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Practice Brief

Implementing Healthcare Career Pathway Training Programs in Rural Settings: Responsive Approaches by Tribal HPOG 2.0 Grantees

This practice brief is the third in a series developed by the Tribal HPOG 2.0 evaluation team. The briefs disseminate important lessons learned and findings from the Evaluation of the Tribal Health Profession Opportunity Grants (HPOG) Program, which is sponsored by the Office of Planning, Research, and Evaluation within the Administration for Children and Families. The Tribal HPOG 2.0 Program supports 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. This practice brief examines the challenges faced by the Tribal HPOG 2.0 programs that operate in remote, sparsely populated rural communities and describes the strengths-based approaches they have developed or leveraged in response.

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. The five Tribal HPOG 2.0[1] grantees are Cankdeska Cikana Community College (CCCC), Great Plains Tribal Chairmen's Health Board (GPTCHB), Turtle Mountain Community College (TMCC), Ute Mountain Ute Tribe (UMUT), and Cook Inlet Tribal Council, Inc. (CITC).

Nationally, most of the areas with the highest need for healthcare workers are rural.[2] In addition to a shortage of primary care providers, rural areas experience shortages of other healthcare workers, including physician assistants, physical therapists, and registered nurses.[3] Additionally, healthcare workforce shortages are exacerbated as more workers near retirement age; for example, nearly a third of registered nurses will be of retirement age within the next decade.[4] The HPOG Program aims to address the shortage of healthcare workers by providing individuals with the necessary training to obtain employment in healthcare professions in their communities.

Four of the five Tribal HPOG 2.0 grantees (CCCC, GPTCHB, TMCC, and UMUT) largely serve participants who live and work in rural areas. CITC primarily implements their program in an urban area, though does serve some individuals who have relocated from rural native villages and regions.

The purpose of this brief is to examine the opportunities and challenges in implementing education and training programs in rural communities and describe how the Tribal HPOG 2.0 grantees have leveraged their communities' strengths to maximize these opportunities and overcome these challenges.

WHAT IS RURAL?

According to the Federal Office of Rural Health Policy (FORHP) approximately 84 percent of the geographic area in the United States and 18 percent of the population are classified as rural.[5] While there are multiple ways to define "rural,"[6] the FORHP definition broadly includes counties that feature a core urban area with a population of less than 50,000 (i.e., non-metropolitan counties).[7] We use this definition as it characterizes the extensive land areas, long distances to services, and sparse populations served by the Tribal HPOG 2.0 grantees.

Demographically, rural populations tend to be older and more homogenous than populations in other parts of the country, although this varies significantly by region.[8,9] While rural populations tend to be less racially and ethnically diverse than urban populations, almost all rural areas have seen an increase in racial and ethnic diversity over the past four decades.[10]

AMERICAN INDIANS/ALASKA NATIVES IN RURAL AREAS

Most tribal reservations are located in rural areas.[11] However, while rural populations tend to be older than populations in other parts of the country, the median age for American Indians/Alaska Natives (AI/ANs) living on reservations is younger (26 years) than the rest of the country (37 years).[12]

According to the 2010 Census, 5.2 million people in the US identified as AI/ANs.[13] The First Nations Development Institute estimates that 54 percent of the AI/AN population in the United States live in rural and small town areas and 68 percent live near tribal homelands.[14]

THE TRIBAL HPOG 2.0 GRANTEES AND THEIR GEOGRAPHIC SETTINGS

The five Tribal HPOG 2.0 grantees include two tribal colleges, one tribal organization (representing 18 tribal nations and communities), one tribe, and one tribal social service organization. The grantees implement their programs in 12 locations, of which seven are in rural areas (according to the FORHP definition). Four of the five Tribal HPOG 2.0 grantees implement their programs on tribal reservations with a rural designation per the FORHP definition.

