Health Profession Opportunity Grants

Year Two Annual Report
2011–2012

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HPOG
Health Profession Opportunity Grants

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Overview

The Health Profession Opportunity Grants (HPOG) Program, established by the Affordable Care Act of 2010 (ACA), 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 grantees in 23 states with five-year grants, disbursed annually. In Year 2, ACF provided approximately $67 million to these grantees. Progress to date and HPOG grantee applications suggest that HPOG will serve more than 30,000 individuals over the five-year period of the grants (2010–2015).

This Annual Report summarizes data through the second year of grantee activities. Data for this report are drawn primarily from the HPOG Performance Reporting System (PRS) and grantees' Year 2 Performance Progress Reports (PPRs) submitted to ACF. This report provides an overview of HPOG grantees, characteristics of participants, activities in which participants were engaged, training and employment outcomes, and how grantee programs continued to evolve in the second year of the program.

During the second grant year, the HPOG Program continued to grow, enrolling 8,973 new participants and serving 5,588 continuing participants, for a total of 14,561 participants in Year 2. The majority of HPOG participants were single females with one or more dependent children and most had household income of less than $20,000 when starting the program.

About three-quarters of Year 2 participants were enrolled in a healthcare training. The most common training was to become a nursing assistant, aide, orderly, or patient care attendant, generally short training courses that can be the first step in a longer career pathway. Other common trainings included licensed and vocational nurse, registered nurse, and medical assistant. Fifteen percent of participants engaged in multiple healthcare trainings in Year 2.

HPOG participants also engaged in pre-training activities, including orientations to healthcare careers and college study skills, as well as basic skills education classes (e.g. general equivalency degree classes, English as a second language) and prerequisite courses. Grantees provided a variety of support services to help participants succeed. Commonly received services include case management and counseling services, financial assistance with tuition, books, and fees, and social service supports, including assistance with transportation, child care and emergency assistance (e.g. car repair, utilities, food, rent). Grantees also provided employment assistance in the form of job search workshops, career coaches, and placement and retention assistance.

Many participants had positive outcomes in Year 2. About half of the participants who engaged in healthcare training completed that training within the year. Many participants found employment in healthcare jobs, while enrolled in the program or at exit, and gained higher wages. About half of those completing the HPOG program were employed at exit.

The results in this report are a snapshot of the HPOG Program at the end of its second year of operation. Future annual reports will continue to tell the story of how grantees' programs develop and participants progress in completing healthcare training and gaining employment.

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1. Introduction

The Health Profession Opportunity Grants (HPOG) Program, established by the Patient Protection and Affordable Care Act of 2010 (ACA), funds training programs in high-demand healthcare professions, and these programs target 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 grantees in 23 states with five-year grant funding disbursed annually. In Year 2, ACF provided approximately $67 million to these grantees. HPOG grantees are post-secondary educational institutions, workforce investment boards (WIBs), state or local government agencies, and community-based organizations (CBOs). Five are Tribal organizations. Grantees are implementing new and promising approaches to providing education and training activities and support services to low-income and low-skilled adults, many of whom have multiple barriers to employment. Progress to date and HPOG grantee applications suggest that HPOG will serve more than 30,000 individuals over the five-year period of the grants (2010–2015).

This is the annual report for the second year of the HPOG program. It summarizes data through the second year of grantee activities. The remainder of this section provides an overview of the HPOG Program and related evaluation activities. Section 2 of the report provides an overview of HPOG grantees, including their characteristics and program activities. This is followed by a section summarizing HPOG participants' characteristics. Section 4 describes participant activities, including training and engagement in support and employment services. Section 5 describes participant outcomes through the end of Year 2. Section 6 discusses how HPOG programs continue to evolve to be responsive to participant and employer needs. The final section is a summary.

This report is based on a rich set of data sources:

- The HPOG **Performance Reporting System (PRS)** [1] is a participant-tracking and management system that provides data on participant characteristics, engagement in activities and services, and education and employment outcomes. The PRS also tracks the education and training programs offered by grantees.
- Grantees' **Year 2 Performance Progress Reports (PPRs)** are semi-annual reports submitted to ACF that include documentation of grantees' progress towards goals and narrative summaries of the implementation of their grants.
- ACF's 2012 report **Health Profession Opportunity Grants Compendium of Promising Practices** provides information on the diverse approaches used by grantees to serve participants and local healthcare employers.[2]

Combined, these data provide a comprehensive point-in-time description of HPOG programs.[3]

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[1] The PRS is a "live" data system, meaning grantees continue to enter new data. Grantees have the ability to revise or update past data that were incorrect, missing, or had not yet been entered. All results in this report are based on data extracted in January 2012, and thus are subject to revision.

[2] For more information, the full report on promising practices, developed by ICF International, can be found at https://www.acf.hhs.gov/sites/default/files/ofa/hpog_promisingpracticesnov12_final1.pdf.

[3] Additional information on the data used for this report is provided in Appendix A.

Health Profession Opportunity Grants Program Overview

As part of the ACA, Congress authorized the HPOG Program "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 and are expected to either experience labor shortages or be in high demand."[4]

The need for healthcare workers is predicted to grow over the next several decades, as the population ages, medical technology advances, and the number of persons living with chronic medical conditions increases. HHS and the U.S. Department of Labor report that by 2050 the nation will need between 5.7 million and 6.5 million long-term care nurses, nursing aides, and home health and personal care workers to meet the needs of baby boomers.[5] In the short term more individuals are expected to obtain insurance as a result of the ACA, resulting in an increased demand for care.[6] Further, employment in health occupations that do not require a four-year degree—including nurses, psychiatric and home health aides, and health technologists and technicians (such as pharmacy technicians)—is projected to grow by 26 to 39 percent by 2020, much faster than the average rate projected across all occupations in the economy (14 percent). [7]

The HPOG Program is structured to meet the dual goals of demonstrating new ways to increase the supply of healthcare workers while creating vocational opportunities for low-income, low-skilled adults. This is achievable in part because the healthcare industry has great flexibility. Multiple points of entry exist for low-skilled individuals to find a job after attaining a short-term training credential. They then can move up the career ladder through additional education and work experience. Median wages in healthcare jobs that do not require a four-year degree range from $11.00 to $19.50 an hour.

The five-year grants may be used for education and training activities and support services to prepare TANF recipients and low-income individuals to enter and advance in the healthcare sector in nursing, long-term care, allied health, health information technology, and child care health advocate occupations. Exhibit 1.1 lists the goals of the HPOG grants.[8]

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[4] Authority for these demonstrations is included in PPACA, 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).

[5] See Human Resources and Services Administration. *Changing Demographics: Implications for Physicians, Nurses, and Other Health Workers*. Washington, DC: U.S. Department of Health and Human Services, Spring 2003. ftp://ftp.hrsa.gov/bhpr/nationalcenter/changedemo.pdf.

[6] The ACA is estimated to reduce the number of uninsured by 30 to 33 million, potentially greatly increasing the demand for care. Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 2012.

[7] Lockard, C. Brett and Wolf, Michael "Occupational employment projections to 2020," *Monthly Labor Review*, January 2012.

[8] See the original Funding Opportunity Announcement for the Health Profession Opportunity Grants to Serve TANF and Other Low-Income Individuals at http://www.acf.hhs.gov/grants/open/foa/view/HHS-2010-ACF-OFA-FX-0126.

Exhibit 1.1: Goals of the HPOG Grants

- Prepare participants for employment in the healthcare sector in positions that pay well and are expected to either experience labor shortages or be in high demand
- Target skills and competencies demanded by the healthcare industry
- Support career pathways, such as an articulated career ladder
- Result in employer- or industry-recognized, portable educational credentials (e.g., certificates or degrees and professional certifications and licenses, which can include 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

Studying the HPOG Program

Congress, ACF, and other stakeholders are interested in determining whether the HPOG Program improves the training and employment outcomes of participants. ACF's Office of Planning, Research and Evaluation is using a multi-pronged research and evaluation strategy to assess the success of the HPOG Program. These research and evaluation projects examine program implementation, systems change resulting from HPOG programs, and outcomes and impacts for participants. They are described in Exhibit 1.2.

Exhibit 1.2: OPRE's HPOG Research and Evaluation Strategy

The six related HPOG research and evaluation projects are designed to identify what types of approaches work well in achieving the goals of HPOG and in what circumstances and for whom they work, so they can be replicated in the future. The projects are as follows:

- **HPOG Implementation, Systems, and Outcomes (ISO) Evaluation Design and Performance Reporting.** The HPOG ISO project has two parts. The first develops an evaluation plan for measuring the implementation, systems change, and outcomes of HPOG programs, including enrollment, program retention, training completion, job entry, employment retention and advancement, and earnings. The second builds and maintains the HPOG Performance Reporting System (PRS), a management information system, to track grantee progress for program management and accountability and to record participant data for use in the evaluation.
- **HPOG National Implementation Evaluation (NIE).** The HPOG NIE is the execution of the study devised in the ISO evaluation plan (above). The NIE includes an in-depth examination of the HPOG grantee program design and implementation, a systems analysis of networks created by HPOG programs (e.g., among grantees, employers, and other partners), and a quantitative descriptive analysis of HPOG program outputs and outcomes. Twenty-seven grantees—excluding the five Tribal organizations—are included in this analysis.
- **HPOG Impact Study.** The HPOG Impact Study uses an experimental design to examine the effect of the HPOG Program on participants' educational and economic outcomes. This evaluation aims to identify which components of HPOG programs (e.g., types of support services, program structure, and training areas) contribute to participant success. For some grantees, a multi-arm experimental design will be implemented, creating a control group that will not have access to HPOG, an "HPOG service as usual" treatment group, and an "enhanced HPOG" group that will receive additional supports and services. The 20 grantees that are not part of the Tribal evaluation, University Partnership Research Grants, or ISIS evaluation are included in the HPOG Impact Study.
- **Evaluation of Tribal HPOG.** A separate evaluation has been designed for the five Tribal grantees, given the unique contexts in which these programs operate. This evaluation focuses on the implementation and outcomes for the Tribal grantees.
- **Innovative Strategies for Increasing Self-Sufficiency (ISIS) Project.** The ISIS evaluation is a nine-site experimental study of promising career pathway programs. Three HPOG grantees are included in the ISIS study.
- **University Partnership Research Grants for HPOG.** These studies are being conducted by research partners at universities that have partnered with one or more HPOG programs to answer specific questions about how to improve HPOG services within local contexts.

