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Practice Brief

Responding to the COVID-19 Pandemic: Tribal HPOG 2.0 Grantees' Program Adaptations

This practice brief is the fifth in a series developed by the Tribal HPOG 2.0 evaluation team. These briefs disseminate important lessons learned and findings from the Evaluation of the Tribal Health Profession Opportunity Grants (HPOG) 2.0 Program, which is sponsored by the Office of Planning, Research, and Evaluation within the Administration for Children and Families (ACF). The Tribal HPOG 2.0 Program supports demonstration projects that provide eligible individuals with the opportunity to obtain training and education for occupations in the healthcare field that pay well and are expected to either experience labor shortages or be in high demand.[1] This practice brief examines how the Tribal HPOG 2.0 grantees adapted their programs in response to the COVID-19 pandemic.

The Health Profession Opportunity Grants (HPOG) Program supports demonstration projects that provide Temporary Assistance for Needy Families (TANF) recipients and other low income individuals with the opportunity to obtain education and training in healthcare professions. In 2010, the Administration for Children and Families (ACF) awarded the first round of HPOG grants, referred to as HPOG 1.0, to 32 organizations, including five Tribal organizations. In September 2015, ACF awarded a second round of HPOG grants, referred to as HPOG 2.0, to 32 organizations, including five Tribal organizations.[1] The five Tribal HPOG 2.0 grantees are Cankdeska Cikana Community College (CCCC), Cook Inlet Tribal Council, Inc. (CITC), Great Plains Tribal Leaders Health Board (GPTLHB), Turtle Mountain Community College (TMCC), and Ute Mountain Ute Tribal (UMUT).[2]

In March 2020, during the fifth year of HPOG 2.0 program implementation, the World Health Organization declared the COVID-19 outbreak a pandemic. For the Tribal HPOG 2.0 grantees, this public health emergency and the associated closures and social distancing guidelines led to changes in program implementation across a number of areas, including program staffing, recruitment and enrollment of program participants, healthcare training and certification, and participant supports. It also affected grantees' employer partnerships and healthcare workforce needs in local labor markets. This practice brief examines how the COVID-19 pandemic affected the

[1] HPOG was authorized by the Affordable Care Act (ACA), Public Law 111-148, 124 Stat. 119, March 23, 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). The second round of grant awards has been extended until September 29, 2021.

[2] For a description of these grantees' programs, including characteristics of their participants: Hafford, C., Fromknecht, C., Dougherty, M., Holden, C., Maitra, P., MacLean, K., Chmelir, S. Forthcoming. Tribal Health Profession Opportunity Grants (HPOG) 2.0 Evaluation: Final Report, OPRE Report 2021-XX, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

implementation of Tribal HPOG 2.0 programs from March 2020 through September 2020, with a focus on the steps that grantees took to adapt their programs in response. Findings presented in this brief primarily come from qualitative data collected during the fourth annual grantee site visits. This brief also draws on quantitative data collected through the HPOG Participant Accomplishment and Grant Evaluation System (PAGES) where appropriate.

TRIBAL HPOG 2.0 TIMELINE

Implementation of Tribal HPOG 2.0 was originally set to occur September 30, 2015 - September 29, 2020. In February 2020, the ACF Office of Family Assistance notified grantees of the opportunity to apply for a 12-month extension and supplemental funding. In April 2020, all five Tribal HPOG 2.0 grantees were awarded the extension and supplemental funding, extending the implementation period through September 29, 2021.

The **Evaluation** period of Tribal HPOG 2.0 remained October 1, 2015 - September 30, 2020. Therefore, the evaluation includes only participants who enrolled on or prior to September 30, 2020 and who consented to participate in the evaluation. Because implementation of Tribal HPOG 2.0 continued beyond this date, we are unable to fully report outcomes related to the number of trainings started and completed after September 2020.

ONSET OF THE COVID-19 PANDEMIC: IMPLICATIONS AND RESPONSE AMONG STATES, TRIBES, AND GRANTEES

Within the United States, the spread of the virus across the population and the response by state and Tribal governments varied. As shown in Figure 1, the response varied in the four states where the Tribal HPOG 2.0 grantees are located. Colorado, where UMUT is located, and Alaska, where CITC is located, both issued a stay-at-home order in March 2020 and April 2020, respectively. In contrast, North Dakota, where CCCC and TMCC are located, and South Dakota, where GPTLHB is located, did not issue state-wide stay-at-home orders; however, local municipalities and Tribal governments instituted restrictions related to COVID-19. For three of the grantees, Tribal leaders issued emergency orders as shown below.

