Descriptive Implementation and Outcome Study Report

National Implementation Evaluation of the Health Profession Opportunity Grants (HPOG) to Serve TANF Recipients and Other Low-Income Individuals

OPRE Report No. 2016-30

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Overview

The Health Profession Opportunity Grants (HPOG) Program, established by the Patient Protection and Affordable Care Act of 2010 (ACA), funded training programs in high-demand healthcare professions, targeted to Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals. In 2010, the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS) awarded 32 five-year HPOG grants to organizations in 23 states; five were tribal organizations.

This report presents findings of the Descriptive Implementation Study and Outcome Study of the National Implementation Evaluation (NIE) of the HPOG Program. The NIE includes the 27 non-tribal HPOG grantees serving TANF recipients and other low-income individuals. The two NIE studies reported here addressed the following research questions:

1. How are health profession training programs being implemented across the grantee sites?
2. What individual-level outputs and outcomes occur?

All 27 grantees implemented HPOG, with 49 distinct programs in operation overall. The HPOG grants were not intended to cover the entire cost of the Program. HPOG program operators collaborated with partner organizations and accessed other community resources to provide the full complement of program activities, support services, and training courses needed to meet HPOG's goals. On average, each HPOG program had 19 partner or stakeholder organizations in its organizational network.

All HPOG programs recruited and served "low-income" individuals, with that precise definition left to grantee discretion. Income eligibility ranged generally from 150 to 250 percent of the federal poverty line, with the median standard at 200 percent. Most programs also set minimum grade-level standards for literacy and numeracy and assessed applicants' suitability for a career in the health professions. Overall, HPOG program participants were mostly female (88 percent), were racial or ethnic minorities (62 percent), had children (63 percent), and were unmarried (83 percent).

HPOG programs provided a full array of participant support services including case management, academic and career counseling, personal and family supports, and financial assistance. Nearly all programs offered training for select entry-level positions, including nursing aides, orderlies, and attendants; other commonly offered courses included those for medical assistants and pharmacy technicians. HPOG programs also offered longer-term training courses for higher-wage jobs, such as licensed vocational and registered nursing. At 18 months after entering HPOG, 85 percent of participants had enrolled in an occupational training course, 70 percent had completed a course, and 14 percent were still enrolled. For those who had completed at least one course, average time in training was 3.5 months.

At program exit, 72 percent of those who had completed at least one occupational training course were employed and 61 percent were employed in a healthcare job and at higher wages than those with jobs in other sectors. By two years after program entry, 70 percent were employed in any sector and were earning an average $5,357 per quarter. Other research funded by ACF is determining: (1) whether the jobs held at program exit represent the first step in a career progression of higher-skilled and better-paying jobs, and (2) whether the HPOG Program led to better outcomes for its participants than would have occurred in its absence.

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Executive Summary

The Health Profession Opportunity Grants (HPOG) Program, established by the Patient Protection and Affordable Care Act of 2010, funds training programs in high-demand healthcare professions, targeted to Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals. In 2010, the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS) awarded 32 HPOG grants for five-year project periods to organizations in 23 states, with approximately $67 million disbursed each year through fiscal year 2015. Twenty-seven of the HPOG grantees were post-secondary educational institutions, workforce investment boards, state or local government agencies, and community-based organizations. Five HPOG grantees were tribal organizations. [i]

HPOG is intended to meet the dual policy goals of demonstrating new ways to increase the supply of healthcare workers while creating career opportunities for low-income, low-skilled adults. Grantees designed and implemented programs to provide eligible participants with education, training, and employment activities, as well as general support services, to help them enter and advance in a variety of healthcare professions.

ACF's Office of Planning, Research and Evaluation (OPRE) is using a multipronged research and evaluation strategy to assess the success of the HPOG Program. The HPOG National Implementation Evaluation (NIE) is part of this strategy and includes the 27 non-tribal HPOG grantees. NIE has three major components: a Descriptive Implementation Study, a Systems Change Analysis, and an Outcome Study. This report presents findings from the Descriptive Implementation Study and the Outcome Study. These two studies address the following two major research questions, respectively:

1. How are health profession training programs being implemented across the grantee sites?
2. What individual-level outputs and outcomes occur?

The findings in this report are based largely on data from the following sources:

- Surveys of: HPOG grantee representatives;[ii] HPOG management and staff; HPOG stakeholders; and employers with relationships with HPOG programs
- Administrative data on participant characteristics, program experiences, and outcomes from the HPOG Performance Reporting System (PRS)
- Administrative data on quarterly employment and earnings from the National Directory of New Hires (NDNH)
- Qualitative data from on-site interviews with HPOG program management, staff, and partners

[i] This report includes findings on 27 HPOG grantees. The five tribal HPOG grantees were evaluated separately.

[ii] The Grantee survey was fielded with designated liaisons from each grantee who sought input from HPOG program staff. Survey instructions indicated that some questions required the perspective and experience of frontline staff members who provided services to participants and that others required input from administrators.

Key Findings in Brief:

Who participated in the HPOG Program?

At program entry (N = 23,664)

- Eighty-eight percent of participants were female and 62 percent were from racial or ethnic minorities.
- Sixty-three percent of participants were parents and 83 percent were unmarried.
- Sixty-five percent of participants had annual incomes below $10,000 and 15 percent were receiving TANF cash assistance.
- Thirty-two percent of participants were in school.

How did participants fare in educational attainment?

At 18 months after program entry[iii] (N = 12,614)

- Eighty-five percent had enrolled in a healthcare training course.
- Seventy percent had completed at least one training course and another 14 percent were still enrolled.
- The average time in training for those who had completed a course was 3.5 months.
- Of those who had completed at least one training course, about two-thirds had received a license or a third-party certification.
- Eleven percent of those who had completed a course had begun at least one additional healthcare training course.

How did participants fare in employment and earnings?[iv]

All participants, two years after program entry (N = 12,251)[v]

- Nearly 70 percent of participants were employed in a job in any sector, an increase from about 50 percent in the quarter of program entry.
- Participants who had completed at least one training course were about 10 percent more likely to be employed than those who had dropped out before completing training.
- For those who had completed training and were employed, average quarterly earnings were $3,942 following course completion, increasing to $5,357 at two years after course completion.

[iii] Restricting analysis to those with an 18-month follow-up period makes it possible for the report to include more comprehensive information on training completions and post-training-completion employment.

[iv] All employment and earnings data are for those with 18 months or more of follow-up data after program entry.

[v] N ranges from 12,251 to 6,210 in final quarters due to time lags in available data and not all participants having had eight quarters post-enrollment.

Those who had completed a healthcare training course, at program exit (N = 6,739)[vi]

- Seventy-two percent of those who had completed at least one training course were employed and 61 percent were employed in healthcare.
- Among training course completers, average hourly wages were higher for those in healthcare jobs ($12.42) than for those working in other sectors ($9.98).
- Training completers in healthcare jobs were almost four times as likely to have employer-provided health insurance as completers in non-healthcare jobs.

How were HPOG programs designed and implemented?

Who received HPOG grants? Who operated programs?

- Most grantees and program operators were higher education institutions or workforce development agencies; others included other public agencies and non-profit organizations.
- Most grantees operated a single program with a unique set of services, but four grantees funded multiple programs. Overall, the 27 non-tribal grantees implemented 49 distinct programs.
- On average, HPOG programs collaborated with 19 other partner and stakeholder organizations; partners' contributions included recruitment, occupational training, support services, and employment assistance.

Who was eligible to participate?

- Most programs used the federal poverty level (FPL) to set income eligibility for non-TANF applicants, with a median standard of 200 percent of FPL and a range of 150 percent to 250 percent.
- Most programs set minimum grade-level numeracy and literacy standards for eligibility. Because many states prohibit persons with criminal records from working in direct patient care, most programs checked for past felonies or misdemeanors and prohibited those with criminal records from participating. Some programs provided training in occupations that do not entail patient contact, such as dental prostheses technicians.
- Most programs also screened applicants in other ways to determine suitability for healthcare training and employment, assessing, for example, their motivation, work ethic, and interpersonal skills.

What healthcare training courses were provided?

- Most HPOG programs offered pre-training activities to prepare participants for occupational training; the most common topics were soft-skills training and introduction to healthcare careers.
- Almost all programs offered occupational training for nursing aides, orderlies, and attendants; other commonly offered courses included those for medical assistants and pharmacy technicians.
- HPOG programs also offered longer-term training courses for higher-wage jobs, such as those for licensed vocational and registered nursing.

[vi] Information on employment was collected, only at program exit, in the Performance Reporting System (PRS), the participant-tracking and management information system that provides data on participant characteristics, engagement in activities and services, and training and employment outcomes and the source of these data. Program exit was defined separately by each program. These results are for a subset of all training program completers; they exclude those who had completed a training course but had not exited the program at the time of this analysis.

- Most programs incorporated career pathways elements into training, such as work-based learning, flexible and accelerated scheduling, stackable credentials, contextualized basic skills, and support services.

What support services were provided?

- Almost all programs had case managers. They monitored progress; provided personal, financial, academic, career, and employment counseling; and referred participants to other support services.
- Other academic supports included tutoring, peer support groups, and mentoring.
- Financial supports included tuition assistance or waivers; free course materials, supplies, and uniforms; and financial support for outside exams, licenses, and certifications.
- Programs also provided personal and family supports (directly or through referral), such as child care and transportation assistance.

What employment assistance was provided?

- All programs provided multiple types of employment development and assistance services; the most common were individual job search assistance, career and employment counseling, and job listings.
- In most programs, employer partners played a role, including, for example, requesting referrals for job openings, placing job lists with programs, and asking programs to screen job candidates.

Conclusion

Overall, the Descriptive Implementation and Outcome studies found that HPOG programs enrolled eligible participants generally at their target enrollment levels. In addition, the study revealed that the majority of participants completed their course(s) of study and found healthcare jobs. However, many of those first jobs after leaving the program were in relatively low-wage positions. Further research is needed to determine whether (1) these positions represent the beginning of career pathways that combine employment with further training to advance in an occupation, and (2) HPOG participants fare better than they would have in the absence of the program. Research on both questions is currently under way via the HPOG Impact Study and the Career Pathways Intermediate Outcomes Study (see Appendix A for descriptions).

1. Introduction

Important Terms for this Chapter

Career Pathways—a framework for occupational training that combines education, training, and support services that align with the skill demands of local economies and help individuals to enter or advance within a specific occupation or occupational cluster

HPOG Program—the national HPOG initiative, including all grantees and programs

HPOG grantee—the entity receiving the HPOG grant and responsible for funding and overseeing one or more local programs

HPOG program—a unique set of services, training courses, and personnel; a single grantee may fund one or more programs

HPOG program operator—the lead organization directly responsible for the administration of an HPOG program

HPOG partners—other organizations directly involved in the operations of the HPOG program

HPOG stakeholders—organizations that play no role in program operations but have an interest in the HPOG program's implementation and success

Network—the group of organizations that interact to support HPOG program operations

Contextual factors, or "system"—the economic and service delivery environment in which the HPOG program operates

Outputs—the direct results of program activities or services received by HPOG participants and/or the accomplishments associated with completing a service

Outcomes—end goals for HPOG, including employment and earnings in general and in healthcare specifically

TANF recipient—an individual receiving TANF cash benefits at time of program application

This report presents findings of the Descriptive Implementation Study and the Outcome Study of the National Implementation Evaluation (NIE) of the Health Profession Opportunity Grants (HPOG) Program. The NIE is part of a multipronged research strategy supported by the Office of Planning, Research and Evaluation (OPRE) of the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS). The NIE has three major components: a Descriptive Implementation Study, a Systems Change Analysis, and an Outcome Study. These studies address the following three research questions, respectively:

1. How are health professions training programs being implemented across the grantee sites?
2. What changes to the service delivery system are associated with program implementation?
3. What individual-level outputs and outcomes occur?

More specifically:

- The Descriptive Implementation Study describes the design and operation of the HPOG Program at the national level.
- The Systems Change Analysis describes the HPOG programs' partnership and network structure and whether and how it has changed under HPOG. The analysis also examines the extent to which HPOG has changed systems for recruiting, training, and placing low-income individuals into the health professions.
- The Outcome Study describes participant characteristics, participation patterns, outputs, and outcomes.

This report presents findings of the Descriptive Implementation Study and the Outcome Study; a separate report presents the Systems Change

Analysis.[1,2,3] This first chapter begins with an introduction to the HPOG Program, proceeds with an overview of the conceptual framework for the HPOG NIE, and concludes with summaries of the data collection strategies and analysis approach.

1.1 The HPOG Program: Healthcare Training for Low-Income Adults in Career Pathways

As part of the Patient Protection and Affordable Care Act of 2010, Congress authorized funds "to conduct demonstration projects that provide eligible individuals with the opportunity to obtain education and training for occupations in the healthcare field that pay well."[4] ACF developed and funded the HPOG Program to prepare, train, and support Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals for stable, well-paying careers in healthcare. Education and training programs funded in 2010 through the five-year HPOG grants were required to:

- Prepare participants for healthcare sector employment in positions that pay well and are expected either to experience labor shortages or to be in high demand
- Target skills and competencies demanded by the healthcare industry
- Support career pathways, such as articulated career ladders
- Result in employer- or industry-recognized, portable educational credentials (e.g., certificates or degrees) and professional certifications and licenses (e.g., third-party certification, a credential awarded by a Registered Apprenticeship program)
- Combine support services with education and training services to help participants overcome barriers to employment
- Provide training services at times and locations that are easily accessible to targeted populations[5]

OPRE is using a multipronged research and evaluation strategy to assess the success of career pathways programs for low-income populations. These research and evaluation activities examine program implementation, systems change resulting from HPOG programs, and participant outcomes and impacts. Appendix A describes these activities.

1.2 The HPOG Program Logic Model: A Conceptual Framework for Research

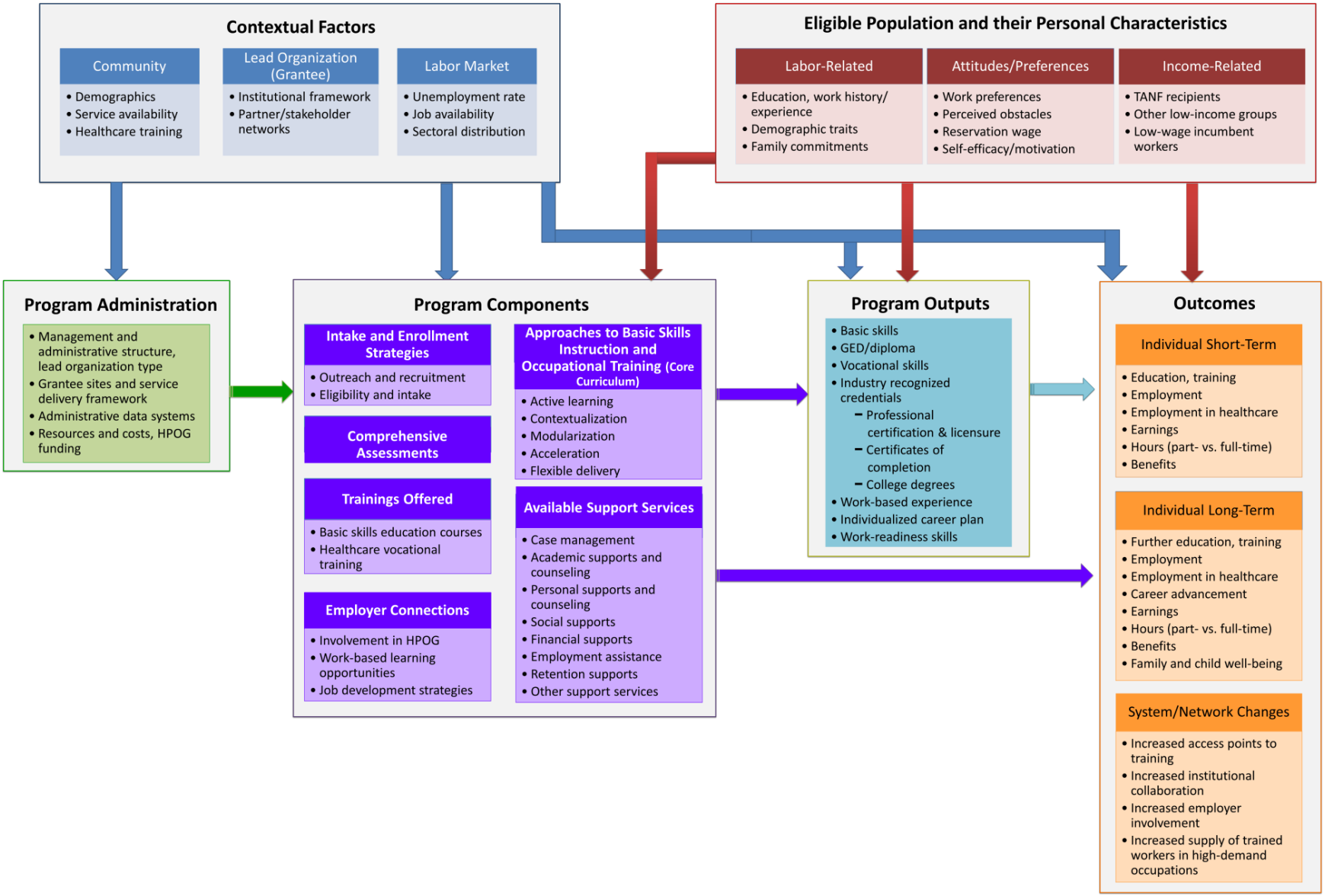
Exhibit 1-1 illustrates the HPOG Program's logic model. A logic model describes the "theory" of a program by showing how all of the parts fit together and relate to desired outcomes. It also shows the contextual factors that influence a program's design, implementation, and results. The boxes in the model contain the factors and the arrows indicate influence or causality. Short- and long-term individual outcomes are theorized to be influenced by a combination of participant characteristics, program components and features, and contextual factors.

In addition to providing a framework for understanding how programs are supposed to work, logic models also help organize program evaluations. The HPOG logic model provides a structure for the NIE's descriptive goals: (1) how the specific components in each of the domains of the logic model—contextual factors, eligible populations and their personal characteristics, program administration, and program components—either are being implemented or may affect implementation, and (2) the extent to which HPOG's hypothesized program outputs and outcomes are realized.

The major components of the HPOG logic model are:

- ***Contextual factors.*** These are characteristics of HPOG programs' communities and local healthcare labor markets, as well as the grantees' institutional frameworks and networks of partners and stakeholders. The logic model hypothesizes that these characteristics influence program design, operation, and results.
- ***Eligible populations and their personal characteristics.*** These include the HPOG program-specific target populations and the characteristics of those populations that may be associated with (1) accessing and completing academic and occupational training for good jobs in the healthcare sector, and (2) obtaining and advancing in those jobs. Many individuals in the eligible populations may have barriers to occupational training or employment that require remediation.
- ***Program administration.*** This includes the management and administrative structure of the HPOG grantee institution, program sites, and service delivery; administrative data systems and resources; and costs and HPOG funding resources.
- ***Program components.*** These include intake and enrollment strategies, such as program outreach and recruitment of target populations; comprehensive assessments of participants' academic and non-academic skills and needs; delivery of a core curriculum of basic skills and occupational training courses; academic and non-academic support services designed to address barriers to training or employment; and connections with employers.
- ***Program outputs.*** Outputs are defined as the direct results of program activities or services received by HPOG participants and/or the accomplishments associated with completing a service, such as obtaining a certificate of completion, license, or diploma.
- ***Outcomes.*** Ultimately, the logic model hypothesizes that participation in the HPOG Program will result in participant-level outcomes, such as a positive change in employment status, earnings, and/or occupation and career. In addition to participant-level outcomes, outcomes involve system and network changes, including increased access to training and more institution and employer involvement in training, as well as a greater supply of healthcare workers for high-demand occupations. This report covers only participant-level outcomes; system and network outcomes are described in a separate report.

Exhibit 1-1. HPOG Program Logic Model



1.3 Multiple Data Sources

To support its analyses, the NIE uses a variety of data sources and collection strategies. Principal data sources for the Descriptive Implementation Study are surveys of HPOG grantees, program management and staff, HPOG partners and stakeholders, and healthcare employers. These surveys were fielded between November 2013 and April 2014, when HPOG was in its fourth year of implementation. The response rates ranged from 38 percent for the combined Stakeholder/Network and Employer survey to 100 percent for the Grantee survey.[vii, viii] The Outcome Study uses output from the HPOG Performance Reporting System (PRS), a participant-tracking and management system that provides data on participant characteristics, engagement in activities and services, and training and employment outcomes; HPOG program management materials (e.g., grant applications, progress reports); quarterly wage data from the National Directory of New Hires (NDNH); and secondary data sources on local area labor markets and socioeconomic environments. The NIE also uses data collected by implementation study researchers for the HPOG Impact Study. A final report will update the Outcome Study, including data from a 15-month follow-up survey of HPOG participants included in the HPOG Impact Study and a sample of HPOG participants from programs not included in the Impact Study.

A more detailed description of the various HPOG NIE data sources is included in Appendix B of this report.

1.4 Descriptive Implementation and Outcome Studies Designs

Following the structure and content of the HPOG logic model, the Descriptive Implementation and Outcome studies describe contexts, program administrative structures, and program components of the non-tribal HPOG grantee programs, as well as personal characteristics of participants, program outputs, and outcomes. The studies describe and analyze the variations across HPOG programs while synthesizing this information at the national level to characterize the HPOG Program as a whole, either by presenting the number and percentage of programs that have implemented a specific feature, by averaging results at the program level, or by presenting outcomes across all participants. To that end, the study developed the NIE measures, concepts, and variables to capture the same information from all survey respondents and other data sources. This section provides an overview of the studies' analysis approach.[6]

The primary unit of analysis for most of the Descriptive Implementation Study is the local program, defined as "a unique set of services, training courses, and personnel." The program is the major analytic unit because it is where policy and practice interface directly with participants; it is where all the HPOG participants are offered the same range of services and training activities regardless of physical location. Grantees may fund and supervise one or more programs, depending on grantees' configurations, particularly in regard to the number of communities being served and the nature of their partnerships. For some variables, notably contextual ones, both grantees and programs may be the analytic units.

The primary unit of analysis of the Outcome Study is the HPOG participant. With respect to participant characteristics, the Outcome Study includes all participants with records in the PRS through October 1,

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[vii] Response rates for all surveys are available in Appendix exhibit B-6.

[viii] The sample for the combined Stakeholder/Network and Employer survey was relatively small and composed of those employers identified by grantees as program partners or stakeholders. Forty-two surveys were fielded and 16 completed, yielding a response rate of 38 percent.

2014 (the fourth year of the HPOG Program). With respect to participant experiences, outputs, and outcomes, the Outcome Study includes participants who enrolled through April 1, 2013 (which is in the third year of the HPOG Program), to allow for at least 18 months of follow-up data post enrollment. Restricting analysis to those with an 18-month follow-up period makes it possible for the report to include more complete information on training completions and post-program employment.[7]

Most of the findings in the Descriptive Implementation Study are based on statistical tabulations or manipulations of closed-ended survey data. These data have important limitations when interpreted as descriptions of the national HPOG Program design, implementation, and results. That is, the data generally report the number and proportion of programs that include a specific program feature or characteristic (for example, the presence of workshops about careers in healthcare) and some information about how that program feature or characteristic may have been designed and implemented (for example, how long the workshop lasted, whether it was mandatory, and whether it was a group or individual activity). For some program characteristics, the study presents the average distribution across programs, usually referred to as "the percentage of characteristic *x* in the average program." In addition, for some core program features or implementation strategies, the study presents data on the proportion of participants in the HPOG Program nationally enrolled in a program that offered that feature.[8] What these measurements may not reveal, however, are qualitative details about a program characteristic. For example, information about workshops in this report will not indicate whether the workshops engaged HPOG participants, covered the most important material, or took place in comfortable surroundings.

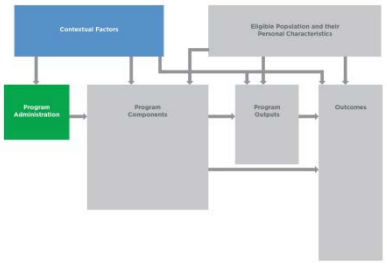
In part because the Descriptive Implementation Study findings are based largely on closed-ended measures, to add nuance to the findings the study uses some qualitative information from the HPOG Impact Study site visits made to programs implemented by 20 of the 27 non-tribal grantees. In no instance, however, should readers interpret the examples as necessarily representative of all programs implementing a particular feature; such examples are illustrative only.

Outcome Study findings are based on administrative data sources (the PRS and NDNH) that provide information on participation, outputs, and outcomes. The report presents results for different groups of participants by individual characteristics and by program participation status. Readers should not interpret presented results as impacts of participating in HPOG. The HPOG Impact Study will present results on the causal impacts of the HPOG Program on participant outcomes. Nevertheless, the findings in this report indicate progress and provide a picture of the HPOG Program's performance.[9]

To the extent feasible, the organization of this report seeks to mirror the structure and flow of the HPOG logic model, with chapters arranged as follows:

- Chapter 2—HPOG Program Context and Administration
- Chapter 3—HPOG Program Outreach, Application, and Enrollment
- Chapter 4—HPOG Program Healthcare Education and Training Activities
- Chapter 5—HPOG Program Support Services
- Chapter 6—HPOG Program Employment Assistance Services and Outcomes
- Chapter 7—HPOG Program Management and Staff Perspectives
- Chapter 8—Conclusion

2. HPOG Program Context and Administration



This chapter focuses on the features in the logic model sections labeled "Contextual Factors" and "Program Administration." Specifically, it describes (1) the types of institutions implementing HPOG and their backgrounds in serving similar populations with similar programs; (2) the community context, including the availability of public transportation and the availability of healthcare training and support services; (3) the local healthcare labor market; (4) the administration of program services and activities across HPOG programs and their partners; (5) management and staffing patterns and backgrounds; and (6) HPOG grant expenditures.

Summary of Major Findings about HPOG Program Context and Administration

The 27 non-tribal HPOG Program grantees either operated directly or funded and oversaw 49 individual HPOG programs. About three-quarters of the grantees and program operators were either workforce development agencies or higher education institutions, with the remainder being other state or local government agencies or non-profit organizations. About half of grantees and program operators relied on their institutional experience with similar programs to create their HPOG programs; the other half created new programs or program components in designing and implementing HPOG. Although most program operators served low-income individuals and operated sectoral training programs before HPOG, a majority of program organizations specifically targeted one or more new groups for service.[10]

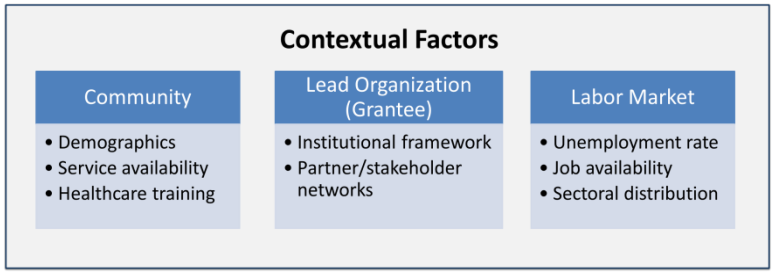
The vitality and nature of local healthcare labor markets affected HPOG programs' success in placing participants in the occupations for which they had trained. Overall, the demand for healthcare workers increased steadily after the HPOG Program had begun operations. Also, about two-thirds of the HPOG programs were in local labor markets with favorable demand and supply conditions for newly trained health professionals.

As outlined in the HPOG Program funding opportunity announcement (FOA), grantees were not expected to deliver all HPOG services and training courses by themselves or solely with HPOG grant resources. Rather, grantees were expected to establish partnerships with local or state institutions to provide the range of activities, services, and courses needed to implement HPOG and to leverage existing community resources where possible. To implement their programs, grantees and program operators relied on networks of institutional partners and referred HPOG participants to other community resources for a variety of support services.

All HPOG programs had management and staff dedicated to program administration. HPOG frontline staff interacted with applicants and participants through a variety of activities and services including, for example: program recruitment, applications, and intake; case management; career and academic counseling; direct provision of and referral for support services; and job search assistance. HPOG managers that supervised frontline staff were also heavily involved with participants, either directly or indirectly by conferring with staff about student needs and progress. HPOG management and staff were generally representative of HPOG participants in gender and ethnicity. That is, they were overwhelmingly female and about two-fifths were members of ethnic and racial minorities.

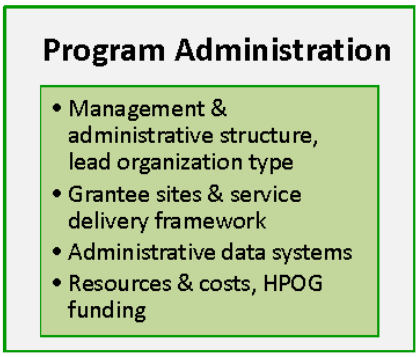
Annual HPOG grants ranged from about $1 million to $5 million, but the grant expenditures per participant-year varied widely.[11] Variations in per-participant grant expenditures were due largely to differences in programs' reliance on partners and community resources for services and courses, as well as the range of courses and services provided and the mix of students each program served.

2.1 HPOG Program Context



Like all community employment initiatives, HPOG programs were partly shaped by the labor markets in which they operate as well as various institutional, community, and environmental factors. For example, the institutional capabilities and level of experience with similar programs and service populations of program operators and their partners likely influenced decisions about which services and training opportunities grantees offered. Similarly, both local healthcare labor markets and the availability of similar service opportunities in the community influenced decisions regarding the healthcare occupational training courses made available to HPOG participants. This section describes key program context features and explores how those features may have interacted to influence program design and implementation.

2.1.1 HPOG Program Institutional Type



Several different types of institutions oversaw HPOG grants and operated HPOG programs, including (1) higher education institutions; (2) workforce development agencies, including Workforce Investment Boards (WIBs)[12] and One-Stop career centers;[13] (3) government agencies; and (4) non-profit organizations.[14] The institutional identity of the program operator and its capabilities likely determined the types of services or training activities that had to be provided by partner organizations.

Key Finding

Most HPOG grantees were either higher education institutions or workforce development agencies.

The 27 HPOG grantees serving TANF recipients and other low-income individuals implemented 49 distinct HPOG programs. Most grantees (23 grantees, 85 percent) funded and oversaw or operated one program, while four grantees funded and oversaw or operated from 4 to 11 programs.[15] Higher education institutions operated almost half of HPOG programs (24 programs, 49 percent) and workforce development agencies operated just over a quarter of programs (12 programs, 24 percent) (Exhibit 2-1). Non-profit institutions, such as community action programs, operated 10 programs (20 percent). Non-workforce development state or local government agencies operated the remaining three programs (6 percent).[16]

Exhibit 2-1. HPOG Program Operator Institutional Type

Institutional Type	Number	Percentage
Higher education institution	24	49%
Workforce development agency	12	24
Non-profit organization	10	20
State or local government agency	3	6

Source: HPOG Grantee survey, 2014, Q1.1.
N=49
Missing: 0 programs

2.1.2 Experience Working with Low-Income Populations and Implementing Healthcare Training Programs

Key Findings

Most HPOG program operators had served low income individuals previously, but many targeted at least one new low income group for their HPOG program.

Many program operators expanded or adapted existing programs, but nearly half designed new programs for HPOG.

All HPOG programs targeted TANF recipients for participation, as mandated by the grant requirements, but the other low-income groups programs chose to target varied (Exhibit 2-2). For instance, 46 programs (94 percent) specifically targeted unemployed individuals for HPOG participation, 36 programs (73 percent) targeted Supplemental Nutrition Assistance Program (SNAP) recipients, and 30 programs (61 percent) targeted single parents.

Thirty-two program operators (65 percent) targeted their services on at least one group they had not focused on before HPOG (Exhibit 2-2).[17] For example, a meaningful number of programs had no prior experience targeting low-income individuals (11 programs, 22 percent) and/or TANF recipients (17 programs, 35 percent). Many programs similarly introduced other new groups of low-income individuals as priorities.

Exhibit 2-2. HPOG Programs' Experience with Targeted Groups

Targeted Group	Targeted for HPOG		New Targeted Group	
	Number	Percentage	Number	Percentage
TANF recipients	49	100%	17	35%
Low-income individuals	49	100	11	22
Unemployed individuals	46	94	11	24
SNAP recipients	36	73	12	33
Single parents	30	61	10	33
Post-secondary students	29	59	10	34
Incumbent workers	23	47	9	39
Individuals without a GED or high school diploma	20	41	5	25
Veterans	20	41	3	15
Non-custodial parents	18	37	5	28
LEP individuals*	18	37	1	6
Victims of domestic violence	15	31	6	40
Youth transitioning out of foster care	12	24	6	50
Homeless individuals	12	24	4	33
Individuals with disabilities	11	22	4	36
Ex-offenders	2	4	0	0

*Persons with Limited English Proficiency
Source: HPOG Grantee survey, 2014, Q1.3, Q3.3.
N=49
Missing: 0 programs

HPOG program operators also varied somewhat in their experience providing sectoral training in general and training in healthcare in particular (Exhibit 2-3). A majority of HPOG programs (40 programs, 89 percent) had some prior experience with sectoral training, and over three-quarters had experience offering sectoral training in healthcare (34 programs, 76 percent). Most program operators had provided sectoral training in other fields before HPOG (30 programs, 67 percent). As should be expected, this pattern was most consistent for higher education institutions and for workforce development agencies. Only one of 24 programs led by a higher education institution and one of 12 programs led by a workforce development agency were completely new to sectoral training.