These research components are being coordinated to avoid duplication of effort, maximize the usefulness of collected data, reduce burden on grantees participating in the federal evaluation activities, meet performance management requirements, and promote cross-project learning.

Abt Associates, in collaboration with the Urban Institute, is conducting the ISO, NIE, and Impact evaluation projects. NORC at the University of Chicago is conducting the evaluation of Tribal HPOG, in partnership with Red Star Innovations and the National Indian Health Board. Abt Associates is conducting the ISIS project. Five university research institutions are leading the University Partnership Research Grants, including the Institute for Policy Research at Northwestern University, the School of Social Work at Temple University, the Institute on Assets and Social Policy (IASP) at Brandeis University, the School of Social Work at Loyola University Chicago, and North Dakota State University.

2. What Are the Characteristics of HPOG Grantees?

The 32 HPOG grantees, representing a range of organizations in diverse communities, are implementing a variety of approaches to education and training activities and support services. Within the required HPOG framework and goals described previously in Section 1, grantees have flexibility in how they design specific program components to meet the needs of their target populations and local employers. This section describes key characteristics of the HPOG grantees and grants and summarizes the types of education and training activities and support services they offer.

There is significant variation among the 32 HPOG grantees in their location, program size, and organizational characteristics. Grantees are located across the country (Exhibit 2.1). Nine are in the Northeast, four in the Southeast, nine in the Midwest, and ten in the West. Half of the grantee organizations are institutions of higher education (mainly community colleges), and about 30 percent are WIBs, regional organizations responsible for implementing the federal Workforce Investment Act. The remaining grantees are local or state government agencies (13 percent) or CBOs (9 percent). Five of the HPOG grants are to Tribal organizations, four of which are Tribal higher educational institutions and one of which is a CBO.

Grantees also vary in the number of participants they intend to serve. About one-third of the grantees (10) have five-year enrollment goals of less than 500. Another nine have goals of between 500 and 999, and 10 have goals between 1,000 and 1,999. Three grantees have enrollment goals of 2,000 or more. In part because of these different enrollment goals, the size of HPOG grants also varies. Program grants for Year 2 of HPOG ranged between $1 million and $5 million, with most grantees (20) receiving awards between $1 million and $2 million. Another nine were awarded between $2 and $3 million, and three have grants between $3 and $5 million.

Grantees also differ in participant eligibility criteria and target populations. HPOG targets TANF recipients (TANF cash beneficiaries are automatically income-eligible for HPOG) and other low-income individuals; grantees define "low-income" as appropriate for their communities. Twenty-five grantees define "low-income" based on the HHS federal poverty line.[9] Among those 25, the standard ranges from 70 percent of poverty to 300 percent of poverty, with 200 percent of poverty most common, adopted by 14 grantees. Five grantees have different income standards for HPOG participants employed at intake (called "incumbent workers") than for those who are not employed, allowing those with jobs to be eligible at higher income levels. Other grantees determine income eligibility based on participants' qualifications relative to the Workforce Investment Act eligibility standards, TANF eligibility standards, or median state income.

Target populations differ among grantees. Often reflective of the communities they serve, grantees target their program outreach to specific populations, such as youth aging out of foster care, veterans, single mothers, those with barriers to education and/or employment, incumbent low-income workers, or members of certain ethnic groups (such as Native populations in the Tribal grantee programs).

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[9] HHS federal poverty guidelines for 2012 can be found at Federal Register Volume 77, Number 17, pp. 4034-4035. According to these guidelines, the poverty line for a family of three was income of $19,090 and for a family of four was income of $23,050 in 2012.

Exhibit 2.1: HPOG Grantee Location, Organization Type, and Five-Year Enrollment Goal

State (City)	Grantee Name	Organization Type	Five-Year Enrollment Goal
AZ (Tucson)	Pima County Community College District	Higher Education Institution	1,000–1,999
CA (San Diego)	San Diego Workforce Partnership	WIB	2,000+
CT (Bridgeport)	The WorkPlace, Inc.[a]	WIB	500–999
FL (Pensacola)	Pensacola State College	Higher Education Institution	1,000–1,999
IL (Chicago Heights)	Southland Health Care Forum, Inc.	CBO	Less than 500
IL (Joliet)	Workforce Investment Board of Will County	WIB	500–999
KS (Topeka)	Kansas Department of Commerce	Government Agency	2,000+
KY (Florence)	Gateway Community and Technical College	Higher Education Institution	500–999
LA (Monroe)	Workforce Development Board (SDA-83)	WIB	1,000–1,999
MO (Kansas City)	Full Employment Council	WIB	500–999
NE (Grand Island)	Central Community College	Higher Education Institution	1,000–1,999
NH (Concord)	New Hampshire Department of Health and Human Services, Office of Minority Health	Government Agency	1,000–1,999
NJ (Hackensack)	Bergen Community College	Higher Education Institution	2,000+
NY (Buffalo)	Buffalo and Erie County Workforce Development Consortium, Inc.	WIB	1,000–1,999
NY (Bronx)	Research Foundation of the City of New York	Higher Education Institution	500–999
NY (Schenectady)	Schenectady County Community College	Higher Education Institution	1,000–1,999
NY (Suffolk)	Suffolk County Department of Labor/Suffolk County WIB	WIB	500–999
OH (Steubenville)	Eastern Gateway Community College	Higher Education Institution	1,000–1,999
OK (Tulsa)	Community Action Project of Tulsa County Inc.	CBO	Less than 500
PA (Lewisburg)	Central Susquehanna Intermediate Unit	Government Agency	Less than 500
PA (Philadelphia)	Temple University of the Commonwealth System of Higher Education	Higher Education Institution	Less than 500
SC (Columbia)	South Carolina Department of Social Services	Government Agency	500–999
TX (San Antonio)	Alamo Community College District and University	Higher Education Institution	Less than 500
WA (Lynnwood)	Edmonds Community College	Higher Education Institution	500–999
WA (Seattle)	Workforce Development Council of Seattle-King County	WIB	500–999
WI (Kenosha)	Gateway Technical College	Higher Education Institution	Less than 500
WI (Milwaukee)	Milwaukee Area Workforce Investment Board	WIB	1,000–1,999
AK (Alaskan Natives)[b]	Cook Inlet Tribal Council, Anchorage	CBO	Less than 500
MT (Browning, Blackfeet Reservation) [b]	Blackfeet Community College	Higher Education Institution	Less than 500
ND (Fort Totten, Spirit Lake Dakota Nation) [b]	Cankdeska Cikana Community College	Higher Education Institution	Less than 500
ND (Turtle Mountain Band of Chippewa Indians) [b]	Turtle Mountain Community College, Belcourt	Higher Education Institution	Less than 500
WI (Keshena) [b]	College of Menominee Nation	Higher Education Institution	1,000–1,999

[a] This grantee was awarded funding later in Year 1 than the other grantees.
[b] HPOG Tribal Grantee.
Source: HPOG initial grant applications

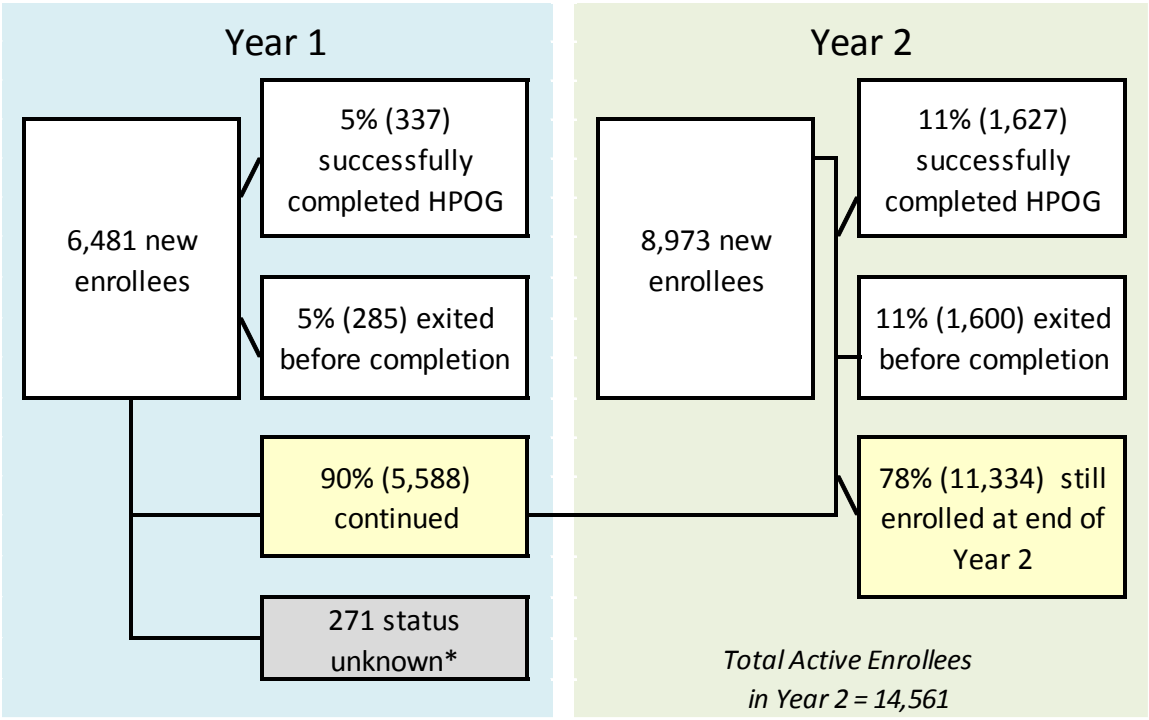
3. Who Participated in HPOG in Year 2?

As in program Year 1, HPOG served a large and diverse group of individuals in the second grant year. This section begins with a description of the number and flow of HPOG participants in the first two years of the program. It then describes the demographic and socioeconomic characteristics of participants in Year 2.[10]

Participation in HPOG

Large numbers of participants enrolled in HPOG during the first two years of the program. Exhibit 3.1 shows the enrollment and the flow of participants over the first two years. In Year 1, 6,481 individuals enrolled in HPOG.[11] Grantee enrollment numbers varied, with the smallest grantees enrolling as few as 20 participants and the largest enrolling more than 1,000 participants.

Exhibit 3.1: HPOG Participation in Years 1 and 2



Source: Year 1 PPRs and PRS.

*Completion status information for these enrollees is missing and they are not recorded in the PRS. Percentages shown are calculated for those for whom status is known (6,210 participants in Year 1).