Grantee and Program Name	Implementation Location	Rurality
Cankdeska Cikana Community College (CCCC) – Next Steps II	Fort Totten, ND (Spirit Lake Reservation)	**Rural**
	Bismarck, ND	**Urban**
	Fargo, ND	**Urban**
	Grand Forks, ND	**Urban**
	Minot, ND	**Rural**
Cook Inlet Tribal Council, Inc. (CITC) – CITC HPOG	Anchorage, AK	**Urban**
Great Plains Tribal Chairmen's Health Board – Pathways to Healthcare Professions	Rapid City, SD	**Urban**
	Eagle Butte, SD (Cheyenne River Reservation)	**Rural**
	Pine Ridge, SD (Pine Ridge Reservation)	**Rural**
	White River/Mission, SD, (Rosebud Reservation)	**Rural**
Turtle Mountain Community College (TMCC) – HEART Project	Belcourt, ND (Turtle Mountain Reservation)	**Rural**
Ute Mountain Ute Tribe – Healthcare Ute Project	Towaoc, CO (Ute Mountain Reservation)	**Rural**

The CITC HPOG program is located in the Anchorage metropolitan area in Alaska and primarily serves urban participants. However, some of the individuals served by CITC are Alaska Natives who have relocated to Anchorage from rural native villages and regions. Recognizing this movement, CITC offers programs to address the needs of AI/AN residents living in or new to urban areas, such as skills-based classes designed to help residents navigate challenges they may encounter in an urban setting. Classes cover topics such as online learning and computer skills, money management, and job sustainability.

Similar to CITC, several of the other Tribal HPOG 2.0 grantees serve individuals from rural communities at their urban implementation locations. GPTCHB and CCCC, for example, serve many students in Rapid City, Fargo, Bismarck, and Grand Forks who have relocated from rural tribal communities to pursue work or education. In addition, many students at these sites commute regularly from rural areas to pursue educational opportunities.

INTERSECTION OF STRENGTHS AND CHALLENGES OF RURAL AND TRIBAL CONTEXTS

Rural communities frequently leverage cultural and historical assets to facilitate program development and implementation.[15] Examples of commonly cited rural community assets include cross-sector cooperation, where organizations from various sectors collaborate to address community challenges; social cohesion, which describes community members' willingness to cooperate with each other to survive and prosper; and community resilience, which describes a community's ability to prepare and recover from adverse events.[16,17] These assets often result in the creation of formal and informal partnerships that reach across sectors, including health care, education, business, and social services. These partnerships are anchored in the relationships built between individuals and they allow communities to address economic and social challenges in resourceful ways.

In tribal communities, social relations and networks, such as kinship systems, are also key assets and can help support community and economic development.[18] Kinship systems establish networks and relationships beyond family relationships and provide a mechanism for individuals to engage in the community.[19] Some tribal members feel a sense of belonging to their broader community and cultural heritage, which can drive efforts to improve the quality of life and well-being of the community.[20]

Despite these strengths, education and training programs that operate in rural areas experience barriers to serving their populations. Rural populations tend to experience high levels of poverty, particularly within tribal lands.[21,22] Fifteen percent of all rural counties are persistently poor, meaning that 20 percent or more of the population has lived in poverty for over 30 years.[23] Some rural populations also experience a lack of adequate infrastructure. For instance, more than 30 percent of rural residents and more than 35 percent of tribal residents lack access to high-speed internet, which limits opportunities for economic growth.[24,25] Other barriers may include geographic isolation, a need to travel long distances to access services, and high costs for these services. Residents in rural areas are less likely than those in other areas to have access to a vehicle or public transportation and average trips for healthcare services are

around nine miles longer in rural areas than in urban areas.[26,27] Many rural areas have limited child care options for young children.[28] In rural areas, affordable housing is often scarce due to high costs, and housing options are often limited due to substandard conditions and quality.[29]

Additionally, rural populations often experience limited job opportunities and sporadic access to local employment and social service offices due to reduced state and local resources. While economic development by tribal nations has increased over the past two decades through tribally-owned businesses and institutional infrastructure,[30] many tribal communities still experience significant challenges, with some lacking employment opportunities that offer a living wage. Given these circumstances, people often leave their communities in search of jobs in urban areas to support themselves and their families.[31]

PROGRAM RESPONSES TO RURAL CHALLENGES

As described, most of the Tribal HPOG 2.0 grantees serve participants who live and work in rural areas. The grantees have leveraged community assets to develop their programs and address unique challenges of these areas.

Leveraging Partnerships to Expand Healthcare Training Opportunities

Rural areas have a limited number of higher education institutions and training facilities, particularly institutions that offer healthcare training programs. Tribal HPOG 2.0 grantees capitalize on assets such as longstanding relationships and often partner with institutions across their geographic region to provide a variety of training opportunities for their HPOG participants.

