Health Profession Opportunity Grants (HPOG 2.0) Program Operator and Partner Perspectives on Local Service Delivery Systems

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OVERVIEW

INTRODUCTION

Following on a first round of Health Profession Opportunity Grants (HPOG) Program awards in 2010 ("HPOG 1.0"), the Office of Family Assistance of the Administration for Children and Families (ACF), within the U.S. Department of Health and Human Services, awarded a second round of 32 grants ("HPOG 2.0") in 2015. Local HPOG 2.0 programs provided education, training, and support services (including financial and other assistance) 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.

This report presents findings from the Systems Study component of the Descriptive Evaluation for the HPOG 2.0 National Evaluation. It describes the local service delivery systems in which 15 of the 38 second-round HPOG programs selected for the study operated, explores both how these systems influenced the HPOG programs, and how the HPOG programs influenced these systems, from the perspectives of program operators and their partners on their local systems.

HPOG program operators included institutions of higher education (e.g., community colleges), community-based organizations, workforce system agencies (e.g., local workforce development boards), and state or local government agencies. Program operators were required to partner with other organizations in their local workforce system (called "local service delivery system" for the purposes of HPOG) to operate their local healthcare training programs (OFA 2015). To do so, they often interacted in ways that could improve how their local workforce system functioned. These activities included collaboration, improved access to and quality of training and services (including career pathways), employer engagement, data sharing, and sustaining of successful initiatives (Bernstein and Martin-Caughey 2017). This study examines HPOG program operator and partner perspectives on the systems activities as implemented as a part of HPOG 2.0 activities. The study also explores how the existing system, which includes the economic, policy, and social context, may influence the design and implementation of the HPOG 2.0 programs.

PRIMARY RESEARCH QUESTIONS

- What were the local service delivery systems in which HPOG 2.0 programs operated?
- How did local service delivery systems influence the implementation of the HPOG programs?
- How did the implementation of the HPOG programs influence how local service delivery systems functioned?

PURPOSE

One of the goals of the HPOG 2.0 National Evaluation is to provide information on the local service delivery systems in which the HPOG 2.0 programs operated and on changes within

systems that occurred during the grant period. Systems activities can include collaboration, improved access to and quality of training and services, employer engagement, data sharing, and sustaining of successful initiatives (Bernstein and Martin-Caughey 2017). The Systems Study seeks to identify the extent to which these activities, as implemented by HPOG program operators and their partners, may have influenced the local system. The study also seeks to understand how the economic and policy contexts and existing training and support services within the local system may have influenced HPOG program design and implementation.

KEY FINDINGS AND HIGHLIGHTS

Within their local service delivery systems, the 15 programs included in this study had a range of partnerships they developed for HPOG, with one to 50 partners for each program. The most common HPOG partners involved in program operations were community and technical colleges (116), with 14 of the 15 programs partnering with them. Other common HPOG partner organizations were nonprofit community- and faith-based organizations (9 programs), One-Stop Career Centers/American Job Centers (6 programs), and state government agencies (6 programs). Across all study partners, the most frequently provided services included occupational training (15 programs), basic skills and other nonoccupational training (14 programs), employment assistance support (12 programs), and marketing and outreach (12 programs). The three most common systems activities program operators and their partners engaged in were data sharing (13 programs), conducting outreach to market healthcare training and careers (13 programs), and increasing capacity for healthcare training and services that HPOG participants and others in need could access in their service area (12 programs). The main difference observed between HPOG 2.0 programs that did and did not receive funding under HPOG 1.0 is that all HPOG 2.0 programs (not only those in this study) reported having employers involved in the programs beyond hiring participants, compared to 60 percent of all HPOG 1.0 programs. Otherwise, few differences in systems activities between programs in the study that received HPOG 1.0 funding and those that only received HPOG 2.0 were observed.

The local and regional labor markets, various community factors, and the policy context within the systems in which the HPOG programs operated appeared to influence the HPOG programs' design and implementation. Program operators and partners felt that HPOG programs successfully responded to local employer demand by training new healthcare workers in their service areas. Some program operators and partners also thought that HPOG responded to systemic barriers to training and employment such as child care and transportation by providing intensive supports. Policies (e.g., TANF work requirements) and regulations (e.g., student privacy) sometimes hindered HPOG program implementation.

HPOG programs influenced local service delivery systems, as reported by various program operators and partners, in the following ways:

- HPOG increased access to healthcare training and services for people with low incomes and barriers to employment. There is also some evidence that HPOG improved the quality of training and services, mainly by increasing the availability and intensity of support

services to program participants that enabled them to complete their programs and find a job in healthcare.

- HPOG may have helped to spur new collaborations with organizations or enhance existing ones among partners in the system. In a few cases, HPOG did not seem to create new opportunities for collaboration. Reasons included competition among training providers for resources and placements and among employers for new hires. Competing priorities and bureaucracy could also constrain systemwide collaboration.
- HPOG increased employer engagement by inviting employers to serve as advisors on curriculum and credentials and supporting participants' entry into the healthcare workforce. In some cases, HPOG appeared to help employers see participants as qualified for jobs.
- Data sharing as part of the HPOG program helped improve coordination across partners. A few systems had formal cross-organization data sharing for the local public workforce system, but most data-sharing arrangements were informal and ad hoc.
- Ensuring the sustainability of HPOG programs was challenging as program operators needed to identify new funding sources to enable program components to last beyond the grant. Some systems activities that were expected to be sustained included collaborations built, policies and processes that promote access to healthcare training, and support services.

METHODS

This Systems Study report primarily presents program operator and partner perspectives on how systems activities conducted as part of their HPOG 2.0 programs may have influenced the local service delivery system functioned and how the local system may have influenced the HPOG program implementation. The study design is guided by the Urban Institute's Systems Change Framework for Workforce Development (Bernstein and Martin-Caughey 2017). This framework highlights five key activities for strong workforce development systems: collaboration; improved access to and quality of training and services; employer/industry engagement; data-driven decision making; and scaling and sustaining of training and services. The main data source for the Systems Study is one-hour interviews with 15 program operators and between 3 and 7 of their partners conducted between October 2019 and February 2020. The study team used a purposive sampling strategy to select the 15 programs that would reflect the variety of types and intensity of systems activities to explore a range of experiences and perspectives. The team selected programs with a range of partners, systems activities, and employer partnerships. (Employer partners are those involved in HPOG program activities to help ensure the programs and its participants success beyond hiring.) The team also ensured that a range of programs with varying characteristics, such as lead organization type, types of occupational training, and size of planned enrollment, was included. The team found that all programs had one or more partners, so none were excluded in the sampling process. The study used additional data sources for information on the 15 programs, including 2017 Implementation Study interviews with program staff, grant applications, and data from the management information system used by all HPOG 2.0 grantees. The study team analyzed the qualitative data using descriptive and thematic analysis.

RECOMMENDATIONS

This study has several implications for future initiatives that aim to support sustainable local and regional healthcare training for people with low incomes and that are responsive to the needs of workers and employers. Individuals leading new initiatives should consider the following:

- Continuing to encourage new partnerships and leverage and strengthen existing partnerships with a variety of organizations, which could be helpful for improving access to and the quality of healthcare training for people with low incomes.
- Providing a robust set of wraparound support services through grant-funded training programs, with the types and intensity of services tailored to participant needs, which could help improve access to training and address systemic barriers to completing training and advancing beyond entry-level credentials and jobs.
- Encouraging a greater focus on advancement in healthcare careers, which could help improve access to and the quality of training in the systems.
- Continuing to encourage and emphasize strong employer relationships, especially industry-wide or sector partnerships, which could help ensure that healthcare training is responsive to employer needs, shifts employer perceptions about participants in programs for people with low incomes, and supports participant advancement.
- Setting expectations about data sharing to guide program and systems efforts for grantees, which could support improvements in healthcare training and services across the system, although federal and state data privacy requirements may continue to hinder data sharing.
- Supporting successful sustainability for future initiatives, which may take guidance and technical assistance from funders after the grants ends.