[10] Most of the data in this report are for Year 2 of the HPOG Program. The PRS was implemented at the beginning of Year 2 on September 30, 2011. The data for Year 1 in this report come from the grantees' PPRs for Year 1, which were submitted on paper. We do not have individual-level data for Year 1 of the HPOG Program. Therefore, we cannot examine certain subgroups or cross-tabulations in Year 1 that are possible using the individual level data for Year 2 from the PRS.

[11] Enrollment is defined as meeting the program eligibility criteria and receiving a substantive program service, specifically, a support service, pre-training, or training activity. This number is based on the Year 1 PPRs.

All grantees used some time in Year 1 to start up and implement their programs, so programs did not enroll individuals immediately upon grant receipt. Also, many participants first engaged in pre-training activities. This, combined with the length of many training courses, meant that a large percentage (90 percent excluding those with missing data) of first year enrollees were still active in the program as Year 2 began, as indicated in Exhibit 3.1. About 5 percent completed HPOG in Year 1 and another 5 percent exited before completion.[12] Completing the program is defined by each grantee, but generally means the participant has completed pre-training, vocational/occupational healthcare trainings, and any employment-related activities and is no longer receiving HPOG services.

In Year 2, in addition to those continuing on from Year 1, 8,973 new enrollees entered HPOG. This was a 38 percent increase over enrollment in Year 1. The number of participants ever actively enrolled in Year 2 was 14,561. Slightly more than one-tenth of all enrollees successfully completed HPOG in Year 2 (11 percent), and the same percentage exited the program before completing. Of participants who left the program before completion, about 35 percent dropped out or their caseworkers were unable to locate them. Another 35 percent left for another reason, most often because they did not meet academic requirements, had excessive absences, or did not meet background or drug test requirements. As in Year 1, a large percentage (78 percent) of all active participants in Year 2 remained enrolled at the end of the year.

HPOG Participant Characteristics

HPOG participants vary on a number of characteristics. Exhibit 3.2 shows selected characteristics of HPOG participants in Year 2.

The majority of HPOG participants were female (89 percent), never married (61 percent), and had one or more dependent children (69 percent). About 40 percent of HPOG participants were non-Hispanic white and another 36 percent were non-Hispanic black. Fifteen percent identified as Hispanic or Latino. Half of HPOG participants were less than 30 years old, and about 9 percent were age 50 or older.

[12] Year 1 PPRs included 6,481 enrollees. When the PRS began at the start of Year 2 grantees were only required to enter Year 1 enrollees who continued to be active in Year 2. The PRS includes data on 5,588 Year 1 enrollees. An additional 271 enrollees were not entered into the PRS by grantees and are not included in Year 1 reports on exits. Information for this group is unavailable.

Exhibit 3.2: Demographic Characteristics at Intake of HPOG Participants in Year 2

Characteristic	Number	Percentage of Participants (%)
Gender		
Female	12,930	89
Male	1,598	11
Missing	33	
Marital Status		
Married	2,165	18
Separated or Divorced	2,247	19
Widowed	124	1
Never Married	7,190	61
Missing	2,835	
Number of Dependent Children		
None	3,791	31
One	3,478	28
Two	2,695	22
Three	1,479	12
Four or More	844	7
Missing	2,274	
Race/Ethnicity		
Non-Hispanic White/Caucasian	5,564	40
Non-Hispanic Black/African-American	4,996	36
Hispanic/Latino of Any Race	2,092	15
Asian, Native Hawaiian, or Pacific Islander	362	3
American Indian or Native Alaskan	558	4
Two or More Races	398	3
Missing	591	
Age		
Less than 20 Years	517	4
20 to 29 Years	6,662	46
30 to 39 Years	3,892	27
40 to 49 Years	2,111	15
50 + Years	1,282	9
Missing	97	

Source: PRS. Table includes all enrollees active in Year 2 (N=14,561).

Percentages are of participants without missing data. Categories may not sum to 100 percent due to rounding.

Exhibit 3.3 shows education and income of participants. Most participants had no prior college experience. More than half of HPOG participants completed high school (41 percent) or equivalent (13 percent), and 5 percent had not graduated high school. Slightly more than one-third (35 percent) had one to three years of education beyond high school, either in college or technical school, and 6 percent had four or more years of college.

By design, HPOG targets individuals with limited annual household and individual income. Almost half of participants (49 percent) had annual household incomes of less than $10,000 at program intake. Another 28 percent had household incomes between $10,000 and $20,000. To put these figures in context, in 2012, the poverty level for a one-person household was $11,170 and for a one adult and two children household was $19,090, meaning many of these households had incomes well below the poverty

line.[13] Similarly, participants' individual incomes were very low at intake. Twenty-nine percent had no individual income and 38 percent had individual incomes below $10,000.

Exhibit 3.3: Education and Income of HPOG Participants at Intake in Year 2

Characteristic	Number	Percentage of Participants (%)
Educational Attainment		
Less than 12th Grade	598	5
High School Equivalency/GED	1530	13
High School Graduate	4,870	41
1–3 Years of College/Technical School	4,226	35
4 Years or More of College	772	6
Missing	2,565	
Household Income		
$9,999 or Less	5,286	49
$10,000 to $19,999	2,990	28
$20,000 to $29,999	1,468	14
$30,000 to $39,999	528	5
$40,000 or More	441	4
Missing	3,848	
Individual Income		
$0	3,179	29
$1 to $9,999	4,138	38
$10,000 to $19,999	2,500	23
$20,000 to $29,999	952	9
$30,000 or Over	292	3
Missing	3,500	

Source: PRS. Table includes all enrollees active in Year 2 (N=14,561).

Percentages are of participants without missing data. Categories may not sum to 100 percent due to rounding.

Many HPOG participants received public assistance at the time of program entry, shown in Exhibit 3.4. The Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps) was the most common program, received by 57 percent of entrants. TANF recipients (a target population for HPOG) made up 18 percent of participants at program intake.

Forty-one percent of program entrants reported Medicaid receipt. Only a small percentage of HPOG participants received benefits from Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI), programs that provide cash assistance for individuals with disabilities. Finally, 15 percent of HPOG participants were receiving Unemployment Insurance (UI) at intake, indicating they had recently lost a job, and 4 percent had exhausted these benefits.

[13] Statistics are based on the HHS federal poverty guidelines for 2012. See Federal Register Volume 77, Number 17, pp. 4034-4035.

Exhibit 3.4: Receipt of Public Benefit Programs by HPOG Participants at Intake in Year 2

Program	Number	Percentage of Participants (%)
Temporary Assistance for Needy Families (TANF)		
Yes	2,309	18
No	10,444	82
Missing	1,808	
Supplemental Nutrition Assistance Program (SNAP)		
Yes	7,306	57
No	5,510	43
Missing	1,745	
Medicaid		
Yes	4,224	41
No	6,151	59
Missing	4,186	
Supplemental Security Income (SSI)		
Yes	402	3
No	11,594	97
Missing	2,565	
Social Security Disability Insurance (SSDI)		
Yes	226	2
No	11,593	98
Missing	2,742	
Unemployment Insurance (UI)		
Claimant	1,792	15
Exhaustee	415	4
Not Claimant or Exhaustee	9,575	81
Missing	2,779	

Source: PRS. Table includes enrollees active in Year 2 (N=14,561).

Percentages are of participants without missing data. Categories might not sum to 100 percent due to rounding.

4. What Activities Did Participants Undertake in Year 2?

The key components of HPOG programs are education and training activities to prepare participants for in-demand healthcare occupations; academic, career, and personal support services to ensure that participants successfully complete training; and employment development activities and employment assistance to help participants enter employment. These components align with a career pathways framework, an innovative strategy that is being tested in several ACF initiatives. A career pathway provides instruction in a series of manageable and well-articulated steps leading to successively higher credentials and employment and addressing the learning and life challenges of adult students.[14] In HPOG, grantees are adapting these principles to implement education and training activities and support services

[14] See Fein, David J. 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 # 2012-30, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2012. https://www.acf.hhs.gov/programs/opre/resource/career-pathways-as-a-framework-for-program-design-and-evaluation-a-working.

that meet the needs of TANF recipients and low-income individuals. These activities and services are provided by the grantee or through its network of partners.

During Year 2, HPOG participants engaged in a wide range of programming across these key components. Of all Year 2 HPOG enrollees, 82 percent (11,939 people) participated in a pre-training activity or healthcare training. Another 6 percent were engaged in employment development activities. The remaining 12 percent did not participate in any of these activities; they may be recent enrollees waiting to begin activities or have recently completed training and are searching for employment. The following subsections describe in more detail the activities in which HPOG enrollees participated.

Pre-Training Activities

Grantees offered a mix of pre-training activities to help participants prepare to enter healthcare training, ranging from basic skills courses to occupational prerequisite courses, college success courses, or orientations to the healthcare industry.

Grantees used different assessment tools or pre-screening processes to determine the pre-training activities in which participants should engage based on skill levels and aptitude for a particular occupation (see Exhibit 4.1 for examples). Some grantees required most or all of their HPOG participants to enroll in career exploration or orientation classes. For example, several grantees required participants to enroll in a "boot camp" (an intensive preparation for training that usually takes place over a relatively short period of time) prior to training to help prepare them to succeed in school and in future employment. Boot camps varied in intensity and duration. Pre-training activities such as basic skills education courses are generally targeted to specific participants based on an assessment of limited basic skills and identified remediation needs.

Exhibit 4.1: Preparing for Training

Both the South Carolina Department of Social Services and the College of Menominee Nation run orientation boot camps for all new HPOG enrollees. During the boot camps, participants undergo screenings and assessments, are paired with mentors, develop training and career plans, discuss how to overcome employment barriers, and learn about support services. The South Carolina boot camp is four weeks, and the Menominee boot camp is two days. Participants enter boot camp as a cohort, as these grantees intend the shared experience to foster positive peer support.

Some grantees connect students with external providers for pre-training activities. For example, Workforce Investment Board SDA-83's Professional Healthcare Opportunities—Careers and Support (PHOCAS) program in Louisiana has a staff member who serves as a Student Liaison with DeltaLINC, a local literacy program, to help participants who need assistance completing their GED or with other adult education activities.

