Tribal Health Profession Opportunity Grants (HPOG) 2.0 Evaluation: Final Report

OPRE Report #2021-201 | September 2021

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Overview

The Health Profession Opportunity Grants (HPOG) Program awards grants to organizations to provide education and training to Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals for occupations in the healthcare field that pay well and are expected to either experience labor shortages or be in high demand. In 2015, the Office of Family Assistance of the Administration for Children and Families (ACF), within the U.S. Department of Health and Human Services, awarded a second round of five-year HPOG grants (HPOG 2.0) to 32 grantees, including five Tribal organizations. These grants have since been extended an additional 12 months, ending in September 2021. NORC at the University of Chicago conducted an implementation and outcome evaluation of the Tribal HPOG 2.0 Program. The evaluation examined program implementation at the systems level and participant outcomes at the individual level. This final report provides a summary of findings from the five-year evaluation.

Primary Research Questions

1. To what degree do the HPOG programs conform to the career pathways framework? What are the pathways?
2. How are health professions training programs being implemented across the grantee sites?
3. What occupational training opportunities are available to HPOG participants? What is the nature of pre-training, support services, job placement, and retention services?
4. What are the individual-level outputs and outcomes for participants in the Tribal HPOG programs?

Purpose

The purpose of this final report is to summarize findings from the five-year evaluation of the Tribal HPOG 2.0 Program. The report is organized to present findings on the structure and context, career pathways approach, and outcomes of the five Tribal HPOG 2.0 programs.

Key Findings

- The Tribal HPOG 2.0 grantees used a career pathways framework to provide post-secondary training to participants. All grantees implemented a career pathway in nursing, with opportunities for entry-level training and employment as a Certified Nursing Assistant (CNA) and mid-to-higher level opportunities as a Licensed Practical Nurse (LPN) or Registered Nurse (RN). Some grantees offered other trainings in allied health professions, such as Emergency Medical Responses, Phlebotomy, and Medical Administrative Assistant.
- Grantees formed partnerships with a variety of training providers to deliver healthcare training across their service areas. Partners included educational institutions, such as two-year and four-year colleges and universities, as well as workforce development organizations that provided entry-level training programs.

- Grantees tailored academic and non-academic supports to meet participant needs. Academic supports included financial assistance for tuition and other training-related costs. To varying degrees, grantees and their partners provided academic advising, tutoring, and mentoring to help participants prepare for and complete training.
- Non-academic supports included transportation assistance, food assistance, emergency assistance, childcare assistance, and employment-related supports such as job search assistance. However, across grantees, there was low uptake of some of these non-academic supports, such as emergency assistance and childcare assistance.
- Tribal HPOG 2.0 participants were typically low-income women in their 20s and 30s, many of whom have dependent children. Most participants (61 percent) identified as American Indian/Alaska Native (AI/AN).
- The majority of participants (69 percent) completed at least one healthcare training**.** Of that 69 percent, 74 percent completed one training and 26 percent completed one training and enrolled in a second training. Eighty percent of participants who enrolled in a second training completed it.
- Forty-two percent of participants obtained employment after enrollment. The majority of participants (93 percent) who obtained employment after enrollment worked in a healthcare occupation (e.g., Nursing Assistant, Registered Nurse, and Personal Care Aide).

Methods

The Tribal HPOG 2.0 Evaluation team used a community-based, participatory research approach to examine program implementation by the five grantees and participant outcomes. The seven values described in the *Roadmap for Collaborative and Effective Evaluation in Tribal Communities* guided our efforts. The Tribal HPOG 2.0 Evaluation team collected qualitative data during four annual site visits to grantees. We conducted focus groups with participants and interviews with grantee and partner administrative staff, program implementation staff, employers, and participants who completed training, as well as those who did not complete training. Quantitative data comes from the HPOG 2.0 Participant Accomplishment and Grant Evaluation System (PAGES), a management information system used by all grantees to record participant characteristics, engagement in programs, and training and employment outcomes. More than 2,600 participants enrolled in Tribal HPOG 2.0; of those, 63 percent (1,681) consented to participate in the evaluation. Data in this report reflects only those who consented to participate in the evaluation.

Glossary

- **ACF:** Administration for Children and Families
- **AI/AN:** American Indian/Alaska Native
- **CCCC:** Cankdeska Cikana Community College
- **CITC:** Cook Inlet Tribal Council, Inc.
- **GPTLHB:** Great Plains Tribal Leaders Health Board
- **HPOG:** Health Profession Opportunity Grants
- **NDNH:** National Directory of New Hires

- **PAGES:** Participant Accomplishment and Grant Evaluation System
- **TANF:** Temporary Assistance for Needy Families
- **TMCC:** Turtle Mountain Community College
- **TWG:** Technical Work Group
- **UMUT:** Ute Mountain Ute Tribe

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Executive Summary

The Health Profession Opportunity Grants (HPOG) Program awards grants to organizations to provide education and training to Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals for occupations in the healthcare field that pay well and are expected to either experience labor shortages or be in high demand.

In 2015, the Office of Family Assistance of the Administration for Children and Families (ACF), within the U.S. Department of Health and Human Services, awarded a second round of five-year HPOG grants (HPOG 2.0) to 32 grantees, including five Tribal organizations. These grants have since been extended an additional 12 months, ending in September 2021.[1]

The HPOG 2.0 Program uses the career pathway approach articulated in the Workforce Innovation and Opportunities Act (WIOA) of 2014. As defined by WIOA, a career pathway approach involves a rigorous and high-quality education, training, and services. In the HPOG 2.0 career pathways framework, post-secondary training is "organized as a series of manageable and well-articulated steps accompanied by strong (academic and non-academic) supports and connections to employment." The career pathways model is designed to support students with education and workforce preparation as they gain successively higher credentials and obtain employment in growing occupations.[2]

ACF awarded HPOG 2.0 grants to five Tribes and Tribal organizations.

- Cankdeska Cikana Community College (CCCC)
- Cook Inlet Tribal Council, Inc. (CITC)
- Great Plains Tribal Leaders Health Board (GPTLHB)
- Turtle Mountain Community College (TMCC)
- Ute Mountain Ute Tribe (UMUT)

Two grantees, CCCC and TMCC, are Tribal colleges. CITC is a Tribal human services agency, and GPTLHB is a Tribal health board. UMUT is a Tribal government. Three of the five grantees (CCCC, CITC, and TMCC) also implemented programs under Tribal HPOG 1.0.

From 2015–2020, NORC at the University of Chicago conducted an implementation and outcome evaluation of the five Tribal HPOG 2.0 grantees to examine program implementation

[1] HPOG was authorized by the Affordable Care Act (ACA), Public Law 111-148, 124 Stat. 119, March 23, 2010, sect. 5507(a), "Demonstration Projects to Provide Low-Income Individuals with Opportunities for Education, Training, and Career Advancement to Address Health Professions Workforce Needs," adding sect. 2008(a) to the Social Security Act, 42 U.S.C. 1397g(a). The second round of grant awards has been extended through September 29, 2021.

[2] David J. Fein. (2012). *Career Pathways as a Framework for Program Design and Evaluation: A Working Paper from the Pathways for Advancing Careers and Education (PACE) Project*. OPRE Report 2012-30. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation. https://www.acf.hhs.gov/sites/default/files/documents/opre/cp_as_a_framework_final_508b.pdf.

and participant outcomes.[3] The evaluation was grounded in a community-based, participatory research approach, guided by the principles and values described in the *Roadmap for Collaborative and Effective Evaluation in Tribal Communities*.[4] The Tribal evaluation team engaged with the grantees over the five-year period to design the evaluation, develop the data collection protocols, and carry out this work. The evaluation used multiple sources of primary data, including document reviews; curricula reviews; qualitative interviews and focus groups during annual site visits with the five grantees, their partners, and participants; and participant-level and grantee-level data collected through the HPOG Participant Accomplishment and Grant Evaluation System (PAGES).

This report presents findings from the five-year evaluation of the Tribal HPOG 2.0 Program. The report is organized around findings on participant characteristics, administrative structure, the career pathways approach, academic and non-academic support services, and participant outcomes.

Participant Characteristics

Tribal HPOG 2.0 participants were primarily low-income women in their 20s and 30s, many of whom had dependent children. Most participants identified as American Indian/Alaska Native (61 percent), 14 percent identified as two or more races, and 13 percent as White or Caucasian. Almost all participants (87 percent) had a high school diploma at enrollment, and nearly 40 percent had some college experience. At enrollment, more than three-quarters of participants (76 percent) had annual household incomes of less than $20,000. Approximately 60 percent of participant households were receiving at least one public benefit at enrollment (e.g., TANF, Supplemental Nutrition Assistance Program, Free and Reduced-Price School Lunch, etc.), with 16 percent of participants receiving TANF at enrollment.

Administrative Structure of the Tribal HPOG 2.0 Grantee Programs

For all grantees, HPOG program administration was based within an organizational department focused on employment training or education at the grantee institution. Four grantee institutions offered few or no healthcare training programs themselves. To implement their programs, these grantees formed partnerships with a variety of training providers, including academic institutions and workforce development organizations, to deliver healthcare training across their service areas. The other grantee, a Tribal college, delivered all but one of its training programs in-house.

Partnerships were critical to the implementation of the Tribal HPOG 2.0 programs. Partners had several key roles in implementation, including providing training, referring participants to HPOG,

[3] Abt Associates is leading the National Evaluation of the 27 non-Tribal HPOG grantees. That evaluation includes a descriptive evaluation (including implementation, outcome, and systems studies), an experimental impact evaluation, and a cost benefit analysis.

[4] Tribal Evaluation Workgroup. (September 2013). *A Roadmap for Collaborative and Effective Evaluation in Tribal Communities*. Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/cb/training-technical-assistance/roadmap-collaborative-and-effective-evaluation-tribal-communities

and serving as partners for students to complete clinical practicums and internships. The number and type of partners with which each grantee worked varied, depending on whether the grantee institution offered healthcare training programs and the size of their HPOG service area. Partnerships were both formal (e.g., defined by a Memorandum of Understanding) and informal (e.g., grantee and partner staff established communication channels to share information about training and work-readiness opportunities).

Grantees had flexibility to organize their staffing structure and to adapt the staffing approach over time. Grantees hired staff to fulfill key roles, including staff responsible for building and maintaining employer partnerships, engaging with academic partners, coordinating data collection, and recruiting and providing case management for participants. Grantees changed their staffing structure over time to meet program goals and in response to staff turnover.

Employer engagement was a major focus of the Tribal HPOG 2.0 program. Four of the five grantees created staff positions focused on engaging employers and providing employment assistance supports. Grantee directors and institutional leaders also built relationships with employers. Grantees worked with healthcare facilities in their region to better understand workforce needs and establish communication channels with employers.

Establishing Career Pathways and Healthcare Training Programs

The Tribal HPOG 2.0 program used the career pathways framework, a model that provides students with a clear and sequential approach to training and acquiring credentials within their field of interest.[5] This framework structures postsecondary education in a set of manageable steps: for example, starting with basic bridge programs, moving into short-term certificate programs, then from one- to two-year certificates into associate's degree programs and ending with bachelor's-level education or above.

The Tribal HPOG 2.0 grantees designed their education and training programs in response to local workforce needs, taking into consideration anticipated labor shortages or areas of high demand, including nursing and allied health.

The grantees offered training programs along career pathways to varying degrees. Across grantees, training programs were offered along five career pathways: nursing, emergency response, phlebotomy-medical lab technician, health administration, and health and fitness. All grantees offered courses along the nursing career pathway and four grantees offered the emergency medical response pathway. In addition to programs along these career pathways, grantees offered certificate and degree programs in a wide range of healthcare fields, such as Medical Billing and Coding, Pharmacy Technician, and Healthcare Social Work. Grantees and training providers had flexibility in designing tailored, short-term training programs.

Healthcare training programs combined classroom instruction with work experience. Instructors led students through classroom-based curriculum and laboratory work, which was supplemented by hands-on clinical practicums or internships. Across four grantees, instructors

[5] Fein, 2012.

incorporated Tribal culture into training programs, either by instilling Tribal values as the foundation for learning or tailoring curricula to resonate with students' cultural background.

Implementing the Career Pathways Programs

Recruitment and Orientation

The HPOG 2.0 Program is designed to provide education and training for TANF recipients and other low-income individuals. In the grant applications, each grantee defined the target population and eligibility thresholds for their program. All of the grantees prioritized TANF recipients, aligning with HPOG 2.0 Program guidance. Additionally, all of the Tribal grantees emphasized AI/AN individuals as the population of focus, though non-native individuals were also eligible to enroll. Grantees defined "low-income" for eligibility purposes in different ways, typically defined as a percentage of the federal poverty threshold.

The Tribal HPOG 2.0 grantees used a variety of methods to recruit participants for their programs, including advertising campaigns, social media, outreach events at schools, and community events. Word of mouth was one of the primary recruitment tools. Referrals from partner agencies were another important component of recruitment, including TANF agencies, workforce development organizations, or academic partners.

All Tribal HPOG 2.0 grantees implemented an application process for prospective participants. Grantees assessed eligibility first (i.e., confirming if the prospective participant met the income eligibility requirements and resided in the grantee's service area). If the individual qualified, then the grantee worked with the applicant to complete the application and submit supporting materials. Grantees also developed screening processes to assess participants' commitment to healthcare training and academic readiness for training programs. Once accepted into the HPOG program, participants were oriented to the grantees' programs in different ways. Two grantees used group orientation. The other three grantees used one-on-one orientation. Generally, during orientation, grantee staff provided participants with an overview of the program, defined expectations, and answered questions.

Assessing Participant Needs and Participant Retention

All Tribal HPOG 2.0 grantees assessed participant needs and goals at program intake and on an informal basis throughout a participant's time in the program. HPOG program staff discussed potential barriers to completing training during initial meetings with participants, and together they identified what supports would be most helpful for each participant to address those barriers and challenges. At each grantee site, program staff established protocols for communication with participants (e.g., weekly check-ins). Staff used those meetings to monitor participants' progress and assess changes in participants' needs during their time in the program.

Grantees used multiple strategies to support student retention. The most common strategy was regular communication between program staff and participants to keep participants engaged. Grantees also identified trends and developed policies to improve retention in training programs.

For example, one grantee observed low attendance rates for an entry-level training and developed incentives to improve retention in the program.

Academic and Non-academic Supports Offered by Grantees

All Tribal HPOG 2.0 grantees offered a variety of academic and non-academic supports to participants. Academic supports included financial support for tuition and training-related needs, as well as academic advising, tutoring, and mentoring to help participants prepare for and complete training. Non-academic supports included personal supports such as transportation assistance, food assistance, childcare assistance, and emergency assistance, as well as employment assistance supports.

More than three-quarters of participants received academic advising and training-related cost assistance (77 and 81 percent, respectively). Nearly three-quarters received case management services (73 percent). For personal and logistical support services, designed to provide wrap-around support, just under half (45 percent) and nearly a third (32 percent) received transportation assistance and non-emergency food assistance, respectively. Under the category of employment assistance supports, 29 percent of participants engaged in job search assistance. Staff, partners, and participants across grantees emphasized the importance of the supports that HPOG programs provided in helping students complete their programs.

Program and Participant Outcomes

During the five-year evaluation period, 2,632 participants enrolled in Tribal HPOG 2.0. Of those, 1,681 participants consented to participate in the evaluation. Data in this report reflect only those who consented to participate in the evaluation.

Over half of all Tribal HPOG 2.0 participants (857) enrolled in a Nursing Assistant training. Over 100 participants enrolled in each of the following trainings: Personal Care Aides, Medication Technician/Aide, LPN, and RN. Emergency Medical Technician (EMT) and Medical Administrative Assistant programs also had high enrollments (98 and 96 participants, respectively). Many training programs had 50 or fewer participants enrolled.

The majority of participants (69 percent) completed at least one healthcare training. Of that 69 percent, 74 percent completed one training and 26 percent completed one training and enrolled in a second training. Thirty-one percent of participants did not complete a training. Of that 31 percent, 46 percent did not enroll in healthcare training, 44 percent did not pass or dropped out of training, and 9 percent are still enrolled in training.

A limited number of participants completed a training and enrolled in a training at a higher career pathways level.[6] Of the 1,167 participants who completed one training, 10 percent enrolled in a second training at a higher level. Another 16 percent of the participants who

[6] This designates whether the healthcare occupational training activity is at the entry-level, mid-level, or high-level of a career pathway. A general guide for these levels is as follows: entry-level training is for occupations with average wages less than $15 an hour; mid-level for occupations with average wages greater than $15 but less than $25 an hour; and high-level for occupations with average wages greater than $25 an hour. This is the definition used in PAGES; grantees used this definition to categorize their trainings in PAGES.

completed one training enrolled in a second training at the same or lower career pathways level, such as participants who completed a CNA training and enrolled in a Certified Medication Aide training. In both groups, 80 percent who enrolled in a second training completed it.

Forty-two percent of participants obtained employment after enrollment in Tribal HPOG 2.0. The majority of participants who obtained employment after enrollment worked in a healthcare occupation (93 percent). Of those, 51 percent earned $15 or more per hour, and 58 percent worked 35 hours or more per week. Most Tribal HPOG 2.0 participants that were employed in healthcare obtained employment in occupations that provide hands-on, direct patient care (76 percent). These occupations included nursing, psychiatric, and home health aides, personal care aides, LPNs, and RNs.

Staff, Partner, and Participant Satisfaction

Employers, partners, grantee staff, and participants expressed broad appreciation for the Tribal HPOG 2.0 grant programs and described the value of these programs for participants and their communities. Employers appreciated having mutually beneficial relationships with the Tribal HPOG 2.0 grantees. Partners described their appreciation for grantee staff and recognized HPOG programs as important for individual participants as well as the larger community. Staff from all five grantees expressed pride and satisfaction in their work, recognizing that their programs helped many participants identify and achieve their education and employment goals. Participants expressed overall satisfaction with the program and reported grantee staff and instructors provided encouragement and made them feel empowered. Participants also reported that HPOG affected their lives in transformative ways, particularly by helping attain financial stability for them and their families.

Conclusion

These results indicate that the Tribal HPOG 2.0 grantees were largely successful in designing and implementing career pathways programs to train low-income individuals for jobs in the healthcare industry. Grantees successfully engaged academic partners to provide training that increased the geographic reach of their programs beyond their Tribal communities and, in some cases, across states. Extending the network of partners also expanded the number of participants the grantees could support.

Grantees structured their programs to offer multiple access points to training, where participants could enter, exit, and re-enter a career pathway at different steps, depending on their prior education, employment goals, personal circumstances, and local conditions for healthcare employment. Most participants completed at least one entry-level healthcare training, and many enrolled in a second training at the same or lower-level. Few participants, however, followed a defined career pathway by completing a lower-level training and then enrolling in a higher-level training. In some grantee communities, there was a high demand for entry-level workers (e.g., CNA) and, in some cases, limited opportunities for employment in higher-level positions. For some grantees, staff and participants noted that there was reluctance to move away from their communities for employment opportunities. This suggests a need for greater alignment of

higher-level trainings with local and regional labor force conditions and additional supports for participants who are interested in moving for employment opportunities.

Some participants enrolled in HPOG but did not enroll in healthcare training, while others did not complete training. Participants who did not complete training indicated reasons for non-completion, including family obligations, health concerns, and balancing work and schooling. Although case management and support services were a key component of the grantees' programs, this suggests a need for more emphasis on retention strategies and case management to support participants and address barriers to completion.

Grantees provided case management and supportive services, such as tutoring, transportation, and food assistance, to encourage training program retention and completion, which participants found to be helpful. Grantees engaged employers to support work-readiness activities through clinical practicums and internships, and job search assistance. However, there was limited implementation of job placement and job retention assistance and low uptake by participants where this support was available. For future implementation, it would be important to have earlier implementation of job placement services and to sustain communication with participants once they completed their training in order for grantees to assist with job retention.