GLOSSARY

ACF—Administration for Children and Families

TANF—Temporary Assistance for Needy Families

HPOG or HPOG Program—the national Health Profession Opportunity Grants initiative, including all grantees and programs

HPOG grantee—the entity receiving the HPOG award and responsible for funding and overseeing one or more local programs

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

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

HPOG partner—another organization involved in the operations of an HPOG program

HPOG employer partner—an employer who is involved in HPOG program activities to help ensure the program's and its participants' success beyond hiring

local service delivery (workforce) system—the network of organizations that conduct activities within their local economic and policy contexts and existing service structure to improve how they prepare people for employment, help workers advance in their careers, and ensure a skilled workforce exists to support local industry and economy

systems activities—activities such as collaboration, improvements to training and services, employer engagement, data sharing, and sustaining of successful initiatives that can help improve how local service delivery systems function

EXECUTIVE SUMMARY

The goal 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 are expected to either experience labor shortages or be in high demand. Following on a first round of HPOG awards in 2010 ("HPOG 1.0"), the Office of Family Assistance 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 grants ("HPOG 2.0").

Each HPOG 2.0 grantee designed and implemented one or more local programs to meet these goals by providing education, occupational training, and support and employment services. The resulting programs were diverse. Compared to HPOG 1.0, ACF increased the emphasis in HPOG 2.0 on articulated career pathways, serving those with low basic skills, and employer engagement.

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**. The evaluation is an opportunity to learn more about job training in general and job training for the healthcare professions in particular—overall, and for adults with low incomes and TANF populations.

Important Terms

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

HPOG or HPOG Program—the national Health Profession Opportunity Grants initiative, including all grantees and programs

HPOG grantee—the entity receiving the HPOG award and responsible for funding and overseeing one or more local programs

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

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

HPOG partner—another organization involved in the operations of an HPOG program

HPOG employer partner—an employer who is involved with HPOG program activities to help ensure the program's and its participants' success beyond hiring

local service delivery (workforce) system—the network of organizations that conducts activities within its local economic and policy context and existing service structure to improve how it prepares people for employment, helps workers advance in their careers, and ensures a skilled workforce exists to support local industry and economy

network—the group of organizations that interact to improve how a local service delivery system functions

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 awards

systems activities—activities such as collaboration, improvements to training and services, employer engagement, data sharing, and sustaining of successful initiatives that can help improve how local service delivery systems function

The National Evaluation of the 27 non-Tribal grantees includes a Descriptive Evaluation (comprising an Implementation Study, Systems Study, and Outcomes Study), an Impact Evaluation, and a Cost-Benefit Analysis.[1] This is the Systems Study final report.[2]

Working within their local workforce systems, organizations conduct activities to prepare people for employment, help workers advance in their careers, and ensure a skilled workforce exists to support the local industry and economy (Eyster et al. 2016). These organizations—which include employers and industry, government agencies, education and training providers, nonprofit and collaborative entities and funders, and others—often partner with other organizations to provide training and services to adults and youth to prepare them for the workforce (Cordero-Guzman 2014; Eyster et al. 2016). To provide training and service delivery, organizations may undertake activities that improve how their workforce system functions ("systems activities"). These activities include collaboration, improved access to and quality of training and services, employer engagement, data sharing, and sustaining of successful initiatives (Bernstein and Martin-Caughey 2017).

Organizations awarded grants included institutions of higher education (e.g., community colleges), community-based organizations, workforce system agencies (e.g., local workforce development boards), and state or local government agencies. The grantees were required to partner with other organizations in their local workforce system (called "local service delivery system" for the purposes of HPOG) to operate their local healthcare training programs (OFA 2015). To do so, they often interacted in ways that could improve how their local system functioned.

HPOG 2.0 Systems Study Design

The Systems Study addresses the following major research questions:

- What were the local service delivery systems in which HPOG 2.0 programs operated?
- How did local service delivery systems influence the implementation of the HPOG programs?
- How did the implementation of the HPOG programs influence how local service delivery systems functioned?

The HPOG 2.0 Systems Study is guided by the Urban Institute's Systems Change Framework for Workforce Development (Bernstein and Martin-Caughey 2017). This framework highlights five key activities for strong workforce development systems: collaboration; improved access to and quality of training and services; employer/industry engagement; data-driven decision making; and scaling and sustaining of training and services.

The HPOG 2.0 Funding Opportunity Announcement (FOA) highlights how partnerships among the program operators and other organizations in their local system can help to support training

[1] Programs of five HPOG 2.0 Tribal grantees were evaluated separately from 27 non-Tribal grantees. For details of the Tribal HPOG 2.0 Evaluation, see https://www.acf.hhs.gov/opre/project/tribal-evaluation-2nd-generation-health-profession-opportunity-grants-tribal-hpog-20.

[2] See Appendix A for a description of the HPOG research and evaluation portfolio.

and service delivery for improved participant outcomes. A possible result of these partnerships is that they may induce local service delivery systems as a whole to better serve adults with low incomes and healthcare employers in their area. The Systems Study captures the perspectives of 15 program operators and their partners on the extent to which systems activities of the HPOG 2.0 programs—collaboration, improved access to and quality of training and services, employer engagement, data sharing, and sustainability—improved how their systems functioned.[3]

The economic and policy contexts of the systems—such as local economic conditions or the availability of child care subsidies—likely influenced the design and implementation of HPOG programs. Thus, the Systems Study also explores the economic and policy contexts and existing training and support services within a system that could influence the HPOG program design and implementation. If potential trainees had young children, for example, the program operators and partners could respond by putting more resources into support services like child care. During the data collection for this study (late 2019 to early 2020), local labor markets usually had low unemployment rates and high demand for healthcare workers. Most of the HPOG implementation period (and the data collection period for this study) occurred before the onset of the COVID-19 pandemic in March 2020, which launched an economic crisis that has continued into 2021.

This study report primarily presents program operator and partner perspectives on how systems activities conducted as part of the HPOG programs may have improved or hindered how the local service delivery system functioned and how the local system may have influenced HPOG program implementation. The study team used a purposive sampling strategy to select 15 of the 38 HPOG 2.0 programs that would reflect the variety of types and intensity of systems activities to explore a range of experiences and perspectives. The team selected programs with a range of partners, systems activities, and employer partnerships. They also ensured that a range of programs with varying characteristics, such as lead organization type, types of occupational training, and size of planned enrollment, were included. The team found that all programs had one or more partners, so none were excluded in the sampling process.

This report builds on lessons from the Systems Change Analysis conducted as part of the HPOG 1.0 National Implementation Evaluation, which described and assessed the collaboration across organizations in the HPOG service delivery systems based on a survey.[4]

KEY FINDINGS

Characteristics of Selected HPOG 2.0 Programs, Their Partners, and Their Systems Activities

- A variety of organizations operated the 15 selected HPOG 2.0 programs, including 5 higher education institutions, 5 workforce system agencies, 4 community-based organizations, and

[3] For the study, the team selected 15 of the 38 programs operated by the 27 HPOG 2.0 non-Tribal grant recipients.

[4] See Bernstein et al. (2016) for findings from the HPOG 1.0 Systems Change Analysis.