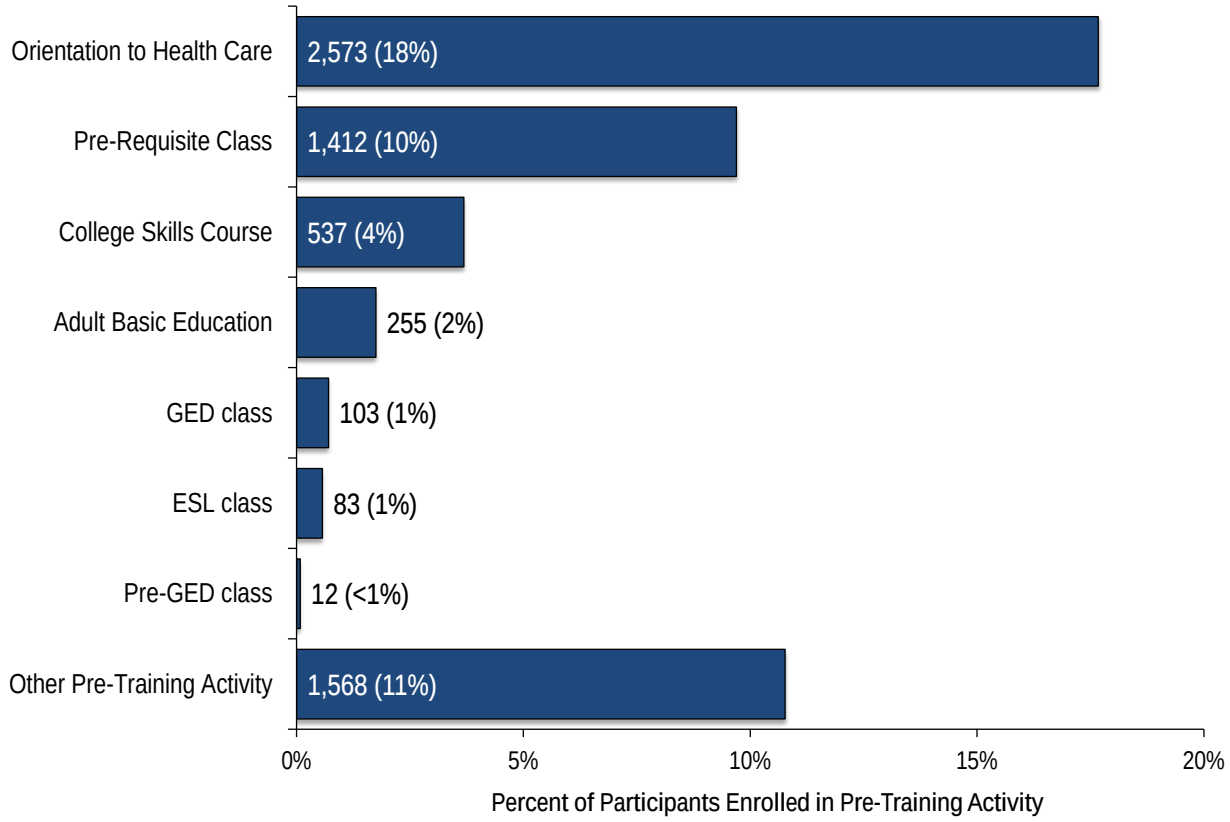
In the second year of the grant, almost all of the grantees (29 out of 32) offered some pre-training activities. The extent to which grantees used pre-training in their programs differed, with eight grantees enrolling fewer than 10 percent of participants in these activities, while three grantees had over 80 percent of all HPOG participants enter a pre-training activity. Overall, in Year 2 of the HPOG program, 33 percent of enrollees (4,871 people) participated in at least one pre-training activity, and over a third of these participated in multiple activities.

Exhibit 4.2 presents the number of enrollees that participated in each type of pre-training activity as a percentage of all enrollees. The most common pre-training activity was orientation to healthcare, which

was taken by 18 percent of participants in Year 2. Ten percent of participants took prerequisite classes for training. Smaller percentages of participants took college skill courses, adult basic education, GED classes, English language education (ESL) or pre-GED classes—basic skills education necessary for some students to take prior to college-level training.

About one-tenth (11 percent) of participants were involved in other pre-training activities .The most common "other" activities were CPR/first aid, financial training, placement testing, and foundational pre-requisite courses that did not fall into pre-defined categories.

Exhibit 4.2: Participants Enrolled in HPOG Pre-Training Activities in Year 2



Source: PRS. Table includes enrollees active in Year 2 (N=14,561).
Participants that enrolled in multiple different pre-training activities are represented more than once.

Overall, the variety and number of pre-training activities HPOG programs provided were consistent with the goals of serving low-skilled, low-income adults. Pre-training was an important step for these students toward being able to complete healthcare training.

Healthcare Occupational and Vocational Trainings

Providing healthcare training is central to the HPOG Program's goal to prepare participants for high-demand healthcare occupations. HPOG vocational/occupational training (also referred to as healthcare training) is intended to lead to skills and credentials that are in demand by employers. Training providers include community or technical colleges, four-year colleges, non-profit or community-based orgnizations, or private for-profit training providers.

In Year 2 of the program, 74 percent of HPOG enrollees (10,745 people) participated in healthcare training. Of these, 15 percent (1,585 people) engaged in more than one healthcare training in Year 2.

HPOG grantees provide training in many occupations. In Year 2, grantees offered trainings to prepare participants for employment in jobs that fall into 62 occupations, as defined by the Bureau of Labor Statistics' (BLS) Standardized Occupational Classifications (SOCs).[15] Over half of the grantees provided trainings for the occupations of registered nurse (RN), licensed practical and licensed vocational nurse (LPN/LVN), medical records and health information technician, nursing assistant/aide/orderly/attendant, medical assistant, and phlebotomist. Depending on the occupation, training may last a short period of time (for example, less than eight weeks for nursing assistants) and result in a certificate or may take two years or more to complete an Associate's degree.

Training for an entry-level position in an occupation may also be "stacked" with progressively higher-skill trainings to build a career pathway for participants. Some occupations have established career pathways. Nursing, for example, can start at a certified nursing assistant (CNA) position, progress to an LPN or LVN, and even lead to an RN program, which generally requires an Associate's or Bachelor's degree.

Some grantees developed new programs in response to an emerging demand for skills. For example, Buffalo and Erie County developed a new CNA program, and Temple University created a new tiered training program through which HPOG participants can progress from entry level to graduate degree level for health information technology (see Exhibit 4.3). Other HPOG projects offered a "menu" of trainings that represent a range of occupations and skill levels from which participants may choose. Grantee staff often worked with participants to assess their career interests and aptitude and counsel them about the trainings for which they may qualify.

Exhibit 4.3: Developing New Training Programs

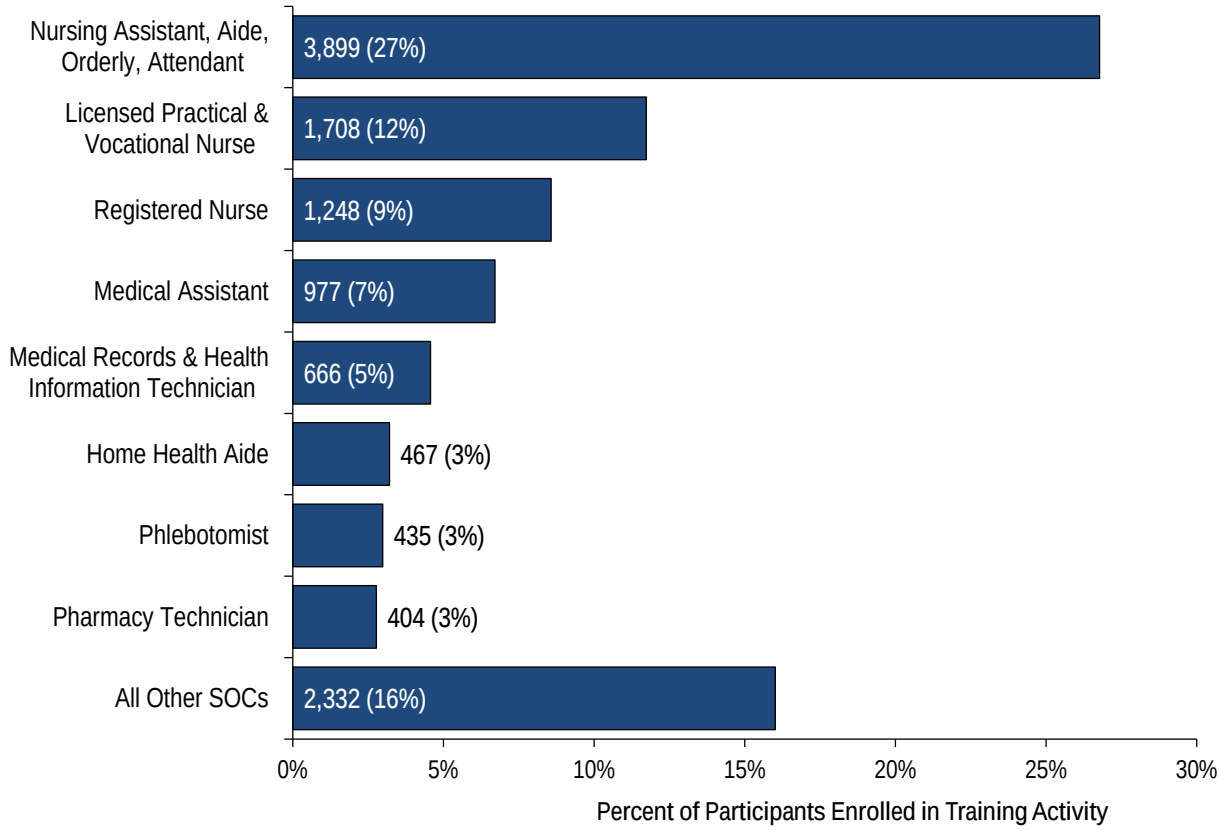
Buffalo and Erie County Workforce Development Consortium added CNA and home health aide training in the second year of HPOG because they believe that these programs provide a strong foundation to a career ladder. The Full Employment Council in Kansas City created a "CNA Plus" program where CNA training is bundled with medication aide level 1, CPR and basic life support, and insulin injection to meet employer demand for CNAs with specialties in mental health and dementia issues.

At Temple University in Pennsylvania, the information technology program has five tiers. Tier 1 provides entry-level participants the opportunity to achieve four certifications in administrative/ billing/coding and electronic health records. Tier 2 provides training for higher-level certification in a specialty area. Tier 3 is the equivalent of an Associate's degree, Tier 4 is commensurate with a Bachelor's degree, and Tier 5 provides training at the Master's level. This tier structure provides multiple entry points for participants to seek employment and progress in their careers.

Exhibit 4.4 lists the eight most common healthcare trainings in which HPOG participants enrolled in Year 2. Together these account for more than 80 percent of all HPOG training enrollments in the second year of the program.