Figure 1: State, Local, and Tribal Responses to the COVID-19 Pandemic by Grantee

Grantee	State of Grantee	State Response	Local/Tribal Organization Response
UMUT	Colorado	Issued a stay-at-home-order.[1]	Local and Tribal organizations instituted closures per state orders.
CITC	Alaska	Issued stay-at-home and social distancing mandate and an order prohibiting intrastate travel.[2]	
GPTLHB	South Dakota	No state-wide stay-at-home orders issued for South Dakota or North Dakota.	Oglala Sioux Tribe instituted traffic checkpoints on reservation borders,[3] declared a state of emergency on March 10,[4] and ordered a lockdown on the Pine Ridge reservation after the first case was reported there on April 7.[5]
TMCC	North Dakota		Turtle Mountain Band of Chippewa issued a *Proclamation of Health State of Emergency in response to COVID-19 Pandemic* on April 11.[6] In this proclamation, Tribal leadership requested that individuals stay at home and required that non-essential business and operations cease.
CCCC	North Dakota		Spirit Lake Nation, home of CCCC, issued an Executive Order establishing restrictions and closures to slow the spread of COVID-19 on April 16.[7]

Disproportionate Impact of COVID-19 and the Resilience of Tribal Communities

The COVID-19 pandemic underscored the historic economic and health disparities facing Tribal nations, as well as the continued strength and resilience of Tribal communities. Prior to the onset of the COVID-19 pandemic, American Indian and Alaska Native (AI/AN) populations experienced a range of health and structural inequities, including higher rates of chronic diseases, such as asthma, heart disease, diabetes, and obesity.[8,9] Disproportionate rates of these chronic diseases in conjunction with economic disparities – rooted in a history of colonization, disinvestment, and historical trauma[10,11] – put AI/AN populations at increased risk for serious illness and inadequate care if infected by COVID-19.[12] Data from 23 states collected between January 31, 2020 - July 3, 2020, revealed that the cumulative incidence of COVID-19 among AI/AN populations was 3.5 times that of non-Hispanic white populations.[13] Another analysis showed that lack of access to indoor plumbing and lack of public health messaging translated to Indigenous languages were key factors associated with increased incidence.[14] High rates of COVID-19 stressed the already limited healthcare resources available to Tribal communities. [15, 16] Furthermore, the pandemic caused the death of many older adults who safeguarded Tribal languages, history, and traditions.[15, 16]

As the COVID-19 pandemic continued, business closures and transitions to remote work and learning had a deep impact on Tribal communities with limited resources. Casinos and other businesses on Tribal lands closed, limiting the funds available for Tribal governments to support healthcare and other public services.[17] As of 2018, approximately one third of AI/AN populations lacked access to broadband internet,[18] making the move from in-person to remote learning for Tribal colleges and other academic institutions in rural areas particularly difficult.[19, 20]

In the face of these challenges, Tribes and Tribal organizations worked together to share critical information and resources. In April 2020, the National Congress of American Indians began convening virtual forums to showcase innovative responses from Tribal nations.[21] In that same time frame, the National Indian Health Board began offering an array of webinars and resources for Tribal leaders, including expert panels on mitigating the risk of COVID-19 in Tribal communities, response plans developed by Tribal leaders, information on funding opportunities, as well as opportunities to collaborate with federal agencies.[22] Fifteen Tribal communities across the U.S. in conjunction with Indigenous faculty associated with the Johns Hopkins Center for American Indian Health developed and disseminated COVID-19 resources adapted for Tribal communities.[23] As described later in this brief, Tribal HPOG 2.0 grantees also responded to the COVID-19 pandemic, demonstrating perseverance and resilience in the midst of challenging circumstances.