1 state and local government agencies.[5] The programs offered training courses for a variety of healthcare occupations that were in demand by employers but did not necessarily pay well. All but 2 programs had at least 20 percent of participants enrolled in training courses to become a certified nursing assistant.[6]

- The selected programs reported engaging an average of 20 partners per program. The most common partners were community and technical colleges. These partners played many and often multiple roles including making referrals for programs and services and engaging in curriculum development and design. All programs had partners that provided healthcare occupational training.
- For HPOG 2.0, ACF more strongly emphasized that programs partner with employers over the course of the grant (OFA 2015). The HPOG 2.0 programs seemed to follow this guidance. The HPOG 1.0 Systems Change Analysis found that 60 percent of programs reported that they engaged business-sector partners and stakeholders (Bernstein et al. 2016). In contrast, all of the 15 HPOG 2.0 programs selected for this study partnered with employers. The number of employer partners, defined as those involved with HPOG program activities to help ensure the program's and its participants' success beyond hiring, ranged from as few as 1 employer up to 150 employers, with an average of 39 employer partners per program. The most common roles played by employers were providing job information, implementing special hiring considerations for HPOG participants, and participating in career fairs.
- Program operators and partners often collaborated to improve how their local service delivery system worked. The three most common systems activities were data sharing, increasing capacity for healthcare training and services in their service area, and developing new or improved referral systems across partners. Examples of these systems activities are provided below.

Local Service Delivery Systems' Influence on HPOG Program Implementation

- At the time of the data collection (late 2019 to early 2020), program operators and partners across all 15 systems noted a strong local labor market demand for entry-level healthcare workers, especially certified nursing assistants. HPOG programs considered such demand in designing their training offerings but recruiting participants could be difficult due to low pay for challenging work. In most systems, HPOG programs successfully responded to the increasing employer demand by building a pipeline of in-demand healthcare workers in their service areas.
- Most HPOG programs appeared to increase the capacity of the local system to provide healthcare training to people with low incomes in response to local employer demand. They increased the number of healthcare training slots and provided intensive supports that would

[5] The organizational types of selected programs for this study are roughly proportional in make-up to the 38 HPOG 2.0 programs.

[6] Using administrative data on HPOG 2.0 program participants, Loprest and Sick (2018) determined that the most common initial training was certified nursing assistant and the most common follow-on training was for a certified nursing assistant–plus credential such as certified medication aide or a patient care technician.

increase the number of trained workers for employers and improve the pipeline of healthcare workers.

- Systemic barriers faced by people with low incomes often make participation in healthcare training difficult. These barriers shaped how HPOG supported participants. In most systems, respondents mentioned a lack of child care and transportation, the cost of training, and a lack of basic academic skills as major barriers to succeeding in healthcare jobs. The HPOG programs often addressed these needs by providing support services (e.g., transportation, child care), paying for tuition and other costs, and providing adult education classes.
- Public policy often played a role in HPOG program implementation. Respondents in all systems indicated that HPOG leveraged other funds and resources available in the community, including community college financial aid, Pell grants, Workforce Innovation and Opportunity Act training vouchers, and other public and private workforce grants, to share the cost of trainings or supplement the wraparound services that HPOG could offer. Programs reported that certain public policies, including public benefits policies (e.g., TANF work requirements) and strict regulations in the healthcare industry (e.g., training and licensure requirements), could make implementing the HPOG programs challenging for program operators and partners.

HPOG 2.0 Programs' Influence on Local Service Delivery Systems

- HPOG programs seemed to bolster existing and spur new collaboration. Respondents from most systems noted that the HPOG program was responsible for new or increased collaboration or coordination activities in their healthcare systems. The nine programs included in this study that received HPOG 1.0 funding often built on relationships with system partners established under their first grant. In some systems, however, HPOG programs did not appear to create new opportunities for collaboration. For some respondents, competitiveness among training providers (for resources and placements) and among employers (for new hires), competing priorities, and bureaucracy constrained systemwide collaboration.
- Respondents from all systems believed that HPOG increased access to healthcare training and services for individuals who otherwise might not have been able to enroll and succeed in a healthcare training program.[7] There is also some evidence that HPOG improved the quality of training and services, mainly by increasing the availability and intensity of support services to program participants that enabled them to complete their programs and find a job in healthcare. Reasons cited included HPOG's provision of support services and staff, such as navigators, as well as financial assistance. However, some barriers to participation in healthcare training and jobs, such as lack of preparedness for postsecondary education and work-life responsibilities, were too difficult for HPOG programs to overcome.

[7] The HPOG 2.0 Short-term Impact Report found that "HPOG 2.0 moderately increases starting training." 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). The study also found that treatment group members received more career-related and caseworker services than control group members. For more information, see Klerman et al. 2022.

- Respondents from most systems felt that the HPOG programs created or strengthened healthcare career pathways. These improvements included the movement of participants through various partners' education, training, or support service programs, as well as HPOG staff supporting participants to move to higher levels of training and education beyond HPOG-funded programs. However, respondents in a few systems noted challenges related to the development of career pathways through HPOG, with some respondents noting that the model was not successful in helping people advance in healthcare careers.
- Employers in most systems supported HPOG programs through direct engagement with program participants, co-creating curricula, and financial support. All 15 HPOG program operators included in this study reported partnering with employers for work-based learning opportunities. Respondents in five systems thought that the HPOG programs helped facilitate increased collaboration with employers. Respondents also described the challenges associated with building employer partnerships with organizations that were large and decentralized. Employer respondents were generally positive about the HPOG programs building a hiring pipeline for them.
- Respondents in three systems described how they leveraged shared data to manage partner relationships and improve coordination between partners. Some highlighted how they used shared data to address issues around program capacity and performance and to conduct strategic planning efforts. Data-sharing arrangements for HPOG programs could be formal or informal and were sometimes ad hoc. Respondents in a few systems highlighted how organizations already shared data across the local service delivery system, usually as a part of the local public workforce system.
- Respondents from most systems indicated that the HPOG programs would sustain some components of their healthcare training and services after the grant ended. However, they reported they would not be able to continue providing training and support services for individuals with low incomes at the same level without additional funding. Respondents in some systems noted that other aspects of HPOG programs, such as collaboration and coordination across various organizations and policy changes, were likely to be sustained after the grant ended.

Implications for Future Initiatives

This study has implications for future initiatives that aim to support sustainable local and regional healthcare training for people with low incomes and that are responsive to the needs of workers and employers. Individuals leading new initiatives should consider the following:

- Continuing to encourage new partnerships and leverage and strengthen existing partnerships with a variety of organizations, which could be helpful for improving access to and the quality of healthcare training for people with low incomes.
- Providing a robust set of wraparound support services through grant-funded training programs, with the types and intensity of services tailored for participants, which could help improve the quality of training and services and address systemic barriers to completing training and advancing beyond entry-level credentials and jobs.

- Encouraging a greater focus on advancement in healthcare careers, which could help improve access to and the quality of training in the systems.
- Continuing to encourage and emphasize strong employer relationships, especially industry-wide or sector partnerships, which could help ensure that healthcare training is responsive to employer needs, shifts employer perceptions about participants in programs for people with low incomes, and supports participant advancement.
- Setting expectations about data sharing to guide program and systems efforts for grantees, which could support improvements in healthcare training and services across the system, although federal and state data privacy requirements may continue to hinder data sharing.
- Supporting successful sustainability for future initiatives, which may take guidance and technical assistance from funders after the grants ends.

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.[8]

In addition, employers, especially those in the healthcare industry, need workers who are trained to perform in-demand jobs.[9] Building a pipeline of trained healthcare workers for these open positions, including those that require less than a college degree, can support a stronger healthcare system.