Exhibit 2-3. HPOG Programs' Experience with Sectoral Training Before HPOG

Program Experience	Number	Percentage
Had prior experience with sectoral training program	40	89%
…in healthcare*	34	76
…in non-healthcare field*	30	67
Completely new to sectoral training	5	11

*Items in these rows had multiple responses; the percentages use 45 as the denominator.
Source: HPOG Grantee survey, 2014, Q1.2.
N=49
Missing: 4 programs

Although many program operators were providing healthcare occupational training when HPOG was implemented, most did not simply expand an existing program (Exhibit 2-4).[18] In fact, just under half of the programs (22 programs, 45 percent) were newly designed to meet the specifications of the HPOG

grant or the needs of the target populations. An equal number of institutions adapted an existing program in designing their HPOG programs, and 10 programs (20 percent) were expansions of existing efforts.

Exhibit 2-4. Development of HPOG Programs

HPOG Program Development	Number	Percentage
Newly designed	22	45%
Based on a prior program with modifications	22	45
Expansion of a prior program	10	20
Other	2	4

Note: Responses do not sum to 100 percent because multiple responses were permitted. Most programs chose one response.
Source: HPOG Grantee survey, 2014, Q3.1.
N=49
Missing: 0 programs

2.1.3 Area Healthcare Labor Market Conditions

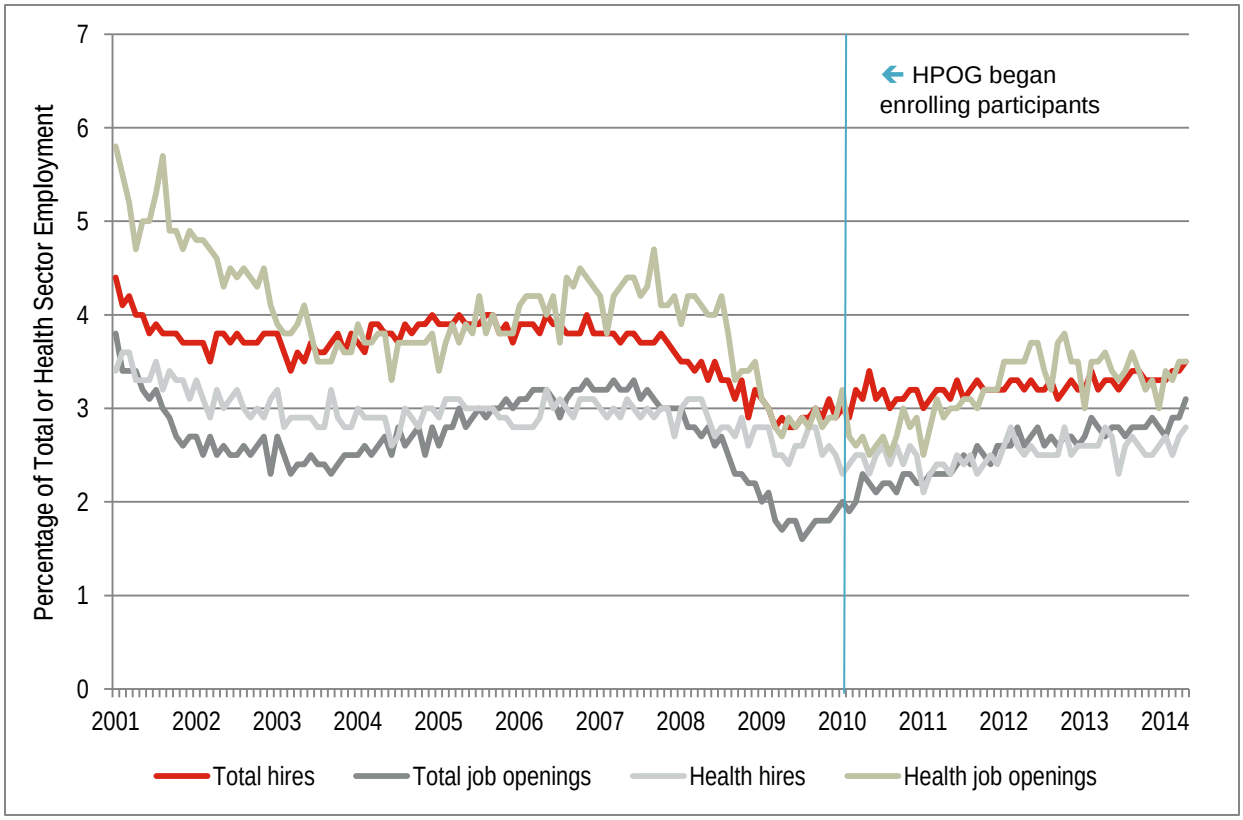
Key Finding

Local labor market conditions favored employment for 65 percent of the occupations for which HPOG programs offered training.

Local labor markets and, in particular, healthcare labor markets, were important contextual factors for the local service delivery system, especially as they relate to HPOG programming choices and employment outcomes. This section describes the labor markets for HPOG programs.[19] It documents the demand for healthcare occupations nationally and in HPOG program local labor markets, focusing on the most common occupations for which HPOG programs provided training.

The health sector experienced dramatic growth, beginning before and continuing throughout the implementation of the HPOG Program. From 2003 to 2013, both employment and wages grew for most of the occupations for which HPOG programs provided training.[20] The rates of growth in job openings and hiring (openings and hires, each divided by number employed) are important indicators of labor demand.[21] As shown in Exhibit 2-5, the rate of health sector job openings exceeded job opening rates for the economy as a whole from 2001 to 2014, indicating that the job market for healthcare workers expanded faster than the job market for all workers. At the same time, health sector hiring rates were consistently lower than total hiring rates, indicating ample openings in the health sector for new trainees relative to other sectors. Exhibit 2-5 shows that after a decline overall and in health sector jobs during the recent recession, job opening and hiring rates have recovered somewhat since 2009.

Exhibit 2-5. Total and Health Sector Job Opening and Hiring Rates Relative to Employment, 2001–2014



Source: Job Opening and Labor Turnover Survey, Bureau of Labor Statistics (BLS).
Note: Each series depicts that measure as a percentage of employment. Total hires or total job openings are divided by total employment, and health sector hires or openings are divided by health sector employment.

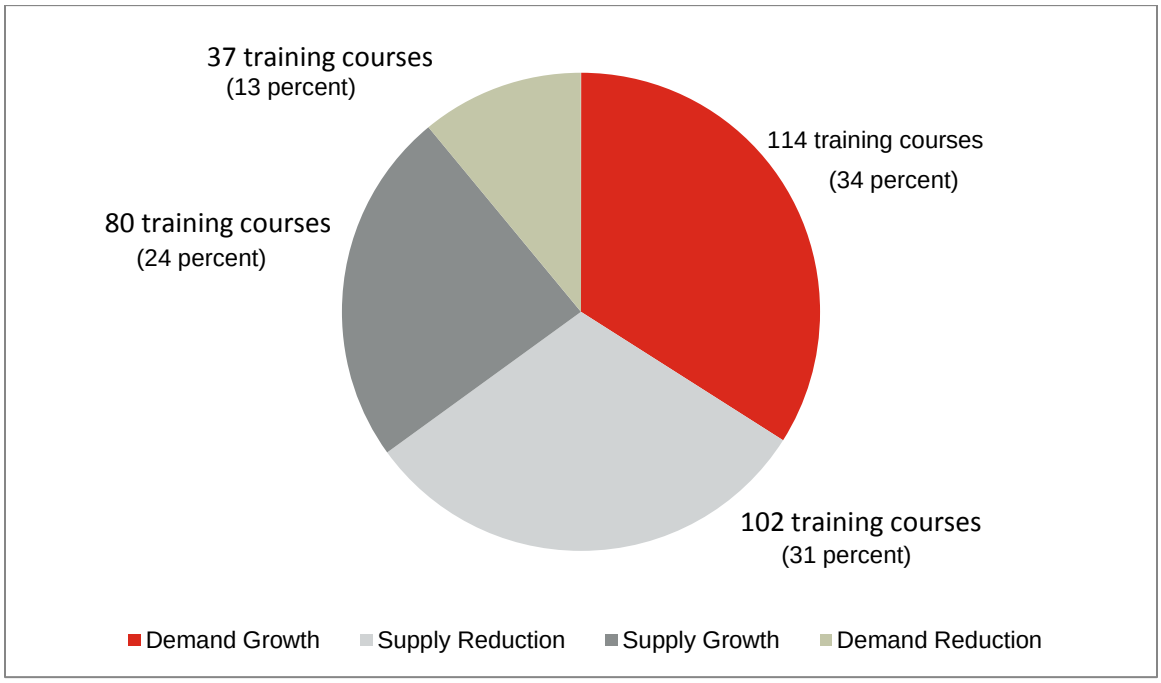
The 49 HPOG programs operated in 29 distinct labor markets with differing levels of supply and demand for specific healthcare occupations.[22] Labor market conditions for a given occupation can be categorized into four groups:[23]

- **Demand growth.** A period during which an occupation experiences an increase in both employment and real wages (an ideal situation for a training program).
- **Supply reduction.** A period during which an increase in wages is paired with a decline in employment. Even though wages are increasing, workers are choosing other occupations for a variety of reasons (this is also a good market for trainees).
- **Supply growth.** A period during which wages decline while employment increases (suggests a labor surplus relative to demand and so not a favorable market for trainees).
- **Demand reduction**. A period during which both wages and employment decrease (also a less favorable market for trainees).

Periods of demand growth and supply reduction are relatively favorable for new trainees entering the market for a given occupation, while supply growth and demand reduction are relatively unfavorable. The Systems Change Study analyzed the percentage of HPOG healthcare training courses in each labor market condition category for each of the 15 most frequently enrolled healthcare training courses (representing

90 percent of all HPOG students).[24] On average, each program offered seven of these top 15 training courses. When considering these courses across the 49 non-tribal HPOG programs, a majority of courses (65 percent) were in occupations with relatively favorable local labor market conditions for trainees (Exhibit 2-6).

Exhibit 2-6. Percentage of HPOG Training Courses by Local Labor Market Conditions



Sources: Bureau of Labor Statistics Occupational Employment Statistics, 2007–2010; PRS, 2014.
N=333 training courses across 49 programs

2.1.4 Community Context

All HPOG programs operated within the context of a local community or communities. This section begins with a discussion of program service area sizes, and then describes the availability of public transportation and similar training opportunities in the service areas for low-income populations before and after HPOG was implemented.

Key Finding

Many HPOG programs were located in areas with extensive public transportation systems. For example, 26 programs (53 percent) reported that program service locations either everywhere or almost everywhere (about 75 percent) in their catchment area could be accessed by public transportation; 24 programs (49 percent) reported the same level of access to healthcare employers by public transportation.

In addition to operating in diverse labor markets, HPOG programs also varied in the size of their service areas, from single counties to an entire state, with programs most frequently serving multiple counties (21 programs, 43 percent) (Exhibit 2-7). Programs served urban, suburban, and rural communities, with 33 programs (67 percent) providing services in urban settings, 34 programs (69 percent) providing services in suburban settings, and 21 programs (43 percent) providing services in rural settings.[25] Many programs served participants in multiple settings.[26]

Exhibit 2-7. HPOG Programs' Catchment Areas

Size	Number	Percentage
A single county	16	33%
Multiple counties	21	43
Entire state	1	2
Other	11	22

Source: HPOG Grantee survey, 2014, Q2.2.
N=49
Missing: 0 programs

Given the relatively high costs of owning and maintaining an automobile, the availability of public transportation can be an important factor in supporting participation among low-income individuals. Many HPOG programs were located in areas with extensive public transportation systems (Exhibit 2-8). For example, 26 programs (53 percent) reported that program service locations either everywhere or almost everywhere in their catchment area could be accessed by public transportation; 24 programs (49 percent) reported the same level of access to healthcare employers by public transportation.

However, about one-third of programs were located in communities with public transportation challenges. Fifteen programs (31 percent) reported limited access to service locations and 17 programs (35 percent) reported limited access to healthcare employers. Staff at several programs indicated that transportation barriers affected participants' ability to attend class and their employment opportunities. Management at one program noted that public transportation does not cover the entire county served by the program and students need cars to reach the main campus of the community college where HPOG training is held. Staff from another program said many employment opportunities are in suburban nursing homes, which are very difficult for their students residing in urban areas to reach due to transportation barriers, especially during non-standard work hours.[27] The statement suggests that sometimes even having public transportation available in an area does not guarantee access to all potential jobs.

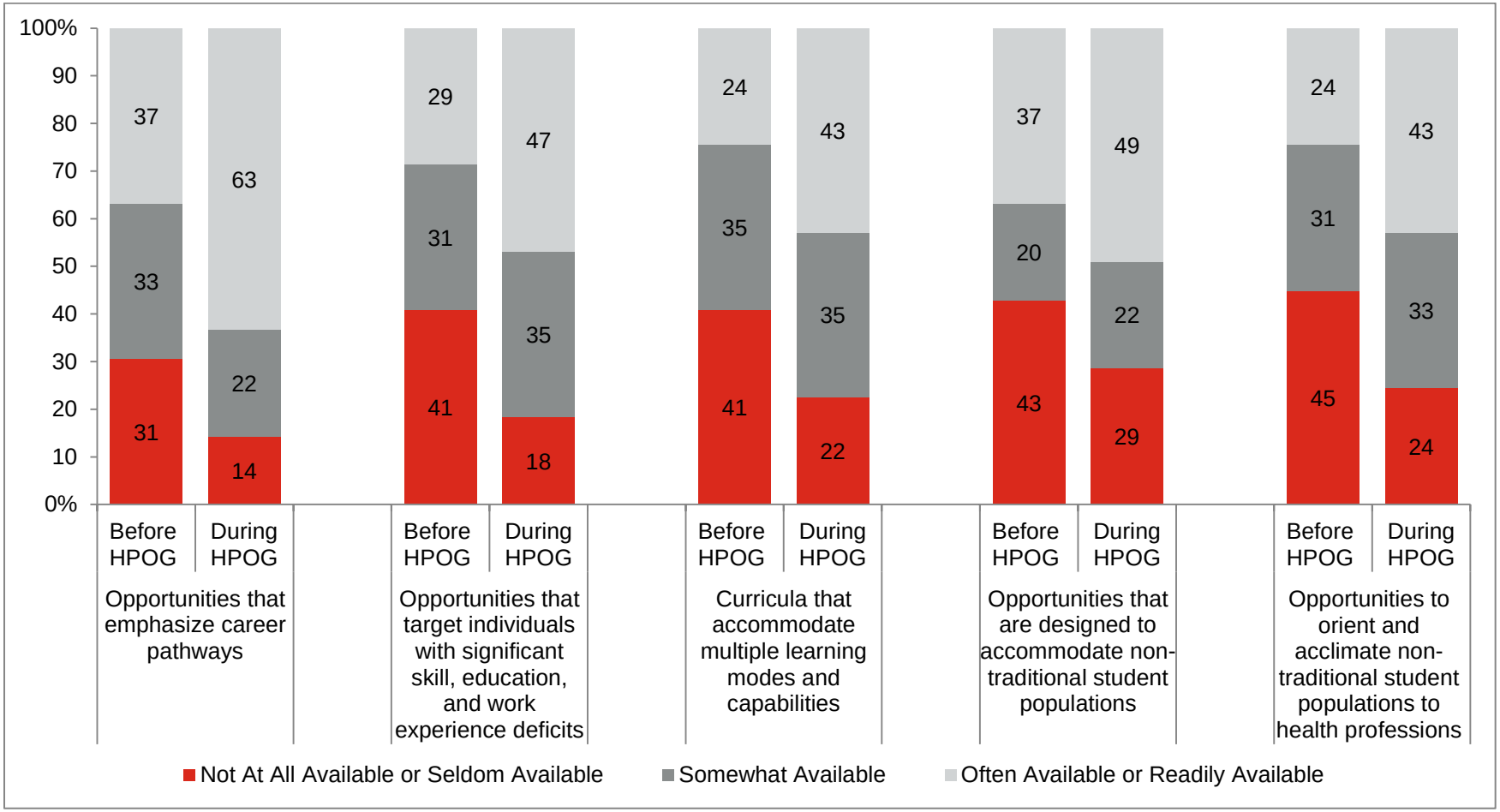
Exhibit 2-8. Availability of Public Transportation

	To Service Locations		To Major Healthcare Employers	
Availability	Number	Percentage	Number	Percentage
Everywhere in catchment area	9	18%	3	6%
Almost everywhere in catchment area (~75 percent)	17	35	21	43
Roughly half catchment area	8	16	8	16
Limited number of places in catchment area (~25 percent)	15	31	17	35

Source: HPOG Grantee survey, 2014, Q2.3a, b.
N=49
Missing: 0 programs

Findings from the Grantee survey indicated that HPOG expanded opportunities in healthcare occupational training for low-income populations (Exhibit 2-9).[28] This is despite the fact that many grantees and other institutions were operating similar programs for similar populations before HPOG began. More notably, Grantee survey respondents perceived that HPOG increased opportunities for low-income individuals. A minority of respondents, however, still felt that some unmet local demand for similar services remained even after HPOG was implemented (14 to 29 percent of programs, depending on the specific type of training opportunity).

Exhibit 2-9. Availability of Healthcare Training Before and After HPOG Implementation



Source: HPOG Grantee survey, 2014, Q4.1, 4.2.
N=49
Missing: 0 programs

2.2 HPOG Program Operations

This section presents findings on HPOG Program administration, staffing, and grant expenditures. The subsection on program administration is an overview of how programs used their own institutional resources and their networks of partners and available community services to deliver HPOG services and training.[29] While the design and implementation of HPOG Program activities, services, and training courses are described in greater detail in subsequent chapters, this subsection introduces the core theme that each program had to rely in part on other community resources to fulfill its goals. The following subsection on staffing patterns and characteristics is critical to understanding how programs interacted on a personal level with their students to help them achieve their training and employment goals. A subsection on the use of grant resources presents information on grant expenditures and the range in grant expenditures per HPOG participant-year.

2.2.1 Service Delivery Framework

HPOG grantees developed programs to help HPOG participants prepare for and enroll in healthcare training and provided a range of support services designed to help participants remain in and complete training. ACF expected that grantees and program operators would leverage community resources where available and rely on institutional partners to provide some HPOG services and training. In fact, in addition to providing many services directly themselves, program operators used institutional partners and other community resources to provide core program services or courses. For example, some program operators provided no occupational training directly but either paid for individual participants to enroll in a training course elsewhere or contracted directly with a partner institution to provide one or more courses for HPOG students. Similarly, many HPOG programs referred participants to available community resources, such as subsidized child care.

Key Findings

Program operators relied on a network of partners to implement HPOG programs. On average, program operators had 19 partners.

Partners contributed to virtually every aspect of program operations and services, including outreach and referral, pre training services and activities, support services, and occupational training in healthcare.

On average, each HPOG program operator worked actively with 19 other organizations,[30] with the number of partners varying by the type of institution leading the HPOG program (Exhibit 2-10). Non-profit agencies leading HPOG programs had on average 13 program partners and stakeholders, while state or local government agencies had on average 40.[31]

Exhibit 2-10. HPOG Program Partners and Stakeholders

Program Institutional Type	Average Number of Partners
All programs (N=49)	19
Higher education institutions (N=24)	21
Workforce development agencies (N=12)	17
Non-profit organizations (N=10)	13
State or local government agencies (N=3)	40

Note: Network size is reported in the Systems Change Analysis report, which includes the number of partners and stakeholders as well as the program operator.
Source: HPOG Sampling questionnaire for the HPOG surveys, 2014.
N=49
Missing: 0 programs

Network partners included a variety of institutions.[32] About one-third of HPOG partner organizations were educational institutions (34 percent), including community or technical colleges (18 percent). Less than one-quarter were non-profit organizations (18 percent), government agencies (17 percent), workforce development agencies (15 percent), or business sector organizations (11 percent; 10 of this 11 percent were healthcare employers). The remaining 4 percent of partners were other types of organizations.[33]

Along with program operators, HPOG partner organizations were engaged in virtually every facet of program implementation, including outreach and referral, pre-training services and activities, support services, and occupational training in healthcare (Exhibit 2-11). In the average program, partner organizations were nearly always involved in referring applicants (47 programs, 98 percent); counseling and support services (47 programs; 98 percent); job development (46 programs, 96 percent); marketing and outreach (45 programs, 94 percent); occupational training (45 programs, 94 percent); and job placement activities (44 programs, 92 percent).

Exhibit 2-11. Partner and Stakeholder Involvement in HPOG Activities

Activity in Support of HPOG	Programs with at Least One Partner or Stakeholder Reporting Involvement in Activity		Program Partners and Stakeholders Involved in Activity, Average Across All Programs
	Number	Percentage	Percentage
Referral and Outreach	**47**	**98%**	**81%**
Referral of applicants	47	98	71
Marketing and outreach	45	94	66
Training	**47**	**98**	**66**
Curriculum development	34	71	21
Occupational training	45	94	46
Pre-training activities	42	88	39
Basic academic skills	41	85	38
Employment assistance	**47**	**98**	**64**
Job development activities	46	96	56
Job placement activities	44	92	41
Recruitment or hiring of graduates	36	75	26
Planning and design of grant activities	**38**	**79**	**35**
Counseling and support services	**47**	**98**	**57**

Note: Referral and outreach, training, and employment assistance are aggregates that were not specified in the surveys. Involvement in one of these activity groups means involvement in any of the activities grouped below it. Tabulations are only of non-missing responses.
Source: HPOG Stakeholder/Network survey, 2014, Q14.
N=48
Missing: 1 program

HPOG programs coordinated service delivery across partners in different ways.[34] For example, case managers in one program provided or coordinated all intake and services for participants while local community colleges and other educational institutions provided training. In another program operated by a community college, program staff monitored the progress of participants as they accessed most services through existing college resources.

ACF required grantees to include signed memoranda of understanding, contracts, or other partnership agreements from a prescribed set of state or local public agencies in their HPOG applications, but not all of those agencies were identified as partners in HPOG networks (Exhibit 2-12). For example, only 23 programs (47 percent) identified the state WIB as a partner, although 36 programs (73 percent) did partner with their local WIB. Slightly more than half of programs cited as part of the network their state apprenticeship agency (29 programs, 59 percent). While more than half of programs partnered with their state TANF agency (26 programs, 53 percent), only a small number partnered with their local or county TANF agency (8 programs, 16 percent).[35] Similarly, only 30 programs (61 percent) partnered with one or more local employers.[36]

Exhibit 2-12. Inclusion of Required Partners in HPOG Networks

Required Partner	Number	Percentage
Local or state WIB or One-Stop career center	**48**	**98%**
Local WIB	36	73
State WIB	23	47
One-Stop	13	27
State apprenticeship office	**29**	**59**
Local/county TANF provider or state TANF agency	**31**	**63**
Local/county TANF provider	8	16
State TANF agency	26	53
All three types (including state TANF agency)	**21**	**43**
All three types (either state TANF agency or local/county TANF provider)	**23**	**47**
Any one type	**48**	**98**

Note: Inclusion of a given type of required partner means that at least one organization in the network (including the program operator) meets the definition of that type of organization. Research staff used Internet research to categorize organizations during the development of the sampling frame. America's Service Locator was used to validate the list of WIBs and One-Stops. The state apprenticeship office is the state agency responsible for overseeing apprenticeship programs in the state. In states without their own agency, the federal apprenticeship office has that responsibility. The U.S. Department of Labor (DOL) maintains a list of state apprenticeship agencies at www.doleta.gov/oa/stateagencies.cfm.

Source: HPOG Sampling Questionnaire and follow-up protocol, 2013, with additional coding by the research team.

N=49 HPOG program networks

Missing: 0 programs

2.2.2 Program Staffing and Management Patterns and Backgrounds

The previous section described how HPOG programs relied on partners and community resources to implement a variety of services and training opportunities. This section presents analyses of HPOG program staffing responsibilities and patterns, as well as staff and management educational and professional backgrounds.[37] Chapter 5 below includes more details about the services provided by staff and management.

Staffing Patterns

HPOG staff provided a variety of services and activities for HPOG applicants and participants. The most common primary staff responsibility was intake and enrollment, with 28 percent of staff in the average program reporting this as their primary duty (Exhibit 2-13). Eighteen percent of staff reported that their primary responsibility was providing employment assistance. In the average program, between 9 and 14 percent of staff reported that their primary responsibility was advising students with either academic, career, or non-academic issues. Other commonly reported primary responsibilities included instruction and administrative duties.

Key Findings

Nearly all program staff performed more than one duty. More than half of staff in the average program had one or two additional duties.

As it relates to providing direct assistance to HPOG participants, HPOG staff reported spending the largest amount of their time advising students on careers, followed by helping participants develop soft skills, advising on personal issues and needs, and helping participants find jobs.

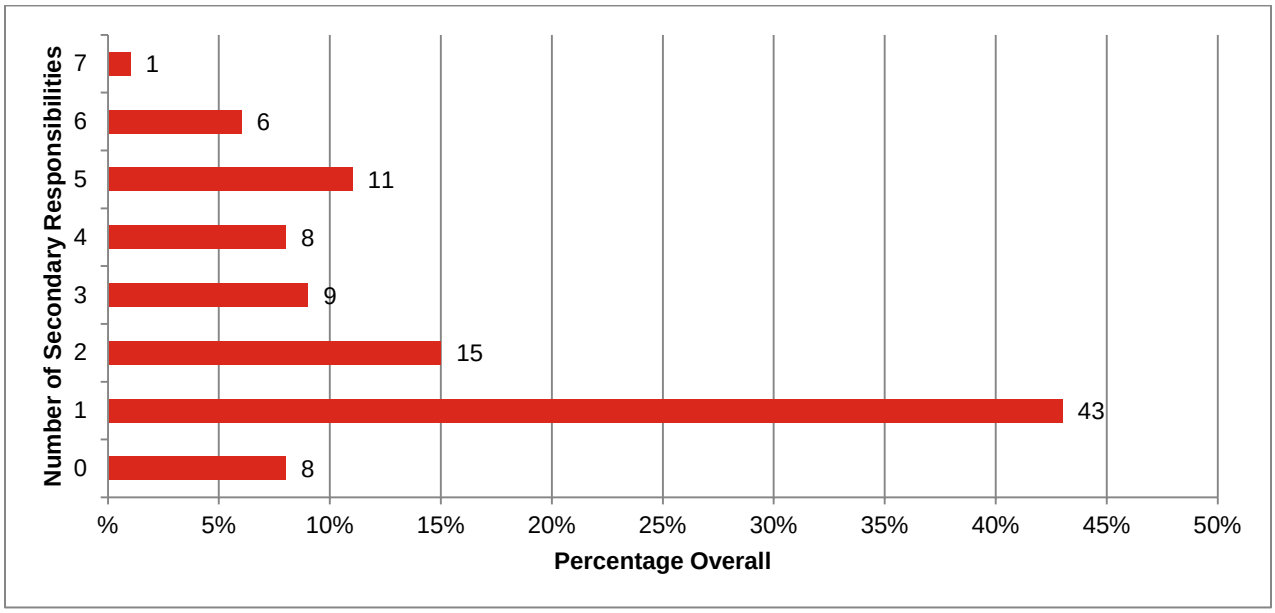
Exhibit 2-13. Primary Responsibility of HPOG Program Staff in the Average Program

Primary Responsibility	Percentage
Intake and enrollment	28%
Employment assistance	18
Academic advising	14
Career advising	10
Non-academic advising	9
Recruitment	3
Other	18

Source: HPOG Management and Staff survey, 2014, Q11-S.
N=234 staff across 49 programs
Missing: 1 program

In addition to their primary responsibility, most staff members (92 percent in the average program) had other duties as well (Exhibit 2-14).[38] In the average program, 58 percent of staff had one or two additional duties. Reflecting the distribution of primary duties, the three most common additional duties were academic advising, employment assistance, and intake and enrollment, with many staff also reporting non-academic advising as a secondary responsibility.[39] Note that the most common primary responsibility—intake—usually includes a variety of tasks, many of which can be labor-intensive, such as helping applicants fill out forms, entering data in the PRS, administering objective skills tests, and questioning applicants about their interests and needs.[40]

Exhibit 2-14. Number of Secondary Responsibilities for the Average Staff Person in the Average Program



Source: HPOG Management and Staff survey, 2014, Q12-S.
N=234 staff across 49 programs
Missing: 0 programs

The staff sections of the Management and Staff survey asked respondents to indicate how much of their time is spent providing specific types of direct assistance to HPOG participants. In the average program, the largest proportion of staff ranked assistance to participants as occupying "most of my time" in the following order: (1) providing career information and advice (31 percent); (2) identifying job openings for participants (29 percent); (3) assisting with developing academic and soft skills needed for school and work (27 percent); and (4) helping participants develop career goals (27 percent).[41]

The management sections of the Management and Staff survey were exclusively targeted to program managers who supervised line staff directly. As expected, most of these managers listed supervising staff as their primary responsibility.[42] In the average program, these managers supervised seven staff members, with a range of 2 to 32 staff members per program.[43] Most staff supervision involved managers' oversight of student issues. For example, in the average program, 70 percent of managers reported discussing student issues with case management and counseling staff at least once a week, and 43 percent reported similar discussions weekly with instructional staff.[44]

All HPOG programs were part of larger agencies or institutions, such as WIBs, community colleges, or community action programs. Many HPOG staff and managers had other job responsibilities in their programs' parent organizations and did not work full-time for HPOG. For the average program, only 51 percent of staff reported working full-time on HPOG, with the average proportion of the work day devoted to HPOG at approximately 80 percent for staff and 60 percent for managers. Similarly, not all HPOG personnel were full-time employees of their parent organizations. For example, while 94 percent of managers were full-time employees, only 78 percent of staff worked full-time.[45]

Staff Demographic, Educational, and Professional Backgrounds

HPOG staff and managers had diverse demographic, educational, and professional backgrounds. Exhibit 2-15 presents staff and management gender, race, and ethnicity in the average program and comparisons to HPOG participants in the average program on these demographic characteristics. Like most participants, management and staff were overwhelmingly female. Management and staff were also racially and ethnically diverse, although not as diverse as participants. For example, HPOG personnel were more likely to be white than HPOG participants (56 percent versus 37 percent) and less likely to be Hispanic (13 percent versus 20 percent).[46]

Key Findings

Most HPOG managers and staff had a bachelor's degree or higher, and over half had held their position or a similar one for two years or more.

Managers and staff were ethnically diverse; slightly less than half were Hispanic, African American, or from another minority ethnic group.

Exhibit 2-15. HPOG Staff and Participant Demographic Characteristics

	Percentage of Management and Staff in the Average Program	Percentage of HPOG Participants in the Average Program
Gender		
Female	83%	87%
Male	17	13
Race/Ethnicity		
White Non-Hispanic	56%	37%
Black Non-Hispanic	26	35
Hispanic/Latino, any race	13	20
Asian or Hawaiian, Pacific Islander	3	3
Native American or Alaska Native	< 1	<1
Two or more races, non-Hispanic	3	2

Notes: PRS sample is all HPOG participants from September 30, 2010, to October 1, 2014. Percentages are of non-missing responses at intake.

Sources: HPOG Management and Staff survey, 2014, Q3, 5, 6 and PRS, 2014.

N=309 managers and staff across 49 programs; 12,614 HPOG participants across 49 programs

Missing: Management and Staff survey: 0 programs. PRS: Race/ethnicity is missing for 1 percent of participants.

Most tasks HPOG staff and management performed require post-secondary training. As expected, the majority of managers and staff had earned post-secondary degrees. In fact, in the average program, over 80 percent of managers and staff had a bachelor's degree or higher (Exhibit 2-16). About 90 percent of managers and 79 percent of staff had a bachelor's degree or higher.[47]

Exhibit 2-16. Highest Education Level of HPOG Managers and Staff in the Average Program

Highest Education Level	Percentage
High school diploma or GED	<1%
Some college (no degree)	11
Associate's degree	6
Bachelor's degree	45
Master's degree	34
Doctoral degree or equivalent	3
Other	1

Source: HPOG Management and Staff survey, 2014, Q7.
N=86 managers and 234 staff across 49 programs
Missing: 0 programs

When considering whether HPOG management and staff had the backgrounds needed to perform their duties, professional experience is also important. In the average program, managers and staff reported an average 35 months of experience working in their current position or a similar one, with a range of 7 to 129 months.[48] In the average program, 56 percent of management and staff had been employed in current or similar positions for two or more years, and 29 percent had been in such a position for 12 months or less (Exhibit 2-17).[49]

Exhibit 2-17. Amount of Time Managers or Staff Had Been in Current or Similar Position in the Average Program

Amount of Time in Position	Percentage
12 months or less	29%
More than 12 but less than 24 months	15
24 months or more	56

Source: HPOG Management and Staff survey, 2014, Q2a.
N=86 managers and 229 staff across 49 programs
Missing: 0 programs

In addition to the training and experience that HPOG managers and staff brought to their jobs, all HPOG programs provided opportunities for professional development.[50] In the average program, 96 percent of management and staff said that they had attended a workshop or professional training activity; almost two-thirds (63 percent) said that they had attended a professional conference (Exhibit 2-18). [51]

Exhibit 2-18. Professional Development Activities Used by HPOG Management and Staff in the Average Program

Professional Development Opportunity	Percentage of HPOG Management and Staff Accessing Opportunity
Workshops/training courses	96%
Professional conferences	63
Online learning resources	49
Professional association memberships or journals	23
Mentoring/coaching	21
Learning communities or listservs	17
Other	2

Source: HPOG Management and Staff survey, 2014, Q17b.
N=82 managers and 192 staff across 49 programs
Missing: 0 programs

2.2.3 HPOG Program Grant Expenditures

HPOG grantees received five-year grants of between $1 million and $5 million annually. More than half (16) received five-year annual grants of between $1 and $2 million. Another seven received grants from $2 to $3 million and the remaining four received grants of $3 to $5 million per year. Funds were used to support the range of administrative activities, training courses, and support services described in Chapters 3–6 of this report.