The majority of participants who obtained employment after enrollment worked in a healthcare occupation. Most worked in occupations that provided direct patient care, such as nursing assistants, medication technician/aides, LPNs, and RNs. As we learned from participants, many began or continued their education and employment journey in healthcare, and many realized their goals through HPOG 2.0.

Chapter 1: Introduction

The Health Profession Opportunity Grants (HPOG) Program awards grants to organizations to provide education and training to Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals for occupations in the healthcare field that pay well and are expected to either experience labor shortages or be in high demand. This report summarizes findings from the evaluation of the Tribal HPOG 2.0 Program. This chapter provides an overview of the HPOG program and evaluation, and introduces the five Tribal HPOG 2.0 grantees.

Overview of the HPOG Program

The Office of Family Assistance (OFA) of the Administration for Children and Families (ACF), within the U.S. Department of Health and Human Services, administers the HPOG Program. In 2010, OFA awarded a first round of five-year HPOG grants (HPOG 1.0) to 32 organizations located across 23 states. In 2015, ACF awarded a second round of five-year HPOG grants (HPOG 2.0) to 32 organizations located across 21 states. In both rounds of HPOG, five of the 32 grantees were Tribes or Tribal organizations. The second round of grant awards was extended an additional 12 months, ending on September 29, 2021.[7]

The HPOG 2.0 Program uses the career pathway approach articulated in the Workforce Innovation and Opportunities Act (WIOA) of 2014. As defined by WIOA, a career pathway approach involves a rigorous and high-quality education, training, and services. In the HPOG 2.0 career pathways framework, post-secondary training is "organized as a series of manageable and well-articulated steps accompanied by strong (academic and non-academic) supports and connections to employment." The career pathways model is designed to support students with education and workforce preparation as they gain successively higher credentials and obtain employment in growing occupations.[8]

The Tribal HPOG 2.0 Evaluation

The authorizing legislation for HPOG calls for a comprehensive evaluation of the demonstration projects funded under this program. In 2015, ACF's Office of Planning, Research, and Evaluation (OPRE) awarded a contract to conduct the National and Tribal Evaluation of HPOG 2.0 to Abt Associates and their partners, including NORC at the University of Chicago. Under this contract, Abt Associates is leading the national evaluation that includes impact, outcome, and implementation studies of the 27 non-Tribal grants awarded under HPOG 2.0. NORC is leading the Tribal evaluation, which includes an implementation and outcome evaluation of the five Tribal HPOG 2.0 grantees. The Tribal evaluation examined program implementation at the systems level and participant outcomes at the individual level. The Tribal HPOG 2.0 evaluation design is descriptive; as such, the results do not attribute causality between HPOG programs

[7] HPOG was authorized by the Affordable Care Act (ACA), Public Law 111-148, 124 Stat. 119, March 23, 2010, sect. 5507(a), "Demonstration Projects to Provide Low-Income Individuals with Opportunities for Education, Training, and Career Advancement to Address Health Professions Workforce Needs," adding sect. 2008(a) to the Social Security Act, 42 U.S.C. 1397g(a). The second round of grant awards has been extended through September 29, 2021.

[8] Fein, 2012.

and outcomes. However, the results of the evaluation can provide valuable descriptions and documentation of HPOG programs as they were implemented in the field.[9]

Throughout, the evaluation is grounded in a community-based, participatory research approach that emphasizes mutual engagement between researchers and partners. In particular, the Tribal HPOG 2.0 evaluation is guided by the seven values described in the *Roadmap for Collaborative and Effective Evaluation in Tribal Communities*.[10] These values provide an approach for partnering with Tribal communities to conduct the evaluation. We designed the evaluation in collaboration with the Tribal HPOG 2.0 grantees as well as a Tribal HPOG 2.0 Technical Work Group (TWG) composed of Tribal evaluators and subject matter experts. Because NORC served as the evaluator for the first round of the Tribal HPOG grants, we also applied lessons learned from the Tribal HPOG 1.0 evaluation.[11]

Exhibit 1 presents the key research questions for the Tribal HPOG 2.0 evaluation, which were developed in consultation with OPRE, the Tribal HPOG 2.0 grantees, and the TWG. In addition, the Tribal evaluation team aligned our research questions with questions addressed in the national evaluation where appropriate. The Tribal evaluation team used Donabedian's theoretical framework as a guiding structure for the evaluation approach, focusing on structure, processes, and outcomes.[12]

The goal of the evaluation is to provide in-depth, systematic analysis of program implementation, operations, and outputs and outcomes of the Tribal HPOG 2.0 Program. Several of the research questions in the final evaluation plan are associational and seek to understand the relationship between program components and outputs or participant outcomes (indicated with an asterisk in Exhibit 1). The evaluation was not designed to estimate impact, neither of the program as a whole nor of the specific components. Instead, the evaluation addresses the associational research questions descriptively, by reporting the subjective perceptions of grantee staff, partners, employers, and participants.

[9] OPRE, ACF, U.S. Department of Health and Human Services. (2016). *The Administration of Children & Families Common Framework for Research and Evaluation.* OPRE Report 2016-14. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/opre/report/administration-children-families-common-framework-research-and-evaluation.

[10] Tribal Evaluation Workgroup, 2013.

[11] Meit, M., Hafford, C., Fromknecht, C., Knudson, A., Gilbert, T., & Miesfeld, N. (2014). *Tribal HPOG Evaluation Final Report.* OPRE Report 2016-38. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/sites/default/files/documents/opre/tribal_hpog_1_0_final_report_3_25_16_508compliant.pdf.

[12] Donabedian, A. (1966). "Evaluating the Quality of Medical Care." *Milbank Memorial Fund Quarterly 44*(1): 166-203.

Exhibit 1. Key Research Questions

1. In what ways was the program designed or modified for Tribal organizations?
2. To what degree do the HPOG programs conform to the career pathways framework? What are the pathways?
3. What changes to the service delivery system are associated with program implementation?
4. How are health professions training programs being implemented across the grantee sites?
5. What occupational training opportunities are available to HPOG participants? What is the nature of pre-training, support services, job placement, and retention services?
6. Which program components do stakeholders believe to be the most effective in improving outcomes?
7. What are the individual-level outputs and outcomes for participants in the Tribal HPOG programs?
8. Do some programs or program components appear to be associated with positive outputs and outcomes for Tribal populations? If so, what are the hypothesized reasons for differences between outcomes?*
9. Do different program models, strategies, or components appear to lead to different outcomes for participants?*
10. Is there evidence that participation in the program is positively associated with successful employment and work force capacity building outcomes?*

*These questions are associational and are addressed descriptively.

In 2020, the conditions for HPOG implementation differed significantly from previous years. In March 2020, the World Health Organization declared the COVID-19 outbreak a pandemic. State, local, and Tribal leaders implemented emergency orders to address the pandemic, including stay-at-home orders. As a result, the Tribal HPOG 2.0 grantees adjusted their operations. When appropriate, the report describes grantees' response to the pandemic and changes they made to program structure and processes. A detailed description of the effects of the pandemic can be found in a separate Practice Brief, *Responding to the COVID-19 Pandemic: Tribal HPOG 2.0 Grantees' Program Adaptations*.[13]

Tribal HPOG 2.0 Grantees

OFA awarded HPOG 2.0 grants to five Tribes and Tribal organizations. Three of the five grantees (Cankdeska Cikana Community College, Cook Inlet Tribal Council, Inc., and Turtle Mountain Community College) also received Tribal HPOG 1.0 grants. Exhibit 2 provides an overview of each of the five Tribal grantee organizations, their locations, and their HPOG service areas.

[13] Dougherty, M., Hafford, C., Fromknecht, C., Holden, C., & Maitra, P. (2021). *Responding to the COVID-19 Pandemic: Tribal HPOG 2.0 Grantees' Program Adaptations.* OPRE Report 2021-146. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Exhibit 2. Tribal HPOG 2.0 Grantees

Grantee Name and HPOG Program Name	HPOG 1.0 Grantee	Location	Organization Type	HPOG Service Area
Cankdeska Cikana Community College (CCCC) — *Next Steps II*	Yes	Fort Totten, ND, on the Spirit Lake Reservation	Tribal Land Grant College chartered in 1974	State of North Dakota
Cook Inlet Tribal Council, Inc. (CITC) — *CITC HPOG Program*	Yes	Anchorage, AK	A Tribal nonprofit social service organization, serving AI/AN people within the Cook Inlet Region of Alaska	Municipality of Anchorage, Eagle River, Chugiak, and the Matanuska-Susitna (Mat-Su) Valley
Great Plains Tribal Leaders Health Board (GPTLHB)* — *Pathways to Health Professions*	No	Rapid City, SD	A nonprofit organization representing 18 Tribes and Tribal communities in the four-state region of South Dakota, North Dakota, Nebraska, and Iowa	Urban sites, rural areas, and reservations across western South Dakota and northern Nebraska
Turtle Mountain Community College (TMCC) — *HEART Project (Health Education Access through Rural Training)*	Yes	Belcourt, ND, on the Turtle Mountain Chippewa Reservation	Tribal Land Grant College chartered in 1972	Turtle Mountain Reservation and surrounding Rolette County, North Dakota
Ute Mountain Ute Tribe (UMUT) — *Health-Care UTE Project (HCUTE)*	No	Towaoc, CO	A reservation-based Tribe located in the southwest corner of Colorado, with reservation lands extending into Utah and New Mexico	Ute Mountain Ute and White Mesa Reservations, in Montezuma County, Colorado, and in the municipalities of Blanding, Utah; Ignacio, Colorado; and Farmington, New Mexico

*Great Plains Tribal Leaders Health Board was known as Great Plains Tribal Chairman's Health Board until September 2020.

Organization of the Report

This report presents findings from the five-year evaluation of the Tribal HPOG 2.0 program. The report is organized to present findings on the structure and context, career pathways approach, and outcomes of the program. Chapter 2 describes the evaluation methodology and study limitations. Next, Chapter 3 presents characteristics of the Tribal HPOG 2.0 participants. Chapter 4 describes the structure of the Tribal HPOG 2.0 programs, including grantees' administrative structure, partnerships, and employer engagement. Chapter 5 describes the career pathways approach and how this model was implemented by the Tribal HPOG 2.0 grantees, including the array of academic and non-academic supports provided to support retention, completion, and employment. Chapter 6 presents the educational and employment outcomes from the five-year evaluation. Finally, Chapter 7 summarizes findings on program implementation and participant outcomes across the five grantees.

Chapter 2: Methodology

This chapter presents the study methodology. It begins by describing the approach for working with the Tribal HPG 2.0 grantees to design and implement the mixed-methods evaluation. Next, the chapter describes data collection and analysis, followed by the limitations of the study.

Approach to Working with the Tribal HPOG 2.0 Grantees

The Tribal HPOG 2.0 evaluation team drew on a community-based, participatory research approach to examine program implementation by the five grantees and participant outcomes. The seven values described in the *Roadmap for Collaborative and Effective Evaluation in Tribal Communities* guided our efforts.[14] The Tribal evaluation team committed to putting these values into practice to sustain a trusting partnership with the Tribal grantees and foster a collaborative learning experience. The seven values and their practical application to the Tribal HPOG 2.0 evaluation are described in a separate Practice Brief, *Principles to Guide Research with Tribal Communities: The Tribal HPOG 2.0 Evaluation in Action*.[15] We conducted a literature review about conducting research and evaluation in AI/AN communities and the implementation and evaluation of similar programs in AI/AN communities.[16] This informed the evaluation design and approach, which are described in detail in the Tribal HPOG 2.0 Evaluation Plan.[17]

Seven Values in the *Roadmap*

- Indigenous Ways of Knowing
- Respect for Tribal Sovereignty
- Strengths Focus
- Cultural and Scientific Rigor
- Community Engagement
- Ethical Practices
- Knowledge Sharing

We engaged with the grantees throughout the five years of the evaluation. At the beginning of the evaluation, the team met with grantees to learn about their Tribal history and culture and to ask what they hoped to learn through the evaluation, as well as their preferred strategies and methods for data collection. We negotiated Memoranda of Understanding (MOUs) with the Tribal grantees and their leadership to outline the roles and responsibilities for the evaluation team and the grantees. Additionally, we obtained the Tribal approvals necessary to conduct research with the grantees.

[14] Tribal Evaluation Workgroup, 2013.

[15] Meit, M., et al. (2017). *Principles to Guide Research with Tribal Communities: The Tribal HPOG 2.0 Evaluation in Action*. OPRE Report #2017-61. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/opre/report/principles-guide-research-tribal-communities-tribal-hpog-20-evaluation-action

[16] Meit, M., Hafford, C., Fromknecht, C., Phillips, E., Miesfeld, N., & Nadel, T. (2017). *Informing the Tribal Health Profession Opportunity Grants (HPOG) 2.0 Evaluation Design: A Brief Review of the Literature*. OPRE Report 2017-62. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/opre/report/informing-tribal-health-profession-opportunity-grants-hpog-20-evaluation-design-brief

[17] Meit, M., Hafford, C., Fromknecht, C., Phillips, E., Miesfeld, N., & Nadel, T. (2017). *Health Profession Opportunity Grants (HPOG) 2.0 Tribal Evaluation: Evaluation Plan.* OPRE Report 2016-37. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/opre/report/health-profession-opportunity-grants-hpog-20-tribal-evaluation-evaluation-plan

We met with each grantee to review the evaluation design and protocols and gather input. During these meetings, we sought input on the evaluation design, discussed questions that were important to the grantees or Tribal organizations, and discussed culturally responsive approaches to qualitative data collection methods and protocols. The Tribal evaluation team also held meetings with the Tribal HPOG 2.0 TWG to gather insights on data collection. The TWG provided guidance on the content, cultural relevance, and completeness of the interview and discussion guides, as well as ways to increase respondent participation and decrease burden. We incorporated this feedback into the evaluation plan and protocols. The final data collection protocols can be found in the Tribal HPOG 2.0 Evaluation Plan.[18]

Providing evaluation technical assistance (TA) was another key component of our evaluation approach. In addition to one-on-one technical assistance and group sessions, we worked with the grantees to prepare "program snapshots" for each grantee program (see text box for evaluation TA topics and activities). The program snapshots were requested by the grantees to help them share data about their programs within their communities. The program snapshots highlight key features of the Tribal HPOG 2.0 programs and outcomes from the first four years of program implementation.[19] In working with the grantees, the Tribal evaluation team committed to learning from each other and sharing knowledge. All of the products developed from the Tribal HPOG 2.0 evaluation were shared with the grantees to ensure that we had interpreted the findings appropriately and within their contexts and to share with their leadership and communities.

Evaluation TA Activities

- One-on-one TA to explain the evaluation approach and provide guidance on evaluation procedures
- Training on obtaining and recording informed consent
- Webinar on using data for program improvement
- Program snapshots
- Asset-mapping workshop to further identify opportunities to leverage community strengths to support grantee programs

Data Collection and Analysis

We used multiple sources of primary data to conduct the evaluation, including document reviews; curricula reviews; primary data collection through interviews and focus groups; and participant-level and grantee-level data collected through the HPOG Participant Accomplishment and Grant Evaluation System (PAGES).

Qualitative Data

The Tribal evaluation team reviewed program documentation and conducted interviews and focus groups. Exhibit 3 describes the qualitative data sources for the Tribal HPOG 2.0 evaluation and the total number of interview and focus group respondents over the five-year evaluation period.

[18] Meit, M. (2017). *Health Profession Opportunity Grants (HPOG) 2.0 Tribal Evaluation: Evaluation Plan*.

[19] Tribal Health Profession Opportunity Grants 2.0 Snapshots. https://www.acf.hhs.gov/opre/report/tribal-health-profession-opportunity-grants-20-snapshots

Exhibit 3. Qualitative Data Sources and Cumulative Interview and Focus Group Respondents, Tribal HPOG 2.0 Evaluation, 2015–2020

Data Source	Description	Number of Respondents
Program documentation	Grant applications, grantee websites, program recruitment materials, curricula, and semiannual progress reports	not applicable
Grantee and partner administrative staff interviews	60-minute interviews with project leadership (e.g., program directors) and staff from partner organizations	121
Program implementation staff interviews	90-minute interviews with program staff (e.g., case managers, instructors, etc.)	134
Employer interviews	45-minute interviews with employers	37
Participant interviews	60-minute interviews with participants who completed training and participants who did not complete training (i.e., program completers and non-completers, respectively)	91 completers, 16 non-completers
Participant focus groups	90-minute focus groups with participants	45 focus groups with 315 respondents

We conducted interviews and focus groups during annual site visits. The first round of site visits was conducted in fall 2017, just over two years into program implementation (which began in October 2015). The second and third round of site visits were conducted in fall 2018 and spring 2019, respectively. The final round of site visits was planned for early 2020 and was intended to occur in the final year of program implementation. We conducted the site visit to CITC in late February 2020, prior to the onset of the COVID-19 pandemic. Given the stay-at-home orders implemented in March 2020, we adapted our evaluation procedures to collect data remotely. We conducted a follow-up interview with one CITC staff in June 2020 to document the effects of the pandemic on program operations. We conducted remote site visits (by video conference or telephone) with the other grantees – CCCC, GPTLHB, TMCC, and UMUT – between August 17, 2020, and September 30, 2020. This timeframe aligned with the conclusion of the fifth year of program implementation and our evaluation period. Although the evaluation period ended in September 2020, program implementation continues for a sixth year per the 12-month extension awarded to all of the Tribal HPOG 2.0 grantees.

After each site visit, we coded interview and focus group data in NVivo 12 qualitative data analysis software, using a codebook that mapped to the interview protocols, and identified themes through content analysis. We organized the themes to align with the overall evaluation questions, including program structure (e.g., administrative structure and partnerships); program processes (e.g., recruitment and enrollment, implementation facilitators and challenges); and program outcomes (e.g., educational and employment outcomes). After each site visit, we prepared a standalone report that summarized findings for each grantee. In keeping with our community-based participatory research approach to actively engage partners, we shared the report with each grantee to review and confirm the accuracy and interpretation of the findings. We also shared the annual site visit reports with ACF.[20] For the final report, we conducted

[20] Annual site visit reports were shared with the grantees and ACF and are not publicly available.

cross-grantee analysis to identify commonalities and differences and grantee-specific examples to address the evaluation questions.

Quantitative Data

PAGES is a participant tracking and program management system designed for the HPOG 2.0 Program. It includes data on participant characteristics, engagement in activities and services, and training and employment outcomes. PAGES also includes the activities and supports that grantee programs offer. Using PAGES, grantees collected participant-level data, including participant characteristics, dates of enrollment, training programs, certificates and licenses obtained, receipt of academic and non-academic supports, and educational and employment outcomes. PAGES is also used for grant performance reporting. Grantees generate their semi-annual performance progress reports for ACF through PAGES. The PAGES team granted "researcher" access to the Tribal evaluation team to obtain participant-level data, view aggregate reports, and view the semi-annual progress reports for all grantees. Only participants who consented to participate in the evaluation are included in the analyses presented in this report. During the five-year evaluation period, 2,632 individuals enrolled in the Tribal HPOG 2.0 program across the five grantees. Nearly 65 percent of participants (1,681) consented to participate in the evaluation. We conducted analyses of univariate descriptive statistics that identify participant characteristics, enrollment in HPOG 2.0, enrollment in training, support services receipt, training completion, and employment.

Study Limitations

Evaluation Design

As mentioned, the Tribal HPOG 2.0 evaluation was not designed to measure impact and does not use an experimental design. As noted in the Funding Opportunity Announcement, the Tribal HPOG 2.0 grantees were given the opportunity to participate in the impact evaluation with the 27 non-Tribal HPOG 2.0 grantees. In the impact evaluation, eligible participants were randomly assigned to a treatment group that could access HPOG services or to a control group that could not receive HPOG services but could receive other services available in the community. We discussed the benefits and challenges of participating in the impact evaluation with the grantees. None of the Tribal HPOG 2.0 grantees opted to participate in the impact study. The process-oriented design of the Tribal evaluation limits our ability to determine whether participant outcomes are directly attributed to the Tribal HPOG 2.0 program. As noted, some of the research questions for the Tribal HPOG 2.0 evaluation were associational, seeking to estimate the relationship of the Tribal HPOG 2.0 program or its specific components to outputs and participant outcomes. Therefore, we are limited in addressing these questions quantitatively.

