Health Profession Opportunity Grants (HPOG 2.0) National Evaluation Implementation Study Report

National and Tribal Evaluation of the 2nd Generation of Health Profession Opportunity Grants (HPOG 2.0)

OPRE Report 2022-237

HPOG
Health Profession Opportunity Grants
OFFICE OF FAMILY ASSISTANCE

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Note: At the request of OPRE, some of the text in this report is taken verbatim or with only minor edits from earlier reports for OPRE—for the Pathways for Advancing Careers and Education project, and for the national evaluations of two rounds of Health Profession Opportunity Grants (HPOG 1.0 and HPOG 2.0).

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Overview

Introduction

Following on a first round of Health Profession Opportunity Grants (HPOG) awards in 2010 ("HPOG 1.0"), the Office of Family Assistance (OFA) of the Administration for Children and Families (ACF), within the U.S. Department of Health and Human Services, in 2015 awarded a second round of 32 five-year grants ("HPOG 2.0"). Local HPOG 2.0 programs provided education, training, and support services to Temporary Assistance for Needy Families recipients and other adults with low incomes for occupations in the healthcare field that pay well and were expected to either experience labor shortages or be in high demand.

This *Implementation Study Report* documents how non-tribal HPOG 2.0 grantees designed and implemented their programs, including program contexts, administration, grant expenditures, training and support services, and employment assistance services. It also documents participant characteristics and their engagement in program services and training activities. This report does not document participants' outcomes; those are covered in a subsequent report.

Research Questions

- How was HPOG 2.0 designed and implemented?
- What were the characteristics of HPOG 2.0 participants?
- At what rates did HPOG 2.0 participants take up program activities, training courses, and support services?

Purpose

HPOG 2.0 is an opportunity to learn how to improve healthcare workforce training and job training programs. The Implementation Study describes in detail the variety of program components and implementation strategies; the context in which programs operate; and participants' characteristics, experiences, and engagement in healthcare occupational training and support services. It spotlights program implementation and participants' experiences from grant award through August 2019, the fourth year of HPOG 2.0 operations.

Key Findings

Program Administration

- Higher education institutions were the most common operators of HPOG 2.0 programs.
- On average, HPOG 2.0 programs partnered with 23 organizations.[1]

[1] The data on partners is based on responses to telephone interviews conducted with program representatives in 2017. The number and types of partners reported during those interviews may differ from the number and types reported during additional interviews conducted with program operators in late 2019 for the Systems Study (see Eyster et al. 2022).

- All programs engaged employers as they helped participants find jobs, and many involved employers in other aspects of program operations.

Participants

- HPOG 2.0 participants were primarily women, never married, and older than students entering college immediately after high school.
- At intake, almost one-quarter were already enrolled in school or training.
- At intake, slightly over four-fifths were living in households receiving a public benefit.

Healthcare Education and Training

- All HPOG 2.0 programs offered basic skills education; about half of participants received it.
- Nearly four-fifths of HPOG 2.0 participants enrolled in healthcare occupational training courses.
- Training for Nursing Assistant was the most popular occupational training; more than a third of participants enrolled in it.
- More than two-thirds of programs offered work-based learning opportunities, such as on-the-job training or job shadowing, but few participants engaged in them.
- All programs offered other skill-development activities (e.g., work readiness, digital literacy, college readiness, CPR training); about half of participants participated in them.

Support Services

- All HPOG 2.0 programs offered:
  - case management and counseling services, and nearly all participants received them;
  - academic advising and training-related financial assistance, and more than half of participants received them;
  - personal and logistical supports, including transportation and child or dependent care assistance, but fewer than half of participants received transportation assistance and only 5 percent received child or dependent care assistance.
  - employment supports, and fewer than one-third of participants received them.

Methods

The HPOG 2.0 Implementation Study collected data through two rounds of telephone interviews with program staff and other informants. Data from the evaluation's management information system on participant characteristics and receipt of program services, training, and support services supplement these findings. The study also highlights staff insights on recommended strategies in five focus areas of interest to ACF. Insights into the motivations, decision making, expectations, and experiences of HPOG 2.0 Program participants gathered through in-depth interviews are also included.

Executive Summary

Following on a first round of Health Profession Opportunity Grants (HPOG) Program awards in 2010 ("HPOG 1.0"), the Office of Family Assistance (OFA) of the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services, in 2015 awarded a second round of 32 five-year grants ("HPOG 2.0"). The statutory purpose of the Health Profession Opportunity Grants (HPOG) Program is to provide education and training to Temporary Assistance for Needy Families (TANF) recipients and other adults with low incomes for occupations in the healthcare field that pay well and were expected to either experience labor shortages or be in high demand.

Each HPOG 2.0 grantee designed and implemented one or more local program to provide education, occupational training, and support and employment services. Compared to HPOG 1.0, in HPOG 2.0 ACF increased the emphasis on articulated career pathways, serving participants with low basic skills, and employer engagement.

ACF's Office of Planning, Research, and Evaluation (OPRE) oversees a multipronged research and evaluation strategy to assess the effectiveness of the HPOG funding stream. The "National Evaluation" examines 27 of the 32 HPOG 2.0 grantees; five Tribal grantees were evaluated separately. The National Evaluation includes an Implementation Study, a Systems Study, an Outcomes Study, an Impact Evaluation, and a Cost-Benefit Analysis. This report presents findings from the Implementation Study.

Study Design

The Implementation Study describes in detail the variety of HPOG 2.0 program components and implementation strategies adopted by grantee programs. Aligning with requirements in the 2015 Funding Opportunity Announcement, the HPOG 2.0 Implementation Study highlights insights of program staff on recommended strategies in five focus areas of interest to ACF: (1) employer engagement, (2) basic skills education, (3) work-readiness training, (4) career pathways training opportunities, and (5) program sustainability after the end of the HPOG 2.0 grant period.

The study describes and analyzes variation across local HPOG 2.0 programs while synthesizing information at the national level to characterize the HPOG 2.0 initiative as a whole. It presents the number and percentage of programs that implemented specific features by averaging results at the program level, or by presenting service receipt across all participants enrolled in the study period. The study also describes program outputs, including participation patterns and service receipt across all programs. It spotlights program implementation and participants' experiences from grant award through August 2019, the fourth year of HPOG 2.0 operations.

HPOG 2.0 program activities were relatively stable for the first four years of the grant period, the observation period for the Implementation Study. However, programs were forced to rethink how to deliver services starting in March 2020 when the United States declared a state of emergency in response to the COVID-19 pandemic. By May 30, 2020, all but a few states and territories had issued stay-at-home orders or advisories. As part of ACF's effort to learn more about how HPOG programs and participants fared during the pandemic, a separate brief looks

into HPOG 2.0 program implementation adaptations during the first 10 months of the COVID-19 pandemic.[2]

Research Questions

The study's main research questions are:

- How was HPOG 2.0 designed and implemented?
- What were the characteristics of HPOG 2.0 participants?
- At what rates did HPOG 2.0 participants take up program activities, training courses, and support services?

Data Sources

The HPOG 2.0 Implementation Study relied on data collected through two rounds of telephone interviews with staff and other informants from each program.

These telephone interview data were augmented with several other data sources. The Participant Accomplishment and Grant Evaluation System (PAGES), HPOG's web-based management information system, provided individual-level information on participant characteristics and receipt of program services. Case studies developed in each of the five focus areas provide insights from program operators, staff, and partners for a selection of programs. In-depth interviews with program participants provide insights into their motivations, decision making, expectations, and experiences.

Findings

Overall findings:

- HPOG 2.0 grantees designed and implemented programs to provide eligible participants with education, training, and support services to help them train for and find jobs in a variety of healthcare professions.
- HPOG 2.0 programs incorporated key features of the career pathways framework. Participant receipt of services varies considerably across program offerings. Available data for this report do not allow us to determine why such variation is the case. We are not able to assess whether programs offered all services to all participants or were intentionally or unintentionally selective when offering services. It could also be that participants simply chose to take up particular program offerings at different rates.

Findings by domain:

Program Administration

- Higher education institutions were the most common operators of HPOG 2.0 programs, followed by government agencies and workforce system agencies.

[2] See Roy et al. 2022.

- On average, programs partnered with 23 organizations.[3]
- All programs engaged employers as they helped participants find jobs, and many involved employers in other aspects of program operations.

Participants

- HPOG 2.0 participants were primarily women, married, and older than students entering college immediately after high school.
- At intake, almost one-quarter were enrolled in school or training.
- At intake, slightly over four-fifths were living in households receiving a public benefit.
- More than three-quarters of HPOG 2.0 participants had completed high school; more than half had attended college.

Healthcare Education and Training

- All HPOG 2.0 programs offered basic skills education, and about half of participants received it.
- Nearly four-fifths of HPOG 2.0 participants enrolled in healthcare occupational training courses.
- Training for Nursing Assistant was the most popular program offering, and more than a third of HPOG 2.0 participants enrolled in this course.
- More than two-thirds of programs offered work-based learning opportunities, such as on-the-job training or job shadowing (beyond clinical placements required as part of training), but few participants engaged in these opportunities.
- All HPOG 2.0 programs offered other skill-development activities (e.g., work readiness, digital literacy, college readiness, CPR training), and about half of participants participated in these activities.

Support Services

- All HPOG 2.0 programs offered case management and counseling services, and nearly all participants received these services.
- All HPOG 2.0 programs offered academic advising and training-related financial assistance, and more than half of participants received these services.
- All HPOG 2.0 programs offered personal and logistical supports, including transportation and child or dependent care assistance, but fewer than half of participants received

[3] The data on partners is based on responses to telephone interviews conducted with program representatives in 2017. The number and types of partners reported during those interviews may differ from the number and types reported during additional interviews conducted with program operators in late 2019 for the Systems Study (see Eyster et al. 2022).

transportation assistance and only 5 percent received child or dependent care assistance from the program.

- All HPOG 2.0 programs offered employment supports such as job search assistance and job retention services, but fewer than one-third of participants received these services.

Discussion

HPOG 2.0 provides examples of the types of education, training, and academic and logistical supports that grantees implemented to help TANF recipients and other adults with low incomes access and complete occupational training in healthcare. Local programs had discretion to design and implement their programs within the guidelines set by ACF.

The most widely available training through HPOG 2.0 was Nursing Assistant, and more than a third of HPOG 2.0 participants enrolled in this course. That training is short and employment in the long-term care and acute care sectors is typically readily available upon completion. These occupations, however, do not pay well, and the workplaces where nursing assistants are initially employed provide limited opportunities for career progress. The next step in a nursing career pathway requires considerably more training than a Nursing Assistant and can be challenging (Loprest and Sick 2018). Based on analysis results from the HPOG 2.0 Short-Term Impact Evaluation (about 15 months after random assignment), these types of entry-level healthcare occupations do not serve as gateways to a broad array of better-paying, higher-skilled jobs in healthcare professions (Klerman et al. 2022). Furthermore, an analysis of HPOG 1.0 found that few enrollees completed further training that could lead to higher-paying jobs after completing entry-level training (Klerman, Litwok, and Morris 2022).

All local HPOG 2.0 programs described offering or providing program participants with referrals to personal and logistical supports, including child care assistance. HPOG child care assistance needed to be from a State approved and licensed provider. Interviews with HPOG 2.0 participants indicated that many service areas had limited options with long wait lists and many did not have child care options for students working nontraditional hours. Some participants already had child care for which HPOG could not pay (i.e., with family, friends, or non-licensed providers). These insights may in part explain the low take-up rates and participant reports of problems getting child care assistance. Other HPOG 2.0 evaluation reports look in more detail at program outcomes such as training progress and completion, as well as at program impacts for study members offered access to HPOG 2.0 services compared to a control group who are not.

Important Terms for This Report

adult basic education (ABE): a class or instructional program which teaches basic skills including reading, mathematics, and writing, provided to adults with skills at or below 8th grade level, and which does not charge college tuition.

adult secondary education: a class or instructional program which teaches secondary education material to adults with skill levels between 9th and 12th grade levels and which does not charge college tuition. Such classes typically prepare students for testing to receive a high school equivalency credential such as GED, HiSET, or the Test for Assessing School Completion (TASC).

career pathways: a framework for occupational training that combines education, training, and support services that align with the skill demands of local economies and helps individuals to enter or advance within a specific occupation or occupational cluster.

clinicals: hands-on application of skills learned in a healthcare setting, required as part of occupational training and/or licensing. In HPOG administrative data, clinicals are not counted as work-based learning or work experience activities.

college developmental education: a class or series of classes offered by a college and charging tuition which are designed to raise participants' math, reading, or writing skills to enable them to succeed in college-level work.

contextual factors, or "system": the economic and service delivery environment in which an HPOG program operates.

contextualized basic skills: adult basic education taught using concepts and materials related to occupational training.

English language acquisition training: a class or instructional program to help adult English language learners improve their proficiency in the English language.

HPOG or HPOG Program: the national Health Profession Opportunity Grants initiative, including all grantees and programs; recipients of the funding stream from the Administration for Children and Families (ACF), Office of Family Assistance (OFA).

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

HPOG partners: other organizations directly involved in the operations of an HPOG program.

HPOG (local) program: a unique set of services, training courses, and personnel; a single grantee may fund one or more programs.

HPOG program operator: the lead organization directly responsible for the administration of an HPOG program (either operating it directly or funding/overseeing it).

integrated basic skills: adult basic education integrated into occupational training curriculum.

job placement assistance: referring individuals to jobs matching their abilities and interests. It may entail interviewing, assessing, and/or testing participants for the purpose of achieving suitable job placements where there is a good match between management needs and employee qualifications.

job retention services: practices that help participants maintain employment or change jobs without a period of unemployment, including counseling for specific job-related issues, incumbent worker career advancement counseling, and job-specific workplace behavior training. These services take place while participants are employed.

job search assistance: offering information on labor markets, occupations, and job search techniques (resumes, interviews, applications, and follow-up letters). It does not include helping to place participants in specific jobs; the resulting job search is self-directed by participant.

job shadowing: opportunities for students to observe workers in their chosen occupation on the job.

network: the group of organizations that interact to support HPOG program operations.

on-the-job training: training by an employer that is provided to a participant who is paid while engaged in productive work in a job that (a) provides knowledge or skills essential to the full and adequate performance of the job; b) is made available through the HPOG grant or a federally-funded program, such as WIA/WIOA or TANF, that provides reimbursement to the employer of up to 75 percent of the wage rate of the participant for the extraordinary costs of providing the training and additional supervision related to the training; and c) is limited in duration as appropriate to the occupation for which the participant is being trained, taking into account the content of the training, the prior work experience of the participant, and the service strategy of the participant, as appropriate.

outcomes: end goals for HPOG participants, including employment and earnings in general and in healthcare specifically.

outputs: the direct results of program activities or services received by HPOG participants and/or the accomplishments associated with completing a service, such as participation in basic skills training and healthcare training.

participants: individuals who meet program eligibility criteria and who participate in an education and training program and/or receive related services supported by HPOG 2.0 grants.

stackable credentials: recognized skills based on courses that connect with other courses representing successive steps on occupational career pathways.

Temporary Assistance for Needy Families (TANF) recipient: individual receiving TANF assistance, cash assistance, or non-assistance benefits at time of program application.

training course: a series of modules, or manageable and stackable chunks of training, that lead to an industry-recognized credential.

work-based learning: instruction that takes place in a workplace setting. For HPOG, it includes job shadowing, unpaid internships or externships, on-the-job-training, or work experience. It excludes clinicals required as part of training or licensing.

work experience: a planned, structured learning experience that takes place in a workplace for a limited period for the purpose of exposing the participant to the occupation. It is provided in combination with classroom or other training but is not a requirement for completion of training. For the purposes of HPOG, it is unpaid. It does not include clinical experience that is required as part of a specific course of training.

1. Introduction

Many Americans have low hourly wages and low earnings. Because individuals with higher educational attainment tend to have lower unemployment and higher earnings than those with less education, policymakers frequently turn to job skills training and other postsecondary education as a strategy for increasing earnings by preparing people for higher-skilled, better-paying occupations (BLS 2019).

The **Health Profession Opportunity Grants (HPOG) Program** was one effort implementing that strategy. Following on a first round of awards in 2010 ("HPOG 1.0"), the Office of Family Assistance (OFA), within the Administration for Children and Families (ACF) in the U.S. Department of Health and Human Services, in 2015 awarded a second round of 32 grants ("HPOG 2.0") to 27 non-Tribal ("National") grantees and 5 Tribal grantees.[4] The HPOG Program funded grantees to provide education, training, and support services to Temporary Assistance for Needy Families (TANF) recipients and other adults with low incomes for occupations in the healthcare field that pay well and were expected to either experience labor shortages or be in high demand. Altogether, HPOG 2.0 served more than 35,000 adults.

The HPOG Program's Authorizing Legislation and Guidelines

As part of the Affordable Care Act of 2010, Congress authorized funds for the Health Profession Opportunity Grants (HPOG) Program

> *to conduct demonstration projects that are designed to provide eligible individuals* [defined elsewhere as an "individual receiving assistance under the State TANF program" or "other low-income individuals"] *with the opportunity to obtain education and training for occupations in the healthcare field that pay well and are expected to either experience labor shortages or be in high demand. (OFA 2010)*

From this, the evaluation draws its three focal outcomes: increasing educational progress, building a healthcare workforce, and increasing wages and benefits.

HPOG was authorized as a demonstration program with a mandated federal evaluation. ACF's Office of Planning, Research, and Evaluation (OPRE) oversees a multipronged research and evaluation strategy to assess the effectiveness of the HPOG Program. In 2015, OPRE awarded a contract to Abt Associates and its partners the Urban Institute, MEF Associates, NORC at the University of Chicago, and Insight Policy Research to conduct the **National and Tribal Evaluation of the 2nd Generation of Health Profession Opportunity Grants**.[5] This *Implementation Study Report* documents how the non-Tribal HPOG 2.0 grantees designed and implemented their programs, including program contexts, administration, grant expenditures,

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4 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 were extended until September 29, 2021.

5 This Implementation Study is part of OPRE's diverse research portfolio to assess the success of the HPOG funding stream on participants' educational attainment, employment, and earnings. For an overview, see Appendix A.

training and support services, and employment assistance services. It also documents participant characteristics and their engagement in program services and training activities.

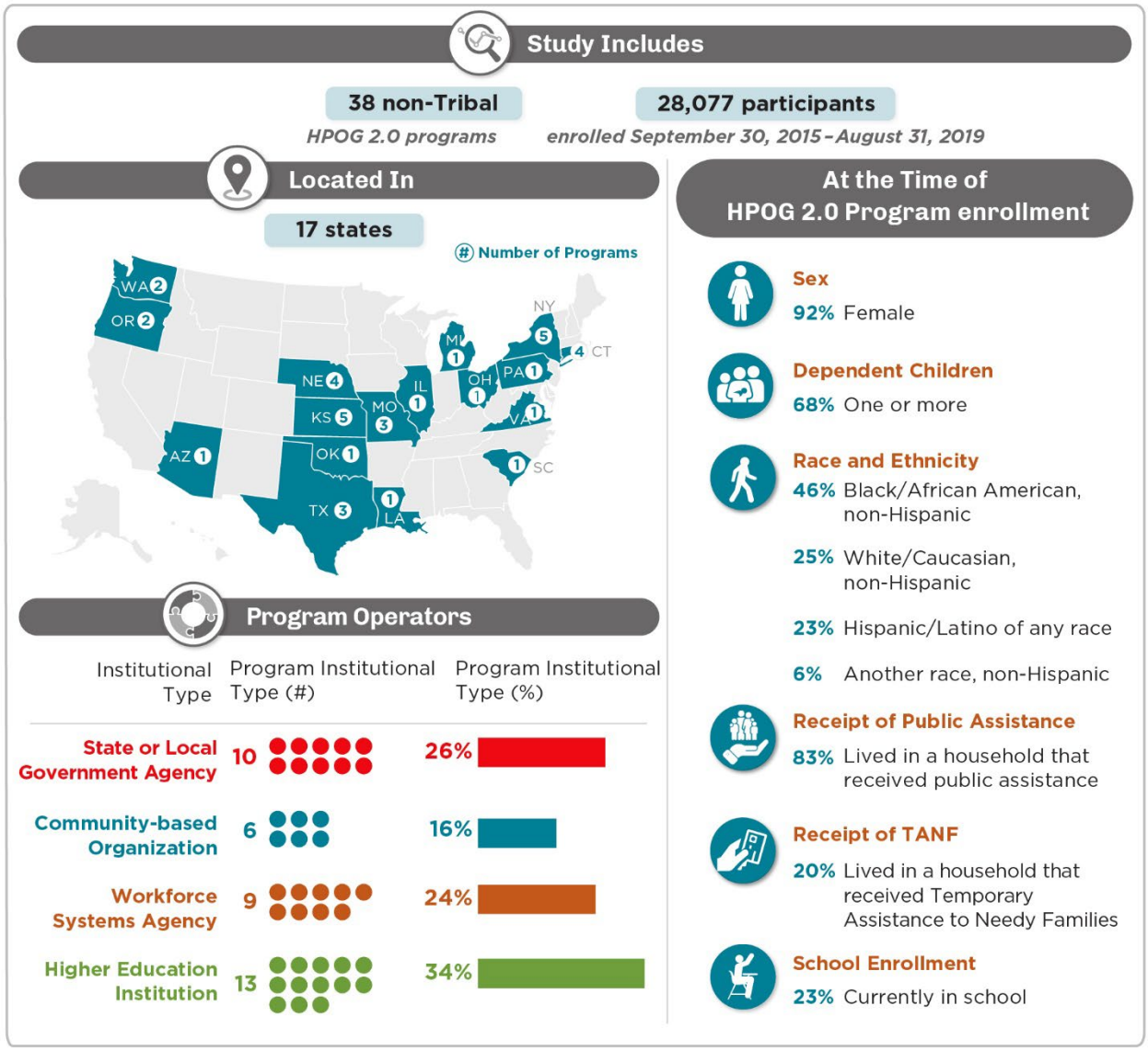
HPOG 2.0 program activities were relatively stable for the first four years of the grant period, which is the observation period for the Implementation Study. However, programs were forced to rethink how to deliver services starting in March 2020 when the United States declared a state of emergency in response to the COVID-19 pandemic. By May 30, 2020, all but a few states and territories had issued stay-at-home orders or advisories. The type and duration of restrictions varied and had differing effects on local operations. As part of ACF's effort to learn more about how HPOG programs and participants fared during the pandemic, a separate brief looks into HPOG 2.0 program implementation adaptations during the first 10 months of the COVID-19 pandemic. The brief describes the challenges HPOG 2.0 programs experienced while adjusting to guidance on COVID-19 precautions and how they adapted to those challenges.[6]

1.1 Overview of the HPOG 2.0 Program

Twenty-seven non-Tribal HPOG 2.0 grantees implemented 38 distinct programs located across 17 states, the majority concentrated in the Midwest and Northeast. HPOG 2.0 grantees began a five-year grant period in September 2015. Grants were extended for one additional year and ended on September 29, 2021. Exhibit 1-1 provides an overview of the Program. More detail is provided in subsequent chapters.

[6] See Roy et al. 2022.

Exhibit 1-1: Overview of the HPOG 2.0 Grantees and Programs



Source: Program data: HPOG 2.0 grantee applications. Participant data: PAGES; enrolled between September 30, 2015, and August 31, 2019.
N=27 grantees; 38 programs; 28,077 participants
Missing=0 grantees; 0 programs; 1-2 percent of participants

The next section (Section 1.2) gives an overview of this study. Section 1.3 describes the organization of the balance of the report.

About the HPOG 2.0 National Evaluation's Implementation Study

The Implementation Study is one of three studies under the HPOG 2.0 National Evaluation's Descriptive Evaluation. Findings from the other two studies, the Outcomes Study and the Systems Study, are presented in separate reports. The National Evaluation's Descriptive Evaluation presents descriptive findings only. It does not analyze causal relationships or estimate impacts.