Key Finding

Expenditures of the HPOG grants averaged $5,802 per program for a participant year; this ranged from $1,712 to $17,646 for individual programs.

As discussed earlier in this chapter, HPOG grantees were not expected to fund all HPOG activities, services, and training courses with the resources of the grant alone. Grantee programs leveraged a variety of available institutional and community resources to operate HPOG. The study did not have access to non-grant costs of HPOG participation. Consequently, when analyzing program costs, this study is limited to the amount of the HPOG grant award that each program spent per participant per year or for a "participant-year."[52] Note also that the calculation of costs per participant-year include all grant expenditures, such as staff salaries, administration, overhead, as well as direct grant expenditures on support services, adult education, or occupational training. Grant expenditures per participant-year varied widely across grantees, from $1,712 to $17,646.[53] Expenditures also varied across grantee institutional types. For example, workforce development agencies had the lowest average expenditure per participant-year ($4,155) and non-profit organizations the highest ($11,233) (Exhibit 2-19).[54]

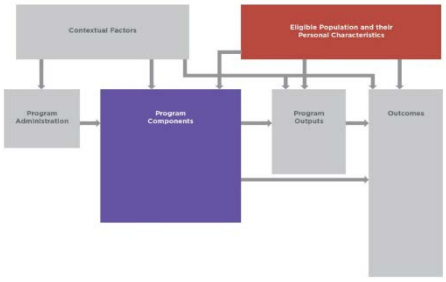
Exhibit 2-19. Grant Expenditures per Participant-Year (FY 2014)

Grantee Institutional Type	Number	Grantee Mean
All institutional types	27	$5,802
Higher education institutions	12	$5,874
Workforce development agencies	9	$4,155
Non-profit organizations	2	$11,233
State or local government agencies	4	$6,576

Source: SF-425 Federal Financial Reports (FFRs) submitted by HPOG grantees for fiscal year 2014.
N=27
Missing: 0 grantees

This chapter examined a variety of contextual issues and highlighted the manner in which they potentially shape the design, operations, and eventual success of HPOG. Key factors included the programs' institutional context, administration and staffing, and grant expenditures. The next chapter is the first of a series of chapters on HPOG operations and examines marketing and outreach efforts as well as the application and enrollment processes.

3. HPOG Program Outreach, Application, and Enrollment



This chapter focuses on intake and enrollment strategies and comprehensive assessments, which fall under the program component section of the logic model. Specifically, this chapter describes outreach and recruitment; financial, academic and other eligibility criteria; and the application process, including applicant burden and comprehensive assessments. The chapter closes with a description of the personal characteristics of HPOG Program participants.

Summary of Major Findings about HPOG Program Outreach, Application, and Enrollment

All HPOG program operators faced the task of making their programs known among their target populations and other community institutions serving their target populations, making outreach and recruitment critical activities in implementing HPOG. Over time, most programs relied heavily on "word of mouth" and referrals from other agencies as lead marketing and recruitment strategies. Overall, recruitment was successful, and the national HPOG Program achieved within four years its five-year projection of approximately 30,000 individuals enrolled.[55]

To assess and screen applicants, HPOG programs had to develop and implement eligibility requirements and application processes. The HPOG FOA required grantees to serve TANF recipients and other low-income individuals. Most programs used federal poverty line (FPL) guidelines to define "low-income." Many programs had other eligibility requirements, such as minimum academic skill levels; screenings for criminal backgrounds or drug use; and personal qualities programs identified as needed for success in training and employment. Application processes were lengthy; to complete the application and eligibility determination process, all programs required applicants to attend at least one in-person meeting, with a majority of programs requiring two or more in-person appearances.

The group of individuals who applied for and enrolled in the HPOG Program were overwhelmingly female. About two-thirds were from a racial or ethnic minority and a majority had children and were unmarried. A prime target group—individuals who were receiving TANF cash benefits at application—comprised about 15 percent of participants. Participants had a range of educational backgrounds, although the vast majority had attained high school equivalency or higher and had at least eighth-grade-level literacy skills; about one-third were enrolled in post-secondary education when they applied.

3.1 HPOG Program Recruitment Strategies

ACF required HPOG grantees to undertake a comprehensive outreach and recruitment strategy that defined a clear process for identifying individuals and referring them to training programs.[56] Also, ACF required grantees to develop specific enrollment goals. This report section focuses on the logic model section labeled "Intake & Enrollment Strategies."

3.1.1 Outreach and Recruitment

Most programs used a variety of strategies to inform prospective applicants about HPOG (Exhibit 3-1).[57] Some strategies were used more extensively than others. For example, all 49 programs relied on partnerships and referrals from other organizations, and more than 95 percent relied on word-of-mouth and print materials to reach prospective applicants (48 and 47 programs, respectively). Other common modes of marketing and recruitment included using the Internet (41 programs, 84 percent) and making in-person presentations at various locations in the communities served by HPOG (39 programs, 80 percent). Less common modes included referrals from employers (32 programs, 65 percent) and TV or radio public service announcements (17 programs, 35 percent). All programs also used other strategies, including toll-free information hotlines, direct mail campaigns, and door-to-door marketing. As reported in in-person interviews, program management and staff in most sites felt word of mouth was the most successful strategy.[58]

Key Findings

Nearly all programs relied heavily on referrals from partner organizations and word of mouth.

Low educational attainment of the target population, prospective applicants' need to work, and a lack of good public transportation and quality child care in the local community were serious challenges to recruitment.

Exhibit 3-1. Modes of Outreach and Recruitment

Mode	Number	Percentage
Partnerships with or referrals from other organizations	49	100%
Word of mouth	48	98
Distributed print materials	47	96
Internet-based strategies	41	84
In-person presentations in the community	39	80
Partnerships with or referrals from employers	32	65
TV or radio public service announcements	17	35
Other strategies	49	100

Note: Responses do not sum to 100 percent because multiple responses were permitted.
Source: HPOG Grantee survey, 2014, Q6.1.
N=49
Missing: 0 programs

HPOG program operators and their partners played a variety of roles in marketing and recruitment activities (Exhibit 3-2). In most programs, both the program operator (43 programs, 88 percent) and HPOG partner organizations (47 programs, 96 percent) referred applicants interested in other programs to HPOG instead. In well over half of the programs, staff in program operator organizations (30 programs, 61 percent) and partner organizations (31 programs, 63 percent) who were not directly involved in the HPOG program described this opportunity when presenting service options to their clients.

Program staff and partners in over four-fifths of programs conducted presentations in the community (40 programs, 82 percent) and/or sponsored presentations at their service delivery locations (39 programs, 80 percent) (Exhibit 3-2). Staff from one program noted that Facebook was an effective outreach tool, both when the program operators posted on their Facebook pages and when other organizations posted information about HPOG on their pages.[59] Another program found Craigslist to be effective. Several programs found that working with partners helped them reach a broader population.[60] For example, staff at one program noted that referrals from the local WIB and TANF agency had a significant impact on bringing in applicants for HPOG. Another program reported that it had formed several new partnerships in the community for its HPOG program, which had resulted in referrals from a variety of sources, including neighborhood resource centers and other community-based organizations.

Exhibit 3-2. Roles in Outreach and Recruitment

Mode of Outreach or Recruitment	Program		Program Operator		Program Partners	
	Number	Percentage	Number	Percentage	Number	Percentage
Develop HPOG outreach materials	42	86%	31	63%	28	57%
Conduct presentations in community	40	82	22	45	25	51
Sponsor presentations on site	39	80	29	59	34	69
Review HPOG during orientation for agency's/organization's non-HPOG services	38	78	30	61	31	63
Review HPOG during non-HPOG assessment and counseling sessions	37	76	22	45	28	57
Refer other program applicants to HPOG	NA		43	88	47	96
Employers refer employees to HPOG	NA		13	27	19	39

Note: Responses do not sum to 100 percent because multiple responses were permitted.

Source: HPOG Grantee survey, 2014, Q6.2a, 6.2b.

N=49

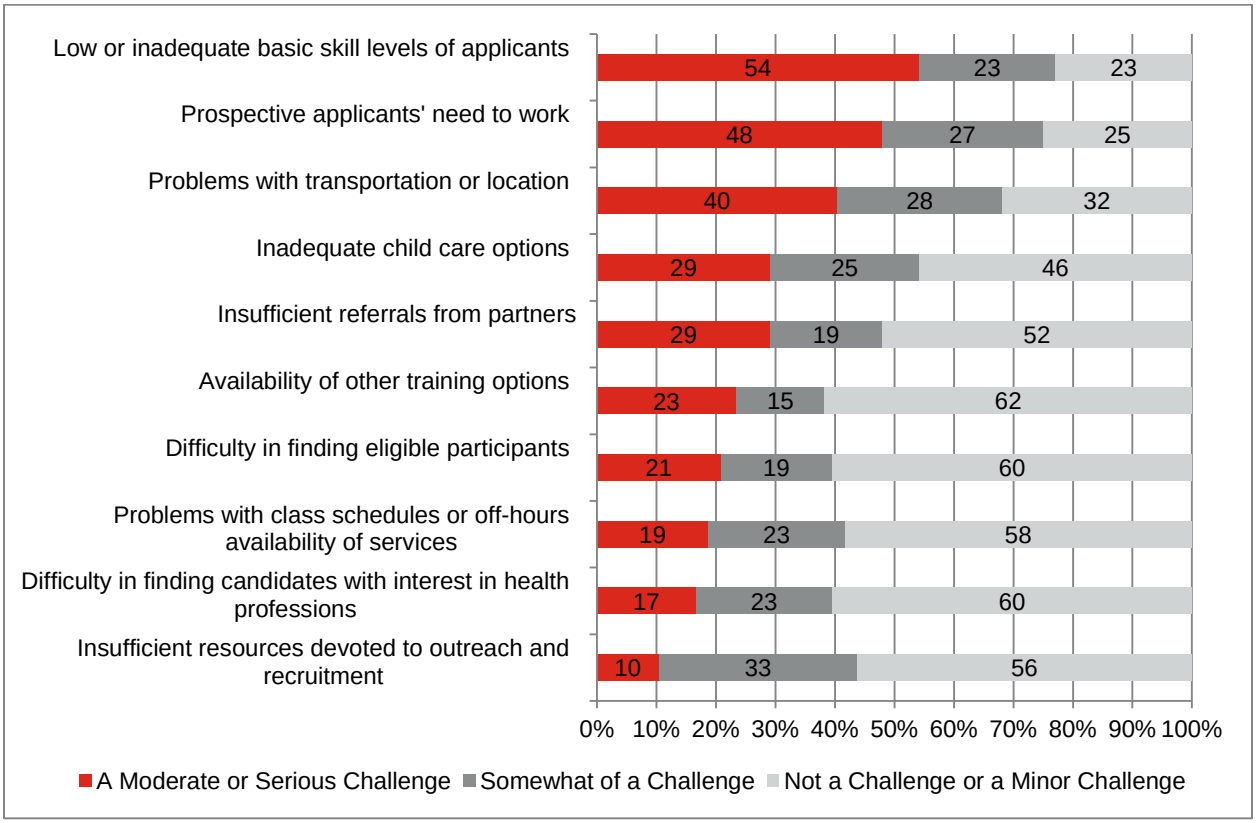
Missing: 0 programs

3.1.2 Recruitment Challenges

HPOG programs reported some challenges in recruiting HPOG participants (Exhibit 3-3).[61] Programs cited the need for immediate employment and a relative lack of adequate basic educational skills among otherwise eligible individuals as particularly problematic. Approximately half of the programs rated these as "moderate" to "serious" challenges. Other recruitment challenges had to do with factors associated with a program's location or its community resources. Using this same scale, a meaningful number of Grantee survey respondents cited the lack of convenient public transportation (20 programs, 40 percent) or options for affordable child care (14 programs, 29 percent) as recruitment challenges. Finally, programs also cited problems with inadequate recruitment or referral efforts, due to either lack of resources devoted to recruitment (5 programs, 10 percent) or lower-than-expected referrals from other community agencies (14 programs, 29 percent). On the other hand, some programs did not commonly perceive competition with other similar training opportunities in the community as a serious HPOG recruitment challenge (11 programs, 23 percent).

TANF recipients were a priority group for recruitment for the national HPOG Program. Overall, about 15 percent of participants were receiving TANF cash assistance when they were found eligible for HPOG (see Exhibit 3-15). However, TANF recipient participation varied widely across programs, from less than 3 percent of participants to almost 40 percent.[62] Federal TANF policy requires states to have at least 50 percent of all families and 90 percent of two-parent families in their TANF caseload participate in approved work or work-related activities for 30 hours a week (20 hours for single parents with children under age six). Although federal policy also restricts the degree to which occupational training may count toward the work participation rate, states have the flexibility to implement more restrictive rules, and many do. This variability in work requirements may partly explain some of the differences in participation rates among TANF recipients across HPOG programs. TANF time limits on training participation also likely affected HPOG participation.[63] Some programs also reported poor relationships with local TANF agencies due to differences in institutional goals and coordination and communication barriers. On the other hand, many HPOG programs reported relatively good success in working with local TANF agencies to recruit qualified TANF recipients for training.

Exhibit 3-3. Recruitment Challenges



Note: "Insufficient referrals…" averages responses to the four related items in the Grantee survey and rounds up to nearest whole number.

Source: HPOG Grantee survey, 2014, Q6.3.

N=49

Missing: 1–2 programs

3.2 HPOG Program Eligibility Criteria

HPOG programs developed eligibility standards that both met the requirements of the HPOG grant and helped select participants most likely to successfully complete training and enter employment. Specific criteria varied somewhat, but virtually all programs screened applicants for financial eligibility, academic background and ability, and suitability for healthcare training and employment. For example, all programs included TANF recipients and other low-income individuals in their

Key Findings

Programs used a variety of criteria to determine income eligibility, including percentage of the FPL (ranging from 150 to 250 percent), TANF eligibility, and SNAP eligibility.

Just over half of programs required eighth grade or higher level skills for reading; under half of programs required eighth grade or higher level skills for math.

Most programs screened for criminal records; many accepted applicants with criminal records but used this information to place participants in appropriate training courses.

Nearly all programs assessed applicants' personal qualities to judge their suitability for occupational training and employment in healthcare, but very few participants were screened out of the program on this basis.

eligibility criteria as required by the HPOG Program, but programs varied in how they defined "low-income." Similarly, while most programs tested for basic educational skills, programs varied on the minimum skill levels for eligibility. Many programs required candidates who met basic financial and academic eligibility criteria to complete several rounds of interviews to help ensure that those who enrolled had the suitable personal qualities and motivation to attend and complete training. Finally, since many states have policies barring individuals with felony convictions and/or substance abuse issues from working in most direct care occupations, HPOG program candidates may also have had to undergo criminal background checks and substance abuse screenings. This section presents findings about financial and academic eligibility criteria as well as background checks and "suitability" screenings.

3.2.1 Financial Eligibility

For applicants who were not TANF recipients, programs used one or more of three different measures to determine financial eligibility.[64] These included household income (31 programs, 61 percent), individual income (15 programs, 31 percent), and individual earnings (14 programs, 29 percent).

In determining financial eligibility, programs applied the following measures of income and earnings to a variety of standards, including: some percentage of the FPL; a program-specific income threshold; income eligibility for TANF (whether receiving TANF or not); income eligibility for SNAP; and other standards, such as eligibility for Workforce Investment Act (WIA) services for low-income individuals, for the National School Lunch or School Breakfast program, or for housing subsidies (Exhibit 3-4).

Exhibit 3-4. Financial and Categorical Eligibility Measures

Financial Eligibility Measure	Number	Percentage
A percentage of the FPL, TANF eligibility, or SNAP eligibility	21	43%
A percentage of the FPL or TANF eligibility	12	24
A percentage of the FPL only	7	14
Eligible for TANF or SNAP	7	14
Eligible for SNAP	1	2
Program-specific income threshold	1	2

Note: Twelve programs combined the measures in the exhibit with one or more other measures, as indicated in the text.
Source: HPOG Grantee survey, 2014, Q7.8a.
N=49
Missing: 0 programs

HPOG programs varied in their financial eligibility standards or income thresholds. Of the 40 programs that used some percentage of the FPL for income eligibility, 36 provided information in the Grantee survey about the specific thresholds used. The median program eligibility threshold was 200 percent of FPL, and the eligibility threshold ranged from 150 to 250 percent of FPL.[65]

3.2.2 Academic Skill Requirements

Success in completing post-secondary healthcare occupational training courses requires adequate basic educational skills, although there is a range in the minimum skills required by specific training courses.[66] A majority of HPOG programs (34 programs, 69 percent) maintained minimum academic skill requirements for both reading and math. Fewer programs required applicants to have a high school or equivalency degree (24 programs, 49 percent) (Exhibit 3-5). Importantly, some HPOG programs maintained no minimum academic skill levels for eligibility (11 programs, 23 percent) and may have

admitted individuals who needed substantially improved basic skills before engaging in occupational training.

Exhibit 3-5. Academic Skill and Educational Attainment Requirements for HPOG Applicants

Academic Skill or Degree Requirement	Number	Percentage
No minimum skill level required	11	23%
Minimum skill level in math and reading	34	69
Minimum skill level in reading only	4	8
High school degree or alternative high school credential, such as GED	24	49

Source: HPOG Grantee survey, 2014, Q7.6, Q7.7a.
N=49
Missing: 0 programs

The 38 programs that set eligibility standards for reading and/or math skills varied in grade-level requirements (Exhibit 3-6). Most of the programs required reading skills at an eighth-grade level (12 programs, 32 percent) or above (15 programs, 41 percent). Among the 34 programs that required minimum math skills, the results are similar, with 7 programs (21 percent) requiring an eighth-grade level or above (13 programs, 39 percent). Among the 10 programs with minimum reading levels and the 13 with minimum math levels below eighth grade, three required applicants to have reading skills at the fourth- or fifth-grade level, and two required applicants to have math skills at these levels.[67]

Exhibit 3-6. Grade-Level Eligibility Requirement

Minimum Grade Level	Programs with Minimum Reading Levels (N=38)		Programs with Minimum Math Levels (N=34)	
	Number	Percentage	Number	Percentage
Below eighth grade	10	27%	13	39%
Eighth grade or equivalent	12	32	7	21
Above eighth grade	15	41	13	39

Source: HPOG Grantee survey, 2014, Q7.7b, 7.7c.
N=48
Missing: 1 program

3.2.3 Background Checks and Other Screenings

Due in large part to state licensing regulations and employer practice, most HPOG programs screened applicants for conditions that might pose barriers to employment, such as criminal records or current use of illegal drugs. Although HPOG programs had discretion in deciding which screenings to implement and how to use the results, their decisions reflected the fact that state boards generally place restrictions on who may be awarded licenses or certifications for specific occupations. Healthcare providers may impose even more stringent requirements for employment.

To ensure that individuals would not be training for jobs for which they could not qualify, most HPOG programs checked applicants' criminal backgrounds (Exhibit 3-7). Thirty-five programs (73 percent) checked for past felonies, and 32 programs (68 percent) also checked for misdemeanors. Similarly, 25 programs (52 percent) tested at least some applicants for signs of current drug use. Finally, almost half of all programs (23 programs, 48 percent) tested at least some applicants for medical conditions that might interfere with employment in healthcare or pose a risk for participants, patients, or staff. For example, one program required a doctor's note clearing pregnant participants for training.

Although most HPOG programs used one or more of these additional screenings, program staff indicated they did not necessarily reject all applicants who failed them. For the most part, programs tried to find appropriate training courses and career ladders for applicants with criminal records. For example, one HPOG program developed a course for dental prosthesis technicians specifically for individuals with felony convictions, since that occupation entails no direct patient contact and does not ordinarily automatically disqualify individuals with felony convictions.[68]

Exhibit 3-7. Applicant Screenings

Screenings Used at Application	Number	Percentage
Background check for felonies (N=48)	35	73%
Background check for misdemeanors (N=47)	32	68
Drug screening (N=48)	25	52
Physical or other medical exam (N=48)	23	48
Other (N=19)	12	63

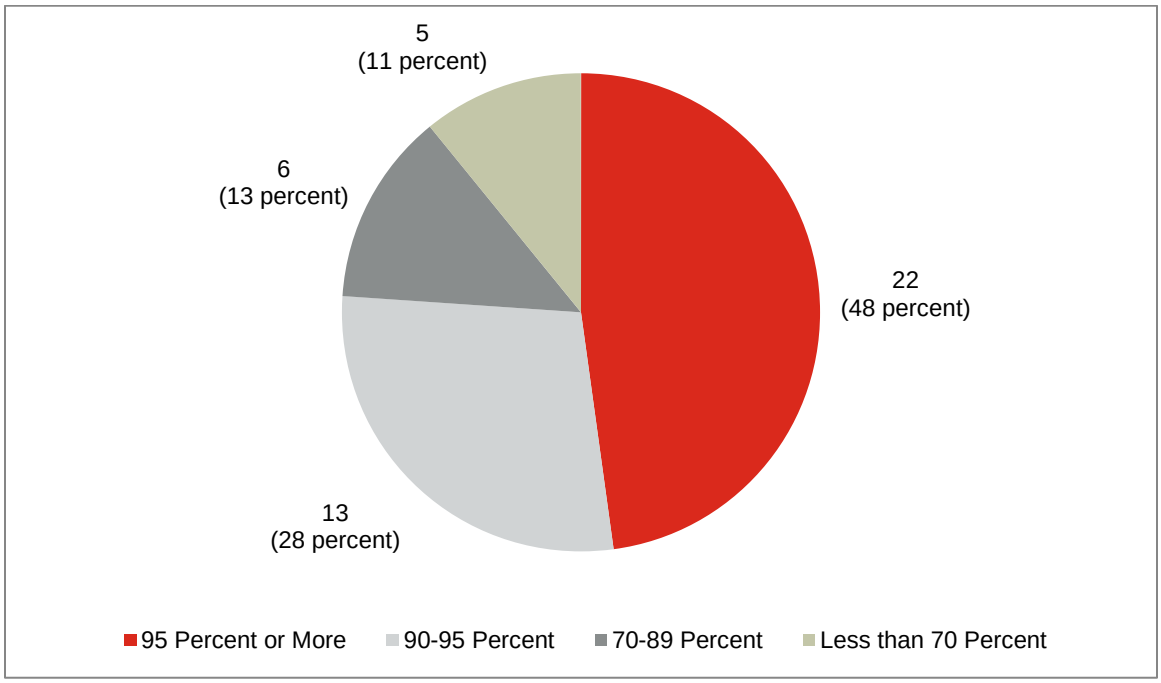
Note: Responses do not sum to 100 percent because multiple responses were permitted.
Source: HPOG Grantee survey, 2014, Q7.4.
N=49
Missing: 1–2 programs

3.2.4 Personal Screening

Almost all HPOG programs (46 programs, 94 percent) assessed relevant personal qualities of applicants before enrolling those who were eligible based on objective criteria.[69] Those programs included in the application process an evaluation of applicants' general suitability for training and employment in healthcare, including comfort with healthcare work; personal circumstances, such as working hours that conflict with course schedules, which might make program retention challenging; and motivation. All but one of the programs assessing suitability did so through one or more in-person interviews with program management and staff and also used the results of competency and personality tests. Although programs varied in the use of these additional criteria (as well as how, when, and by whom the personal assessments were conducted), most applicants were required to pass a suitability screening.

Despite the wide use of suitability criteria in the application process, programs screened out very few otherwise eligible applicants because of unsuitability (Exhibit 3-8). For example, nearly half of the programs (22 programs, 48 percent) that used suitability criteria reported that more than 95 percent of applicants who met all other eligibility criteria were found to be suitable for their programs. Only five programs (11 percent) found that fewer than 70 percent of applicants met suitability standards. One program noted it changed its intake model to include only those students already enrolled in healthcare training programs at the HPOG program's educational partners.[70] This guaranteed that program participants met a certain level of academic proficiency and commitment. Another program looked at a number of attributes when assessing suitability, including whether applicants could handle the pressure of working in a pharmacy, whether they could maintain discretion, and whether they were truly interested in employment.

Exhibit 3-8. HPOG Programs by Percentage of Eligible Applicants Meeting Suitability Criteria



Source: HPOG Grantee survey, 2014, Q7.13d.
N=46
Missing: 0 programs

3.3 HPOG Program Application Processes

In addition to using formal (e.g., standardized tests) and informal eligibility and suitability criteria (e.g., personal interviews), HPOG programs had to design and implement application and program intake procedures. In doing so, programs sought to balance the need to collect information required to determine eligibility, suitability, and training plans against the aim of minimizing applicant burden. In designing intake procedures, programs sought to implement the most efficient and effective way to assess participant training and career goals and need for support services. This section presents an overview of how HPOG programs conducted the application and eligibility determination processes as well as how they conducted academic and personal needs assessments.

Key Findings

Programs sought to balance the need to collect appropriate and complete information about eligibility and suitability with the aim of minimizing applicant burden.

All programs required at least one in person meeting, and most required two to three meetings.

Across all programs, the average time to process an application was just over three weeks.

3.3.1 Overview of the HPOG Application Process

HPOG programs differed in the locations where applications were made available, the modes and timing of application submissions, and the length and behavioral requirements of their application processes. In addition to having applications available on site, 25 programs (51 percent) made applications available at workforce development agency offices, One-Stop career centers, or Unemployment Insurance offices (Exhibit 3-9). Applications also were available for 25 programs (51 percent) at post-secondary education institutions; 21 programs (43 percent) made

applications available at TANF or SNAP offices. Fewer programs had applications available at other government agencies, secondary schools, community action agencies, and hospitals or health clinics. Ten programs (20 percent) developed online applications.

Exhibit 3-9. Where HPOG Applications Were Available

Places	Number	Percentage
Workforce development offices, One-Stop career centers, or Unemployment Insurance offices	25	51%
Post-secondary education institutions	25	51
TANF or SNAP offices	21	43
Other government agencies	11	22
Online (including email from staff)	10	20
Community action agencies	9	18
Secondary schools	8	16
Hospitals or health clinics	6	12

Note: Responses do not sum to 100 percent because multiple responses were permitted.
Source: HPOG Grantee survey, 2014, Q7.2.
N=49
Missing: 0 programs

Almost all programs accepted applications in person (48 programs, 98 percent), with 39 of them (80 percent) accepting applications in person only. Other submission modes were relatively uncommon, with only seven programs (17 percent) allowing applicants to mail or fax submissions, five programs (12 percent) allowing email submissions, and three programs (7 percent) allowing online submissions.[71]

Programs varied in the number of in-person meetings applicants were required to attend and in the length of time needed for the application process (Exhibit 3-10). Only seven programs (15 percent) required only one in-person meeting with applicants; almost three-quarters (34 programs, 72 percent) required two or three applicant meetings. Six programs (13 percent) required four or more meetings.

The length of time needed to complete the application process also varied. Across all 47 programs that reported application completion time, the average was 22 days.[72]

Exhibit 3-10. Number of Required Meetings and Length of Time Needed for the Application Process

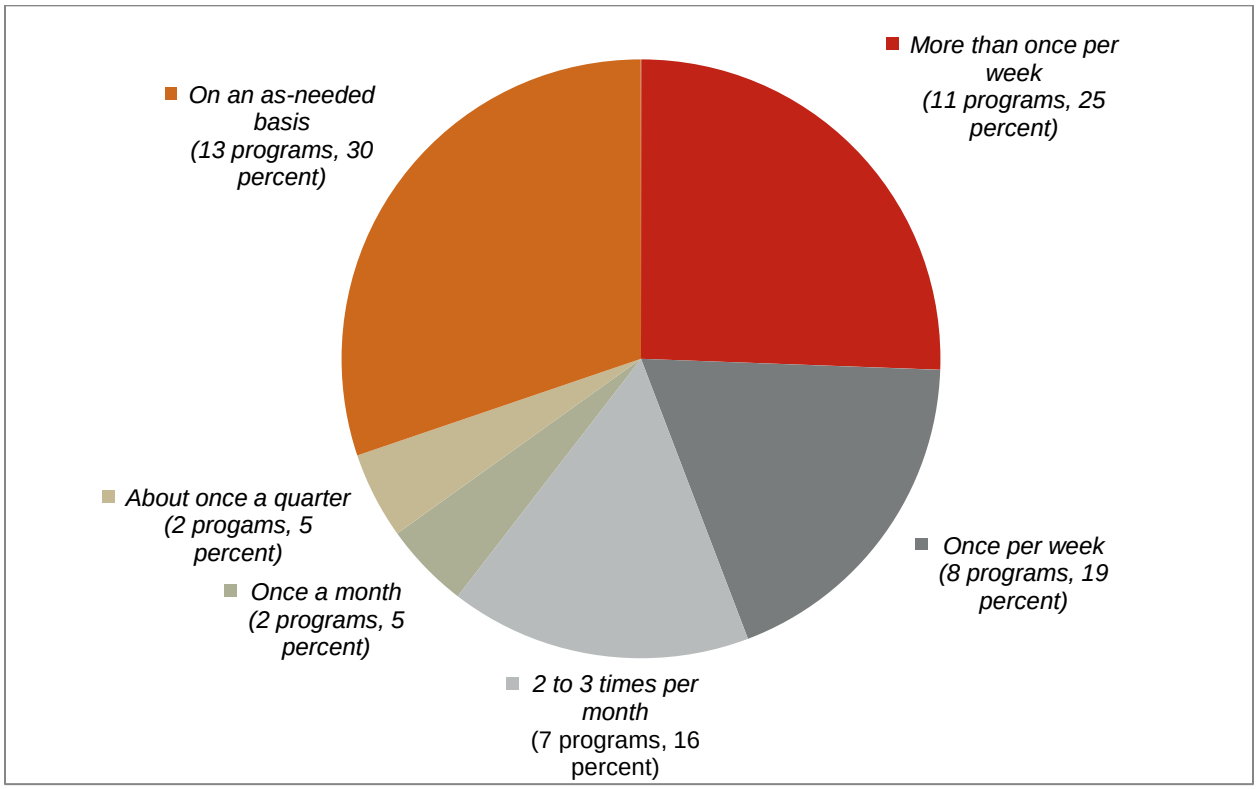
	Number	Percentage	Average Length of Time for Application Process (Days)
One required in-person meeting	7	15%	18
Two to three required in-person meetings	34	72	22
Four or more required in-person meetings	6	13	23

Source: HPOG Grantee survey, Q7.16b, 7.17.
N=47
Missing: 2 programs

In addition to requiring in-person interviews, most programs (43 programs, 88 percent) held mandatory program orientation sessions for applicants.[73] Orientations were designed to offer prospective applicants information that could assist in their decision to apply for HPOG. For example, they usually informed

applicants about which courses were available, their academic requirements, and the types of jobs for which the courses prepare participants. The requirement to attend orientations as a condition for applying likely added to applicant burden and to the time needed to complete the application process. Most programs held the mandatory orientations relatively frequently or on an as-needed basis. For example, only four programs (10 percent) held the orientations less frequently than two to three times a month (Exhibit 3-11).

Exhibit 3-11. Frequency of Mandatory Applicant Orientation Sessions



Source: HPOG Grantee survey, 2014, Q7.5b.
N=43

3.3.2 Comprehensive Assessments

Comprehensive assessments were an important part of the HPOG application process. Assessments were conducted (1) to determine whether applicants met minimal academic skill levels for eligibility, (2) to identify the supports needed by eligible applicants, and (3) to help determine appropriate academic and occupational training choices.[74] Career pathways programs often use multiple assessments to monitor students' skill development and provide information for adjusting instructional plans.

While all HPOG programs conducted assessments, they varied in the scope and breadth of the process (Exhibit 3-12). Most programs assessed basic educational skills at some point in the application process (45 programs, 92 percent). A high percentage of programs also used the application process to assess support service needs (42 programs, 86 percent), career interests (34 programs, 69 percent), personal motivation (32 programs, 65 percent), and job-readiness or soft skills (28 programs, 57 percent). At least half of HPOG programs also assessed English language proficiency and life skills.

Exhibit 3-12. Applicant Competencies Assessed During Intake

Skills or Needs Areas	Number	Percentage
Basic educational skills	45	92%
Support service needs	42	86
Career interests	34	69
Motivation	32	65
Job-readiness or soft skills	28	57
Life skills, coping skills, or social skills	27	55
English language proficiency	26	53
Career aptitudes	14	29
Learning styles	10	20

Note: Responses do not sum to 100 percent because multiple responses were permitted.
Source: HPOG Grantee survey, 2014, Q7.11.
N=49
Missing: 0 programs

As mentioned, comprehensive assessments were useful in helping determine a viable range of occupational training choices and a career path. For example, various programs required minimum scores on specific formal academic assessments, depending on the industry standard for a specific occupation. A participant who scored below the required minimum might have been placed in college remediation courses or basic skills bridge programs, or referred to an adult basic education (ABE) program. Some HPOG programs assessed participants again as they progressed to the next sequence of courses in a given career pathway and/or to determine whether they should be awarded a certificate of completion for a specific course or courses. The process of ongoing assessment is a core principle of the career pathways framework.[75] For example, one program had participants take the Test of Adult Basic Education (TABE) as part of intake and again after participation in basic skills education. Other programs sometimes repeated assessments to determine whether an individual could continue on to more advanced healthcare training.