A limitation of the qualitative data concerns self-report bias. Respondents may have overstated or omitted positive or negative aspects of the program or their participation. To mitigate potential self-report bias, we triangulated qualitative responses across respondents to confirm our

conclusions.[21] In addition, the evaluation team used quantitative PAGES data to support the themes identified through the qualitative analysis.

To mitigate any potential researcher effects, all staff were trained on study procedures and protocols. Each site visit team used the same protocols (with details tailored to each grantee) to ensure consistent implementation.

Evaluation and Program Implementation Timeline

The evaluation and program implementation timeline has implications for data collection/analysis and findings reported. As noted, the evaluation period for the Tribal HPOG 2.0 evaluation was October 2015 to September 2020, and the Tribal HPOG 2.0 grants were extended for an additional 12 months through September 2021. The one-year extension of the program period beyond the evaluation period allows the evaluation team to continue to engage with grantees on the final report and dissemination. We note, however, that the evaluation data reported are not reflective of the entire program period. This report presents data for program years 2015–2020 and does not include the final year of grantee implementation from October 2020–September 2021. During this final year of program implementation, the grantees continued enrolling new participants.

Only participants with an enrollment date on or before September 30, 2020, are included in the Tribal HPOG 2.0 evaluation. Enrollment is defined as having received at least one HPOG 2.0 service (including case management, activities in preparation for training, support services, or training) after being found eligible. PAGES is a live data system, meaning grantees continue to enter new data. Grantees also have the ability to revise or update past data that were incorrect or missing or had not yet been entered. Because program implementation is ongoing, and the grantees continue to update PAGES, we had to select a time period for analysis, even though participants continue to receive services. We selected February 2, 2021, to extract data from PAGES. All analyses of PAGES data report participant outcomes as of February 2, 2021. However, some participants enrolled at the end of the evaluation period, so we would not expect to see long-term outcomes (educational attainment, employment) for these participants, as we can only report on their outcomes as of February 2, 2021. Although this analysis will not capture long-term outcomes for all participants, short-term outcomes may be captured. Additionally, while the Tribal evaluation is limited to reporting on outcomes through early February 2021, participant outcomes for the sixth year of program implementation will be documented in the HPOG annual report prepared by the PAGES team.

Data Sources

The evaluation design called for recruiting participants that did not complete a training program (referred to as non-completers), but recruiting these participants was challenging across all grantee sites. As noted, only 16 non-completer interviews were conducted during the evaluation, despite the grantees' efforts to recruit them to participate in in-person interviews. Non-completers were less likely to be engaged with HPOG staff, unlike current students or those who completed training, which made it more difficult to connect with them. The non-

[21] Patton, M. Q. (1999). Enhancing the Quality and Credibility of Qualitative Analysis. *Health Services Research*, *34*(5 Pt 2): 1189.

completer interviews were designed to provide information about why participants leave the program, challenges experienced, elements of the program that were effective, how the program could be improved, and the participants' future plans after HPOG. However, the small number of non-completer interviews resulted in limited data on these topics from the participant perspective.

Because PAGES is used for grant performance reporting, grantees are motivated to ensure that the data are accurate and complete. However, we note limitations to the PAGES data. The Tribal HPOG 2.0 grantees enter data into PAGES and have identified some gaps in the employment data. The grantees have reported challenges in communicating with program completers and collecting certain types of information, such as employment data for participants who may obtain jobs months after they completed their training. Staff turnover and challenges using PAGES also resulted in inconsistent data entry when reporting on other trainings and supports, particularly early in the grant while grantees learned how to use the system and received technical assistance. Additionally, we have found low uptake reported for some categories of support services in PAGES; however, qualitative interviews across grantees suggest there is greater uptake than reported.

A planned component of the Tribal HPOG 2.0 evaluation design was to use administrative data from the National Directory of New Hires (NDNH) for long-term employment and earnings outcomes, when possible.[22] The NDNH is a national database of wage and employment information, including information on new hires, quarterly wages, and unemployment insurance. Participant data could be linked to NDNH by matching Social Security Numbers (SSNs). To use this data source, however, participants would have to consent to provide their SSNs. Four of the five grantees collected SSNs for some or all of their participants. In 2019, we matched participants enrolled between February 2016 and March 2017 to NDNH data. This early data identified discrepancies between employment reported in PAGES and the NDNH data. Specifically, only 8 to 16 percent of participants who reported employment at baseline were reflected in the NDNH data. This suggests that NDNH is not capturing a significant number of employed Tribal HPOG 2.0 participants. Given this discrepancy, it appears this data source is not reliable for this evaluation, and we determined we would not report on long-term employment and earnings data using NDNH. Additionally, without this data source, we are unable to answer one of the original evaluation questions, which examined what proportion of program participants have sustained employment.

[22] For more information on the National Directory of New Hires (NDNH), please see https://www.acf.hhs.gov/css/training-technical-assistance/guide-national-directory-new-hires.

Chapter 3: Participant Characteristics

In this chapter, we present demographic characteristics as well as the education and income levels for participants at enrollment in Tribal HPOG 2.0 programs. We also present the number and percent of Tribal HPOG 2.0 participant households that received public benefits at enrollment. Across the five-year evaluation period, 2,632 individuals enrolled in Tribal HPOG 2.0. Nearly 65 percent of participants (1,681) consented to participate in the Tribal HPOG 2.0 evaluation. We present data only for the participants who consented to participate in the evaluation.

Demographic Characteristics

Tribal HPOG 2.0 participants were primarily low-income women in their 20s and 30s, many of whom had dependent children. Participants were mostly women (87 percent); most under age 35 (53 percent), with more than a quarter under age 25 (27 percent); and most were parents (69 percent). Nearly 7 in 10 participants were never married, separated, or divorced or otherwise not living with a partner, while just over a quarter were currently married or living with a partner. Most participants identified as AI/AN (61 percent), 14 percent identified as two or more races, and 13 percent as White or Caucasian. Of those who identified as AI/AN, participants were affiliated with Alaska Native villages and Tribal Nations in the grantees' local and regional area (including the Turtle Mountain Band of Chippewa, the Ute Mountain Ute Tribe, Spirit Lake Tribe, Three Affiliated Tribes, Oglala Sioux Tribe, Cheyenne River Sioux Tribe, and Rosebud Sioux Tribe). Exhibit 4 shows the demographic characteristics for all consented participants, including gender, marital status, race or ethnicity, number of dependent children, and age.

Exhibit 4. Demographic Characteristics of Tribal HPOG 2.0 Participants at Enrollment (N = 1,681)

Characteristic	Number	Percentage (%)
Gender		
Female	1457	87
Male	218	13
Missing	6	0.4
Marital Status		
Currently married	231	14
Living with unmarried partner	217	13
Separated or divorced	244	15
Widowed	17	1
Never married	899	53
Missing	73	4

Characteristic	Number	Percentage (%)
Race or Ethnicity		
White or Caucasian	216	13
Black or African-American	70	4
Asian	17	1
Native Hawaiian or Pacific Islander	5	0.3
American Indian or Native Alaskan	1,018	62
Other/Two or more races	240	14
Hispanic or Latino of any race	115	7
Number of Dependent Children		
None	502	30
One	425	25
Two	327	19
Three or more	414	25
Missing	13	0.8
Age		
Below 18	46	3
18 to 24	405	24
25 to 29	274	16
30 to 34	237	14
35 to 39	167	10
40 to 44	91	5
45 to 49	64	4
50 to 54	57	3
55 to 59	36	2
60+ years	15	0.9
Missing	289	17

Source: PAGES. Participants enrolled between October 1, 2015, and September 30, 2020.
N = 1,681 participants who consented to provide evaluation data. Percentages may not total 100 due to rounding.

Education and Income

Many participants already had education and credentials before enrolling in Tribal HPOG 2.0. At the time of enrollment, almost all participants had at least graduated high school (87 percent) and nearly 40 percent had some college experience. A little over 10 percent of participants had received an associate's or higher degree prior to enrollment in HPOG. Slightly more than one-third (37 percent) held a professional, state, or industry certification or a license at enrollment.

At enrollment, more than three-quarters of participants (76 percent) had annual household incomes of less than $20,000. This amount is lower than the 2019 poverty level for a family of three ($21,330).[23] Nearly 90 percent of individual participants (88 percent) earned less than that amount yearly. Exhibit 5 shows highest level of education attained, certificates and licenses obtained, and individual and household income for Tribal HPOG 2.0 participants at enrollment.

Exhibit 5. Education, Employment, and Income of Tribal HPOG 2.0 Participants at Enrollment (N = 1,681)

Characteristic	Number	Percentage
Highest Education Attainment		
Less than 12th grade	217	13
High school equivalency or GED	207	12
High school graduate	410	24
Some college, but less than one year	282	17
One or more years of college credit, but no degree	362	22
Associate's degree	138	8
Bachelor's degree	49	3
Graduate degree	4	0.2
Missing	12	0.7
Licenses and Certificates		
Holds professional, state, or industry certification or license	622	37
Does not hold certificate or license	1024	61
Missing	35	2
Employment Status		
Employed	596	36
Not employed	932	55
Missing	153	9
Annual Household Income		
$0	241	14
$1 to $9,999	674	40
$10,000 to $19,999	366	22
$20,000 to $29,999	179	11
$30,000 or more	212	13
Missing	9	0.5

[23] ASPE. U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs. https://aspe.hhs.gov/2019-poverty-guidelines

Characteristic	Number	Percentage
Annual Individual Income		
$0	481	29
$1 to $9,999	716	43
$10,000 to $19,999	279	17
$20,000 to $29,999	128	8
$30,000 or more	69	4
Missing	8	0.5

Source: PAGES. Participants enrolled between October 1, 2015, and September 30, 2020.
N = 1,681 participants who consented to provide evaluation data. Percentages may not total 100 due to rounding.

Receipt of Public Benefits

Approximately 60 percent of Tribal HPOG 2.0 participant households were receiving at least one public benefit at enrollment. The authorizing legislation for the HPOG Program identified TANF recipients and other low-income individuals as the primary target population of the Program. Exhibit 6 shows the number and percent of Tribal HPOG 2.0 participant households who reported receiving selected public benefits, including TANF, Supplemental Nutrition Assistance Program (SNAP), Medicaid, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), housing support, or free and reduced-price lunch, at enrollment. Across all grantees, 16 percent of Tribal HPOG 2.0 participants were TANF recipients. Over 50 percent of households received SNAP benefits, and over 60 percent of households were enrolled in Medicaid. A quarter of participants' households received WIC benefits, and one-third were part of the free and reduced-price lunch program. Fifteen percent received housing supports, either though Section 8 vouchers or public housing.

Exhibit 6. Receipt of Public Benefits by Tribal HPOG 2.0 Participant Households at Enrollment (N = 1,681)

Program	Number	Percentage
Temporary Assistance for Needy Families		
Yes	277	16
No	1373	82
Missing	31	2
Supplemental Nutrition Assistance Program		
Yes	904	54
No	752	45
Missing	25	1
Medicaid		
Yes	1048	62
No	608	36
Missing	25	1

Program	Number	Percentage
Special Supplemental Nutrition Program for Women, Infants, and Children		
Yes	427	25
No	1209	72
Missing	45	3
Section 8 or Public Housing		
Yes	243	14
No	1381	82
Missing	57	3
Free and Reduced-Price School Lunch		
Yes	569	34
No	1051	63
Missing	61	4

Source: PAGES. Participants enrolled between October 1, 2015, and September 30, 2020.
N = 1,681 participants who consented to provide evaluation data. Percentages may not total 100 due to rounding.

Chapter 4: Structure and Context

In this chapter, we describe how the Tribal HPOG 2.0 grantees organized their programs within diverse organizational contexts, including the key partners that were critical to program implementation. It addresses the following research questions:

- In what ways was the program designed or modified for Tribal organizations?
- What changes to the service delivery system are associated with program implementation?

We describe how the grantees designed and implemented their programs, highlighting their organizational models, partnerships, staffing, and employer engagement strategies. We also note how implementation changed over time. Last, we describe implementation facilitators and challenges related to program structure.

Administrative Structure of the Tribal HPOG 2.0 Grantee Programs

The Tribal HPOG 2.0 grantees tailored their organizational structures and staffing roles to implement their programs in their unique contexts.

Organizational Models

The five Tribal HPOG 2.0 programs were administratively housed in different types of institutions. Two grantees, CCCC and TMCC, are Tribal colleges. CITC is a Tribal human service agency, and GPTLHB is a Tribal health board. UMUT is a Tribal government.

Three of the five grantees (CCCC, CITC, and TMCC) were returning grantees and built on their HPOG 1.0 organizational structure and staffing for HPOG 2.0. CCCC and TMCC employed some of the same staff in HPOG 2.0 as in HPOG 1.0. All three grantees expanded on programs offered in HPOG 1.0. For example, TMCC used HPOG 2.0 funds to enhance the CNA program it began in HPOG 1.0.

For all grantees, HPOG program administration was based within an organizational department focused on employment training or education at the grantee institution. However, four grantee institutions (CCCC, CITC, GPTLHB, UMUT) offered few or no healthcare training programs themselves. To implement their programs, these grantees formed partnerships with a variety of training providers, including academic institutions and workforce development organizations, to deliver healthcare training across their service areas. In contrast, all but one of TMCC's training programs was delivered in-house at the Tribal college. TMCC had one partner that served as a training provider. Within TMCC, college administrators initially provided administrative oversight to the HPOG program. In Year 3, oversight was transferred to the career and technical education department within TMCC, which also provided oversight of the allied health programs at the college.

Partnerships

The HPOG 2.0 funding opportunity announcement (FOA) noted that HPOG programs must be implemented in consultation with the agency responsible for administering TANF, state and/or

local Workforce Investment Boards, and the state Apprenticeship Agency. The FOA also highlights technical assistance documents that describe lessons learned in engaging TANF participants and state apprenticeship agencies.

Partnerships were critical to the implementation of the Tribal HPOG 2.0 programs. Partners had several key roles in implementation, including providing training, recruiting participants and making referrals to the grantees, and serving as partners for participants to complete clinical practicums and internships.

The number and types of partners that each grantee worked with to implement their program varied based on two key factors: 1) type of grantee organization, and 2) geographic service area. As described, four grantees offered few healthcare trainings themselves and worked closely with academic institutions and workforce development organizations to offer healthcare trainings. The number of training partners varied depending on the area served by the grantee. For example, CCCC implemented their program across the state of North Dakota and worked with academic partners across the entire state. Exhibit 7 provides an overview of each grantee's partnerships.

Exhibit 7. Overview of Grantee Partnerships

Grantee	Training Partners	Implementation Partners
CCCC	• Two- and four-year colleges and universities, employers and workforce development organizations	• Job Service North Dakota, a state workforce agency, provided office space for the CCCC mentors in Bismarck, Fargo, and Minot.
CITC	• Two- and four-year colleges, employers, and other training providers	• As a human services organization that implements a variety of programs, the HPOG staff leveraged the resources of other departments within CITC for child care or referrals (e.g., referrals from Tribal TANF).
GPTLHB	• Two- and four-year colleges and universities • Employers across its service area provided classroom space for the health educator to deliver CNA and Medication Aide programs	• TANF agencies, including the South Dakota Department of Social Services (DSS) in Pine Ridge and the South Dakota Department of Labor and Regulation (DOLR) in Rapid City, who referred TANF clients to HPOG.
TMCC	• One two-year college offered one additional academic program	• The Adult Education Center provided basic skills training and referred clients interested in healthcare to HPOG. • Job Service North Dakota, Rolette County Social Services, and Tribal Training and Employment referred clients to the HPOG program.
UMUT	• Four academic partners, including two- and four- year colleges and an adult education center	• Did not have formal partnerships with non-training partners

Partnerships were both formal and informal. For some partnerships, grantees established an MOU to describe the roles and responsibilities of each entity. For example, some training providers agreed in an MOU to give HPOG participants priority placement in their training programs. Other partnerships were informal, where grantee staff and partner staff communicated about opportunities through HPOG, and partner staff referred potential candidates to HPOG when appropriate. For example, training providers referred students interested in healthcare training to HPOG or advertised the program at their institutions. Workforce development and social service agencies referred their clients to HPOG.

> *"The beauty of this partnership is that [students] have someone else they can reach out to in another time and place. That is part of the strength of partnership: we support students together. It's not just one program that cares about them. We need to do that collaboratively, not competitively. It's a great partnership and cannot say enough good things for that*."
> – Partner

One grantee developed articulation agreements with other institutions. Articulation agreements are commonly used between colleges and universities to document the transfer policies between two institutions. Only two grantees – CCCC and TMCC, as Tribal colleges – were in a position to develop such policies between academic institutions. For the healthcare social work degree, CCCC and its partners offered a "2+2 program" in which the student completes an associate's degree from a two-year college and then transfers to a four-year institution to complete a bachelor's degree as part of an articulation agreement. While there are job opportunities for individuals with an associate's degree in healthcare social work, most healthcare social work and counseling positions require at least a bachelor's degree. The associate's degree in healthcare social work was offered through two Tribal colleges, CCCC and United Tribes Technical College in Bismarck. The bachelor's degree in healthcare social work was offered at North Dakota State University through a partnership with Minot State University (at its campuses in Minot and Bismarck) and the University of North Dakota in Grand Forks.

While TMCC formed a partnership with Dakota College at Bottineau to support HPOG students enrolled in the LPN program, it did not involve a transfer or articulation agreement. Rather, TMCC students applied to Dakota College, and the HPOG program paid tuition and provided non-academic supports while students were enrolled in the LPN training.

Staffing

The HPOG 2.0 FOA encouraged grantee programs to include staff responsible for:

1. Building and maintaining employer partnerships and assisting participants with job placement
2. Engaging regional partners and relevant stakeholders, including instructors and other academic staff
3. Coordinating project data and supporting data collection, entry, and use of data to inform program management and operations

Consistent with the FOA, grantees hired staff to fulfill these roles and carry out a number of other key responsibilities, including recruitment and enrollment of participants; case management; provision of support services; and overall project management and coordination. Although the number of staff varied from year to year as a result of evolving staffing structures and periodic vacancies, grantees' program staff generally consisted of five to seven individuals. This count excludes instructors that some grantees employed directly though HPOG (more information below).

Grantees had the flexibility to design their staffing structures to carry out program activities. While there was similarity in terms of staffing structure, grantees' staffing approaches evolved over time. Exhibit 8 shows the key staff functions, a description of the role, and the grantee positions that fulfilled each function.