[15] See Appendix B for a detailed listing of the occupations and BLS SOCs for which HPOG grantees offered training in the second year.

Exhibit 4.4: Eight Most Common HPOG Healthcare Trainings in Year 2



Source: PRS. Table includes enrollees active in Year 2 (N=14,561).
Participants that enrolled in multiple different trainings are represented more than once.

The nursing assistant, aide, orderly, attendant occupational category was the most common healthcare training, with 27 percent of HPOG enrollees participating or 3,899 enrollees across all grantees. This healthcare category includes training to become a CNA. In addition, there were 1,708 enrollees in LPN/LVN training and 1,248 enrollees in RN training.

Medical assistant was another common training program, with 977 participants or 7 percent of all HPOG enrollees. Similarly to nursing assistant training, the length of this training course is generally short. Medical assistants perform administrative and basic clinical duties, such as scheduling appointments, taking vital signs, and preparing patients for examination. Medical assistants commonly work in physician's offices while nursing assistants generally work in hospitals or residential care facilities.

In Year 2, 5 percent of HPOG enrollees also trained to become medical records and health information technicians. This occupation, responsible for compiling and maintaining medical records, typically does not involve direct patient care and is open to individuals who would be ineligible for healthcare positions due to health conditions or past criminal records.

Other common occupations that HPOG participants trained for include home health aide (467 enrollees), phlebotomist (435 enrollees), and pharmacy technician (404 enrollees). All other occupations each had participation of less than 3 percent of enrollees. Altogether, roughly one-sixth of HPOG enrollees participated in one of these other occupational/vocational trainings.

Overall, almost three-quarters of HPOG participants in Year 2 were engaged in a training activity. The most common healthcare trainings were for relatively short courses that can serve as the first step in a longer career pathway. However, almost 10 percent of enrollees were training to become an RN, which can be a two- to four-year course of study. In addition, 15 percent of enrollees engaged in multiple healthcare trainings in Year 2.

Support Services

An integral part of HPOG is the provision of support services to facilitate participants' success in the HPOG Program. The original funding opportunity announcement requires grantees to provide support services to participants and to leverage key support resources through a range of partners. Services offered aim to promote academic success (e.g., assessments and counseling), help with training and work-related expenses, and identify and remove barriers to program participation and completion through social services. HPOG program services can be grouped into the following eight categories:

- Pre-enrollment/intake assessment services
- Training and work-related resources (e.g., books, license fees, tools, uniforms)
- Case management
- Counseling services (e.g., mentoring, peer support, academic advising, tutoring)
- Social and family services (e.g., emergency assistance) and social services resources (e.g., connecting to child care, legal assistance, family preservation)
- Housing support services
- Cultural programming
- Other support services (e.g., help obtaining government benefits, assistance with fees, and incentive payments for exceptional performance)

All grantees provided some of these support services, although the specific offerings varied. All grantees offered case management, training and work-related resources, and social and family services and resources. Almost all provided pre-enrollment/intake assessments and counseling. Common "other" support services were: assistance applying for government benefits, resources for class or other fees, and non-monetary incentives based on performance. In addition to these support services, all grantees directly paid all or part of tuition for training and education for some or all of their participants.

Service provision among grantees varied. Some grantees delivered support services in-house, using grantee staff to dispense a range of services "under one roof." Other grantees made referrals to a network of providers in the community.[16]

Participant receipt of support services by category is shown in Exhibit 4.5. Many recipients received different types of support services during the year and some received a specific type of support service

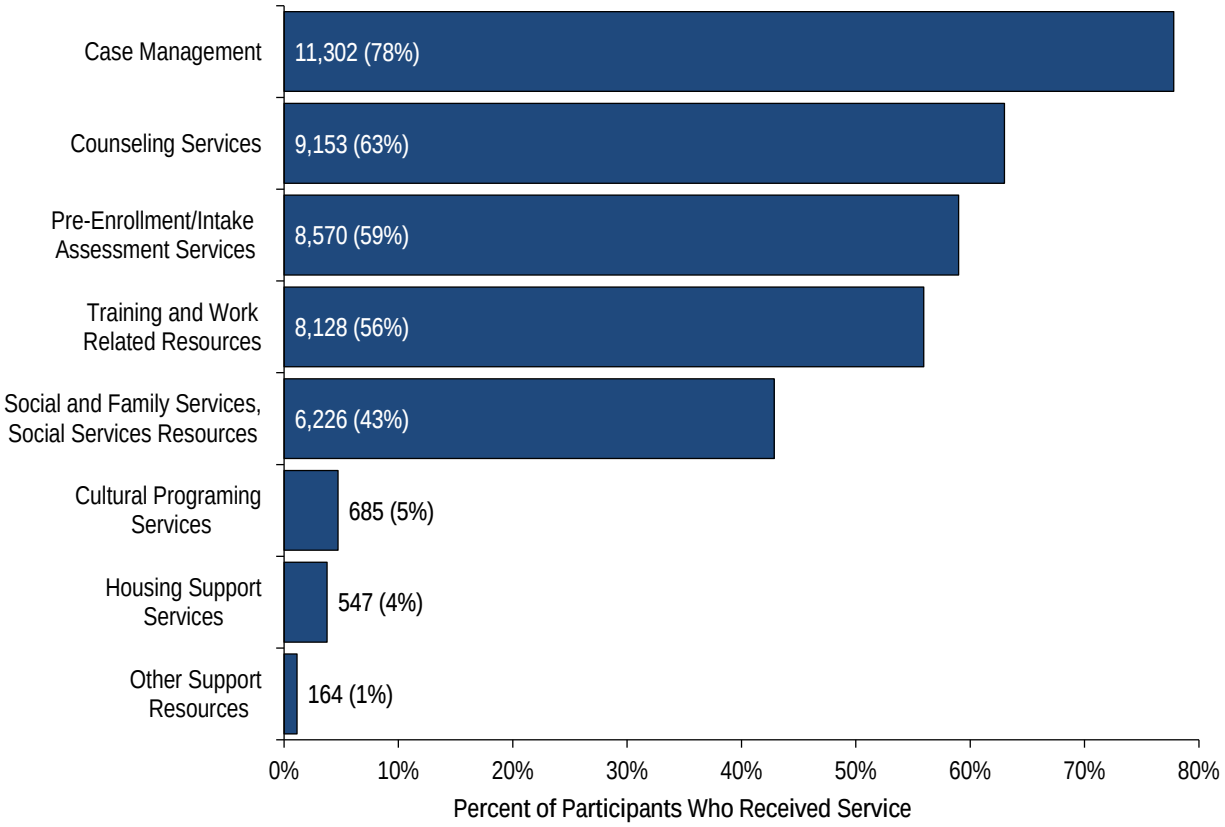
[16] HPOG services reported here only include direct provision by a grantee (by HPOG program staff) or by a key HPOG program partner. In cases where a participant is provided a support service by a key partner, the receipt of the service must be known, monitored, and followed up by HPOG program staff to be included here. Referrals to services in the community, with minimal or no follow-up by HPOG staff, are not included.

more than once over the course of the year. The three most common support services received were case management, counseling, and pre-enrollment and assessment.

Seventy-eight percent or more than 11,300 HPOG participants received case management services. Case management pairs a case manager (also called career advisors, navigators, or career coaches in some programs) with a participant, usually providing services or service referrals from intake to program completion and employment. Sixty-three percent of HPOG participants (9,153) received counseling services—training or academic-related counseling, including mentoring, peer support groups, comprehensive assessments, academic planning, or tutoring. Fifty-nine percent or 8,570 participants received pre-enrollment or intake assessments to help determine participants' eligibility for training and provide information to help participants make training choices.

Training and work-related resources (e.g., financial assistance for books, license fees, and work expenses) both were important sources of financial support for participants' training. Assistance with training and work expenses was provided to 56 percent of all HPOG participants (8,128).

Exhibit 4.5: Participants Receiving HPOG Support Services in Year 2



Source: PRS. Table includes enrollees active in Year 2 (N=14,561).
Participants that received multiple different types of services are represented more than once.

Social services resources or social and family services include assistance that supports participants' continuation in the program but is not specifically related to academic, training, or employment needs. Supports in this category include emergency assistance (e.g., car repair, utilities, food, and shelter) and assistance with social service needs (sometimes through partner agencies) such as child care, substance

abuse, legal needs, or family preservation services. While less frequently provided than the academic and training related supports, 6,226 participants (43 percent) received this type of assistance.

Cultural programming and housing support services were provided less frequently. Cultural programming services aim to integrate cultural practices into healthcare training, most commonly among Tribal grantees. An example is the Working with Tradition soft skills workshop at Blackfeet Community College for Native Americans entering the workforce. Cultural programing services were received by 5 percent of HPOG participants. Housing support services include financial assistance with short-term housing or rent or connection to a government housing assistance program. Four percent of HPOG participants received this form of support. Another 1 percent of participants received some other support service not already described.

The widespread use of support services suggests the importance of these services in grantees' HPOG programs. A majority of participants received training-related or academic supports and financial training or work-related assistance. More than two-fifths of all participants received social and family services and other social service resources, including help with emergency, family, or basic needs.

Employment Activities

In addition to support services, all grantees offer activities to prepare HPOG participants for employment. HPOG programs provided specific employment development activities designed to help participants gain employability skills and work experience and assist participants in finding employment. HPOG grantees designed their programs with the understanding that employers are often searching for candidates who have not only technical skills but also professionalism and the social and workplace skills needed to thrive in a healthcare workplace, preferably with practical experience working in a healthcare environment.

HPOG programs provided several specific employment development activities including workshops and placements with employers. A listing of these activities is shown in Exhibit 4.6.

Exhibit 4.6: HPOG Employment Development Activities

Soft skills/life skills training: Training to develop employer-sought personal behaviors, including responsibility, punctuality, self-confidence, ability to get along with others, and ability to work well in a group or team.

Job readiness workshops: Workshops including soft/life skills needed in the workplace (see above) and occupation- and job-specific issues, including job search skills.

Work experience: Non-paid work assignments that primarily provide orientation and general exposure to the workplace.

Job shadowing: Short-term scheduled activity (e.g., a day or a week) in which individuals, usually trainees, follow a worker engaged in an occupation to learn about that occupation and what the job is like.

On-the-job training: Formal agreement where employers receive a subsidy for a portion of wages if they hire and provide training to participants while they are engaged in productive work.