The **Health Profession Opportunity Grants (HPOG) Program** is one effort that seeks to improve workers' education and employment and build a pipeline of healthcare workers. 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, awarded a second round of 32 grants ("HPOG 2.0") in 2015 to 27 non-Tribal ("National") grantees and 5 Tribal grantees.[10] The HPOG Program funded grantees to provide education, training,

Important Terms

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

HPOG or HPOG Program—the national Health Profession Opportunity Grants initiative, including all grantees and programs

HPOG grantee—the entity receiving the HPOG award and responsible for funding and overseeing one or more local programs

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

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

HPOG partner—another organization involved in the operations of an HPOG program

HPOG employer partner—an employer who is involved with HPOG program activities to help ensure the program's and its participants' success beyond hiring

local service delivery (workforce) system—the network of organizations that conducts activities within its local economic and policy context and existing service structure to improve how it prepares people for employment, helps workers advance in their careers, and ensures a skilled workforce exists to support local industry and economy

network—the group of organizations that interact to improve how a local service delivery system functions

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 awards

systems activities—activities such as collaboration, improvements to training and services, employer engagement, data sharing, and sustaining of successful initiatives that can help improve how local service delivery systems function

[8] "Unemployment Rates and Earnings by Educational Attainment," Employment Projections, U.S. Bureau of Labor Statistics, last modified September 4, 2019, https://www.bls.gov/emp/chart-unemployment-earnings-education.htm.

[9] For more information on demand for healthcare workers, see "Healthcare Occupations," Occupational Outlook Handbook, U.S. Bureau of Labor Statistics, last modified September 8, 2021, https://www.bls.gov/ooh/healthcare/home.htm.

[10] ACF initially awarded five-year grants. They then extended the grants by one year.

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 40,000 l adults with low incomes.

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**.[11]

The National Evaluation of the 27 non-Tribal grantees includes a Descriptive Evaluation (comprising an Implementation Study, Systems Study, and Outcomes Study), an Impact Evaluation, and a Cost-Benefit Analysis.[12] This is the Systems Study final report.[13]

Working within their local workforce system, organizations conduct activities to prepare people for employment, help workers advance in their careers, and ensure a skilled workforce exists to support the local industry and economy (Eyster et al. 2016). These organizations—which include employers and industry, government agencies, education and training providers, nonprofit and collaborative entities and funders, and others—often partner with other organizations to provide training and services to adults and youth to prepare them for the workforce (Cordero-Guzman 2014; Eyster et al. 2016). To provide training and service delivery, organizations may undertake activities that improve how their workforce system functions ("systems activities"), including collaboration, improved access to and quality of training and services, employer engagement, data sharing, and sustaining of successful initiatives (Bernstein and Martin-Caughey 2017).

The Systems Study addresses the following research questions:

1. What were the local service delivery systems in which HPOG 2.0 programs operated?
2. How did local service delivery systems influence the implementation of the HPOG programs?
3. How did the implementation of the HPOG programs influence how local service delivery systems functioned?

The Systems Study describes the local service delivery systems in which 15 of the 38 HPOG 2.0 programs selected for the study operated and explores the ways in which the HPOG programs may have influenced how their systems functioned and how systems may have

[11] The Systems Study is part of OPRE's diverse research portfolio to assess the success of HPOG on participant educational attainment, employment, and earnings. For an overview of the HPOG research and evaluation portfolio, see Appendix A. Programs of the five Tribal grantees were evaluated separately.

[12] Programs of five Tribal grantees were evaluated separately from 27 non-Tribal grantees. For details of the Tribal HPOG 2.0 Evaluation, see https://www.acf.hhs.gov/opre/project/tribal-evaluation-2nd-generation-health-profession-opportunity-grants-tribal-hpog-20.

[13] See Appendix A for a description of the HPOG research and evaluation portfolio.

influenced the HPOG program implementation. The study primarily uses interviews with the 15 selected HPOG 2.0 program operators (the lead organizations directly responsible for the administration of a local HPOG program) and selected partners to address these questions.[14, 15] This report builds on lessons from the Systems Change Analysis conducted as part of the HPOG 1.0 National Implementation Evaluation, which described and assessed the collaboration across organizations in the HPOG 1.0 service delivery systems based on a survey.[16] It presents the perspectives of program operators and their partners on their local systems to understand the economic and policy contexts in which the programs operated and a range of systems activities.

1.1 Context for the Study on HPOG Programs and Their Local Service Delivery Systems

The HPOG 2.0 National Evaluation is exploring the implementation of local HPOG 2.0 programs and measuring their impacts on participants' educational and labor market outcomes.[17] The Systems Study, part of the Descriptive Evaluation, provides information on the local service delivery systems in which the HPOG 2.0 programs operated and on how local HPOG 2.0 programs may have influenced the systems in which they operated and how the local system may have influenced HPOG program implementation during the grant period (Werner et al. 2018). In its FOA for the HPOG 2.0 grants, OFA specifically called for grantees to support learning "about the effectiveness of such partnerships" (OFA 2015, 4).

The FOA highlights how partnerships among the program operators and other organizations in their local system can help to support training and service delivery for improved participant outcomes. A possible result of these partnerships is that they may induce local service delivery systems as a whole to better serve adults with low incomes and healthcare employers in their area. The Systems Study captures the perspectives of 15 program operators and their partners on the extent to which systems activities of the HPOG 2.0 programs—collaboration, improved access to and quality of training and services, employer engagement, data sharing, and sustainability—may have improved how their systems functioned.

The system's economic and policy contexts—such as economic conditions or the availability of child care subsidies—likely also influenced how the HPOG programs were designed and implemented. Thus, the Systems Study also explores the economic and policy contexts and existing training and support services within a system that could have influenced the HPOG program design and implementation. If potential trainees had young children, for example, the program operators and partners could respond by putting more resources into support services like child care. The economic conditions during HPOG program operations may have played a

[14] For the study, the team selected 15 of the 38 programs operated by the 27 HPOG 2.0 non-Tribal grant recipients.

[15] Additional information about HPOG 2.0 program design and implementation can be found in two companion reports. The HPOG 2.0 Implementation Study Report (Roy et al. forthcoming) provides detail about HPOG 2.0 programs and the roles of program operators and their partners. The forthcoming HPOG 2.0 Outcomes Study Report will characterize participants' enrollment and completion of training courses, credentials, and career progress, as well as employment rates and earnings.

[16] See Bernstein et al. (2016) for findings from the HPOG 1.0 Systems Change Analysis.

[17] See Appendix A for a full description of the HPOG 2.0 research and evaluation portfolio.

role in how the programs were designed and implemented. During the data collection for this study (late 2019 to early 2020), the programs and their local systems generally were experiencing low unemployment rates and high demand for healthcare workers. Most of the HPOG implementation period (and the data collection period for this study) occurred before the onset of the COVID-19 pandemic in March 2020, which launched an economic crisis that has continued into 2021.[18]

This section introduces the HPOG 2.0 Program and requirements for grantees to form and expand partnerships, describes the concepts related to local service delivery systems within the HPOG context, provides a framework for understanding systems activities, and discusses how this study builds on the findings from the HPOG 1.0 systems study.

1.1.1 The HPOG 2.0 Program and Partnership Requirements

ACF's FOA for HPOG 2.0 (OFA 2015) said it expected grantees to meet the following requirements:

- prepare program participants for healthcare-sector employment in positions that pay well and are expected to either experience labor shortages or be in high demand
- target skills and competencies demanded by the healthcare industry
- support career pathways, such as articulated career ladders
- result in employer- or industry-recognized, portable education credentials (e.g., certificates or degrees) and professional certifications and licenses (e.g., a credential awarded by a Registered Apprenticeship program)
- combine support services with education and training services to help program participants overcome barriers to employment
- provide training services at times and locations that are easily accessible to targeted populations

HPOG 2.0 grantees varied in their location, organization type, and size (Mikelson, Damron, and Loprest 2017). ACF awarded grants across 21 states to 32 organizations, including 5 Tribal organizations. Just over half of the grantees (17 of 32) received funding under the first round of HPOG awards. Nearly one-third of the non-Tribal grantees were institutions of higher education (10 grantees), 7 were workforce system agencies, 6 were community-based organizations, and 4 were state government entities. HPOG 2.0 grants ranged from $900,000 to $3 million annually. Grantees' five-year enrollment projections reflected this variation, ranging from fewer than 500 to over 2,000 participants.