Data Sources

- Two rounds of telephone interviews with program staff and other informants.
- Data from the HPOG Participant Accomplishment and Grant Evaluation System (PAGES), on participant characteristics and receipt of program services. Participants included those enrolled between September 30, 2015 and August 31, 2019.
- Data from case studies developed in each of five focus areas for insights from program operators, staff, and partners from a selection of programs.
- In-depth interviews with program participants for insights into their motivations, decision making, and experiences.
- Review of HPOG 2.0 program management materials (e.g., grant applications); other evaluation-related materials such as grantees' Evaluation Design and Implementation Plans and site monitoring notes; and
- U.S. Bureau of Labor Statistics data on healthcare sector job openings and hiring.

Limitations

This report presents the basic skills education, healthcare occupational training, and support services that HPOG 2.0 grantee programs offered, as well as the percentage of participants receiving them. It does not, however, capture how many participants were provided the opportunity to partake in a service or training course.

For More

See Appendix B for details of the Implementation Study's data sources, methods, and analysis. See the *HPOG 2.0 Descriptive Evaluation Analysis Plan* and the *Descriptive Evaluation Design Report Plan* for more information. (Werner et al. 2019, Werner et al. 2018)

1.2 Overview of the HPOG 2.0 Implementation Study

The Implementation Study's goal is to describe in detail the variety of HPOG 2.0 program components and implementation strategies adopted by programs. This objective is important to help identify opportunities for program improvement. In addition, the Implementation Study is the evaluation's primary way to characterize the intervention assessed by the Impact Evaluation.

The HPOG 2.0 Implementation Study's major research questions are:

- How was HPOG 2.0 designed and implemented?
- What were the characteristics of HPOG 2.0 participants?
- At what rates did HPOG 2.0 participants take up program activities, training courses, and support services?

The study also highlights program staff's insights on recommended strategies in five focus areas aligned with requirements in the Funding Opportunity Announcement (FOA), and of

interest to ACF: (1) employer engagement, (2) basic skills education, (3) work-readiness training, (4) career pathways training opportunities, and (5) program sustainability after the end of the HPOG 2.0 grant period.

Overview of HPOG 2.0 Logic Model Components

The HPOG 2.0 logic model provides a structure for the Implementation Study's descriptive goals: (1) how the specific components in each of the following domains of the logic model – contextual factors, eligible populations and their personal characteristics, program administration, and program components – either were implemented or affected implementation; and (2) the extent to which HPOG 2.0's hypothesized program outputs and outcomes were realized.

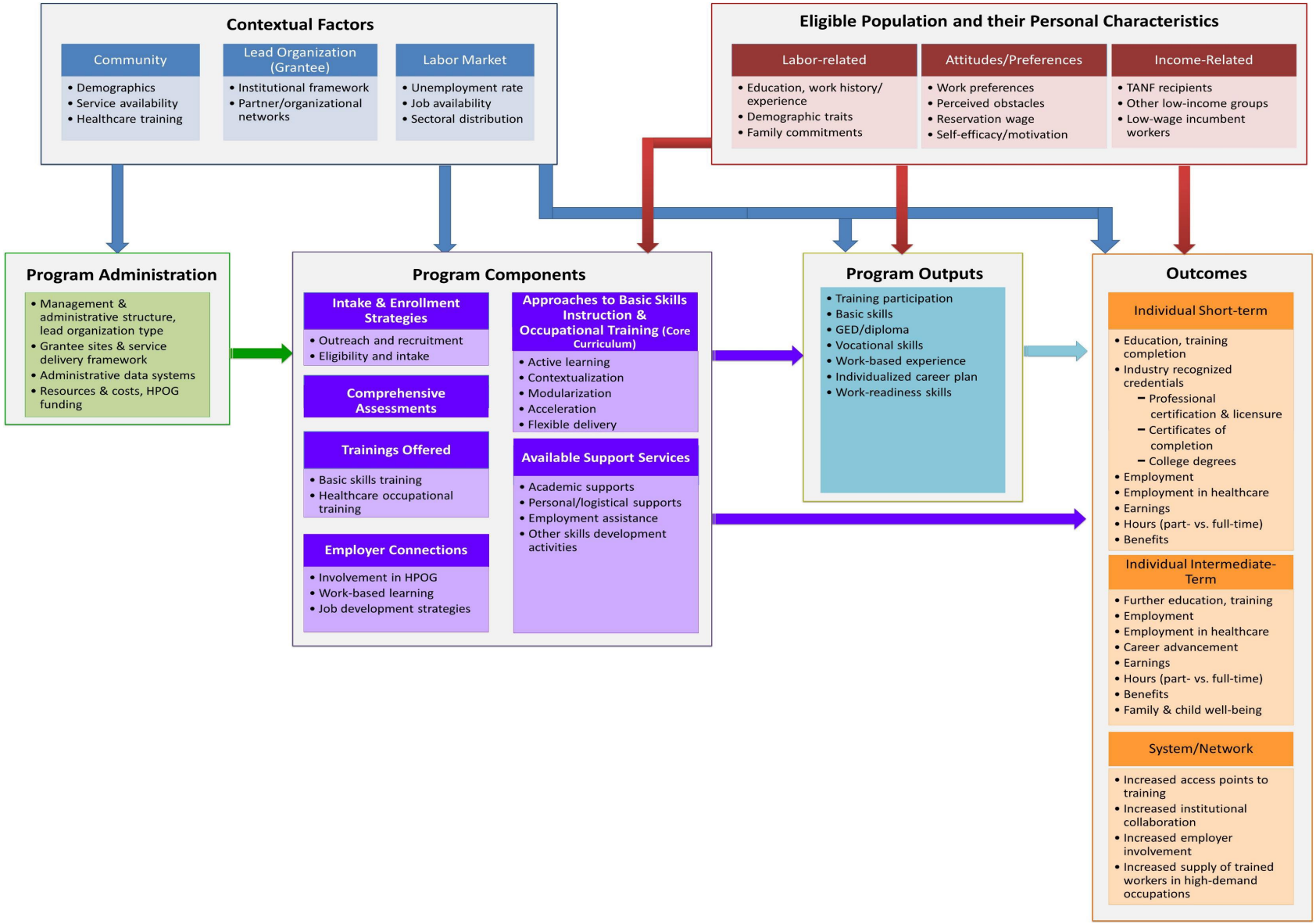
This report addresses the first five components of the HPOG 2.0 logic model:

- ***Contextual factors***. These are the HPOG 2.0 programs' overall community demographics and services landscape, the healthcare labor market environment, the grantees' institutional frameworks and networks of partners and other organizations with an interest in the success of the local HPOG program, as well as the overall occupational training and postsecondary training systems. The logic model hypothesizes that these characteristics influence program design, operations, and results.
- ***Eligible population and their personal characteristics***. These include the target population for HPOG 2.0 programs and the characteristics that may be associated with accessing and completing basic skills education and healthcare occupational training and obtaining and advancing in good jobs in the healthcare sector.
- ***Program administration***. This includes the management and administrative structure of HPOG 2.0 grantee institutions, local programs, and service delivery frameworks. It also includes administrative data systems, resources and costs, and HPOG 2.0 funding.
- ***Program components.*** These include intake and enrollment strategies such as outreach and recruitment of target populations; comprehensive assessments of participants' academic and non-academic skills and needs; delivery of basic skills education and healthcare occupational training; academic and non-academic support services to address participants' barriers to training or employment; and connections with employers.
- ***Program outputs.*** These include participant engagement in basic skills education, healthcare training, support services, and employment assistance.

The final component of the HPOG 2.0 logic model is addressed in companion Outcomes and Systems Studies, as well as the Impact Evaluation:

- ***Outcomes***. Ultimately, the logic model hypothesizes that participation in the HPOG 2.0 Program will result in participant-level outcomes, including accomplishments associated with completing training, such as certificates of completion, licenses, or diplomas; employment; career advancement; and well-being. In addition to participant-level outcomes, outcomes involve systems and network changes, including increased access to training and more institution and employer involvement in training, as well as a greater supply of healthcare workers for high-demand occupations. The Outcomes Study addresses participant-level outcomes; the Systems Study addresses system outcomes.

Exhibit 1-2: HPOG 2.0 Evaluation Logic Model



The study describes and analyzes variation across local HPOG 2.0 programs while synthesizing information at the national level to characterize the HPOG 2.0 Program as a whole. It presents the number and percentage of programs that implemented specific features by averaging results at the program level, or by presenting service receipt across all participants. The study also describes program outputs, including participation patterns and service receipt across all programs. It spotlights program implementation and participants' experiences from grant award through August 2019, the fourth year of HPOG 2.0 operations. Additional information about the study's data sources, methods, and analytic approach can be found in Appendix B.

Exhibit 1-2 illustrates the HPOG 2.0 logic model, describing the "theory of change" by showing how all parts fit together and relate to desired outcomes.

1.3 Organization of This Report

The balance of this report proceeds as follows:

- Chapter 2 – Program Context and Administration
- Chapter 3 – Recruitment Strategies and Participant Characteristics
- Chapter 4 – Healthcare Education and Training Activities
- Chapter 5 – Support Services
- Chapter 6 – Program Adaptations to a Changing Environment
- Chapter 7 – Discussion

2. Program Context and Administration

Chapter 2 Key Findings

- Higher education institutions were the most common operators of HPOG 2.0 programs, followed by government agencies, and workforce system agencies.
- On average, programs had 23 partner organizations.
- Almost all programs worked with partner organizations that provided basic and other skill-development activities and training for healthcare occupations.
- All programs engaged employers to help participants find jobs.
- On average, programs allocated more than half of their HPOG grant funds to staff salaries and providing occupational training.

In September 2015, HHS awarded 27 HPOG 2.0 five-year grants to a variety of non-Tribal institutions.[7] More than half had previously received a grant under HPOG 1.0. Grantees either operated directly or funded and oversaw one or more local HPOG 2.0 programs. The HPOG 2.0 FOA encouraged grantee programs to form partnerships with employers and other organizations to provide training and support services and to improve outcomes for participants (OFA 2015). This chapter examines the local context in which programs operated and the administrative structure of programs, including the role of partners in program implementation.[8] It ends with a brief discussion of grant expenditures.[9]

2.1 Program Context

HPOG 2.0 grantees varied in their location, institutional type, and the number of programs overseen. The 27 HPOG 2.0 grantees implemented 38 distinct HPOG 2.0 "programs" with each program having a unique set of services, training courses, and personnel. These programs were located across 17 states, the majority concentrated in the Midwest (15 programs) and Northeast (11 programs) (Exhibit 2-1). A list of all HPOG 2.0 non-Tribal grantees and programs, including their location and enrollment, is provided in Appendix C.

HPOG 2.0 grantees varied in the size of their service areas, ranging from single cities or counties to metropolitan areas to state-wide. Populations in the grantees' service areas ranged from about 210,000 to more than 8 million people[10] in urban, suburban, and rural communities. Many programs served participants in multiple communities. About two-thirds of grantees served participants in mostly urban areas and surrounding suburban communities; nearly a quarter of grantees served a mix of urban, suburban, and rural communities; and a tenth served

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7 Grants were extended for one additional year and ended on September 29, 2021.

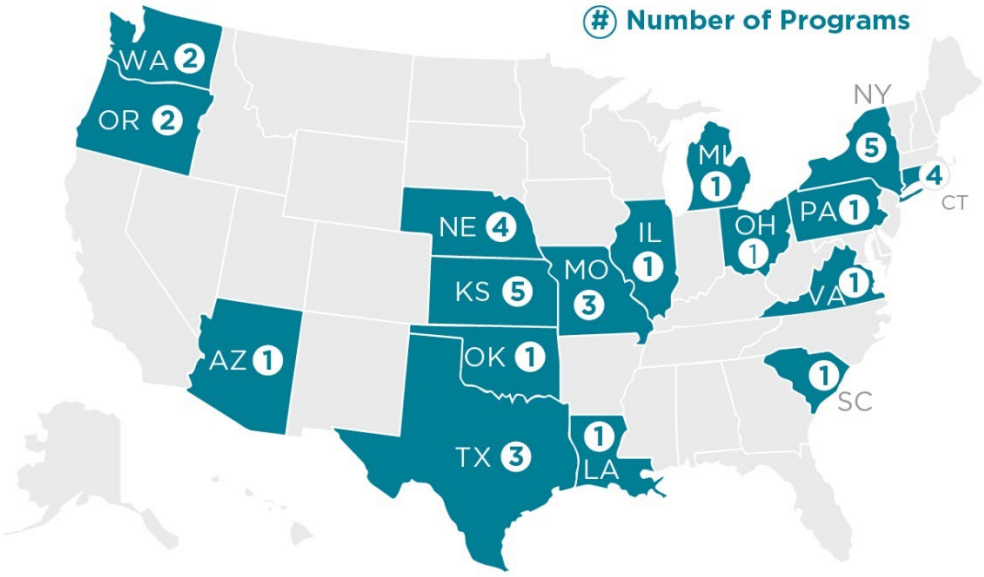
8 A separate Systems Study investigates how local service systems (including partners and organizations in the community with an interest in the success of the local HPOG program) influenced HPOG 2.0 implementation (Eyster et al. 2022).

9 A separate and forthcoming Cost-Benefit Analysis will examine program spending in more detail.

10 *Source:* Grantee applications. N=22, missing=5.

exclusively rural areas.[11] Local HPOG 2.0 programs were partly shaped by the labor markets in which they operated and partly by various institutional, community, and environmental factors.

Exhibit 2-1: HPOG 2.0 Program Locations



Source: HPOG 2.0 grantee applications
N=27 grantees; 38 programs
Missing=0 grantees; 0 programs

2.2 Program Operator Institutional Type

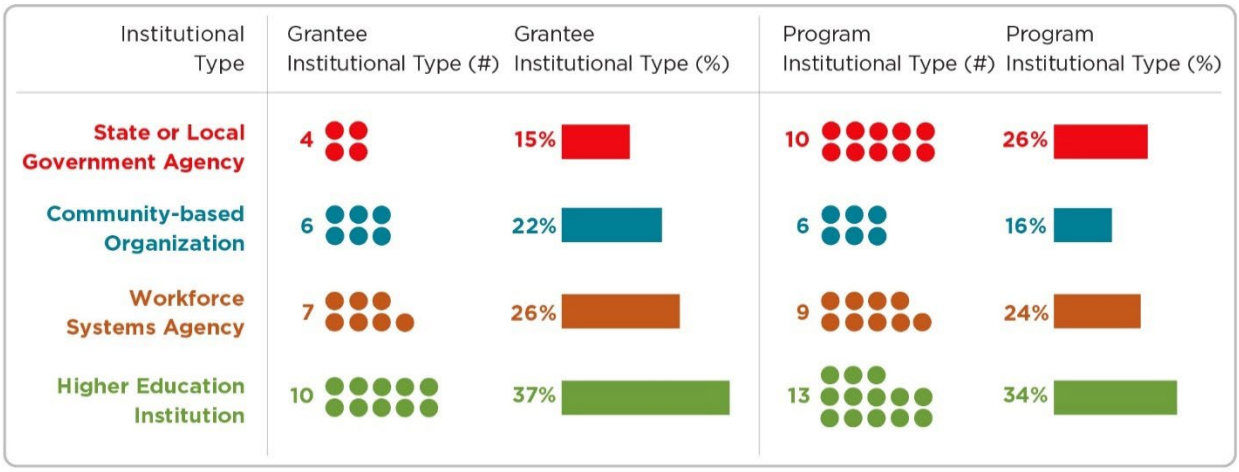
The 27 HPOG 2.0 grantees and their 38 programs were a diverse group. Grantees and their program operators included higher education institutions, workforce system agencies, community-based organizations, and government agencies. The overwhelming majority of HPOG 2.0 grantees (85 percent) funded and oversaw one program, whereas the other grantees funded and oversaw three to five programs each.

- **Higher education institutions were the most common operators of HPOG 2.0 programs.**

Higher education institutions operated about a third of programs (Exhibit 2-2).[12] State or local government agencies and workforce system agencies each operated about a quarter of programs. Community-based organizations, such as community action programs and nonprofit charitable organizations, operated about a fifth of programs.

[11] *Source:* Grantee applications. N=21, missing=6.
[12] See Appendix D, Table 2-2.

Exhibit 2-2: HPOG 2.0 Grantee and Program Operator Institutional Type



Source: HPOG 2.0 grantee applications
N=27 grantees; 38 programs
Missing=0 grantees; 0 programs

2.3 Local Labor Market Conditions

HPOG 2.0 programs operated within their local labor markets. This section describes general economic conditions during the period leading up to the HPOG 2.0 grant awards through to the end of 2019.[13] It also presents staff perceptions about the local labor markets for HPOG 2.0 programs during 2015–2019.

At the time HPOG 2.0 grants were awarded (the last quarter of 2015), unemployment had fallen to 5 percent from a high of 10 percent in October 2009.[14] This came after a period of recovery following the worst economic downturn since the Great Depression.[15] The Great Recession of 2007-2009, however, was less harsh on the healthcare sector than the overall economy. Despite national employment decreasing by 6.9 percent (–7.8 million jobs) during the Great Recession, healthcare employment rose by 6.6 percent (+850,000 jobs) and continued to grow through 2019.[16]

The HPOG 2.0 grants were implemented in a strong labor market for healthcare workers. The rates of growth in job openings and hiring (openings and hires, each divided by the number employed) are important indicators of labor demand. The gap between job openings and job hires in the healthcare sector started to widen throughout the HPOG 1.0 period, from 2010 to 2015 (Exhibit 2-3). At the beginning of 2015, the year HPOG 2.0 grants were awarded, the gap

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13 Data collection for this study largely occurred prior to the COVID-19 pandemic beginning in March 2020.

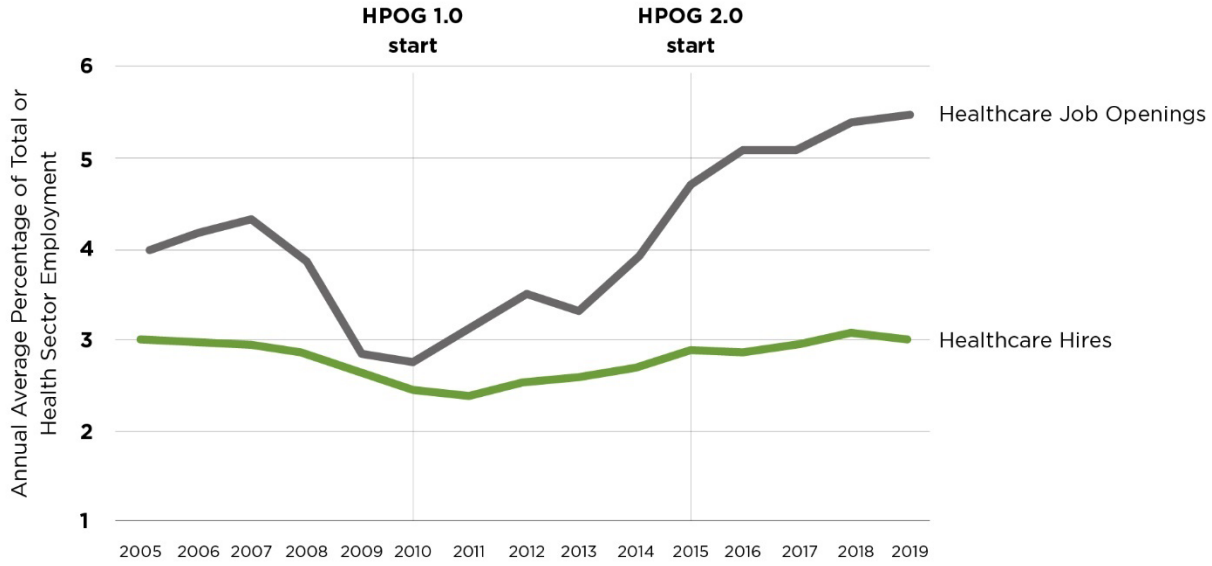
14 *Source:* https ://www.bls.gov/opub/mlr/2016/article/unemployment-rate-nears-prerecession-level-by-end-of-2015.htm.

15 *Source:* https ://www.bls.gov/opub/mlr/2018/article/great-recession-great-recovery.htm.

16 *Source:* https://www.bls.gov/opub/mlr/2018/article/healthcare-jobs-and-the-great-recession.htm and https://www.bls.gov/careeroutlook/2014/spring/art03.pdf.

between job openings and job hires in the healthcare sector grew dramatically, showing a growth in demand for labor in healthcare that sustained through 2019.

Exhibit 2-3: Healthcare Sector Job Openings and Hiring Rates Relative to Employment, 2005-2019



Source: Job Opening and Labor Turnover Survey, Bureau of Labor Statistics[17]
Note: Series depicts that measure as a percentage of employment. Healthcare sector hires or openings are divided by healthcare sector employment. Annual averages were calculated from monthly percentages.

- **Staff in most HPOG 2.0 programs reported a favorable local economy, with high demand for healthcare workers and low unemployment rates.**

Staff from nearly all programs reported either high demand for healthcare workers or strong economies with overall low unemployment rates, conditions that helped place program participants in jobs.[18] Some program staff also highlighted the extensive availability of entry-level healthcare jobs and a growth in jobs in long-term care, home healthcare, and community care in their communities due to an aging population.

According to several staff, the local labor market presented challenges for recruiting program participants. They reported increased opportunities in other industries due to a strong economy. Program staff also pointed to new minimum wage laws resulting in non-healthcare jobs that paid as much as or more than entry-level healthcare jobs but often did not require completing demanding training and were not as physically demanding as those in healthcare.[19] In a handful of programs, staff mentioned that higher wages in other industries competed with low wages for entry-level healthcare jobs, making potential participants less interested in healthcare jobs.

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17 *Source*: https ://www.bls.gov/help/one_screen/JT.htm#select-select-rate-and-or-level.

18 HPOG 2.0 2019 grantee interviews, Q 3.1.

19 HPOG 2.0 2019 grantee interviews, Q 3.2a.

2.4 Program Partnerships and Employer Connections

HPOG 2.0 grantees developed programs to help participants prepare for and enroll in healthcare occupational training. Programs provided a range of support services designed to help participants succeed in their training and find suitable employment. To do so adequately, program operators developed partnerships with other public and private organizations and connected with healthcare employers and professional organizations. At a minimum, ACF required grantees and program operators to coordinate with their state TANF agencies, state and local Workforce Investment Boards, and state apprenticeship agencies to design and implement their programs (OFA 2015). In addition, HPOG programs partnered with many other types of community organizations.[20]

- **On average, programs partnered with 23 organizations. Programs run by state government agencies had the highest number of partners on average.**

As noted earlier, different types of institutions oversaw HPOG 2.0 grants and operated HPOG 2.0 programs, including higher education institutions, state or local government agencies, workforce system agencies, and community-based organizations. The institutional identity of the program operator and its capabilities likely determined the types of services or training activities that were provided by partner organizations.[21]

All programs partnered with at least one local organization to offer HPOG 2.0 training and services. On average, each program had 23 partners in its network, with an extensive range of between 4 and 75 partners (Exhibit 2-4).[22] The median number of partners per program was 19. State government agencies on average had the greatest number of partners (38 on average) and higher education institutions, such as colleges and universities, had the fewest (10 on average), possibly because they can provide many HPOG services themselves, such as healthcare occupational training, basic skills education, and academic advising.