For example, GPTCHB has partnered with eight higher education institutions across the state of South Dakota, including South Dakota State University, a four-year university located in Rapid City, to offer advanced training in nursing. Similarly, UMUT has partnered with a local community college in Mancos, Colorado, 32 miles from their implementation site in Towaoc, which offers courses along the nursing career pathway. Participants can complete Certified Nursing Assistant (CNA), Licensed Practical Nurse (LPN), and Registered Nurse (RN) training at this community college.

Articulation agreements that allow the transfer of credits from one institution to another, such as a "2+2" program, enable students to complete some of their education in their local communities before transferring to finish their studies in an urban area. Many of the colleges and universities in North Dakota have these agreements in place, where a student can transfer two years of credit from a community college to a four-year college and complete a bachelor's degree with two additional years of coursework. For example, CCCC uses this approach to support participants to obtain a bachelor's degree in Healthcare Social Work. CCCC participants can start the social work program at a Tribal college and then finish the program at the University of North Dakota in Grand Forks or Minot State University's satellite campus in Bismarck.

Grantees also partner with other types of training organizations to offer healthcare training courses that enable participants to conduct some of the training in their local communities. For instance, UMUT has a strong partnership with the Unlimited Learning Center, an adult education center 15 miles away from Towaoc. Participants at UMUT enroll in both in-person and distance-learning courses at Unlimited Learning Center. Participants are able to enroll and complete CNA and Emergency Medical Response programs on site, and can continue with phlebotomy and nursing prerequisite classes through Unlimited Learning Center via distance learning provided by Utah State University-Blanding, enabling them to complete the trainings remotely from areas that may be far from the initial training site.

Distance Education

Due to a strong partnership with the Unlimited Learning Center, an adult education center, participants at UMUT can enroll and complete certain programs on site and then continue their education remotely via distance learning classes provided by Utah State University-Blanding.

In addition, some grantees have developed partnerships with academic institutions that work specifically with the AI/AN population. This enables the programs to expand their service delivery area and increase access to opportunities for participants while strengthening alliances between tribal institutions and expanding social networks. For example, GPTCHB's partner, South Dakota State University, has a well-regarded program aimed at attracting and retaining Native Americans to the state's nursing workforce. It features an inclusive alliance of tribal partners, community members, and academic leaders called the *Wokunze Wicaske* Alliance for Native American Nursing Students.[32] The program provides culturally tailored supportive services to native students enrolled in the South Dakota State University nursing program, which can be a source of support for students who have relocated to Brookings, South Dakota, from a tribal reservation for training.

Addressing Geographic Isolation and Increasing Access to HPOG Training and Services

In rural areas, several components of the healthcare training programs are geographically dispersed, with long distances separating participants' homes and grantee program offices, colleges and training centers, or worksites. Travelling to and from a training site requires time and financial resources. Grantees have addressed these barriers in a number of ways.

One of the supportive services offered by all of the Tribal HPOG 2.0 grantees is assistance with fuel or other transportation costs. CCCC provides financial support for fuel to participants who have to travel over 10 miles between school and home, while TMCC distributes gas cards with monetary amounts based on the roundtrip distance from the college, and UMUT provides transportation assistance for travel over 40 miles round trip. In addition to transportation assistance such as gas cards and bus vouchers, the GPTCHB staff help to arrange carpools and sometimes even offer rides themselves when they know a participant is in need.

Traveling Instructors

To provide CNA and CMA trainings to individuals living in isolated areas, GPTCHB hired a certified instructor who travels to rural locations to conduct training, which has helped address healthcare staffing shortages on and near tribal reservations.

Grantees have responded to the challenges posed by geographic isolation in creative ways. When possible, grantees conduct training programs at locations that are convenient for participants. For example, GPTCHB brings CNA and CMA (Certified Medication Aide) trainings directly to participants who live in isolated areas. They hired a certified instructor as part of their core program staff who travels to various implementation sites within their service area to conduct trainings. The CNA and CMA trainings last for two to three weeks, during which the instructor temporarily lives near the training site. In some locations, GPTCHB was able to work with local partners to find housing for the instructor at no cost. GPTCHB also established partnerships with healthcare facilities near the training sites for participants to complete the clinical component of their training. Nursing homes and assisted living facilities on and near the tribal reservations that serve as clinical sites also benefit from the partnership with GPTCHB. These facilities have reported past difficulties employing and retaining CNA staff, a position that is known for high turnover rates, and note that they are able to identify and hire qualified applicants from the HPOG participants who complete training at their facility.[33]

Administering Exams Onsite

TMCC and GPTCHB proctor CNA certification exams on site so participants do not have to travel long distances to urban testing centers.