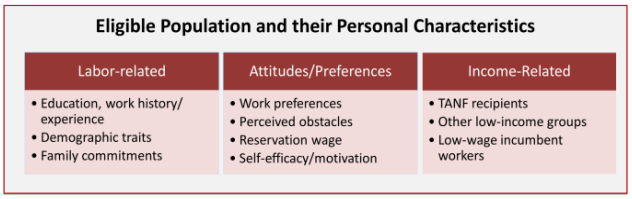
Nearly all HPOG programs reported using standardized assessment instruments recognized by the healthcare industry and by post-secondary education institutions (Exhibit 3-13). Forty-seven HPOG programs (94 percent) required one or more of these formal assessments as part of the eligibility process or as part of the intake and enrollment process.[76] Of these, 31 programs (66 percent) used TABE, 11 programs (23 percent) used the Comprehensive Adult Student Assessment Systems (CASAS), 10 programs (22 percent) used COMPASS, 6 programs (13 percent) used WorkKeys, and 5 programs (11 percent) used ACCUPLACER. Programs used additional assessment instruments including the DiSC Profile Assessment, the Sphere Reflectment System (SPHERit), Online Work Readiness Assessment (OWRA), Prove It!, WisCareers, and the Global Appraisal of Individual Needs (GAIN).[77] For some programs, the type of assessment used depended upon the training provider.[78] For example, one program used WorkKeys if it was required as part of a training provider's application process. Another program used ACCUPLACER for credit programs and TABE for non-credit programs.

Exhibit 3-13. Formal Assessments at Intake

Formal Assessments	Number	Percentage
TABE (N=47)	31	66%
CASAS (N=47)	11	23
COMPASS (N=45)	10	22
WorkKeys (N=45)	6	13
ACCUPLACER (N=45)	5	11
Other (N=45)	13	29

Note: Responses do not sum to 100 percent because multiple responses were permitted.
Source: HPOG Grantee survey, 2014, Q7.12.
N=45 to 47
Missing: 2–4 programs

3.4 HPOG Program Participants



"eligible population and their personal characteristics."

The majority of participants (88 percent) were female (Exhibit 3-14).[79] Close to equal proportions of participants were white non-Hispanic (38 percent) and black non-Hispanic (36 percent). Participants were generally young, with close to half in their twenties and another 8 percent younger than 20. Eighty-three percent were single (62 percent had never married and the remainder were divorced, widowed, or separated). Almost two-thirds of participants had children. Fewer than 4 percent fell into any of the following groups: veterans, people with a disability, foster children, people experiencing homelessness, limited English speakers, and individuals with criminal backgrounds (not shown in exhibit).

HPOG served individuals with diverse educational backgrounds, including those who did not complete high school as well as those with multiple years of college experience. The majority of HPOG participants had no post-secondary education. Six percent had less than a 12th-grade education, 13

HPOG programs were required to serve TANF recipients and other low-income individuals. Programs enrolled a variety of participants with different demographic characteristics and educational backgrounds. This report section focuses on the logic model section labeled

Key Findings

Large majorities of HPOG participants were female and were single. Almost two thirds of HPOG enrollees had dependent children.

Participants represented a diversity of races and ethnicities. About a third were white, a third black, and one fifth were Hispanic/Latino (of any race).

Fifteen percent of participants were receiving TANF cash assistance as they entered the program, and more than half were receiving SNAP benefits.

HPOG participants had a range of education levels at intake; more than one third had at least some post secondary education, and the vast majority had a high school diploma or equivalency and at least eighth grade literacy skills.

Almost half of participants reported household incomes of less than $10,000 at the time of program entry and 40 percent were working.

percent had a high school equivalency certificate or GED, and 37 percent had a high school diploma. However, more than one-third (37 percent) had some years of college or technical school, and 7 percent had four or more years of college. As described above, most HPOG programs assessed participants at intake for their level of literacy and numeracy.[80] Of participants with these assessments, 14 percent had less than eighth-grade literacy skills and 27 percent had less than eighth-grade numeracy skills.

Some participants were in school or working at the time they started HPOG. Almost one-third of participants (32 percent) were in school at time of program entry. Forty percent of participants were working when they enrolled in the program (15 percent worked in a healthcare occupation and 17 percent for a healthcare employer—not shown in exhibit).

Exhibit 3-14. Demographic Characteristics of HPOG Participants at Intake

Characteristic	Number	Percentage
Gender		
Male	2,727	12%
Female	20,936	88
Race/Ethnicity		
White non-Hispanic	8,845	38
Black non-Hispanic	8,503	36
Hispanic/Latino, any race	4,472	19
Asian or Hawaiian, Pacific Islander	746	3
Native American or Alaska Native	167	1
Two or more races, non-Hispanic	611	3
Age		
< 20	1,863	8
20–29	10,706	46
30–39	5,539	24
40–49	3,307	14
50+	2,037	9
Marital status		
Married	3,762	17
Never married	14,021	62
Divorced, widowed, or separated	4,773	21
Dependent children		
Yes	14,254	63
No	8,240	37
Highest educational attainment		
Less than 12th grade	1,320	6
High school equivalency or GED	2,997	13
High school graduate	8,559	37
One to three years of college/technical school	8,500	37
Four years or more of college	1,596	7
Literacy at eighth grade or higher		
Yes	16,381	86
No	2,767	14
Numeracy at eighth grade or higher		
Yes	13,605	73
No	4,910	27
Currently in school		
Yes	6,949	32
No	15,013	68
Currently employed		
Yes	9,431	40
No	14,016	60

Notes: Sample is all 23,664 HPOG participants in the PRS as of October 1, 2014. Percentages are of non-missing responses at intake. Literacy and numeracy are missing in 19 and 22 percent of responses, respectively, which includes those enrollees for whom these skills were not tested at intake. For all other characteristics, percentages missing range from 1 to 7 percent, depending on the variable. Characteristics of the sample of participants with at least 18 months post-enrollment data (the sample used in other sections of this report) can be found in Appendix Exhibit D-28.

Source: PRS, 2014.

As would be expected given the requirement to serve low-income individuals, HPOG participants had low individual and household incomes (Exhibit 3-15). Almost two-thirds (65 percent) had individual annual incomes of less than $10,000, and almost half (46 percent) were in households with incomes under $10,000. To put these income levels in context, the poverty line in 2014 was $11,670 for a one-person household and $19,790 for a household of three.[81] Fifteen percent of participants were receiving TANF cash assistance at program intake and more than half (54 percent) were receiving SNAP benefits. In addition, over half were low-income single mothers (not shown in exhibit), many of whom may be eligible or near-eligible for TANF benefits.

Exhibit 3-15. Income and Benefit Receipt of HPOG Participants at Intake

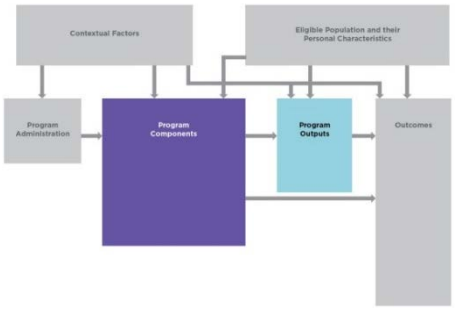
Characteristic	Number	Percentage
Individual income		
$0–$9,999	14,097	65%
$10,000–$19,999	4,960	23
$20,000–$29,999	1,986	9
$30,000+	578	3
Missing	2,043	
Household income		
$0–$9,999	9,401	46
$10,000–$19,999	5,652	28
$20,000–$29,999	3,022	15
$30,000+	2,094	10
Missing	3,495	
Receiving TANF		
Yes	3,244	15
No	18,974	85
Missing	1,446	
Receiving SNAP		
Yes	12,173	54
No	10,459	46
Missing	1,032	

Notes: Sample is all 23,664 HPOG participants in the PRS as of October 1, 2014. Percentages are of non-missing responses at intake.
Source: PRS, 2014.
Missing: Missing responses range from 4 to 15 percent.

This chapter described HPOG programs' marketing and recruitment strategies, eligibility criteria, and eligibility processes. It closed with an overview of the types of individuals participating in HPOG. The next chapter begins a multi-chapter account of the various activities, services, and educational courses made available to, and accessed by, the HPOG program participants described in this chapter.

4. HPOG Program Healthcare Education and Training Activities

This chapter focuses on program components in the HPOG logic model. Specifically, it describes how HPOG programs designed and implemented education and training activities, including healthcare occupational training opportunities, as well as pre-training activities to prepare participants to succeed in occupational training and employment in healthcare.



In addition to documenting what types of pre-training activities and training courses programs provided, this chapter describes the degree to which HPOG programs implemented strategies drawing on the career pathways framework. The chapter closes with an account of HPOG participants' education and training experiences and program outputs such as credentials obtained.

Important Terms for this Chapter

Adult basic education (ABE)—instructional programs in basic academic skills such as reading and mathematics designed for adults with skill deficiencies

Career orientation—instruction in the range of healthcare occupations and their training requirements and career paths

College skills preparation—preparation for post-secondary level training

Contextualized basic skills—adult basic education taught using concepts and materials related to occupational training

English as a second language (ESL)—instruction for English language learners

High school equivalency degree—instruction and assistance in obtaining the functional equivalent of a high school degree for those without a high school diploma

Job shadowing—opportunities for students to observe workers in their chosen occupation on the job

On-the-job training—training that takes place as part of regular employment, usually paying a lower "training wage"

Soft skills training—instruction in and modeling of appropriate professional workplace behavior and interpersonal skills

Stackable credentials—recognized skills based on courses that connect with other courses representing successive steps on occupational career pathways

Work-based or "active" learning—instruction that takes place in a workplace setting

Work experience or transitional job—time-limited paid employment, usually subsidized by government funds and intended to help transition the unemployed into jobs

Main Findings about Healthcare Education and Training Activities and Participant Experiences

All HPOG programs made decisions about how best to prepare their students for post-secondary occupational training and about which training courses to make available to HPOG participants. Generally, four types of pre-training activities were offered: ABE (sometimes contextualized and/or combined with occupational training); soft-skills training; orientation to healthcare careers; and college skills preparation. Most programs considered one or more of these activities important enough to make attendance mandatory for all or some students.

HPOG programs offered multiple healthcare training course options to students, with more than half of programs creating or adapting courses specifically for HPOG. Programs most commonly provided courses for entry-level positions in healthcare, such as orderlies, attendants, and nurses' assistants. Most programs also offered more advanced courses for higher-level, higher-paying positions, such as licensed practical nurse, pharmacy technician, and registered nurse. In terms of course structure and delivery, a majority of programs incorporated some core principles of the career pathways framework, as was strongly recommended by ACF in the FOA. These included, for example, courses organized for stackable credentials, supporting one or more career pathways, and courses offered on a flexible schedule to accommodate working and parenting students.

Most HPOG participants began a healthcare training course (defined as one or more classes that together provide the required preparation for a specific healthcare occupation) within 18 months of enrolling in HPOG. Of those who started, a majority also finished at least one course within 18 months of enrolling, and a majority of course completers received a third-party certification recognized by the healthcare industry. Most of these participants completed relatively short courses. Of all course completers, 68 percent completed courses that were four or fewer months in duration and the average duration for completed courses was about four months. A relatively small number of course completers began a second training course within 18 months of enrolling.

4.1 Activities to Prepare Participants for Healthcare Training

To be successful in healthcare training courses and jobs, many HPOG participants needed additional preparation in one or more areas, such as basic academic skills, knowledge of healthcare career options, and soft skills. Within the framework provided by the HPOG grant, programs decided which specific pre-training and basic skills activities should be included, whether to tailor the activity for HPOG, and whether any or all HPOG participants should be required to attend the activity. This section reports on the variety of pre-training activities offered by HPOG programs and available to HPOG participants.

Key Findings

Most HPOG programs offered pre training activities to prepare participants for healthcare training. The most common were soft skills training and introduction to healthcare careers.

Pre training activities were generally required for some or all program participants.

Pre training activities were usually created or adapted specifically for the HPOG program.

4.1.1 Pre-Training Activities: Availability, Implementation, and Participation

The majority of programs (41 programs, 85 percent) offered soft skills training (Exhibit 4-1). Nearly all participants (91 percent) were in a program in which soft skills training was available. In general, this type of training focuses on personal and social skills and behavior appropriate to the workplace. In HPOG, this included a particular emphasis on how to behave around patients and in healthcare

settings. In addition, about one-half of programs (26 programs, 54 percent) offered introduction to healthcare careers workshops. These generally explore the range of jobs in healthcare, their potential career pathways, and how to combine academic training and practical experience to enter and move along those pathways. Over half (60 percent) of HPOG participants had such a workshop available to them. Slightly fewer programs offered computer and financial literacy courses, prerequisite subject courses (such as Chemistry or Biology, for example), and training in study skills and other behaviors needed for success in college (from 14 to 20 programs offered each activity, 29 to 42 percent).

Exhibit 4-1. Pre-Training Activities Offered

Pre-Training Activities	Number	Percentage of Programs	Percentage of Participants in a Program with Activity Available
Soft skills training (N=48)	41	85%	91%
Introduction to healthcare careers (N=48)	26	54	60
Computer/technological skills training (N=48)	20	42	48
Financial literacy workshop (N=48)	19	40	46
Prerequisite subject courses (N=48)	15	31	45
College skills training (N=49)	14	29	38
Other (N=8)	6	13	16

Notes: Results do not sum to 100 percent because multiple responses were permitted. Percentage of participants calculated using average monthly HPOG enrollment from October 2013 through September 2014 using PRS data.
Source: PRS, 2014; HPOG Grantee survey, 2014, Q8.1.
N=48 to 49 programs and 13,086 participants
Missing: 0–1 programs

Programs made most pre-training activities mandatory for all or some HPOG participants (Exhibit 4-2). Soft skills training—the most widely available pre-training activity—was mandatory for all participants in 28 of the 41 programs that offered it. Introduction to healthcare careers, financial literacy workshops, and computer/technological skills training were also more likely than not to be mandatory for all participants.

Exhibit 4-2. Required Pre-Training Activities

Pre-training Activities	Required of All		Required of Some		Voluntary for All	
	Number	Percentage	Number	Percentage	Number	Percentage
Soft skills training (N=41)	28	68%	5	12%	8	20%
Introduction to healthcare careers (N=26)	20	77	4	15	2	8
Financial literacy workshop (N=19)	10	52	2	11	7	37
Computer/technological skills training (N=20)	10	50	4	20	6	30
College skills training (N=14)	5	36	8	57	1	7
Prerequisite subject courses (N=15)	2	13	12	80	1	7
Other (N=6)	0	0	4	67	2	33

Source: HPOG Grantee survey, 2014, Q8.2.
N=14 to 41
Missing: 0 programs

Most HPOG programs either created new or adapted existing workshops and courses for some pre-training (Exhibit 4-3). For example, programs implementing introduction to healthcare workshops were most likely to create or adapt them (22 of 26 programs, 85 percent), followed by college skills training (11 of 14 programs, 79 percent), and soft skills training (31 of 41 programs, 76 percent).

Exhibit 4-3. Pre-Training Activities Created or Adapted for HPOG

Pre-Training Activity	Created or Adapted	
	Number	Percentage
Soft skills training (N=41)	31	76%
Introduction to healthcare careers (N=26)	22	85
Computer/technological skills training (N=20)	12	60
Financial literacy workshop (N=19)	12	63
Prerequisite subject courses (N=15)	6	46
College skills training (N=14)	11	79

Note: Results do not sum to 100 percent because multiple responses were permitted.
Source: HPOG Grantee survey, 2014, Q8.1.
N=14 to 41
Missing: 0 programs

More than a third of HPOG participants had enrolled in at least one pre-training activity within 18 months of enrollment. They most commonly attended soft skills training, with 43 percent of participants enrolled (Exhibit 4-4). Second most common was introduction to healthcare careers, with 30 percent of participants enrolled.

Exhibit 4-4. Participation in Pre-Training Activities

Pre-Training Activity	Number	Percentage
Soft skills training	5,460	43%
Introduction to healthcare careers or occupations	3,785	30
Prerequisite subject courses for healthcare training	1,544	12
College skills training	872	7

Note: Sample is 12,614 HPOG participants in the PRS with at least 18 months post-enrollment data from September 30, 2010, to October 1, 2014. Participation in multiple activities is included in multiple rows.
Source: PRS, 2014.

4.1.2 Basic Skills Education Offered and Attended

Compared to the pre-training activities described above, HPOG programs were less likely to include formal basic skills education as part of their programs. For example, ABE and high school equivalency degree classes were offered directly by only 21 and 19 programs, respectively (43 and 39 percent) (Exhibit 4-5). Just over half of participants had ABE and high school equivalency degree classes available to them (52 percent and 53 percent, respectively). Fewer than 20 percent of programs offered ESL instruction or pre-high school equivalency degree classes, with fewer than one-quarter of all participants having access to them (20 percent and 19 percent, respectively).

Key Findings

Fewer than half of programs offered ABE, high school equivalency degree, and ESL programs as a separate activity. Fewer than a third of programs reported combining basic skills instruction with other courses.

Most programs that offered basic skills education made it mandatory for at least some participants.

Exhibit 4-5. Basic Skills Education Offered

Basic Skills Education	Number	Percentage of Programs	Percentage of Participants with Activity Offered
ABE	21	43%	52%
High school equivalency degree classes	19	39	53
ESL instruction	9	18	20
Pre-high school equivalency degree classes	7	14	19

Notes: Responses do not sum to 100 percent because multiple responses were permitted. Percentage of participants calculated using average monthly HPOG enrollment from October 2013 through September 2014.
Source: PRS, 2014.
N=49 programs and 13,086 participants
Missing: 0 programs

There are a variety of reasons why relatively few HPOG programs offered basic skills education as a separate activity. Programs may have reduced the need for basic skills training by establishing eligibility criteria that specify minimum grade-level requirements in reading and math. Also, some programs reported that ABE was readily available in their communities. As such, they opted to refer HPOG participants in need of basic education to other providers rather than using HPOG funding to support the activity.[82] Alternatively, ten programs (31 percent) indicated they integrated basic skills into some healthcare training courses.[83] Over half of these programs (six were identified during visits for the HPOG Impact study) implemented a specialized model for contextualized basic skills instruction in at least one healthcare course.[84] In this model—Integrated Basic Education and Skills Training (I-BEST)—an occupational training instructor is paired with a basic skills instructor in the same course.

For three of the four basic education activities, more than half of programs offering them required attendance for at least some HPOG participants (Exhibit 4-6). The exception was pre-high school equivalency degree classes. Among the seven programs that offered pre-high school equivalency degree classes, three made this mandatory for at least some HPOG participants.

Exhibit 4-6. Basic Skills Education Required for Any Participants in Programs Offering the Activity

Required Basic Skills Education	Number Offering Activity	Number Requiring Participation	Percentage
ABE	21	13	62%
High school equivalency degree classes	19	11	58
ESL instruction	9	8	89
Pre-high school equivalency degree	7	3	43

Source: HPOG Grantee survey, 2014, Q8.4.
N=7 to 21
Missing: 0 programs

Relatively few participants enrolled in basic skills education. About 5 percent of HPOG students participated in ABE classes, 2 percent in high school equivalency degree/pre-high school equivalency degree classes, and 1 percent in ESL classes (Exhibit 4-7). These numbers likely understate the proportion of students who received basic skills education, since, as reported above, basic skills education was sometimes integrated into occupational training and sometimes provided through referrals to outside agencies. Also, as noted above, most programs had minimum grade-level eligibility requirements for academic skills.

Exhibit 4-7. Participation in Basic Skills Education

Basic Skills Activity	Number	Percentage
ABE	675	5%
High school equivalency degree or pre-high school equivalency degree classes	180	2
ESL instruction	141	1

Notes: Sample is 12,614 HPOG participants in the PRS with 18 months or more of post-enrollment data, from September 30, 2010, to October 1, 2014. Participation in multiple activities is included in multiple rows.
N=12,614
Source: PRS, 2014.

The majority of participants who participated in basic skills education completed these classes.[85] For example, of those who had begun an adult education class, 75 percent had completed it by 18 months after enrolling in HPOG. In the same time period, 74 percent of HPOG participants who had begun an ESL class and 57 percent of those who had begun a pre-high school equivalency degree or high school equivalency degree class had completed.

4.2 Training for Careers in Healthcare

The HPOG FOA recommended that grantees focus on healthcare training activities that

- target skills and competencies demanded by the healthcare industry;
- support career pathways, such as an articulated career ladders;
- result in an employer- or industry-recognized degree (which can include a license, as well as a Registered Apprenticeship certificate or degree);
- provide training services at time and locations that are easily accessible to targeted populations.

HPOG grantees were charged with preparing participants for jobs in the healthcare field that pay well and are expected either to experience labor shortages or be in high demand.[86]

In response to FOA recommendations,[87] HPOG programs provided a range of healthcare training opportunities based on contextual factors and eligible target populations. The training activities varied in length and intensity, depending on the requirements of the target profession. Some programs for entry-level positions were as short as two weeks, while others, such as training for technical or nursing positions, required commitments of four years or more.

4.2.1 Healthcare Training Provided

The HPOG programs offered participants a wide array of healthcare training opportunities. Forty-four HPOG programs (90 percent) offered HPOG training for nursing aides, orderlies, and attendants, the training that typically leads to becoming a certified nursing assistant (Exhibit 4-8). Nearly all participants (94 percent) had these courses available to them. Other commonly offered training courses included those for medical records and health information technicians (39 programs, 80 percent) and medical assistants (38 programs, 78 percent). Most participants had access to these healthcare training courses as well, with 93 percent having access to medical records and health information technician

Key Findings

On average, programs offered 13 healthcare training courses.

Programs most often offered training for nursing aides, orderlies, and attendants.

Programs also frequently offered courses for medical assistants and for medical records and health information technicians.

training and 83 percent having access to medical assistant training. Fewer than 20 percent of programs offered training for health diagnosing and treating practitioners, community and social service specialists, and counselors, with fewer than one-quarter of participants having access to these types of healthcare training. Finally, many programs offered longer-term training courses for higher-waged and higher-skilled occupations, such as licensed and vocational nurses (30 programs; 61 percent) and registered nurses (29 programs; 59 percent).

Exhibit 4-8. Occupational Activities Offered by HPOG Programs

Healthcare Training	Number	Percentage of Programs	Percentage of Participants with Course Available
Nursing aides, orderlies, and attendants	44	90%	94%
Medical records and health information technicians	39	80	93
Medical assistants	38	78	83
Pharmacy technicians	36	73	74
Licensed and vocational nurses	30	61	68
Registered nurses	29	59	67
Diagnostic-related technologists and technicians	29	59	52
Phlebotomists	28	57	73
Healthcare support occupations (all others)	27	55	72
Emergency medical technicians and paramedics	25	51	65
Health practitioner support technologists and technicians	22	45	60
Psychiatric and home health aides	21	43	53
Physical therapist assistants and aides	19	39	43
Health technologists and technicians	15	31	33
Clinical laboratory technologists and technicians	14	29	51
Occupational therapy assistants and aides	10	20	26
Health diagnosing and treating practitioners	9	18	20
Community and social service specialists	7	14	19
Counselors	4	8	10
Other	15	31	40

Notes: Responses do not sum to 100 percent because multiple responses were permitted. The types of training courses listed correspond to standard occupational classifications from the Bureau of Labor Statistics. Percentage of participants calculated using average monthly HPOG enrollment from October 2013 through September 2014.
Source: PRS, 2014.
N=49 programs and 13,086 participants
Missing: 0 programs

Programs varied in the number of different healthcare training opportunities made available to HPOG participants (Exhibit 4-9). On average, programs offered 13 healthcare training courses. At the lowest and highest range of courses offered, nine programs (18 percent) offered five or fewer healthcare training courses and eight programs (16 percent) offered from 21 to 35 training courses. The remaining HPOG programs fell between these two extremes, with the most common number of training courses offered being from 11 to 20 courses (19 programs, 39 percent).

Exhibit 4-9. Number of Different Healthcare Training Courses Offered by Programs

Number of Healthcare Training Courses Offered	Number	Percentage
1 to 5	9	18%
6 to 10	13	27
11 to 20	19	39
21 to 35	8	16

Source: PRS, 2014.
N=49
Missing: 0 programs

4.2.2 Programs and Partners Provided Training

As discussed in Chapter 2, HPOG grantees were not expected to provide all program services and training courses themselves. HPOG grantees formed partnerships extensively with other public and private institutions to implement their programs, including providing healthcare training courses. However, many grantees also provided healthcare training directly in addition to using partner institutions.

Thirty-one of the HPOG programs (63 percent) directly provided either healthcare training courses or faculty for the courses (Exhibit 4-10). Twenty-six programs provided work-based learning opportunities (53 percent). Thirty-two programs (65 percent) provided other direct support for training, such as space, equipment, and learning technologies.

Exhibit 4-10. Role of Programs in Providing Healthcare Training

Role	Number	Percentage
Provides healthcare training or faculty or instructors	31	63%
Provides work-based learning opportunities	26	53
Provides other support for training	32	65

Source: HPOG Grantee survey, 2014, Q8.14.
N=49
Missing: 0 programs

HPOG partners also were heavily involved in providing healthcare training. Specifically, partners offered healthcare training in 35 HPOG programs (71 percent); work-based learning opportunities in 38 programs (78 percent); and other support for healthcare training, including space, equipment, and learning technologies, in 39 programs (80 percent).[88] The average HPOG program had three or four partners helping to provide healthcare training.

4.2.3 Healthcare Training Activities and the Career Pathways Approach

HPOG programs varied in the degree to which they followed a career pathways approach in providing training.[89] Training activities that follow the career pathways model are

- associated with clearly defined and industry-recognized credentials that are "stackable," that is, other available training may build on those credentials to add higher and higher competencies in a defined career pathway;
- offered as part of a career pathway articulated to healthcare industry needs and requirements;
- delivered in a flexible way in regard to location, schedule, pace (accelerated courses) and strategy; and
- combined with work-based learning opportunities, such as internships, externships, and clinical placements.

Key Findings

Most HPOG programs offered stackable training options.

Nearly two thirds provided training options that supported career pathways.

Most programs offered flexible scheduling.

Nearly all HPOG programs offered training in multiple locations.

Most offered work based learning opportunities.

Stackable Credentials in a Career Pathway

Most HPOG programs indicated that training options were stackable (42 programs, 86 percent) (Exhibit 4-11). In addition, nearly two-thirds of programs provided training options that support multiple career pathways (32 programs, 65 percent) or a single career pathway (31 programs, 63 percent). Slightly more than half of the programs indicated they offered a range of training activities that participants could pursue independently, without necessarily connecting them to related courses to stack credits (25 programs, 51 percent).

Some HPOG programs limited participants' opportunities to take additional courses mainly due to resource constraints and performance goals.[90] That is, programs may have limited participants to one course to maximize enrollment to ensure reaching course enrollment and completion goals. For example, one program balanced the need for a job with the importance of additional training by encouraging HPOG participants to enter the workforce immediately after completing one training course and then to return for more training after gaining some employment experience.[91]

Exhibit 4-11. Characteristics of Healthcare Training Courses Supporting Career Pathways

Characteristics of Training Courses Offered	Number	Percentage
Training options provide credentials that are stackable	42	86%
Set of training options support multiple career pathways	32	65
Set of training options support a single career pathway	31	63
Program offers a range of training activities that can be pursued independently	25	51

Note: Reponses do not sum to 100 because multiple responses are permitted.
Source: Grantee survey, 2014, Q8.7.
N=49
Missing: 0 programs

Flexible Delivery and Course Acceleration Approaches

Most HPOG programs offered flexible scheduling, a component of the career pathways approach defined in this report as holding at least some training activities in the evening or on weekends. Forty-four of the 49 HPOG programs (90 percent) reported providing at least one training activity that was available in the evening or on the weekend (Exhibit 4-12). On average, programs offered approximately seven courses during at least one of those two time periods. Fewer programs offered flexible course delivery in other ways. For example, 16 of the 49 programs (33 percent) included at least one healthcare training course that was either accelerated or offered online.

Programs accelerated some courses, delivering them in a shorter time than usual, to accommodate working students or students needing to finish training as quickly as possible to move to full-time employment. Programs most commonly offered accelerated training for the following occupations: nursing aides, orderlies, and attendants (9 programs); medical assistants (5 programs); and medical records and health information technicians (4 programs).[92] Only four programs (8 percent) offered a healthcare training activity with individualized, or one-on-one, instruction and only two programs (4 percent) offered an activity that included self-paced instruction.

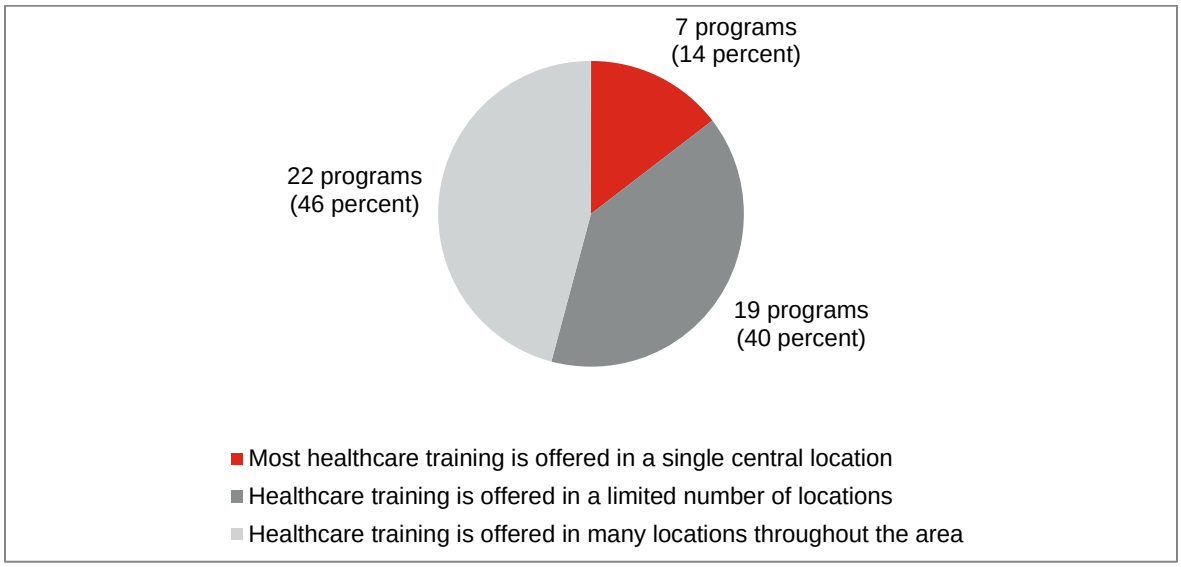
Exhibit 4-12. Number of Programs that Offered Healthcare Training Courses that Include Career Pathways Elements for Course Delivery

Method of Course Delivery	Number	Percentage	Average Number of Courses
Training activities available weekends and evenings	44	90%	7
Accelerated training activities	16	33	3
Online courses/tutorials	16	33	3
Individualized (one-on-one) instruction	4	8	1
Self-paced instruction	2	4	2

Note: Reponses do not sum to 100 because multiple responses are permitted.
Source: HPOG Grantee survey, 2014, Q8.9, 8.11, 8.12.
N=49
Missing: 0 programs

HPOG programs also varied in the number of locations where healthcare training was offered (Exhibit 4-13). Twenty-two programs (46 percent) offered healthcare training courses in many locations; 19 programs (40 percent) offered training in a more limited number of locations; and seven programs (14 percent) offered training in a single, central location.

Exhibit 4-13. Number of Healthcare Training Locations



Source: HPOG Grantee survey, 2014, Q3.6.
N=48
Missing: 1 program

4.2.4 Work-Based Learning Opportunities

Many HPOG programs offered work-based learning opportunities as a way of teaching and reinforcing clinical skills. Most commonly, this came in the form of a clinical section that was part of a course (45 programs, 92 percent).[93] Some programs offered paid experiences for participants, such as transitional employment. Because programs were prohibited from using HPOG funds to subsidize wages or pay stipends to participants, paid work experience had to be funded by other sources.

Some programs implemented work-based learning outside of formal coursework. The most common of these work-based learning opportunities was work experience assignments or transitional jobs, with 8 percent of HPOG participants engaged (Exhibit 4-14). Three percent of participants were engaged in on-the-job training and less than 1 percent participated in a job-shadowing activity. Hours of participation in these activities varied; for example, work experience participants averaged 112 hours in this activity while job-shadowing participants averaged 8 hours.[94]

Exhibit 4-14. Participation in Work-Based Learning Opportunities Outside of Formal Coursework

Type of Work-Based Learning Opportunity	Number of Participants	Percentage of Participants	Average Hours Completed
Work experience or transitional job	1,054	8%	112
On-the-job training	339	3	67
Job shadowing	62	<1	8

Note: Sample is participants in the PRS with at least 18 months post-enrollment data as of October 1, 2014, who began any HPOG activity or received any service. Participation in multiple types of activities is included in multiple rows. Average hours completed is the median of those with known hours. The number of participants missing employment development activity hours ranges from 7 to 30.
N=12,614
Source: PRS, 2014.