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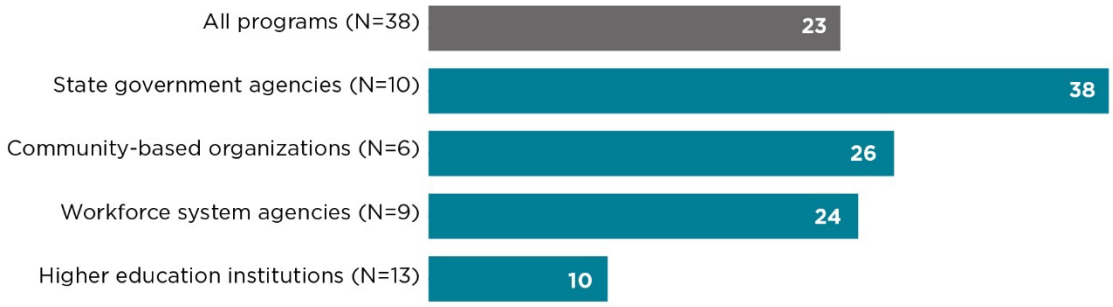
[20] The companion HPOG 2.0 Systems Study report, *Program Operator and Partner Perspectives on Local Service Delivery Systems* (Eyster et al. 2022), provides information about how local HPOG 2.0 program operators engaged with partners in their local service delivery systems; how healthcare training service delivery systems influenced HPOG 2.0 programs; and how HPOG 2.0 programs influenced local service delivery systems.

[21] *Partners* are organizations directly involved in the operations of an HPOG program. The data on partners is based on responses to telephone interviews conducted with program representatives in 2017. The number and types of partners reported during those interviews may differ from the number and types reported during additional interviews conducted with program operators in late 2019 for the Systems Study (see Eyster et al. 2022)

[22] See Appendix D, Table 2-3.

Exhibit 2-4: Average Number of HPOG 2.0 Partner Organizations by Type of Program Operator



Source: HPOG 2.0 2017 grantee interviews, Q 2.1
Note: This exhibit includes 100 partners who were no longer involved with the local programs at the time of the 2017 grantee interviews.
N=38 programs, 875 partners
Missing=0 programs, 0 partners

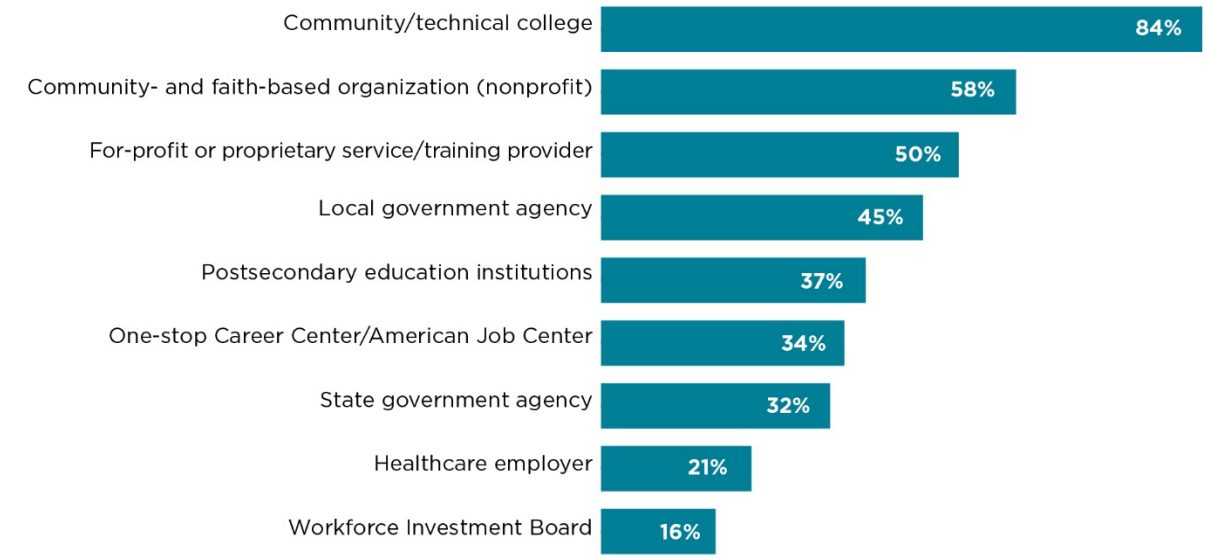
- **Most programs partnered with at least one community/technical college. Many programs partnered with a range of organization types.**

Community and technical colleges were the most common type of partner; more than four-fifths of programs partnered with at least one (Exhibit 2-5).[23] All programs operated by state government agencies, community-based organizations, and workforce system agencies partnered with at least one community or technical college. Of 13 programs operated by higher education institutions, about half partnered with at least one community or technical college. More than half of all programs partnered with at least one community- or faith-based organization; half partnered with a for-profit or proprietary training provider.

[23] See Appendix D, Table 2-4.

Exhibit 2-5: Types of HPOG 2.0 Partner Organizations

Percentage of Programs Partnering with Each Type of Organization



Source: HPOG 2.0 2017 grantee interviews, Q 2.1
Note: Responses do not sum to 100% because multiple responses were permitted. This exhibit excludes 100 partners who were no longer involved at the time of the 2017 grantee interviews.
N=38 programs, 775 partners
Missing=0 programs, 0 partners

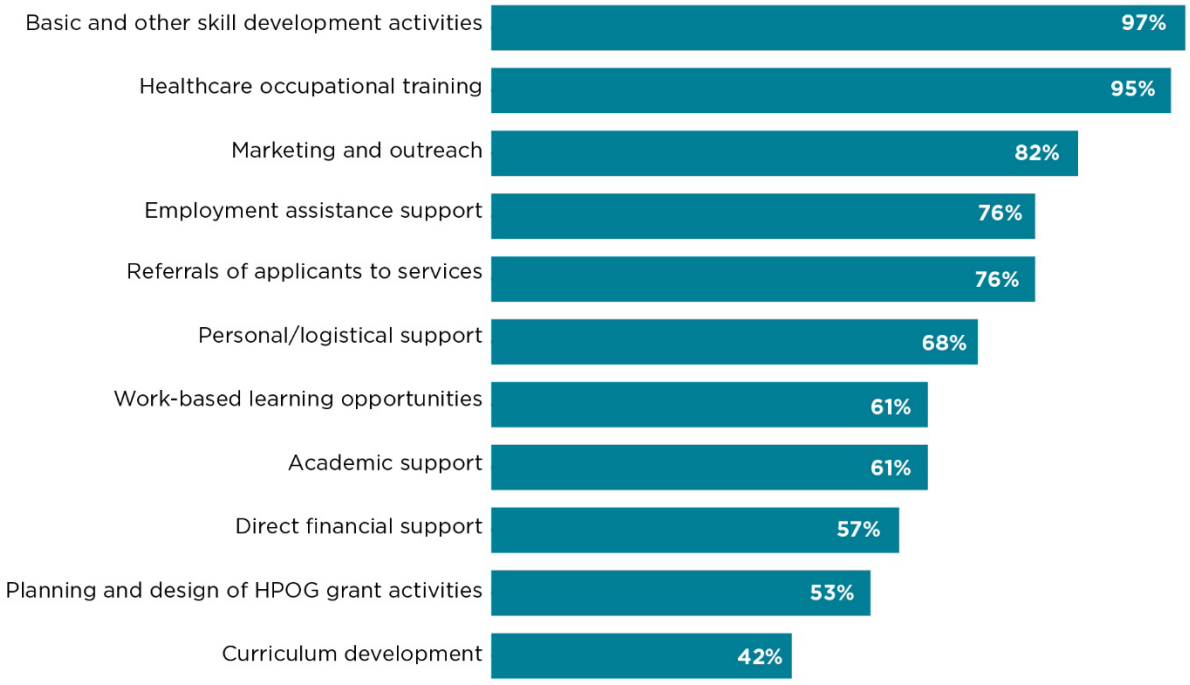
- **Almost all programs had partners that provided basic and other skill-development activities and healthcare occupational training.**

HPOG 2.0 partners were involved in almost all aspects of program implementation, including outreach and referral, and providing basic skills education, supports, healthcare occupational training, and employment assistance services. Most commonly, partners provided basic skills and other skill-development activities to participants (Exhibit 2-6).[24] In addition, almost all programs had at least one partner that provided healthcare occupational training.

[24] See Appendix D, Table 2-5.

Exhibit 2-6: HPOG 2.0 Partner Organization Involvement in Program Activities

Percentage of Programs with Partner(s) Involved in Activity



Source: HPOG 2.0 2017 grantee interviews, Q 2.2
Note: Responses do not sum to 100 percent because multiple responses were permitted.
N=38 programs, 775 partners
Missing=0 programs, 0 partners

2.5 Employer Engagement

Strong connections with local employers are a key component of the career pathways framework.[25] The HPOG 2.0 FOA encouraged programs to involve employers in designing the program, offering work-based learning opportunities, reviewing and approving curricula, participating on an employer advisory board, and committing to screen and hire HPOG 2.0 participants (OFA 2015). By developing relationships with employers, programs can better align their training with the skills needed to succeed in the workforce (JFF 2010).

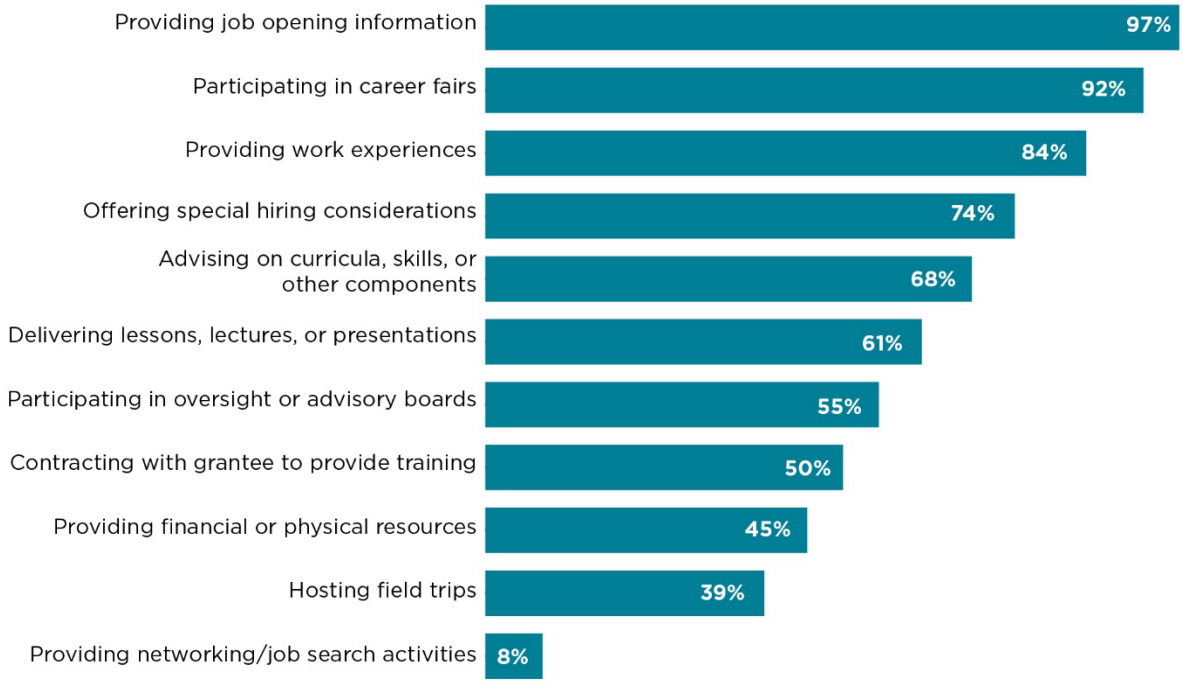
[25] For additional information, see ACF's "Career Pathways Research Portfolio" page at https://www.acf.hhs.gov/opre/project/career-pathways or Fein (2012).

- **All programs engaged employers as they assisted participants in finding jobs and many involved employers in other aspects of program operations.**

Employers were engaged in a variety of ways. Most commonly, programs worked with employers to obtain information about job openings, participate in career fairs, provide work experiences, or establish special hiring considerations for participants (Exhibit 2-7).[26] At least half of programs involved employers in curricula development, lessons, program oversight, or training provision. On average, programs engaged with 31 employers, although the number varied widely across programs from 1 to 150 employers.[27]

Exhibit 2-7: Employer Involvement in HPOG 2.0 Program Activities

Percentage of Programs with Employer Involvement in Activity



Source: HPOG 2.0 2017 grantee interviews, Q 6.14a
Note: Responses do not sum to 100 percent because multiple responses were permitted.
N=38 programs
Missing=0 programs

Program staff described areas that would benefit from additional employer involvement, including more work-based learning opportunities, additional employer-hosted field trips, and greater involvement from an employer advisory board in curricula development. In addition, staff emphasized the importance of face-to-face interactions between participants and employers through employer-hosted tours, workshops, mock interviews, networking events, and externships or clinicals, as they typically lead to a placement or job referral.

[26] See Appendix D, Table 2-6.

[27] See Appendix D, Table 2-7.

- **More than three-quarters of programs reported having strong connections with employers throughout the HPOG 2.0 grant.**

Programs reported successful strategies for establishing and maintaining contacts with employers including communicating regularly with employers and providing opportunities for feedback, understanding employer needs, assigning specific staff for employer engagement, leveraging existing networks to identify potential employer partners, and involving employers in the early stages of program development.[28]

Advice from the Field: Three HPOG 2.0 Programs Share Their Strategies for Employer Engagement

HPOG 2.0 programs engaged with employers as they helped participants find jobs. Some programs worked with employers to design and implement their healthcare training and other learning opportunities. Three HPOG 2.0 programs were purposively selected for site visits focused on employer engagement. Staff from these programs shared their lessons learned and promising practices:

- Engage with employers on multiple activities across different parts of the program, beyond hiring.
- Invest time and effort in building employer relationships.
- Continually work to understand and meet the needs of employers in addition to meeting the needs of students.

2.6 Grant Expenditures

HPOG 2.0 grantees received five-year grants of between $1.5 and $3 million annually. Grant funds were to be used to support administrative activities and the HPOG 2.0 training and support services described in Chapters 4 and 5 of this report. HPOG 2.0 grantees were not expected to fund all program activities, services, and training courses through the grant. Local HPOG 2.0 programs leveraged a variety of institutional and community resources to provide training and support services. This section presents some early discussion of spending patterns. A separate study of the costs and benefits of HPOG 2.0 Program will examine spending in more detail, to be provided in a future report.[29]

- **On average, programs allocated more than half of their funds to staff salaries and providing occupational training.**

Programs allocated grant funds to a variety of activities (both in-house or through partners), including staff salaries; overhead expenses; outreach; direct provision of healthcare occupational training, support services, and basic skills and other skill-development activities; and contracted program staff, training providers, and support services. Allocation of grant funds

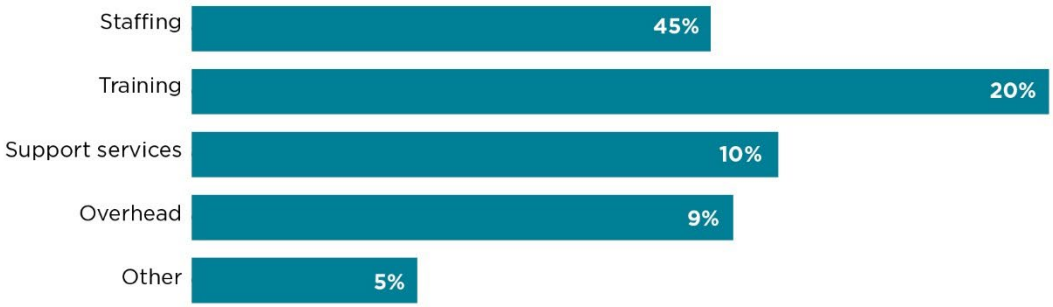
[28] See Appendix D, Table 2-8.

[29] See Loprest, Lerman, and Klerman (2020) and Loprest, Lerman, and Klerman (2019) for additional information.

to any specific activity varied widely across programs. On average, however, programs allocated the most funds to staff salaries and providing occupational training (Exhibit 2-8).[30]

Exhibit 2-8: Median HPOG 2.0 Program Grant Expenditures by Type

Percentage of HPOG 2.0 Grant Funds



Source: HPOG 2.0 2019 grantee interviews, Q 4.1

Note: Percentages reflect median program grant expenditures for each category and therefore do not sum to 100 percent.
The number of programs reporting grant expenditures in each category ranges from 32 to 37. The number of programs reporting any grant expenditures in Staffing=37, Training=32, Support services=35, Overhead=37, and Other=34.
N=37 programs
Missing=1 program

Half of programs estimated spending 45 percent or less of HPOG 2.0 grant funds on staff salaries and contracted staff. The next largest expenditure was training, including both direct provision of healthcare occupational training and contracted training providers. Half of programs also spent 10 percent or less of their grant funds on provision of support services, including direct support services and contracted support services.[31]

The next chapter describes program recruitment strategies, eligibility criteria, intake processes, and characteristics of program participants.

[30] See Appendix D, Table 2-9. Staffing includes staff's salaries, benefits such as health insurance, and social security taxes, and contracted program staff; Training includes direct provision of healthcare occupational training and contracted training providers; Support services include direct provision of support services and contracted support services; Overhead includes office space, office supplies, internet/telephone costs, and hardware; Other includes outreach materials, direct provision of basic skills and other skill-development activities, tuition paid to individual training accounts, and other miscellaneous items.

[31] *Source:* HPOG 2.0 2017 grantee interviews, Q 6.15.

3. Recruitment Strategies and Participant Characteristics

Chapter 3 Key Findings

- HPOG 2.0 programs used multiple recruitment strategies. Referrals from partner agencies, social media postings, and community events were identified as the most successful strategies.
- Eligibility criteria varied by program. Despite fewer than half of programs having an academic requirement, most HPOG 2.0 participants had at least a high school diploma or equivalent at intake.
- Most programs included criminal background checks as eligibility criteria; however, all programs accepted otherwise eligible applicants with misdemeanors, and more than half accepted otherwise eligible applicants with felonies.
- HPOG 2.0 participants were primarily women, young, and had never been married, with an average age of 32. Almost two-thirds had one or more dependent children.
- Reflecting ACF's encouragement of programs to recruit individuals who would not otherwise have access to education or training, fewer than one-quarter of participants were enrolled in school or training at intake.
- At intake, only 10 percent of HPOG 2.0 participants had less than a high school education; 15 percent of participants had a college degree.
- Consistent with ACF requirements, most participants had low household incomes; many were living in households receiving a public benefit at intake.
- Fewer than half of participants at intake reported barriers to work or study; transportation was the most common barrier, followed by child care and illness or health.

ACF required HPOG 2.0 programs to establish procedures to identify and recruit individuals who were citizens of the United States or who met the immigrant eligibility requirements for federal public benefits, were Temporary Assistance for Needy Families (TANF) recipients or other low-income adults, and did not otherwise have access to similar education and training opportunities (OFA 2015). This chapter describes those procedures, eligibility criteria, and intake processes. It also discusses the characteristics of program participants.

Exhibit 3-1 shows the processes HPOG 2.0 programs implemented.

Exhibit 3-1: HPOG 2.0 Program Enrollment Process

3.1 Outreach and Recruitment

Based on early characterizations of programs offered by HPOG 1.0 grantees, ACF adjusted for HPOG 2.0 two key requirements related to program enrollment. These changes encouraged or required grantees to (1) enroll more TANF recipients and (2) enroll fewer applicants already participating in training (OFA 2015). That is, HPOG 2.0 programs were encouraged to recruit and enroll individuals who did not otherwise have access to education and training, although programs were not prohibited from serving those already enrolled in training.[32] Programs were also encouraged to work with partners to identify potential participants.[33] This section describes the recruitment strategies that programs used and the challenges they faced.

- **Referrals from partner agencies, social media postings, and community events were considered the most successful recruitment strategies.**

HPOG 2.0 program staff described using multiple strategies for recruiting participants, including referrals from partners and local employers, word of mouth, TV or radio advertising, online postings, flyers and other print material distribution, employer and school outreach, and in-person meetings with potential applicants. Staff from various programs identified referrals from state and local agencies, including departments of labor, human services, and other workforce development agencies, among their most successful recruitment strategies. Several program staff reported success with social media postings and online advertisements, including Facebook and Craigslist. Others also identified community events, including job fairs, and referrals from partners.

> "The most effective strategies are when we present in-person to the community agencies and the social media campaign. Being at a One-Stop where people are coming in looking for education and training and being co-located at a TANF office where they provide work activities has also been successful for enrollments. social media (Facebook) has also increased referrals. Other than that it's word of mouth."
>
> – HPOG 2.0 Program Staff

- **Common recruitment challenges included a strong local economy, personal barriers to participation, and the work-first nature of local TANF programs.**

As described in the Chapter 2, staff from most programs reported that local economic conditions affected their ability to recruit and retain HPOG 2.0 participants: that unemployment rates were low and that other industries with no training requirements paid higher wages. According to some program staff, personal barriers made it difficult to recruit and

> "The raise in the minimum wage may have a larger influence on TANF recipients relative to the general HPOG population. TANF participants are very workforce-oriented because of the TANF program's work participation requirements. Higher wages in non-healthcare occupations provide a disincentive for [TANF recipients] to participate in training because they can earn a living wage in non-healthcare occupations while also fulfilling work requirements."
>
> – HPOG 2.0 Program Staff

[32] This includes participants who were eligible for HPOG 2.0 but were exempt from random assignment for several reasons including prior participation in HPOG 1.0, grantee use of wild cards (i.e., under certain conditions, grantees allowed a very limited number of applicants to bypass randomization and automatically receive the offer of an HPOG slot), or specific programmatic exemptions.

[33] The role of program partners is discussed in Chapter 2.

retain participants, and an immediate need for income often led potential participants to choose work over training.

HPOG 2.0 programs were required to prioritize recruitment of TANF recipients. Staff reported that TANF's "work-first" nature was an additional recruitment barrier, as recipients were focused on meeting their TANF work requirements rather than on participating in training.

3.2 Eligibility Determination

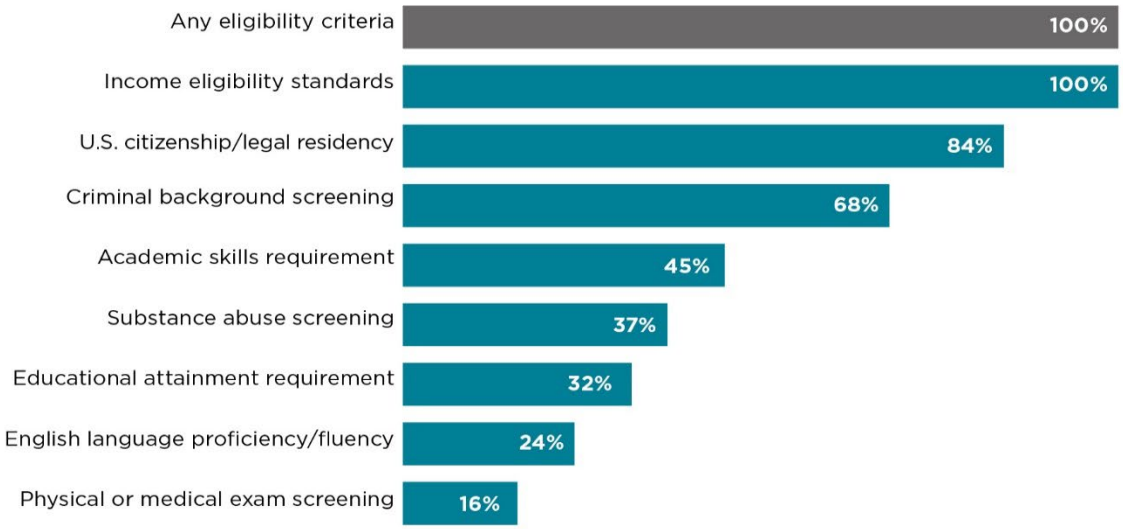
The HPOG 2.0 FOA established general eligibility criteria for all applicants: Applicants had to be receiving TANF or meet other program-defined criteria for being "low income" (OFA 2015). Programs had broad discretion to set other eligibility criteria to select participants they believed most likely to successfully complete training and obtain employment. This section describes those eligibility criteria.