TMCC holds their CNA training course at the TMCC South Campus, which is located in the center of town and is more convenient for participants than the Main Campus, which is three miles north of the town center. The tribal transportation service has a stop near the South Campus building, providing access for students who do not have a car. To further serve participants, TMCC also offers their case management services at the South Campus so participants can access case management services and training courses at the same location.

Once training is completed, some HPOG participants face challenges traveling to the site of certification exams, which are often administered at testing sites in urban areas. To address this barrier, TMCC and GPTCHB proctor CNA certification exams on site. For other certification exams, such as Medication Aide, GPTCHB has also assisted students by renting a van and transporting students as a group 200 miles to the testing site on the day of an exam.

For the most isolated communities, employment opportunities may be limited. For example, there are limited healthcare employment opportunities in Belcourt, ND, where TMCC is located. Grantee staff recognize that some graduates may have to relocate to larger communities in the region to obtain employment in their chosen profession and inform participants during the intake process about the transitional assistance that TMCC provides. If participants decide to relocate for employment, TMCC offers these graduates financial assistance for relocation expenses, such as a rental deposit, moving expenses, and up to three months of rent. However, staff noted that it can be difficult for program graduates to move away from their community and social support networks and a limited number of participants have used transitional assistance.

Communication and Maintaining Engagement

Working with a population that is dispersed across a large geographic area requires strategic communication to develop relationships and maintain engagement between participants and the program. Grantees have implemented a variety of strategies to ensure effective communication with program participants.

In-person meetings with case managers are often not an option for Tribal HPOG 2.0 participants, as they may live a considerable distance from a site where grantee staff are located, or have limited options for transportation. In three of its four training regions, CCCC participants have at least weekly communication with their case manager, in person when possible and via text message. At GPTCHB, the staff communicate with participants at least once a week by phone to assess their needs and provide support through mentorship and advising. Nursing students enrolled in TMCC's HPOG program take classes at Dakota College at Bottineau (40 miles from TMCC), so case managers have adapted their processes to provide supportive services to those students and communicate via email and telephone instead of in person.

Regular Communication

To offset the distance, case managers maintain frequent contact with HPOG participants through a variety of virtual communication methods, including email, phone calls, and text messages to provide support and sustain participant engagement.

Grantees also collaborate with their partners to provide on-site support for participants who reside far from HPOG program staff. For example, CCCC has case managers across the state, located in Fargo (Southeast), Minot (Northwest), and Bismarck (Southwest), in addition to the case manager who serves the region immediately surrounding CCCC. The three long-distance case managers work in dedicated office space that is rented from Job Service North Dakota, a state agency that provides workforce development services. This colocation allows students easier access to HPOG program staff and allows case managers the flexibility to address the specific needs of their local area and work closely with partners in their region. Additionally, colocation at the Job Service offices helps with HPOG recruitment and maintaining partnerships with other social service organizations. Colocation of services reduces the barriers associated with traveling to multiple offices to access training or services.

Additionally, grantees have worked with partners to identify liaisons to serve participants at other institutions. For example, the Unlimited Learning Center designated a staff person to serve as a UMUT program liaison. The liaison collects necessary paperwork, answers questions about the program, and can directly contact UMUT staff as needed.

CONCLUSION

Implementing employment and training programs like HPOG in a rural area presents unique challenges and barriers, including geographic isolation, the need to travel long distances, and limited employment and education opportunities. Despite these challenges, the Tribal HPOG 2.0 grantees have leveraged community assets and strengths to implement their programs and address participant needs. These approaches include leveraging partnerships with education and healthcare institutions to provide healthcare training to participants, increasing access to services by providing transportation assistance and training opportunities in convenient areas, and maintaining engagement with participants either in person or remotely. As the Tribal HPOG 2.0 programs have developed and evolved, the grantees have adapted their programs to meet rural challenges and continued to train individuals to obtain employment in healthcare professions that are in high demand in their communities.

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