Exhibit 8. Roles and Responsibilities of Grantee Staff

Function	Role and Grantee Staff Positions
Project oversight	Provided oversight of grants management and program activities. Formed and maintained partnerships (per the second staff responsibility outlined in the FOA).
	Grantee staff • CCCC: project director and assistant project director • CITC: program manager • GPTLHB: project director and program manager • TMCC: project director • UMUT: project director and assistant project director
Case management	Provided case management services to participants, which included assessment of the need for support services and academic, career, or personal counseling. Supported participants in a variety of ways: orienting them to the program; working with them to identify education and training goals; and coordinating support services.
	Grantee staff • CCCC: four mentors • CITC: two program specialists • GPTLHB: two student coaches • TMCC: two success coaches • UMUT: two case managers and one case specialist
Employment supports	Provided employment supports to participants and developed and maintained relationships with employers (per the first staff responsibility outlined in the FOA)
	Grantee staff • CCCC: mentors, job developer • CITC: employment developer, employment specialist • GPTLHB: career advisor, student coach • TMCC: placement coordinator • UMUT: case managers

Function	Role and Grantee Staff Positions
Data collection and management	Conducted data collection and management (per the third staff responsibility outlined in the FOA).
	Grantee staff • CCCC: data coordinator • CITC: HPOG administrative assistant • GPTLHB: student coaches, program coordinator • TMCC: data coordinator, success coaches • UMUT: case managers
Training	Taught training programs funded entirely by HPOG and housed at grantee institutions.
	Grantee staff • CITC: Medical Office Assistant instructor • GPTLHB: health educator • TMCC: CNA instructors

Continuity and Changes in Structure over Time

> "*We have an amazing team; we don't get caught up in [thinking] 'That's your job, I'm not doing that,' because we keep in mind that whatever needs to get done will get done for that student.*"
> – Grantee staff

Across the program implementation period, there was continuity in at least one position over time for each grantee. This continuity was critical for consistency, given that all grantees experienced staffing changes each year. In cases in which staff vacancies extended multiple months, remaining staff took on additional responsibilities to ensure continuity in program activities and participant support. Remaining staff helped onboard new staff. For example, existing CCCC mentors onboarded new mentors as they were hired. GPTLHB's project director emphasized the importance of cross-training staff at every level, explaining that this was instrumental in ensuring continuity of services amid staff transitions.

Grantees changed their staffing structure over time to meet program goals and in response to staff turnover. CITC, GPTLHB, TMCC, and UMUT modified their staffing structures as they ramped up program implementation. To manage participant enrollment and focus on employer engagement more effectively, CITC grew from five staff members at the outset to 11 by the third year of implementation. UMUT hired an additional case manager and adult education teacher, while TMCC increased its employment-focused staff toward the end of the program implementation period.

Grantees' partnerships changed over the course of program implementation. Grantees identified and formed partnerships with additional training partners over time or ended partnerships if training providers changed their course offerings. Some partnerships were intended to be short-term: for example, a partnership with an employer to provide a training for their employees. Grantee staff also reported fluctuations in the intensity of partnerships over the years.

The COVID-19 pandemic impacted staff workflows and responsibilities. In spring 2020, staff across grantees largely transitioned to working remotely. To meet participants' needs in the wake of the pandemic and related social distancing guidelines, staff took on additional responsibilities. For example, while the GPTLHB program manager was detailed to help with the pandemic response, other staff stepped in to carry out her responsibilities. TMCC placement coordinators took on additional responsibilities to implement employment supports virtually.

Employer Engagement

Employer engagement was a major focus of the Tribal HPOG 2.0 program. Connecting participants with employers for employment experience during training and employment after training is a key component of the career pathways framework.[24] The FOA encouraged grantees to build their programs on existing relationships with employers and engage these employers in the design of the program. The FOA also directed grantees to engage employers through a variety of ways, including creating work-based learning opportunities, providing resources to support education (e.g., facilities and instructors), and committing to hiring HPOG participants, among others. For all grantees, forming and maintaining relationships with employers was a cornerstone of their program activities; it was critical for ensuring certificate and degree programs aligned with the healthcare workforce needs, providing work-based learning, and empowering students to meet their employment goals. In this section, we summarize how grantee staff and partners built and managed employer relationships; engaged employers to provide work-readiness and work-based learning activities for participants; and worked with employers to address health workforce needs.

Employer Engagement Strategies

All grantees pursued similar strategies for building and maintaining relationships with employers and providing employment-related supports to participants. These relationships varied with respect to their formality. While one or more staff members across all grantees built informal relationships with employers, other relationships – particularly those with clinical affiliates facilitating training for HPOG participants – were formalized, often via an MOU.

Four of the five grantees created staff positions focused on engaging employers and providing employment assistance supports to participants. Exhibit 9 presents the employment-focused staff positions and their responsibilities. In contrast, at UMUT, these roles were fulfilled by other staff. The project director was responsible for establishing relationships with potential employers, and the case managers provided employment assistance supports.

[24] Fein, 2012.

Exhibit 9. Employment-focused Grantee Staff Positions

Grantee	Position (# of staff)	Timeframe When Position Active	Role Description	
			Establishing and maintaining relationships with potential employers	Providing employment assistance supports
CCCC	Job Development Specialist (1)	Years 1–3	●	●
CITC	Employment Developer (1)[a]	Years 2–4	●	●
	Employment Specialist (1–2)[b]	Years 3–5	●	●
GPTLHB	Career Advisor (1)	Years 1–3	●	●
TMCC	Career Coach (1)	Years 1–3	●	●
	Placement Coordinators (1–3)[c]	Years 4–5	●	●

[a.] With the addition of the employment specialist, this role became more focused on employer engagement.

[b.] In year 4, these staff members also focused on employer engagement.

[c.] These roles had a stronger focus on employer engagement compared to career coach.

Three grantees included these positions in their initial staffing structures, and one grantee, CITC, added this position in Year 2. The employer engagement role evolved over time as grantees determined the best approaches for developing employer relationships. For example, in Year 2, CITC's employment developer focused on both establishing connections with employers and providing students with employment supports. CITC shifted responsibilities in Year 3 so that the employment developer focused only on employer relationships while the employment specialist focused on working with students. This change ensured staff had sufficient time to focus on their primary job function. Other grantees took similar approaches, adapting the responsibilities of employer engagement positions over time and shifting responsibilities to other HPOG staff to best serve the needs of their participants. For example, TMCC created additional employment-focused staffing positions in the fourth year of implementation to provide enhanced job placement assistance.

In addition to employment-focused staff, grantee directors and institutional leaders also built relationships with employers. Grantee staff and directors employed a variety of strategies to establish employer connections. For example, project leadership at CITC and GPTLHB met with healthcare facilities to learn about their workforce needs and open positions at their facilities. Employment-focused staff at CITC attended networking events and career fairs as well as met with human resources staff at a variety of facilities, including hospitals, home health agencies, and senior centers, to identify sought-after skills and establish channels for participant referrals. For TMCC, relationships with employers already existed at an institutional level. Each academic program at the college has an advisory board made up of local stakeholders who are responsible for approving curricula for state accreditation standards and local employment needs. TMCC leadership (not directly connected with HPOG) met with local employers and engaged with TMCC's advisory boards.

Academic institutions and instructors, including those directly employed by HPOG grantees and those employed by partner institutions, helped establish and maintain employer partnerships in their healthcare field and assist with job placement. For example, CNA instructors at TMCC received notification from a nursing facility where they worked when there were open positions; these instructors were able to serve as references for CNA students who chose to apply there.

While all grantees developed strategies to engage with employers, the number and type of employer partnerships varied across grantees. Grantees serving a larger geographic area (CCCC, GPTLHB) focused on employer engagement across their region. Some grantees were able to leverage existing partnerships for the HPOG program. For some grantees, employer engagement was a challenge, despite their efforts. For example, UMUT described various efforts to engage with the main hospital in their region to establish job-shadowing opportunities for HPOG participants. Although the organizations were unable to formalize an agreement, these efforts increased awareness of the HPOG program among the employer's human resources staff.[25]

Employers provided work-readiness and work-based learning activities for participants. Three grantees engaged employers to actively support work-readiness training and job search assistance for participants. GPTLHB hosted an Employer Day at which employers presented on open positions, pay rates, employee benefits, and company culture. TMCC staff encouraged participants to attend the TMCC career fair, providing them a similar opportunity to gain exposure to employers and learn about open positions. CITC hosted bimonthly employer-participant meetings, in which employers gave short presentations about available jobs and expectations, including dress codes and communication skills. As part of these meetings, participants also had the opportunity to participate in initial interviews. Participants found that job readiness activities helped them gain exposure to potential employers, facilitating their job search.

Grantee institutions and their academic partners worked closely with healthcare employers to host participants at their work sites for internships and clinical practicums. Two grantee institutions (GPTLHB, TMCC) had clinical affiliate agreements or MOUs in place with employers, including pharmacies, labs, clinics, nursing home and care facilities, or hospital wards and administrative offices. Grantee partners also had clinical affiliate agreements with employers to provide students with opportunities to complete clinical practicums. Through internships and clinical practicums, participants gained hands-on experience to fulfill their training requirements.

Grantee staff, faculty, and academic training partners helped arrange student placements for clinical practicums, creating a pipeline from training to employment. Participants across all grantee programs reported that they established connections with employers though clinical placements, which led to employment. Some examples include:

[25] To address challenges with employer engagement, OFA provided employment-related technical assistance at roundtable meetings, at annual meetings, and through virtual learning cohorts. Over the course of the HPOG 2.0 grant, three grantees participated in Employment Virtual Learning Cohorts, where they worked with an employment subject matter expert and other HPOG 2.0 peers to strengthen and revamp their employment strategies.

- At CCCC, one of the mentors leveraged connections in the healthcare field and a professional relationship with an employer to help students arrange internships positions and get jobs a healthcare facility.
- Staff at a nursing facility that partnered with GPTLHB oversaw the clinical training of CNA students, reviewed the applications of participants who applied for CNA jobs, and supervised these students once employed.
- TMCC participants in CNA and LPN programs pursued employment at the care facility where they completed their clinical training because it was familiar place, which brought a sense of comfort.
- CITC nursing students were hired as graduate nurses by the hospital where they completed their clinical practicums; once they passed their NCLEX (National Council Licensure Examination), the hospital hired them as full nurses with increased salary.

Grantees and employers formed partnerships to address identified healthcare workforce needs. Grantees and employers built relationships characterized by reciprocity and a joint interest in filling healthcare jobs with appropriately trained staff. One grantee staff member remarked that part of employer engagement involves sharing information about HPOG with employers but also noted that it is a reciprocal process: *"We want to listen at the same time, and if there are things we could do [in HPOG] to make more marketable students, we're open to that."*

GPTLHB was responsive to employer training needs on a broader scale. Early on, GPTLHB collaborated with a long-term care facility in need of entry-level nursing staff and provided CNA training to potential employees. GPTLHB then replicated this approach with other employers across its service area. GPTLHB entered into MOUs with two assisted living facilities to provide Certified Medication Aide (CMA) training and increase staff capacity to provide medication management. GPTLHB arranged similar partnerships with healthcare facilities on and near Tribal reservations and provided CNA and CMA training to staff in non-nursing roles; these staff then transferred to the nursing departments, which had a need for skilled staff and also offered a higher wage.

Employers appreciated grantees' efforts to forge and maintain relationships. Both CITC and TMCC employers commented on the high level of professionalism and preparation exhibited by HPOG participants. Some employers provided input on various aspects of grantees' programs. For example, employers suggested changes to training programs to ensure HPOG graduates would be successful in the work place, such as additional soft skills training or providing additional time for hands-on clinical experience. However, employers also emphasized the value of HPOG graduates even if they required additional on-the-job training; one GPTLHB employer said: *"Some of them have turned out to be the best CNAs I've ever worked with. I had one who was not quite sure when she came in, and now she's probably my best day aide."*

Employer-grantee reciprocity was also rooted in a recognized need to provide culturally sensitive care to the Tribal populations served by employers in and around Tribal communities. GPTLHB and CCCC both partnered with employers located on Tribal lands, such as long-term care facilities, that valued hiring participants with CNA certifications or EMT credentials to serve

their majority AI/AN populations. UMUT forged a relationship with one partner because this partner recognized a need to employ more individuals of Tribal backgrounds.[26]

The COVID-19 pandemic affected employer engagement strategies. The COVID-19 pandemic created barriers to employer engagement, as adherence to social distancing requirements limited avenues for work-readiness training and job placement assistance. GPTLHB and TMCC were not able to hold the career networking events they typically held (i.e., Employer Day and the TMCC career fair). For both of these grantees, employer contacts were harder to reach amid the pandemic. Despite these challenges, grantees continued working with employers to fill increasing workforce needs related to the pandemic. For example, TMCC worked with the Tribal health department to identify potential candidates to fill between 10 and 25 contact-tracing jobs.

Facilitators and Challenges Related to Program Structure

Facilitators

All grantees cited stable leadership at the director level or consistent staffing throughout the majority of program years as conducive to program success. For example, CCCC, CITC, and TMCC were continuing grantees from HPOG 1.0 and described the return of their mentors (CCCC) and director (CITC, TMCC) as helpful when implementing HPOG 2.0 and providing relevant knowledge and expertise to new staff teams. UMUT, GPTLHB, and TMCC staff members noted continuity in key staff roles facilitated the implementation of HPOG and provided stability in later years. GPTLHB staff explained that a core team that remained consistent over time led to a strong team dynamic and opportunities for cross-training across roles.

All grantees also described their ability to build and expand on relationships with partners as a key facilitator. CCCC described its expansive network of partnerships as beneficial in bolstering referrals and recruitment to HPOG. TMCC staff leveraged their relationships with Tribal partners (such as the Adult Education Center and Tribal Employment and Training Office) to refer participants to HPOG. CITC reported collaborating closely with training providers to support participants as they pursued their education: for example, by doing "warm hand-offs" to the training provider to facilitate participants' enrollment in training. Throughout the grant, UMUT worked with academic partners to increase the number of courses offered at the Ute Mountain Learning Center, which allowed participants to complete the classroom portions of their programs in a familiar setting and closer to home. Similarly, during the grant, GPTLHB staff expanded the number of partners to increase the number of training options and locations to participants, such as the online course offered through We Care starting in the fourth program year.

[26] For more information on how culturally tailored curricula enhances the provision of culturally sensitive healthcare services to AI/AN patients, please see a separate Practice Brief, *Integration of Tribal Culture into Healthcare Training Programs*, available at https://www.acf.hhs.gov/opre/report/tribal-hpog-20-integration-tribal-culture-healthcare-training-programs.

A strong team dynamic among program staff was beneficial to implementation. GPTLHB staff described positive relationships among team members and working together to achieve their shared goals as beneficial to program implementation. Additionally, staff worked as a team, cross-training on different roles and stepping in to fill gaps when there was staff turnover. The TMCC project director (who was hired in Year 2) used frequent staff meetings to emphasize team-building and operating as "one unit" in implementing the program and worked to make sure all program staff clearly understood the roles and responsibilities of each team member. This team emphasis continued during the COVID-19 pandemic as the team continued to work closely together while remote by instituting daily video conference meetings. Additionally, TMCC staff explained that team members all worked together to address challenges during the COVID-19 pandemic, with some staff taking on duties outside of their normal roles to ensure all of the work was completed.

Challenges

Despite stability at the project director level, all grantees experienced challenges with staff turnover and vacancies within other staff roles. Over time, staff left for personal reasons (e.g., family obligations, retirement) and for new educational or employment opportunities. Staff turnover affected programs in several ways. First, grantee staff explained that vacancies on the team led to low morale among remaining staff, as staff had to take on additional work while the program hired a replacement. Second, new staff required training and needed time to establish relationships with partners and participants. Last, depending on the length of a vacancy, grantees described instances where certain program components were adjusted or delayed until a position was filled. For example, TMCC and GPTLHB reported scaling down employer engagement or employment assistance supports at times because staff had to focus on recruitment and case management for current participants.

Chapter 5: Healthcare Career Pathways Approach

In this chapter, we provide an overview of the career pathways framework implemented and healthcare trainings offered by the Tribal HPOG 2.0 grantees. It addresses the following research questions:

- To what degree do the HPOG programs conform to the career pathways framework? What are the pathways?
- How are health professions training programs being implemented across the grantee sites?
- What occupational training opportunities are available to HPOG participants? What is the nature of pre-training, support services, job placement, and retention services?
- Which program components do stakeholders believe to be the most effective in improving outcomes?

We describe the career pathways model used by the Tribal HPOG 2.0 grantees, how grantees designed their education and training programs, and the healthcare training programs offered. We also describe the grantees' processes for implementing career pathways programs, the academic and non-academic supports offered, and grantee staff, partners and participants' perceptions of the supports offered. Last, we provide a description of grantees' fidelity to their original implementation plans and facilitators and challenges around program implementation.

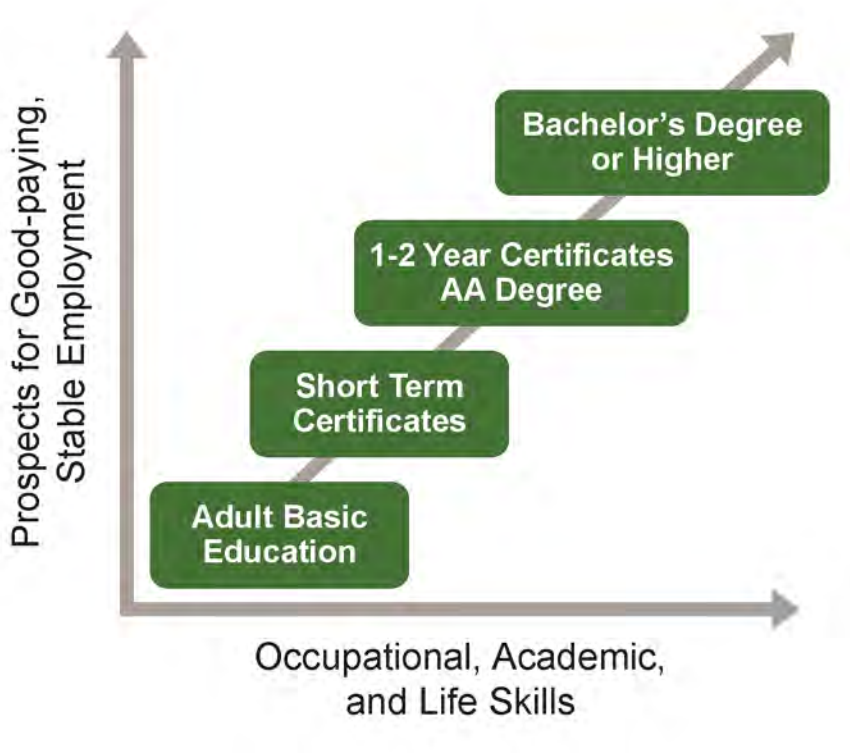
Establishing Career Pathways and Healthcare Training Programs

Career Pathways Framework

The Tribal HPOG 2.0 program used the Career Pathways framework, a model that provides students with a clear and sequential approach to training and acquiring credentials within their field of interest.[27] This framework structures postsecondary education in a set of manageable steps: for example, starting with basic bridge programs, moving into short-term certificate programs, then from one- to two-year certificate into associate's degree programs, and ending with bachelor's-level education or higher. The career pathways model is designed to allow students to enter, exit, and re-enter at different steps, depending on their prior education, employment, and personal circumstances. Exhibit 10 shows the basic career pathways model, which guided the Tribal HPOG 2.0 grantees.

[27] Fein, 2012.

Exhibit 10. Career Pathways Model That Guided Tribal HPOG 2.0 Programs



Source: Career Pathways Model Adapted from Fein, 2012.

Addressing Local Demand

The HPOG 2.0 grantees designed their education and training programs in response to local workforce needs, taking into consideration anticipated labor shortages or areas of high demand. Targeting training in areas with high demand is an important component of the career pathways framework and the basis for fostering employer engagement and employment for participants after training.[28] In their grant applications, the Tribal HPOG 2.0 grantees identified gaps in the healthcare workforce and areas of projected growth in the near future:

- **CCCC:** Based on healthcare labor market projections for the state of North Dakota, CCCC identified the career pathways in nursing, emergency medicine, medical laboratory technician, dentistry, and pharmacy as areas of growth and demand. Job Service North Dakota data projected significant increases in CNA (17.5 percent), LPN (20 percent), and Registered Nurse (RN) (21 percent) employment over the 10-year period from 2012–2022. Labor market indicators forecasted a 22 percent increase in EMT/Paramedic employment and a 28 percent increase in Medical Lab employment over this 10-year period. CCCC also intended to increase the representation of American Indians in the healthcare industry in North Dakota, noting that only .01 percent of nurses were American Indian.[29]

[28] Fein, 2012.