- **Eligibility criteria varied by program, but all programs assessed applicants for income eligibility and most screened for citizenship/legal residency.**

Eligibility criteria varied somewhat, but all programs screened applicants for income eligibility and nearly all did for U.S. citizenship or legal residency (Exhibit 3-2).[34] To determine income eligibility, programs used one or more of the following standards: income at a specific percentage of the federal poverty level, TANF program eligibility, household income level, individual income or earnings, and SNAP eligibility.[35]

Exhibit 3-2: Eligibility Criteria for HPOG 2.0 Enrollment

Percentage of Programs Using Criteria



Source: HPOG 2.0 2017 grantee interviews, Q 4.0
Note: Responses do not sum to 100 percent because multiple responses were permitted.
N=38 programs
Missing=0 programs

[34] See Appendix D, Table 3-1.

[35] See Appendix D, Table 3-2.

- **Of the programs that used criminal background checks (68 percent), all accepted otherwise eligible applicants with misdemeanors, and more than half accepted otherwise eligible applicants with felonies.**

> "It depends on the severity of the crime and the charges. For example, if a person applying for the Pharmacy Technician training was charged with selling drugs, they would not be able to apply to the HPOG program. It also depends on the willingness of the employer."
>
> – HPOG 2.0 Program Staff

Due in large part to state licensing regulations and employer practice in the healthcare industry, many HPOG 2.0 programs screened applicants for a criminal record and substance abuse. Although programs had discretion in deciding which screenings to implement and how to use the results, their decisions reflected restrictions that state boards generally placed on who may be awarded licenses or certifications for specific healthcare occupations. Forty-seven percent of HPOG 2.0 programs listed "applicants cannot pass criminal background screenings" as a common reason for applicants who met income standards being determined ineligible. Sixteen percent listed "applicants cannot pass substance abuse screenings" as a common reason for ineligibility.[36]

More than two-thirds of programs screened for criminal background, and more than one-third screened for substance abuse.[37] Of the programs that initially indicated they used criminal background screenings to assess program eligibility, all accepted otherwise eligible applicants with misdemeanors, and 60 percent accepted otherwise eligible applicants with felonies.[38] Staff in programs that accepted applicants with misdemeanors and/or felonies reported they generally considered individual circumstances, the nature of individuals' charges, and how long ago they occurred. According to staff in these programs, they tried to steer applicants towards occupational trainings that were suitable given their criminal backgrounds, such as administrative jobs with little or no direct patient contact.

- **Fewer than half of programs required minimum skills in reading or math or both.**

The HPOG 2.0 FOA emphasized programs providing basic skills education to TANF recipients and other low-income adults so they could succeed in postsecondary education (OFA 2015). The FOA suggested programs offer innovative approaches, such as accelerated basic skills education or integrating basic skills with healthcare occupational training.[39] Successful completion of postsecondary healthcare occupational training required participants to have some level of basic skills, although the minimum basic skills required by such training courses varied. Almost three-quarters of participants had literacy skills above the eighth-grade level at intake, and two-thirds had numeracy skills above the eighth-grade level.[40] Perhaps reflecting the

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36 See Appendix D, Table 3-16.

37 See Appendix D, Table 3-1.

38 See Appendix D, Table 3-3. During grantee interviews, one program did not initially indicate it used a criminal background screening, but later did so in an open-ended response. Therefore, it was not asked follow-up questions about applicants with misdemeanors and felonies (HPOG 2.0 2017 grantee interviews, Q 4.4a and Q 4.4d).

39 Basic skills training offerings are discussed in Chapter 4.

40 See Appendix D, Table 3-4.

FOA's emphasis on providing basic skills education, less than half (45 percent) of all programs required minimum skills in reading or math or both.[41] Fewer programs (32 percent) required applicants to have a high school diploma or equivalent.

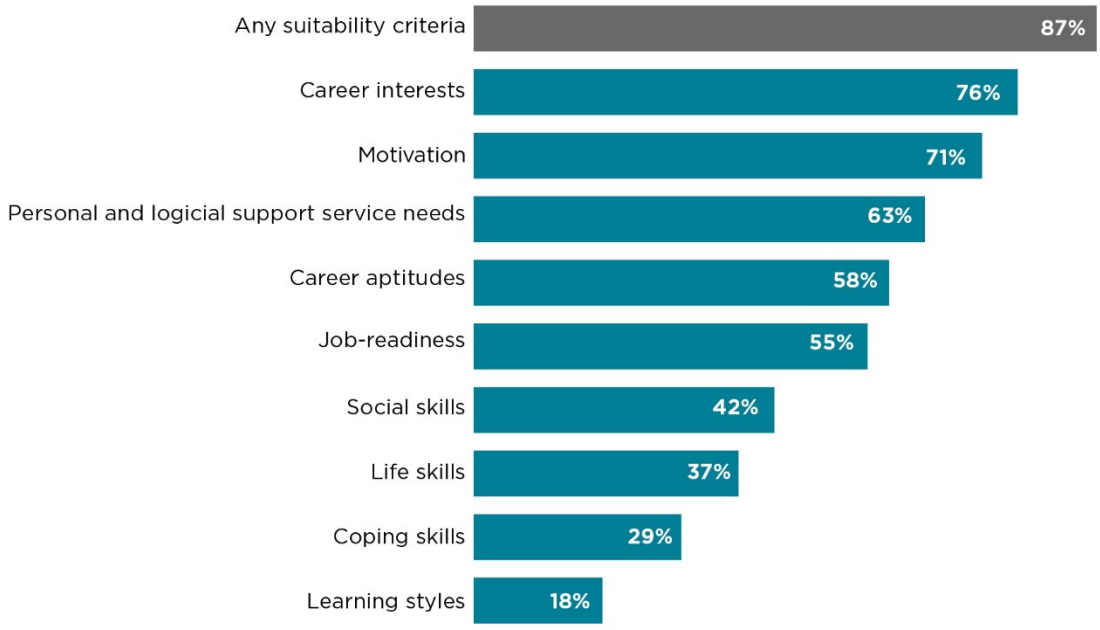
The 17 programs that did set eligibility standards for reading and/or math skills varied in their grade-level requirements.[42] Their minimum required levels ranged from fourth to ninth grade for reading and fourth to 10th grade for math. Most programs set their minimum below eighth grade.

- **Most programs assessed participant's general suitability for the program, including motivation, service needs, and career interests and aptitude.**

In addition to the criteria described above, most programs included an evaluation of applicants' general suitability for healthcare training as part of their intake process (Exhibit 3-3).[43] About three-quarters assessed applicants' career interests and motivation. Many programs also assessed applicants' personal and logistical support service needs, career aptitudes, job-readiness or "soft skills," and social skills.

Exhibit 3-3: Evaluation of General Suitability for Healthcare Training

Percentage of Programs



Source: HPOG 2.0 2017 grantee interviews, Q 4.6a
Note: Responses do not sum to 100% because multiple responses were permitted.
N=38 programs
Missing=0 programs

41 See Appendix D, Table 3-5.

42 See Appendix D, Table 3-6.

43 See Appendix D, Table 3-7.

3.3 Program Enrollment

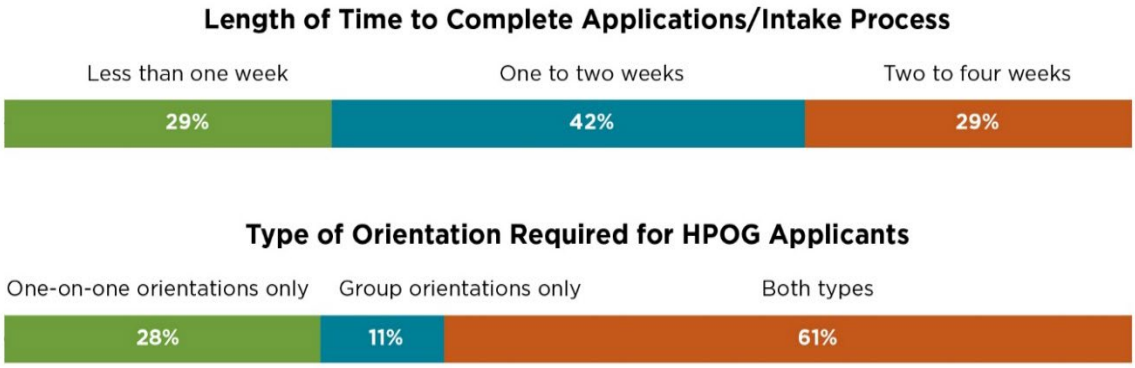
The HPOG 2.0 FOA did not require programs to use a specific application process, but programs were required to describe in their grant proposals the procedures they planned to use to assess barriers to beginning training, such as literacy and numeracy skills (OFA 2015). In addition to using formal (e.g., standardized tests) and informal eligibility and suitability assessments (e.g., personal interviews), HPOG 2.0 programs designed and implemented application and intake procedures. This section presents an overview of the application processes and how program staff conducted academic and personal needs assessments.

- **HPOG 2.0 programs differed in terms of the length, mode, and requirements of their application processes.**

The amount of time required to complete the application and intake process (from the day an application is filed to the day an eligibility determination is made) ranged from less than one week to four weeks (Exhibit 3-4).[44]

Exhibit 3-4: Length of Application Process and Type of Required Program Orientation

Percentage of Programs



Source: HPOG 2.0 2017 grantee interviews, Q 4.9 and Q 4.7a
N=36 programs, 38 programs
Missing=0 programs, 2 programs

As part of the application process, all programs required some form of orientation. More than half required both one-on-one and group orientations.[45] The remaining programs required only one type of orientation (Exhibit 3-4). All orientations were shorter than one day.[46]

- **Most programs also accepted applicants who tested just below the program's minimum basic skills requirements.**

Comprehensive assessments were an important part of the HPOG 2.0 application processes. Forty-five percent of HPOG 2.0 programs assessed participants on literacy or numeracy.[47] Of

[44] See Appendix D, Table 3-8.
[45] See Appendix D, Table 3-9.
[46] See Appendix D, Table 3-10.
[47] See Appendix D, Table 3-5.

these, about three-quarters used the Test of Adult Basic Education (TABE). Among programs that assessed participants on basic skills, about two-thirds used an additional formal literacy or numeracy assessment.[48] Formal assessments were used to assess applicants' needs for basic skills education, such as adult basic or secondary education, English as a second language classes, or college developmental education, or to verify applicants' readiness for healthcare occupational training.[49]

Of those programs that assessed basic skills, more than three-quarters still enrolled applicants who tested just below the program's minimum reading and math requirements.[50] Of these programs, 71 percent required applicants testing below minimum requirements to upgrade their basic skills before enrolling in training courses, and two advised participants to upgrade their basic skills but did not require it.[51]

- **Few applicants who met income eligibility standards were still found ineligible for the program. Common reasons for ineligibility were applicants' loss of interest in healthcare and/or prior criminal background.**

Most HPOG 2.0 programs reported that few income-eligible applicants were otherwise found to be ineligible for the program. About three-quarters of programs reported that 10 percent or fewer income-eligible applicants were found ineligible for the program; one-quarter of programs reported that between 11 and 30 percent of applicants were ineligible.[52]

Programs reported the most common reasons for applicants who met income standards to be determined ineligible were applicants losing interest in healthcare after orientation, applicants not passing criminal background screenings, and applicants not meeting U.S. citizenship or legal residency requirements (Exhibit 3-5).[53]

48 See Appendix D, Table 3-11.

49 See Appendix D, Table 3-12.

50 See Appendix D, Table 3-13.

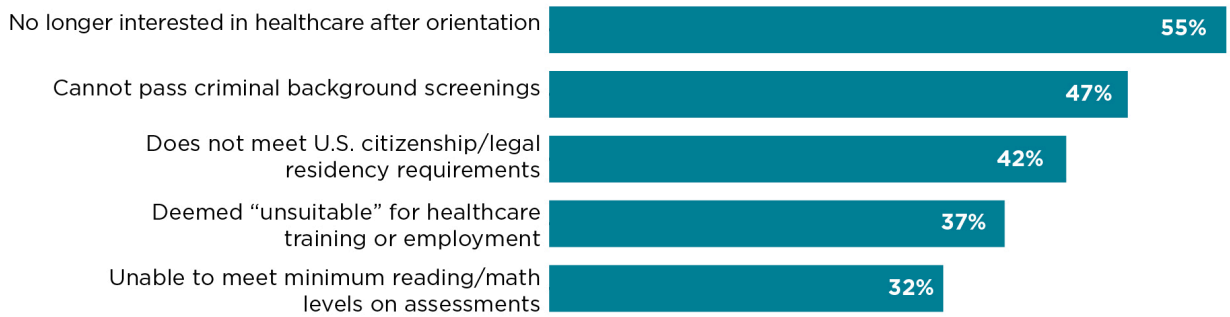
51 See Appendix D, Table 3-14.

52 See Appendix D, Table 3-15.

53 See Appendix D, Table 3-16.

Exhibit 3-5: Common Reasons Applicants Who Met Income Standards Were Determined Ineligible

Percentage of Programs



Source: HPOG 2.0 2017 grantee interviews, Q 4.10c
Note: Responses do not sum to 100 percent because multiple responses were permitted.
N=38 programs
Missing=0 programs

More than one-third of programs cited "unsuitability" for healthcare training or employment as a common reason for applicants being determined ineligible.[54] Among these programs, lack of motivation was the most common reason applicants were thought to be unsuitable.[55] Most programs provided applicants deemed unsuitable with a list of alternative services in the community or referred them to another agency or community service organization.[56]

3.4 Participant Characteristics

This section describes the characteristics of HPOG 2.0 participants at intake, including their demographic characteristics, the barriers they faced, their employment and education status, and their income and receipt of p ublic assistance.

- **HPOG 2.0 participants were primarily women who had never been married, with an average age of 32. Almost two-thirds had one or more dependent children.**

Exhibit 3-6 provides demographic details on the HPOG 2.0 participants.[57]

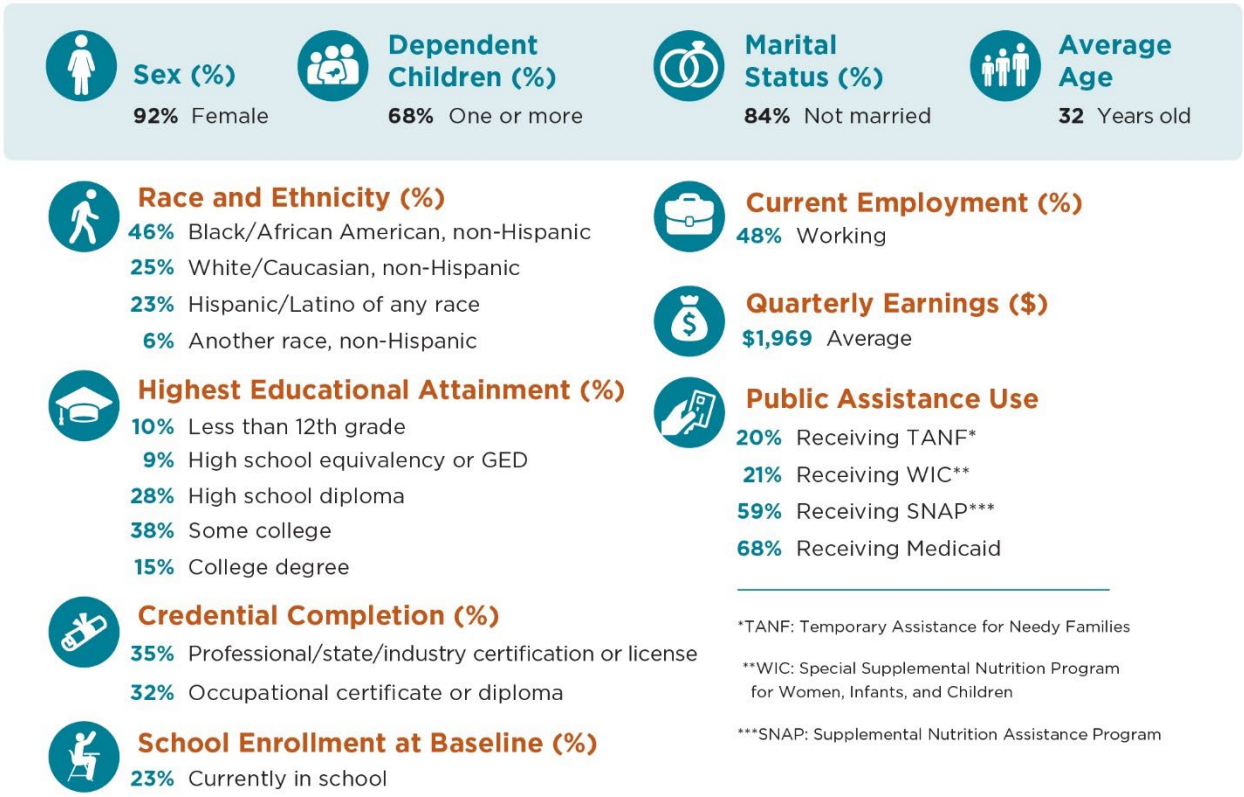
[54] See Appendix D, Table 3-16.

[55] See Appendix D, Table 3-17.

[56] See Appendix D, Table 3-18.

[57] See Appendix D, Table 3-19.

Exhibit 3-6: Characteristics of HPOG 2.0 Participants at Intake



Source: PAGES. Participants enrolled between September 30, 2015, and August 31, 2019
N=28,077 participants
Missing=Percentages missing range from 1-2 percent, depending on the category.

- **At intake, more than three-quarters of HPOG 2.0 participants had completed high school; more than half had attended college.**

HPOG 2.0 participants had higher educational attainment relative to TANF recipients nationally. Over one-third (37 percent) of participants had a high school diploma or equivalent, and 53 percent had education beyond high school. In contrast, according to fiscal year 2019 data, 54 percent of TANF recipients had completed high school and only 9 percent had education beyond high school (OFA 2020).

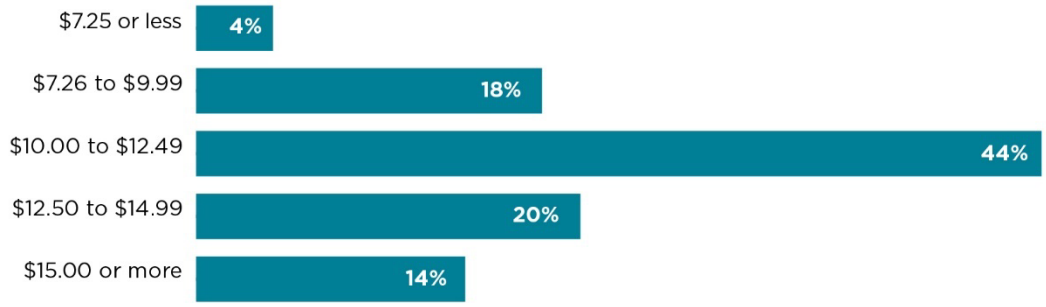
- **Nearly half of HPOG 2.0 participants were already employed at intake.**

Many HPOG 2.0 participants were already working: Almost half were employed at intake, and half of those employed were employed in healthcare.[58] As shown in Exhibit 3-7,[59] most HPOG 2.0 participants who were employed at intake earned an hourly wage below $12.50 (66 percent) and worked less than full-time (63 percent).

[58] See Appendix D, Table 3-20.

[59] See Appendix D, Table 3-21.

Exhibit 3-7: Hourly Wages of Employed Participants at Intake

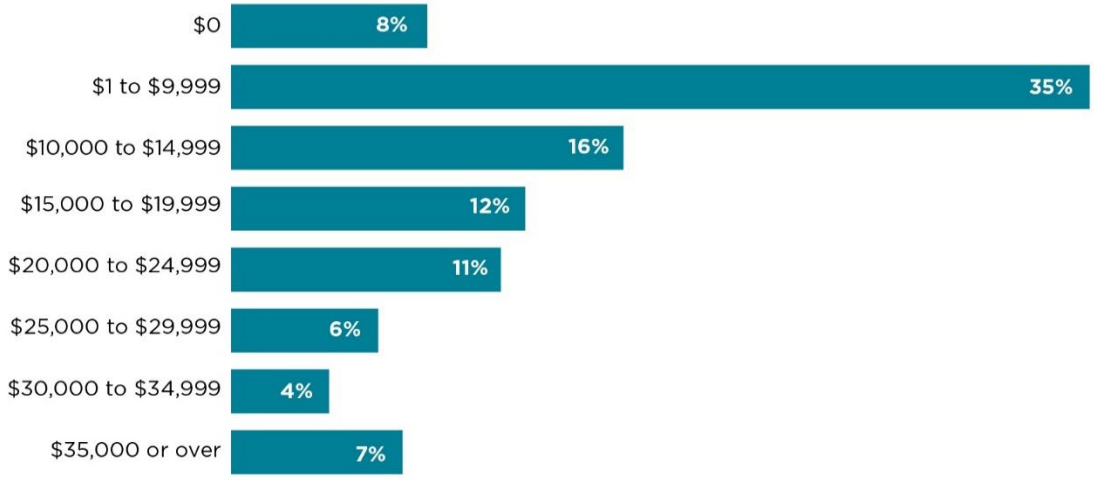


Source: PAGES. Participants enrolled between September 30, 2015, and August 31, 2019
Note: Percentages may not sum to 100 percent because of rounding.
N=12,793 participants
Missing=Percentage missing is less than 1 percent.

- **Most HPOG 2.0 participants had low household income, with 83 percent receiving some form of public assistance.**

Consistent with the low-income target population for HPOG 2.0 programs, most participants had low household income at intake. As shown in Exhibit 3-8,[60] about 44 percent had an annual household income of less than $10,000. Moreover, nearly one-fifth of participants (19 percent) reported having no individual income at intake, and nearly one-quarter (24 percent) reported annual individual income between $1 and $4,999. The federal poverty level for a single-person household was $12,880 in 2021; the level for a three-person household was $21,960 (HHS 2021).

Exhibit 3-8: Annual Household Income of Participants at Intake



Source: PAGES. Participants enrolled between September 30, 2015, and August 31, 2019
Note: Percentages may not sum to 100 percent because of rounding.
N=28,077 participants
Missing= Percentage missing is 1 percent.

[60] See Appendix D, Table 3-22.

Almost 60 percent of participants were receiving SNAP and 20 percent of participants were receiving TANF at intake.[61] Consistent with the goal of HPOG 2.0 to serve more TANF recipients, this is an increase from HPOG 1.0, where 15 percent of participants were receiving TANF at intake (Werner et al. 2016). More than two-thirds were receiving Medicaid, and 21 percent were receiving WIC. About 19 percent were receiving Section 8 or public housing. About 41 percent lived in a household receiving free or reduced-price lunch.[62]

- **Fewer than one-quarter of participants were enrolled in school or training at intake and many had obtained professional credentials.**

Consistent with the goals of HPOG 2.0, fewer participants (23 percent) were already enrolled in training at intake compared to the percentage of HPOG 1.0 participants already enrolled (Werner et al. 2016). About one-third of participants already had a professional, state, or industry certification or license and nearly one-third had an occupational certificate or diploma at intake.[63]

- **Transportation, child care, and illness were the most common barriers to work or study at intake.**

Fewer than half (44 percent) of participants reported barriers to work or study at intake.[64] Among those who reported barriers, transportation was the most common (23 percent of participants), followed by child care (21 percent) and illness or health (16 percent).

The next chapter describes the types of basic skills education, other skill-development activities, and occupational training courses provided and how these activities fit into the career pathways framework.