[18] Pandemic-related changes are described in more detail in an HPOG 2.0 brief documenting how programs adapted their procedures (Roy et al. 2022). Changes in the healthcare labor market during the first seven months of the COVID-19 pandemic are described in a separate HPOG 2.0 brief (Epstein and Sarna 2021). The Intermediate-term Impact Report will include COVID-specific analyses, including describing shifts in outcomes and impacts in the time of COVID. The evaluation will also include a report on short-term impacts specifically for HPOG 2.0 participants who entered the study after the onset of the pandemic.

Grantees had flexibility to design programs to meet the needs of their target populations and local employers, within the overall goals of HPOG 2.0 (Mikelson, Damron, and Loprest 2017). This flexibility led to varied program offerings across grantees. Trainings and other activities included basic skills training and healthcare occupational training, other skill-development activities (e.g., introduction to healthcare careers and work-readiness workshops), support services (e.g., assistance with transportation and child care), and work-based learning opportunities.

To support the implementation of HPOG programs, ACF required grantees to develop formal and informal partnerships with a range of organizations, including, but not limited to, the following:

- state and local agencies involved in Workforce Innovation and Opportunity Act (WIOA) implementation (e.g., workforce development boards, American Job Centers)
- state and local Temporary Assistance for Needy Families (TANF) agencies
- state apprenticeship offices or a U.S. Department of Labor regional apprenticeship office
- community colleges and other training providers
- community-based organizations

ACF encouraged building employer and industry partnerships, calling for HPOG 2.0 programs to develop partnerships with industry organizations and formal relationships with employers as part of their activities. The emphasis on employer partnerships was stronger in the HPOG 2.0 award announcement than in the HPOG 1.0 award announcement (OFA 2010).

ACF also encouraged grantees to develop partnerships with organizations that could “provide resources and expertise for coordinating services and improve outcomes for program participants” (OFA 2015, 7). These organizations and agencies could provide

- Supplemental Nutrition Assistance Program assistance,
- Medicaid assistance,
- legal aid, and
- services funded by ACF such as Head Start, child care, domestic violence prevention, and refugee resettlement.

ACF (2015) encouraged HPOG 2.0 grantees to develop effective partnerships by establishing business processes, protocols, partnership agreements, referrals, implementation strategies, and memoranda of understanding and by committing staff and HPOG program funds to coordinate services. HPOG programs could also engage in partnerships to develop and implement apprenticeship programs.

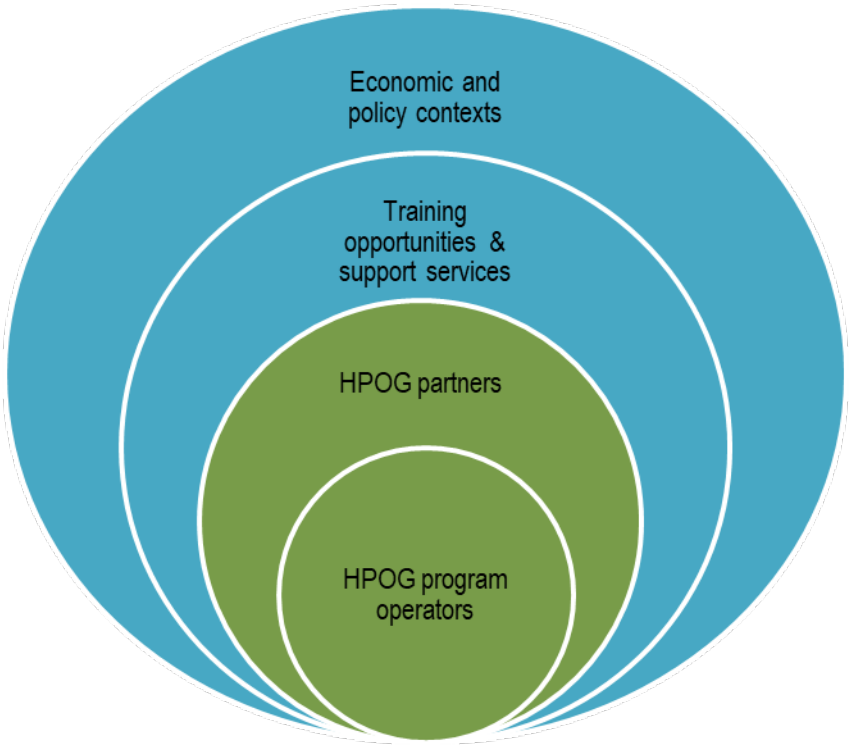
The *Health Profession Opportunity Grants 2.0: Year One Annual Report (2015–16)* documented how partners supported program operations under HPOG 2.0 (Mikelson, Damron, and Loprest 2017). HPOG 2.0 grantees partnered with one or more organizations to provide trainings and services to participants. Grantees may have built new partnerships or expanded existing ones

as a part of the grant activities. The partners contributed to the implementation of HPOG programs by providing occupational and nonoccupational training, referrals to services, marketing and outreach, academic support, employment assistance, work-based learning opportunities, curriculum development, program planning and design, personal or logistical support, and direct financial support.

1.1.2 Understanding Local Service Delivery Systems

Systems are more than a set of organizations; they are the activities, services, and training and employment opportunities within a community. They are a network of organizations that conduct activities within their local economic and policy contexts and existing service structure to improve how they prepare people for employment, help workers advance in their careers, and ensure a skilled workforce exists to support local industry and economy. Systems, as depicted in Exhibit 1-1, include the HPOG program operator and its network of partners (highlighted in green) and the broader training, social service, and economic contexts in which the HPOG program operates (highlighted in blue) (Bernstein et al. 2016).

Exhibit 1-1 Local and Regional Service Delivery Systems for Healthcare Training



Source: Bernstein et al. (2016).

The contextual factors in a local service delivery system are economic and policy contexts and the training opportunities and support services available to low-income individuals. The economic context reflects both the labor market demand for healthcare workers and the hiring activities of employers. It may also include challenges the system faces, such as poverty and low education levels, in developing a pipeline of workers. The policy context reflects the federal, state, and local legislation and policy governing healthcare training and public programs for

training and supporting low-income adults. The policy context also includes the healthcare education and training opportunities and support services that exist in a system. All of these factors may influence local HPOG program design and implementation.