[29] Cankdeska Cikana Community College, Next Steps II HPOG Application, May 2015.

- **CITC:** The state of Alaska projected that the healthcare industry would grow by 25 percent from 2012–2022. Due to an aging population, the state anticipated growth in hospital employment (20 percent), ambulatory healthcare (28.5 percent), and social assistance (33 percent) (i.e., in nursing care facilities and retirement communities). The Alaska Health Care Workforce Coalition identified three occupational priority levels: 1) CNA and RN; 2) LPN; and 3) Medical Billing and Coding. For these priority areas, labor market data indicated an 18–25 percent growth rate. CITC noted that 17.5 percent of registered nursing jobs and 18 percent of LPN positions in Alaska were filled by nonresidents. CITC also sought to fill the gap in training due to budget cuts to state-supported nursing education providers.[30]
- **GPTLHB:** In the four-state region comprising South Dakota, North Dakota, Iowa, and Nebraska, GPTLHB identified critical healthcare workforce shortages using Bureau of Labor Statistics data. For the state of South Dakota, where GPTLHB primarily implemented the HPOG program, areas of healthcare growth were for nursing assistants (9 percent), home health aides (9 percent), and nursing (13 percent). GPTLHB sought to build healthcare capacity in the community and the region by expanding the eligible workforce population among individuals with roots in reservation and rural areas.[31]
- **TMCC:** Employment of healthcare workers in the state was expected to increase 22.6 percent from 2010–2020, based on data from the North Dakota Workforce Intelligence Agency. TMCC prioritized jobs in allied healthcare with anticipated growth and need, such as Phlebotomy (13 percent) and Medical Lab Technician (2.5 percent). Labor market information indicated that these occupations – along with Pharmacy Technician, CNA, LPN, Medical Administrative Assistant, and Health and Fitness positions – would experience positive growth and annual job openings and offer a "living wage." Local employers in TMCC's service area also identified these healthcare positions as high-demand careers.[32]
- **UMUT:** Citing Colorado's Department of Labor and Employment's projections, UMUT noted that short- and long-term health support occupations were in demand. Significant openings in the state and region were anticipated for registered nursing; medical and clinical laboratory technicians; and nursing assistants (19 percent, 30 percent, and 20 percent, respectively) from 2012–2022. There was also an increased need for healthcare workers to provide services in the state, due to the increased access to health insurance through the Affordable Care Act. With 20 hospitals and clinics within its 100-mile radius from the Tribal center, local healthcare employers were actively hiring workers. UMUT also sought to provide AI/AN students with a portable credential.[33]

Healthcare Training Programs Offered

The Tribal HPOG 2.0 grantees offered training programs along career pathways to varying degrees. These career pathways include nursing, emergency response, phlebotomy-medical lab technician, health administration, and health and fitness. All grantees offered courses along the nursing career pathway and four grantees offered the emergency medical

[30] Cook Inlet Tribal Council, HPOG Application, May 2015.
[31] Great Plains Tribal Chairmen's Health Board, HPOG Application, May 2015.
[32] Turtle Mountain Community College, HPOG Application, May 2015.
[33] Ute Mountain Ute Tribe, HPOG Application, May 2015.

response pathway. Training programs included adult basic education, short-term certificate programs, longer-term certificate, and two-year degree programs, and bachelor's level or higher programs. One grantee (TMCC) developed career pathways in Phlebotomy-Medical Lab Technician, Health Administration, and Health and Fitness. Other grantees offered courses along these pathways but did not offer options for participants to complete successive trainings in these areas. Exhibit 11 shows which programs were offered by each grantee along each of these career pathways.

Exhibit 11. Pathways and Programs Offered Across Grantees

Career Pathway	Description	Program and Type	CCCC	CITC	GPTLHB	TMCC	UMUT
Nursing	All grantees offered programs along the nursing career ladder, starting with nursing prerequisites or CNA course. Nursing programs train students to provide nursing care at a variety of levels.	Nursing pre-requisite courses	●	●		●	●
		Certified Nursing Assistant (C)	●	●	●	●	●
		Certified medication aide (C)	●		●	●	
		Licensed Practical Nurse (C)	●		●	●	●
		Practical Nurse (D)	●		●		
		Registered Nurse (D)	●	●	●		●
		Associate's Degree in Nursing (D)	●				●
		Bachelor of Science in Nursing (D)	●				●
		Nurse Practitioner/ Doctor of Nursing Practice (D)	●				
Emergency Response	Emergency Response programs train students to respond to medical emergencies in prehospital settings.	Emergency Medical Response (C)					●
		Emergency Medical Technician (C)	●	●	●		●
		Advanced Emergency Medical Technician (C)	●				
		Emergency Trauma Technician (C)		●			
		Paramedic (D)			●		●
		Paramedic Technology (D)	●				

Career Pathway	Description	Program and Type	CCCC	CITC	GPTLHB	TMCC	UMUT
Phlebotomy—Medical Lab Technician	Phlebotomists are trained to draw blood samples from patients; Lab Technicians perform routine laboratory tests.	Phlebotomy Technician (C)		●		●	●
		Medical Laboratory Technician (D)	●		●	●	
Health Administration	Medical administrative assistant programs prepare trainees for clerical work in a medical environment.	Patient Access Specialist (C)				●	
		Medical Office Assistant/ Certified Medical Assistant (C)		●			
		Medical Administrative Assistant (D)	●			●	
Health and Fitness	This program provides training for students to serve as athletic trainers and personal trainers.	Athletic Training (C)		●			
		Prevention and Care of Athletic Injuries (C)				●	
		Sports Nutrition (C)				●	
		Personal Trainer (C)				●	
		Health and Fitness Technician (D)				●	

(C) indicates a certificate program; (D) indicates a degree program.

In addition to programs along these career pathways, grantees offered certificate and degree programs in a wide range of healthcare fields. Some programs were offered by multiple grantees, and others were only offered by one grantee. Exhibit 12 lists the other healthcare training programs offered by grantees.

Exhibit 12. Other Healthcare Training Programs Offered by Grantees

Program	CCCC	CITC	GPTLHB	TMCC	UMUT
Medical Billing and Coding	●	●	●		
Dental Assistant/Dental Hygiene	●	●			
Pharmacy Technician	●	●		●	●
Medical Assistant					●
Personal Care Aide		●			
Substance Abuse Counseling		●			
Health Information	●				
Dietetics	●				
Healthcare Social Work	●				
Human and Social Services	●				

Program	CCCC	CITC	GPTLHB	TMCC	UMUT
Surgical Technology	●				
Radiologic Technology	●				
Occupational Therapy Assistant	●				
Culinary Arts/Nutrition	●				

In addition to healthcare training programs, all grantees offered basic skills training. Grantees offered basic skills trainings focused on literacy and math, as well as GED courses. Participants who were interested in healthcare training but needed to complete their GED or improve academic readiness through basic skills training could enroll in trainings through the HPOG program.

Instructional Models

> "*I feel like I'm ready to jump into a job, and I have a lot of experience with working in the hospitals and nursing homes. I have seen a lot of procedures*."
> – HPOG participant

Healthcare training programs combined classroom instruction with work experience, which prepared students for certification and employment. Instructors led students through classroom-based curriculum and laboratory work, which was supplemented by hands-on clinical practicums or internships. After completing classroom and clinical hours, many programs required a state or national exam for certification or licensing. Across grantee sites, students emphasized the importance of their clinical experiences in preparing them for their certification exams and subsequent employment experiences.

Grantees and training providers had flexibility in designing tailored, short-term training programs that met participants' needs. All of the grantees except TMCC offered CNA training through multiple training partners that offered different schedules and structures (e.g., classroom instruction might be scheduled for weekends or evenings instead of daytime). This approach gave participants the flexibility to select programs that worked best for their schedules. Exhibit 13 provides information about one of the CNA programs offered by each grantee, showing variation in approaches taken by grantees and partners. CNA trainings ranged from four to eight weeks in length and had different requirements for classroom and clinical hours.

Exhibit 13. Example CNA Instructional Models

Grantee	Instructional Mode	Training Provider	Duration	Didactic Instruction	Hands-on Clinical Practice	Location of Clinical Practicum
CCCC	In-person	Bismarck College	1 month	60 hours	16 hours	Health facility on campus; long-term care facilities
	Hybrid		7 weeks, self-paced	32 hours	16 hours	
CITC	In-person	Alaska Vocational Technical Center	6 weeks	3 weeks	3 weeks	Assisted-living home

Grantee	Instructional Mode	Training Provider	Duration	Didactic Instruction	Hands-on Clinical Practice	Location of Clinical Practicum
GPTLHB	Online	We Care	4 weeks	75 hours	16 hours	Nursing homes
TMCC	In-person	TMCC	5 weeks	4 weeks	1 week	Long-term care facilities
UMUT	In-person	San Juan College	8 weeks	45 hours	90 hours lab/clinical	Local healthcare facilities

Note that these are example programs offered by grantees; all of the grantees except TMCC offered CNA training through multiple training providers with different models.

Remote/distance Learning Strategies Implemented During the COVID-19 Pandemic

As a result of the COVID-19 pandemic, grantees and their training partners had to adjust to remote instruction. Training providers had to provide lectures remotely and find alternatives to the traditionally in-person clinical and laboratory training. At the beginning of the pandemic, training providers switched to remote instruction. Instructors had to adjust to this new instructional model, adapting by offering lectures through a mix of media, including pre-recorded and live lectures, publicly available YouTube videos, and online activities and homework. Instructors for clinical programs found creative ways to incorporate clinical components, such as online patient care simulations.

The gradual re-opening and shift back to in-person learning required additional adaptations. In many cases, adherence to social distancing protocols limited the number of students who could attend trainings in person. During the fall 2020 semester, several training providers implemented hybrid models of instruction, where instructors typically conducted lectures remotely but offered in-person instruction for specific programs with hands-on components.[34]

Institutional Capacity Building

Some grantees built capacity – investing in resources and infrastructure that support their educational mission – at their organizations through HPOG. For example, grantees have used HPOG funds to expand their program offerings and capacity for new trainings. CITC used funds to support its Medical Office Assistant program as well as the instructors for adult basic education and the Life Skills class. GPTLHB implemented its unique CNA program model, where the health educator traveled to various locations across the service area to provide training. TMCC established new programs and upgraded facilities and equipment. For example, the Health and Fitness program purchased new gym equipment to use to train students. The CNA and CMA programs purchased equipment that enhanced their programs, including a medication cart and “manikins” (simulated patient dummies), which instructors used to enable students to practice skills.

[34] A detailed description of the effects of the COVID-19 pandemic on instructional models and instructor and student perspectives can be found in a separate Practice Brief, *Responding to the COVID-19 Pandemic: Tribal HPOG 2.0 Grantees' Program Adaptations*, published on the OPRE website.

Integration of Tribal Culture into Healthcare Training Programs

Four grantees (CITC, GPTLHB, TMCC, and UMUT) reported that instructors incorporated Tribal culture into training programs, either explicitly (such as through the Seven Teachings serving as a foundation for TMCC) or through individual instructor efforts to engage students from Tribal backgrounds and to tailor the curriculum to their experiences. Both GPTLHB and CCCC shared the perspective that Tribal culture is not usually incorporated into academic programs where instructors follow a nationally accredited curriculum because of the standardized nature meant to gear students toward their certification exams.

TMCC and Oglala Lakota College (a partner of GPTLHB) are Tribal colleges and universities (TCUs), which build on a foundation of "culture and tradition."[35] Staff from these institutions described the incorporation of Tribal culture into their program curriculum and events. At TMCC, the Seven Teachings of the Anishinaabe People are the foundation of the college and incorporated into the curriculum. Oglala Lakota College in Pine Ridge provided a supplemental course to the nursing curriculum, focused on incorporating Lakota culture into patient care. For example, students received cultural competency training and the chance to participate in a talking circle led by a Lakota elder and a traditional blessing of the hands ceremony.

Non-Tribal colleges and institutions in the HPOG program also noted the importance of recognizing students' Tribal backgrounds and adding discussions of caring for native populations into their curriculum. Instructors at UMUT sought to recognize cultural norms in their classes by using materials that resonated with the cultural background and experience of the students in their classes. CNA instructors at UMUT were sensitive to students' Tribal backgrounds and acknowledged that certain aspects of Western healthcare (such as touching patients directly) may conflict with Tribal cultural values.

Grantees also offered events and services to allow students to celebrate their culture throughout their educational experience. Because most students served by GPTLHB are Lakota, the organization offered spiritual care and rituals. For example, their graduation ceremony includes honor and prayer ceremonies and appearances by Tribal elders. South Dakota State University, a partner of GPTLHB, hosted a monthly "Soup and Learn" (*Wohanpi na Wounspe*) series, which included native speakers and honoring ceremonies. TMCC hosted the annual "Language and Culture Conference" for students to learn more about Anishinaabe culture and language. Each morning at the college, students engaged in smudging and prayer. Three grantees and their partners offered physical spaces in the form of cultural centers for students to receive support services and to connect with students from a similar background (CCCC, CITC, and GPTLHB).

Implementing the Career Pathways Programs

Implementing career pathways requires several steps, including recruitment of participants, facilitation of the application and intake process, orientation of participants, assessment of participants' needs and goals, and provision of support services. Academic and non-academic supports are a key component of career pathways programs, designed to increase completion

[35] AIHEC. *Tribal Colleges and Universities*. AIHEC. http://www.aihec.org/who-we-serve/TCUmap.cfm

in training and encourage participation in successive training.[36] This section describes how grantees addressed each of these steps.

Eligibility

The HPOG 2.0 Program is designed to provide education and training for TANF recipients and other low-income individuals. In the grant applications, each grantee defined the target population and eligibility thresholds for their program. Guided by the FOA, grantees had some commonalities in their target populations. All of the grantees prioritized TANF recipients, aligning with the guidance in the FOA. Additionally, all of the grantees emphasized AI/AN individuals as the population of focus, though non-native individuals were eligible for enrollment in Tribal HPOG 2.0 programs. Grantees developed their own definitions for low-income eligibility, which are presented in Exhibit 14.

Exhibit 14. Eligibility Requirements

Grantee	Low-income eligibility as defined in grantee applications
CCCC	Up to 200% of the federal poverty threshold
CITC	Up to 185% of TANF need standard monthly gross income
GPTLHB	Up to 200% of the federal poverty threshold
TMCC	Family income below the federal poverty guidelines or individuals who qualified for any federal subsidy (e.g., TANF, SNAP, General Assistance, Fuel Assistance, Free and Reduced Meals through National School Lunch Program, Life Line Phone Assistance)
UMUT	Up to 188% of the federal poverty threshold

Recruitment

The Tribal HPOG 2.0 grantees used a variety of methods to recruit participants for their programs, including advertising campaigns, social media, outreach events at schools, and community events. Beyond these more formal recruitment approaches, grantees and participants reported that word of mouth was one of the primary recruitment tools. Across grantees, participants reported hearing about the HPOG programs from family, friends, former participants, and program staff.

> "*There was a Pow Wow; each college has one, and we put up a booth and tell people what we do, and we give away cups and pencils and brochures. We've always gotten interest from those.*"
> – Grantee staff

Referrals from partner agencies were another important component of recruitment, including TANF agencies, workforce development organizations, or academic partners. These referral processes worked in different ways, depending on the grantee's administrative structure. For example, TMCC worked closely with the Turtle Mountain Tribal Training and Employment Office, which provides adult education and job placement services for TANF clients. If Tribal Training and Employment clients were interested in healthcare, staff referred them to HPOG and worked closely with HPOG staff to ensure there was no duplication of

[36] Fein, 2012.

services. CCCC staff used office space at three Job Service North Dakota locations, a state workforce development agency. Co-location at Job Service facilitated referrals from Job Service staff to the HPOG program. Additionally, instructors and other college administrators reported that they informed students interested in health professions about the opportunities available through HPOG. Partner institutions often advertised HPOG on campus through fliers or by holding joint information sessions with HPOG staff.

> "*Programs in the community refer the students [to HPOG] and give [their clients] this [program] as an option to do something. We are glad for that*."
> – Grantee staff

After the onset of the COVID-19 pandemic, grantees had to adapt some of their recruitment methods. For example, they were not able to hold any in-person recruitment events. Additionally, because of the disruption to program operations due to stay-at-home orders and the uncertainty in how training programs would be offered in the summer and fall, grantees delayed marketing campaigns that were set to launch in spring 2020. However, as the pandemic continued and academic partners announced their plans for the fall 2020 semester, grantees adapted their recruitment strategies. Social media became an even more important tool for reaching potential participants. CCCC conducted some virtual recruitment sessions with their partners. UMUT conducted distance recruitment for a Medical Assistant course by emailing recent CNA and EMR completers to identify individuals interested in furthering their education.

Application, Intake, and Orientation

All Tribal HPOG 2.0 grantees implemented an application process for prospective participants. Grantees assessed eligibility first (i.e., confirming if the prospective participant met the income eligibility requirements and resided in the grantee's service area). If the individual qualified for HPOG, then the grantee worked with the applicant to complete the application and submit supporting materials. Application materials varied slightly across grantees. Generally, the application materials included proof of eligibility and results of assessments (e.g., from HPOG staff, academic readiness tests). CCCC, TMCC, and GPTLHB also required proof of initial acceptance in a healthcare training program prior to enrollment in HPOG.

To ensure that participants would not be barred from obtaining employment in healthcare, CCCC, CITC, and GPTLHB required criminal background checks as part of the application process. This was particularly important for CITC HPOG applicants due to Alaska administrative code governing Barrier Crimes.[37] The Barrier Crimes code prohibits for a certain amount of time individuals who are charged, convicted, or adjudicated as a delinquent of specific crimes (e.g., endangering the welfare of a child or vulnerable adult) from receiving licensure, certification, or being associated with entities or service providers that receive payments from the state. If a Barrier Crime was identified, CITC staff worked with the prospective participant to apply for a variance from the state, which would allow them to obtain employment in healthcare even with a Barrier Crime on their record.

[37] The Barrier Crimes matrix identifies crimes that are subject to this Alaska administrative code: http://dhss.alaska.gov/dhcs/Documents/Residential-Licensing-Background/bgcheck/assets/BarrierCrimeMatrix.pdf

While TMCC and UMUT did not conduct background checks as part of their application process, some of their partner institutions conducted background checks. For example, the Turtle Mountain Tribal Employment and Training Office screened TANF clients prior to referring them to HPOG, which included a background check. Although UMUT did not conduct background checks as part of its application process, partner academic institutions typically required background checks prior to admission to healthcare training programs. In some cases, UMUT participants accepted into HPOG were unable to enroll in training due to the results of their background checks.

Grantees also developed screening processes to assess participants' commitment to healthcare training and academic readiness for training programs. These screening processes helped identify motivated students who were likely to succeed in their programs. For example, CCCC implemented a policy that participants in college or university programs must be accepted to the institution and major before they were eligible to apply for HPOG funding. Grantees also noted that pre-screening, such as TABE testing and referrals to basic skills training for participants who may need more instruction to be college-ready, also helped to improve retention in healthcare training programs.

> "*You have to have a real passion to be in healthcare [and] if you don't have that passion, you won't want to pursue it and it won't be a priority to you*."
> – Grantee staff

Typically, HPOG program staff gathered application materials for a prospective participant and met with them in-person to better understand their goals. At CCCC, CITC, and UMUT, the project director made the final decision for acceptance, based on application materials and input from HPOG staff. At TMCC and GPTLHB, the HPOG team reviewed applications together and came to a consensus on whether to accept an applicant into HPOG.

Once accepted into the HPOG program, participants were oriented to the grantees' programs in different ways. Two grantees used group orientation. GPTLHB's orientation consisted of a one-day program, which covered support services, expectations for participants, and staff introductions. The orientation also included a success class that covered college readiness skills and assisted with job-related supports such as résumé development. TMCC required participants to attend orientation each semester. At the orientation, HPOG staff reviewed the HPOG program handbook and expectations for the program. Students were required to sign a document acknowledging the program expectations and agreeing to maintain a 2.0 GPA.