4.3 Healthcare Training Attended and Completed

Program Outputs

- Basic skills
- GED/diploma
- Vocational skills
- Industry recognized credentials
  - Professional certification & licensure
  - Certificates of completion
  - College degrees
- Work-based experience
- Individualized career plan
- Work-readiness skills

The final section of this chapter presents the record of participants' healthcare training course participation, completion status, and receipt of credentials. These data are part of the HPOG logic model's program outputs.

4.3.1 Healthcare Training Participation

Of all HPOG participants for whom at least 18 months had passed since program enrollment, 85 percent (10,660) participated in healthcare training, either beginning a course or continuing one started before enrollment. HPOG enrollees who did not participate in a healthcare training course were in pre-training activities such as basic skills education, or waiting for a training course to begin; or they had dropped out before beginning a training course.[95] Participants pursued a variety of healthcare training courses, with the vast majority enrolling in the 10 most popular. The most common was training for nursing aides, orderlies, and attendants, which included training to become a certified nursing assistant (42 percent) (Exhibit 4-15). Licensed vocational nurse training was the next most common course (12 percent), followed by training to become a registered nurse (10 percent).

Key Findings

Eighty five percent of HPOG participants enrolled in a training course during the 18 months following program enrollment.

Of those who enrolled, over two thirds completed the course during the first 18 months. For completers, the average time spent in training was 3.5 months.

Of those who completed healthcare training, almost two thirds received an occupational license or third party certification.

Eleven percent of those who completed a training course within 18 months of enrollment also began a second course in that time period.

In contrast to the relatively large percentage of HPOG participants enrolled in courses for nursing and nursing-related occupations, lower numbers participated in a broad range of other healthcare training courses. For example, 10 percent of participants who began a course enrolled in a medical records and health information technician course; a similar proportion enrolled in a medical assistant course. Participants trained for other common occupations including, for example, psychiatric and home health aides (7 percent of participants who began training), phlebotomists (5 percent), and pharmacy technicians (4 percent). Less than 4 percent of participants enrolled in each of an additional 11 types of occupational training.

Exhibit 4-15. Participants' Enrollment in Healthcare Training Courses by Type of Occupation

Training Activity	Number	Percentage
Nursing aides, orderlies, and attendants	4,519	42%
Licensed and vocational nurses	1,320	12
Registered nurses	1,083	10
Medical records and health information technicians	1,052	10
Medical assistants	1,044	10
Psychiatric and home health aides	782	7
Phlebotomists	567	5
Pharmacy technicians	422	4
Diagnostic-related technologists and technicians	383	4
Healthcare support occupations (all others)	309	3
Emergency medical technicians and paramedics	256	2
Health practitioner support technologists and technicians	143	1
Physical therapy assistants and aides	87	1
Clinical laboratory technologists and technicians	106	1
Community and social service specialists	85	1
Occupational therapy assistants and aides	45	<1
Health diagnosing and treating practitioners	31	<1
Health technologists and technicians	39	<1
Counselors	15	<1
Other	59	<1

Note: Sample is 10,660 participants in the PRS with at least 18 months post-enrollment data as of October 1, 2014, who began healthcare training programs. Participants who enrolled in more than one type of training are included in multiple rows. Activities are categorized following BLS Standard Occupational Classifications. Phlebotomists and pharmacy technicians are in healthcare support occupations but are recorded separately from the rest of the category given high rates of participation.
Source: PRS, 2014.

4.3.2 Healthcare Training Completion

Within 18 months of enrollment in HPOG, 70 percent of HPOG participants who had started or continued a healthcare training course had completed at least one course (Exhibit 4-16). Another 14 percent were still participating in training 18 months after enrollment.[96] Participants who engaged in training activities that lasted longer than 18 months or who required basic skills education or prerequisite training before starting a healthcare training are included in this category. Another 16 percent of those who began training dropped out before completing it.[97, 98]

Healthcare Training Completion by Occupation Type

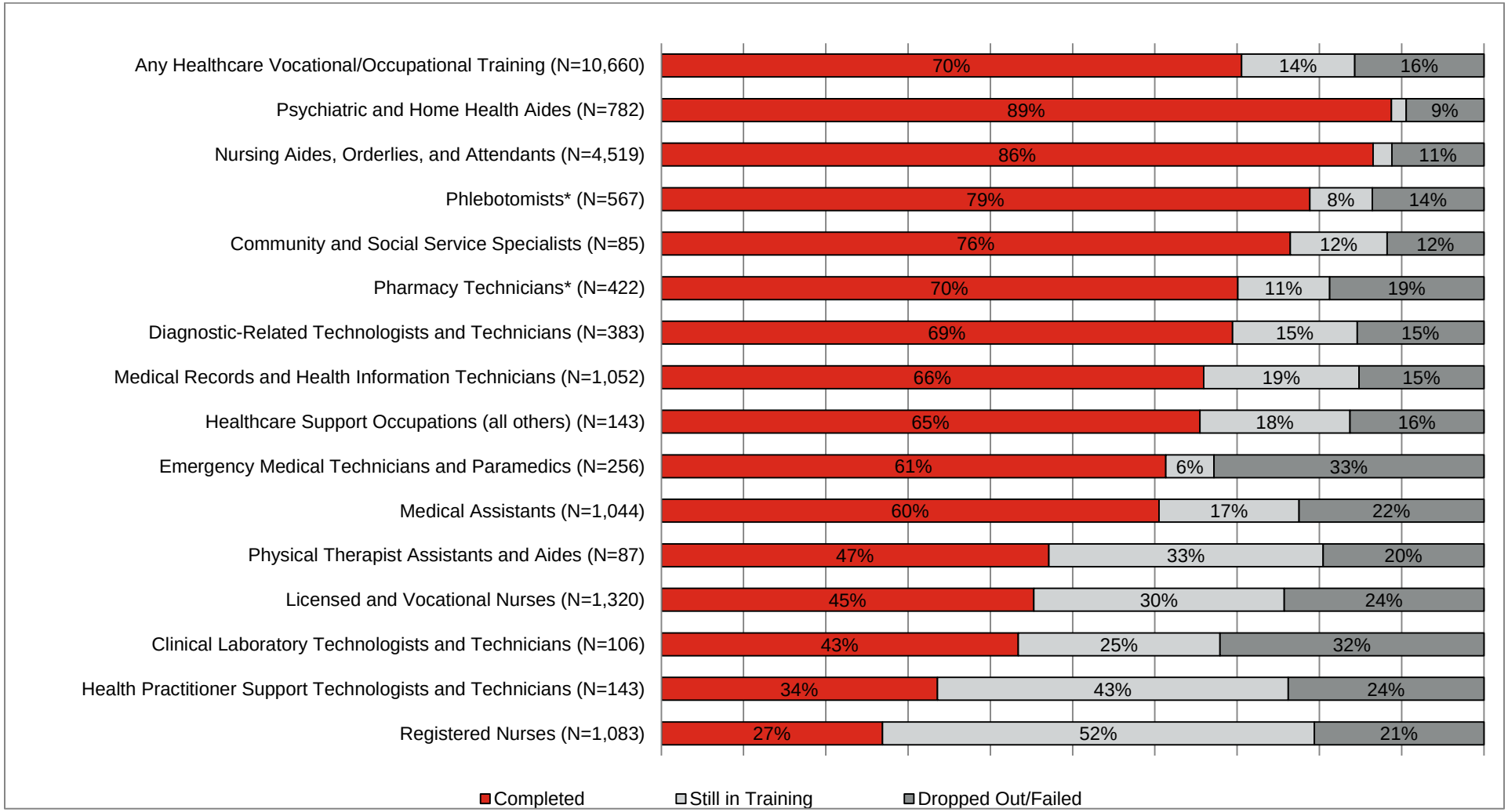
Completion rates of healthcare training courses varied by the occupation for which participants were training (Exhibit 4-16). At the high end, these included relatively short-term training courses, such as psychiatric and home health aides (89 percent of those who enrolled completed the course); nursing aides, orderlies, and attendants (86 percent completed); phlebotomists (79 percent completed); and community and social service specialists (77 percent completed).

Training for registered nurses had the lowest rate of completion at 18 months after enrolling in HPOG (27 percent). Low completion rates at 18 months would be expected for this course because becoming a registered nurse typically requires an associate's or bachelor's degree.[99] It is not surprising that 52 percent

of participants were still pursuing their certification at 18 months after enrollment, even though some were already in a registered nursing program when they began HPOG.

Training courses with relatively high drop-out rates included emergency medical technicians and paramedics (33 percent) and clinical laboratory technologists and technicians (32 percent) (Exhibit 4-16). Other healthcare occupations with drop-out rates at or above 20 percent included medical assistants, physical therapy assistants and aides, licensed and vocational nurses, health practitioner support technologists and technicians, and registered nurses.

Exhibit 4-16. Completion Status at 18 Months by Healthcare Occupation Types Among Participants Who Began Training



Notes: Sample is 10,660 participants in the PRS with at least 18 months post-enrollment data as of October 1, 2014, who participated in a healthcare training course. Participants who enrolled in more than one type of training course are included in the percentages for each corresponding row. Each bar shows percentages of those who enrolled in the corresponding training program listed in Exhibit 4-17. Percentages are of participants with known completion statuses. Less than 1 percent of training programs with end dates are missing completion status. Only healthcare training programs with more than 50 participants are shown.
*Phlebotomists and pharmacy technicians are in healthcare support occupations, but are recorded separately from the rest of the category given high rates of participation.
Source: PRS, 2014.

Time to Complete Healthcare Training

The majority of HPOG participants who had completed healthcare training 18 months after enrolling were in relatively short-term training courses (i.e., three or fewer months).[100] On average, participants who completed a training course spent about 3.5 months in that course, with the median time to complete a training course being about two months. The length of an HPOG healthcare training course is defined as the number of months between the first day and last day of training, as indicated in a participant's administrative record.[101] Exhibit 4-17 shows the distribution of time spent in healthcare training for those who had completed a training course. Since this sample is limited to 18 months post-enrollment data, we expect that the percentage of all training completers spending more than 12 months in training would increase with a longer follow-up period.

Exhibit 4-17. Time Spent in Healthcare Training by Participants Who Had Completed a Healthcare Training Course within 18 Months of Enrollment

Months to Completion	Number	Percentage of Completers
1 month or less	1,325	18%
>1–2 months	2,449	33
>2–3 months	1,301	17
>3–6 months	1,440	19
>6–9 months	747	10
>9–12 months	617	8
>12–18 months	466	6

Notes: Sample is 7,511 participants in the PRS with at least 18 months post-enrollment data as of October 1, 2014, who had completed a training course within 18 months of enrollment. Participants who completed more than one training course are included in multiple rows.
Source: PRS, 2014.

The length of time participants spent in a particular training course varied by training occupation, as well as by whether they were already in the training course when they enrolled in HPOG. Training occupations that lead to entry-level positions are typically completed more quickly. For example, participants spent an average of 1.3 months training for jobs as community and social service specialists; 1.6 months for jobs as psychiatric and home health aides; and 1.9 months for jobs as nursing aides, orderlies, and attendants (Exhibit 4-18).[102]

Other training programs took longer to complete. For example, participants training for jobs as physical therapy assistants and aides took almost 11 months to complete and those in registered nurse training reported spending 12 months on average to complete (Exhibit 4-18). Note that some participants had probably partially completed these longer-term courses before enrolling in HPOG. In fact, of those completing the physical therapy assistants and aides training courses, 85 percent were in school at the time they enrolled in HPOG.[103] Similarly, for those completing registered nurses training, 78 percent were in school at HPOG enrollment. More than half of the participants in registered nurse training were still in school 18 months after enrollment.[104]

Exhibit 4-18. Time to Complete Healthcare Occupational Training

Healthcare Occupation	Mean Length to Completion (in months)	Percentage of Participants in School at HPOG Enrollment
Any	3.6	40%
Community and social service specialists	1.3	30
Psychiatric and home health aides	1.6	12
Nursing aides, orderlies, and attendants	1.9	26
Phlebotomists	3.2	35
Pharmacy technicians	3.6	30
Diagnostic-related technologists and technicians	3.9	46
Emergency medical technicians and paramedics	4.2	48
Medical records and health information technicians	4.3	36
Healthcare support occupations (all others)	4.6	18
Clinical laboratory technologists and technicians	5.8	51
Medical assistants	6.9	40
Physical therapy assistants and aides	10.9	85
Licensed and vocational nurses	11.4	69
Health practitioner support technologists and technicians	11.6	65
Registered nurses	12.3	78

Notes: Sample for length to completion includes all participants completing each specific training course as of October 1, 2014. Participants who completed more than one training course are included in multiple rows. The sample for percentage in school at HPOG intake is 7,511 participants in the PRS with at least 18 months post-enrollment data as of October 1, 2014 who enrolled in the specific training course within 18 months of program enrollment.

Source: PRS, 2014.

Receipt of Certifications, Licenses, or Degrees

A primary goal of HPOG is for participants to receive credentials recognized by healthcare employers. Credentials may include employer-recognized third-party occupational certifications or licenses.[105] About 62 percent of all participants (4,666) who completed at least one healthcare training course received a regulatory license or third-party certification.[106] Many received multiple certifications, as the total number of certifications earned was 5,689. About 6 percent (473) received an associate's, bachelor's, or master's degree. The majority of all degrees earned (80 percent) were associate's degrees.

Two occupational training courses accounted for most of the degrees received—registered nurses and licensed vocational nurses made up roughly two-thirds of the degrees received.[107] Of all participants who completed a registered nurse training course, about 60 percent received an associate's degree and about 17 percent received a bachelor's degree. About 12 percent of those completing training for jobs as licensed vocational nurses received an associate's degree. Other, less common occupational training courses yielded degrees as well, including for physical therapy assistants and aides (76 percent), occupational therapy assistants and aides (76 percent), and health practitioner support technologists and technicians (36 percent).

Participants in some programs or in some training courses were more likely to obtain a credential in 18 months than those in other programs or courses (Exhibit 4-19). For example, within the first 18 months

of enrollment, 70 percent of participants successfully completing the nursing aide, orderly, or attendant training courses received a certification. Other healthcare training courses that had a high percentage of completers receiving certifications included licensed vocational nurse (67 percent), physical therapy assistant and aide (63 percent), phlebotomist (60 percent), registered nurse (57 percent), emergency medical technician and paramedic (57 percent), and psychiatric and home health aide (56 percent). Other training courses had fewer participants who received certifications. This variation across occupations is expected, as not all occupations require or have third-party certifications.

Exhibit 4-19. Credential Attainment of Participants Who Completed a Healthcare Occupation Training Course by Healthcare Occupation

Training Course Occupation	Number	Percentage
Nursing aides, orderlies, and attendants (N=3,908)	2,743	70%
Licensed and vocational nurses (N=597)	399	67
Physical therapy assistants and aides (N=41)	26	63
Phlebotomists (N=447)	268	60
Registered nurses (N=291)	165	57
Emergency medical technicians and paramedics (N=157)	89	57
Psychiatric and home health aides (N=694)	392	56
Diagnostic-related technologists and technicians (N=266)	146	55
Health practitioner support technologists and technicians (N=48)	26	54
Medical assistants (N=630)	339	54
Medical records and health information technicians (N=691)	365	53
Pharmacy technicians (N=295)	103	35
Healthcare support occupations (all others) (N=169)	58	34
Community and social service specialists (N=65)	58	34
Clinical laboratory technologists and technicians (N=46)	7	15

Notes: Sample is 7,511 participants in the PRS with at least 18 months post-enrollment data as of October 1, 2014, who completed a training course within 18 months of enrollment. Participants who received a certification in more than one training course are included in multiple rows.
Source: PRS, 2014.

Participation in and Completion of Multiple Healthcare Training Courses

The career pathways framework suggests that after completing occupational training students may advance by taking additional training courses, sometimes immediately and sometimes after a period of employment. HPOG grantees had flexibility to allow participants to enroll in additional training after completing a first course. Within 18 months of enrollment, a relatively small percentage of HPOG participants who had completed one course then enrolled in another (11 percent).[108]

The percentage of participants moving on to a second training course varied considerably across HPOG programs. Four grantees had a third or more of their participants move on to a second training course, while 12 grantees had less than 5 percent doing so and two of these had none. This reflects, in part, varying program models, with some programs restricting additional training course enrollment in an effort to serve as many low-income individuals as possible within the grant period. It also may reflect participants' decisions to enter employment after completing one training course.

The most common progression of all those moving on to a second training course was for both occupational training courses to fall within the nursing aide, orderly, and attendant occupational category. An example of this progression is an individual taking a nursing assistant training course and then an

electrocardiogram (EKG) technician course. Another common occupational progression was from the nursing aide, orderly, and attendant category to phlebotomist. Exhibit 4-20 illustrates these paths to second courses taken by all who completed a first course, and separately for those whose first course was in the nursing aide, orderly, and attendant group and those whose first course was for other healthcare occupations.

Exhibit 4-20. Progression to Second Course for Participants Who Completed a Healthcare Occupation Training Course

	Completed First Training (N=7,462)	Completed First Training in Nursing Aide, Orderly, or Attendant Training (N=3,435)	Completed First Training In Course Other Than Nursing Aide, Orderly, or Attendant Training (N=4,027)
Began second course in nursing aide, orderly, or attendant training	461 (5%)	319 (9%)	142 (4%)
Began second course in other than nursing aide, orderly, or attendant training	367 (6%)	179 (5%)	188 (5%)
Total*	**828 (11%)**	**498 (14%)**	**330 (9%)**

*Percentage is of those who completed first training.
N=7,462 in the PRS who completed at least one training course.
Source: PRS, 2014.

The completion rate for the second training course within 18 months is 75 percent across all types of healthcare occupations. We can expect the completion rates for the second training courses to increase over time, since this sample is limited to data 18 months after enrollment.

This chapter reviewed in detail the availability, implementation, participation patterns, and outcomes of HPOG programs' pre-training and training activities. The next chapter describes the supports HPOG programs made available and provided to participants.

5. HPOG Program Support Services

Important Terms for This Chapter

Academic supports and counseling—helping participants with course selection and guiding them to course completion; tutoring; helping participants to prepare for examinations and fulfill license or credential requirements

Case management—monitoring participant progress, assessing needs, and providing supports

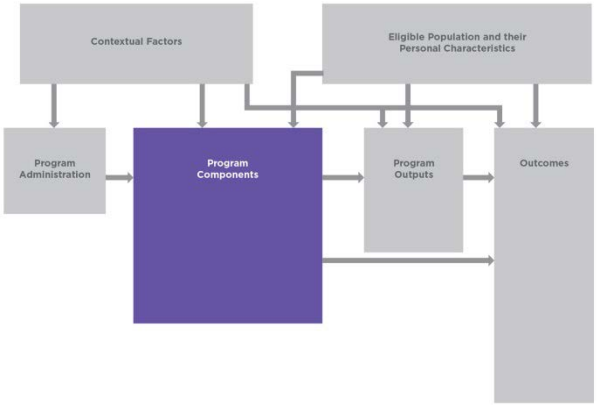
Cultural supports—culturally sensitive activities or services designed to integrate cultural or ethnic practices into healthcare training courses, or to train enrollees on culturally appropriate delivery of health services

Financial assistance—financial support for participation-related expenses

Personal advising and counseling—advising and assisting with behavioral issues and other personal challenges to program retention and completion

Personal and family services and supports—services or supports for individuals and their families to help solve life situations that may interfere with successful program retention and completion

Social supports—services and activities designed to socialize HPOG participants into the academic and training community



This chapter focuses on program components in the HPOG logic model. Specifically, it describes how HPOG programs designed and provided case management; academic, career, and personal advising and counseling; cultural supports; personal and family supports; financial supports; and social supports. Another important support service is employment assistance, which is included in the next chapter, which focuses on transitioning to suitable employment. The chapter closes with an account of the support services programs provided to HPOG participants.

Summary of Major Findings about Support Services

Comprehensive support services are an important part of the HPOG Program and a key feature of the career pathways framework.[109] To help participants meet their needs, virtually all programs employed case managers, who performed a variety of duties intended to support program retention and completion. In a majority of programs, case managers helped participants by providing academic and career counseling, connections to needed support services, personal and financial advice and guidance, and help finding employment.

In addition to case management, the most common support services focused on academic success and career choice. Nearly all programs provided these

services in a variety of ways, including personal advising and counseling, individual and group tutoring, and career workshops. Programs also offered services to address personal and family material needs of participants that might have otherwise interfered with stable training participation and completion. The most commonly provided personal and family services and supports were transportation and child care assistance. Finally, all HPOG programs offered comprehensive financial assistance for tuition and other education- and training-related costs, with almost all programs covering all or some tuition costs, as well as the cost of books, licensing fees, and exam preparation fees.

As expected, HPOG participants widely used support services. For example, nearly all participants received case management services within 18 months after enrolling. A majority of participants received career counseling/advising and help with training-related costs. Over half received some personal or family support service within 18 months of enrolling in HPOG, most commonly transportation assistance.

5.1 Case Management Services

Case managers provided a wide variety of supports to assist HPOG participants in planning, attending, and completing training, and finding and retaining employment. For example, case managers (1) assessed participant support service needs; (2) provided support directly or referred participants to needed supports in the community; (3) monitored participants' progress; and (4) provided coaching and counseling services to help participants address crises and life challenges. More information about the nature of these services is provided throughout this chapter.

Key Findings

Virtually all programs had case managers, and they were usually employed directly by the lead program organization.

Full time case managers had average caseloads of 64 participants and part time case managers had average caseloads of 34 participants.

Case managers' responsibilities spanned a range of services including case monitoring, academic or career counseling, personal and financial counseling, and employment counseling.

On average, case managers had in person one on one contact with participants two to three times a month.

Virtually all HPOG programs had case managers (48 programs, 98 percent).[110] Of these, four-fifths directly employed case managers (38 programs, 79 percent), and the remaining programs used case managers employed by partner organizations, either for all HPOG participants (10 percent of programs) or for some portion of participants (10 percent of programs).[111] Of the 48 programs with case managers, 43 programs (90 percent) had full-time case managers, averaging four per program.[112] Less than half (21 programs, 44 percent) used part-time case managers (two per program on average).[113] Sixteen programs used both full-time and part-time case managers, with an average of six case managers per program in these programs.[114]

The average caseload size was 64 participants for full-time case managers and 34 participants for part-time case managers.[115] Caseload size varied widely by program, from 20 to 150 participants for full-time case managers and 10 to 75 participants for part-time case managers. The median caseload for full-time case managers was 57 participants, and for part-time case managers it was 35 participants.

5.1.1 Specific Activities of HPOG Staff Providing Services Directly to Participants

Key Findings

Key responsibilities of staff providing direct services to participants included providing career information and advice, helping participants develop career goals, and assisting participants with developing life skills.

On average, staff were in contact with participants in person a few times a month. Staff also used email and other electronic communication to stay in touch. About two fifths of staff reported initiating the majority of participant meetings.

In the average program, 60 percent of HPOG frontline staff, or case managers and other staff who provided services directly to participants, reported spending much of their time providing career information and advice to participants and 55 percent reported helping participants develop career goals (Exhibit 5-1).[116] Also, in the average program, many staff reported spending much of their time identifying job openings (47 percent of staff in the average program), referring participants to job search and placement services (45 percent of staff), helping participants prepare resumes (41 percent of staff), conducting mock interviews (31 percent of staff), and assisting participants with internships, externships, or clinical placements (28 percent of staff).

In addition to counseling students about careers and job opportunities, frontline staff provided a variety of academic-related services, including advising on admission requirements (38 percent of staff in the average program), monitoring academic progress (33 percent of staff in the average program), reviewing academic assessment results (33 percent of staff), helping with class enrollment (32 percent of staff) and course selection (30 percent of staff), providing assistance with financial aid or scholarships (22 percent of staff), and arranging instructional support (20 percent of staff). Among non-academic advising activities, staff assisted participants with developing personal and social skills needed at school, at work, and in other areas of life (53 percent of staff in the average program) and provided advice on personal issues and needs (45 percent of staff). Staff in the average program also recruited participants for the program (29 percent of staff). Frontline staff had many other responsibilities including administrative tasks, overseeing program logistics, serving on advisory boards, hiring and supervising tutors, and program planning.[117]

Exhibit 5-1. Key Activities of Program Staff in the Average Program

Activity	Percentage of Staff
Providing career information and advice to participants	60%
Helping participants develop career goals	55
Assisting participants with developing skills needed for success at school, at work, and in other areas of life	53
Identifying job openings for participants	47
Referring participants to job search/placement services	45
Advising participants on personal issues and needs	45
Helping participants prepare resumes	41
Advising participants on admissions requirements or prerequisites	38
Monitoring participants' day-to-day academic progress	33
Obtaining and reviewing participants' academic assessment results	33
Referring or connecting participants to support services	32
Assisting participants with enrollment in classes	32
Conducting mock interviews with participants	31
Advising participants on course selection	30
Recruiting participants for the program	29
Assisting participants with internships/externships/clinical placements	28
Advising or assisting participants with financial aid or scholarships	22
Arranging instructional support, such as tutoring or study groups, for participants	20

Notes: Averaged across all programs, the right-hand column lists the percentage of staff providing direct services who reported a score of 5, 6, or 7 on a Likert scale where 1 was "none of my time" and 7 was "most of my time." In addition to activities presented in the table, 54 percent reported at least one responsibility in the "other" category with an average score of 5, 6, or 7.

Source: HPOG Management and Staff survey, 2014, Q18-S.

N=234 staff across 49 programs

Missing: 1–2 programs

Some case managers worked with HPOG participants in multiple ways. In 30 of the 48 programs using case managers (63 percent), case managers' responsibilities ranged from case monitoring to providing academic or career counseling, personal and financial counseling, and employment counseling (Exhibit 5-2). In other programs, case managers worked with HPOG participants on a narrower set of issues. All but one program included participant monitoring as a responsibility for case managers.

Exhibit 5-2. Case Managers' Responsibilities

	Number	Percentage
Participant monitoring, academic or career counseling, personal or financial counseling, and employment counseling	30	63%
Participant monitoring, academic or career counseling, and personal or financial counseling	9	19
Participant monitoring and personal or financial counseling	6	13
Participant monitoring and academic or career counseling	2	4
Personal or financial counseling	1	2

Source: HPOG Grantee survey, 2014, Q9.2.

N=48

Missing: 0 programs

5.1.2 HPOG Program Staff Contact with HPOG Program Participants

HPOG program staff were in contact with participants through a variety of modes, including email and other electronic communication and meetings (individually, in groups, and by telephone). On average, staff were in contact with participants two to three times a month in person in an individual setting.[118]

Program staff often initiated the meetings with participants. Slightly over two-fifths of staff in the average program (41 percent of staff) reported initiating the majority of participant meetings.[119] For nearly half of staff in the average program, meeting initiation either varied case by case (27 percent of programs) or was equal between staff and other individuals (either other program staff or participants; 18 percent of programs). Fewer than 5 percent of staff in the average program reported that participants initiated the majority of meetings.

5.2 Academic and Training Support Services

Academic and training support services included services and resource assistance to address participants' academic needs and help them complete training. This section first describes academic and personal counseling offered by HPOG programs before turning to a description of training-related financial assistance and cultural programming offered.

Key Findings

Nearly all HPOG programs provided academic and career counseling to participants. Programs also provided tutoring, peer support activities, and mentoring activities.

All HPOG programs offered some form of financial assistance for education and training related costs. Nearly all covered at least part of participants' tuition costs and nearly half covered all tuition costs.

All programs also covered the cost of books, licensing and certification fees, and exam preparation fees. All but one also covered the cost of uniforms, supplies, and tools.

5.2.1 Academic and Career Services

HPOG programs provided a variety of academic services designed to promote students' success. These services included academic and career counseling, tutoring, peer support activities, and mentoring.[120] Research suggests that intensive academic and career advising can improve participant outcomes.[121] Mentoring and peer support services aim to cultivate social connections between participants and their peers, as well as with program instructors, case managers, counselors, and other HPOG program staff. These strategies may include having tutors, mentors, and peer support groups. This section describes what services were available and how they were delivered.

Almost all HPOG programs (45 programs, 92 percent) offered academic and career counseling and over three-fourths offered tutoring services (38 programs, 78 percent) (Exhibit 5-3). Over two-thirds (34 programs, 69 percent) offered peer support activities and almost half (23 programs, 47 percent) offered mentoring activities. For example, one program provided mentoring to medical assistants during their clinical rotations.[122]

Exhibit 5-3. Academic and Career Counseling and Support Services Provided

Service	Number	Percentage
Academic and career counseling	45	92%
Tutoring	38	78
Peer support activities	34	69
Mentoring activities	23	47

Note: Responses do not sum to 100 percent because multiple responses were permitted.
Source: HPOG Grantee survey, 2014, Q8.15, 9.8.
N=49
Missing: 0 programs

The majority of the 45 programs that offered academic and career counseling required participation by all students (36 programs, 82 percent). However, tutoring was available on a voluntary basis for HPOG participants in over two-thirds of the 38 programs (25 programs, 68 percent) that offered it.[123] Most programs that offered academic counseling and advising services noted that the HPOG program operator employed staff (including case managers, for example) responsible for these services (35 programs, 78 percent of programs). Similarly, a majority of the program operators offering tutoring services directly employed staff providing the service (23 programs, 62 percent of those offering tutoring).[124]

Programs delivered academic support services through various formats. Outside regular classroom hours, academic support was most frequently provided through group study sessions (34 programs, 69 percent of programs that provided academic support), with assigned tutors being the next most common form of delivery (29 programs, 59 percent), followed by one-on-one time with the instructor (27 programs, 55 percent) (Exhibit 5-4).

Exhibit 5-4. Most Common Delivery Methods for Academic Support Services

	Number	Percentage
Study group or help sessions	34	69%
Tutoring	29	59
Extra time with the instructor	27	55
Provision of self-study resources	19	39
Instructor referral to case manager to determine next steps	17	35
Instructor referral to training institution help center	14	29
Other	2	4

Note: Responses do not sum to 100 percent because multiple responses were permitted.
Source: HPOG Grantee survey, 2014, Q8.19.
N=49
Missing: 0 programs

A majority of programs that offered peer support and mentoring activities provided these services directly (23 of the 34 programs with peer support, 68 percent; 13 of 23 with mentoring, 57 percent). A sizable minority provided the service both directly and through referrals to other agencies (30 percent for mentoring and 24 percent for peer support).[125] Mentoring and peer support services were provided on a voluntary, as-needed basis by most of the programs that offered them (20 of the 23 mentoring programs, 87 percent; 27 of the 34 peer support programs, 79 percent).[126]

5.2.2 Training and Work-Related Financial Assistance

Unmet financial needs can be a major barrier to post-secondary training for low-income individuals.[127] Many programs provided training and work-related financial assistance, such as tuition assistance or tuition waivers, payments for school supplies and uniforms, and payments for, or waivers of, fees for certifications and licensing exams. As might be expected, given that HPOG programs served low-income individuals, all programs offered some form of financial assistance for education and training-related costs. In fact, 47 programs (96 percent) covered all or part of participants' tuition costs, with about half of all programs (24 programs, 49 percent) covering all tuition costs.[128] In addition to providing direct tuition assistance, many programs also relied on other sources of financial assistance for participants. The two most common non-HPOG-funded sources of financial support included Pell Grants (40 programs, 82 percent) and WIA Individual Training Accounts (ITAs) (28 programs, 58 percent).[129]

Among the 25 programs that did not use HPOG funds to cover participants' full tuition costs, 13 (52 percent) required applicants to apply for Pell Grants and usually offered applicants assistance to complete the Free Application for Federal Student Aid (FAFSA) form (12 programs).[130]

In addition to providing resources to cover tuition costs, all programs covered the cost of books; licensing and certification fees; and exam preparation fees; and all but one program (98 percent) covered the cost of uniforms, supplies, and tools.[131] Almost half of all programs (22 programs, 46 percent) offered financial support for computers or other equipment. Of the programs that offered assistance for academic-related expenses, about a third (32 percent or more, depending on the specific expense) did so for all participants without request. Programs most commonly offered without request assistance with the cost of books (25 programs, 51 percent).[132]

5.2.3 Non-Cash Incentives[133]

Programs sometimes used non-cash incentives (for example, vouchers to purchase school supplies, uniforms, and food) to assist and motivate participants to persist in and complete their programs. About one-quarter (12 programs, 24 percent) offered non-cash incentives to encourage participants to achieve specific program benchmarks. One program used a "point incentive program." [134] Participants received points for attending meetings and completing tasks assigned by staff which they could use to obtain gas vouchers, food vouchers, textbooks, fees, tuition, and other needed items. Some incentive schemes also awarded additional points to participants who did not use support services for a year. Program staff noted that some students used these incentives rather than requesting emergency support, which allowed them to develop self-sufficiency.

5.3 Personal and Family Services and Supports

Personal and family services and supports are among the non-academic services that promote program retention and completion but are not explicitly related to the academic, training, or employment needs of participants. These supports include financial assistance for transportation and child care, housing assistance, and support for a range of other social service needs.

Among personal and family services and supports, programs most commonly provided transportation and child care assistance (48 programs, 98 percent and 45 programs, 92 percent, respectively) (Exhibit 5-5). Programs also often provided medical care services, non-SNAP food assistance, legal assistance, and addiction or substance abuse services (offered by 33 to 36 programs, 67 to 73 percent).

Key Findings

Nearly all programs provided transportation assistance and a large majority provided child care assistance.