[61] See Appendix D, Table 3-23.

[62] See Appendix D, Table 3-23.

[63] See Appendix D, Table 3-20.

[64] See Appendix D, Table 3-24.

4. Healthcare Education and Training Activities

Chapter 4 Key Findings

- All HPOG 2.0 programs offered basic skills education, and about half of participants received it.
- Training for Nursing Assistant was the most popular program offering. All HPOG 2.0 programs offered this occupational training, and more than a third of HPOG 2.0 participants enrolled in it.
- Almost all programs offered training courses that conveyed credentials that were stackable within an occupational career pathway.
- More than two-thirds of programs offered work-based learning opportunities (excluding clinical placements required as part of training courses), such as on-the-job training or job shadowing, but few participants engaged in them.
- All HPOG 2.0 programs offered other skill-development activities, and about half of participants participated in them.

Healthcare occupational training is the heart of the HPOG 2.0 Program. The HPOG 2.0 FOA encouraged programs to include clearly articulated healthcare career pathways (OFA 2015). It also directed HPOG 2.0 programs to offer innovative approaches to basic skills education, such as basic skills education acceleration, contextualization, and integration with occupational training. The FOA also emphasized other skill-development activities, such as training in work-readiness skills.

This chapter describes the strategies programs used to prepare participants to succeed in healthcare training and occupations. It also describes the education and healthcare training activities that programs offered and participants received. In addition to documenting the types of basic skills education, other skill-development activities, and occupational training courses provided, this chapter discusses the extent to which trainings and other activities fit into the career pathways framework.

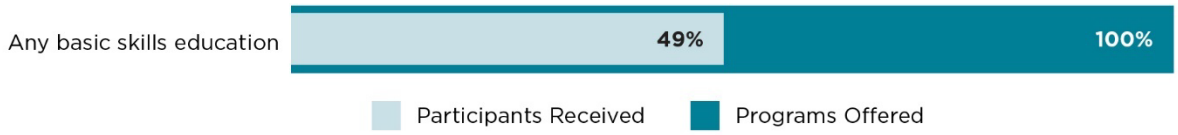
4.1 Basic Skills Education

HPOG 2.0 participants had varied levels of reading, writing, or math skills at program intake and many needed to improve these skills before enrolling in healthcare occupational training. Evidence suggests that strategies such as accelerating basic skills education or integrating it into occupational training can help engage participants who feel a sense of urgency to complete their training (Endel, Anderson, and Kelley 2011; Zacker 2011). Building on evidence from HPOG 1.0, the HPOG 2.0 FOA highlighted basic skills education as a strategy likely to help individuals advance along a career pathway (OFA 2015). All HPOG 2.0 programs offered some basic skills education and used a variety of strategies to make it accessible to participants. This section describes the basic skills activities and strategies offered by HPOG 2.0 programs and participants' engagement in these activities.

- **All HPOG 2.0 programs offered basic skills education, and about half of participants received it.**

All HPOG 2.0 programs provided education in basic skills. About half of HPOG 2.0 participants engaged in it, perhaps reflecting ACF's emphasis on serving those with basic skills needs within the HPOG program under HPOG 2.0 (OFA 2015).[65] Analysis results from the HPOG 2.0 Short-Term Impact Evaluation (about 15 months after random assignment) suggest that HPOG 2.0 programs increased enrollment in basic skills education over what enrollment would have been in the absence of the programs.[66]

Exhibit 4-1: Basic Skills Education Offered and Received



Source: PAGES. Program data: offerings between September 30, 2015, and July 8, 2020, and receiving basic skills education. Participant data: enrolled between September 30, 2015, and August 31, 2019; data through February 29, 2020.
Note: Because the grantee interviews did not include questions about program offering of basic skills education, we used PAGES data on participation in basic skills education to determine whether programs offered it. If a program did not have any participants enrolled in basic skills education, the program is counted as not offering it. Participants may have enrolled in more than one type of basic skills education.
N=38 programs; 28,077 participants
Missing=0 programs; 0 participants

- **Strategies for basic skills education included flexible delivery, accelerated education, and basic skills integrated into healthcare training.**

Basic skills education has traditionally been delivered before healthcare occupational training (Endel, Anderson, and Kelley 2011). Though most HPOG 2.0 programs provided basic skills education as a stand-alone component taken independently of healthcare training activities (Exhibit 4-2)[67], most programs also allowed participants to enroll simultaneously in basic skills courses and healthcare training. Some staff reported that sequential enrollment—basis skills *and then* occupational skills—discouraged participants who felt a sense of urgency to complete their training and did not want to delay its start.[68]

> "Allowing participants to simultaneously enroll in basic skills courses and healthcare training seems to be the most effective. Many of these students are single mothers or single fathers who might have to work and raise their family at the same time. This option allows them to proceed slightly faster through the course and successfully complete it."
>
> – HPOG 2.0 Program Staff

65 See Appendix D, Tables 4-1, 4-2.

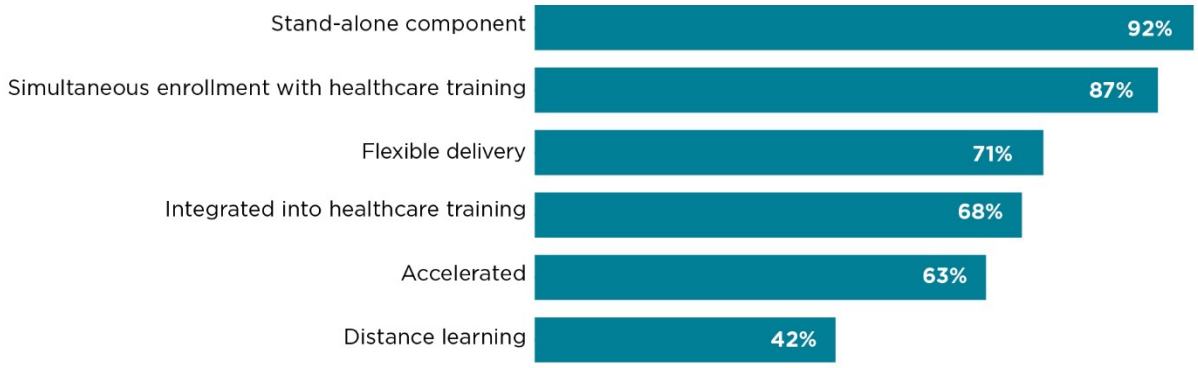
66 The proportion of the treatment group (i.e., individuals who consented to be part of the HPOG 2.0 evaluation and were randomly assigned to the group offered access to the local HPOG program) enrolling in basic skills or developmental education was 6 percentage points higher than the corresponding portion of the control group participants (Klerman et al. 2022).

67 See Appendix D, Table 4-3.

68 *Source:* HPOG 2.0 2019 grantee interviews, Q 5.3a.

Exhibit 4-2: Strategies for Delivering Basic Skills Education

Percentage of Programs



Source: HPOG 2.0 2017 grantee interviews, Q 5.1a
Note: Responses do not sum to 100 percent because multiple responses were permitted.
N=38 programs
Missing=0 programs

More than 70 percent of HPOG 2.0 programs offered flexible delivery formats in location, schedule, pace, and strategy. More than two-thirds of programs offered some courses that integrated basic skills education into healthcare training (Exhibit 4-2). According to staff from some of those programs, offering contextualized basic skills education or basic skills education integrated with occupational training made it more likely that participants would complete the training. They believed it was easier for students to understand concepts and see the connection between basic skills and healthcare goals.[69]

Programs that accelerate basic skills education (or occupational training) courses "reorganize instruction and curricula in ways that allow [participants] to complete them more quickly than in a traditional format."[70] For example, participants might attend class for fewer weeks but for more hours per week. More than half of all programs offered basic skills education in an accelerated format. Among participants who received any basic skills education, more than half enrolled in adult basic education and a quarter participated in college developmental education.[71] Enrollment in occupational healthcare training with integrated basic skills activities was less common, with about a third of participants enrolling.[72] Finally, about a fifth participated in accelerated basic skills education.[73]

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69 *Source:* HPOG 2.0 2019 grantee interviews, Q 5.3a.

70 *Source:* PAGES, HPOG 2.0 Glossary of Terms.

71 Basic skills training includes adult basic education, adult secondary education, college developmental education, and English language acquisition. See "Important Terms for This Report" for definitions of each type.

72 See Appendix D, Table 4-2.

73 The PAGES data extract used to determine the percentage of participants who received basic skills education in an accelerated format was pulled at a later date than the PAGES extract used for the rest of the report. See Appendix D, Table 4-2.

Advice from the Field: Three HPOG 2.0 Programs Share Their Strategies for Delivering Basic Skills Education

Three HPOG 2.0 programs shared the following lessons learned and promising practices during site visits focused on the delivery of basic skills education:

- Seek out basic skills instructors with experience in healthcare to contextualize basic skills education to the greatest extent possible.
- Balance participants' eagerness to begin healthcare training with the extent to which they need to improve their basic skills levels first.
- Integrating basic skills education with healthcare training is difficult and depends on partnerships with the training providers that would have to implement integrated training models.
- Alternatives to integrating basic skills education with healthcare training include co-delivering basic skills education with training on employability skills or work-readiness.
- Self-paced or online basic skills education, with supports from case managers or navigators, may also address participants' needs.

4.2 Healthcare Occupational Training

The HPOG 2.0 FOA tasked grantee programs with preparing participants for jobs in the healthcare field that paid well and were expected to either experience labor shortages or be in high demand (OFA 2015). At the same time, they were asked to train large numbers of individuals, targeting those with low incomes and low skills. Consistent with HPOG 1.0, HPOG 2.0 training courses were typically for entry-level occupations that are in high demand but do not pay well (Werner et al. 2016).[74] Analysis of HPOG 1.0 and 2.0 participants found that the most common training patterns for participants were completing no occupational training or completing only entry-level training, which does not result in jobs that pay well (Klerman, Litwok, and Morris 2022).

Programs offered a range of healthcare training courses based on local context and eligible target populations. This section presents an overview of healthcare occupational training courses offered by HPOG 2.0 programs and participant take-up of training. It also discusses the role of partners in providing healthcare occupational training.

- **All HPOG 2.0 programs offered Nursing Assistant training courses, and more than a third of HPOG 2.0 participants enrolled in this course.**

HPOG 2.0 programs offered training courses in a variety of healthcare occupations. Nursing Assistant training was the most common, with all programs offering the course (Exhibit 4-3).[75] Other commonly offered training courses were for Registered Nurse (RN), Medical Assistant,

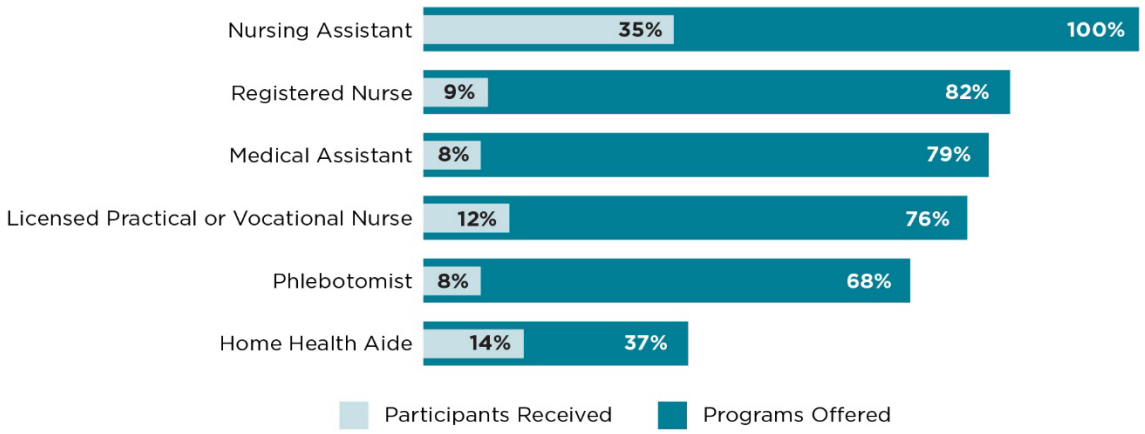
[74] See Appendix D, Table 4-5.

[75] See Appendix D, Tables 4-4, 4-6.

and Licensed Practical or Vocational Nurse (LPN/LVN). About two-thirds of the training courses offered by programs were entry-level trainings.[76]

Nearly four-fifths of HPOG 2.0 participants enrolled in healthcare occupational training courses. Most programs did not formally "exit" participants from HPOG, so there may be participants who withdrew from the program without completing any training courses. HPOG 2.0 participants who did enroll pursued a variety of healthcare training courses, with three-quarters enrolling in the six most popular (Exhibit 4-3).[77]

Exhibit 4-3: Healthcare Occupational Training Courses Offered and Received, Top Six Most Commonly Received Trainings



Source: Program data: HPOG 2.0 2017 grantee interviews, Q 5.5. Participant data: PAGES; enrolled between September 30, 2015, and August 31, 2019; data through February 29, 2020.
Note: Responses do not sum to 100 percent because multiple responses were permitted and not all occupational training courses are shown. Participants may have enrolled in more than one type of healthcare occupational training. Percentages of participants who received each training were calculated among participants who had enrolled in at least one training course.
N=38 programs, 21,799 participants
Missing=0 programs, 3 participants

Analysis in the HPOG 2.0 Short-Term Impact Evaluation found that HPOG 2.0 "moderately" increased the likelihood of starting training.[78] In addition, HPOG 2.0 increased *educational progress*, defined as having completed training by earning a credential or having been

[76] See Appendix D, Table 4-5. Grantees self-categorized their healthcare training courses in PAGES into career pathways training levels based on average expected wages of those completing training. Because grantees categorized their own training courses, classifications may vary from grantee to grantee. Levels include entry-level training (e.g., Nursing Assistant, Home Health Aide, Medical Assistant); mid-level training (e.g., LPN/LVN, Medical or Clinical Laboratory Technologist, Paramedic, Medical Records or Health Information Technician); and high-level training (e.g., RN, Medical and Health Services Manager, Radiologic Technician, Dental Hygienist). For more information, see Sick and Loprest (2021).

[77] See Appendix D, Table 4-6.

[78] The proportion of the treatment group starting training (broadly defined to include both basic skills education and occupational healthcare training) was 19 percentage points higher than the corresponding portion of the control group participants (Klerman et al. 2022).

continuously enrolled in training 15 months after random assignment.[79] HPOG 2.0 also substantially increased the attainment of healthcare credentials.[80]

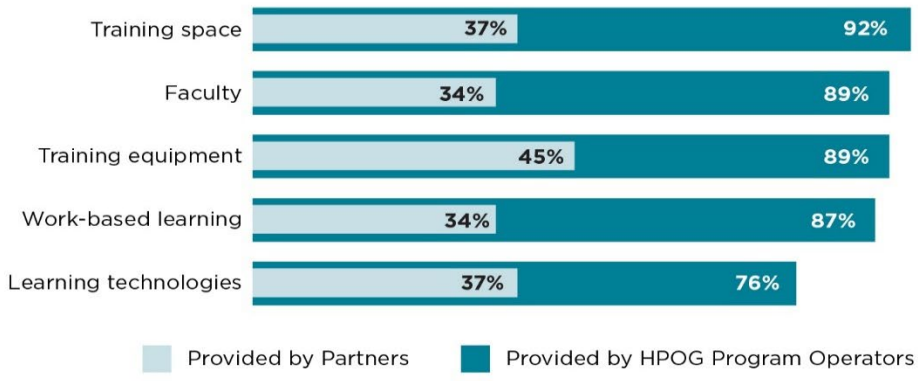
HPOG 2.0 programs generally offered healthcare occupational training courses that were also available to non-HPOG 2.0 students in the community,[81] such as healthcare training at community or technical colleges. All programs placed participants in healthcare training courses that were available to both HPOG 2.0 and non-HPOG 2.0 students. A minority of programs (18 percent) created or paid for some healthcare occupational training courses that were only available to HPOG 2.0 participants.

- **Programs relied on partners to provide training space, faculty, training equipment, work-based learning opportunities, and learning technologies.**

The HPOG 2.0 FOA did not expect programs to provide all services and training courses themselves (OFA 2015). Programs formed partnerships with other public and private organizations to provide at least some of that, including healthcare occupational training. In fact, most HPOG 2.0 programs relied heavily on partners to provide training space, faculty or instructors, training equipment, work-based learning opportunities, and learning technologies (Exhibit 4-4).[82] Programs did provide some of these resources themselves, with nearly half providing training equipment such as labs or computers. About one-third of HPOG 2.0 programs provided their own training space; learning technologies such as a learning management system or software; faculty or instructors; and work-based learning opportunities such as clinicals.

Exhibit 4-4: Role of Program Operators and Partners in Providing Healthcare Training

Percentage of Programs



Source: HPOG 2.0 2019 grantee interviews, Q 6.3
Note: Responses do not sum to 100 percent because multiple responses were permitted.
N=38 programs
Missing=0 programs

79 The proportion of the treatment group making educational progress was 17 percentage points higher than the corresponding portion of the control group participants (Klerman et al. 2022).

80 The proportion of the treatment group earning a healthcare credential was 18 percentage points higher than the corresponding portion of the control group participants (Klerman et al. 2022).

81 See Appendix D, Table 4-7.

82 See Appendix D, Table 4-8.

4.3 Career Pathways

HPOG 2.0 programs were encouraged to take a career pathways approach to providing training (OFA 2015). Training activities that follow the career pathways framework:

- award clearly defined and industry-recognized credentials;
- build to add higher competencies in a defined career path;
- are flexibly delivered to accommodate participants with non-traditional education paths;
- are integrated with work-based learning opportunities (such as internships, externships, and clinical placements); and
- integrate varied academic and non-academic supports to promote students' program persistence, program completion, and subsequent workplace success. (Fein 2012)

This section describes the variety of career pathways approaches offered by HPOG 2.0 programs. It also discusses the barriers faced by participants that could be addressed by a career pathways approach. The Outcomes Study explores the extent to which HPOG 2.0 participants enrolled in additional occupational training courses allowing them to obtain additional credentials and move along a defined career pathway to better paying jobs.

> "When I went to the information session, they did show you how a person can go from a CNA to medical assistant, to LPN or RN. You don't have to take that path – you can go straight to RN if you want to. A lot of people seem more successful when they start at CNA and take it step by step. They say it's easier, and you learn more, and you're just more efficient at your job."
>
> – HPOG 2.0 Program Participant

- **Almost all HPOG 2.0 programs considered themselves a career pathways program.**

Nearly all HPOG 2.0 programs presented themselves as a career pathways program.[83] Program staff introduced participants to the concept of career pathways early on, through information sessions with potential applicants, at intake, and at orientation.[84] Many programs reported that case managers had one-on-one discussions with participants about career pathways. Some programs gave participants examples of career trajectories, such as Certified Nursing Assistant (CNA) to LPN then RN. A few programs used information sheets,

> "We first introduce the concept of career pathways and healthcare training course offerings during the initial orientation as part of intake. For example, if they are interested in becoming a Certified Nursing Assistant, we let them know about opportunities to pursue a career as a Licensed Vocational Practitioner or Registered Nurse. If someone is interested in becoming a Pharmacy Technician Assistant, we encourage them to think about becoming a Pharmacy Technician after getting some work experience."
>
> – HPOG 2.0 Program Staff

[83] See Appendix D, Table 4-9. The *HPOG 2.0 Short-Term Impact Report* (Klerman et al. 2022) found that training along a career pathway occurred infrequently. This is further examined in the Outcomes Study.

[84] HPOG 2.0 2017 grantee interviews, Q 5.8b.

flyers, or career maps. Staff from some programs reported that they built customized pathway plans for participants.

- **Most programs offered trainings at flexible times and nearly all offered "stackable" credentials.**

All programs offered healthcare training courses during the day, and nearly all also offered evening courses.[85] About three-quarters of programs offered courses on the weekends.

Almost all programs offered occupational training associated with clearly defined and industry-recognized credentials that are "stackable" with credentials from other available trainings within the same career pathway.[86] When sequentially accumulated over time, these credentials allowed participants to move along a career pathway to potentially higher paying jobs. Programs varied in the percentage of trainings offered that conveyed stackable credentials.[87] About one-half of HPOG 2.0 programs offering such trainings indicated at least 50 percent of their training courses conveyed stackable credentials.

- **Over a third of programs offered accelerated courses to allow participants to complete their healthcare occupational training more quickly than a traditional format.**

Slightly more than half of programs offered accelerated training courses[88] that potentially helped participants earn credentials and gain employment more quickly. Programs most commonly offered accelerated training for Nursing Assistant, RN, LPN/LVN, Medical Assistant, and Patient Care Technician (Exhibit 4-5).[89] Small numbers of programs offered accelerated training courses in a variety of other occupations.

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85 See Appendix D, Table 4-10.

86 See Appendix D, Table 4-11.

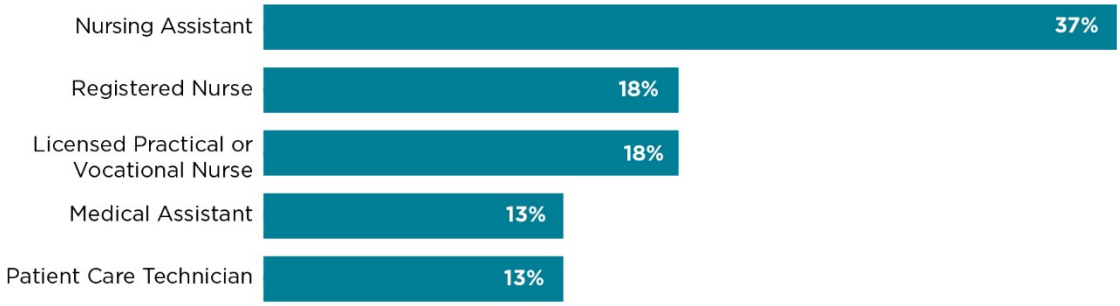
87 See Appendix D, Table 4-12.

88 Under HPOG 2.0, "accelerated courses reorganize instruction and curricula in ways that allow students to complete them more quickly than in a traditional format. This may mean students move through the content in fewer hours of instruction or it may mean that students attend class for more hours per week." *Source:* PAGES, *HPOG 2.0 Glossary of Terms.*

89 See Appendix D, Table 4-13.

Exhibit 4-5: HPOG 2.0 Programs Offering Training Courses Designed for Accelerated Completion, Top 5 Most Common Healthcare Occupations

Percentage of Programs



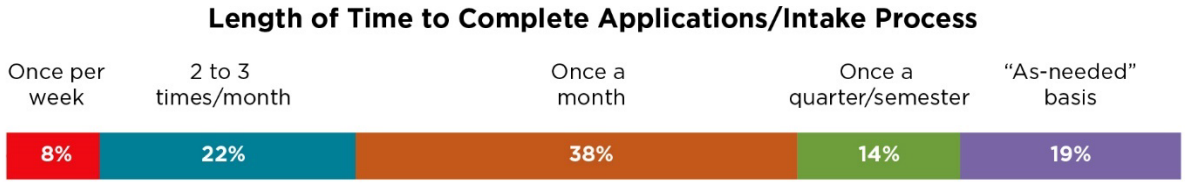
Source: HPOG 2.0 2017 grantee interviews, Q 6.1a
Note: Responses do not sum to 100 percent because multiple responses were permitted.
N=38 programs
Missing=0 programs

- **Most programs monitored participants' career paths, trainings, and results of licensing and credential exams after completion of HPOG 2.0–funded training.**

Most programs monitored whether participants passed licensing or other credentialing exams after completing HPOG 2.0–funded training and routinely followed up with participants about their next career path or training.[90] Programs monitored whether participants passed their exams through communication with participants and training providers and with state licensing boards. Across programs, HPOG 2.0 staff and participants discussed their short- and long-term educational and employment goals. Staff revisited goals with participants ranging from weekly to about once per quarter or semester (Exhibit 4-6).[91] For the most part, case managers initiated check-ins with participants to monitor their goals, using a mix of telephone, in-person, email, text messages, and social media.[92]

Exhibit 4-6: Frequency of HPOG 2.0 Program Staff Revisiting Goals with Participants

Percentage of Programs



Source: HPOG 2.0 2017 grantee interviews, Q 5.10b
N=37 programs
Missing=1 program

90 See Appendix D, Table 4-14 and Table 4-15, respectively.

91 See Appendix D, Table 4-16. The study did not collect information on dosage or quality of case management services.

92 See Appendix D, Table 4-17.

Advice from the Field: Three HPOG 2.0 Programs Share Their Career Pathways Training Strategies

Three HPOG 2.0 programs shared the following lessons learned and promising practices during site visits focused on career pathways training strategies:

- Present the program to participants as having a clear sequence, or "pathway," of coursework, training, and credentials.
- Emphasize career pathways early and often with participants, particularly with participants in entry-level training.
- Provide individualized, one-on-one guidance to participants about career pathways.