The other three grantees used a one-on-one orientation. At CCCC, the mentors met with each participant to create a student plan and review the handbook. There was no standardized process for this meeting; students reported some discrepancies in knowing about what types of supports were available. At CITC, participants met with their program specialist one-on-one to discuss training opportunities and barriers. Participants were also required to complete the HPOG PATH Academy to learn basic first aid skills before they began training. UMUT staff worked one-on-one with participants to orient them to the program. Early in HPOG, UMUT staff implemented a group orientation for EMR students but found it was not effective as students

viewed the group session as optional. UMUT staff determined that orienting participants individually was more appropriate for their participants.

Assessing Participant Needs and Goals

All Tribal HPOG 2.0 grantees assessed participant needs and goals at program intake and on an informal basis throughout a participant's time in the program. HPOG program staff discussed potential barriers to completing training during initial meetings with participants, and together they identified what supports would be most helpful for each participant to address those barriers and challenges. At each grantee site, program staff established protocols for communication with participants (e.g., weekly check-ins). Staff used those meetings to monitor participants' progress and assess changes in participants' needs during their time in the program.

Grantee staff reported that they continued to assess participant needs regularly during the COVID-19 pandemic. They reached out to all students to ensure their needs were met and to address unanticipated challenges and barriers. For example, CITC staff explained that they contacted participants at the beginning of the stay-at-home orders and were able to provide emergency aid for participants. At TMCC, staff described similar efforts to contact every participant early in the pandemic, involving all HPOG staff in this effort. As the pandemic continued, grantee staff noted that more frequent communication was needed as participants adjusted to remote instruction and some experienced delays in completing their clinical practicums.

Retention Strategies

Grantees used multiple strategies to support student retention. The most common strategy was regular communication between program staff and participants. Across grantees, staff and participants reported that scheduling routine meetings and ensuring consistent communications with participants was important to keeping participants engaged in the programs.

> "*[The student coach] told me if I ever needed help they provide tutors. For any questions I needed answers to, I reached out through text, email, phone. She wasn't too far away, she was helpful.*"
> – HPOG participant

Grantees also identified trends and developed policies to improve retention in training programs. For example, an initial CNA training program offered by CCCC had low attendance rates, so the program instituted a daily attendance incentive to encourage participation and retention through the end of the training. Similarly, CITC initially offered gift cards as attendance incentives for participants but later switched to providing incentives for achieving good grades and for clothing when participants obtained employment. TMCC initially provided participants with financial assistance in the form of a scholarship at the beginning of the semester that could be used for tuition. TMCC later changed their process to provide the scholarship funds mid-semester to ensure students were truly committed to the program and met attendance and GPA requirements.

GPTLHB updated their training offerings based on student retention. They originally offered an online Medical Billing and Coding course but observed that many students were successful in

the billing component of the training but struggled with the coding portion of the training. Given these trends, grantee staff decided to switch the program to focus only on the Medical Billing component of the training. In addition, they adapted the 12- to 14-week course curriculum to develop a nine-month course, which allowed participants more time to complete the course work.

When possible, grantees tracked participants' attendance in class and communicated with instructors to identify students who may need tutoring or other supports. Grantees were able to implement this strategy for classes that occurred at grantee institutions, such as CITC's MOA program and the trainings held at the Ute Mountain Learning Center. Given the close connection of HPOG staff at TMCC to the faculty, TMCC HPOG staff were able to use this strategy for nearly all of its participants.

Grantees also facilitated connections between participants to form peer groups to support one another. In addition to in-person connections, social media was also a method for making connections with other students. Grantee staff at GPTLHB maintained a Facebook group for participants to join, which provided an opportunity for participants to stay connected. GPTLHB also encouraged participants to engage their family members in their education so that they could understand what the participants were taking on and be supportive.

Academic and Non-academic Supports Offered by Grantees

All five Tribal HPOG 2.0 grantees offered a variety of academic and non-academic supports to participants. Academic supports included financial support for tuition and training-related needs, as well as supports such as academic advising, tutoring, and mentoring to help participants prepare for and complete training. Non-academic supports included personal supports, such as transportation assistance, food assistance, child care assistance, and emergency assistance, as well as employment assistance supports. Exhibit 15 shows the number of participants who received each type of support service over the five-year evaluation period.

Exhibit 15. Receipt of Support Services Among Enrolled Participants by Type of Service, 2015–2020

	Number	Percentage
Academic Supports		
Training-related costs assistance (other than tuition)	1365	81
Academic advising	1299	77
Case management	1233	73
Peer support	379	23
Mentoring	206	12
Tutoring	189	11

	Number	Percentage
Personal and Logistical Supports		
Transportation assistance	748	45
Food assistance	534	32
Other	199	12
Child/dependent care assistance	44	3
Emergency assistance	31	2
Housing supports/assistance	12	0.7
Employment Assistance Supports		
Job search assistance	489	29
Job placement assistance	170	10
Job retention assistance	82	5

Source: PAGES. Participants enrolled between October 1, 2015, and September 30, 2020.

Indicates how many participants received each service at least once in the five-year period. Participants could receive multiple services; data is reported for N = 1,681 participants who consented to provide evaluation data. Percentages are of participants with data.

Tribal HPOG 2.0 grantees offered participants a variety of academic, personal, and employment services designed to support their training, retention, and program completion. Here we report on the number of participants who received a service at least once during their enrollment in the HPOG program.[38] More than three-quarters of participants received academic advising and training-related cost assistance (77 and 81 percent, respectively). Nearly three-quarters received case management services (73 percent). Under personal and logistical support services, those designed to provide wrap-around support, just under half (45 percent) and nearly a third (32 percent) received transportation assistance and non-emergency food assistance, respectively. Under the category of employment assistance supports, 29 percent of participants engaged in job search assistance.

Academic Supports

Tuition assistance. Grantees provided tuition assistance in several ways, depending on the type of program the student attended (e.g., a short certificate program or a longer-term degree program) or the type of institution the student attended. CCCC and UMUT paid tuition directly to the training provider. CCCC offered a standard amount per semester, which varied depending on whether a student was full-time or part-time, while UMUT covered full tuition for all students. CITC's tuition support varied depending on the program: CNA tuition was fully covered, but students in more expensive programs received partial tuition.

Scholarships. GPTLHB and TMCC provided scholarships to participants, which participants could use at their discretion to cover academic needs. At GPTLHB, participants in longer-term training programs earned a scholarship that was distributed in three installments each semester. The amount was based on the number of credit hours. Participants could use this scholarship for tuition and supplies for class (e.g., books, equipment, scrubs, etc.). TMCC participants

[38] As noted in the study limitations, we found low uptake reported for some categories of support services in PAGES.

enrolled in certificate and degree programs at the college received a scholarship mid-semester, which students could use toward tuition or other unmet academic needs. In many cases, these scholarships did not cover the full cost of tuition, and students paid for the remaining balance through other sources (e.g., Pell grants, loans, other scholarships). For TMCC participants enrolled in the LPN program at TMCC's partner institution, TMCC covered full tuition paid directly to the partner institution.

Four grantees had one or more academic programs that were fully funded by the HPOG grant. Because HPOG funding supported these courses, HPOG participants did not pay tuition individually. These were programs offered in-house by grantees, including CITC's MOA program, TMCC's CNA and CMA programs, and GPTLHB's CNA training, which was taught by a traveling instructor. The instructors for these courses were HPOG staff. UMUT also offered several courses (e.g., Phlebotomy, Medical Assistant) at the Ute Mountain Learning Center; these were fully funded by HPOG. However, HPOG staff did not teach the courses; instructors at partner institutions developed and taught the courses. Instead of individual students paying tuition to the academic partner, UMUT paid for all costs associated with the course through an agreement between UMUT and the educational institution.

Training-related books and supplies. CCCC, TMCC, and UMUT provided additional financial support for other training related costs, such as books, scrubs, or other supplies. Participants purchased the books and supplies needed for their training program and submitted receipts to HPOG staff. The program then reimbursed participants for these out-of-pocket costs. As noted, some grantees did not provide supplemental funds for these costs, but instead participants could use scholarship funds to cover other training-related supplies.

Academic supports. Other types of academic supports provided by all grantees included academic advising, tutoring, and mentoring. Grantee staff used regular meetings with students to provide academic advising and to check in on participant needs. All grantees arranged tutoring support, as needed. Some grantees arranged for tutoring with the HPOG program, while other grantees coordinated with the academic institution where the participant was enrolled to arrange for tutoring from that institution. For example, CCCC made arrangements with partner institutions and paid for tutoring, if needed. TMCC funded an allied health tutor as part of the HPOG staff, who was available to meet with students on site and often attended some of the allied health classes to stay current on the material students were learning.

Certification and licensure exam support. All of the grantees provided support to participants to take certification and licensure exams after completion of training. Participants often had to travel to take licensure exams, such as the nursing licensure exam (NCLEX, National Council Licensure Exam), because states have a limited number of certified testing sites. For example, there were only two certified NCLEX testing centers in North Dakota, located in Fargo and Bismarck. Given that participants often had to travel long distances, four of the grantees – CCCC, GPTLHB, TMCC, and UMUT – provided financial support for students to travel to the testing site, including the cost of transportation and lodging for the night prior to the exam. HPOG programs also covered exam fees. In some cases, the grantee institution or training provider administered the certification and licensure exams. For example, TMCC was a testing site for CNA and phlebotomy, so HPOG students could take the exams onsite with faculty

serving as the proctor. CITC administered the Certified Medical Administrative Assistant exam to MOA students on site. One of UMUT's training partners administered the CNA exam to students at the partner's facility.

Personal Supports

All grantees offered personal supports to assist participants in overcoming barriers to completion of training. Personal supports included transportation assistance, food assistance, emergency assistance, and child care assistance.

Transportation assistance. CCCC, CITC, GPTLHB, and TMCC provided transportation assistance via gas cards distributed to students. The amounts were determined based on the distance a student had to travel for class or clinical practicums. Instead of gas cards, UMUT offered reimbursement for mileage traveled. Grantees also offered support for other transit options, where appropriate. For example, CITC, located in Anchorage, Alaska, also provided bus passes for participants. TMCC and UMUT offered assistance to use the Tribal transit system, though this was not widely used by participants as the transit schedules did not always align well with class schedules. Grantees also used innovative approaches to provide transportation assistance. For some classes over the years, staff at GPTLHB coordinated carpools for students. UMUT experimented with organizing a bus to transport students from Towaoc to the training partner, located about 15 miles away. All students were able to meet the bus and travel together. However, this was not ultimately a successful approach as grantee staff found that there were not enough students using the bus consistently to continue operating this service. Almost half of participants received transportation assistance during their time in the program.

Food assistance. Grantees varied in their approaches to providing food assistance to participants, with three grantees providing non-emergency or emergency food assistance. At TMCC, students who attended classes at the main college campus received meal cards for the college cafeteria; students at the South Campus and at TMCC's partner academic institution received gift cards to purchase meals at locations convenient to those campuses. CCCC did not offer nonemergency food assistance but did provide food assistance in emergency situations. GPTLHB also provided food assistance in the form of food for support groups, trainings, and cultural activities. Around 30 percent of participants received food assistance.

Emergency assistance. All grantees offered participants emergency assistance for one-time issues, such as an unexpected car repair, rent, or utility assistance. Grantee staff assessed participants' needs during regular check-in meetings. If emergency issues arose, grantee staff worked with participants to address the issue and provide the appropriate assistance. Grantees made emergency assistance payments directly to the vendor providing the service (e.g., the mechanic, landlord, or utility company). While all grantees offered this support, less than 2 percent of participants used emergency assistance.

Child care assistance. All grantees offered participants child care assistance but did so in different ways. CCCC and UMUT paid child care assistance directly to child care vendors, which had to be licensed providers. TMCC provided copayments for participants that received state or Tribal child care assistance and also provided financial assistance for participants who did not

qualify for state or Tribal assistance. At GPTLHB, participants could use some of the scholarship they received for child care costs if needed. CITC referred participants to its in-house child care services and supports, including child care at the Clare Swan Early Learning Center or support through the Child Care Assistance program. Only 3 percent of participants received child care assistance from the HPOG program.[39]

Employment Assistance Supports

All grantees provided employment-related assistance to prepare participants to obtain employment in their chosen field.

Job search assistance. Three grantees, CITC, GPTLHB, and TMCC, had staff dedicated to supporting students with job search assistance while enrolled and after completing training. HPOG staff assisted students with developing their résumés and cover letters, as well as searching for jobs and completing job applications. Grantee staff also conducted mock interviews with students and implemented trainings or workshops to assist students in developing soft skills. Thirty percent of participants received job search assistance.

Job placement assistance. Four grantees provided job placement assistance, and each tailored their approach. CCCC mentors provided individual or group assistance to participants. CITC program specialists worked with hiring managers and local employers to place HPOG program graduates. GPTLHB staff conducted interviews and assessed participants for relevant job placements. TMCC offered financial support for program completers who moved for employment in their field; this included financial assistance toward a security deposit and two months of rent, moving expenses, and child care assistance for up to three months. Only 10 percent of participants received job placement assistance.

Job retention services. To varying degrees, all of the grantees developed supports to help program completers retain employment. These supports included periodically verifying employment with participants, working with participants to ensure there was a good fit at their jobs, encouraging participants to progress within a job, and helping participants address job-related issues. However, there was low uptake of these supports; only 5 percent of participants received job retention services.

Additional Supports

Three grantees developed unique supports for their participants. CCCC coordinated opportunities for participants to meet and discuss their experiences in their training programs. This was particularly important for CCCC participants, as they enrolled at many different academic institutions across the state. CITC offered life skills classes for participants, covering topics such as self-esteem building, communication styles, healthy relationships in the home and work environment, Alaska Native language and values, parenting, money management, and techniques to transition from living in rural to urban communities. GPTLHB offered spiritual services and organized cultural events for participants. They also implemented a graduation recognition program for HPOG participants. CCCC, CITC, and GPTLHB also provided financial

[39] Neither GPTLHB nor CITC provided direct child care assistance payments, and this type of assistance would not be tracked as child care assistance in PAGES.

support to assist participants in purchasing professional attire for interviews or upon hire at a new job.

Two grantees leveraged other resources for employment assistance supports. For example, UMUT participants were referred to the Sustainable Employment and Economic Development Strategies (SEEDS) program, also administered by the Ute Mountain Learning Center, to take soft skills classes, which address personal and social skills and behavior appropriate to the workplace. The SEEDS class includes basic computer skills, résumé development, and mock interviews. At TMCC, all of the certificate and degree programs that HPOG students enrolled in include a one-credit job readiness course.

Impact of the COVID-19 Pandemic on Supports

During the pandemic, participants' needs changed, and grantees made some changes in the supports provided. For example, because academic institutions switched to remote instruction, participants did not need transportation assistance to travel to class. In addition, many child care centers closed temporarily in response to the pandemic, so grantees provided less child care assistance. However, grantees reported an increase in requests for emergency assistance during the pandemic. For example, CCCC noted that because completion of some academic programs were delayed, some students stayed on campus longer than anticipated and requested emergency assistance for additional room and board costs. CITC revised their policies to expand services provided, including adding food delivery support and expanding their housing support beyond emergency housing relief to provide transitional housing support. If a participant was seeking employment after training, CITC could provide financial assistance for rent and utilities.

Because academic instruction shifted to a remote delivery model, students needed laptops and Wi-Fi access to continue their education. To address this need, CITC provided monthly financial assistance for internet services. CCCC, GPTLHB, and UMUT began loaner laptop programs for participants. In some cases, academic institutions provided laptops or Wi-Fi hotspots to students (so students did not require additional support from HPOG to address this need). For example, TMCC provided all students enrolled at the college with laptops. UMUT HPOG students enrolled in the Medical Assistant program with San Juan College obtained Wi-Fi hotspots from the college.

Program Staff and Students' Perceptions of the Value of Support Services

Staff, partners, and participants across grantees emphasized the importance of the supports that HPOG programs provided in helping students complete their programs. Staff remarked that transportation and child care assistance were particularly important to ensuring student success.[40] Grantee staff explained that these supports can be especially important for participants that have recently decided to enroll in a healthcare training and are adjusting to the academic schedule.

[40] Grantee staff explained that child care assistance was important, although PAGES does not reflect significant uptake of child care assistance.

Academic partners who taught HPOG participants found that supports help with student retention in training programs. One partner explained that the *"program does everything necessary to make sure that they're succeeding."* Another academic partner shared, *"I think the opportunities that HPOG gives them are outstanding. Support is key. Because I think without the support we wouldn't have near as many students as we do have*."

Across grantees, participants also described the importance of personal, academic, and employment supports as they completed their training. Participants reported that financial supports were also critical to their success, particularly nontraditional students who went back to school while also supporting their families. One participant shared, *"The financial help they offered … helped me focus on school and advancing my career, not having to worry how to put food on the table, or daycare, or 'I can't work anymore because what am I going to do with my kid.' It really helped in that aspect."* Many participants shared that they would not have been able to complete their training programs without the academic and personal supports that HPOG provided.

Participants indicated that case management and support from HPOG staff were also particularly important. As described by a participant, *"HPOG staff are emotionally making sure you're in the right spot. Making sure you're able to make it to trainings and seeing how training is going."* Other participants had similar experiences, sharing, "*They kind of take you under their wing and set you on the right path. Without them guiding me, I wouldn't be where I am today*." and *"If it wasn't for the HPOG staff, I wouldn't be in the program anymore.… She wants me to receive assistance and succeed*."

Across grantees, students felt supported from enrollment to the final stage of gaining employment. One participant explained, *"They are there for you pretty much from the beginning to the end and after that. So it's not just for me but a lot of students do go back to them for that support and to help guide them through getting jobs or whatever those resources are, not just emotional or financial support*."

Fidelity of Implementation

Although they made some adaptations, grantees largely implemented their programs as intended with respect to the partnerships developed, programs offered, and supports provided. Throughout the program implementation period, grantees made adjustments to their program designs in response to challenges as well as opportunities for improvement that they identified.

As described above in the section on staffing, all grantees experienced staff turnover, which led to shifts in staff roles and responsibilities. Grantees added or changed staff positions to increase workflow efficiency for staff and participants, facilitate employment opportunities for participants, and optimize the provision of participant supports. For example, CITC and TMCC hired additional staff to focus on engaging employers and providing employment assistance supports to participants.

All grantees ultimately implemented the training programs and formed the partnerships described in their initial plans, although some experienced barriers to doing so. After losing an

instructor and experiencing an earthquake in November 2018, CITC discontinued its in-house Medical Office Assistant program. TMCC temporarily suspended LPN and Pharmacy Technician programs after instructors for these programs left the institution; however, TMCC was able to form a partnership with another institution to offer the LPN program and eventually reinstated its Pharmacy Technician program in 2020. For the first few years of the project period, UMUT experienced challenges with implementing the formal partnerships needed to offer training programs using their intended delivery model. Despite these challenges, UMUT was able to put these partnerships in place to offer training programs using this model by Year 4.

Grantees' requirements for participant eligibility and participation largely remained the same over time, with a few exceptions. For example, in Year 5, CITC began requiring that participants take a Personal Care Aide training (PCA) and become employed as a PCA to gain experience in the healthcare field and maintain an income while pursuing longer-term training goals.

Four grantees expanded their service areas to increase training opportunities, with some expanding services in-state and others expanding services to adjoining states. Early in its implementation period, UMUT expanded its service area to include non-natives and eligible participants living in designated areas outside of the Ute Mountain Ute Tribe reservation lands. CCCC and GPTLHB sought out additional partnerships in different areas, increasing accessibility to HPOG 2.0 programs for participants in these areas. For example, in Year 4, CCCC expanded its service area to begin working with a training partner in Moorhead, Minnesota, which is across the state border from Fargo, ND, where CCCC already offered training. Also in Year 4, CITC worked with a partner in the Matanuska-Susitna Valley (also called Mat-Su Valley), a region 40 miles north of Anchorage, to expand CNA training in this area.