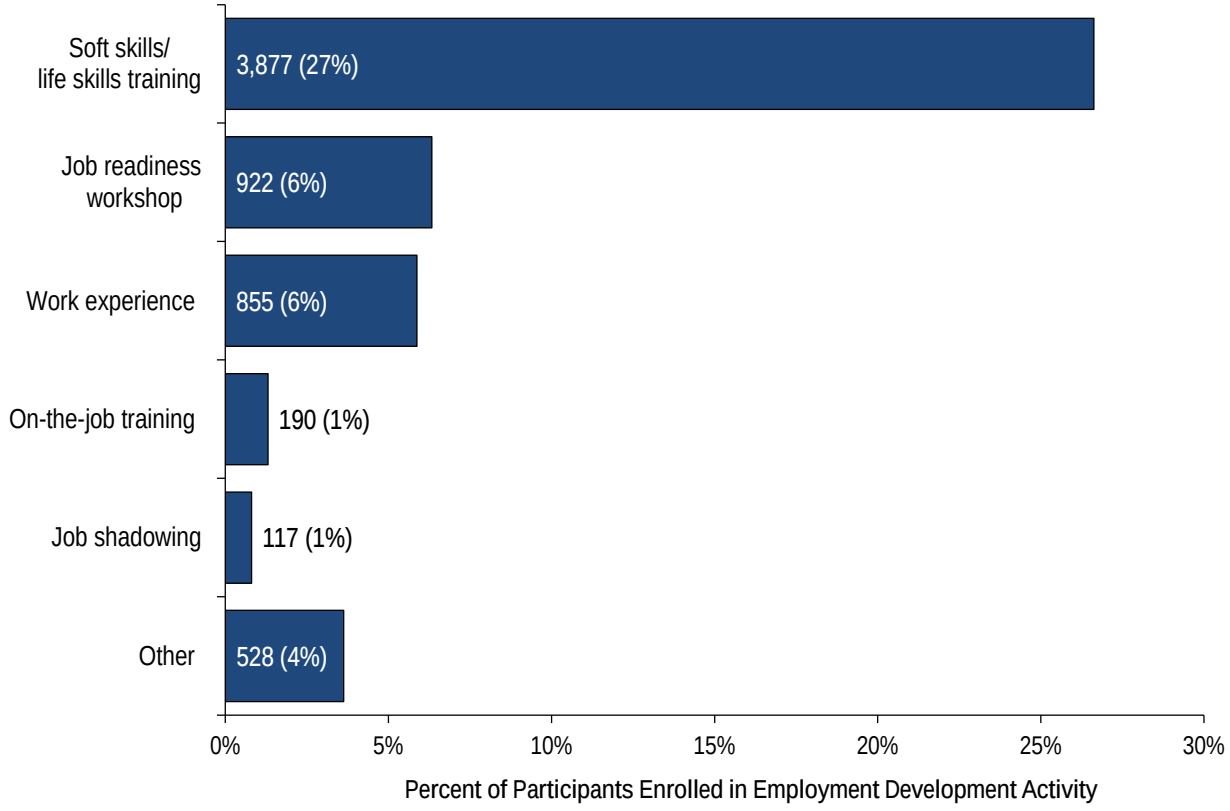
In some grantee programs, employers also provided input into the design of the HPOG employment development components. See Exhibit 4.7 for an example.

Exhibit 4.7: Improving Job Readiness Training

The College of Lake County, part of the Workforce Investment Board of Will County HPOG program in Illinois, modified its job readiness class curriculum based on employer input to include onsite visits to employers and a stronger soft skills component. Instructors and other staff are coordinating with employers through job fairs, open houses, and other connections to encourage their engagement with these classes and to identify potential job candidates. Previously, the College of Lake County provided job readiness classes after participants had completed training. In Year 2, this changed so that these classes are available throughout a participant's tenure in the HPOG program.

Exhibit 4.8 shows the number and percentage of enrollees participating in these different employment development activities in Year 2. The most common was soft skills/life skills training, provided to 3,877 enrollees (27 percent). In addition, 922 enrollees participated in job readiness workshop trainings. Work experience jobs were held by 855 participants, while smaller numbers were placed in on-the-job training slots (190), or job shadowing (117). Another 4 percent of enrollees participated in other activities, including job fairs and mock interviews.

Exhibit 4.8: Participants in HPOG Employment Development Activities in Year 2



Source: PRS. Table includes enrollees active in Year 2 (N=14,561).
Participants in multiple different employment development activities are represented more than once.

In addition to these skill-building employment development activities, each HPOG program also provided support to recipients in finding and retaining employment. This assistance was provided as job placement,

job retention, and career coaching services. Career coaches (sometimes called career navigators or job coaches) teach participants strategies to find employment opportunities, helping individuals build skills in identifying jobs, applying for jobs, networking, interviewing, developing resumes and cover letters, and creating a balance between work and personal life. In Year 2, HPOG grantees provided employment services to 8,548 individuals, 59 percent of all participants.

HPOG programs in Year 2 went beyond training to help participants succeed in the job market through employment development activities and assistance in finding and retaining employment.

5. What Outcomes Did Participants Achieve in Year 2?

The goal of the HPOG Program is to help participants complete healthcare training and obtain related employment. These outcomes for Year 2 are described below. As noted earlier, Year 2 participants included those who enrolled in Year 1 and were still in training. Additionally, some Year 2 participants enrolled later in the program year or were participating in longer trainings and will continue services into Year 3. For this reason, the outcomes described below are point-in-time estimates and not indicative of the eventual outcomes of all Year 2 enrollees.

Healthcare Occupational/Vocational Training Completion

In Year 2, 4,590 participants completed 5,588 occupational/vocational trainings.[17] Exhibit 5.1 shows completions for the eight most common trainings.[18]

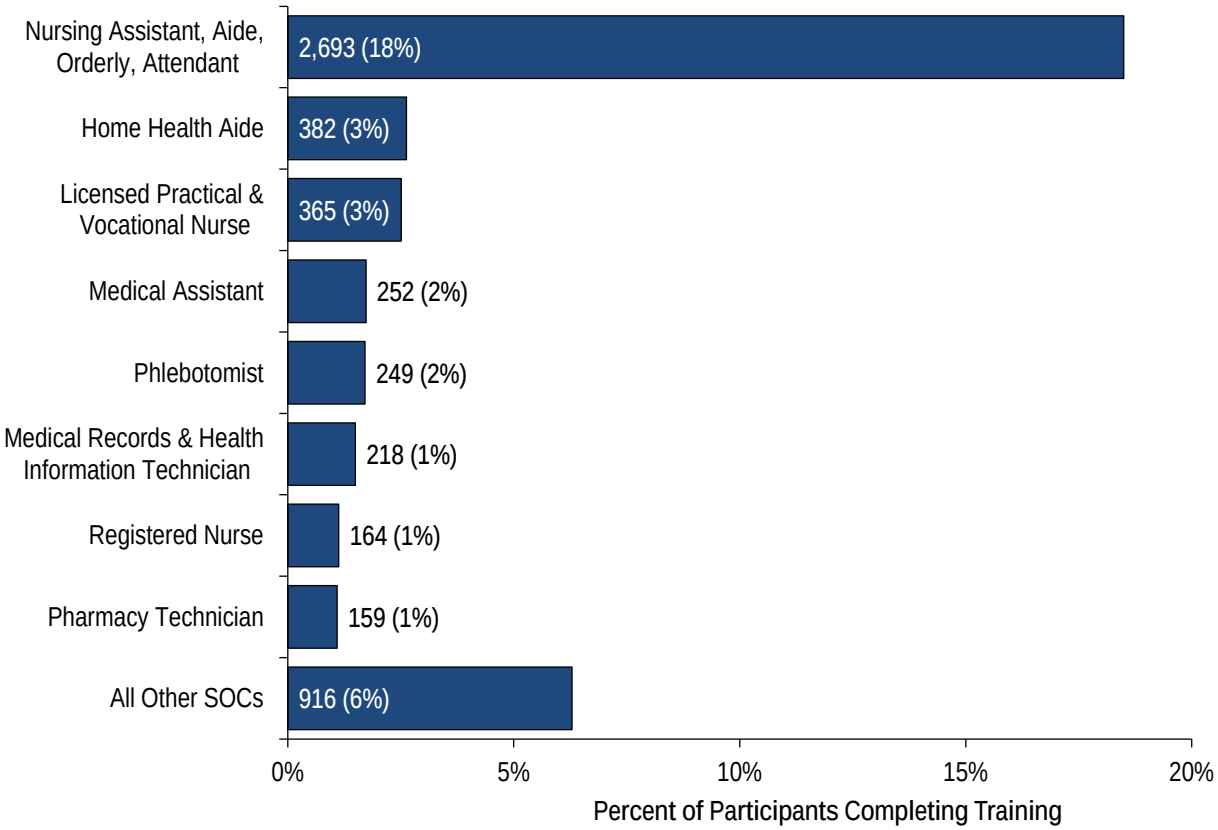
The most frequently completed occupational training was for nursing assistant, aide, orderly, and attendant. Eighteen percent of all enrollees completed this training (2,693 enrollees). Completions were high in this occupation because it is the most common training in which HPOG participants enrolled and because it is a relatively short training course. The second most commonly completed training was home health aide (382 enrollees), followed closely by LPN or LVN programs (365 enrollees). Fewer enrollees completed RN courses (164 enrollees), although this was the third most commonly participated in training program. This is likely because an RN is usually at least a two-year Associate's degree program, so many participants were still enrolled as of the end of the second grant year.

Medical assistant, phlebotomist, and medical records and health information technician training were each completed by between 200 and 300 participants. Pharmacy technician training was completed by 159 participants.

[17] Completing a training activity is not the same as completing the entire HPOG program. Grantees each define successful program completion depending on their own program model, but it may include completing multiple trainings or post-training employment-related activities and supports.

[18] Meaningful completion rates (completions as a percentage of trainings begun) cannot be calculated with these numbers because so many participants in the enrollment group were still in the midst of their training in Year 2.

Exhibit 5.1: HPOG Participants Completing Training for Most Commonly Trained-for Occupations



Source: PRS. Table includes enrollees active in Year 2 (N=14,561).
Participants that completed multiple different trainings are represented more than once.

Employment Outcomes

Participant employment in the healthcare industry is the ultimate goal of HPOG programs. This section presents several different measures of employment outcomes.[19]

One employment outcome measure is whether a participant is employed upon completion of the HPOG Program. Among those 1,627 participants who completed HPOG in Year 2, 826 (51 percent) were employed at program exit. Of these participants employed at exit, 81 percent were employed in healthcare jobs.