Tribal HPOG 2.0 Institutional Response: Grantees' Shift to Remote Operations

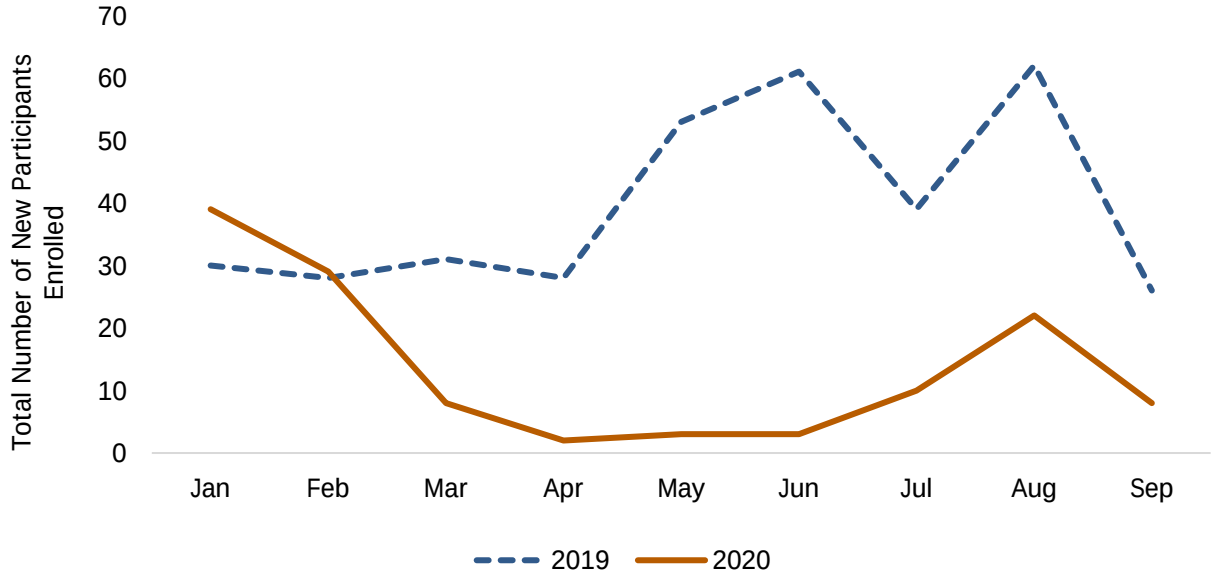
In spring 2020, the Tribal colleges, learning centers, and public health and human service organizations that administer the Tribal HPOG 2.0 programs closed their offices; staff across all five grantee programs began working remotely. Grantee institutions began to slowly "open-up" depending on the reduced incidence of COVID-19 cases, but also "closed" again when positive cases increased. By mid-May, some CITC staff, including the CITC HPOG staff, began working in the office on a part-time basis depending on their childcare needs and whether they were among a high-risk population for contracting COVID-19. UMUT staff similarly began returning to the office in late June 2020 and conducted in-person activities (following CDC guidelines) from July 2020 to October 2020 before moving to remote operations again. By September 2020, TMCC staff and GPTLHB staff were still working primarily from home and CCCC staff worked from home on an intermittent basis. In September 2020, GPTLHB staff noted that GPTLHB was one of the only organizations in Rapid City still to have a remote work policy in place.

Tribal HPOG 2.0 Enrollment

For the remainder of the spring 2020 semester, grantees and academic training partners postponed trainings or switched to virtual instruction. According to grantees, the cancellation or delay of training programs in the spring of 2020 was a primary challenge to recruiting and enrolling participants. Our

analysis of data from PAGES showed that fewer participants enrolled in Tribal HPOG 2.0 between March and August of 2020 compared to the same period in 2019 (Figure 2).[3]

Figure 2: Total Number of New Tribal HPOG 2.0 Participants Enrolled January-September 2019 vs January-September 2020



The blue line, representing new Tribal HPOG 2.0 enrollments in 2019, shows a steady rate of enrollment of participants in January through April, followed by an overall increase through August and a decrease in September. This trend reflects the academic year that most grantee training programs follow, enrolling students in summer prior to the start of school in the fall. In contrast, the orange line, which illustrates the number of new participants enrolled in Tribal HPOG 2.0 in 2020, shows a decline from January through April 2020. After initial closures in March and April of 2020, grantees and training partners adapted to the circumstances by shifting their training to a virtual format. In summer and fall of 2020, institutions began to offer in-person instruction with social distancing protocols in place. Although many programs had returned to in-person instruction for the fall semester, some remained virtual. This gradual reopening is reflected in the increase in enrollment numbers beginning in June 2020 in Figure 2 above.