Just over half of HPOG programs provided services to address short term emergency needs, including utility shutoffs, car insurance, and car repairs.

Most programs offered participants one or more housing services (such as short term or temporary housing, assistance with rent, security deposits, and housing program fees).

Exhibit 5-5. Types of Personal and Family Services and Supports Available

Service	Number	Percentage
Transportation assistance	48	98%
Child care assistance	45	92
Food assistance (other than SNAP)	36	73
Primary or medical care	36	73
Short-term/temporary housing	36	73
Legal assistance	34	69
Addiction or substance abuse services	33	67
Family preservation services	28	57
Family engagement services	25	51
Driver's license assistance	24	49
Other housing assistance	24	49

Source: HPOG Grantee survey, 2014, Q9.11.
N=49
Missing: 0 programs

Short-term emergency needs might hinder participants' capacity to attend or complete training; examples of unanticipated crises include utility shutoff and car repair or insurance costs. Of the 26 programs (53 percent) providing emergency assistance,[135] nearly all (25 programs, 96 percent) provided utility assistance, most helped with car repairs (21 programs, 81 percent), and just under half helped with car insurance costs (11 programs, 42 percent) (Exhibit 5-6).

Exhibit 5-6. Selected Types of Emergency Assistance: Car Repairs and Car Insurance

Type of Assistance	Number	Percentage
Car repair costs	21	81%
Car insurance costs	11	42

Note: Responses do not sum to 100 percent because multiple responses were permitted. Table limited to programs that provide emergency assistance for car repair costs, and/or car insurance costs.
Source: HPOG Grantee survey, 2014, Q9.19.
N=26
Missing: 0 programs

Forty programs (82 percent) made available one or more housing services to HPOG participants.[136] Most commonly, programs offered short-term or temporary housing (36 programs, 90 percent), utilities assistance (25 programs, 63 percent), and rental assistance (23 programs, 58 percent). (Exhibit 5-7). Twenty-four programs (60 percent) offered other types of housing assistance. Note that very few HPOG participants took up any program-related housing services (see Exhibit 5-10, below).

Exhibit 5-7. Types of Housing Services

Service	Number	Percentage
Short-term/temporary housing	36	90%
Utilities assistance	25	63
Rent	23	58
Security deposit	14	35
Housing program fees	9	23
Other housing assistance*	24	60

*Note that this survey response item did not permit respondents to write in examples of other housing assistance.
Note: Responses do not sum to 100 percent because multiple responses were permitted.
Source: HPOG Grantee survey, 2014, Q9.11, 9.19.
N=40
Missing: 0–1 programs

HPOG grant resources either partially or fully funded these personal and family supports. While about a quarter of programs (11 programs, 22 percent) indicated that they did not impose spending limits on personal and family support services, most programs reported setting limits on program funds that could be spent on these supports.[137]

Programs varied in how they provided personal and family services and supports, providing them either directly or through referrals to community resources (Exhibit 5-8). Most HPOG programs provided direct assistance for participants' transportation needs (48 programs, 98 percent). Programs typically provided other, more specialized services through referrals to local service providers. Nearly all programs offering addiction or substance abuse services, legal assistance, family preservation services, family engagement services, and primary or medical care did so through referrals.

Exhibit 5-8. Provision of Personal and Family Services and Supports

Support Service	Provided Directly Only		Provided by Referral Only		Provided Both Directly and by Referral	
	Number	Percentage	Number	Percentage	Number	Percentage
Transportation assistance	38	79%	3	6%	7	15%
Child care assistance	24	53	12	27	9	20
Primary or medical care	3	8	31	86	2	6
Short-term/temporary housing	5	14	28	78	3	8
Food assistance (other than SNAP)	7	19	25	69	4	11
Legal assistance	1	3	33	97	0	0
Addiction or substance abuse services	1	3	31	94	1	3
Family preservation services	1	4	25	89	2	7
Family engagement services	2	8	22	88	1	4
Driver's license assistance	10	42	12	50	2	8
Other housing assistance	5	21	19	79	0	0

Source: HPOG Grantee survey, 2014, Q9.11.
N=49
Missing: 0 programs

5.4 Support Services Delivered to Participants

Almost all HPOG participants (97 percent) received an academic or training support service in the first 18 months after enrollment (Exhibit 5-9). Case management was the most common academic or training support service, almost universally received (92 percent). Counseling services also were common: 82 percent of participants received services such as academic counseling, advising, mentoring or peer support, comprehensive academic assessments, and tutoring in the first 18 months.

Given the low-income status of the HPOG target population, financial assistance—for training or work-related expenses—was common. Seventy-five percent of participants received training and work-related resource assistance for such needs as books, exam or licensing/ certification fees, and supplies.

Key Findings

Almost all HPOG participants received academic or training supports in the first 18 months after enrollment, most commonly case management and counseling services.

Three quarters of participants received training and work related resource assistance, including help with books, exam or licensing/certification fees, and supplies.

Over half of participants received personal and family support services within 18 months of enrollment, most commonly transportation assistance. Only 9 percent of participants received child or dependent care assistance within 18 months of enrollment.

Exhibit 5-9. Participants' Receipt of Academic and Training Support Services in the First 18 Months After Enrollment

Service	Number	Percentage
Pre-enrollment/intake assessment	**11,244**	**89%**
Case management/career advisor/navigator	**11,583**	**92**
Counseling services	**10,351**	**82**
Academic counseling/advising	8,637	68
Mentoring/peer support	4,696	37
Comprehensive assessment	6,443	51
Tutoring	2,354	19
Other counseling services	1,650	13
Cultural programming	**846**	**7**
Training and work-related resource assistance	**9,482**	**75**
Books	7,544	60
Exam/exam prep fees (for licensing/certification)	4,588	36
Licensing and certification fees	4,400	35
Work/training uniforms, supplies, tools	6,984	55
Computer/technology	2,185	17
Any academic and training support total	**12,275**	**97**
No academic and training support	**339**	**3**

Note: This sample includes all enrolled HPOG participants with at least 18 months post-enrollment data as of October 1, 2014. Participants receiving multiple types of services are included in multiple rows.
N=12,614
Source: PRS, 2014.

HPOG programs also provided personal and family support services. Over half of participants (58 percent) received personal and family support services within 18 months of enrollment (Exhibit 5-10). Transportation assistance was by far the most common of these supports, provided to 49 percent of participants. Programs provided other personal and family support services to fewer participants, including, for example, child or dependent care provided directly by the program (9 percent), and help with medical care (9 percent), including assistance accessing healthcare screenings or physicals required by employers.[138] Five percent of participants received assistance for utilities and 4 percent received food assistance separate from federally funded SNAP benefits. Although a number of programs reported offering other social support resources, such as addiction and substance abuse services and family preservation services, few participants used these services.

Exhibit 5-10. Participants' Receipt of Personal and Family Services and Supports in the First 18 Months After Enrollment

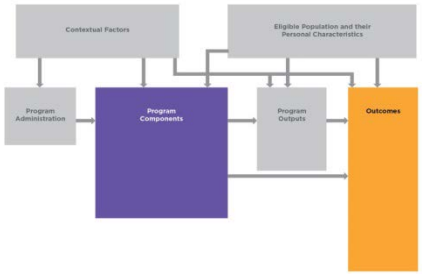
Service	Number	Percentage
Transportation Services		
General transportation assistance	6,160	49
Driver's license assistance	117	1
Car repair costs	421	3
Car insurance costs	161	1
Housing Services		
Security deposit	53	<1
First month's rent	162	1
Funds for housing program	45	<1
Short-term/temporary housing program	139	1
Home heating assistance	154	1
Utilities assistance	594	5
Other housing support services	370	3
Other Personal and Family Supports		
Child/dependent care assistance	1,178	9
Food assistance (non-SNAP)	499	4
Addiction and substance abuse services	31	<1
Family preservation services	173	1
Family engagement services	197	2
Legal assistance	61	0
Primary/medical care	1,117	9
Food and shelter	394	3
Other emergency assistance	274	2
Any personal and family services and supports	**7,325**	**58**
No personal and family services and supports	**5,289**	**42**

Note: This sample includes all enrolled HPOG participants with at least 18 months post-enrollment data as of October 1, 2014. Participants receiving multiple types of services are included in multiple rows.
N=12,614
Source: PRS, 2014.

This chapter presented details about support services provided to and received by participants, including case management, academic and training support services, and personal and family services and supports. The next chapter describes HPOG program employment assistance services and outcomes.

6. HPOG Program Employment Assistance Services and Outcomes

This chapter focuses on program components and outcomes in the logic model. Specifically, it describes how HPOG programs designed and provided employment assistance and employment retention services. The chapter closes with an account of the jobs HPOG participants obtained when they left the programs, and jobs they held 18 months after program enrollment.



Important Terms for This Chapter

Career and job choices advising—advice on how specific job opportunities relate to career growth

Employment assistance—counseling and supporting participants in finding suitable employment

Employment retention services—program staff work with HPOG participants and/or their employers to help HPOG participants retain their jobs

Individual job search assistance—one-on-one ongoing assistance for a job search including, for example, labor market information, counseling on job search, application and interview techniques

Job fairs—organized events at which employers seeking staff gather to recruit potential employees

Job-readiness workshops—classroom instruction in how to find, apply for, and obtain employment

Job search/placement—general counseling and information on how to locate and obtain jobs

Job screening—program staff screen participants as potential recruits for specific employers

Summary of Major Findings about Employment Services and Outcomes

Employment in a healthcare job with a career path is an important outcome for HPOG participants. To assist participants in attaining this goal, all HPOG programs provided multiple employment assistance services including, for example, personal employment and career counseling, individual employment assistance, job search training, job listings, and ongoing communication with local healthcare employers. Almost all programs also provided job retention services. HPOG program staff listed employment assistance among their most common counseling activities. About half of participants received employment assistance within 18 months of enrollment and about a quarter received post-placement services.

More than two-thirds of participants completing a healthcare training course within the 18 months after enrolling were employed in the subsequent quarter and even more were employed a year later. Students who completed their training were more likely to be employed, and more likely to be employed in a healthcare job, when they left their program than those who left without finishing training. In fact, most participants who completed training and found jobs were employed in healthcare. Note that this finding does not necessarily mean that completion of training alone caused the higher employment rates. For example, the same personal and academic skills that allowed some participants to complete training may also have been a factor in finding employment. The wages and benefits of those in healthcare

jobs were on average better than the wages and benefits of those employed in non-healthcare jobs. However, many of those who found healthcare jobs were also working in relatively low-wage positions. The average hourly wage for healthcare jobs after completing training was $12.42.

6.1 HPOG Programs Provided Multiple Employment Assistance Services

All HPOG programs used multiple strategies to help HPOG participants obtain employment (Exhibit 6-1). For example, every HPOG program provided individual job search assistance, advised HPOG participants on career and job searches, and provided job listings. Over 90 percent of programs (between 45 and 47 programs) offered job search skills workshops, met with potential employers, provided job-readiness workshops, and operated or referred HPOG participants to job fairs.

Exhibit 6-1. Employment Assistance Services Provided

Service	Number	Percentage
Individual job search assistance	49	100%
Advising on career and job choices	49	100
Providing job listings	49	100
Job search skills workshops	47	98
Identifying job openings for program graduates	47	96
Meeting with employers to identify job openings for graduates	47	96
Operating or referring to job fairs	46	94
Job-readiness workshops	45	94
Job screening	39	81

Note: Responses do not sum to 100 percent because multiple responses were permitted.
Source: HPOG Grantee survey, 2014, Q9.21.
N=49
Missing: 0–1 programs

Typically, almost all the employment assistance services HPOG programs offered were a standard part of their services, although a minority of programs delivered these services only upon request (Exhibit 6-2). Individual job search assistance and providing participants with job listings were the most common employment assistance activities delivered only upon request (11 programs, 23 percent).

Key Findings

All programs offered multiple employment assistance services, with the most common being individual job search assistance, advising on career and job choices, and providing participants with job listings.

A little more than half of program participants received job search/placement assistance and three quarters received career counseling and advising.

Though job retention services were offered in the vast majority of programs, less than a quarter of participants received job retention services.

In most programs, employer partners played a role in employment services (by contacting the HPOG program for referrals for job openings, placing job listings with the HPOG program, or contacting the HPOG program to provide job screening).

Most programs reported that placements were spread between employer program partners and other employers.

Exhibit 6-2. Access to Employment Assistance Services

Service	Standard Part of Program Services		Available upon Request	
	Number	Percentage	Number	Percentage
Individual job search assistance (N=49)	37	77%	11	23%
Advising on career and job choices advising (N=49)	40	83	8	17
Providing job listings provided (N=49)	37	77	11	23
Job search skills workshops (N=47)	41	89	5	11
Identifying job openings for program graduates (N=47)	41	89	5	11
Meeting with employers to identify job openings (N=47)	39	87	6	13
Operating or referrals to job fairs(N=46)	39	87	6	13
Job-readiness workshops (N=45)	40	91	4	9
Job screening (N=39)	31	84	6	16

Note: Responses do not sum to 100 percent because multiple responses were permitted.
Source: HPOG Grantee survey, 2014, Q9.23.
N=39 to 49
Missing: 1–2 programs

Program staff provided most employment assistance services directly but some were available by referral to other agencies (Exhibit 6-3). Very few HPOG programs offered any of these employment services only through referrals. Programs led by workforce development agencies offered all employment assistance services directly, never through referrals.[139]

Exhibit 6-3. Employment Assistance Service Delivery Mode

Service	Provided Directly		Provided Through Referrals		Both	
	Number	Percentage	Number	Percentage	Number	Percentage
Individual job search assistance (N=48)	38	79%	0	0%	10	21%
Career and job choices advising (N=47)	36	77	0	0	11	23
Job listings provided (N=47)	34	72	1	2	12	26
Job search skills workshops (N=46)	31	67	0	0	15	33
Job openings identified for program graduates (N=45)	36	80	0	0	9	20
Employer meetings to identify job openings (N=45)	37	82	1	2	7	16
Job fairs, operating or referrals to (N=44)	25	57	3	7	16	36
Job-readiness workshops (N=44)	30	68	0	0	14	32
Job screening (N=37)	29	78	0	0	8	22

Source: HPOG Grantee survey, 2014, Q9.24.
N=37 to 48
Missing: 0–3 programs

About three-quarters of HPOG programs had staff assigned to providing employment assistance services.[140] Programs operated by higher education institutions, non-profit organizations, or state and local government agencies were much more likely than those operated by workforce development agencies to have HPOG staff assigned to providing employment services. Workforce development agencies operating HPOG programs have staff assigned to employment assistance services as a standard part of their regular services and so were less likely to use the HPOG grant to fund those staff. In the average program, more than half of staff providing employment assistance services reported spending

most of their time providing career information and advice to participants and helping participants develop career goals (60 and 55 percent of staff, respectively).[141]

6.2 Most HPOG Programs Provided Employment Retention Services

Nearly all programs (46 programs, 94 percent) provided job retention support to HPOG participants once they were employed.[142] Most used multiple communication methods for post-placement follow-up with participants, including telephone calls (44 programs, 90 percent), emails (42 programs, 88 percent), and in-person meetings (39 programs, 81 percent). Nearly half (22 programs, 49 percent) used social media for this purpose. Fewer programs were in contact with the participants' employers (19 programs, 40 percent).

More than half of all programs provided post-placement services for a full 90 days after employment; others provided such assistance for up to 30 or 60 days (Exhibit 6-4). Some HPOG programs also provided more tangible supports to HPOG participants once they became employed. In one program, for example, participants were eligible for six weeks of transitional transportation assistance once employed. Child care and additional emergency supports also were available.[143] Some programs also provided post-placement incentives. For example, one program provided bus passes during the first six months of employment and gift cards for groceries or gas after 90 days of employment. Another program offered post-placement incentives to those remaining employed at 90 days, six months, and one year.[144]

Exhibit 6-4. Duration of Post-Placement and Retention Services

Service	First 30 Days		First 60 Days		First 90 Days	
	Number	Percentage	Number	Percentage	Number	Percentage
Phone check-ins with participant (N=44)	11	28%	5	13%	24	60%
Email check-ins with participant (N=42)	9	26	5	14	21	60
In-person meetings with participant (N=39)	10	29	4	11	21	60
Social media check-ins with participant (e.g., Facebook, LinkedIn) (N=22)	5	31	0	0	11	69
Phone calls or meetings with participant's supervisor (N=19)	4	25	2	13	10	63
Other (N=4)	1	33	0	0	2	67

Note: Responses do not sum to 100 percent because multiple responses were permitted.
Source: HPOG Grantee survey, 2014, Q9.22.
N=4 to 44
Missing: 1–7 programs

All programs led by workforce development agencies offered in-person post-placement meetings with participants, which compares to less than three-quarters of programs (17 programs, 71 percent) operated by higher education institutions and government agencies (2 programs, 67 percent) that offered those services.[145]

Among the 43 programs that provided post-placement services, 63 percent (27 programs) used staff dedicated to employment services for this purpose and the remaining 37 percent (16 programs) used staff with other primary responsibilities.[146]

6.3 Who Received Employment Assistance Services?

While all programs offered multiple types of employment assistance services, not all participants took part in these activities. Participants most commonly received career counseling and job choice advising from a job coach or career navigator, which was reported for 75 percent of HPOG participants (Exhibit 6-5). As noted above, all programs reported using multiple ways to assist participants in job search or placement. About half (52 percent) of participants received these services. Most programs (46) offered job retention services, and almost a quarter of HPOG participants (24 percent) received these services. Finally, although 45 programs offered job-readiness workshops, only 13 percent of participants took part.[147]

Exhibit 6-5. Participants' Receipt of Employment Assistance Services

Service	Number	Percentage
Career and job choices advising	9,460	75%
Job search/placement assistance	6,522	52
Job retention services	2,974	24
Job-readiness workshop	1,636	13

Notes: Sample is 12,614 HPOG participants in the PRS with 18 months post-enrollment data as of October 1, 2014. Participants receiving multiple types of service are included in multiple rows.
Source: PRS, 2014.

In addition to these activities, HPOG programs helped participants find jobs while they were still active in the program. Some of these jobs were related to healthcare and provided an opportunity for gaining relevant experience and additional skill-building. In other cases, the jobs may have simply generated income, providing the resources that participants needed to continue in training, as well as general work experience. Forty-four percent of participants began employment while enrolled in HPOG. More than one-third (35 percent) of all participants began a job in a healthcare occupation or with a healthcare employer while enrolled in HPOG.[148]

6.4 Local Healthcare Employers Were Involved in Job Placement

Many HPOG programs worked with local employers to place participants in jobs (Exhibit 6-6). Most programs (40 programs, 82 percent) had employers contacting them for referrals for specific job openings. Slightly more than half (27 programs, 55 percent) worked with employers who placed job listings with local HPOG programs. In nearly half of all HPOG programs (22 programs, 45 percent), employers contacted the program to screen or assess participants' skills, qualifications, and suitability for specific job openings.

Exhibit 6-6. Employment Assistance Services Provided by Employers

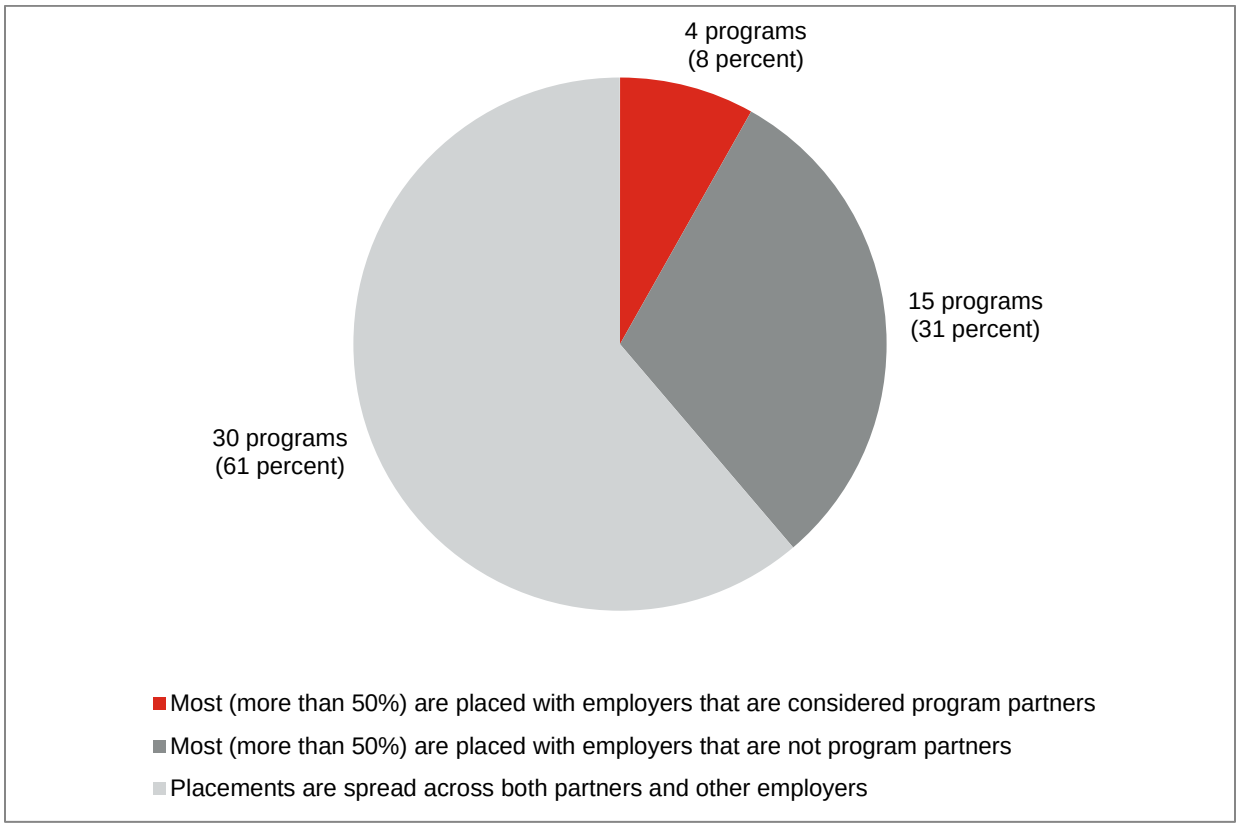
Service	Number	Percentage
Contacting HPOG program representative(s) to obtain referrals for job openings	40	82%
Placing job listings with HPOG program	27	55
Contacting HPOG program representative(s) to provide job screening	22	45
Other	3	6

Note: Responses do not sum to 100 percent because multiple responses were permitted.
Source: HPOG Grantee survey, 2014, Q9.27.
N=49
Missing: 0 programs

Programs operated by workforce development agencies and higher education institutions were more likely to have had connections with employers that provided job listings. Nearly two-thirds of workforce development agencies (8 programs, 67 percent) and just over half of programs led by higher education institutions (14 programs, 58 percent) had these connections with employers compared to approximately 40 percent (4 programs) of programs operated by non-profits.[149]

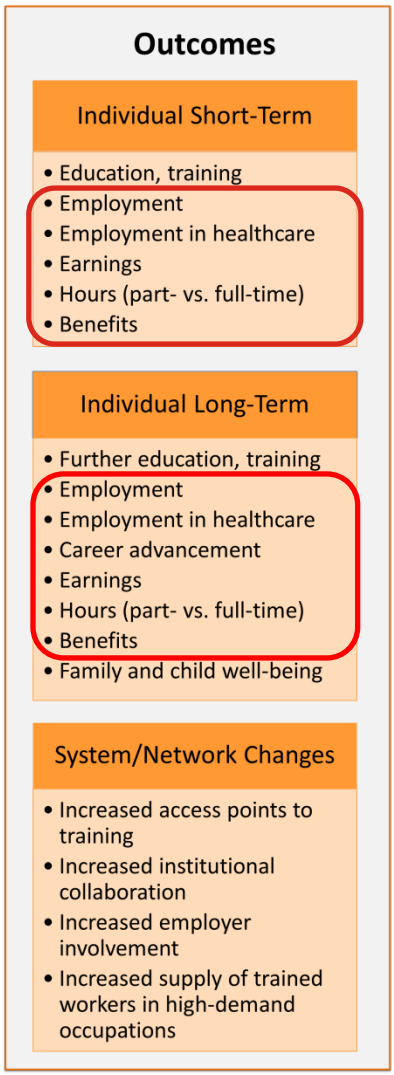
More than half of HPOG programs placed participants both with employers they considered to be program partners and with other employers (30 programs, 61 percent) (Exhibit 6-7).[150] About one-third of programs placed the majority of their graduates with employers that were not program partners (15 programs, 31 percent). Programs operated by non-profits were most likely to place the majority of their participants with employers that were not partners.[151] Eight percent (4 programs) placed most of their participants with employers who were program partners.

Exhibit 6-7. Employment of HPOG Participants by Employer Partners



Source: HPOG Grantee survey, 2014, Q9.28.
N=49
Missing: 0 programs

6.5 Number and Types of Jobs HPOG Participants Obtained



Employment is a primary goal of HPOG as indicated in the logic model under Outcomes. This section examines employment and earnings of HPOG participants and the quality of the jobs they found. The study relies on two sources of information, the NDNH and the PRS. The chapter first reports quarterly employment and earnings. These results are based on data from the NDNH that employers are required by law to report, and thus are likely to be more accurate and complete than PRS data. The chapter then reports characteristics of jobs. These results are based on data from the PRS, since this information is not included in the NDNH.

Key Findings

Two years after HPOG enrollment, 68 percent of HPOG participants were employed, compared to 50 percent in the quarter of enrollment.

In the quarter after completing training, 67 percent of HPOG participants were employed, and employment increased to over 70 percent in subsequent quarters.

Those who did not complete training were less likely to be employed than those who did complete.

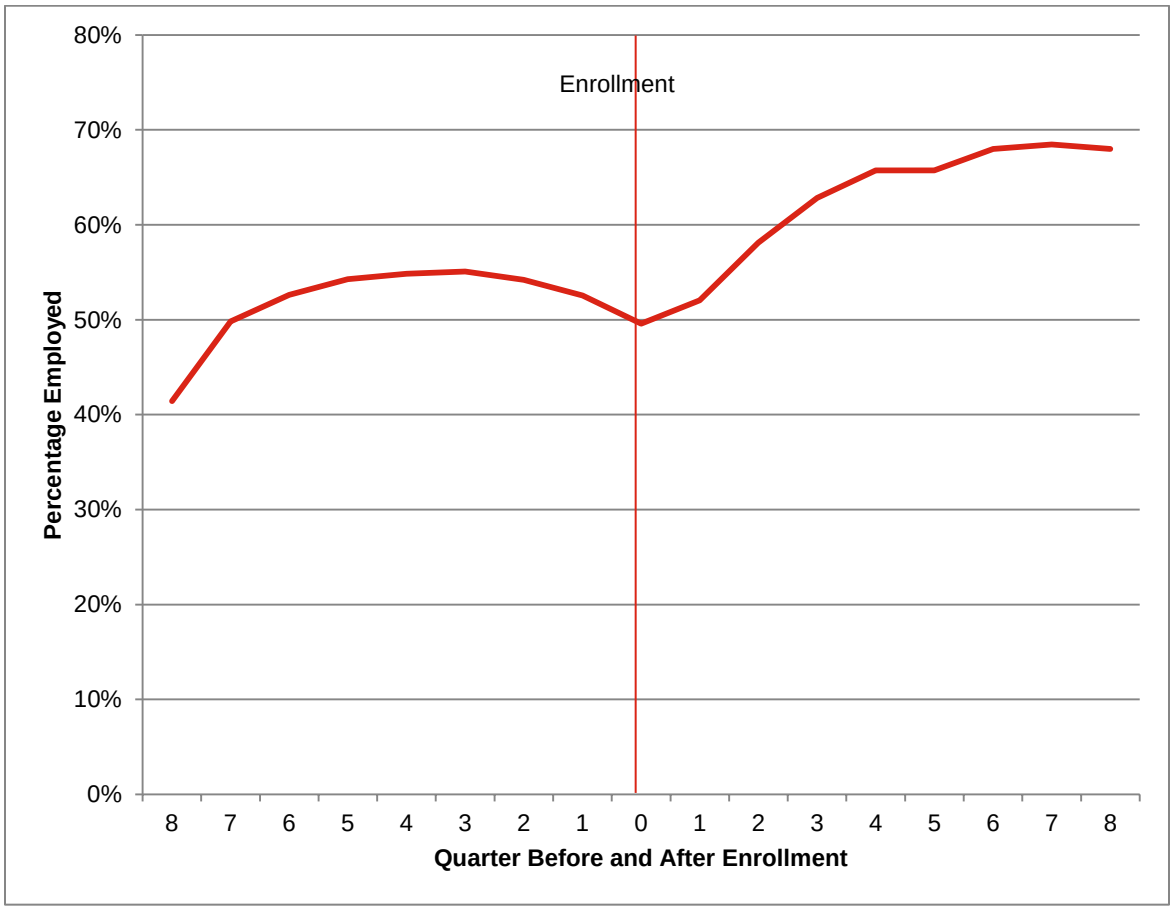
Average quarterly earnings for those completing HPOG training were about $4,000 in the first quarter after training completion, higher than in each of the four quarters before HPOG enrollment. Earnings continued to increase over the first eight quarters after completing training.

Average quarterly earnings were higher for those who completed a training course than for those who did not.

6.5.1 Quarterly Employment and Earnings

On average, employment of HPOG participants increased in the quarters after HPOG enrollment, from 50 percent employed in the quarter of enrollment to 68 percent employed two years after enrollment (Exhibit 6-8). The percentage of participants employed was higher in almost all quarters after they had entered HPOG than in the two years before enrollment.

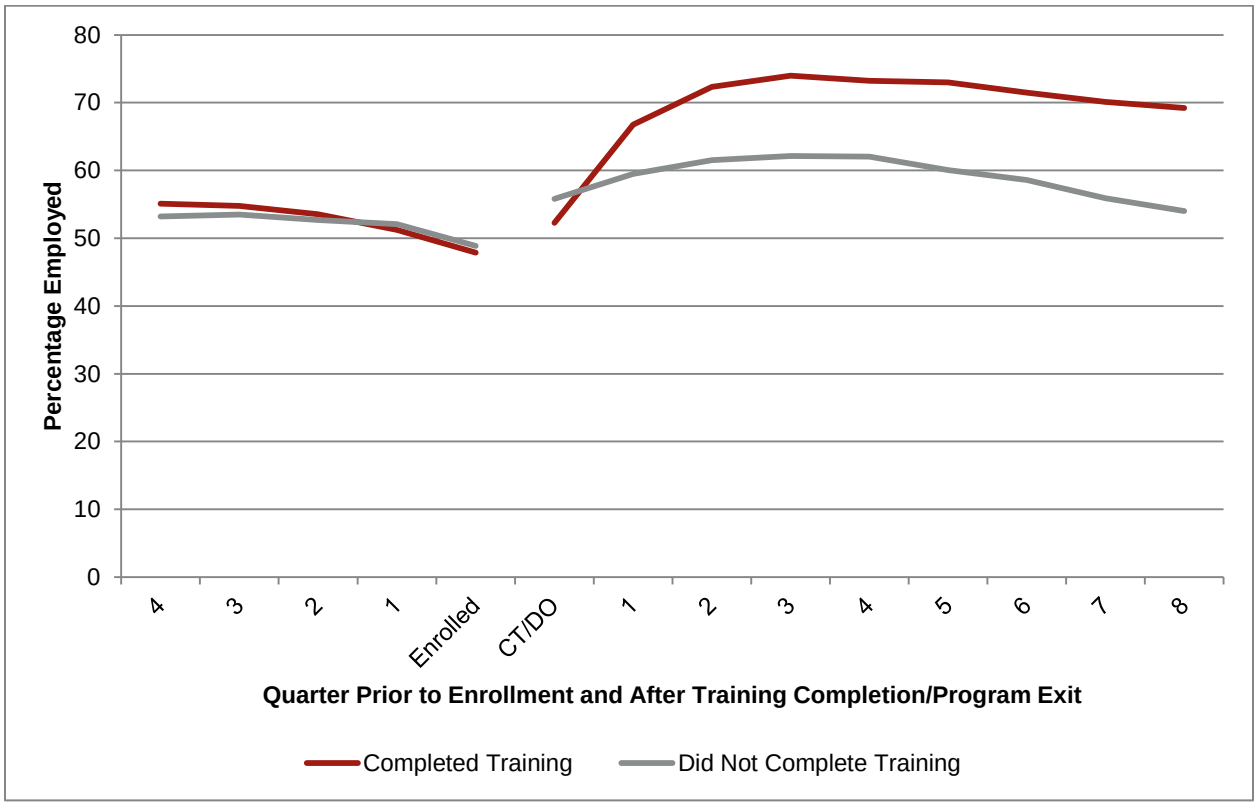
Exhibit 6-8. Quarterly Employment of HPOG Participants



Notes: Sample is participants in the PRS with 18 months post-enrollment data as of October 1, 2014. N ranges from 12,251 to 6,210 in final quarters due to time lags in available data and not all participants having had eight quarters post-enrollment.
Source: NDNH.