Another way to measure employment is the change in employment status subsequent to starting the program. This includes measures of those who were not employed at program intake but became employed while participating in the program or at exit, and those who were employed in non-healthcare employment at intake but subsequently found employment in healthcare during the program or at exit. Many HPOG grantees help participants find healthcare employment during participation in the program,

[19] These results are an early picture of employment outcomes for Year 2 participants because many were still engaged in program pre-training or training activities in Year 2 and may not have actively searched yet for healthcare employment. Also, employment at exit and six-month follow-up will be understated because inevitably some participants exit before completion and/or cannot be reached to determine employment status.

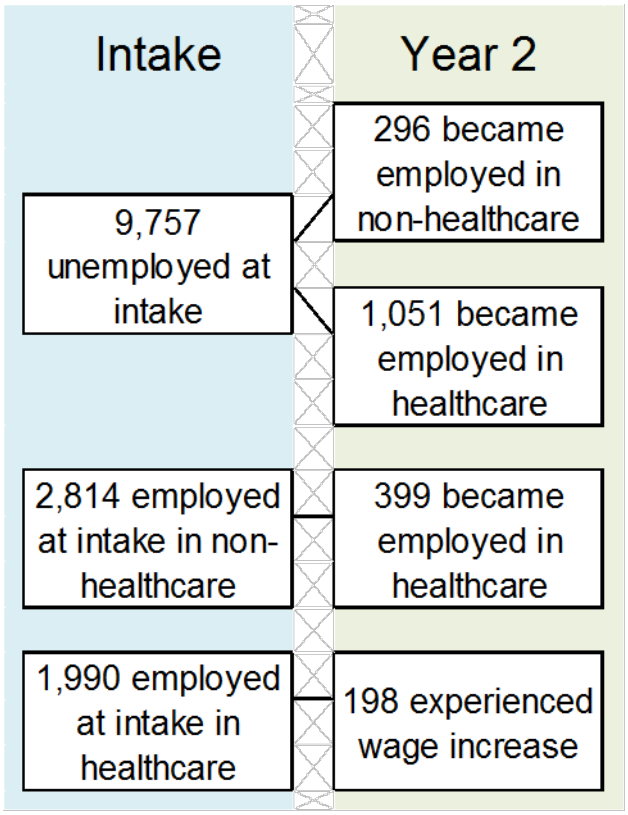
as a way of gaining occupational experience and improving employment prospects post-training, as well as upon completion of the program.

Two-thirds of those who participated in HPOG in Year 2 (9,757 participants) did not have a job at program intake. Many of these participants experienced employment gains (Exhibit 5.2). Eleven percent of them (1,051 participants) became employed in a healthcare occupation or industry during the program year. An additional 3 percent (296) became employed in a non-healthcare job.

Of the 2,814 participants who were employed at intake in a non-healthcare job, 14 percent (399 participants) found employment in the healthcare field in Year 2.

Some HPOG entrants already had healthcare jobs at intake, but in less-skilled, lower-paying positions. For these participants, HPOG's goal is to advance their career to better paying jobs. Of the 1,990 who entered HPOG with a job in a healthcare occupation or industry, 10 percent (198) experienced a wage increase in Year 2. The average wage increase was 24 percent, from $11.33 to $14.05 per hour. This includes those with wage increases during program participation well as upon program completion.

Exhibit 5.2: Employment and Wage Progression through HPOG for Year 2 Participants



The level of wages received by employed HPOG participants is an important employment outcome. Across all active HPOG participants who became employed in healthcare in Year 2, both during the program and at completion, the average wage was $12.28 per hour, more than enough to bring a family of three out of poverty with full-time employment. [20]

Exhibit 5.3 shows the number of HPOG participants who became employed in the most common healthcare occupations in Year 2 and the average wages earned by those participants. Overall, RN was the highest-paid occupation at $23.91 per hour.[21] Home health aide was the lowest paid at $10.24 per hour. However, even this lower wage of $10.24 per hour is 141 percent of the $7.25 federal minimum wage, and at full-time, full-year employment, this hourly wage is also enough to bring a family of three out of poverty.

[20] This calculation is based on the HHS federal poverty guideline for 2012.

[21] Wages are calculated for all those finding employment in the given occupation during the program or at completion of the program.

Exhibit 5.3: Wages in the Eight Most Common HPOG Training Occupations in Year 2

Occupation	Number Employed	Average Hourly Wage	Annual Full-Time Equivalent Earnings
Nursing Assistant, Aide, Orderly, and Attendant	1,590	$11.13	$23,150
Licensed Practical and Licensed Vocational Nurse	188	$18.17	$37,794
Registered Nurse	91	$23.91	$49,733
Medical Assistant	124	$12.65	$26,312
Medical Records and Health Information Technician	72	$13.59	$28,267
Home Health Aide	251	$10.24	$21,299
Phlebotomist	35	$11.80	$24,547
Pharmacy Technician	52	$13.83	$28,766

Even at this early stage of the HPOG Program, many participants are finding employment. Half of all participants who completed the program were employed at exit, the majority in healthcare jobs. In addition, HPOG participants were finding jobs during the program to help them gain experience to improve their post-program employment outcomes.

6. HPOG Program Implementation

As discussed earlier, HPOG was designed to meet the growing demand for healthcare jobs by helping low-income individuals obtain the skills and competencies required to obtain high-demand jobs that pay well. Every HPOG program has common elements, but each program works to meet the specific needs of the communities it serves.

In Year 2 of the program, the HPOG grantees continued to reflect, learn, and make program adjustments to meet the overall goals of the HPOG Program. Some tailored their programs to match individuals more effectively with training programs and to support their success. Others made efforts to provide timely responsiveness to local healthcare industry needs or crafted solutions to work around other constraints. This section describes ways that grantees reported continuing development of their programs in Year 2 to meet newly identified needs of their target populations and employers.

Tailoring the Program to Meet the Needs of the Population

To serve low-income populations that may have significant barriers to employment and may have had poor educational experiences in the past, HPOG programs must develop strategies to ensure that applicants understand what will be required of them and what working in a healthcare profession entails. The grantees also must provide support services to meet academic and personal needs and to address challenges that could serve as barriers to completing the program or becoming employed. Grantees planned ahead for these expected challenges, but in some cases the challenges were greater than anticipated. In other cases, grantees learned through program implementation that the planned strategies needed some adjustment. Grantees reported adjusting their approaches in many ways, sometimes learning from each other, to better meet the needs of their target populations.

Twelve grantees reported changing their assessment tools and/or pre-screening processes to better assess skill levels, adding boot camps or altering their remedial services. Assessment tools help grantees determine the extent to which applicants and their programs are a good match and what kinds of remedial services participants may need to be successful in the program. Five grantees reported adopting new assessment tools, while three other grantees reported maintaining the same tools but using the findings

from the assessments differently in determining program eligibility. For example, both Schenectady County Community College in New York and Temple University in Philadelphia stated that participants with Test of Adult Basic Education (TABE) scores somewhat below program requirements were not automatically excluded and other criteria, such as motivation, attitude, and commitment were considered in training enrollment decisions.

Assessments may indicate the need for basic skills instruction to ensure that a participant's reading and math skills are at sufficient levels to succeed in the program. Traditional basic skills instruction, however, is sometimes not popular with participants who are in need of immediate employment, because that model requires that participants improve reading, writing, and math skills prior to beginning occupational training. Program models such as Washington State's Integrated Basic Education and Skills Training (I-BEST) provide basic and occupational skills instruction concurrently in the same courses. Some grantees included this program model from the start, and two recently added this approach. The boot camp model provides an intensive introduction to healthcare careers, training, and participant expectations. Some grantees included this model in their original HPOG plan, but three grantees recently adopted the boot camp model, with one adapting the approach used by another grantee. Although not calling it a boot camp, another grantee adopted a model of similar content and intensity.

Many healthcare professions require criminal background checks, and employers will not hire individuals with certain kinds of criminal records. Criminal background checks, however, are not always part of the college admission process, which means that some individuals were being trained in fields in which they could never be employed. Three HPOG grantees moved the criminal background screening to an earlier point in the training process to ensure that individuals are only enrolling in programs where they could eventually become employed. Schenectady County Community College, however, took a different approach by adding a training program for a field that does not exclude workers based on criminal records (see Exhibit 6.1).

Exhibit 6.1: Helping Ex-Offenders

Schenectady County Community College (SCCC) in New York developed a dental lab technician apprenticeship program in collaboration with the NY State Office of Apprenticeships. The dental lab technician occupation does not exclude individuals with criminal records. This option allows SCCC to help ex-offenders train for an occupation rather than excluding them from the program, while helping employers meet their growing needs for dental lab technicians.

Apprenticeships enable participants to learn and practice healthcare career skills in a professional setting while earning a salary, an important consideration for many participants. Developing apprenticeships differs from developing classroom training. Apprenticeships require approval from a state regulatory agency and support of employers who will provide the apprenticeship slots. In many states, healthcare has not been a traditional field for apprenticeships. Some grantees are working to partner with their state apprenticeship agencies and to educate employers about the benefits of apprenticeship programs. For example, the Workforce Development Council of Seattle-King County in Washington State developed partnerships with migrant and community health agencies to create a medical assistant apprenticeship.

Finally, some grantees are adjusting their case management approaches. Eleven grantees reported changing this support in some way during Year 2. One approach adopted requires participants to use certain support services, for example, job-seeking skills training at the College of Menominee Nation; an intensive, three-week session to help with attitude, motivation, and commitment (STRIVE) at The

WorkPlace in Connecticut; and tutoring for struggling students at Southland Health Care Forum in Illinois. Another strategy used was creating a rewards system to encourage positive participant behavior (see Exhibit 6.2.)

Exhibit 6.2: Creating HOPE

Eastern Gateway Community College (EGCC) in Ohio helps its participants make educational gains through HOPE rewards. HOPE points are earned through certain behaviors or benchmarks, such as perfect weekly attendance, 4.0 grade point averages, and self-sufficiency (no need to use financial support for an entire semester). Participants can redeem the HOPE points for allowable items that support their healthcare coursework (such as scrubs and stethoscopes) and that support their basic family needs (like diapers, utility vouchers, and gas cards). EGCC reports a marked improvement in attendance, an important step toward training completion.