Enrollment trends should be interpreted in the context of when the COVID-19 pandemic occurred in the program implementation period (see Tribal HPOG 2.0 Timeline description above). In late 2019, prior to the onset of the COVID-19 pandemic, grantees had not yet received the opportunity to apply for an extension and were thus preparing for to finish their implementation in the next year (i.e., by September 29, 2020). Therefore, decreased enrollment across grantees during 2020 as compared to 2019 may have not only been a response to the COVID-19 pandemic, but also reflective of the grant life cycle, which

[3] We included participants in our analysis if at the time of our PAGES data extraction they were eligible, active, enrolled on or before 9/30/2020, and provided consent to participate in the study.

typically includes a ramp-up period, followed by steady implementation, before winding down in the later years.

Tribal HPOG 2.0 Training Completion and Licensure

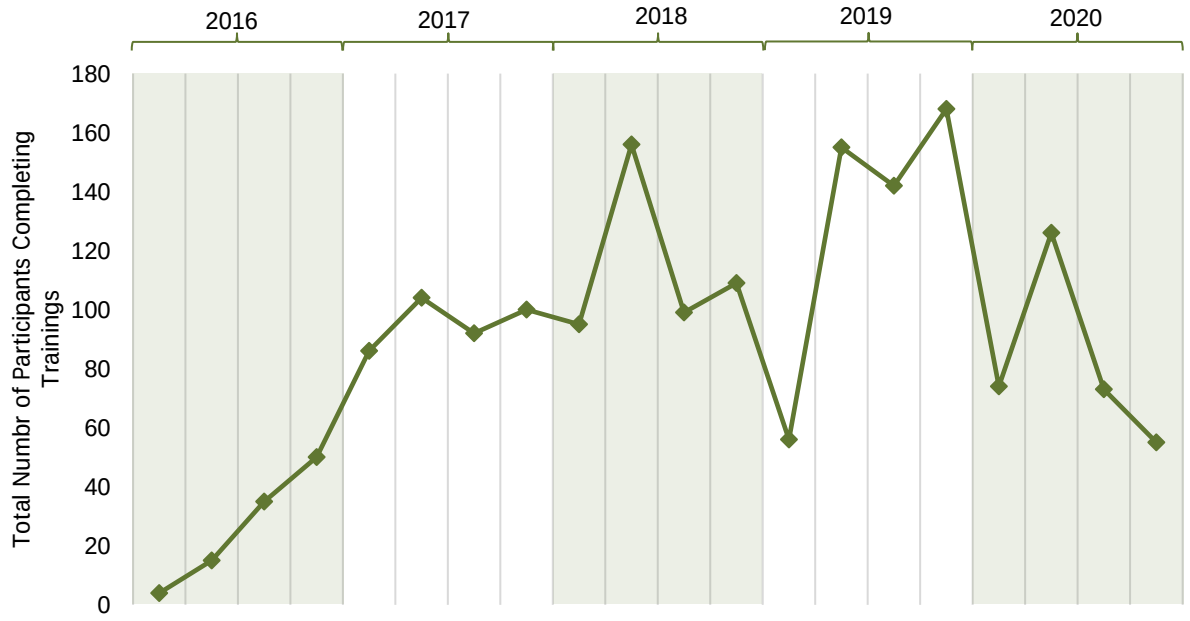
During the spring 2020 semester, most clinical partners and affiliates (e.g., rehabilitation centers, nursing homes, and long-term care facilities) closed to all but essential staff, constraining participants' ability to meet clinical practicum requirements.[4] In many cases, grantees and training partners postponed clinical practicums until the summer.

