival day and time. Providing the local sites with adequate information ahead of time in a professional manner helps build rapport, facilitates a more fluid interview process, and establishes that interviewees are available and responsive.

Data reliability

Interviewers use an interview guide, based on the previously approved interview topic list to conduct the semi-structured staff interviews. The interviewer takes notes and obtains permission to record each interview. The VRFD evaluation team uses separate discussion guides for each potential respondent type (for example, KIR project director, RF, DVRS staff) so they do not ask respondents about activities or issues that do not apply to them. The evaluation team reviews program documentation ahead of the interviews to minimize burden and supplement information that respondents share during the interviews, rather than ask respondents to answer detailed questions about specific operations. After the evaluation team completes all interviews for a site visit, the evaluator develops a summary of the information collected.

Tests of Procedures

Follow-up survey. The VRFD evaluation team pretested the follow-up survey instrument with five respondents. The follow-up survey did not require revisions based on findings from the pretest. In addition, the evaluation team assessed flow and respondent comprehension by debriefing each respondent to determine whether any words or questions were difficult to understand and answer. Similar to actual study subjects, participants in the pretest of the follow-up survey received an incentive for their time.

Qualitative data from the implementation and operations staff. The VRFD evaluation team based site visit protocols on those that evaluation teams used during similar evaluations, and the protocols the VRFD evaluation team used during the first interview with the KIR project director as a pilot to test the interview protocol. During this pilot test, the interviewer conducted a cognitive test of the semi-structured interview protocol to establish that the respondent interprets questions as intended and has the information necessary to answer the questions. The interviewer asked the respondent to explain how they arrived at their answers and whether any items were difficult to answer. At the end of the pilot interview, the evaluation team modified or clarified the interview questions where necessary to improve the data collection tools and procedures. Senior research staff also assessed the site visit agenda including: the data collection activities conducted and how these activities are structured; and to check that they can feasibly conduct all interviews as part of the site visits and yield the desired information.

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