The COVID-19 pandemic posed a major challenge for grantees, requiring substantial adaptations to program activities. As described above, in spring 2020, grantees and academic training partners postponed trainings or switched to virtual instruction for the remainder of the semester. Grantees modified the supports they provided to participants and how they provided them, including addressing immediate needs, such as access to laptops and internet. Although the pandemic substantially changed how the grantees operated their programs, staff and partners remained committed to the same goals and activities as in previous years.[41]

Facilitators and Challenges Related to Program Implementation

Facilitators

Staff and participants cited the close relationships between "case management" staff and participants and the provision of support services as essential factors in encouraging participants' retention in the program. Grantee staff described efforts to create strong relationships with their participants, allowing them to identify their needs and provide the

[41] A detailed description of the effects of the COVID-19 pandemic can be found in a separate Practice Brief, *Responding to the COVID-19 Pandemic: Tribal HPOG 2.0 Grantees' Program Adaptations,* published on the OPRE website.

appropriate support services. Continuity in staff serving in case management roles was also an important facilitator, ensuring that participants had a consistent staff person to work with during their time in HPOG. Participants noted that frequent communication (weekly or daily, in some cases) with HPOG staff facilitated strong relationships and encouraged retention in their training programs. In addition, support from HPOG staff was a key factor in helping participants complete their training. Participants appreciated support and encouragement from staff, the accessibility and responsiveness of staff members, and their approachability and ability to make participants feel welcome.

Challenges

To varying degrees, all grantees reported challenges with recruitment, ranging from staff turnover to limited participant preparedness or interest. Staff turnover in the roles responsible for recruitment had an impact on grantees' ability to recruit participants. If positions were vacant, recruitment slowed. Grantees had to train new staff, which also decreased capacity for recruitment until staff were onboarded. Grantee staff also described some participant barriers to HPOG recruitment, making it challenging to reach and enroll new students. For example, potential participants may lack access to a computer in order to complete the application. Another challenge was that some potential participants may not be academically ready for healthcare trainings. Grantees also described challenges recruiting participants to entry-level trainings because these jobs pay low wages and are associated with employee burnout. Participants were also cautious about committing to a healthcare training program, particularly for a low-wage job, when there were other job opportunities available.

Three grantees reported that mandatory background checks affected their ability to recruit and enroll participants. As described, this was a particular challenge for CITC, given the state code in Alaska that barred individuals convicted of certain crimes from working in healthcare roles. GPTLHB staff also reported challenges with participants having a criminal record that may bar them from employment in healthcare as a barrier to recruitment. TMCC staff noted that employers in their region had different requirements for background checks, so it was important to understand what employers required so that participants did not struggle to find employment after completing a training.

Grantees experienced limitations in their course offerings due to market conditions. CITC was unable to offer participants a continuous pathway on the nursing career ladder because there were no LPN programs in their service area. Additionally, seats in RN programs were limited, and admission was competitive. TMCC was unable to offer the LPN and Pharmacy Technician programs for several years because they were unable to hire instructors. Staff noted that this may be due to the rural nature of the area and the inability of TMCC's instructional wages to compete with nursing and pharmacy wages. Although TMCC was not able to hire an LPN instructor to reinstate its LPN program, it partnered with another institution to offer the LPN program to participants. Meanwhile, after the Pharmacy Technician program was suspended in the first year, it returned in the fifth year after an instructor was hired.

Grantee staff and participants described challenges to program implementation as a result of the COVID-19 pandemic. These included difficulty in maintaining contact with participants when programs switched to remote learning, engaging students in an online setting effectively, and the ability for students to access remote courses (both in terms of navigating online learning systems and having adequate equipment, such as a computer and stable internet).[42]

[42] A detailed description of the effects of the COVID-19 pandemic can be found in a separate Practice Brief, *Responding to the COVID-19 Pandemic: Tribal HPOG 2.0 Grantees' Program Adaptations*, published on the OPRE website.

Chapter 6: Program and Participant Outcomes

In this chapter, we present program outcomes across the five-year evaluation of Tribal HPOG 2.0 (2015–2020). It addresses the following research questions:

- What are the individual-level outputs and outcomes for participants in the Tribal HPOG programs?
- Do some programs or program components appear to be associated with positive outputs and outcomes for Tribal populations? If so, what are the hypothesized reasons for differences between outcomes?
- Do different program models, strategies, or components appear to lead to different outcomes for participants?
- Is there evidence that participation in the program is positively associated with successful employment and work force capacity building outcomes?

We provide data on enrollment, educational attainment, and employment. We describe grantees' outlooks on program sustainability, how the grants helped to build healthcare workforce capacity in grantee communities, and satisfaction with Tribal HPOG 2.0.

Enrollment

As noted in Chapter 3, 2,632 participants enrolled in Tribal HPOG 2.0. Of those, 1,681 participants consented to participate in the evaluation. Data in this chapter reflects only those who consented to participate in the evaluation. Exhibit 16 shows the number of consenting participants who enrolled across each of the program years, across all Tribal grantees.

Exhibit 16. Number of Tribal HPOG 2.0 Consenting Participants Enrolled per Program Year (N = 1,681)

Program Year	Number Enrolled and Consented
2016 cohort, enrolled in Year 1	168
2017 cohort, enrolled in Year 2	434
2018 cohort, enrolled in Year 3	452
2019 cohort, enrolled in Year 4	430
2020 cohort, enrolled in Year 5	197
Total	**1,681**

Source: PAGES. Participants enrolled between October 1, 2015, and September 30, 2020.

N = 1,681 participants who consented to provide evaluation data.
Cohort Year = program year running from October 1 to September 30.

Healthcare Training

As described in Chapter 5, the Tribal HPOG 2.0 grantees offered a variety of healthcare trainings to participants. Exhibit 17 shows the types of healthcare occupational trainings in which participants enrolled (in descending order), as well as the number and percent of enrollees that completed training. As noted above, some participants enrolled in more than one training.

Over half of all participants enrolled in a Nursing Assistant training. All grantees offered CNA training programs. Completion for nursing assistant training programs was 83 percent.

Over 100 participants enrolled in each of the following trainings: Personal Care Aides, Medication Technician/Aide, LPN, and RN. Completion rates for the entry-level programs along the nursing career pathway – Personal Care Aides and Medication Technician/Aide – were high, with nearly 100 percent of Personal Care Aides completing training and over three-quarters of Medication Technician/Aides completing training. Completion rates in the mid- and high-level nursing programs, LPN and RN, were lower, with just over 50 percent of participants completing those trainings to date.

EMT and Medical Administrative Assistant programs also had high enrollments (98 and 96 participants, respectively). Four grantees offered these trainings. Nearly 70 percent of those who enrolled completed these trainings.

Many training programs had 50 or fewer participants enrolled. These programs included Substance Abuse and Behavior Disorder Counselors, Phlebotomists and Medical Lab Technicians, Medical Assistants, Healthcare Social Workers, and Medical Billing and Coding, among others. Fewer than 10 participants enrolled in Dental Assistants and Hygienists, Radiologic Technologists, Dieticians, and Physician Assistant training programs. These programs are collapsed into the "other" category in Exhibit 17. Not all grantees offered these programs (as noted in Exhibits 11 and 12).

Exhibit 17. Number of Tribal HPOG 2.0 Participants Who Enrolled in and Completed Each Healthcare Training Program, 2015–2020

	Enrolled	Completed	Completion Percentage
Type of Training	**n**	**n**	**%**
Nursing Assistants	857	715	83
Medication Technician/Aide	183	141	77
Registered Nurses	132	75	57
Licensed Practical and Vocational Nurses	107	57	53
Personal Care Aides	102	101	99
Emergency Medical Technicians	98	68	69
Medical Office Clerk/Secretary/Specialist	96	64	67
Substance Abuse and Behavioral Disorder Counselors	54	45	83
Phlebotomists	46	28	61

Type of Training	Enrolled n	Completed n	Completion Percentage %
Medical Receptionists and Information Clerks	44	22	50
Medical and Clinical Laboratory Technicians, Other	38	15	40
Healthcare Social Workers	37	25	68
Medical Assistants	37	21	57
Medical Insurance Coder	35	12	34
Athletic Training/Trainer	30	11	37
Substance Abuse and Behavioral Disorder Counselors Advanced	15	15	100
Pharmacy Technicians	13	*	>40
Medical Insurance Biller	11	*	>40
Paramedics	11	*	>30
Other	13	*	>60

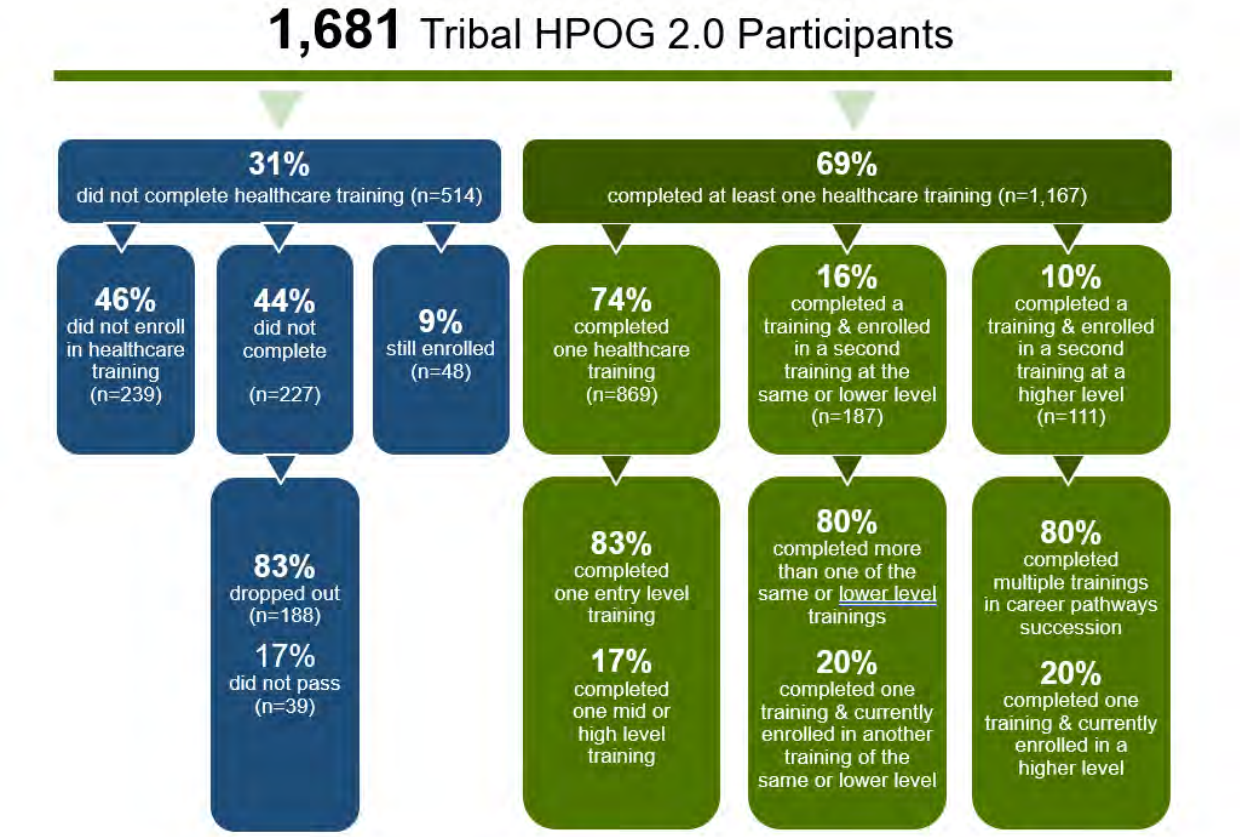
Source: PAGES. Participants enrolled between October 1, 2015, and September 30, 2020.

*Values less than 10 are suppressed.

Participants could enroll in multiple trainings over the course of enrollment; data is reported for N = 1,681 participants who consented to provide evaluation data. Percentages are of participants with data. Percentages may not total 100 due to rounding.

As described in Chapter 5, grantees established career pathway opportunities in the nursing career pathway and the emergency medical response pathway. Grantees also enabled participants to enroll in other healthcare trainings. Exhibit 18 shows the educational pathways for the 1,681 participants who consented to participate in the evaluation.

Exhibit 18. Educational Pathways of Tribal HPOG 2.0 Participants (N = 1,681)



Source: PAGES. Participants enrolled between October 1, 2015, and September 30, 2020.
N = 1,681 participants who consented to provide evaluation data. Percentages are of participants with data. Percentages may not total 100 due to rounding. Training completion is reported as of February 2, 2021.

The majority of Tribal HPOG 2.0 participants (69 percent) completed at least one healthcare training. Of that 69 percent, 74 percent completed one training and 26 percent completed one training and enrolled in a second training. Thirty-one percent of participants did not complete a training. Of that 31 percent, 46 percent did not enroll in healthcare training, 44 percent did not pass or dropped out of training, and 9 percent are still enrolled in training. Participants who did not complete training indicated reasons for non-completion, including family obligations, health concerns, and balancing work and schooling.

A limited number of Tribal HPOG 2.0 participants completed a training and enrolled in a training at a higher career pathways level.[43] Of the 1,167 participants who completed at least one training, 10 percent enrolled in a second training at a higher level and 16 percent enrolled in a second training at the same or lower career pathways level (such as participants who

[43] This designates whether the healthcare occupational training activity is at the entry-level, mid-level, or high-level of a career pathway. A general guide for these levels is as follows: entry-level training is for occupations with average wages less than $15 an hour; mid-level for occupations with average wages greater than $15 but less than $25 an hour; and high-level for occupations with average wages greater than $25 an hour. Grantees assigned career pathways level to each training that was offered. This is the definition used in PAGES; grantees used this definition to categorize their trainings in PAGES.

completed a CNA training and enrolled in a Certified Medication Aide training).[44] In both groups, 80 percent of who enrolled in a second training completed it.

Exhibit 19 presents training status and receipt of certificate or licensure for all Tribal HPOG 2.0 participants who consented to participate in the evaluation. It is important to note that for many of the healthcare jobs for which HPOG 2.0 provides training, such as Medical Assistant and Pharmacy Technician, certificates and licenses are available but not required or requirements vary across states. For this reason, not all HPOG 2.0 healthcare training completers would be expected to receive certification or a license.

Exhibit 19. Training Status and Receipt of Occupational Certificates and Licenses by Tribal HPOG 2.0 Participants (N = 1,681)

Healthcare Training and Certificate or Licensure Receipt	n	%
Completed training(s) and received a certificate or license	867	51.6
Completed training(s) but not yet received a certificate or license	300	17.8
Did not complete a training to date	275	16.4
Not yet enrolled in training	239	14.2
Total	**1,681**	**100**

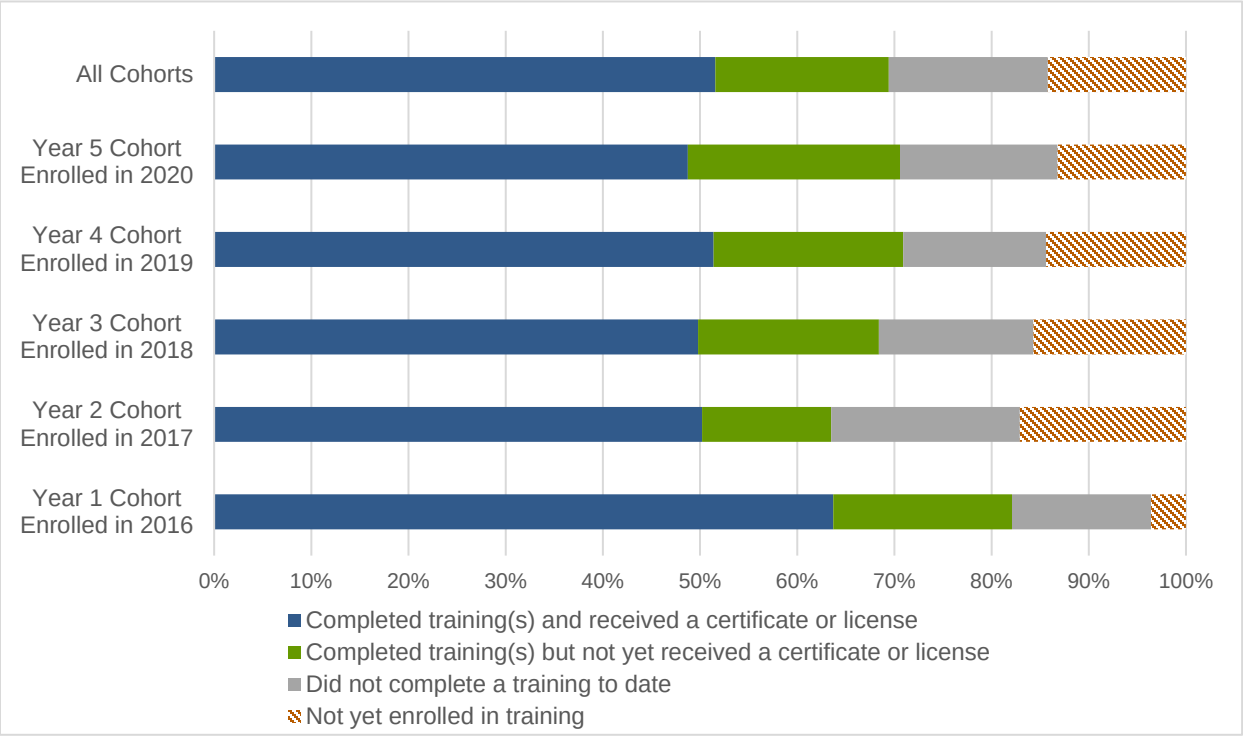
Source: PAGES. Participants enrolled between October 1, 2015, and September 30, 2020.

N = 1,681 participants who consented to provide evaluation data. Percentages are of participants with data. Percentages may not total 100 due to rounding. Training completion could have occurred at any point in the five-year period, not only the year the participant enrolled. "Did not complete training" includes those who did not pass, dropped out, or are currently enrolled in training.

Exhibit 20 presents training status and receipt of certificate or licensure for each yearly cohort of participants. Yearly cohorts are defined based on a participant's enrollment date. Training completion could have occurred at any point in the five-year period, not only the year the participant enrolled. Participants who did not complete training includes those who did not pass, dropped out, or are currently enrolled in training.

[44] Medication Aide is often taken as an add-on course for CNAs to help increase earning potential. This is particularly common among participants at GPTLHB and TMCC.

Exhibit 20. Training Status and Receipt of Occupational Certificates and Licenses by Tribal HPOG 2.0 Participants by Cohort Year (N = 1,681)



Source: PAGES. Participants enrolled between October 1, 2015, and September 30, 2020.
N = 1,681 participants who consented to provide evaluation data. Percentages are of participants with data. Percentages may not total 100 due to rounding. Training completion could have occurred at any point in the five-year period, not only the year the participant enrolled. "Did not complete training" includes those who did not pass, dropped out, or are currently enrolled in training.

In each yearly cohort, approximately half of the participants have completed at least one training and received either a certificate or license. More students in the Year 1 cohort (63 percent) completed training and obtained a certificate or license than in any other cohort. In yearly cohorts 2 through 5, about 50 percent of participants completed training and obtained a certificate or license.[45] Around 20 percent of participants in each yearly cohort completed at least one training but had not yet received a certificate or license.

Employment Outcomes

The Tribal HPOG 2.0 grantees attempted to collect information in PAGES about employment obtained by participants following their participation in the program. However, as noted in the study limitations, grantees found it challenging to connect with participants once they completed their training, and they were not able to collect employment information on all participants. In this section, we report on employment outcomes as documented by grantee staff in PAGES.