4.4 Work-Based Learning and Other Skill-Development Activities

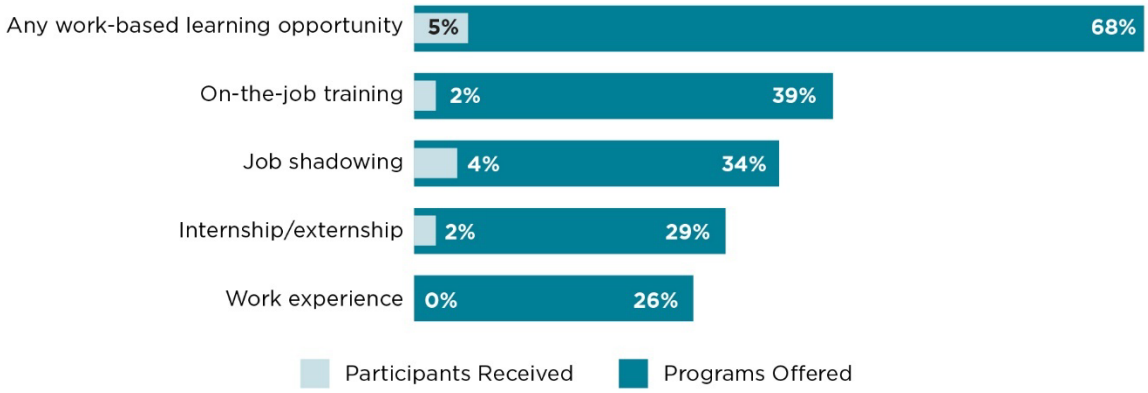
Work-based learning can engage participants and help them develop their skills beyond formal classroom training (Zacker 2011). The HPOG 2.0 FOA instructed programs to include meaningful opportunities for work-based learning provided by employers. It also encouraged HPOG 2.0 programs to offer work-readiness activities either stand-alone or integrated into other education opportunities (FOA 2015). This section describes the activities offered by HPOG 2.0 programs and participation in them.

- **More than two-thirds of programs reported offering work-based learning opportunities (beyond clinical placements required as part of training), but few participants engaged in them.**

Many training courses offered by HPOG 2.0 programs required work-based clinical placements. Because of that, HPOG administrative data considers such placements a normal component of training, not as separate work-based learning activities. Beyond clinicals, many programs also offered work-based learning opportunities such as unpaid internships, externships, job shadowing, and on-the-job training outside of training course curricula. However, although more than two-thirds of programs *offered* work-based learning opportunities, only 5 percent of participants *engaged* in them outside of their training course (Exhibit 4-7).[93]

[93] See Appendix D, Table 4-18 and Table 4-19.

Exhibit 4-7: Work-Based Learning Opportunities Offered and Received outside of Occupational Training Courses (excluding clinical placements)



Source: PAGES. Program data: offerings between September 30, 2015 and August 31, 2019. Participant data: enrolled between September 30, 2015, and August 31, 2019; data through February 29, 2020
Note: Responses do not sum to 100% because multiple responses were permitted. Because the grantee interviews did not ask about work-based learning opportunities offered, we used PAGES data on participation to determine whether programs were offering these opportunities. If a program did not have any participants enrolled in the activity, it is counted as not offering the activity. Participants may have engaged in more than one type of work-based learning opportunity.
N=38 programs, 28,077 participants
Missing=0 programs, 0 participants

- **All HPOG 2.0 programs offered other skill-development activities, and about half of participants engaged in them.**

Almost all programs offered work-readiness skills workshops with an emphasis on positive work habits, attitudes, and behavior in healthcare settings (Exhibit 4-8).[94] In addition, more than four-fifths of programs offered pre-training activities geared towards digital literacy, knowledge of healthcare careers, and college readiness. Healthcare career workshops introduced participants to the range of jobs available in healthcare and their potential career pathways. College-readiness workshops offered training in study, financial, time management, and other skills needed for college success.

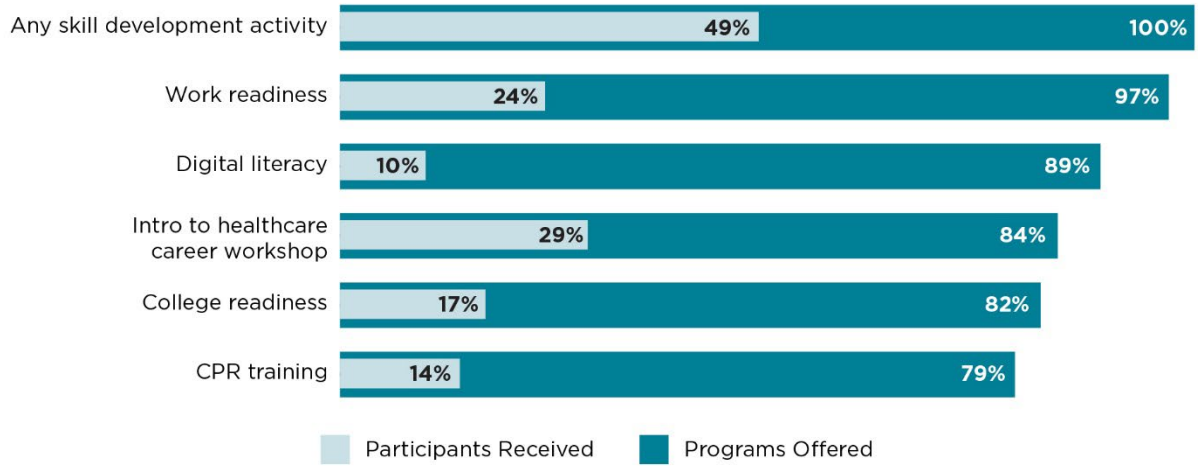
> "During the workshops we provide soft skills, which is also important. In terms of digital literacy, we have a lot of students with low computer skills. Some students have not used computers in years and for others it is their very first time using a computer. We provide valuable training to prepare them on how to use the computer so that they are prepared once they are employed."
>
> – HPOG 2.0 Program Staff

As with basic skills education, about half of participants engaged in other skill-development activities (Exhibit 4-8).[95] Nearly a third of participants (29 percent) engaged in an introductory healthcare career workshop, and one-quarter (24 percent) engaged in a work-readiness workshop. Participation in other types of skill-development activities was lower.

94 See Appendix D, Tables 4-20, 4-21.

95 See Appendix D, Table 4-21.

Exhibit 4-8: Other Skill-Development Activities Offered and Received



Source: Program data: HPOG 2.0 2017 grantee interviews, Q 7.1a. Participant data: PAGES; enrolled between September 30, 2015, and August 31, 2019; data through February 29, 2020.
Note: Responses do not sum to 100 percent because multiple responses were permitted. Participants may have engaged in more than one skill-development activity.
N=38 programs, 28,077 participants
Missing=0 programs, 0 participants

Advice from the Field: Two HPOG 2.0 Programs Share Their Strategies for Delivering Work-Readiness Training

Two HPOG 2.0 programs shared the following lessons learned and promising practices during site visits focused on delivering work-readiness training:

- Develop comprehensive work-readiness training that provides the soft skills employers are looking for. Skills that will help participants thrive in the workplace include punctuality, interpersonal skills, and professionalism.
- Incorporate a range of interactive activities, such as role plays, developing vision boards, positive affirmations, and group discussions, to ensure participants engage, understand, and retain the information.
- Address participants' individual barriers to training completion and employment by developing training components to help participants identify and overcome personal barriers such as low self-esteem, personal or mental health issues, and financial barriers. Assess and address barriers throughout training.
- Integrate digital literacy in work-readiness training to address participants' typically low levels of proficiency in this area.
- Provide regular staff training on the work-readiness curriculum to ensure continuity, given the importance of work-readiness training and high staff turnover.

The next chapter describes the support services HPOG 2.0 programs offered and participants received.

5. Support Services

Chapter 5 Key Findings

- All HPOG 2.0 programs offered case management and counseling services, and nearly all participants received them.
- All HPOG 2.0 programs offered academic advising and training-related financial assistance, and more than half of participants received them.
- All HPOG 2.0 programs offered personal and logistical supports, including transportation and child or dependent care assistance, but fewer than half of participants received transportation assistance and only 5 percent received child or dependent care assistance from the program.
- All HPOG 2.0 programs offered employment supports, including job search assistance, job placement, and job retention services, but fewer than one-third of participants received them.

Comprehensive support services are an important component of the HPOG 2.0 Program and a key feature of the career pathways framework.[96] Building on earlier research showing that greater access to support services was associated with completing training (Stephens 2009), the HPOG 2.0 FOA directed local programs to provide support services such as academic supports, case management, child care assistance, transportation assistance, and tuition assistance and other training-related financial assistance (OFA 2015). The expectation was that these support services would help participants complete training (Hinckley and Hull 2009; Stephens 2009) and gain employment (Hinckley and Hull 2009).

All HPOG 2.0 programs offered a full range of support services including case management, academic supports, personal and logistical supports, and employment supports. As noted in Chapter 2, program operators offered many support services themselves but also relied on partners and other agencies in the community to provide them. Participant take-up varied by type of support service, but analysis results from the HPOG 2.0 Short-Term Impact Evaluation (about 15 months after random assignment) suggest that HPOG 2.0 increased receipt of these services.[97]

This chapter describes the support services HPOG 2.0 programs offered and participants received. It also discusses whether the services were offered directly by program operators, by partners, or through referral to other agencies in the community.

5.1 Case Management and Counseling Services

The HPOG 2.0 FOA listed case management, including academic and career counseling, and personal or financial counseling, as supportive services HPOG 2.0 programs and partners should provide to participants (OFA 2015). Case management typically includes assessing

[96] For additional information, see Fein (2012).

[97] That analysis found a 6-percentage point impact for career counseling services, a 7 percentage point impact for job search or placement assistance, and an 9 percentage point impact for caseworker assistance. No significant impacts were found for tutoring, academic advising, or financial aid advising (Klerman et al. 2022).

participants' needs, providing or referring participants to relevant support services, and monitoring participants' progress (Bloom, Hill, and Riccio 2003). Case managers can help participants address problems that arise by identifying and securing needed and available resources. They can also connect with instructors and other service providers to support participants (JFF 2010). This section presents an overview of case management and counseling services offered by HPOG 2.0 programs and participant take-up of these supports.

- **All HPOG 2.0 programs offered case management services, and nearly all participants received them.**

> "Time management. Managing your finances. I mean that starts from the beginning of the program so you're not just thrown into this program and go right into anatomy..."
>
> – HPOG 2.0 Participant

Research stresses the importance of case management involving ongoing and frequent communication for participant success in programs such as HPOG (Buell, Schneider, and Werner 2016). All HPOG 2.0 programs offered case management. Those services included participant monitoring, career counseling, counseling to identify participants' personal and logistical support service needs, and academic counseling.[98] Financial counseling was offered by most, but not all programs. Nearly all HPOG 2.0 participants (96 percent) received case management services (Exhibit 5-1).[99] Results of short-term impact analysis suggest that HPOG 2.0 participants were more likely to receive case management than similar individuals not enrolled in HPOG 2.0 programs.[100] Additionally, those results indicate the intensity of case management (e.g., how often counselors met with participants individually or in groups) was low in HPOG 2.0 relative to similar services provided in some other, successful workforce programs. Those more intensive programs, however, were typically much smaller and allocated more funding per trainee.[101]

Exhibit 5-1: Case Management Services Offered and Received

Source: Program data: HPOG 2.0 2017 grantee interviews, Q 8.1. Participant data: PAGES; enrolled between September 30, 2015, and August 31, 2019; data through February 29, 2020.
N=38 programs, 28,077 participants
Missing=0 programs, 0 participants

98 See Appendix D, Table 5-1.

99 See Appendix D, Table, 5-2.

100 The proportion of the treatment group receiving caseworker assistance was 8 percentage points higher than the corresponding portion of the control group participants (Klerman et al. 2022).

101 On average, treatment group members received 15 hours of support services within 15 months of randomization. In contrast, participants in Year Up, a high-service program that has shown significant impacts on earnings, were expected to meet with advisors weekly during the first six months of the program and periodically during the following six months (Klerman et al. 2022).

- **All HPOG 2.0 programs employed case managers, navigators, or coaches to help participants meet their needs.**

Most HPOG 2.0 program operators directly employed case managers, with some also using case managers employed by partner organizations.[102] Only a handful of programs relied solely on case managers employed by partner organizations.

Nearly two-thirds of programs relied entirely on full-time case managers, and one-third used a combination of full-time and part-time case managers. Caseload size varied widely by program. On average, full-time case managers had a caseload size of 50 participants, with a range of 12 to 180 participants. Part-time case managers had, on average, 19 participants, with a range of 1 to 60 participants.[103]

- **Case managers monitored participants' progress and provided counseling services at most HPOG 2.0 programs.**

At nearly every program, case managers provided counseling to identify participants' personal and logistical support service needs and monitored participants' progress in training and support service needs.[104] Programs relied less on other frontline staff, such as academic advisors and job developers, to provide these supports.

> "There aren't many situations where clients are academically ready or college-ready, but they can make strides to get ready to do the training. They have case managers to help them throughout the process and it helps clients know they aren't in it by themselves. It can be so easy to get discouraged with the process."
>
> – HPOG 2.0 Program Staff

5.2 Academic Supports

Intensive academic advising can improve rates of credential attainment (Roder and Elliott 2018). Academic supports, such as tutoring and academic advising, can help improve educational outcomes for students with low skills (JFF 2010). The HPOG 2.0 FOA encouraged programs to provide academic supports to participants (OFA 2015). HPOG 2.0 programs offered a range of academic and training supports and services to address participants' academic needs and to support training retention and completion. This section presents an overview of academic supports offered by HPOG 2.0 programs and participant take-up of these supports.

[102] See Appendix D, Table 5-3.

[103] See Appendix D, Table 5-4.

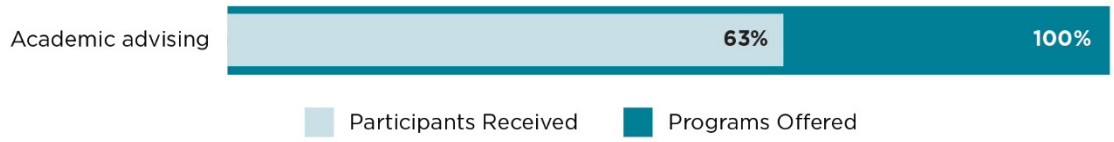
[104] See Appendix D, Table 5-5.

- **All programs offered academic advising, and nearly two-thirds of participants received it.**

All HPOG 2.0 programs offered academic advising services, including advising on course selection, graduation requirements, developing and tracking career goals in healthcare, and exam preparation for licenses and certifications (Exhibit 5-2).[105] All but one program offered advising on college entrance requirements or prerequisites.[106] Nearly two-thirds of participants received academic advising.[107]

> "Case managers and academic advisors work collaboratively to help participants successfully complete the program. Having an open line of communication allows case managers and academic advisors to understand participants' goals and needs."
>
> – HPOG 2.0 Program Staff

Exhibit 5-2: Academic Advising Services Offered and Received



Source: Program data: HPOG 2.0 2017 grantee interviews, Q 8.2. Participant data: PAGES; enrolled between September 30, 2015, and August 31, 2019; data through February 29, 2020.
N=38 programs, 28,077 participants
Missing=0 programs, 0 participants

- **Most programs offered peer support or mentoring activities, but few participants received them.**

Mentoring and peer support activities are intended to foster social connections between students and their peers, as well as between students and their instructional and program staff. Most programs offered mentoring or peer support activities.[108] For example, to cultivate peer support, one program established student clubs of 10 to 15 HPOG 2.0 participants at each training provider. Another arranged student alumni presentations for current participants. Though four-fifths of programs offered peer support activities and 71 percent offered mentoring activities, fewer than one-fifth of participants received them (Exhibit 5-3).[109]

[105] See Appendix D, Table 5-6.

[106] See Appendix D, Table 5-6.

[107] Grantee interview protocols defined academic advising broadly to include advice on course selection and assistance developing and tracking career goals in healthcare. PAGES defined academic advising as guidance for the selection of majors, programs of study, courses, and credentials.

[108] See Appendix D, Table 5-6.

[109] See Appendix D, Tables 5-6, 5-7.

Exhibit 5-3: Peer Support and Mentoring Activities Offered and Received

Source: Program data: HPOG 2.0 2017 grantee interviews, Q 8.3. Participant data: PAGES; enrolled between September 30, 2015, and August 31, 2019; data through February 29, 2020.
Note: Responses do not sum to 100 percent because multiple responses were permitted.
N=38 programs, 28,077 participants
Missing=0 programs, 0 participants

- **All programs offered training-related financial assistance (in addition to tuition assistance), and more than half of participants received it.**

HPOG 2.0 programs served low-income individuals so, as expected, all programs offered training-related financial assistance beyond tuition assistance to strengthen program retention and completion. All programs covered the cost of books; licensing and certification fees; examination preparation fees; and work uniforms, supplies and tools, directly and through referrals to partners and other community service agencies. Some two-thirds offered assistance with the costs of computers or other technology equipment. [110] Nearly three-fifths of participants received training-related financial assistance other than for tuition (Exhibit 5-4).[111]

> "… knowing that they'll take care of my tuition and my books are paid for, I normally don't worry as much as I would if I didn't have it taken care of. It kind of motivates me to do better because they are paying for me to go to school and paying for the things I NEED to go to schools [sic], so why not just do what I need to do to get it done when I have the opportunity to GET it done."
>
> – HPOG 2.0 Participant

[110] See Appendix D, Table 5-6. HPOG 2.0 programs were statutorily prohibited from using grant funds to make cash payments directly to participants.

[111] See Appendix D, Table 5-7.

Exhibit 5-4: Training-Related Financial Assistance (other than tuition) Offered and Received

Source: Program data: HPOG 2.0 2017 grantee interviews, Q 8.8. Participant data: PAGES; enrolled between September 30, 2015, and August 31, 2019; data through February 29, 2020.
N=38 programs, 28,077 participants
Missing=0 programs, 0 participants

5.3 Personal and Logistical Support Services

> "You know if I didn't have my car, I couldn't go to the class. So, by her fixing my car, I continued my class. If I didn't go to class, I wouldn't be having the [job] interviews I have."
>
> – HPOG 2.0 Program Participant

Many participants with non-traditional education paths, face personal and family problems that affect their academic performance and attendance (Estrada 2010). Ongoing assistance with personal needs helps students enroll in school and finish their studies (Hinckley and Hull 2009; Stephens 2009). HPOG 2.0 programs offered personal and logistical supports to help participants overcome life situations that may interfere with training retention and completion. These support services included financial assistance for child care and transportation, emergency assistance, non-emergency food assistance, and housing assistance.[112] At intake, almost a quarter of participants reported that transportation was sometimes, fairly often, or often a barrier to work or study; and more than one-fifth reported that child care arrangements were a barrier. According to some program staff, personal and logistical support services improved participants' training participation and retention outcomes. Transportation and child care assistance were reported by some program staff as particularly beneficial. While programs reported offering various support services, they were not asked to qualify the frequency or intensity of services offered. This section presents an overview of personal and logistical supports offered by HPOG 2.0 programs and participant take-up of these supports.

- **All programs offered personal and logistical support services, including transportation and child care assistance; and about half of participants received at least one personal or logistical support.**

> "Every month you go to her [case manager] and she listens to everything, asks how everything's going. For example, I needed help with my mortgage. I didn't know my school had that program where they would help you pay your bills. So she took me right down to their office. Just anything you need, she'll help you with. She's really great."
>
> – HPOG 2.0 Program Participant

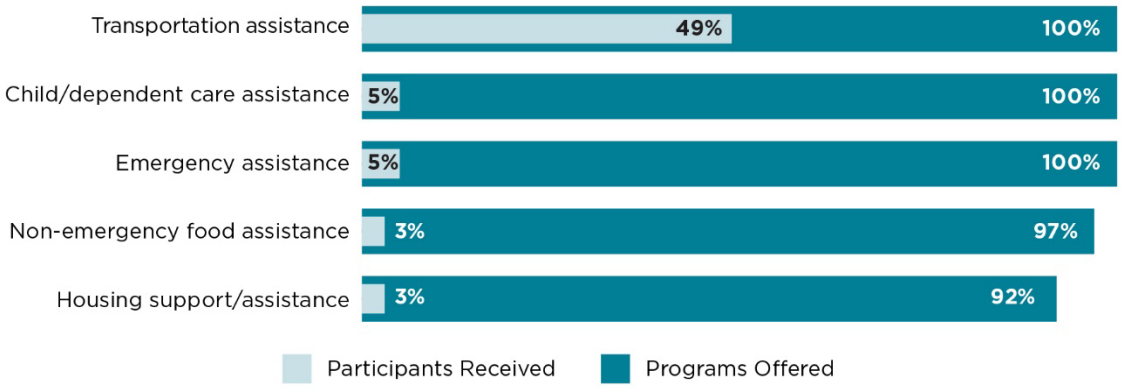
All programs offered assistance for transportation needs and child care or dependent care (Exhibit 5-5).[113] Nearly all offered emergency assistance, non-emergency food assistance, and housing assistance, either directly or through partners or referrals to other agencies. Slightly more than half of HPOG 2.0

[112] See Appendix D, Table 5-8.

[113] See Appendix D, Table 5-8.

participants received at least one type of personal or logistical support. Transportation assistance was most common, with nearly half of all participants receiving it. Very few participants received other personal and logistical supports.[114]

Exhibit 5-5: Personal and Logistical Supports Offered and Received



Source: Program data: HPOG 2.0 2017 grantee interviews, Q 8.7. Participant data: PAGES; enrolled between September 30, 2015, and August 31, 2019; data through February 29, 2020.
Note: Responses do not sum to 100 percent because multiple responses were permitted.
N=38 programs, 28,077 participants
Missing=0 programs, 0 participants

Staff at some programs identified challenges to providing these services, with the most common being limited funds and limited staff capacity in the local community to provide supports; inadequate public transportation in rural areas; shortage of child-care providers; lack of affordable housing and food resources; administrative red tape causing delays; and the need for consistent yet flexible procedures tailored to individual needs. Insights from participant interviews indicate similar challenges in accessing these support services (Thomas et al. 2022).

> "Transportation can also be a challenge for participants who have classes scheduled after public transportation stops running. Some participants can get to the class using public transportation, but have difficulties getting home. In some service areas, public buses stop operating at 8pm. In [name of training location], the public bus systems stop running at 6pm. The participants have difficulty getting home unless they catch a ride with someone."
>
> – HPOG 2.0 Program Staff

5.4 Employment Support Services

Given HPOG 2.0's policy goal to help participants obtain employment in a healthcare job with a career path, employment supports are often necessary to help workers with low incomes and low skills navigate a complicated and rapidly changing job market (Choitz, Soares, and Pleasants 2010).