Across states and healthcare training programs, there was variation in the administration of licensing exams. For example, the state of Colorado offered temporary CNA licenses, while the state of Alaska did not. The state of North Dakota recognized the challenges associated with completing clinical practicum requirements during the pandemic and adjusted licensing requirements to allow students in some training programs to graduate with fewer clinical hours than previous years. For example, one TMCC clinical affiliate reported that Phlebotomy students were required to complete half as many clinical hours and blood draws during this period. According to students and faculty interviewed, many students who were delayed in completing their clinical training requirements were also delayed in taking their licensing exams. However, some students reported no challenges, and GPTLHB and UMUT staff reported that students in high-level nursing degree programs were able to complete their clinical hours and take their licensing exams with little to no delay.

Figure 3, which depicts the total number of Tribal HPOG 2.0 participants completing training from January 2016 through December 2020, shows yearly spikes in training completion in April-June (Q2) of each year; Q2 of 2020 saw a similar spike in training completion, but this was less pronounced than either 2018 or 2019.[5] [6] Of note, individuals enrolled in September 2020 may not have yet completed a healthcare training and would thus not be reflected this figure.[7]

[4] Many training programs (e.g., CNA programs) require that participants complete a specified number of hours of hands-on clinical practice (i.e., clinical practicums).
[5] Although only participants who enrolled on or prior to September 30, 2020 are included in the evaluation, we are able to report on training completions after September 30, 2020 for individuals enrolled prior to this point.
[6] All grantees offered healthcare training programs along the nursing career pathway and some offered training along other career pathways as well: emergency response, phlebotomy-medical lab technician, health administration, and health and fitness. These programs varied in length and included basic bridge programs, short-term certificate programs, one- to two-year certificate into associate's degree programs, and bachelor's-level education or above.
[7] This is because data were extracted from PAGES for the evaluation before the end of the implementation period; thus participants who completed after our data extraction are not included in Figure 3 (please see the Tribal HPOG 2.0 Timeline exhibit on page 2 for more information on the timing of the implementation period the evaluation period).

Figure 3: Total Number of Tribal HPOG 2.0 Participants Completing Trainings January 2016-December 2020



TRIBAL HPOG 2.0 PROGRAM ADAPTATIONS

Although the COVID-19 pandemic and its disproportionate impact on Tribal communities presented many challenges, grantee staff and their partners adapted their programs to continue recruiting, supporting, and training participants despite the unprecedented circumstances.

Program Staffing Changes and Supports

In response to work-from-home policies, grantee staff shifted their communication with one another to virtual formats, including emails, phone calls, and virtual meetings via web-conference software, such as Zoom. To maintain open lines of communication, staff set up regular virtual meetings. Some staff felt that these regular meetings helped foster open communication, which was critical for adapting program processes to support students in response to the pandemic. While most staff reported few challenges with the shift, a few described the challenge of balancing remote work with demands associated with their own children's virtual schooling.

Across grantees, there was largely continuity in staffing structure, but some staff took on additional responsibilities. For example, the GPTLHB Program Manager took on a part-time role with the Health Board's Emergency Operations Center as part of GPTLHB's COVID-19 response. As a result, a Student Success Coach took on the Program Manager role while still maintaining her existing responsibilities supporting students. TMCC

Key Staffing Adaptations

- Establishing regular virtual meetings among staff to maintain open lines of communication
- Coordinating responsibilities to fill in for other staff or implement programmatic adaptations

Placement Coordinators, who typically provide participants with employment assistance supports, took on additional responsibilities with managing the program's Facebook page and assisting the Success Coach with the application and intake process. Additionally, several TMCC staff described taking on new responsibilities or helping their colleagues with their work. As described by one staff member, *"we all have our own role in the HPOG program, but if we need to, there are other ways we will help each other out."*

Recruitment and Enrollment Adaptations

Cancellation or delay of training programs, shifts away from traditional recruitment methods, and adherence to social distancing guidelines posed challenges. For example, grantees were not able to hold any in-person recruitment events and had to delay marketing campaigns that were set to launch in the spring. Despite these challenges, grantees were still able to enroll students into training programs for the fall 2020 semester. Grantees adapted their recruitment approach by shifting from in-person to virtual methods. TMCC and GPTLHB made greater use of social media to recruit students. CCCC staff worked with a partner to offer a virtual information session about the program. UMUT staff were able to conduct remote recruitment for an upcoming Medical Assistant course by emailing recent CNA and Emergency Medical Response completers to identify individuals interested in furthering their education.