[45] Note: Participants in the Year 5 cohort may have enrolled just a few months prior to the end of the evaluation period and may be expected to complete their training in the final year of HPOG program implementation.

Exhibit 21 summarizes the most recent data available (as of February 2, 2021) for Tribal HPOG 2.0 participant wages and total hours worked per week.

Forty-two percent of participants obtained employment after enrollment in Tribal HPOG 2.0. The majority of participants who obtained employment after enrollment in HPOG worked in a healthcare occupation (93 percent). Of the 655 participants that were employed in a healthcare occupation, 51 percent earned $15 or more per hour, and 58 percent worked 35 hours or more per week. It is important to note that, while this report uses the most recently available data, it is possible that participants may not have provided information about their most recent employment.

Exhibit 21. Number and Percentage of Tribal HPOG 2.0 Participants Employed in Healthcare After Enrollment, 2015–2020 (N = 655)

Characteristic	Employed in Healthcare Occupation (N=655)	
	Number	Percentage
Wages		
$14.99 or less	247	38
$15.00 or more	334	51
Missing	74	11
Total	**655**	**100**
Hours Worked per Week		
Fewer than 20 hours	92	14
20–34 hours	87	13
35 hours or more	382	58
Missing	94	14
Total	**655**	**100**

Source: PAGES. Participants enrolled between October 1, 2015, and September 30, 2020.
N = 655 participants who consented to provide evaluation data. Based on the most recent available employment data as of February 2, 2021. Percentages are of participants with data. Percentages may not total 100 due to rounding.

Exhibit 22 shows the number and percent of Tribal HPOG 2.0 participants employed within a healthcare occupation organized by the Standard Occupational Classification (SOC) system. Federal statistical agencies use the SOC system to classify workers and jobs into occupational categories. The SOC system covers all jobs in the U.S. economy, including occupations in the public, private, and military, classifying them into a tiered system of four levels, ranging from major groups to detailed occupation sectors.

Exhibit 22. Number and Percent of Tribal HPOG 2.0 Participants Employed by Standard Occupational Classification (SOC) Code, 2015–2020 (N = 655)

Category Description (SOC code)	Employed	Percentage
Nursing, Psychiatric, and Home Health Aides (31-101)	372	57
Registered Nurses (29-114)	58	9
Personal Care Aides (39-902)	37	6
Licensed Practical and Vocational Nurses (29-206)	35	5
Community and Social Service Specialists (21-109)	32	5
Medical and Health Services Managers (11-911)	20	3
Medical Records Specialists (29-207)	19	3
Paramedics, Emergency Medical Technicians (29-204)	14	2
Dental Assistants, Phlebotomists, Medical Assistants (31-909)	13	2
Medical Office Clerk/Secretary/Specialist (43-601)	10	2
All other categories	45	7

Source: PAGES. Participants enrolled between October 1, 2015, and September 30, 2020.
Participants can be employed in more than one occupation during the five-year evaluation period. Table based on the most recent available employment data as of February 2, 2021.
N = 655 participants who consented to provide evaluation data and obtained employment in healthcare.
Percentages are of participants with data. Percentages may not total 100 due to rounding.

Most participants who were employed in healthcare obtained employment in occupations that provide hands-on, direct patient care (76 percent). These occupations included nursing, psychiatric, and home health aides; personal care aides; licensed practical nurses; and registered nurses. The majority of these participants (56 percent) obtained employment in the occupational category of nursing, psychiatric, and home health aides. This category includes occupations such as nursing assistants, home health aides, and medication technician/aides. About 20 percent of the participants who were employed in healthcare were employed as RNs, personal care aides, and LPNs.

Some participants (between 1 and 5 percent of employed participants) were employed in other healthcare occupations. These occupations included medical administrative functions, paramedics and EMTs, and dental and medical assistants, among others.

Sustainability

The Tribal HPOG 2.0 program funded grantees for five years, with one 12-month extension. While sustainability was discussed with grantees throughout the evaluation, only two grantees shared sustainability plans. They reported that a few components may be sustained after the program ends. However, grantees are more likely to focus on sustainability in the final year of program implementation. Grantees had another full year of program implementation at the time of the final data collection for the evaluation.

One grantee institution may sustain newly developed healthcare training programs. As a Tribal college with career and technical education programs, TMCC reported that they may continue offering allied health professions training that are in demand, such as CNA/CMA and health and fitness training.

Two grantees described leveraging investments made during HPOG for future programming. Investments in facilities, equipment, and instructor training can be carried forward into future programs. For example, UMUT built capacity for distance education at the Ute Mountain Learning Center by purchasing equipment, training staff on how to support distance education, and establishing relationships with academic partners to provide distance education. UMUT can build on these experiences to offer distance education courses at the Ute Mountain Learning Center in the future. TMCC made investments in facilities and equipment, such as purchasing equipment for the college fitness center for the Health and Fitness Technician program, which can be used to support that program after the grant ends.

Building Healthcare Workforce Capacity

By training individuals in healthcare professions, Tribal HPOG 2.0 programs helped to build workforce capacity in healthcare professions in their communities.

Employers and staff described how HPOG programs helped build workforce capacity by training qualified individuals to staff local healthcare facilities. For example, GPTLHB employers emphasized how the HPOG program has allowed them to hire individuals from the community to staff long-term care facilities instead of relying on traveling nurses with hourly rates of "almost double or over double" that of a non-traveling nurse. GPTLHB employers noted this had several benefits, including continuity of care for patients, cost-effectiveness, and greater sustainability of the workforce. TMCC staff noted that they have expanded clinical affiliate agreements with new employers to support new allied health programs. Several TMCC employers noted that hosting HPOG participants for clinical practicums or internships benefited their facility because it helped them fill vacancies with qualified candidates. Over time, these mutually beneficial relationships opened the door for employers to reach out to grantees when they had open positions.

Employers and participants appreciated that the Tribal HPOG 2.0 programs increased culturally competent services and care, by training AI/AN participants to care for members of Tribal communities. Employers described how AI/AN employees, particularly bilingual participants who can speak to AI/AN patients in their language, assist in overcoming language barriers, put patients at ease, and create trust. One employer explained, *"If you're coming to the hospital, it's not a good day for you [because there is usually a] health crisis. [Employees] have to have customer service skills and empathy … so when they see someone familiar and talk their language, you put them at ease."*

Participants commonly described how they were able to relate to AI/AN patients based on their shared culture and build trust with their patients. One participant said, *"[Native American patients] might talk to a native [care provider] more easily and feel more comfortable talking to you about whatever problem they are having [because you may have a better] understanding of their situation."* Another participant said, *"I can tell when I have an instant connection with a Native American patient. I tell them I'm from here, they tell me where they're from, and they trust me.… You trust people who you know and understand."*

Staff, Partner, and Participant Satisfaction

Employers, partners, grantee staff, and participants expressed broad appreciation for HPOG 2.0 grant programs and described the value of these programs for participants and their communities.

Employers appreciated having mutually beneficial relationships with grantees. Employers saw the value of the HPOG 2.0 grantee programs in preparing qualified employees for in-demand positions in their organizations. Although some employers offered suggestions for improvement, multiple employers commented on HPOG participants' strong level of preparedness. For example, one employer serving as a clinical affiliate commented that HPOG clinical practicum students are *"really knowledgeable, and they seem comfortable when they come to us."*

Partners described their appreciation for grantee staff and recognized HPOG programs as important for individual participants as well as the larger community. Similar to employers, partners saw the value of the HPOG program in providing in-demand healthcare training that otherwise would not be available (e.g., due to the remote location). Across grantees, partners expressed appreciation for the academic and non-academic supports that grantees provided to their students, noting its importance for student engagement and retention. Partners also described strong relationships with grantee staff, highlighting open and clear communication as a key element to these relationships. They further described various positive aspects of their relationships with grantees, including staff members' conscientiousness, dedication, reliability, responsiveness, consistency, honesty, and openness.

Staff from all grantee programs expressed pride and satisfaction in their work, recognizing that their programs helped many participants identify and achieve their educational and employment goals. Grantee staff emphasized the sense of purpose they felt in helping participants start out on and progress along a career path. One staff member connected the purpose of their HPOG 2.0 program to AI/AN culture: *"When it comes to our people, the Maslow's Hierarchy of Needs is upside down. The beautiful thing about HPOG is that it gives people their sense of identity and the ability for them to help their families and communities."* Staff also recognized the importance of their work for bolstering the healthcare workforce in their communities.

Participants expressed overall satisfaction and reported that they would recommend the programs they participated in to friends and family. As described above in the Support Services section, participants reported that the supports they received – especially case management and financial supports – were essential to their success. Across programs, participants expressed the sentiment that they would not have been able to reach their training and employment goals without the holistic academic and non-academic supports provided by grantees' programs. They shared that grantees' programs helped them build upon their strengths to overcome challenging life circumstances to attain the training they sought. For example, one participant said, *"A lot of us are below the poverty level.… If I didn't have this program, I would have quit before I [could complete my program]."* Similarly, another participant commented on the cost of training, describing how challenging these programs would be to

access without financial support. Those who had to travel long distances to attend class particularly appreciated the transportation assistance provided. Others expressed appreciation for the academic (e.g., tutoring) and employment (e.g., career advising) supports they received. Some participants noted that the supports available through HPOG grantee programs were not available elsewhere.

Participants reported that grantee staff and instructors provided encouragement and made them feel empowered. Participants appreciated staff members' honesty, openness, kindness, and respect. Some participants described how staff fostered a sense of trust with participants by listening to them and being responsive to their needs, while others expressed appreciation for the accountability and structure that grantee staff provided. They also appreciated the flexibility and understanding that staff and instructors showed when participants encountered challenges. For example, one participant said, *"They made time if I was a few minutes late. With a kid and another on the way, I couldn't always drop everything, and it makes it a lot better for me."* Participants also described how staff went *"above and beyond."* For example, one participant described how staff met her at her place of work to deliver a gas card, and another described how staff stepped in to provide last-minute child care.

Participants reported that HPOG affected their lives in transformative ways, particularly by helping attain financial stability for them and their families. For example, three participants explained:

> *"Before college I was barely scraping by, sometimes I only had $5. This is the first time I've felt secure. I used to be very introverted. I went from hiding from the world to wanting to be part of society."*
>
> *"I actually have savings and a savings account. That's pretty awesome. I'm able to provide: even part-time, I'm able to pay all the bills. I'm able to take care of my family. If I want to, I can put my kids in private school and still pay all the bills. It's been a big blessing to my family."*
>
> *"I am able to provide for my family. I'm more independent and feel like I am able to support my family better than before."*

In addition to realizing their education and employment goals, participants described other benefits of their participation as well. Multiple participants across programs remarked on how grantee programs made them feel more confident and hopeful. They described appreciation for the connections they made, the sense of community they found, and the life skills they learned, including coping skills and teamwork. For example, one participant said, *"Not only has it helped [me] gain knowledge, but it's so much more than that. I feel so hokey saying it, but self-confidence, coping mechanisms, working as a team, knowing you can rely on others – a broad spectrum of things have changed dramatically. I realize there are so many resources and I met really good people and friendships. We all are better people today than when we started."* Participants also described how grantee programs opened their eyes to many opportunities available in healthcare.

A few participants described how their participation in HPOG also helped them be role models for their family members, particularly their children. By participating in grantees' program, participants said that they were able to model perseverance and a commitment to education for their children and younger family members. For example, one participant said, *"Furthering my education means I am a role model to them, even if they don't want to be in the medical field, but just going to school and participating is important. And I want to encourage that."* Several participants described how graduation ceremonies were an important opportunity for their families to witness their achievements. A few described how working hard in school helped them encourage their children to do the same, while others said that they were able to show their children that *"no obstacle is too big"* and "*no matter how old you are you can always go back to school."*

Chapter 7: Conclusion

This report presents the findings of the five-year evaluation of the Tribal HPOG 2.0 Program, addressing program implementation by the five Tribal HPOG 2.0 grantees and participant outcomes. The grantees carried out demonstration projects to provide education and training to TANF recipients and other low-income individuals for occupations in the healthcare field that pay well and are expected to either experience labor shortages or be in high demand. This concluding chapter summarizes findings on program design, program implementation, and participant outcomes across the five grantees.

Program Design

Grantees designed their healthcare education and training programs in response to state and Tribal workforce needs and areas of high demand. Grantees also sought to increase the representation of AI/ANs in healthcare professions and provide opportunities for participants to obtain a portable credential and earn a living wage.

Grantees augmented their service delivery system to offer healthcare trainings to participants, primarily by forming partnerships with state and Tribal partners across their service area. Partnering with additional academic institutions allowed all grantees to expand their geographic reach and the types of training programs offered to Tribal HPOG 2.0 participants. Partners mostly included educational institutions, such as two- and four-year colleges and universities, as well as some workforce development organizations that provided entry-level training programs.

Program Implementation

The grantees used a career pathways framework to provide post-secondary training to Tribal HPOG 2.0 participants. To varying degrees, the grantees implemented a model that allowed participants multiple points of entry: starting with basic bridge programs, moving into short-term certificate programs, then from one- to two-year certificate into associate's degree programs, and ending with bachelor's-level education or higher.

Aligning with the career pathways framework, grantees offered training programs in healthcare professions with high demand, particularly nursing, and emphasized training programs based on the local labor market projections for their region. To varying degrees, grantees offered training programs along defined career pathways. All grantees implemented a career pathway in nursing, with opportunities for entry-level training as a CNA, and mid-to-higher-level opportunities as an LPN or RN. Grantees commonly also offered a career pathway in allied health professions, in particular emergency medical response (4 grantees). In addition to programs along five career pathways, grantees offered certificate and degree programs in a wide range of healthcare fields, such as Medical Billing and Coding, Pharmacy Technician, and Healthcare Social Work.

All grantees provided academic and non-academic supports to participants. Support services are a key component of career pathways programs designed to increase completion in training and encourage participation in successive training. Academic supports included direct financial

assistance (tuition assistance, scholarships) and payment of training-related costs (books, uniforms, or supplies). Grantees and their partners also provided academic advising, tutoring, and mentoring to help participants prepare for and complete training.

All grantees had dedicated staff to provide some form of case management to assess participant needs, offer support, and monitor progress. Grantees provided various personal and family supports to ease barriers to participation; the number of participants who used these supports varied. Grantees provided gas cards or reimbursed participants to offset transportation costs in remote, rural areas or for travel to urban centers. More than 40 percent of participants used transportation support at some point while in the Tribal HPOG 2.0 program. Grantees varied in their approaches to providing food assistance, with two grantees providing meal cards and one grantee providing emergency food assistance. About one-third of all participants received food assistance while in the program. Grantees also offered child care assistance and one-time emergency assistance (for an unexpected car repair, rent, or utility assistance), but there was very low uptake of these supports. Tribal HPOG 2.0 staff, partners, and participants reported that the supports used reduced barriers to participation and facilitated participant retention and program completion.

Grantees provided support to help participants gain employment in their chosen field, primarily though job search assistance, including résumé preparation, search strategies, mock interviewing, and meeting with employers. Four grantees provided some form of job placement assistance (e.g., working with hiring managers or providing moving costs), but few participants used this support. While all grantees had procedures in place to help participants retain employment, there was very low uptake for this support. Grantees also reported that it was challenging to sustain communication with participants once they completed training and obtained employment.

Participant Outcomes

The two key outcomes for HPOG 2.0 participants are educational attainment and employment. More than 2,600 participants enrolled in the Tribal HPOG 2.0 programs; of those participants, 63 percent consented to participate in the evaluation. The findings in this report pertain only to that subset of participants who consented to participate in the evaluation.

Over half of all Tribal HPOG 2.0 participants (857) enrolled in a Nursing Assistant training. Over 100 participants enrolled in each of the following trainings: Personal Care Aides, Medication Technician/Aide, LPN, and RN. EMT and Medical Administrative Assistant programs also had high enrollments (98 and 96 participants, respectively). Many training programs had 50 or fewer participants enrolled.

The majority of Tribal HPOG 2.0 participants (69 percent) completed at least one healthcare training. Of those 69 percent of participants, 74 percent completed one training and 26 percent completed one training and enrolled in a second training. Thirty-one percent of participants did not complete a training. Of that 31 percent, 46 percent did not enroll in healthcare training, 44 percent did not pass or dropped out of training, and 9 percent are still enrolled in training.

A limited number of Tribal HPOG 2.0 participants completed a training and enrolled in a training at a higher career pathways level. Of the 1,167 participants who completed one training, 10 percent enrolled in a second training at a higher level. Another 16 percent of the participants who completed one training enrolled in a second training at the same or lower career pathways level, such as participants who completed a CNA training and enrolled in a Certified Medication Aide training. In both groups, 80 percent of those participants completed their second training.

The career pathways framework is designed to provide participants with industry-recognized credentials or to build additional competencies and gain higher credentials in a field. Over the five-year period (2015–2020), the evaluation found that for each annual cohort, most participants had completed at least one training and received a certificate or license in their chosen field. Notably, 63 percent of the year 1 cohort and about 50 percent of the years 2 to 5 cohorts completed training and obtained a certificate or license.

Forty-two percent of participants obtained employment after enrollment in HPOG. The majority of participants who obtained employment after enrollment worked in a healthcare occupation (93 percent). Of the 655 participants who were employed in a healthcare occupation, 51 percent earned $15 or more per hour and 58 percent worked 35 hours or more per week.

Most participants who were employed in healthcare (76 percent) obtained employment in occupations that involve direct patient care. These occupations included nursing, psychiatric, and home health aides; personal care aides; LPNs; and RNs. The majority of these participants (56 percent) obtained employment in the occupational category of nursing, psychiatric, and home health aides. This category includes occupations such as nursing assistants, home health aides, and medication technician/aides. About 20 percent of the participants who were employed in healthcare were employed as RNs, personal care aides, and LPNs.

Conclusion

These results indicate that the Tribal HPOG 2.0 grantees were largely successful in designing and implementing career pathways programs to train low-income individuals for jobs in the healthcare industry. Grantees successfully engaged academic partners to provide training that increased the geographic reach of their programs beyond their Tribal communities and, in some cases, across states. Extending the network of partners also expanded the number of participants the grantees could support.

Grantees structured their programs to offer multiple access points to training, where participants could enter, exit, and re-enter a career pathway at different steps, depending on their prior education, employment goals, personal circumstances, and local conditions for healthcare employment. Most participants completed at least one entry-level healthcare training, and many enrolled in a second training at the same or lower-level. Few participants, however, followed a defined career pathway by completing a lower-level training and then enrolling in a higher-level training. In some grantee communities, there was a high demand for entry-level workers (e.g., CNA) and, in some cases, limited opportunities for employment in higher-level positions. For some grantees, staff and participants noted that there was reluctance to move away from their communities for employment opportunities. This suggests a need for greater alignment of

higher-level trainings with local and regional labor force conditions and additional supports for participants who are interested in moving for employment opportunities.

Some participants enrolled in HPOG but did not enroll in healthcare training, while others did not complete training. Participants who did not complete training indicated reasons for non-completion, including family obligations, health concerns, and balancing work and schooling. Although case management and support services were a key component of the grantees' programs, this suggests a need for more emphasis on retention strategies and case management to support participants and address barriers to completion.

Grantees provided case management and supportive services, such as tutoring, transportation, and food assistance to encourage training program retention and completion, which participants found to be helpful. Grantees engaged employers to support work-readiness activities through clinical practicums and internships, and job search assistance. However, there was limited implementation of job placement and job retention assistance and low uptake by participants where this support was available. For future implementation, it would be important to have earlier implementation of job placement services and to sustain communication with participants once they completed their training in order for grantees to assist with job retention.

The majority of participants who obtained employment after enrollment worked in a healthcare occupation. Most worked in occupations that provided direct patient care, such as nursing assistants, medication technician/aides, LPNs, and RNs. As we learned from participants, many began or continued their education and employment journey in healthcare, and many realized their goals through HPOG 2.0.