Another important program result is whether more participants who completed at least one training course were employed after completion than before starting the program. In general, employment was higher after training completion than before starting HPOG. Exhibit 6-9 shows employment in the four quarters before HPOG enrollment and in the eight quarters after training completion. For comparison, the exhibit also presents employment for those who dropped out or failed to complete a training course.[152]

Exhibit 6-9. Quarterly Employment of Participants by Training Completion

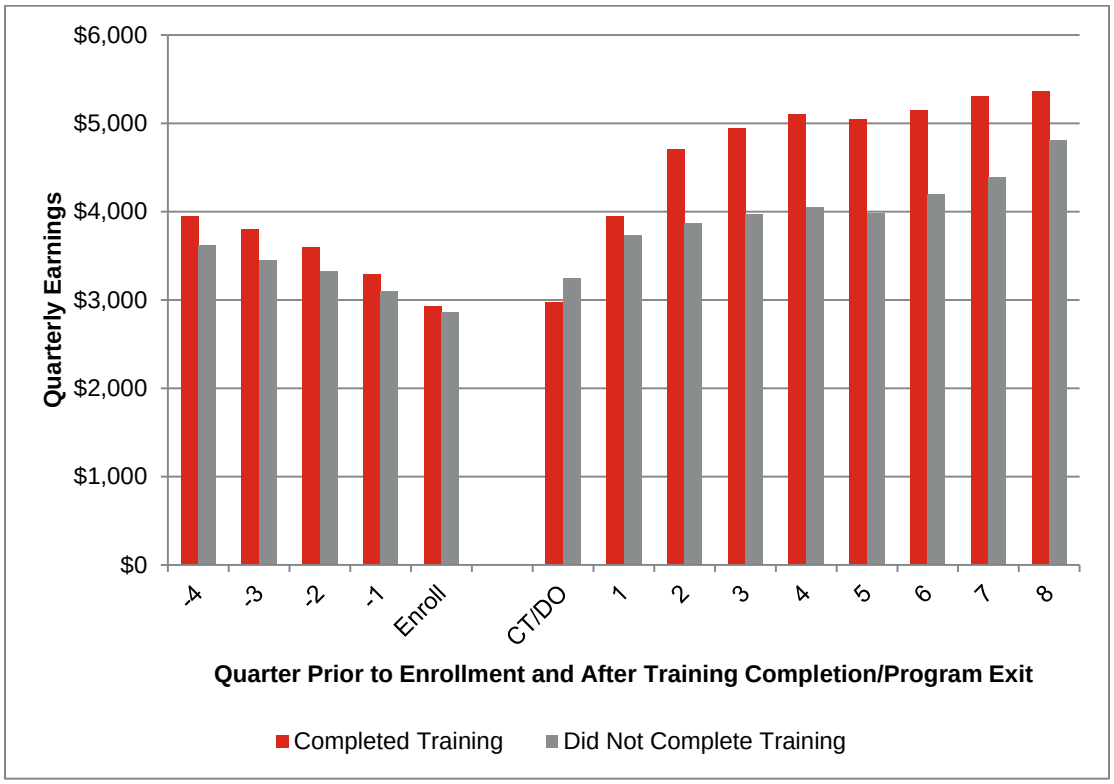


Notes: Sample is participants in the PRS with 18 months post-enrollment data as of October 1, 2014. N ranges from 1,790 to 7,266 for those who completed training and 448 to 1,937 for those who did not complete training, due to time lags in available data and not all participants having eight quarters post-enrollment. CT stands for quarter completed training and DO stands for quarter dropped out of training.
Source: NDNH.

In the quarter after completing training, 67 percent of HPOG participants were employed. This is a substantial increase in employment from the quarter of enrollment in HPOG, when 48 percent of this group was employed. Employment rates for those who did not complete training are lower than for those who did complete training in any quarter following dropping out or completing training. For example, in the fourth quarter after completing training or dropping out, employment for those who completed training was 73 percent compared to 62 percent for those who did not complete training. The quarterly employment rates for both of these groups before HPOG enrollment are similar. This suggests differences in later employment are not due to one group having more work experience in the year before HPOG enrollment. However, there may be other differences across these two groups that could influence outcomes for training completion and employment, so this finding cannot be construed as causal evidence that training completion alone was the reason for training completers' higher rate of employment.[153]

Another important outcome for HPOG is the earnings of those who find employment and whether earnings increased after completing a training course relative to prior earnings. For the most part, average quarterly earnings increased after training completion. Exhibit 6-10 shows quarterly earnings of HPOG participants who completed training for the four quarters before enrollment and the eight quarters after completing training. Only those who were employed in a given quarter are included in the average for that quarter. For comparison, the exhibit also shows the earnings in the same quarters for those who did not complete training.[154]

Exhibit 6-10. Quarterly Earnings of Employed Participants by Training Completion



Notes: Sample is participants in the PRS with 18 months post-enrollment data. N ranges from 1,239 to 5,130 for those who completed training and 242 to 1,401 for those who did not complete training, due to different employment rates in each quarter, time lags in available data, and participants who did not have eight quarters of post-enrollment data. Only those who were employed in a given quarter are included in the average for that quarter. For comparison, the exhibit also shows the earnings in the same quarters for those who did not complete training. CT stands for quarter completed training and DO stands for quarter dropped out of training.
Source: NDNH.

Average quarterly earnings for those completing HPOG training ($3,942) were higher in the first quarter after training completion than in each of the four quarters before HPOG enrollment. In addition, average quarterly earnings continued to increase over the first eight quarters after completing training. Average earnings increased by 36 percent, from $3,942 in the first quarter after training to $5,357 in the eighth quarter after training completion.

Average quarterly earnings were higher for those who completed a training course than for those who did not. In the first quarter after dropping out or completing training, the difference in quarterly earnings for these two groups was $209, but the difference increased to $1,401 in the fifth quarter before beginning to narrow again. Quarterly earnings were somewhat higher in the quarters before HPOG enrollment for those who went on to complete training than for those who dropped out. Since employment rates were similar across the two groups, this indicates that those who went on to complete training held higher-wage-level jobs or had worked more hours before HPOG.

6.5.2 Employment by Subgroups

Employment rates for those completing training and not completing training differed by participant characteristics measured at program intake. Exhibit 6-11 shows employment in the first quarter after either completing training or dropping out of training for each of these groups separately. Across all

subgroups, employment for those who did not complete training was lower than for those who completed training. For example, for those younger than age 25 at program intake, 64 percent of those who completed training were employed in the subsequent quarter compared to 59 percent of those who did not complete training.

For both program completers and dropouts, employment was higher among those who were 25 or older, had higher levels of education coming into the program, were employed at intake, were in school at intake, had a child younger than six, or were not receiving TANF. The largest difference was between those who were and were not employed at intake. In the first quarter after completing training, 84 percent of those who had been employed at intake were employed compared to 56 percent of those who had not been employed at intake.

Exhibit 6-11. Average Quarterly Employment in First Quarter After Completing Training or Dropping Out by Characteristics at Program Intake

	Completed Training (N=7,266)		Did Not Complete Training (N=1,937)	
	Number	Percentage	Number	Percentage
Age				
<25	2,948	64%	674	59%
25+	1,797	73	458	61
Education				
Less than 12th grade	217	60	61	50
High school graduate	1,976	67	460	60
High school equivalency or GED	585	62	131	52
1-3 years college/technical school	1,535	69	396	63
4 years or more of college	283	68	49	64
Employed				
Yes	2,268	84	542	82
No	2,096	56	483	47
In school				
Yes	1,451	69	486	60
No	2,887	66	542	59
Age of youngest child				
Age 0–5	2,610	68	657	60
Age 6 and older	977	64	234	57
Receiving TANF				
Yes	594	56	159	51
No	3,768	69	878	61

Notes: Sample is participants in the PRS with 18 months post-enrollment data as of October 1, 2014.Those missing a characteristic at intake are not included. Missing data for those who completed training/did not complete training are 161/34 for age; 381/92 for education; 826/254 for employed; 778/212 for in school; 780/201 for age of youngest child; and 738/192 for receiving TANF. Missing includes those missing a characteristic at intake and those missing data for the quarter after completing training or dropping out.
Source: PRS, 2014.

6.5.3 Job Characteristics

NDNH data used above to report on quarterly employment and earnings do not include information about the characteristics of jobs, including whether the job was in the healthcare sector, the hourly wage, the hours of employment, and the availability of health insurance coverage. PRS data on employment were collected and entered by HPOG case managers and include much more information about job characteristics than the NDNH data sent to the government by employers. This section provides findings on these characteristics based on data from the PRS on jobs held at program exit. [155] Eighteen months after enrollment, 53 percent of HPOG participants had exited the program.[156] Exhibit 6-12 shows employment status separately for those who exited HPOG after completing at least one healthcare training course and for those who exited the program without completing any healthcare training course.

Key Findings

The majority of participants who found jobs after completing training and exiting the program were employed in a healthcare occupation.

Among those who had completed training and were working in healthcare at program exit, average hourly wages were $12.42; 42 percent were working full time and 43 percent had employer provided health insurance.

Those who had completed training were more likely to have health insurance benefits from their employer than those who were working at exit but had not completed training.

Wages and benefits were generally higher for those in healthcare jobs than for those in non healthcare jobs.

Exhibit 6-12. HPOG Participants' Employment at Exit by Training Completion Status

	Exited, Completed Healthcare Training (N=4,126)		Exited, Did Not Complete Healthcare Training (N=2,613)	
	Number	Percentage	Number	Percentage
Employed	2,305	72%	598	36%
Employed in healthcare	1,951	61	269	16

Notes: Samples are participants in the PRS who left HPOG in the 18 months after enrollment as of October 1, 2014. Percentages are of non-missing responses. The number of those who completed healthcare training missing employment information at exit is 915 and of those who did not is 967.
Source: PRS, 2014.

Of those who completed one or more training courses before exit, 72 percent were employed at exit. Of those employed at exit, more than three-quarters (85 percent) were employed in a healthcare occupation. Employment was lower among those who exited without completing training: 36 percent were employed and only 16 percent were employed in healthcare. These are descriptive findings and should not be interpreted as causal (i.e., healthcare training completion caused higher employment rates) since the findings do not control for other potential reasons for these differences.

Another goal of HPOG is for participants to secure high-quality jobs as measured by average hourly wage, full-time hours, and availability of employer health insurance. According to the data at exit, those who completed training are in higher-quality jobs than those who did not complete training, and those in healthcare jobs are in higher-quality jobs than those who are in non-healthcare jobs.

Those who completed training obtained jobs with higher hourly wages after leaving the program than those who left without completing training (Exhibit 6-13). They also were more likely to work full-time and more likely to have health insurance benefits from their employer.

For both training completers and non-completers, healthcare jobs held after leaving the program appear to be of higher quality than non-healthcare jobs.[157] Among completers, hourly wages and the share working full-time were higher for those employed in healthcare ($12.42 and 42 percent) than employed in non-healthcare ($9.98 and 32 percent). Forty-three percent of this group had employer health insurance coverage compared with 14 percent of completers in non-healthcare jobs. Among non-completers, healthcare hourly wages were higher ($11.43) than wages in non-healthcare jobs ($9.61), and healthcare jobs were more likely to have employer health insurance coverage (23 percent versus 9 percent).

Exhibit 6-13. Job Characteristics of Employed Participants by Training Completion

	Employed at Exit, Completed Healthcare Training (N=2,305)				Employed at Exit, Did Not Complete Healthcare Training (N=598)			
	Number	Non-Healthcare Jobs	Number	Healthcare Jobs	Number	Non-Healthcare Jobs	Number	Healthcare Jobs
Average hourly wage	328	$9.98	1,902	$12.42	310	$9.61	247	$11.43
Full-time (35+ hours/week) (percentage)	328	32.0%	1,902	42.4%	310	27.7%	247	32.3%
Health insurance coverage (percentage)	328	14.0	1,902	43.4	310	9.0	247	23.4

Notes: Sample is participants with 18 months post-enrollment data as of October 1, 2014. Average hourly wage is among those reporting wages. Information on wages, hours, and health insurance is missing for 125 participants that were employed at exit and completed healthcare training and 41 participants employed at exit that did not complete healthcare training.

Source: PRS, 2014.

This chapter reviewed the employment assistance services provided by HPOG programs, including employment retention services and employer involvement in job placement services. It also detailed participants' employment and earnings outcomes. The next chapter provides information about management and staff opinions of the effectiveness of HPOG programs and program sustainability.

7. HPOG Program Management and Staff Perspectives

Social policy research has long maintained that the perspective of human services workers (also known as "frontline staff") that interact directly with clients is a major factor in determining the shape and results of policy and program implementation.[158] Most of the evidence for this theory has come from case studies and other qualitative research. However, in an important study, researchers used information about how case managers approach their work in statistical models and found significant associations between variations in case manager approaches and attitudes and variations in program impacts.[159] Following in this line of research, the HPOG NIE and Pathways for Advancing Careers and Education (PACE) research studies implemented a Management and Staff survey to capture quantifiable data about the attitudes and beliefs of program personnel concerning their work, their program, and their clients.[160]

This chapter begins by providing more detail about the characteristics of frontline workers that may influence the effectiveness of the HPOG Program and includes staff opinions about the needs of HPOG participants and whether their program adequately met these needs. The next section summarizes staff perspectives on the adequacy and effectiveness of program staff. A final section summarizes the opinions of respondents to the Grantee survey regarding HPOG program sustainability.

Summary of Major Findings about HPOG Management and Staff Perspectives

To measure staff and management beliefs about their own work, their programs, and their customers, the HPOG NIE project fielded a survey of largely non-instructional program managers and staff who interacted directly with participants. The survey results show that a majority of HPOG personnel felt that program goals and practices were aligned, and program goals and values were generally shared by management and staff. Importantly, a majority of management and staff respondents felt that having participants quickly enter employment in their chosen field and continue occupational training in their field were equally important goals of the HPOG Program. A large majority of HPOG personnel also expressed confidence in their program's effectiveness.

The Management and Staff survey also gathered opinions about the adequacy of program resources. A majority of respondents reported that program resources were adequate to address the most common challenges to program retention and completion and that staff had sufficient time to serve HPOG participants. However, fewer than half felt that staffing levels were adequate.

This chapter also reports on the opinions of individuals knowledgeable about HPOG programs who responded to the Grantee survey about the prospects for HPOG sustainability after grants expire. While respondents generally indicated a willingness to work with partners after the HPOG grant period ends, many also saw important challenges to sustainability, particularly with regard to program resources.

7.1 Management and Staff Perspectives on HPOG Program Effectiveness and Program Goals

Research has shown that the attitudes and beliefs of social program management and staff may influence program results. Two general areas in which attitudes and beliefs seem to matter are (1) staff recognition of and alignment with program goals, and (2) staff confidence in program efficacy. This section presents detailed findings on these issues for HPOG personnel. This section describes staff and management responses to the NIE survey and places them in the context of findings from earlier research. [161]

Key Findings

A majority of management and staff felt that program goals for education and employment align with what they believed the goals should be, which is valuing employment and continued occupational training equally.

Most HPOG management and staff felt that program personnel shared common program values and goals.

The vast majority of HPOG personnel felt that their colleagues spent the time needed to get to know students personally and to monitor their progress in the program.

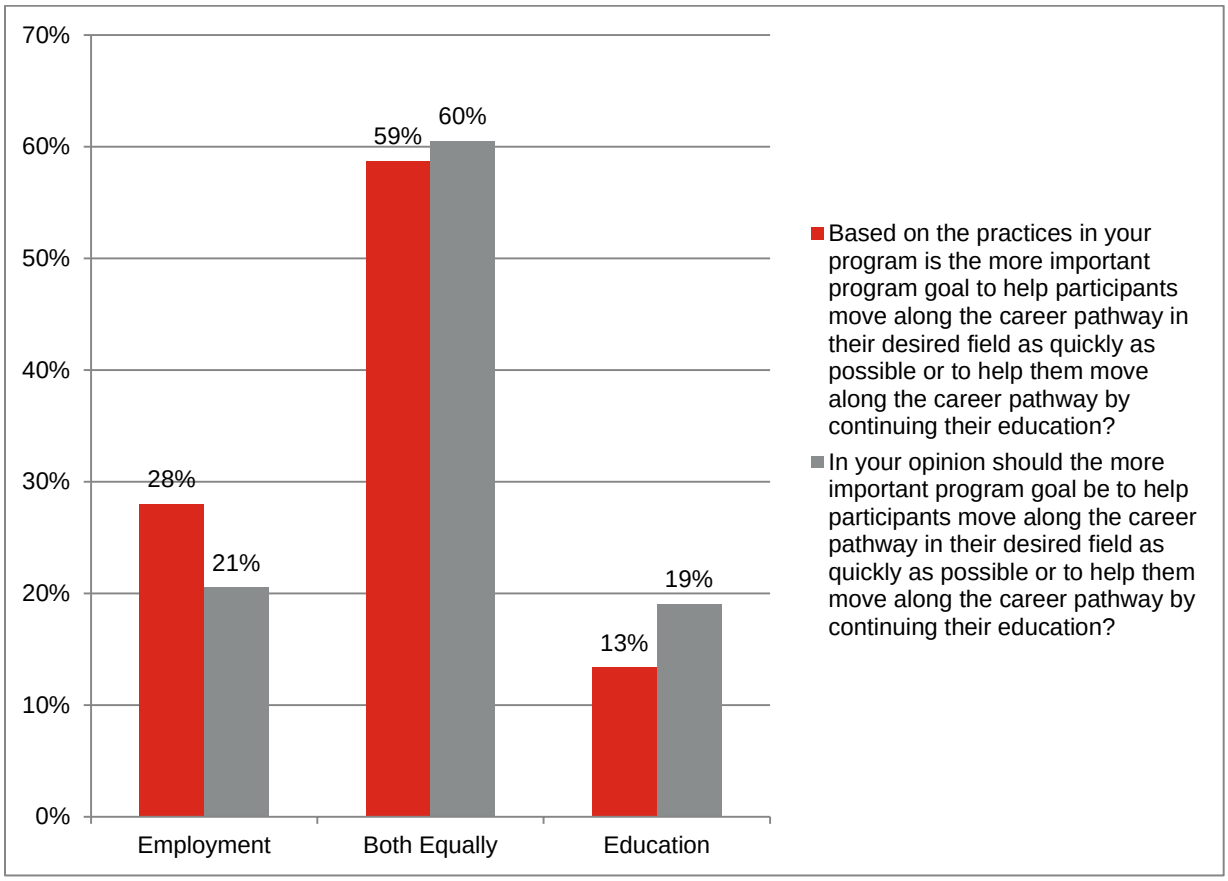
7.1.1 Staff Alignment with Program Goals

The study referenced in the introduction to this chapter analyzed the relationship between worker practices and attitudes and program impacts in a welfare reform project.[162] Among the administrative strategies relevant to HPOG that this study found to be associated with larger program impacts were close personal attention to client needs and progress and a shared vision across management and staff of program philosophy and goals. The HPOG NIE Management and Staff survey included some items from a survey used in that earlier study to similarly examine the use of these strategies in HPOG.

Core Program Goals: Balancing Education and Employment

Management and staff at HPOG programs reported believing that rapid entry into appropriate employment and furthering career education were, and should have been, equally important goals for their program. Specifically, when asked what the most important goal for the HPOG Program *should be*, on average, 60 percent of management and staff in a program believed that both goals were equally important (Exhibit 7-1). When asked what the goal of HPOG *is*, almost 60 percent of personnel also answered both equally. The remaining 40 percent split almost equally in naming education or employment as what the goal is, with slightly more naming employment than education. In the average program, 42 percent of management and staff believed that the most important goal of the HPOG Program *is and should be* equally divided between employment and education.

Exhibit 7-1. HPOG Manager and Staff Opinions on Goals of the HPOG Program

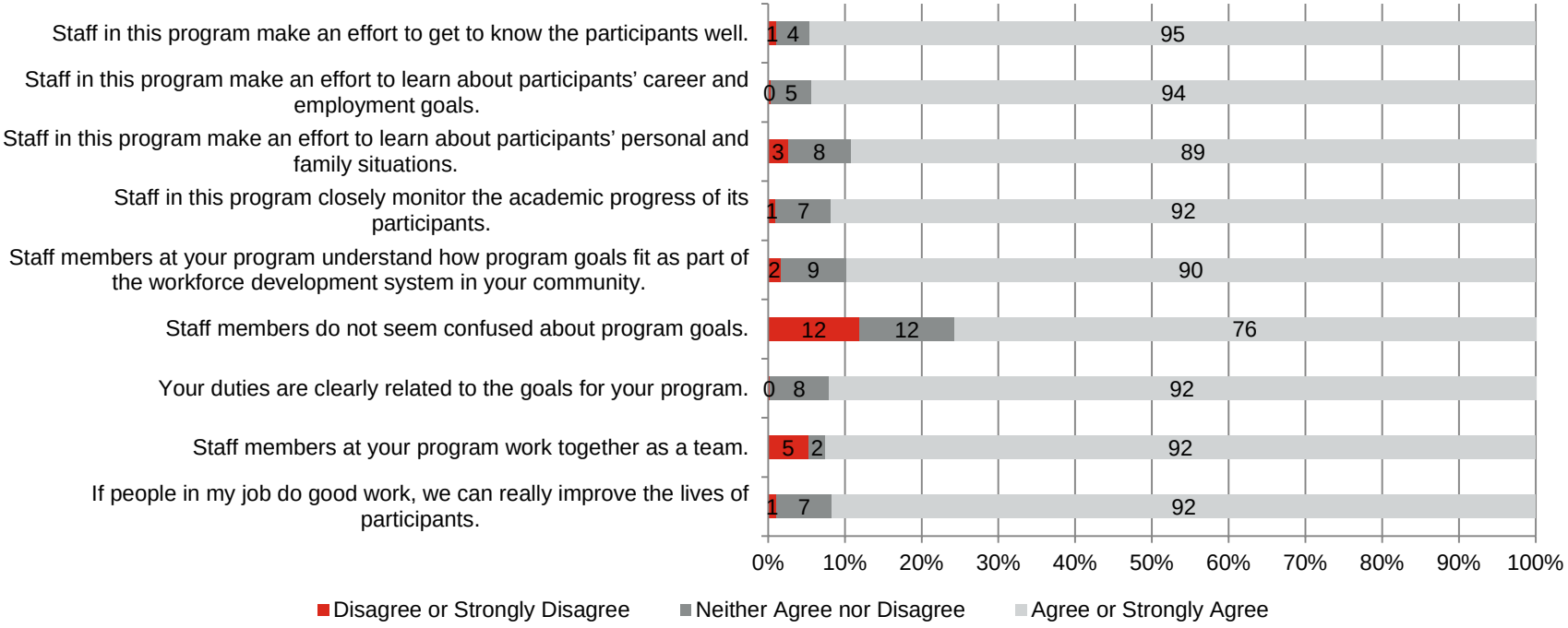


Source: HPOG Management and Staff survey, 2014, Q27, 28.
N=86 managers and 234 staff in 49 programs
Missing: 0 programs

Personal Attention and Participant Monitoring

Most HPOG program personnel expressed the belief that their program staff make an effort to become personally acquainted with participants and to monitor their experience and progress in HPOG. For example, in the average program, more than 89 percent of managers and staff perceived that their program's staff made an effort to get to know participants well, learning about both their career goals and their personal and family situations (Exhibit 7-2). In the average program, 92 percent of managers and staff believed that staff in their program closely monitored the academic progress of HPOG participants.

Exhibit 7-2. Management and Staff Perspectives on HPOG Effectiveness and Program Goals



Source: HPOG Management and Staff survey, 2014, Q23, 24, 68, 69, 71, 73.

N=86 managers and 234 staff in 49 programs

Missing: 0 programs

Note: The Management and Staff survey question "Some staff members seem confused about the main goals for your program" is edited in the table as "Staff members do not seem confused about program goals."

Shared Program Vision and Teamwork

HPOG personnel generally expressed the belief that their colleagues shared a common vision of program goals and understood how those goals interact with their local workforce development system. For example, in the average program, 90 percent of personnel believed that staff members in their program understood how program goals fit with their community's workforce development system (Exhibit 7-2). About three-fourths of personnel (76 percent) disagreed with the statement that some staff members seemed confused about the main goals of their HPOG program, and 92 percent believed that their duties were clearly related to the goals of the program. In the average program, 92 percent of managers and staff agreed that staff in their program worked together as a team, and 92 percent of managers and staff believed that if people in their jobs do good work, they can improve the lives of participants.[163]

7.1.2 Perceived Barriers to Completion and Adequacy of Supports

In the average program, over half of HPOG management and staff believed that the most common barriers to program success experienced by participants were financial issues (57 percent), child care or dependent care issues (56 percent), and transportation problems (52 percent) (Exhibit 7-3). Just under half of staff believed that participant motivational issues were among the most common barriers (48 percent). A relatively small percentage of staff believed that other barriers, such as domestic abuse or housing issues, were common.

Key Findings

Managers and staff felt that the most common barriers to program retention and completion were financial issues, child care, transportation, and participant motivation.

A majority of HPOG management and staff felt that program resources were sufficient to deal with the four most common barriers to program retention and completion.

HPOG management and staff overwhelmingly expressed confidence in their program's efficacy.

Exhibit 7-3. Most Common Barriers to Program Success Experienced by Participants

Perceived Program Barrier	Percentage
Financial issues	57%
Child care or dependent care issues	56
Transportation problems	52
Motivational issues	48
Other domestic issues (e.g., marital or relationship issues)	20
Homelessness or housing problems	14
Criminal history	14
Mental health issues	13
Physical health issues	10
Legal problems	3
Substance abuse issues	2
Domestic violence issues	2
Child behavioral issues	0
Other	8

Source: HPOG Management and Staff survey, 2014, Q25.
N=86 managers and 234 staff in 49 programs
Missing: 0 programs

The majority of managers and staff believed that their HPOG program had adequate support services to address what they perceived to be these common barriers (Exhibit 7-4). In the average program, 88 percent of managers and staff believed that support services were adequate to address transportation problems, and 82 percent believed that child care issues were adequately addressed. More than three-quarters (78 percent) believed that programs could adequately address participant motivational issues, and 68 percent thought similarly about financial issues. However, only 23 percent thought that their HPOG program could adequately address child behavioral issues and only 34 percent thought that the program could adequately address legal problems or substance abuse issues.

Exhibit 7-4. Perceived Adequacy of Available Support Services in the Average Program

Support Services for…	Percentage
Transportation problems	88%
Child care or dependent care issues	82
Motivational issues	78
Financial issues	68
Homelessness or housing problems	55
Domestic violence issues	53
Criminal history	46
Other domestic issues (e.g., marital or relationship issues)	46
Mental health issues	41
Physical health issues	36
Substance abuse issues	34
Legal problems	34
Child behavioral issues	23
Other	38

Source: HPOG Management and Staff survey, 2014, Q26.
N=86 managers and 234 staff in 49 programs
Missing: 0 programs

7.1.3 Perceived Overall Program Impact

HPOG frontline personnel indicated strong belief in the effectiveness of the HPOG Program. When asked to rank on a scale of 1 to 7 how helpful the program was in getting participants a job in the healthcare field (with 7 being "considerably helpful"), in the average program, 81 percent of management and staff ranked their program a 6 or a 7.[164] This confidence aligns with their previously noted perceptions that program staff had a shared vision and maintained close contact with HPOG participants, and that their programs offer adequate supports to address major barriers to program success.

7.2 HPOG Program Staff Perceptions of Job Quality and Program Staffing

The previous section presented results for HPOG management and staff perceptions of overall program mission and efficacy. This section presents findings on management and staff opinions about HPOG staffing adequacy and about their job conditions and quality. Specifically, the survey asked respondents about their degree of job satisfaction and whether staffing levels are adequate to meet the needs of participants and support program effectiveness.

7.2.1 Perceptions of Job Quality

Nearly all managers and staff (99 percent) believed that they had the skills needed to be effective in their job, and 93 percent of staff believed that they had the skills to advise or provide case management effectively to HPOG participants.[165] Management and staff also reported a high degree of job satisfaction. In the average program, 91 percent expressed satisfaction with their present job, and 85 percent believed that staff were given broad authority to carry out their responsibilities.[166]

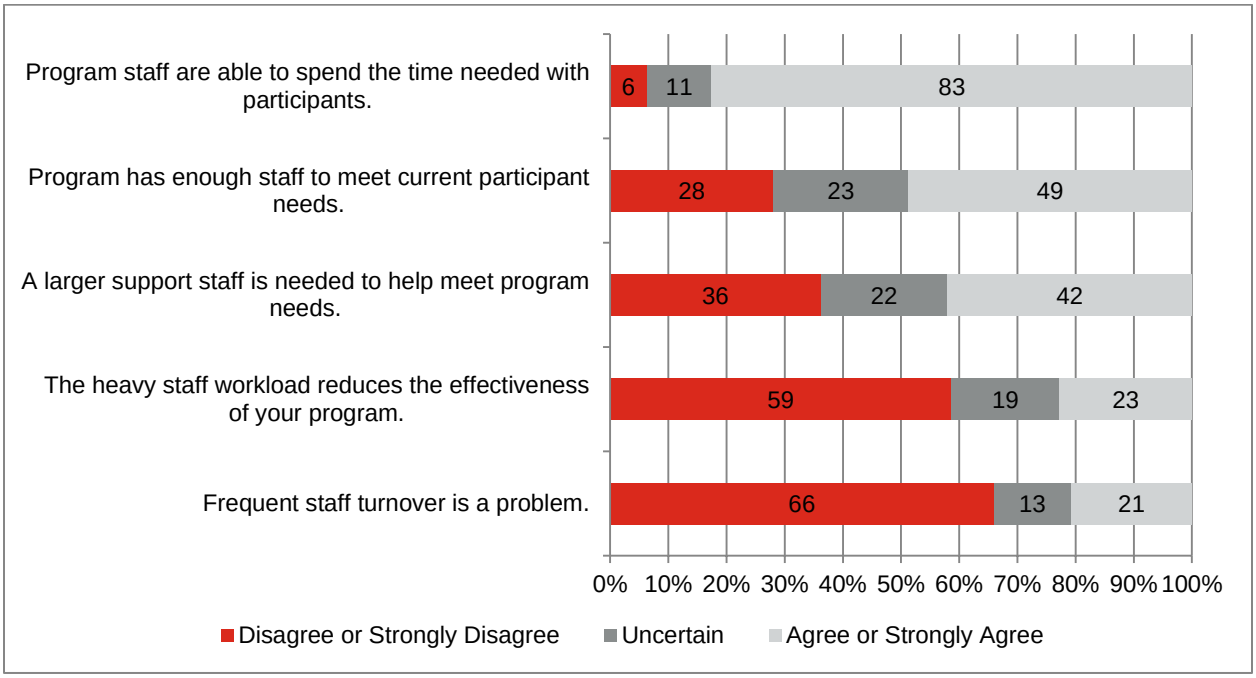
7.2.2 Perceptions of Staffing Adequacy

Key Finding

Although a large majority of HPOG personnel felt that staff had sufficient time to spend with HPOG participants, slightly less than half thought that staffing levels were adequate.

Although HPOG management and staff were very positive about their HPOG programs, they were less consistent in their opinions about whether the programs were sufficiently staffed. In the average program, 83 percent agreed that staff were able to spend sufficient time with participants; however, somewhat contradictorily, only 49 percent of staff believed that their program had enough staff to meet current needs, and 42 percent thought that a larger staff was required to meet program needs (Exhibit 7-5). In the average program, 42 percent of staff were either uncertain about whether the heavy staff workload reduced program effectiveness, or agreed that it did. However, they did not widely perceive that staff turnover was an issue. In the average program, only 21 percent believed that frequent staff turnover was a problem.

Exhibit 7-5. Perceived Staffing Sufficiency



Source: HPOG Management and Staff survey, 2014, Q31, 32, 34, 36, 89.
N=86 managers and 234 staff in 49 programs
Missing: 0 programs

7.3 Management Opinions About HPOG Program Sustainability

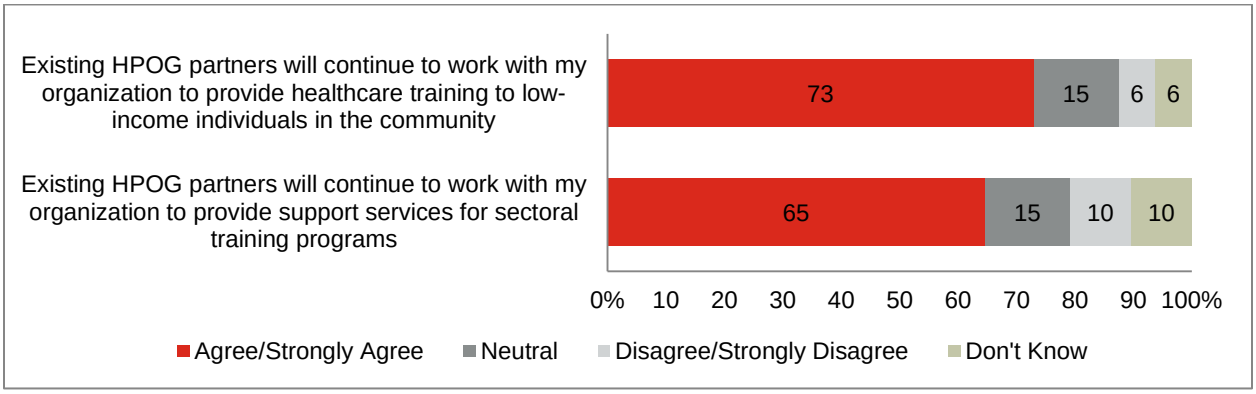
Key Finding

Almost three quarters of program operators reported they will continue to provide healthcare training to low income individuals and almost two thirds reported they will continue to provide support services to participants in sectoral training programs.