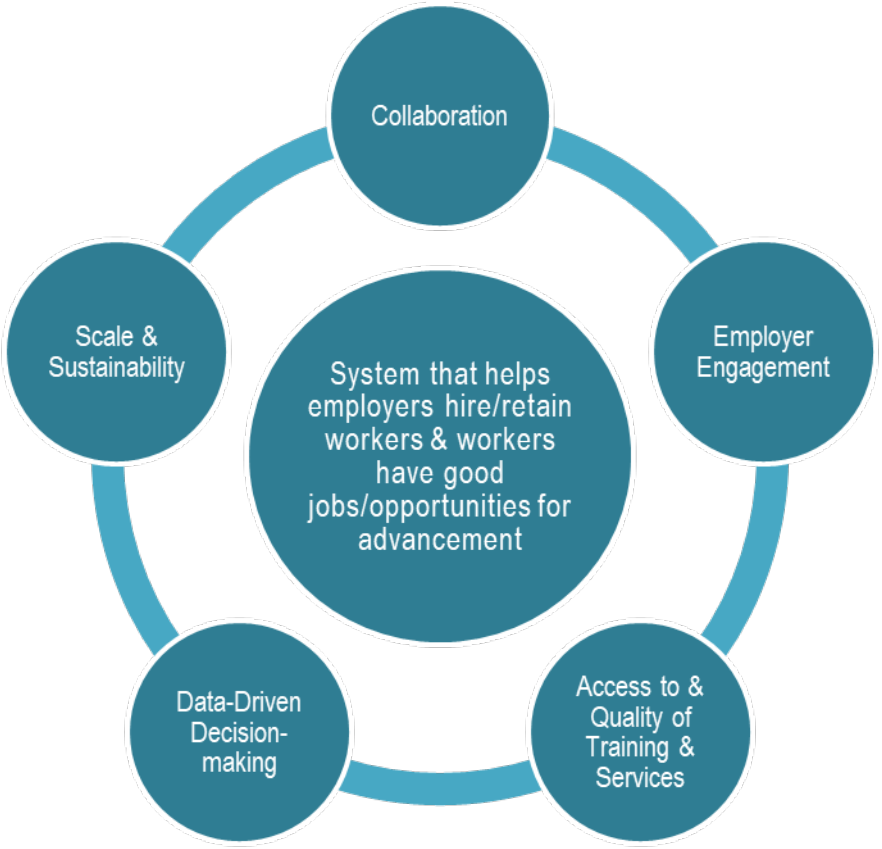
For HPOG, program operators and their partners interacted with each other to support HPOG program operations. The study explores whether these interactions may have spurred local service delivery systems to better serve adults with low incomes as well as healthcare employers in their area. These systems activities and how they may occur in the HPOG context are described next.

1.1.3 Framework for Studying Systems Activities

The HPOG 2.0 Systems Study is guided by the Urban Institute's Systems Change Framework for Workforce Development (Bernstein and Martin-Caughey 2017). As shown in Exhibit 1-2, this framework highlights the five key activities for ensuring strong workforce development systems. These activities are as follows:

- **Collaboration.** The goal of collaboration is for organizations to have a shared vision or coordinated approach to serving workers and employers and to effectively work together to solve problems and share best practices.
- **Improvements to access to and quality of training and services.** The goal of these improvements is for training and services to be visible and accessible to and meet the needs of those who need them, especially people with barriers to employment.
- **Employer/industry engagement.** The goal of employer/industry engagement is for organizations in the system to be informed by business needs, and for employers to become invested partners in workforce efforts.
- **Data-driven decision making.** The goal of data-driven decision making is for organizations in the system to collect and use quality data to design and continuously improve programs and services.
- **Scaling and sustaining of training and services.** The goal of scaling and sustaining programs and services is for the system to have adequate programs, funding, and policies to reliably meet the needs of individuals and employers over time.

Exhibit 1-2 Key Activities for Strong Workforce Systems



Source: Authors' representation of the systems activities in Bernstein and Martin-Caughey (2017).

The goal of workforce development systems, as shown in the center circle of Exhibit 1-2, is to help employers hire and retain workers with needed skills and help workers have good jobs and opportunities for advancement. This Systems Study report uses these five systems activities as an organizational framework and to describe how implementation of the HPOG 2.0 Program supported these systems activities.

1.1.4 Building on the HPOG 1.0 Systems Change Analysis

The Systems Change Analysis under HPOG 1.0 described and assessed the strength of the collaboration between organizations that made up the network of HPOG program operators, partners, and stakeholders (organizations not directly involved in program operations but interested in the program's success) that supported HPOG activities.[19] The study analyzed a survey of HPOG 1.0 program operators, partners, and stakeholders from all 49 programs to examine the changes to the local service delivery system that were associated with HPOG 1.0 program implementation.

[19] The HPOG 1.0 Systems Change Analysis surveyed organizations that were not partners to the HPOG program operator (e.g., those directly involved in grant activities) but supported the program's success. We did not include these groups in the HPOG 2.0 Systems Study as they may not have had as much in-depth knowledge of the HPOG programs as needed to answer our questions.

The first study found that the networks across 49 programs operated by the 27 HPOG 1.0 grantees comprised a diverse set of organizations, including educational institutions, workforce development agencies, other government agencies, nonprofit organizations, and employers and industry organizations (Bernstein et al. 2016). Partners most commonly were involved with local programs through referral and outreach activities but also with education and training activities, employment assistance, counseling and support services, and program planning and design.

On average, HPOG 1.0 programs and networks strengthened their collaborations over the grant period (Bernstein et al. 2016).[20] Most HPOG programs responded to local labor market demand for healthcare occupations, and the program operators perceived that the programs improved healthcare training and supports for low-income populations. Most partners and stakeholders indicated that networks worked together effectively and were satisfied with local HPOG programs. However, respondents viewed participants' personal barriers and their difficulties engaging in and completing the HPOG programs as the most significant challenge to the programs. In addition, partners and stakeholders thought that collaboration with employers could have been stronger. Over the long run, partners and stakeholders were confident that the working relationships developed with program operators and other network organizations would be sustained after the grant.

Unlike the HPOG 1.0 study, this HPOG 2.0 study does not include all programs and does not attempt to measure the strength of partnerships (Werner et al. 2018). In addition, this study focuses on the program operators and partners, not stakeholders as defined in the HPOG 1.0 study. The HPOG 2.0 study is designed to generate an in-depth understanding of the perspectives of selected program operators and their partners of local service delivery systems, the local context in which they operated, and the systems activities in which they engaged. For a subset of programs, the HPOG 2.0 study also documents program operators' and partners' perspectives on HPOG's influence on the system and how the local system may have influenced HPOG program implementation. The study also identifies the successes and challenges for implementing systems activities.

1.2 Study Design

The Systems Study is part of the larger HPOG 2.0 National Evaluation which includes an Impact Evaluation; a Descriptive Evaluation, comprising implementation, outcomes, and systems studies; and a cost-benefit analysis. This report relies on program operator and partner perspectives of the effects of services provided to participants as well as the larger service delivery system.[21]

As discussed above, the HPOG 2.0 Systems Study comprised three overarching categories of research questions: (1) describing local service delivery systems, (2) how the systems may

[20] This finding comes from a social network analysis conducted based on responses to a survey of all program operators, partners, and stakeholders for the 49 HPOG 1.0 programs and their systems.

[21] The HPOG 2.0 Impact Evaluation is using an experimental design to assess the impacts of the HPOG 2.0 Program on employment and earnings. It is largely not examining the effects of individual grantees and programs and does not take partner perspectives into account. For more information, see Klerman et al. (2022).

have influenced HPOG implementation, and (3) how the HPOG programs may have influenced the systems in which they operated.

This section presents the data sources, program and partner selection, data collection and analysis, and study limitations. Appendix B provides a more detailed overview of the Systems Study Design. Additional detail on the study is available in the design report (Werner et al. 2018) and in the analysis plan (Werner et al. 2019) which includes all components of the Descriptive Evaluation.

1.2.1 Data Sources

The main data source for the Systems Study was one-hour semi-structured interviews with the organizations leading the 15 selected HPOG programs ("program operators") and 3 to 7 of their partner organizations. Interviews were conducted from October 2019 to February 2020. The study also used additional data sources for information on the 15 programs, including telephone interviews conducted in 2017 for the Descriptive Evaluation's Implementation Study,[22] grant applications, and aggregate participant data from the Participant Accomplishment and Grant Evaluation System (PAGES), the HPOG 2.0 management information system used by all grantees.