[114] See Appendix D, Table 5-9.

These services also help participants with little employment experience develop needed job search and application skills (Hinckley and Hull 2009). HPOG 2.0 programs offered a range of employment assistance and retention services intended to help participants find and retain jobs in healthcare. Employment assistance services included job search skill development, counseling and support to help participants find suitable healthcare occupations with a career path, hosting or referrals to job fairs, and identifying job openings.[115] Retention services focused on engaging with employed HPOG 2.0 program participants and/or their employers to support job retention. This section discusses employment support services offered by HPOG 2.0 programs and participant take-up of these supports.

> "Some students may not be very motivated to look for employment even after they complete their healthcare training. The program provides the push that they need by setting up meetings with the career coach to go through work readiness skills, such as interviewing, or resume and cover-letter building. This gives participants the skills and confidence to search for employment after graduation."
>
> – HPOG 2.0 Program Staff

- **All HPOG 2.0 programs offered job search assistance and job placement services, and most offered job retention services; but only one-third of participants received employment support services.**

All programs offered job search assistance to help participants obtain employment in healthcare. Job search assistance was the most commonly received employment assistance support—one-quarter of HPOG 2.0 participants received job search assistance (Exhibit 5-6).[116] All programs made available job placement services to participants.[117] About one-fifth of participants received job placement assistance.

> "Dealing with mostly immigrant and refugee women who are scared to death, [I] will do whatever I can to sit them down and make them feel comfortable, less vulnerable going into job search."
>
> – HPOG 2.0 Program Staff

Though fewer than a third of participants received job search assistance or job placement services, results from analysis in the HPOG 2.0 Short-Term Impact Evaluation suggest that HPOG 2.0 increased receipt of career counseling and job search or placement assistance.[118] [119]

[115] See Appendix D, Table 5-10.

[116] See Appendix D, Tables 5-10, 5-11.

[117] See Appendix D, Table 5-10.

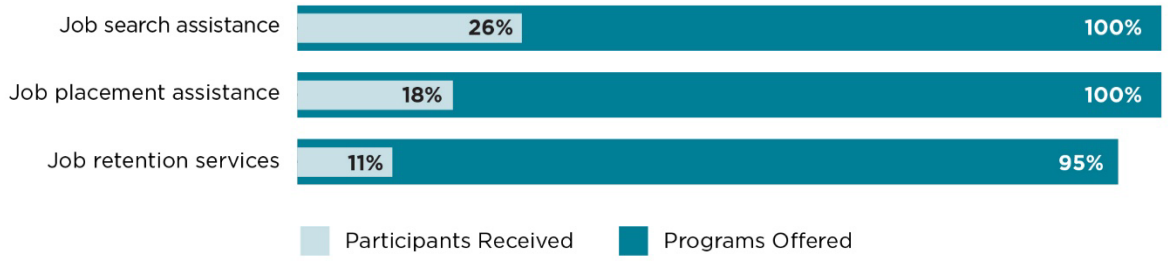
[118] See Appendix D, Table 5-11.

[119] The proportion of treatment group participants receiving these services was 6 percentage points higher than the corresponding portion of control group participants (Klerman et al. 2022).

Most HPOG 2.0 programs offered job retention services. Programs used multiple modes of communication to follow up with participants after they were hired, including phone and email check-ins and in-person meetings.[120] Other services included checking in with participants' supervisors, hosting group events for program graduates, and using social media to connect with participants and employers. Of employment support services offered, job retention services were the least used, received by only 11 percent of participants.[121]

> "Check-ins with participants are very effective. When we have a relationship with their supervisor that can be an important link for job retention because we can communicate with their supervisor one-on-one if there is an issue and try to troubleshoot it before a participant loses their job."
>
> – HPOG 2.0 Program Staff

Exhibit 5-6: Employment Support Services Offered and Received



Source: Program data: HPOG 2.0 2017 grantee interviews, Q 8.1. Participant data: PAGES; enrolled between September 30, 2015, and August 31, 2019; data through February 29, 2020.
Note: Responses do not sum to 100 percent because multiple responses were permitted.
N=38 programs, 28,077 participants
Missing=0 programs, 0 participants

- **Program operators relied most often on case managers and job developers to provide job search, job placement, and job retention services.**

Where programs provided employment assistance services directly to participants, about half used job developers or case managers to perform these functions.[122] Academic advisors and other program staff offered these supports less frequently, helping participants with job search in about one-third of programs and supporting job placement in about one-quarter of programs.

5.5 Role of Programs and Partners in Offering Support Services

Program operators offered most support services directly but also used local partners and other community agencies to provide these services. As described in Chapter 2, the type and number of partners used varied by the type of program operator (e.g., higher education institution, government agency, and workforce system agency).

[120] See Appendix D, Table 5-10.

[121] See Appendix D, Table 5-11.

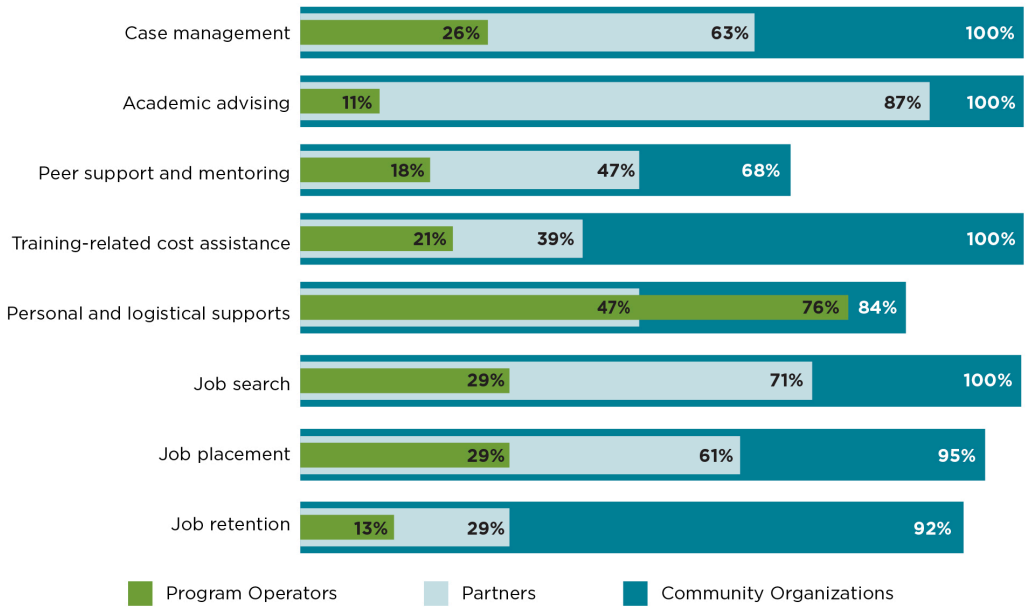
[122] See Appendix D, Table 5-5.

- **All HPOG 2.0 program operators offered support services directly to participants. Partners played a large role in offering academic advising and employment assistance. Most programs referred participants to community service agencies for personal and logistical supports.**

HPOG 2.0 program operators most often offered support services directly to participants (Exhibit 5-7).[123] All program operators offered case management and counseling, academic advising, training-related financial assistance and job search assistance. Nearly all program operators directly offered job placement and retention services, and most offered personal and logistical supports, peer support, and mentoring directly.

Exhibit 5-7: Role of Program Operators and Partners in Offering Support Services

Percentage of Programs



Source: HPOG 2.0 2017 grantee interviews, Q 8.1, Q 8.3, Q 8.7, Q 8.8, Q 8.12, Q 8.13
Note: Responses do not sum to 100 percent because multiple responses were permitted.
N=38 programs
Missing=0 programs

After program operators, partners were most likely to offer support services such as job search and academic advising. Nearly 90 percent of programs had partners that offered job search, and the same is true for academic advising.

[123] See Appendix D, Table 5-12.

Unlike for other support services, such as case management or academic advising, most programs referred participants to community organizations for personal and logistical support services. Most commonly programs referred participants to these organizations for housing and emergency assistance (about three-quarters of programs), non-emergency food assistance (71% of programs), and child/dependent care assistance (61% of programs).[124]

The next chapter discusses how HPOG 2.0 programs adapted to an additional year of funding.

[124] See Appendix D, Table 5-8.

6. Program Adaptations to a Changing Environment

Chapter 6 Key Findings

- During the Year 5 grant extension, most programs emphasized short-term training courses, connected participants to other funding opportunities, and focused on training retention and employment assistance.

By the end of Year 3 of the grant period:

- Personal/logistical and academic supports were at the highest risk of being reduced when the HPOG 2.0 grant ended.
- Almost half of programs had made plans for program sustainability, and about half of these programs had started to put their plans into action.
- Many programs reported that they would strengthen and maintain their partnerships or look for new partners to sustain the HPOG program, and many were looking for additional grants and funding.
- Most programs were optimistic about future funding and sustainability.

As HPOG 2.0 programs were nearing the end of their five-year grant cycle and starting to think about how best to sustain their training programs, they experienced two significant events. First, in March 2020, staff were forced to quickly adapt their programs due to the COVID-19 pandemic. Second, grantees were given an additional year of funding, allowing them to continue delivering services through September 2021.[125] This chapter summarizes the service delivery changes programs adopted during the Year 5 Grant Extension. The chapter concludes with program staff's description of ways to sustain training and services after the grant period ended. A separate brief describes program implementation adaptations during the first 10 months of the COVID-19 pandemic (Roy et al. 2022).

6.1 Changes to Service Delivery due to the Year 5 Grant Extension

In late February 2020, ACF invited all HPOG 2.0 grantees to prepare applications for another year of program funding – extending activities from September 2020 through September 2021. Before ACF's announcement, grantees had started ramping down their enrollment activities or their support for longer trainings. By late spring 2020, all grantees were notified of their extensions, and awardees were expected to continue their programs at current levels of service and support.

- **Most programs did not enroll participants in long training courses during the extension year.**

HPOG 2.0 programs did not make significant changes to service delivery during the extension year. Most programs, however, focused on marketing only short healthcare certification programs to give participants the opportunity to complete their training before the extension period ended. One program focused on enrollment for Nursing Assistant training courses and

[125] The Year 5 grant extension occurred during the COVID-19 pandemic. Program adaptations, including changes to service delivery, in response to the Year 5 grant extension and the COVID-19 pandemic are difficult to untangle.

another on short term training courses, such as Nursing Assistant, Community Health Worker, or Phlebotomist, to meet area demand and to ensure participants had access to HPOG 2.0 support services until they completed their training.

- **Some programs connected participants to other funding opportunities in the community.**

Some programs continued to enroll participants in training courses that would extend beyond the grant period. These programs created pathways for participants to transition to other funding opportunities in the community, such as the Workforce Innovation and Opportunity Act (WIOA) and other grants. For participants enrolled in longer trainings, such as for LPN and RN, one HPOG 2.0 program hosted a financial aid workshop to help students apply for financial aid and other scholarship opportunities to fund their training after grant funding expired. The extension period overlapped with the COVID-19 pandemic, so programs maximized providing wrap-around supports to existing participants to help them weather the pandemic. Often programs combined HPOG funding with funding from the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act available in their communities.

- **Some programs shifted focus from outreach and enrollment to training retention and employment assistance.**

Some programs invested more resources in training retention and job search assistance during the grant extension. Programs also emphasized job search, job placement, and other employment assistance supports to ensure participants were placed in employment after completing their training and before the end of the grant period.

6.2 Program Sustainability

Given the size and flexibility of HPOG 2.0 funding and the large number of participants being served, HPOG 2.0 programs found it challenging to find ways to sustain training and services after the grant period ended. Grantees needed to find support from other resources and institutional partners. If that alternative funding was less generous or flexible than their HPOG grant, then programs needed to decide which activities to continue and which to terminate.

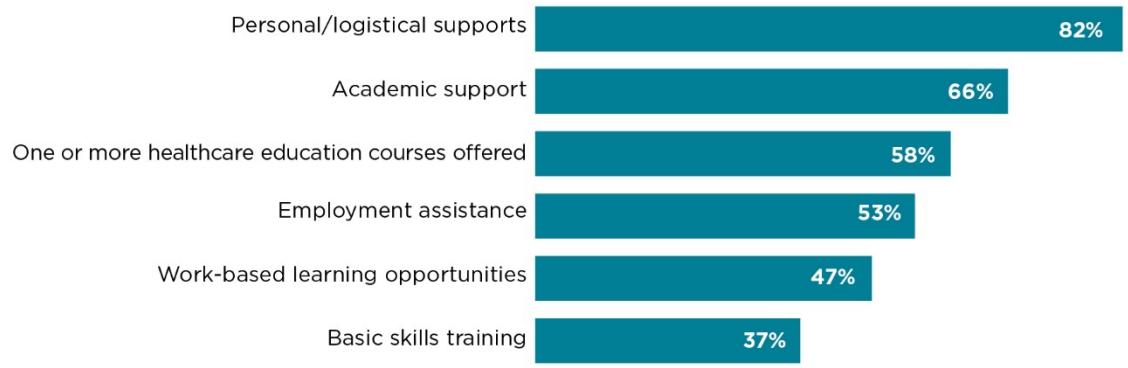
With this in mind, ACF had encouraged HPOG 2.0 programs to “think about sustainability of programming beginning in the first year…[including] how existing programs such as TANF or WIOA-funded programs can be leveraged to sustain practices found to be effective” (OFA 2015). The FOA also encouraged HPOG 2.0 programs to “use business planning tools and engage with employers to explore innovative approaches to sustaining practices that meet the needs of industry” (OFA 2015).

- **Among program services, participant supports were most at risk of being reduced after the HPOG 2.0 grant ended.**

Program staff reported that support services were most at risk of being reduced absent new funding after the HPOG 2.0 grant ended (Exhibit 6-1).[126] More than 80 percent of programs cited personal and logistical supports and two-thirds of programs cited academic supports. More than half of programs reported healthcare occupational trainings and employment assistance were at risk.

Exhibit 6-1: Program Services at Risk of Being Reduced

Percentage of Programs



Source: HPOG 2.0 2017 grantee interviews, Q 8.2
Note: Responses do not sum to 100 percent because multiple responses were permitted.
N=38 programs
Missing=0 programs

- **Almost half of HPOG 2.0 programs had plans for sustainability after the grant ended, and about half of those programs had begun to implement those plans by 2017.**

Early in their five-year grant, some programs had already started making plans for sustainability and were optimistic about their future at the time of data collection in Year 2. Of the 45 percent of programs that reported they had plans for program sustainability[127] when their HPOG 2.0 grant ended, about half had put these plans into action in Year 2.[128] Some programs had reached out to partners to join them in finding and securing other funding. About a third of all programs had assigned staff or hired a consultant to pursue potential future funding or other support.[129]

[126] See Appendix D, Table 6-1.

[127] HPOG 2.0 2017 grantee interviews, Q 8.3a.

[128] HPOG 2.0 2017 grantee interviews, Q 8.3b.

[129] HPOG 2.0 2017 grantee interviews, Q 8.4.

HPOG 2.0 program staff reported their early efforts towards achieving program sustainability included strengthening and maintaining current partnerships or looking for new partners.[130] Program staff also reported looking for additional grants and funding.

Advice from the Field: Three HPOG 2.0 Programs Share Their Strategies for Program Sustainability

Grantees were just beginning sustainability planning at the time data were collected in Year 2 of the five-year grant. The strategies they were using represented what grantees believed at that point would help them sustain HPOG 2.0 programming, which may have changed as they approached the grant's end or they moved into the post-grant period. During site visits focused on program sustainability, three HPOG 2.0 programs shared their early plans for sustaining their HPOG 2.0 activities.

Even these programs—selected for further study because they were working aggressively on sustainability—were finding it challenging to identify alternative sources that offered funding levels and flexibility comparable to HPOG 2.0's. Each of the programs interviewed reported that even if some funding were identified, they would likely need to choose which activities to continue and at what scale.

These HPOG 2.0 programs were using four promising strategies to support their sustainability efforts:

- plan early for sustainability;
- strengthen partnerships that will persist beyond the grant;
- gain recognition for the value of training provided through HPOG 2.0; and
- identify and institutionalize promising components of HPOG 2.0.

The next chapter summarizes the findings of this report and discusses implications for the field.

[130] HPOG 2.0 2017 grantee interviews, Q 8.5.

7. Discussion

The HPOG 2.0 National Evaluation's Implementation Study contributes to the field's collective knowledge about sector-based and career pathways programs. This *Implementation Study Report* is one of a series of publications documenting findings and insights from the HPOG 2.0 National Evaluation. It presents findings on the HPOG 2.0 context and administration; participant characteristics; and operations of the programs implemented by HPOG 2.0 grantees. This chapter summarizes the findings of this report and discusses implications for the field.

7.1 Summary

Like their earlier HPOG 1.0 counterparts, the 38 non-Tribal HPOG 2.0 programs aimed to offer education and training to TANF recipients and other low-income adults for occupations in the healthcare field that pay well and are expected to either experience labor shortages or be in high demand (OFA 2015). Grantees designed and implemented programs to provide eligible applicants with education, training, and support services to help them prepare for and find jobs in a variety of healthcare professions. Overall, programs incorporated key features of the career pathways framework, providing a robust test of the HPOG 2.0's theory of change.

Participant receipt of services varied considerably. Available data for this report do not allow us to determine why such variation is the case. It is unknown whether programs offered all services to all participants or were intentionally or unintentionally selective when offering services. It could also be that participants simply chose to take up particular program offerings at different rates.

This report provides important context for companion reports documenting programmatic and participant outcomes and assessing the short-, intermediate-, and long-term impacts of the HPOG 2.0 funding stream on participants' educational progress and earnings, among other participant outcomes.

7.1.1 Program Design and Implementation

HPOG 2.0 programs were most frequently operated by higher education institutions. Others were operated by government agencies and workforce system agencies. Program operators were not expected to provide all services directly, and they partnered with many agencies and organizations in their communities. They also engaged employers, particularly around helping participants find jobs.

Programs found referrals from partner agencies, social media, and community events to be most successful for recruiting participants. Eligibility criteria varied by program, and fewer than half of programs had academic requirements. Most included criminal background checks, but all programs accepted otherwise eligible applicants with misdemeanors in their records.

Consistent with the FOA's emphasis on helping participants improve their basic skills, all programs offered basic skills education. Healthcare occupational training is the heart of HPOG. The most commonly offered training course was the entry-level Nursing Assistant training. Consistent with ACF's directive to develop clearly articulated career pathways, most programs

offered training courses that conveyed stackable credentials within a pathway. All programs also offered other skill-development activities as emphasized in the FOA, including work-readiness, digital literacy, college readiness, and CPR training.

Comprehensive support services were a key component of the HPOG model as envisioned by ACF. Programs offered case management and counseling services, as well as academic advising and training related financial assistance. Programs also consistently reported they offered personal and logistical supports such as child and dependent care assistance and transportation assistance.

7.1.2 HPOG 2.0 Participants

Consistent with requirements in the FOA, HPOG 2.0 programs served adults with low incomes; at intake, many were living in households receiving a public benefit. Most participants were not enrolled in school or training at program intake, aligned with ACF's goal to serve those who might otherwise not have access to training.

7.1.3 Participant Take-up of Program Activities, Training Courses, and Support Services

Local programs made available program activities, healthcare occupational training, and support services consistent with the HPOG logic model. Participant take-up or receipt of these varied considerably, however. For example, all programs offered skill-development activities such as work readiness, digital literacy, and college readiness training, but only about half of participants engaged in skill-development activities. Similarly, almost all programs offered training courses within an occupational career pathway. Most training received, however, was for entry-level occupations that resulted in small incremental increases in hourly wages. There is little evidence that participants returned for higher-level follow-on training.

Nearly all HPOG 2.0 participants received case management and counseling services, but take-up was lower for support services such as academic advising, training-related financial assistance, and employment supports. Most notably, though all programs offered personal and logistical supports, fewer than half of participants received transportation assistance and only 5 percent received child or dependent care assistance through HPOG despite 61 percent of participants having at least one dependent child at baseline. HPOG child care assistance needed to be from a State approved and licensed provider. Interviews with HPOG 2.0 participants indicated that many service areas had limited options with long wait lists; many did not have child care options for students working "nontraditional" hours. Some participants already had child care for which HPOG could not pay (i.e., with family, friends, or non-licensed providers). These insights help explain the low take-up rates and participant reports of problems getting child care assistance (Thomas et al. 2022).

This report summarizes what basic skills education, healthcare occupational training, and support services programs reported as included in their HPOG 2.0 programs and the percentage of participants receiving them. It does not capture how many participants were provided the opportunity to partake in a service or training course. As noted earlier, the HPOG 2.0 Short-Term Impact Evaluation reports that "HPOG 2.0 moderately increases starting

training" (Klerman et al. 2022). Participant receipt of services and participation in training are examined further in the Outcomes Study.

7.2 Implications for the Field

Career pathways is a well-established and widely adopted strategy to deliver education and training to individuals with low incomes. Though HPOG 2.0 does not provide a single, specific model for replication, it does provide examples of the types of education, training, and academic and logistical supports needed to help TANF recipients and other adults with low incomes access and complete occupational training in healthcare.

The most widely available training through HPOG 2.0 was Nursing Assistant, which lasts only a few weeks and has the potential to provide immediate employment in the long-term care and acute care sectors. Similarly short, Home Health Aide training provides participants with the opportunity to participate in one of the fastest growing healthcare occupations in the United States (BLS 2021). These occupations, however, do not pay well, and the workplaces where nursing assistants and home health aides are initially employed provide limited opportunities for career progress. Based on analysis results from the HPOG 2.0 Short-Term Impact Evaluation (about 15 months after random assignment), these types of entry-level healthcare occupations do not serve as gateways to a broad array of better-paying, higher-skilled jobs in healthcare professions.

All local HPOG 2.0 programs described providing program participants with referrals to child care assistance. Although about one-fifth of HPOG 2.0 participants cite child care as a barrier to training, the low participant take-up of child care assistance might be due to limited availability with long wait lists or lack of options for students working nontraditional hours. This is consistent with research for parents that work nontraditional hours (Schilder et al. 2022).

Though HPOG 2.0 grantees were tasked with training participants for jobs that pay well, grantees also had aggressive enrollment targets. Working within the resource constraints of the HPOG 2.0 grant and limited outside funding, programs had to balance serving more participants (including meeting enrollment goals) and investing more resources in fewer participants to support them through longer-term training. This may have contributed to participants being trained for low-paying entry-level jobs largely not returning for higher level training. Policymakers should consider the inherent tension between these trade-offs when setting goals for similar programs in the future.

Appendix A: The HPOG Research and Evaluation Portfolio

ACF's Office of Planning, Research, and Evaluation (OPRE) is using a multipronged research and evaluation strategy to assess the implementation, outcomes, and impacts of two rounds of HPOG awards.

HPOG First Round (HPOG 1.0)

HPOG Implementation and Outcomes Research. For the first round of HPOG funding, ACF awarded five-year grants in 2010, with 18 grantees receiving extensions into 2016. A research team oversaw development and operation of a management information system called the Performance Reporting System (PRS) used by all grantees. The team also conducted implementation and outcomes research for the 27 non-Tribal grants:

- The descriptive implementation and outcomes report is available here: https://www.acf.hhs.gov/sites/default/files/opre/final_nie_di_and_outcome_study_report_clean_b508.pdf.
- The systems change analysis is available here: https://www.acf.hhs.gov/opre/resource/systems-change-under-the-health-profession-opportunity-grants-program.
- The final report on the implementation research is available here: https://www.acf.hhs.gov/opre/resource/final-report-national-implementation-evaluation-of-the-first-round-health-profession-opportunity-grants-hpog-10.