Key Enrollment and Orientation Adaptations

- Using social media and targeted email listservs to recruit participants
- Shifting application and enrollment processes to a virtual format and providing assistance to students navigating this new platform
- Providing orientation virtually through online videos and platforms, such as Canvas

Despite cancellations, postponements, and recruitment limitations, grantees and program staff reported that interest among prospective students remained strong. Grantee staff at GPTLHB, TMCC, and UMUT reported that the number of students applying to (though not necessarily enrolling in) training programs was similar to previous years, and in some cases higher. Some grantees shifted their application and enrollment processes to a virtual format. For example, CITC staff conducted pre-screening assessments over the phone and then sent application packets to those determined to be initially eligible. TMCC staff transitioned their application process online and provided technical assistance to applicants who needed help navigating the application. In addition, TMCC staff developed a video tutorial showing how to complete the online application on both a desktop and a mobile device.

Staff oriented participants to the program virtually as well. For example, GPTLHB used Canvas (a learning management system that supports online learning and teaching) to conduct their orientation, and TMCC directed students to orientation videos posted on their program's Facebook page. CITC worked with a partner to move their six-day introductory program, the PATH Academy, to an online format after a brief period of suspension. CITC also adapted the classroom (i.e., didactic) portion of this training to focus on timely topics such as working in a crisis, recognizing and providing resources, and working in high-risk situations as a healthcare professional.

Healthcare Training Adaptations

As noted above, grantees and training partners adapted to the circumstances by shifting their trainings to a virtual format. For example, the CITC staff worked with their training partners, the Alaska Vocational Training Center/Alaska CNA and Caregiver Training Academy, to move their CNA and Personal Care Aide trainings online, respectively, by mid-April 2020. GPTLHB forged a new partnership with We Care (a national training vendor) to offer an online CNA training. TMCC supported the transition to remote learning by providing instructors with training for remote instruction and developing how-to videos on the Canvas platform for instructors to reference. Instructors found creative ways to deliver content virtually. For example, one GPTLHB partner found an online platform for conducting patient-care simulations for nursing students. Instructors also offered lectures through a mix of media, including pre-recorded and live lectures, publicly-available YouTube videos, and online activities and homework. Additionally, as a result of the pandemic, CITC began offering a new training program to Tribal HPOG 2.0 participants in contact tracing in partnership with University of Alaska Anchorage.

Key Training Adaptations

- Forging new partnerships with online learning vendors
- Providing instructors with training on remote instruction
- Using online platforms for simulations
- Delivering content through a mix of virtual mediums (e.g. synchronous and asynchronous).
- Increasing training options to include contact tracing
- Using hybrid models with virtual didactic training and targeted hands-on learning in-person with social distancing protocols in place

The gradual re-opening and shift back to in-person learning—with social distancing protocols in place—required additional adaptations. In many cases, adherence to these protocols limited the number of students who could attend trainings in-person. UMUT's training partners implemented a hybrid model of instruction for the fall semester, offering a mix of remote instruction and some on-campus instruction for specific programs with hands-on components. To adhere to public health guidelines, they offered in-person instruction in small groups. TMCC approved limited numbers of staff, faculty, and students to come to campus on an as-needed basis, for example, to complete the laboratory components of their spring semester courses.

Healthcare Training Challenges and Tradeoffs

The shift to remote learning came with several tradeoffs for students and instructors. In some cases, a shift to online learning allowed students the flexibility to complete coursework while also taking care of family obligations (e.g., students could choose to complete coursework at a time that fit their schedules). Students balancing their healthcare training with full- or part-time work schedules also found that the online, asynchronous format made it easier to complete coursework while maintaining employment. In contrast, for some students living in households with many other family members and/or taking care of school-aged children, engaging with online learning was particularly challenging.

Although some students gave positive reviews of the training they received through online formats, others felt they missed opportunities to connect and communicate with their classmates and instructors.

One instructor explained how opportunities for interaction are particularly important for her students: "*Our population of students has familial-based culture, they really thrive on connectivity, on being next to each other."* For their part, other instructors reported that it was challenging to engage students online, explaining that they could not provide the same depth and detail that they did when teaching in-person.