1.2.2 Program and Partner Selection

The team used a purposive sampling strategy to identify 15 HPOG 2.0 programs that would reflect the variety of types and intensity of systems activities. Selecting across those variations allowed the team to explore a range of experiences and perspectives on activities and partnerships that may have contributed to or hindered systems development and improvement. The team selected programs with a range of partners, systems activities, and employer partnerships. The team also ensured that there were a range of programs with varying characteristics, such as lead organization type, types of occupational training, and size of planned enrollment. In the selection process, the team found that all programs had one or more partners, so none was excluded in the sampling process.

For each HPOG 2.0 program selected for the study, the research team interviewed the staff person most knowledgeable about the program's efforts at collaboration with partners, generally the program director. During the interview, the research team members asked about the level of involvement across program partners. At the end of the interview, the team members asked the program operator to identify informants for 3 to 7 of the program's partners to be interviewed, including a mix of highly and less involved partners. They also asked the program operator to identify employer and industry partners to ensure the study captured these perspectives. The team interviewed 76 of the 80 partners recommended by the program operators (4 partners declined to participate).

[22] The National Evaluation team conducted these telephone interviews with the 38 program operators in summer 2017 as part of the Implementation Study.

1.2.3 Data Collection and Analysis

The research team analyzed the qualitative interview data, supplemented by results from the 2017 grantee telephone interviews, using descriptive and thematic analysis. The analysis to address the first research question described the 15 programs and systems included in the study, using the systems interviews and the additional data sources noted above. The unit of analysis for this portion of the study was the program. The analysis to address the second and third research questions, for which the unit of analysis was the system in which the selected HPOG 2.0 programs operated, drew themes from the program operator and partner interviews and identified trends and patterns across the interviews.

1.2.4 Study Limitations

There are several limitations to the Systems Study:

- Specific goals and activities of HPOG 2.0 did not directly support or require a focus on systems change (OFA 2015). Thus, the program operators and partners may not understand the purpose of the study and the questions being asked. To address this limitation, the research team ensured that the study goals and terms were clear to respondents in the request for interviews and in the introduction at the start of the interview.
- The study did not seek to draw causal inferences about whether the HPOG program changed the local system or the local system changed the HPOG program. Rather, it provided descriptive, qualitative data to inform these questions. The study also reported what interviewees *perceived* as the reason or cause of a change in the HPOG program or the system.
- There are limits to the generalizability of the study findings. Because the study did not include all programs and partners, the findings do not represent all systems activities or partner collaborations in HPOG 2.0 programs.
- The findings described in this report may not reflect the changed economic conditions and healthcare training landscape, as the data collection occurred prior to the onset of the COVID-19 pandemic in early 2020, when unemployment rates were very low.

1.3 Roadmap for the Report

The remainder of the report presents the findings from the Systems Study. It is organized as follows:

- **Chapter 2:** Characteristics of Selected HPOG 2.0 Programs, Partners, and Systems Activities
- **Chapter 3:** How Local Service Delivery Systems Influenced HPOG Program Implementation
- **Chapter 4:** How HPOG 2.0 Program Implementation Influenced Local Service Delivery Systems
- **Chapter 5:** Conclusions

2. CHARACTERISTICS OF SELECTED HPOG 2.0 PROGRAMS, PARTNERS, AND SYSTEMS ACTIVITIES

This chapter provides an overview of the characteristics of the 15 HPOG 2.0 programs included in the Systems Study, their partners, and their systems activities. These programs represent a range of programs funded by HPOG and their partnerships with organizations and employers in their local service delivery system. This chapter uses several data sources, including 2017 telephone interviews with program operators, grant applications, and aggregate participant data, to provide a picture of the HPOG programs and their partners and an understanding of the context in which these programs operated.

2.1 Characteristics of HPOG 2.0 Programs in the Systems Study

As shown in Exhibit 2-1, the 15 HPOG 2.0 programs selected for the Systems Study represented a variety of organization types. The table shows the characteristics for the 15 programs selected for the study and for all programs.[23]

Program operator institutional type. Of the selected programs, five were operated by higher education institutions such as a community or technical colleges, five by workforce system agencies (such as a local workforce investment board), four by community-based organizations, and one by a state and local government agency.

Training courses offered. Programs in the study generally focused on providing certified nursing assistant (CNA) training courses, which was true across all HPOG 2.0 programs. CNA is an entry-level healthcare occupation that can be the first step on a nursing career pathway to more advanced occupations such as licensed practical nurse (LPN) and registered nurse (RN).[24] ACF required grant applicants to articulate well-defined career pathways by defining the specific education and employment steps for the career pathway and associated student supports (OFA 2015, 5). Career pathways show how training connects to specific employer-recognized credentials, what competencies are required for each step, how credentials “stack” on each other to lead to higher-paying jobs, and how noncredit training is connected to credit-bearing education. In the 2017 HPOG 2.0 program operator telephone interviews, 12 of the 15 program operators indicated that they used a well-defined career pathway to structure their HPOG trainings. Three of the program operators did not, even though ACF encouraged the use of a well-defined career pathway in the FOA.[25]

Of the 15 selected programs, 13 had at least 20 percent of participants in CNA training courses (Exhibit 2-1). Of them, 7 had at least 20 percent participation in CNA and 20 percent in at least

[23] The 15 selected programs roughly mirror the universe of 38 HPOG 2.0 programs. One exception is size of the program enrollment goals; a much higher proportion of study programs had large enrollment goals.

[24] Impact evaluations of two rounds of HPOG so far have found that this pattern of trainings occurs infrequently. See Klerman et al. (2022) for short-term results from HPOG 2.0 and Peck et al. (2019) for three-year results from HPOG 1.0 for more information. See also Klerman, Litwok, and Morris (2022).

[25] This finding may have changed by the end of the grant in 2021 as OFA required grantees to provide a career pathway description for each new occupational training added during the grant period.

one other occupation, such as LPN, RN, or electrocardiogram technician. One program had at least 20 percent of participants in LPN (not CNA) training courses, and one program had participants in a diverse range of occupational trainings, with less than 20 percent participation in any single occupation.

Exhibit 2-1 HPOG 2.0 Systems Study Program Characteristics

Program Characteristic	Number of Systems Study Programs	Percentage of Study Programs	Number of All HPOG Programs	Percentage of All Programs
Program Operator Institutional Type				
Higher education institution	5	33%	13	34%
Workforce system agency	5	33%	17	45%
Community-based organization	4	27%	6	16%
State or local government agency	1	13%	2	5%
Course in Which Program Trains at Least 20% of its Participants, by Occupation				
Certified nursing assistant	6	40%	18	47%
Certified nursing assistant and other occupations	7	47%	17	45%
Licensed practical nurse	1	7%	2	5%
Not more than 20% of participants in a single occupation	1	7%	1	3%
Program Enrollment Goals (for the Grant Period of Performance)				
Small (1–499)	2	13%	11	29%
Medium (500–999)	6	40%	16	42%
Large (1,000–2,500)	7	47%	11	29%
Geographic Areas Served by HPOG 2.0 Programs				
Urban	11	73%	30	79%
Suburban	7	47%	21	55%
Rural	9	60%	23	61%
Received HPOG 1.0 Grant				
HPOG 1.0 grantee	9	60%	22	57%

Source: HPOG 2.0 2017 grantee interviews, grant applications, and the Participant Accomplishment and Grant Evaluation System. N = 15 study programs; N = 38 all programs. The total number of geographic areas served is greater than 15 because programs could serve multiple areas.

Program enrollment goals. HPOG grantees set their participant enrollment goals at the start of their grants for their entire period of performance as part of program performance reporting. The selected programs had enrollment goals of 220 to 2,500 participants for the five-year grant period.[26] As shown in Exhibit 2-1, two programs had a small projected enrollment, six had a medium projected enrollment, and seven had a large projected enrollment.