The HPOG grants awarded in 2010 were limited to a five-year period. In the latter part of the grant period, many grantees and program operators focused on sustaining at least some components of the HPOG program when grant funding expires. For example, one program planned to institutionalize the coaching model implemented

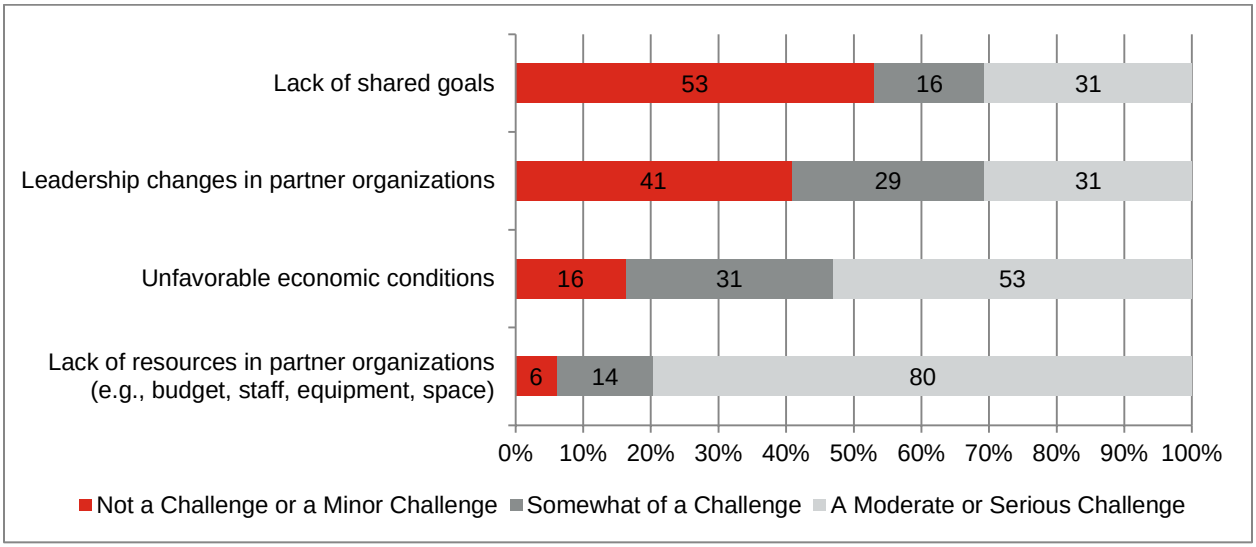
under HPOG.[167] Others hoped to continue offering particular training courses, such as certified nursing assistant and patient care technician courses, after the HPOG grant period. [168] Almost three-quarters of program operators expected that they would continue to collaborate with other organizations to provide healthcare training to low-income individuals (73 percent), and nearly two-thirds (65 percent) expected that they would continue to provide support services for sectoral training programs (Exhibit 7-6).[169] The largest challenges they foresaw were a lack of resources in partner organizations (80 percent) and unfavorable economic conditions (53 percent) (Exhibit 7-7).[170]

Exhibit 7-6. Sustainability of Relationships with Other Organizations After HPOG Ends



Notes: Respondents had the option of answering on a five-point scale from 1="Strongly Disagree" to 5="Strongly Agree."
Source: HPOG Grantee survey, 2014, Q5.12.
N=48
Missing: 1 program

Exhibit 7-7. Potential Challenges to the Sustainability of Relationships with Existing HPOG Partners



Source: HPOG Grantee survey, 2014, Q5.13.
N=49
Missing: 0 programs

This chapter described frontline staff and manager perspectives on their HPOG programs' common sense of mission, program efficacy, and sustainability. The findings indicate general optimism about program efficacy and a unified sense of program goals. While respondents to the Grantee survey indicated a willingness to continue to work with the HPOG program partners, they also foresaw challenges to sustainability. The next chapter concludes with an overall assessment of HPOG Program design, implementation and outcomes, as well as prospects for future research.

8. Conclusion

This report presented detailed findings on the context, design, content, operations, and outcomes of the programs implemented by HPOG grantees. The findings show that the HPOG Program's flexible guidelines resulted in programs with a range of approaches intended to meet ACF's expectations for program design and implementation as outlined in the FOA: [171]

> Successful training programs funded through this FOA will prepare participants for employment within the healthcare sector in positions that pay well, are expected to either experience labor shortages, or be in high demand, and will: (1) target skills and competencies demanded by the healthcare industry; (2) support career pathways, such as an articulated career ladder; (3) result in an employer- or industry-recognized certificate or degree (which can include a license, as well as a Registered Apprenticeship certificate or degree); (4) combine supportive services with education and training services to help participants overcome barriers to employment, as necessary; and (5) provide training services at times and locations that are easily accessible to targeted populations.

This final chapter summarizes the HPOG Program's varying program designs, implementation strategies, and participant results in assessing the degree to which the Program achieved its goals. It closes with an account of remaining questions and the research planned to address them.

8.1 Program Design and Implementation

Overall, most HPOG programs incorporated select key features of the career pathways framework for post-secondary occupational education. For example, a majority of programs offered courses with "stackable credentials," compatible with articulated career ladders and aligned to healthcare industry standards. Relatedly, most programs also reported supporting one or more career pathways. Other aspects of the career pathways framework were less common among HPOG programs. For example, fewer than half of the programs reported offering one or more accelerated courses, online courses, or contextualized basic skills courses.

Given the HPOG Program's goal of serving TANF recipients and other low-income populations, ACF expected grantees to provide, either directly or through other community resources, services to support program retention and completion. The study presented results on the four types of student supports offered by HPOG programs: (1) case management, (2) academic supports, (3) family and personal supports, and (4) financial supports. All but one program used some form of case management to monitor student progress and assess student needs. Similarly, most programs provided academic and career advising. Some family and personal supports were also available to HPOG participants, with transportation and child care assistance available in almost all programs. Finally, financial assistance was generally available, with most programs covering all or part of tuition and most other educational expenses. Overall, a majority of HPOG management and staff felt that their program provided supports to help overcome the most challenging barriers to participant retention and completion.

8.2 Participant Experiences and Outcomes

Among the most important HPOG Program policy goals for participants were completing training, gaining credentials in a healthcare industry-recognized occupation along an articulated career pathway,

and gaining employment in a high-demand job that pays well. The study reviewed the HPOG Program's record of accomplishment in these key outcomes.

The study found that a large majority of HPOG participants enrolled in healthcare training within 18 months of enrollment. Within that timeframe, almost three-quarters of them completed a course of healthcare training, and half of the remaining group was still in training at the end of those 18 months, leaving a small proportion that dropped out before completing training. Training courses completed were largely short in duration, on average about four months long. That is, a large majority of those completing courses within 18 months did so in pursuit of primarily entry-level healthcare jobs, such as nursing aide, orderly, or personal care attendant.

In addition to engaging participants, enrolling them in courses and retaining them to completion, HPOG programs also had the goal of certifying participants with credentials recognized by the healthcare industry. While not all training courses provided by HPOG programs led to certification, more than half of the participants who completed a training course received a license or third-party certification.

The career pathways framework envisions students advancing in a career by taking additional training courses, sometimes immediately after completing one and sometimes after a period of employment. HPOG grantees had flexibility to allow participants to enroll in additional training after completing a first course. However, within the 18 months of enrollment observed by the study, a relatively small percentage of HPOG participants enrolled in multiple healthcare training courses by completing one course and then enrolling in another. Among those who did move on to a second training, both occupational training courses tended to emphasize short-term training for entry-level positions, such as nursing aide, orderly, and personal care attendant.

Whether HPOG participants found jobs is a key measure of HPOG's success. Focusing on HPOG participants who completed one or more training courses, about two-thirds were employed in the quarter after completing training and about three-quarters were employed a year later.[172] Of those employed at program exit, a large majority were in a healthcare job. The results suggest that HPOG was generally successful in training individuals for jobs in the healthcare industry. Consistent with their courses of study, many of those who found healthcare jobs were in relatively low-wage, entry-level positions. The average wage of healthcare jobs held after completing training was $12.42. For those who did not complete training or found jobs outside of healthcare, average wages were lower.

8.3 Concluding Observations and Prospects for Further Research

The HPOG NIE Descriptive Implementation and Outcome studies found that, overall, grantees designed and implemented the HPOG Program as intended by the authorizing legislation. Additionally, HPOG programs on average largely met their own goals for enrollment, course completion, and job placement. However, the pressing need for low-income students to pursue immediate employment may have limited the extent to which participants engaged in multiple training courses within the 18-month period observed for the study. As such, jobs obtained by participants were largely entry-level positions at relatively low wages.

While this study found that grantees overall implemented HPOG as specified in the authorizing legislation, two important questions require further research:

- Did HPOG lead to better outcomes than participants would have achieved in its absence? This question concerns the impacts of HPOG on participants' and their families' lives and is an important measure of its success relative to existing services and other policy initiatives.
- Did HPOG represent a solid first step along a career pathway and will HPOG participants continue to build careers and obtain higher-wage jobs through further work experience and education? Given the relatively short amount of time for HPOG grants, as well as for the observation window afforded to measure outcomes (up to 18 months post-enrollment), it is not possible to address this question adequately within the limits of the current study. More follow-up time is needed to measure subsequent training and career growth.

ACF has funded two projects that begin to address these questions. Answering the first question is a core research goal of the HPOG Impact Study, which uses an experimental design to estimate the effects of HPOG for up to 15 months after random assignment.[173,174] The Career Pathways Intermediate Outcomes Study will analyze results of a follow-up survey fielded at 36 months after random assignment of individuals in the HPOG Impact Study sample and PACE. This longer-term look at HPOG participants' further work and educational experiences and outcomes will help address the second remaining research question.[175]

Endnotes

[1] Hamutal Bernstein, Lauren Eyster, Jennifer Yahner, Stephanie Owen, and Pamela Loprest, *Systems Change Analysis Report: National Implementation Evaluation of the Health Profession Opportunity Grants (HPOG) to Serve TANF Recipients and Other Low-Income Individuals*) (Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, Forthcoming).

[2] This report includes findings on 27 HPOG grantees. The five tribal HPOG grantees were evaluated separately.

[3] This report generally includes findings on the roles of partners from the grantees' perspectives, based on responses to the survey of grantees. Alternatively, the Systems Change Analysis reports on the roles of partners from the partners' and stakeholders' perspectives, drawing largely on responses to the survey of partners and stakeholders.

[4] Authority for these demonstrations is included in the *Patient Protection and Affordable Care Act*, Public Law 111-148, 124 Stat. 119 (2010), sect. 5507(a), "Demonstration Projects to Provide Low-Income Individuals with Opportunities for Education, Training, and Career Advancement to Address Health Professions Workforce Needs," adding sect. 2008(a) to the *Social Security Act*, 42 U.S.C. 1397g(a).

[5] Office of Family Assistance, U.S. Department of Health and Human Services, *Health Profession Opportunity Grants to Serve TANF Recipients and Other Low-Income Individuals (HHS-2010-ACF-OFA-FX-0126)* (Washington, DC: Office of Family Assistance, U.S. Department of Health and Human Services, 2010), 2, http://www.acf.hhs.gov/grants/open/foa/view/HHS-2010-ACF-OFA-FX-0126.

[6] In understanding the domains and constructs that constitute the HPOG Program and its contexts nationally, the NIE developed a series of detailed questions and a set of analytic strategies to address them. These can be found in Appendix C.

[7] The Interim Outcome Study Report used a 12-month follow-up window given the small sample sizes for those with 18 months post-enrollment data at the time of data collection for that report. That report found that, for that sample, training completions increased substantially when moving to an 18-month window. Pamela Loprest (with Allison Stolte), *Interim Outcome Study Report: National Implementation Evaluation of the Health Profession Opportunity Grants (HPOG) to Serve TANF Recipients and Other Low-Income Individuals* (OPRE Report # 2014-53) (Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2014.)

[8] For these analyses we use the number of participants during fiscal year 2014 (October 2013 through September 2014) to correspond to the period during which the NIE surveys were fielded.

[9] Note that while this report includes nearly all of the concepts introduced in the logic model, some concepts are not included. For example, some outcomes, such as family and child well-being and total program costs, were beyond the scope of data collection for the study. Also note that some of the report subsections combine two or more logic model topics or divide one logic model topic across multiple sections for ease of exposition.

[10] "Sectoral training" indicates training that targets occupation within a specific industry, such as healthcare or the automotive industry.

[11] PRS data includes active participants in each calendar month. A participant-year is calculated by dividing annual grant expenditures by the number of participant-months in that year and multiplying by 12. We use fiscal year 2014 as the reference since it coincides with the NIE survey fielding. Note that all grant expenditures—including, for example, staff salaries and overhead—are included in the calculation of expenditures per participant-year.

[12] In 2014 Workforce Investment Boards were renamed Workforce Development Boards under the Workforce Innovation and Opportunity Act. See *Workforce Innovation and Opportunity Act of 2014* at *www.doleta.gov/wioa/*.

[13] In 2012, the U.S. Department of Labor branded One-Stop career centers as American Job Centers. See U.S. Department of Labor Training and Employment Guidance Letter No. 36-11, June 14, 2012. We use "One-Stop centers" in the report because the NIE surveys used that terminology.

[14] Non-profit organizations included community-based and faith-based organizations.

[15] See HPOG NIE Analysis Plan memorandum submitted to ACF October 1, 2014.

[16] The proportion of grantees by institutional type roughly mirrored the breakdown by program. The majority of grantees were either higher education institutions (12 grantees, 44 percent) or workforce development agencies (9 grantees; 33 percent). Among the other six grantees (22 percent), four were state and local government agencies and two were non-profit organizations. See Appendix Exhibit D-1for more detail about program operator institutional type.

[17] Lead organizations that expanded their target populations may have served individual members of those groups before HPOG but may not have made targeting those groups a priority.

[18] In the HPOG Funding Opportunity Announcement, ACF specified that grantees could not use grant funds to augment or expand other *federally funded* programs, but did not expressly prohibit the expansion or augmentation of programs funded by other sources. See OFA HHS, *Health Profession Opportunity Grants to Serve TANF Recipients and Other Low-Income Individuals*, 7–8.

[19] This section is adapted from the description of HPOG labor markets in Bernstein et. al., *Systems Change Analysis Report*.

[20] The jobs for which HPOG programs generally train are included in the Bureau of Labor Statistics (BLS) category "production and non-supervisory workers." This category includes occupations such as nursing aides, home health aides, medical assistants, and medical coders and billing workers that are on the first steps of healthcare career pathways.

[21] Job openings are forward-looking indicators; they suggest that firms expect strong future growth. Job openings are directly relevant to the prospects of new trainees entering a labor market who are concerned with the number of available jobs and not the stock of already filled positions. However, data on openings are available for the health sector as a whole only, and therefore include supervisory and higher-education-level occupations that are not especially relevant for HPOG programs.

[22] There are only 29 distinct HPOG local labor markets because some programs occupied the same local labor market. The main data source is the BLS's Occupational Employment Statistics (OES).

[23] This approach follows Lawrence F. Katz and Kevin M. Murphy, "Changes in Relative Wages, 1963-1987: Supply and Demand Factors," *The Quarterly Journal of Economics*, 107, no. 1 (1997): 35–78. The approach is implicit in any standard model of the labor market. OES data are not available for all occupations in all markets, so the total number of markets presented varies across different occupations.

[24] Bernstein et. al., *Systems Change Analysis Report*.

[25] *Source:* HPOG Grantee survey, 2014, Q2.1.

[26] See Appendix Exhibits D-5 and D-6.

[27] *Source:* HPOG Impact Study site visits, 2014.

[28] See Appendix Exhibits D-7 and D-8.

[29] Bernstein et. al., *Systems Change Analysis Report*.

[30] This section reports the number of partners and stakeholders, not including the program operator. The *Systems Change Analysis Report* (Bernstein et al.) reports on "network size," which is the number of partners and stakeholders plus the program operator.

[31] The average number of partners and stakeholders for the three governmental agencies is driven up by one agency that claimed 72 network members.

[32] *Source:* HPOG Stakeholder/Network survey, 2014, Q5.

[33] *Source*: HPOG Stakeholder/Network survey, 2014, Q5

[34] *Source:* HPOG-Impact Study site visits, 2014.

[35] For a more detailed treatment of the content and nature of HPOG program networks, see Bernstein et. al., *Systems Change Analysis Report*.

[36] Source: HPOG Sampling Questionnaire, 2013.

[37] Note that in keeping with the report's general strategy of focusing on the program as the analytic unit, most data on staffing patterns are described for the mean program.

[38] The Management and Staff survey examined the experiences of managers and staff providing direct services to participants (e.g., case managers and academic or career advisors). Instructors were not surveyed. Designated grantee liaisons identified managers and staff to complete the survey and the list was not necessarily exhaustive.

[39] See Appendix Exhibit D-9.

[40] *Source:* HPOG Impact Study site visits, 2014, and HPOG Impact Study biweekly monitoring calls, 2013–2014.

[41] See Appendix Exhibit D-44.
[42] *Source:* HPOG Management and Staff survey, Q11-M.
[43] *Source:* HPOG Management and Staff survey, 2014, Q14B-M.
[44] *Source:* HPOG Management and Staff survey, 2014, Q22-M.
[45] *Source:* HPOG Management and Staff survey, 2014, Q15.
[46] Exhibit 2-15 presents the percentages of staff and participants in each gender or race/ethnicity group for each program averaged across all programs. Comparison of staff and participant characteristic distributions for individual programs may be more or less similar. See Appendix Exhibits D-11 and D-12.
[47] *Source:* HPOG Management and Staff survey, 2014, Q7. Percentages are of the total population of HPOG managers and staff.
[48] *Source:* HPOG Management and Staff survey, 2014, Q2a.5.
[49] This differed for staff and for managers. In the average program, 72 percent of managers had been employed in current or similar positions for two or more years, and 19 percent had been in such a position for 12 months or less; 54 percent of staff had been employed in a current or similar position for two or more years, and 28 percent had been in the position 12 months or less.
[50] *Source:* HPOG Management and Staff survey, 2014, Q17.a, 17.b.
[51] Note that ACF organized annual HPOG conferences that are likely referenced in many of the responses regarding conference attendance.
[52] To calculate the number of participant-years provided by each program, the study counted and added together the number of active participants in each grantee's program or programs at the end of each month in fiscal year 2014 and divided by 12. Grant expenditures per participant-year were calculated by dividing the annual grant amount by the number of participant-years. Note that the differences across grants in this measure may be due to a variety of factors, including, for example, the range and cost to the grant of activities, services, and training courses provided; the choices students made about which courses to pursue; the availability and cost of activities; the cost to the grant of the services and training courses accessed in the community; and grant practices regarding when to exit participants who have completed the program or dropped out without notice.
[53] *Source:* NIE analysis of SF-425 Federal Financial Reports submitted by HPOG grantees for fiscal year 2014.
[54] Note that only two grantees were non-profit organizations and that the average grant expenditure per participant-year is skewed by one grantee with relatively high per-participant expenditures consistent with their program model.
[55] As of September 30, 2014, the 32 HPOG grantees had enrolled 32,123 individuals. *Source:* Nathan Sick, Thomas Callan, Pamela Loprest, and Alan Werner, *Health Profession Opportunity Grants: Year Four Annual Report (2013-2014).* (OPRE 2015-64) (Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services: Abt Associates and the Urban Institute, 2015).
[56] OFA HHS, *Health Profession Opportunity Grants*, 19.
[57] For more detail, see Appendix Exhibit D-15.
[58] *Source:* HPOG Impact Study site visits, 2014.
[59] *Source:* HPOG Impact Study site visits, 2014.
[60] *Source:* HPOG Impact Study site visits, 2014.
[61] For more detail see Appendix Exhibit D-16.
[62] *Source:* PRS, 2014.
[63] Federal TANF policy requires states to have at least 50 percent of all families and 90 percent of two-parent families in their TANF caseload participate in approved work or work-related activities for 30 hours a week (20 hours for single parents with children under age six); this is referred to as the "work participation rate." Generally, hours in occupational training can count as all or part of the 30 required hours for up to 12 months. However, some TANF recipients who applied for HPOG may have previously used some or all of their countable 12 months of training in other programs. In addition, after 12 months, vocational training hours only count toward the work requirement over and above 20 hours of a "core" work activity, such as work or subsidized employment. Therefore, participation in HPOG training programs may make it more difficult for TANF recipients to meet the 20 hours of "core" work activity requirement. Similarly, participation in the 20 hours of "core" work activity requirement may make it more difficult for TANF recipients to attend HPOG

training programs. Also, basic skills education (such as remedial math or reading) does not count as a "core" work activity and is only countable at all for those without a high school degree or equivalent.
While federal work participation requirements restrict participation in education and training activities, states have the flexibility to implement more restrictive rules, and many do. This variability in TANF work requirements may partly explain the variability in TANF recipient participation rates across HPOG programs. For example, some HPOG programs are located in states and localities that have adopted a "work first" orientation—the idea that recipients should search for and take any available job to gain work experience and generate income. See Alyssa Rulf Fountain, Alan Werner, Maureen Sarna, Elizabeth Giardino, Gretchen Locke, and Pamela Loprest, *Training TANF Recipients for Careers in Healthcare: The Experience of the Health Profession Opportunity Grants (HPOG) Program* (OPRE 2015-89) (Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2015).

64 See Appendix Exhibit D-17.

65 See Appendix Exhibit D-18.

66 See, for example Forest P. Chisman and Gail Spangenberg, *To Reach the First Rung and Higher: Building Healthcare Career Opportunities for Low Skilled Disadvantaged Adults* (New York: Center for Advancement of Adult Literacy (CAAL), 2005), http://www.caalusa.org/firstrungandhigher.pdf; and Louis Jacobson and Christine Mokher, *Pathways to Boosting the Earnings of Low-Income Students by Increasing Their Educational Attainment* (Washington DC: The Hudson Institute, 2009).

67 See Appendix Exhibits D-19 and D-20.

68 *Source:* HPOG Impact Study site visits, 2014.

69 *Source:* HPOG Grantee survey, 2014 Q7.13a.

70 *Source:* HPOG Impact Study site visits, 2014.

71 See Appendix Exhibit D-24.

72 See Appendix Exhibit D-25.

73 *Source:* HPOG Grantee survey, 2014, Q7.5A.

74 Source: HPOG Impact Study site visits, 2014.

75 David J. Fein, *Career Pathways as a Framework for Program Design and Evaluation: A Working Paper from the Innovative Strategies for Increasing Self-Sufficiency (ISIS) Project* (OPRE Report No. 2012-30) (Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2012).

76 *Source:* HPOG Grantee survey, 2014, Q7.12.

77 *Source:* HPOG Grantee survey, 2014, Q7.12.

78 *Source:* HPOG Grantee survey, 2014, Q7.12.

79 Reported characteristics are of all participants through October 1, 2014. Characteristics of the sample of participants with 18 months post-enrollment data (the sample used in other sections of this report) can be found in Appendix Exhibit D-28.

80 Approximately 20 percent of participants are missing this information. These participants may not have been administered an assessment for literacy or numeracy.

81 Federal poverty level guidelines for 2013 can be found at http://aspe.hhs.gov/poverty/14poverty.cfm.

82 *Source:* HPOG Impact Study site visits, 2014.

83 *Source:* HPOG Grantee survey, 2014, Q8.6.

84 *Source:* HPOG Impact Study site visits, 2014.

85 *Source:* PRS, 2014.

86 OFA HHS, *Health Profession Opportunity Grants.*

87 OFA HHS, *Health Profession Opportunity Grants,* 2.

88 *Source:* HPOG Grantee survey, 2014, Q8.14.

89 Other aspects of the career pathways approach include, for example, integrating basic education into occupational training, providing comprehensive support services, and developing relationships with employers.

90 *Source:* HPOG Impact Study site visits, 2014.

91 *Source:* HPOG Grantee survey, 2014, Q8.7.

92 *Source:* HPOG Grantee survey, 2014, Q8.11.

93 *Source:* HPOG Grantee survey, 2014, Q8.13.

[94] *Source:* PRS, 2014.
[95] Note that 32 percent of participants were in school at the time they enrolled in HPOG (see Exhibit 3-14 in Chapter 3). The data do not specify what course or program these individuals were engaged in at enrollment and whether it was a healthcare training course. Some may have been in school for non-healthcare occupational training or in basic skills instruction and may have begun healthcare training after enrolling in HPOG. Others may have continued healthcare training begun before enrolling in HPOG.
[96] This percentage reflects those who have not yet completed any healthcare training and are participating in a training course 18 months after enrollment. This percentage does not include participants who completed one training course within the first 18 months and went on to participate in another training course.
[97] A limitation of these data is that some participants who appear to be in training at 18 months may have dropped out without informing the program. Over time, as training programs end and grantees update their records, some of those instances recorded as "still in training" may change status to "did not complete."
[98] Healthcare training completion by subgroup can be found in Appendix Exhibit D-41.
[99] Bureau of Labor Statistics, U.S. Department of Labor, "Registered Nurses," *Occupational Outlook Handbook, 2014-15 Edition*, http://www.bls.gov/ooh/healthcare/registered-nurses.htm.
[100] Note that time to complete a training course is not the same as time spent in an HPOG program.
[101] The first and last day of training is reported by HPOG grantees for each participant's training courses. For courses that require multiple classes or semesters, the reported length may include periods when participants were not actually in training, for example, during summer breaks.
[102] Average length to completion is calculated using all completed training programs in the PRS and not just those completed within 18 months of enrollment.
[103] The PRS does not track whether the participant was in a particular occupational training at the start of the HPOG program, only whether he or she was in school at that time. Because registered nursing training is usually a four-year program, we can safely infer that some of those completing that training within 18 months after enrolling in HPOG were already engaged in training.
[104] *Source:* PRS, 2014.
[105] Industry-recognized credentials do not necessarily include certifications of course completion awarded by training institutions.
[106] *Source:* PRS, 2014.
[107] *Source:* PRS, 2014.
[108] PRS, 2014, identifies participation and completion of healthcare occupation training, including the type of training, but does not explicitly include information on whether these training courses build on each other in a career ladder. Individuals who take multiple training courses simultaneously or start a second training without completing the first *are not included in this section.*
[109] Fein, *Career Pathways as a Framework for Program Design and Evaluation*.
[110] *Source:* HPOG Grantee survey, 2014, Q9.1.
[111] *Source:* HPOG Grantee survey, 2014, Q9.4.
[112] The minimum was one full-time case manager and the maximum was 15. See Appendix Exhibit D-42.
[113] The minimum was one part-time case manager and the maximum was six. See Appendix Exhibit D-42.
[114] *Source:* HPOG Grantee survey, 2014, Q9.3.
[115] *Source:* HPOG Grantee survey, 2014, Q9.3.
[116] Specifically, on a 7-point Likert scale with 1="none of my time" and 7="most of my time," 60 percent of front-line staff in the average program reported a 5, 6, or 7 for "providing career information and advice" and 55 percent reported a 5, 6, or 7 for "helping participants develop career goals."
[117] *Source:* HPOG Management and Staff survey, 2014, Q18-S.
[118] *Source:* HPOG Management and Staff survey, 2014, Q20-S.
[119] *Source:* HPOG Management and Staff survey, 2014, Q21-S.
[120] Note that the HPOG Impact Study is estimating the impact of peer support groups on key program outcomes.
[121] Alan Werner, Catherine Dun Rappaport, Jennifer Bagnell Stuart, and Jennifer Lewis, *Literature Review: Career Pathways Programs* (OPRE Report #2013-24) (Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2013).
[122] *Source:* HPOG Impact Study site visits, 2014.
[123] *Source:* HPOG Grantee survey, 2014, Q8.16.

[124] *Source:* HPOG Grantee survey, 2014, Q8.18.
[125] *Source:* HPOG Grantee survey, 2014, Q.9.8.
[126] *Source:* HPOG Grantee survey, 2014, Q9.9.
[127] Fein, *Career Pathways as a Framework for Program Design and Evaluation*.
[128] *Source:* HPOG Grantee survey, 2014, Q9.14.
[129] *Source:* HPOG Grantee survey, 2014, Q9.15.
[130] *Source:* HPOG Grantee survey, 2014, Q7.10a, 7.10b.
[131] *Source:* HPOG Grantee survey, 2014, Q9.17.
[132] *Source:* HPOG Grantee survey, 2014, Q9.18.
[133] Note that the HPOG Impact Study is estimating the impact of non-cash incentives on key program outcomes.
[134] *Source:* HPOG Impact Study site visits, 2014.
[135] *Source:* HPOG Grantee survey, 2014, Q9.19. Note that the HPOG Impact Study is estimating the impact of using program discretionary funds for emergency assistance on key program outcomes.
[136] *Source:* HPOG Grantee survey, 2014, Q9.19, 9.11.
[137] *Source:* HPOG Grantee survey, Q9.13a.
[138] HPOG funds cannot be used for medical care unless it is an integral but subordinate part of a social service for which grants may be used.
[139] *Source:* HPOG Grantee survey, 2014, Q. 9.24.
[140] *Source:* HPOG Grantee survey, 2014, Q9.25.
[141] *Source:* HPOG Management and Staff survey, 2014, Q18S.
[142] *Source:* HPOG Grantee survey, 2014, Q9.22.
[143] *Source:* HPOG Impact Study site visits, 2014.
[144] *Source:* HPOG Impact Study site visits, 2014.
[145] *Source:* HPOG Grantee survey, 2014, Q9.22.
[146] *Source:* HPOG Grantee survey, 2014, Q 9.25.
[147] Note that 43 percent of HPOG participants received soft-skills training as preparation for training and employment. See Exhibit 4-4.
[148] Sample is 12,614 HPOG participants with 18 months post-enrollment data as of October 1, 2014.
[149] *Source:* HPOG Grantee survey, 2014, Q9.27.
[150] For the purposes of this study, HPOG programs were asked to identify local area employers that had hired participants or had been contacted by the program about hiring participants. Employer-partners are those employers who were also involved in HPOG program planning or operations. When asked to identify employer partners, 39 percent of HPOG programs (19 programs) identified employers as partners or stakeholders.
[151] *Source:* HPOG Grantee survey, 2014, Q9.28.
[152] Note that past literature has shown that training participants commonly experience a "dip" in earnings right before entering the training program, referred to as an Ashenfelter's dip (Orley Ashenfelter and David Card, "Using the Longitudinal Structure of Earnings to Estimate the Effect of Training Programs," *Review of Economics and Statistics* 67 (1985): 648–60). The effect of any dips is mitigated somewhat here by examining earnings four quarters before entry. However, future experimental results will show whether training caused earnings to increase for the treatment group. This exhibit does not include individuals who had enrolled in HPOG and had not completed a training course but remained in training 18 months after enrollment. It also excludes those who never began a training course.
[153] For example, the reasons why individuals drop out of training also may affect their success in finding a job.
[154] Earnings in the exhibit combine earnings across multiple jobs. Any positive amount of earnings in the quarter is included. Earnings in a quarter were top-coded at $30,000 to limit skewing of averages by potential data error outliers.
[155] These figures must be interpreted with caution, given the large amount of missing data on employment status at the time that participants left the program and variability in the way that program operators defined "program exit."
[156] Program exit indicates that a participant is no longer enrolled in HPOG. The exit date is either (1) the date a participant is determined by the program to have completed HPOG or (2) for participants who drop out or exit the program early (before completion), the date on which a participant received his or her last service funded by

the program or a partner program. Not all participants who have completed healthcare training have exited the program. In some programs these individuals may continue to receive program services or continue on to another training course. While for many participants program exit coincides with their completion of training or dropping out (as defined using the PRS data**)**, in some cases the two differ, including for individuals who completed a training course but went on to a second training course.

157 Note that many of those enrolled in longer-term training for higher-paying jobs (e.g., registered nurse) were still in training at 18 months. To the extent that those individuals complete training and obtain employment, the average wage may rise with longer-term follow up.

158 Michael Lipsky, *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services* (New York: Russell Sage Foundation, 1980). See also Evelyn Brodkin, "Inside the Welfare Contract: Discretion and Accountability in State Welfare Administration," *Social Service Review* 71 (1997): 1–33.

159 Howard S. Bloom, Carolyn J. Hill, and James A. Riccio, "Linking Program Implementation and Effectiveness: Lessons from a Pooled Sample of Welfare-To-Work Experiments," *Journal of Policy Analysis and Management* 22, no. 4 (2003): 551–575.

160 Note that the HPOG Impact and PACE studies use these data to analyze relationships between staff attitudes and practices and program impacts.

161 Bloom, Hill and Ricco, "Linking Program Implementation and Effectiveness."

162 Ibid.

163 HPOG Management and Staff survey, 2014, Q73, 24.

164 HPOG Management and Staff survey, 2014, Q29.

165 HPOG Management and Staff survey, 2014, Q56, 53-S.

166 HPOG Management and Staff survey, 2014, Q62, 80.

167 *Source:* HPOG Impact Study site visits, 2014.

168 *Source:* HPOG Impact Study site visits, 2014.

169 See Appendix Exhibit D-13.

170 See Appendix Exhibit D-14.

171 OFA HHS, *Health Profession Opportunity Grants to Serve TANF Recipients and Other Low-Income Individuals*.

172 Employment data are observational and should not be interpreted as impacts caused by HPOG.

173 For a description of the HPOG Impact Study and other related ACF evaluation efforts see Appendix A.

174 The HPOG Impact Study Final Report is scheduled for release in 2017.

175 CPIO reports are scheduled for release in 2017**–**2019.