Although some students felt missed opportunities for in-person hands-on training limited the quality of their education, some instructors noted that virtual practicums provided new experiences to which students might not otherwise be exposed. One Licensed Practical Nurse (LPN) instructor, who integrated virtual simulations into clinical practicums, explained *"It's not the same, [but students] had more experiences and exposure to a variety of clients and patients then they would in our clinical settings."*

Key Adaptations to Participant Supports

- Proactively reaching out to assess and address basic needs
- Providing loaner laptops and wifi hotspots and increasing access to print materials
- Shifting the provision of supports from in-person to virtual modes of communication
- Offering referrals for mental health counseling
- Honoring Tribal culture and and participants' accomplishments through online events and small group gatherings
- Providing job search assistance while students awaited completing clinicals and licensing exams.

Participant Supports

Prior to the pandemic, grantees offered a variety of academic (e.g. tutoring) and non-academic (e.g., transportation) supports to participants. In response to the COVID-19 pandemic, grantees adapted these supports to meet participants' short-term and ongoing needs.

Addressing Immediate Needs. At the onset of the COVID-19 pandemic, grantee staff diligently reached out to participants to ensure their immediate needs were met. For example, at the start of the pandemic TMCC staff participated in an outreach campaign to connect with students to ensure they had the support they needed. CITC staff who proactively reached out to participants during the COVID-19 stay-at-home orders (effective March 28-April 21) were able to provide emergency support services in addition to existing supports, which helped the programs to develop stronger relationships with participants. These emergency support services included assistance with housing, utilities, and food.

Providing technological support was a major way in which grantees assisted students as they transitioned to online learning. Most grantee programs or grantee institutions offered loaner laptops to students to ensure they could access online classes and participate in career readiness services. Some grantee institutions and their partners, as well as Tribes, offered community hotspots where students could access Wi-Fi. In a few cases, grantee staff provided support to students without access to Wi-Fi by mailing them hard-copy materials.

Supporting Ongoing Needs. Throughout the COVID-19 pandemic, grantees and their training partners continued to offer tutoring and mentoring to facilitate students' academic success; however, they often

provided these supports virtually, as opposed to in-person. For example, instructors hosted study groups and tutoring via Zoom and used other tools like online flashcards and games to assist students. Case management staff also transitioned to supporting participants in an ongoing way through virtual modes of communication (e.g., phone, text, email, social media, and video conferencing).

Although many of the supports available to participants were the same as before the COVID-19 pandemic, participants' use of these supports changed. Prior to the pandemic, transportation services were among the most common forms of support that grantees provided; however, the shift to remote learning led to decreased need for these services. There was also a decreased need for childcare assistance, since many participants were able to stay home with their children while pursuing online learning.

As the COVID-19 pandemic persisted, grantee staff and their partners sought ways to address challenges related to stay-at-home orders and social isolation. GPTLHB's partner Oglala Lakota College (OLC) hired a Native American mental health counselor. Staff at OLC explained that addressing trauma and related stressors that are common among students was more important than ever: *"We've got families [with] 7-11 kids in the house, all educated in home online, and they can't handle the stress."* A grantee staff member similarly noted the stress that students experienced and how she worked with students as they encountered barriers: *"Some days I just have to sit and talk through it because there was nothing I can do on my end. We just had no other options and alternatives. Some days it was listening to them because of what this was causing for them. Obviously their plans just went out the window."*

> "Nobody predicted that [the pandemic] was going to happen, so when it did happen I felt like it was a blessing that I did take this class. I've been making more money and have been able to actually save money. My fiancé was like 'Thank God you took that class, we could have both been out of a job.' [I was] able to support us until my fiancé found a job."
>
> -Tribal HPOG 2.0 Participant

As a result of the pandemic, events could not occur in-person, making it particularly challenging to engage in graduation and pinning ceremonies, foster connections, and partake in cultural practices. Despite these challenges, grantees and their partners adapted by hosting events online and finding other ways to celebrate students' accomplishments. For example, GPTLHB's partner, South Dakota State University, offered a virtual talking circle to help address students' anxiety around the COVID-19 pandemic. They also offered their "Blessing of the Hands" ceremony online, led by a Lakota elder. Rather than holding a graduation ceremony with participants and their families, another Tribal HPOG 2.0 grantee celebrated each student: *"We went to the office and they just gave us a gift, a tablet as a graduation gift. [My college] usually does a ceremony, but due to COVID that changed a lot of things. We went out to eat for supper with [HPOG 2.0 staff], me and another colleague. That was good."*