OPRE also sponsored the **Evaluation of Tribal HPOG**, an implementation and outcomes study of the five Tribal grants. The final report is available here: https://www.acf.hhs.gov/opre/resource/tribal-health-profession-opportunity-grants-hpog-program-evaluation-final-report.

HPOG 1.0 Impact Study. For 23 of the 27 first-round non-Tribal grants, the research team conducted an experimental study—the HPOG 1.0 Impact Study—to assess the impacts of the HPOG intervention. Local HPOG programs randomly assigned eligible applicants to a "treatment" group that could access HPOG or a "control" group that could not. Three of the 23 HPOG grantees are also participating in another OPRE-sponsored evaluation of career pathways programs begun in 2007, Pathways for Advancing Careers and Education (PACE).

- The *Health Profession Opportunity Grants (HPOG 1.0) Impact Study Interim Report* assesses short-term outcomes for the treatment and control groups based on follow-up surveys initiated about **15 months** after study entry and on administrative data on employment and earnings. It also draws on the implementation research results for the 23 grantees and site visits conducted specifically for the Impact Study. The report is available here: https://www.acf.hhs.gov/opre/resource/health-profession-opportunity-grants-hpog-10-impact-study-interim-report-implementation-short-term-impacts.
- The *Health Profession Opportunity Grants (HPOG 1.0) Impact Study Three-Year Impacts Report* shares impacts from administrative data and follow-up surveys initiated approximately **three years** after study entry. The report was produced as part of the Career Pathways Intermediate Outcomes Study, which is continuing to follow HPOG Impact Study and PACE project participants. The report is available here: https://www.acf.hhs.gov/opre/resource/health-profession-opportunity-grants-hpog-10-impact-study-three-year-impacts-report.
- The *Health Profession Opportunity Grants (HPOG 1.0) Impact Study Six-Year Impacts Report* shares impacts from administrative data and follow-up surveys initiated approximately **six years** after study entry. The report was produced as part of the Career Pathways Long-term Outcomes Study, which continued to follow HPOG Impact Study and PACE project participants. The report is available here: https://www.acf.hhs.gov/opre/report/health-profession-opportunity-grants-hpog-10-impact-study-six-year-impacts-report

- The research team is continuing to document longer-term outcomes for HPOG Impact Study and PACE project participants and will describe outcomes approximately **10 years** (pending additional funding) after study entry for HPOG 1.0 and PACE programs. More information is available here: https://www.acf.hhs.gov/opre/project/career-pathways.
- Program-level reports on the implementation and early impacts of each of the nine programs in the PACE project are available here: https://www.acf.hhs.gov/opre/research/project/pathways-for-advancing-careers-and-education.

HPOG Second Round (HPOG 2.0)

In 2015, ACF awarded a second round of five-year HPOG grants (HPOG 2.0) to 32 organizations in 21 states; five are Tribal organizations and 27 non-Tribal. HPOG 2.0 was extended an additional 12 months, ending September 2021. ACF also awarded an evaluation contract for **The National and Tribal Evaluation of the 2nd Generation of Health Profession Opportunity Grants (HPOG 2.0)**.

Like the HPOG 1.0 evaluation, the research team oversaw development of a management information system used by all grantees. The HPOG 2.0 system was known as the Participant Accomplishment and Grant Evaluation System (PAGES). The system was used for program management and performance monitoring, and to record grantee and participant data for use in HPOG 2.0 evaluations.

The **HPOG 2.0 National Evaluation** of the non-Tribal grantees uses follow-up survey, PAGES data, and other administrative data to assess outcomes for new study members who apply to the second-round programs.

- **HPOG 2.0 Impact Evaluation.** The 27 non-Tribal HPOG 2.0 grantees, operating 38 local programs, participated in an experimental study to assess the impacts of HPOG 2.0. Local HPOG programs randomly assigned eligible applicants to a "treatment" group that can access HPOG 2.0 or a "control" group that could not. The study randomized more than 52,000 study members by the end of the program in 2021. All study members completed a survey upon entering the study. The evaluation is assessing short-term impacts (about 15 months after study entry), intermediate-term impacts (about 36 months after study entry), and longer-term impacts (about 66 months after study entry). The evaluation is also assessing the effectiveness of the HPOG 2.0 Program before and after the COVID pandemic through a 15-month follow-up survey of participants who enrolled in HPOG 2.0 after the onset of the pandemic.

In addition to the impact evaluation, OPRE also is sponsoring a descriptive evaluation and cost-benefit analysis of the non-Tribal HPOG 2.0 grants:

- **HPOG 2.0 Descriptive Evaluation.** The research team is conducting implementation, outcomes, and systems studies of the 27 non-Tribal HPOG 2.0 grantees. The evaluation is exploring how the HPOG 2.0 local programs are implemented across grantees (Implementation Study), what individual-level outcomes and outputs occur (Outcomes Study), and how HPOG influences service delivery systems (Systems Study).
- **HPOG 2.0 Cost-Benefit Analysis.** The 27 non-Tribal HPOG 2.0 grantees are participating in a cost-benefit analysis that will compare the estimated costs of operating the average HPOG 2.0 program to the monetized value of benefits produced.

The **HPOG 2.0 Tribal Evaluation** included a separate implementation and outcomes evaluation of the five Tribal grants.

- The final report of the evaluation is available here: https://www.acf.hhs.gov/opre/report/tribal-health-profession-opportunity-grants-hpog-20-evaluation-final-report.

For More Information on All of These Research Activities

https://www.acf.hhs.gov/opre/project/career-pathways

Appendix B: Data Sources, Methods, and Analysis

The Implementation Study is one of three studies under the HPOG 2.0 National Evaluation's Descriptive Evaluation. Findings from its other two studies, the Outcomes Study and the Systems Study, are presented in separate reports. The Descriptive Evaluation's *Design Report* (see Werner, Koralek, et al. 2018) and *Analysis Plan* (see Werner et al. 2019) provide more detail.

The Descriptive Evaluation studies present descriptive findings only. They do not analyze causal relationships or estimate impacts. HPOG 2.0 Program impacts and their monetized value are estimated by the National Evaluation's Impact Evaluation and its Cost-Benefit Analysis, respectively.

B.1 Data Sources

The Implementation Study relied on multiple data sources—some data collected by and for this effort ("primary" data) and others existing independent of this effort ("secondary" data).

Primary data sources for the Implementation Study covering *all* non-Tribal grantees are:

- Grantee and partner telephone interviews
- Participant Accomplishment and Grant Evaluation System (PAGES)

Primary data sources for the Implementation Study covering a *select sample* of grantees are:

- Site visits to programs implementing innovative and/or promising strategies in the areas of basic skills training, work-readiness training, career pathway training opportunities, employer engagement, and sustainability.
- In-depth interviews with program participants to gain insights into the motivations, decision making, expectations, and experiences of HPOG 2.0 Program participants.[131]

Secondary data sources for the Implementation Study are:

- Evaluation Design and Implementation Plans (EDIPs), which describe in detail how grantees planned to integrate the National Evaluation's Impact Evaluation into their local HPOG 2.0 programs' operations. EDIPs also include summary information about program target populations, recruitment, and intake, as well as control conditions.
- Site monitoring notes prepared by the study team based on our ongoing contact with grantee staff, which describe program changes and issues. These notes also capture

[131] Findings from these interviews are primarily presented in a separate series of summary briefs. For additional information about how the in-depth participant interviews were designed and conducted, see https://www.acf.hhs.gov/opre/resource/participant-perspectives-hpog-20-design-report-in-depth-interviews-hpog-20-program-participants.

grantees' implementation adaptations during the COVID-19 pandemic and their experiences during the Year 5 Supplement and Extension.[132]

- Grant applications, which provide some institutional background as well as the grantee's objectives and rationale for a grant award.
- Performance Progress Reports (PPRs), which use PAGES data to compare outcomes against quantitative performance goals for each grantee and provide narrative descriptions from grantees of their programs.
- U.S. Bureau of Labor Statistics data on healthcare employment and wages, which are used for information on local labor markets in the healthcare industry.

Details about each data source are presented below.

B.1.1 Primary Data Sources

Primary data sources used in this study are described below.

Grantee and Partner Telephone Interviews

The research team conducted two rounds of telephone interviews with HPOG 2.0 program representatives and key partners that provided training courses or support services. Interviews were conducted with an average of six staff per program. The first round of interviews was conducted in 2017, when programs were in their second year of HPOG 2.0 operations. The second round of interviews was conducted in 2019, when programs were in their fourth year of HPOG 2.0 operations. These documented changes since the first round of telephone interviews. Because both rounds of interviews occurred prior to early 2020, results do not take into account the COVID pandemic period or the extension year.

The interviews were designed to collect comprehensive and comparable data across all non-Tribal HPOG 2.0 programs using primarily closed-form questions. Data gathered include contextual factors; program components, including application and enrollment; healthcare education and training activities; support services; employment assistance; and sustainability. These domains covered by the grantee and partner telephone interviews are:

- **Contextual Factors**
  - Grantee perceptions of local healthcare labor market and high-demand jobs
  - Program administration, including use of other agency services and contracted service providers
  - Grant expenditures
- **HPOG 2.0 Program Outreach, Application, and Enrollment**
  - Outreach and recruitment
  - Eligibility and intake

[132] The primary data sources did not collect data during this time frame. Site monitoring notes were a key source of information about program implementation and programs' responses to the pandemic during this period.

  - Application process
- **HPOG 2.0 Program Healthcare Education and Training Activities**
  - Basic skills education
  - Healthcare occupational training
  - Training in a career pathways framework
  - Work-readiness training
- **HPOG 2.0 Program Support Services**
  - Case management
  - Academic, personal/logistical, and financial supports
  - Employment assistance and work-based learning opportunities
- **Employer Connections**
- **HPOG 2.0 Program Sustainability**
  - Sustainability efforts

Participant Accomplishment and Grant Evaluation System (PAGES)

PAGES is a web-based management information system developed for the HPOG 2.0 Program and evaluation. PAGES was designed to serve two related purposes: (1) as an information system for program management and performance monitoring; and (2) as a source of data for research purposes. PAGES is the primary source of data on the characteristics of program participants, as well as a record of their participation in HPOG 2.0 program activities and services and their outputs and outcomes. Because PAGES was in operation since the beginning of HPOG 2.0, it contains data for all HPOG 2.0 participants. PAGES information used by the Implementation Study included participant receipt of services as well as grantee program offerings. The Implementation Study analyzed PAGES data only for participants who provided consent for their data to be used. This includes participants who were eligible for HPOG 2.0 and applied to the program, but were exempt from random assignment for several reasons including prior participation in HPOG 1.0, grantee use of wild cards (i.e., under certain conditions, grantees allowed a very limited number of applicants to bypass randomization and automatically receive the offer of an HPOG slot), or specific programmatic exemptions.

At time of application and before random assignment, programs gathered information from program applicants on a range of socioeconomic and demographic characteristics. As participants assigned to the treatment group[133] enrolled in HPOG, engaged in program activities, and received services, grantee staff recorded their service receipt, outputs, and outcomes in individual-level records.

[133] As part of the HPOG 2.0 evaluation, individuals who consented to be part of the study were randomly assigned to a treatment group or control group. Treatment group members were offered access to the local HPOG program. Control group members were not offered access to the local HPOG program, but could access any other education, training, or services available in the community.

Though PAGES is primarily a participant-level database, it also contains some descriptive information about each grantee's organization and service delivery structure. Information collected includes vendors, service delivery sites for training, and the identity of case managers. It also captured information about program offerings: basic skills instruction and healthcare trainings and other activities and support services offered, including the length, hours or credit hours of training courses, and other characteristics of program offerings.

A limitation of PAGES is its reliance on data entry by multiple individual program staff across grantees. This could lead to inconsistencies or incompleteness in the data, which could vary across data elements and across HPOG programs. Quality control procedures and grantee training and support in using PAGES attempted to limit such issues. PAGES may provide more accurate data than some other administrative systems because ACF used the system to monitor grant performance. This use increased the incentive for grantees to make as complete and accurate as possible entries on specific performance outcomes such as training enrollment, training completion, and employment. Below is a summary of PAGES data the research team used for the Descriptive Evaluation.

PAGES data on participant activities used for this report covers the period from September 2015 through February 2020. As a result, these data are not affected by the COVID-19 pandemic.

- **Grantee and Program Information**
  - Grantee information (e.g., name, location, institutional type)
  - Local program/service delivery sites
  - Healthcare trainings offered
    - Healthcare training type (occupational code)
    - Training model (basic skills are integrated, blended learning model)
  - Basic skills and other skill-development activities offered
  - Support services offered
  - Provider (HPOG grantee or partner or referral)
- **Participant Information**
  - Characteristics at intake/enrollment
  - Demographic characteristics
  - Gender, age, race/ethnicity, marital status, parental status
  - Socioeconomic characteristics
    - Receipt of public assistance
    - Education level
    - Credential completion
    - School enrollment status
    - Employment status, wages, work hours
  - Record of basic skills and other skill-development activities
    - Type of activity
  - Record of healthcare training activities
    - Type of activity

    - Occupation code
- Record of work-based learning opportunities
    - Type of activity
- Record of support services
    - Academic support services
    - Personal/logistical support services
    - Employment support services

Focus Area Site Visits

We conducted site visits to 11 HPOG 2.0 programs implementing innovative and/or promising strategies in the five focus areas of interest: (1) employer engagement, (2) basic skills education, (3) work-readiness training, (4) career pathways training opportunities, and (5) program sustainability.[134]

Three HPOG 2.0 programs were selected for each focus area. Programs were purposively selected based on criteria specific to each topic based on information collected through telephone interviews with program staff, partners, and other informants and data from PAGES. Selected programs included a mix of new and returning programs, different institutional types (e.g., community-based organizations, community colleges, workforce development agencies), and geographic locations.

We conducted two-day site visits to each of the three selected programs between August and October 2018. Site visit teams used semi-structured protocols to interview program directors, grantee leadership, and staff; grant coordinators; directors or managers of workforce programs; and partners at local American Job Centers, TANF agencies, One-Stop Centers, and community colleges.

Two factors limit the generalizability of the findings from focus area site visits. First, the research team selected programs based on early outcomes collected from available data sources. Though informative, those data covered a period when HPOG 2.0 grantees were early in implementing their programs. Second, and most importantly, programs were selected based on specific criteria, such as high level of basic skills enrollment at the time of data collection. As such, those selected programs' inclusion in the focus area data collection does not provide evidence of program effectiveness or impact.

Participant In-Depth Interviews

To better understand participants' program experiences, including their motivations, decision making, and expectations, the research team conducted in-depth interviews with participants. We conducted one-on-one conversations of 1-2 hours each with a cross-sectional sample of participants recruited from among participants relatively new to the study (3 months post-intake) and more seasoned participants (9-12 months post-intake). Each interview covered some or all of the following topic areas:

[134] One program was excluded from the work-readiness analysis. During site visits it became apparent that its work readiness efforts were limited, and staff reported challenges implementing them.

- Why they chose the HPOG program and what else they considered.
- Why they chose certain occupations for training.
- Their thoughts about career ladders/pathways, including thoughts about their next steps after the training.
- How they are paying for training and living expenses.
- Experiences with case management (including personal, academic, employment).
- Challenges to participating in and completing the program.

Additional information about the in-depth participant interviews can be found in the *Participant Perspectives on HPOG 2.0: Design Report for In-Depth Interviews with HPOG 2.0 Program Participants* (see Thomas, Locke, and Klerman et al. 2019).

B.1.2 Secondary Data Sources

Secondary data sources used in this study are described below.

Evaluation Design and Implementation Plans (EDIPs)

For each program in the National Evaluation, site teams and program staff developed an Evaluation Design and Implementation Plan. The EDIPs have two major purposes: (1) to document the treatment and control conditions at the time random assignment began and to record any changes in those conditions over the observation period; and (2) to specify plans for implementing the study in the field (e.g., administering informed consent, collecting baseline information, conducting random assignment, maintaining the integrity of the evaluation's experimental design). The Implementation Study avoided duplication of effort in the grantee telephone interviews by relying on information already collected for the EDIPs. In some instances, however, the research team asked informants to confirm or clarify EDIP information during the telephone interviews.

EDIPs included the following information:

- Name of program and grantee organization.
- Marketing and recruitment strategies.
- Eligibility criteria and application process.
- Record of changes in program design and implementation over time.
- High-level account of control group conditions.

Site Monitoring Notes

The research team monitored program implementation through ongoing telephone calls with each program. We reviewed notes from these calls documenting program operations and service provision, adaptations to program implementation during the COVID-19 pandemic, and modifications to service delivery during the Year 5 grant extension period.

Grantee Applications

We reviewed grantee HPOG 2.0 applications for information on program rationale and local need, initial program goals for participation and outcomes, initial program design, initial budget request, and program partners.

Performance Progress Reports (PPR)

Each grantee submitted a Performance Progress Report (PPR) to ACF twice a year during the six-year grant period. In addition to grantees comparing outcomes against their quantitative performance goals, they provided narrative descriptions of their programs, including information about implementation, challenges they faced in meeting performance goals, and how they met those challenges. Though anecdotal, this information provided useful context for the Implementation Study.

U.S. Bureau of Labor Statistics data

The research team used secondary data on the grantees' operating environments, including the conditions that shape the local labor market, and ultimately, the demand for hiring HPOG program participants. Changes in the local economic environment can help explain participant outcomes, as well as help to put in context differences in program features or outcomes.

B.2 Methods

The methods used in this Implementation Study were informed by those used by Abt Associates and its research team for HPOG 1.0 (see Werner, Loprest, et al. 2018). This Implementation Study built from previous work in the HPOG 1.0 National Implementation Evaluation (NIE) but streamlined the NIE's approach to data collection. For HPOG 2.0, the analysis uses data collected through two rounds of telephone interviews with program staff and other informants, rather than through online surveys. The telephone interviews were structured similarly to the HPOG 1.0 online survey but allowed for more open-ended discussions.

Data from PAGES on participant characteristics and receipt of program services, training, and support services supplement these findings. Participant data from PAGES included those randomized between September 30, 2015 and August 31, 2019. The report presents healthcare education and training activities and support services that programs offered as part of HPOG 2.0, as well as the percentage of program participants actually enrolled in or receiving training or services. It does not, however, capture how many treatment group members were provided the opportunity to partake in a training course or service.

Data from case studies developed in each of the five focus areas described in Section A.1.1 provide insights from program operators, staff, and partners. In-depth interviews with program participants contribute insights into the motivations, decision making, expectations, and experiences of participants in grantees' HPOG 2.0 programs.

B.3 Analysis

This section provides an overview of the study's analysis approach. The primary unit of analysis for most Implementation Study measures is the local HPOG 2.0 program, defined as "a unique

set of services, training courses, and personnel." For some variables, notably contextual ones, both grantees and programs may be the analytic units.

The HPOG 2.0 program participant is the primary unit of analysis for measuring participant engagement in basic skills; healthcare training; other skills-development and work-based learning activities; and academic, personal/logistical, and employment support services. With respect to participant characteristics and engagement, the Implementation Study includes all participants with records created in PAGES through August 31, 2019 (the fourth year of the HPOG 2.0 demonstration). It includes data on these participants through February 29, 2020. Therefore, data on participant take-up of training and services do not overlap with the COVID-19 pandemic.

Most of the findings in this report are based on statistical tabulations or manipulations of closed-ended interview responses and administrative data. These data have important limitations when combined and interpreted as descriptions of the national HPOG 2.0 Program's design, implementation, and results. That is, the data generally report the number and proportion of grantee programs that include a specific program feature or characteristic (e.g., the availability of basic skills education) and some information about how that program feature or characteristic may have been locally designed and implemented (e.g., whether it was offered as a stand-alone component or integrated into healthcare training). The data do not specify whether particular training courses or services were available to all participants within a local program or offered only to a subset of them. Nor do the data make clear whether local programs offered particular courses or services and most participants refused them.

Interview respondents were asked several "open-ended" questions and some respondents may have reported features that others did not consider in their responses. For some program characteristics, the study presents their distribution across the 38 programs, usually referred to as "the percentage of programs with characteristic x." Finally, when considering program participation and service receipt, the study presents data on the percentage of participants who engaged in an activity or course or received a service through a local program. It does not, however, assess the quality of a course or service that participants received. For example, information about courses in this report will not indicate whether HPOG 2.0 participants were engaged in the classes, covered the most important material, or took place in comfortable surroundings. Nor does it document similar services that may have been available outside of the HPOG 2.0 program in the local community.

To add nuance to these findings the study uses some qualitative information from the focus area site visits and in-depth participant interviews conducted in a subset of local HPOG 2.0 programs. However, in no instance should readers interpret the examples as being representative of all programs implementing a particular feature; these examples are illustrative only.

Appendix C: HPOG 2.0 Non-Tribal Grantees

Grantee (*N*=27) / Program (*N*=38)	Grantee Location	Was HPOG 1.0 Grantee	Organization Type	Initial Enrollment Goal
Action for a Better Community, Inc.	Rochester, NY		CBO	1,998
Alamo Community College District	San Antonio, TX	✓	Educ	1,322
Buffalo and Erie Workforce Development Consortium Inc.	Buffalo, NY	✓	WSA	995
Central Community College	Grand Island, NE	✓	Educ	1,459
Central Community College				904
Southeast Community College				208
Northeast Community College				183
Mid-Plains Community College				164
Central Susquehanna Intermediate Unit	Milton, PA	✓	State Gov't	643
Chicago State University	Chicago, IL		Educ	907
Community Action Project of Tulsa County Inc.	Tulsa, OK	✓	CBO	627
Community College of Allegheny County	Pittsburgh, PA		Educ	1,894
Eastern Connecticut Workforce Investment Board, Inc.	Franklin, CT		WSA	825
Eastern Connecticut WIB				177
Northwest Regional WIB				228
Workforce Alliance				420
Edmonds Community College	Lynnwood, WA	✓	Educ	1,238
Goodwill Industries of the Valleys	Roanoke, VA		CBO	725
Hostos Community College	Bronx, NY	✓	Educ	1,698
Kansas Department of Commerce	Topeka, KS	✓	State Gov't	2,286
KS LWIB 1 - Kansas WorkforceONE				347
KS LWIB 2 - Heartland Works, Inc.				475
KS LWIB 3 - Workforce Partnership				500
KS LWIB 4 - Workforce Alliance of South Central Kansas				497
KS LWIB 5 - Southeast Kansas Works				467
Missouri Department of Social Services	Jefferson City, MO		State Gov't	2,481
Full Employment Council		✓		928
St. Louis Agency on Training and Employment				1,260
Central Region Workforce Investment Board				293
Montefiore Medical Center	Bronx, NY		CBO	3,727
Pima County Community College District	Tucson, AZ	✓	Educ	1,944
Rogue Community College District	Grants Pass, OR		Educ	995
San Jacinto Community College District	Pasadena, TX		Educ	1,459
Schenectady County Community College	Schenectady, NY	✓	Educ	2,239
South Carolina Department of Social Services	Columbia, SC	✓	State Gov't	1,471
The Workplace	Bridgeport, CT	✓	WSA	1,393
Volunteers of America Texas	Euless, TX		CBO	1,175
Volunteers of America Michigan	Southfield, MI		CBO	1,318
Workforce Development Council of Seattle - King County	Seattle, WA	✓	WSA	953
Workforce Investment Board SDA-83, Inc.	Monroe, LA	✓	WSA	1,053
Worksystems, Inc.	Portland, OR		WSA	1,918
Zepf Center	Toledo, OH		WSA	1,479

Key: CBO=community-based organization. Educ=higher education institution. State Gov't=state government agency. WSA=workforce system agency.

Initial grant enrollment goals may have been modified during the grant extension period.

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