Restructuring to Meet Changing Employer Demands

The healthcare industry is dynamic, responding to both national policy changes and changing demographic and economic conditions at the local level. This environment can mean that plans made one year need to be changed the next to provide timely responses to employer demands. Most HPOG grantees reported responding to this environment with changes to available occupational trainings. During program planning, eight grantees changed or eliminated trainings that had appeared initially to meet employer needs when employer demand proved less than anticipated. The trainings that were eliminated varied across grantees. Some examples are: medical administrative assistant, phlebotomy, qualified service provider, and geriatric technician. In other cases, grantees identified new employer needs, including demand for clinical medical assistants and community health workers. For example, the Southland Health Care Forum added clinical medical assistant and phased out medical administrative assistant due to greater employment opportunities for the former.

HPOG programs also help employers identify needs and then work with them to create solutions. Schenectady County Community College and Temple University provide two examples of such collaborations (Exhibit 6.3). In both cases, employers indicated that they had particular kinds of needs for which there were no existing training programs. Both of these efforts are helping to meet HPOG's twin goals of supporting healthcare employer needs while expanding career options for low-income individuals.

Exhibit 6.3: Employer Collaborations to Meet Emerging Needs

Schenectady County Community College is working with a consortium of employers to develop a new training course for direct support professionals (personal care aides to persons with disabilities). Prior to development of this training, despite employer needs for the skills taught in the program, not many individuals wanted to enroll because there was no industry-recognized certification. The employer consortium is developing a working group to create a mutually agreed upon curriculum to be provided by the HPOG program and a regionally recognized certification. This will provide HPOG graduates with an advantage in the marketplace.

Temple University is piloting a community health worker (CHW) training. Health care employers in the area were beginning to see employing CHWs as a cost-effective strategy to help patients maintain their treatment plans, have positive health outcomes, and reduce healthcare costs. The University is implementing this pilot training, working with employers to refine the curriculum, conduct a portion of the training, and develop an on-the-job training component.

7. Summary

During the second grant year, the HPOG Program continued to grow, enrolling 8,973 new participants and serving 5,588 continuing participants. About three-quarters of Year 2 participants were enrolled in a healthcare training. HPOG programs provided pre-training activities and a variety of support services and employment assistance to help participants succeed. Many participants had positive outcomes in Year 2. Almost half completed a training course and others found employment in healthcare jobs and gained higher wages.

HPOG strives to provide training opportunities that cultivate career ladders or pathways for individuals. The programs provide a variety of career options allowing participants to start at the appropriate level, whether in pre-training or more advanced healthcare training. Once a credential is earned, participants can move on to another training course to progress in their career. Exhibit 7.1 presents stories about individuals who have had some success progressing in their healthcare careers with the help of the HPOG Program.

Exhibit 7.1: Progress in Healthcare Careers

From Grocery Cashier to Successful LPN

The Buffalo and Erie County Workforce Development Council shared the story of a mother of three who has transitioned successfully from a spotty employment history as a one-time grocery cashier and hair stylist to an LPN. When she started HPOG she was unemployed, living on child support, food stamps, and assistance from her mother. Now she earns $16.50 per hour plus health benefits working full-time as an LPN. She is continuing on her nursing career path by taking classes to pursue an RN degree.

From Seasonal Worker to Dental Assistant

The New Hampshire Department of Minority Health and Refugee Affairs enrolled a participant who had left Los Angeles to exit the gang lifestyle and make a better life for his family. Since moving to the east coast, he had only been able to get seasonal construction work. This was not the better life he hoped for. HPOG offered him the opportunity to explore other options while helping him with securing reliable child care, providing him mileage reimbursement for his 55-mile home-to-school route, and helping him to obtain a computer to work on his skills. The HPOG case manager helped him select dental assistant coursework and a program that matched his learning style. Now he earns $20 per hour assisting in the surgical room of a growing dental practice.

The results in this report are a snapshot of the HPOG Program in its second year of operation. Many grantees devoted part of Year 1 to planning and program start-up. Grantees continued to develop their programs throughout Year 2, engaging in an iterative process of learning and improvement. HPOG participant outcomes will build over time. Those enrolling in Year 2 may complete their training in Year 3. Individuals who attained credentials in Year 2 may return for further education. The full HPOG story remains to be told.

In addition to future annual reports, other reports from the HPOG evaluation activities will provide information. These include a more detailed and comprehensive look at HPOG operations and outcomes; an in-depth study of how grantees implemented HPOG programs; a report on the broader HPOG systems, including the role of partnerships and future sustainability; and analysis of the impact of HPOG program features on program outcomes using experimental methods.

Appendix A. Data Sources and Limitations

The statistics presented in this report are based on data from the Performance Reporting System (PRS), the HPOG participant-tracking management information system, and grantees' Performance Progress Reports (PPRs). Participant data are entered by each grantee into the PRS and are quality-controlled by Abt Associates and the Urban Institute. The PRS is specific in defining data items to ensure consistency across grantees. These data are the basis of the PPR measures. Each grantee submitted a PPR in October 2012 (finalized in December 2012) that contained information on Year 2 of HPOG. The Urban Institute extracted the individual-level data on which these reports were based from the PRS on January 10, 2013.

Most of the data reported in this report are for Year 2 of the HPOG Program. The PRS was implemented at the beginning of Year 2, on September 30, 2011. The data for Year 1 in this report come from the grantees' PPRs, which were submitted on paper. We do not have individual-level data for Year 1 of the HPOG Program. Consequently, we cannot examine certain subgroups or cross-tabulations in Year 1 that are possible using the individual-level data for Year 2 from the PRS.

In addition, the PRS is a "live" data system, meaning grantees are continually entering new data. Grantees also have the ability to revise or update data that were incorrect, missing, or had not yet been entered for past recipients. For this reason, results based on data extracted at a point in time are subject to change.

The specific grantee examples and information about program implementation in this report come from the narrative portions of the grantees' PPRs and from ACF's 2012 report *Health Profession Opportunity Grants (HPOG) Compendium of Promising Practices*.[22] Using qualitative coding software, the Urban Institute analyzed information from the narrative portions of the PPRs to identify common themes across grantee experiences. Information was organized into the following categories: accomplishments (including solutions and adjustments to challenges, partnerships), challenges (including administrative issues, inter-agency collaboration, programmatic elements, systems alignment, and grantee-grantor issues), and explanatory statements (including enrollment, outcomes, and support service use). Not all grantees completed the PPRs at comparable levels of detail, and several items are not specifically requested in the PPR, most notably an account of accomplishments (although this was included by some grantees). General information on grantees' enrollment goals and funding levels come from administrative documents provided by ACF.

[22] For more information, see http://hpogcommunity.acf.hhs.gov/Resource%20Library/HPOG_PromisingPracticesNOV12_Final.pdf.

Appendix B: Trainings Offered in Year 2

Standard Occupational Code (SOC)	Number of Grantees Offering Training
Counselors	
21-1010 Counselors	1
21-1011 Substance Abuse and Behavioral Disorder Counselors	1
Community and Social Service Specialists	
21-1090 Miscellaneous Community and Social Service Specialists	5
21-1094 Community Health Workers	3
21-1798 Social and Human Service Assistants	3
31-9999 Child Care Advocate	1
Registered Nurse	
29-1140 Registered Nurse	23
Healthcare Diagnosing and Treating Practitioners	
29-1190 Miscellaneous Health Diagnosing and Treating Practitioners	2
29-1199 Health Diagnosing and Treating Practitioners, All Others	3
29-1128 Kinesiotherapist	1
29-1125 Recreational Therapist	1
29-1126 Respiratory Therapist	1
19-1042 Toxicologist	1
29-2021 Dental Hygienists	4
29-1127 Speech Pathology	1
Emergency Medical Technicians and Paramedics	
29-2040 Emergency Medical Technicians and Paramedics	3
29-2041 Emergency Medical Technicians	7
29-2042 Paramedics	9
Health Practitioner Support Technologist and Technicians	
29-2050 Health Practitioner Support Technologist and Technicians	5
29-2051 Dietetic Technician	2
29-2052 Pharmacy Technician	9
29-2054 Respiratory Therapy Technicians	9
29-2055 Surgical Technologists	13
Licensed Practical and Licensed Vocational Nurses	
29-2060 Licensed Practical and Licensed Vocational Nurses	25
Medical Records and Health Information Technicians	
29-2070 Medical Records and Health Information Technicians	24
29-2071 Medical Records and Health Information Technicians	9
27-3091 Interpreters and Translators	3
43-4171 Receptionists and Information Clerks	4
43-6013 Medical Office Clerk / Secretary / Specialists	10
11-9111 Medical and Health Services Managers	3
Miscellaneous Health Technologist and Technicians	
29-2090 Miscellaneous Health Technologists and Technicians	3
29-2099 Health Technologists and Technicians, All Other	8
Psychiatric and Home Health Aides	
31-1010 Psychiatric, and Home Health Aides	7
31-1011 Home Health Aides	6
Nursing Aides, Orderlies, and Attendants	

Standard Occupational Code (SOC)	Number of Grantees Offering Training
31-1012 Nursing Aides, Orderlies, and Attendants	14
31-1014 Nursing Assistants	23
31-1015 Orderlies	3
31-1016 Patient Care Technician	6
Clinical Laboratory Technologists and Technicians	
29-2010 Clinical Laboratory Technologists and Technicians	2
29-2011 Medical and Clinical Laboratory Technologists	5
29-2012 Medical and Clinical Laboratory Technicians	10
11-9121 Clinical Research Coordinator	1
51-9081 Dental Lab Technician Dental Hygienists	1
Diagnostic Related Technologists and Technicians	
29-2030 Diagnostic Related Technologists and Technicians	3
29-2031 Cardiovascular Technologists and Technicians	10
29-2032 Diagnostic Medical Sonographers	3
29-2034 Radiologic Technologists	11
Occupational Therapy Assistants and Aides	
31-2010 Occupational Therapy Assistants and Aides	1
31-2011 Occupational Therapy Assistants	7
31-2012 Occupational Therapy Aides	3
Physical Therapist Assistants and Aides	
31-2020 Physical Therapist Assistants and Aides	1
31-2021 Physical Therapist Assistants	12
31-2022 Physical Therapist Aides	3
31-9010 Massage Therapists	4
Miscellaneous Healthcare Support Occupations	
31-9090 Miscellaneous Healthcare Support Occupations	6
31-9091 Dental Assistants	13
31-9092 Medical Assistants	23
31-9093 Medical Equipment Preparers	3
31-9094 Medical Transcriptionist	6
31-9095 Pharmacy Aides	2
31-9097 Phlebotomists	20
31-9099 Healthcare Support Workers, All Others	7