While participants awaited the opportunity to take exams and licensure, two grantees connected students to online career readiness trainings and disseminated employment opportunities that students could pursue in the interim (e.g., working as contact tracers). For example, CITC HPOG Employment Specialists connected students with online workshops on interviewing, as well as on phone and email etiquette.

CHANGES IN EMPLOYER PARTNERSHIPS AND OPPORTUNITIES FOR PARTICIPANTS

The COVID-19 pandemic affected local labor markets by increasing demand for some healthcare occupations, limiting others, and opening up new opportunities for contact tracing and testing.[24] [25] [26] Grantees reported that some occupations were in high demand, for example, hospitals and long-term care facilities needed to hire additional nursing staff to care for COVID-19 patients. Several grantees explained that nursing homes and assisted living facilities sought additional staff to ensure they had sufficient nursing staff to cover shifts for employees who were ill or exposed to COVID-19. Local employers contacted grantee staff to inform them about these openings and recruited Tribal HPOG 2.0 graduates to work at their facilities. During the pandemic, grantees continued to maintain communication with the network of employment partners that they had established over the past five years.

Grantee staff and participants reported that while nursing staff continued to be in high demand, job opportunities in other occupations were limited, particularly as some hospitals limited elective surgeries and had fewer patients to care for overall. Tribal HPOG 2.0 participants reported experiences of job loss due to the closure of healthcare facilities or providers limiting care, while others had recently graduated and found employment in their chosen field.

As noted above, the COVID-19 pandemic also created new opportunities for employment for Tribal HPOG 2.0 graduates. Several grantees shared that Tribal HPOG 2.0 graduates were employed as contact tracers in their communities and as staff for COVID-19 testing sites. The pandemic response created an opportunity for the Tribal HPOG 2.0 programs to support their communities during the crisis by providing qualified individuals to staff these positions.

Grantees shared that some participants were hesitant to work in clinical settings, but that their anxiety eased as the pandemic progressed. Grantee staff reported that some participants were concerned about the risk of exposure to COVID-19, but it was fewer than the staff expected. Another grantee staff person noted that as other non-healthcare employment opportunities in the community disappeared, previous Tribal HPOG 2.0 graduates were reconnecting with staff to learn about employment opportunities in healthcare. Though a few students had concerns, grantee staff noted that many of their students were dedicated to their chosen profession, took pride in serving their communities, and were not hesitant about entering the healthcare field, despite the pandemic. As one grantee staff noted, *"People who are interested in healthcare are interested in public service and COVID-19 has heightened the sense of need."*

CONCLUSION

Tribal HPOG 2.0 grantees modified their training programs in response to the COVID-19 pandemic and the associated state, Tribal, and local public health measures. Following initial postponements and then a

rapid switch to online or virtual modalities at the onset of the pandemic, a gradual reopening took place. Some programs were able to offer training in-person with public health safety measures in place, while others continued online training. Amid these shifts, grantees and their partners adapted their program activities to continue meeting participants' needs while keeping them safe. This practice brief showcases the ways grantees adapted recruitment and enrollment, training, and the delivery of participant supports. It describes how grantees and their partners shifted to enrolling, training, supporting, and communicating with students through virtual mediums. Given this shift, supporting participants' needs for technology access to access online training (e.g., through loaner laptops and Wi-Fi hotspots) was key. As the COVID-19 pandemic persisted, grantees continued to provide academic and non-academic supportive services virtually; these continued supports were important for addressing ongoing challenges related to closures, stay-at-home orders, and isolation. The COVID-19 pandemic exacerbated existing inequities in Tribal communities and created many challenges for Tribal HPOG 2.0 grantees, partners, and participants. However, this practice brief documents the perseverance of students in continuing with their training programs, as well as the tenacity and creativity of grantee staff and partners as they continued recruiting participants, offering training, and providing an array of participant supports.

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