Geographic regions served. The programs served urban, suburban, and rural regions across the country, often serving more than one type of region. Exhibit 2-1 shows that most (11)

[26] These enrollment goals included the initial five-year period of performance (October 2015-September 2020) and the one-year grant extension (October 2020 -September 2021).

programs served urban areas. Nine programs served rural areas, and seven served suburban areas.

HPOG 1.0 grantee. Nine of the 15 programs had also been funded through HPOG 1.0. Thus, they had more experience with the grant program and may have had more partnerships and employers in place at the start of the HPOG 2.0 award than those programs that first received funding through HPOG 2.0.

2.2 HPOG Program Partners

As discussed in Chapter 1, HPOG program operators partnered with a variety of organizations, including government agencies and business. HPOG 2.0 programs were not expected to provide all services and training courses themselves.[27] In fact, the 15 HPOG programs in the study reported engaging 294 partners, or an average of 20 partners per program, that were involved in or supported program operations.[28] These program operators engaged from as few as 3 to as many as 35 partners.

Exhibit 2-2 shows that 15 program operators engaged a variety of partner types that were directly involved in program operations. The most common program partners were community and technical colleges (116), with 14 of the 15 programs partnering with them. The lone program that did not partner with a community or technical college was itself a community college. The least common partners were local workforce investment boards.[29] However, five program operators were workforce system agencies, which includes local boards, and six programs partnered with American Job Centers, which local boards oversee.[30]

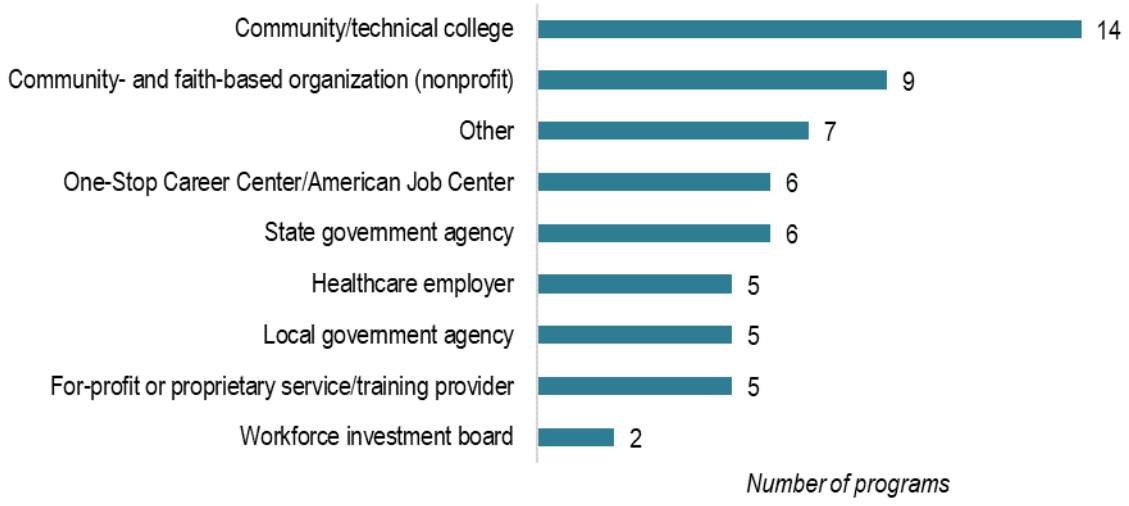
[27] See the HPOG 2.0 Implementation Study Report (Roy et al. forthcoming) for more information on the roles of the HPOG partners across all programs.

[28] The data on partners are 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.

[29] The 2017 grantee interview instrument used the term “workforce investment boards.” However, they are known as “workforce development boards” under the Workforce Innovation and Opportunity Act.

[30] All but one of the four community-based organization-led programs partnered with other community-based organizations. The one state or local government agency-led program partnered with other state and local government agencies.

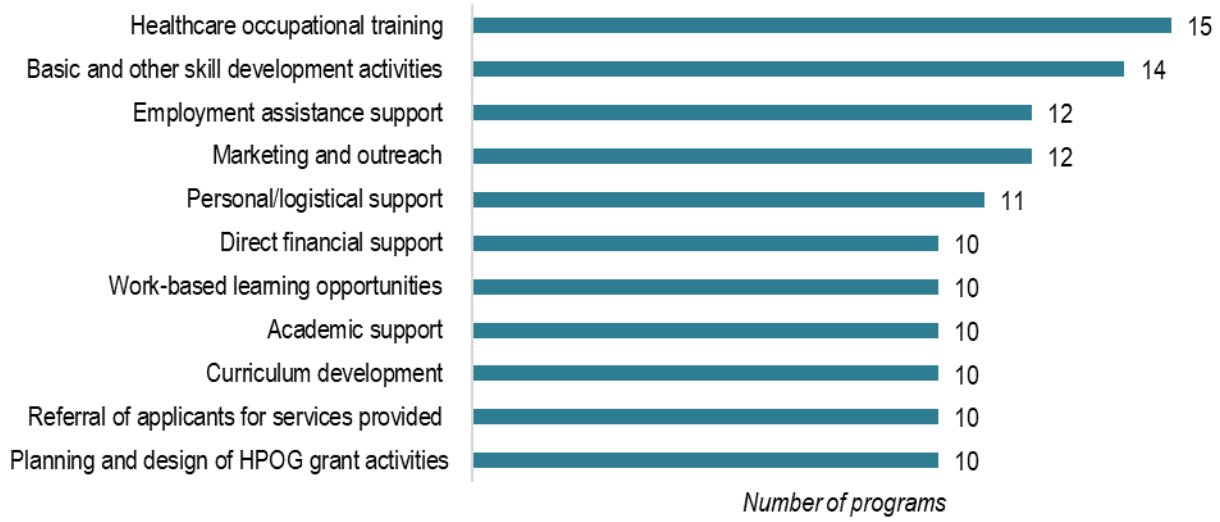
Exhibit 2-2 Partner Organization Types Engaged by HPOG 2.0 Systems Study Programs



Source: HPOG 2.0 2017 grantee interviews. N = 15 programs.

The partners played many and often multiple roles in HPOG programs (Exhibit 2-3). All programs had partners that provided healthcare occupational training, with an average of 10 partners per program in this role. The second most common role for partners was providing basic and other nonoccupational skill-development activities (for 14 programs by an average of 9 partners). Program operators that were workforce system agencies tended to collaborate with more partners providing this service. The next most common roles for partners were providing employment assistance support (12 programs with an average of 6 partners) and providing marketing and outreach (12 programs with an average of 9 partners). Community- and faith-based program operators tended to partner with more organizations offering these services. For the remaining roles, 10 programs partnered with organizations to serve in each of these roles.

Exhibit 2-3 Partners' Roles in HPOG 2.0 Systems Study Programs



Source: HPOG 2.0 2017 grantee interviews. N = 15 programs.

Most HPOG programs worked with employers who hired or could potentially hire participants trained by the program. For this report, the study team defines an employer partner as involved with the HPOG program to help ensure the program's and its participants' success. Beyond hiring HPOG participants, potential employer partner activities included direct involvement in program operations (as described above). Other employer activities included providing in-kind resources, participating in job fairs, presenting career opportunities to participants, and offering job shadowing and mock interviews.[31]

For HPOG 2.0, ACF provided additional guidance on its requirement that grantees partner with employers over the course of the grant (OFA 2015). The FOA indicated that grantees should consult employers in the design of their HPOG programs. It also strongly encouraged grantees to develop formal employer relationships with clear roles and responsibilities delineated in a memorandum of understanding, contract, or a similar agreement.

The HPOG 2.0 grantees seemed to follow this additional guidance. All 15 HPOG 2.0 programs included in the Systems Study partnered with employers. The number of employer partners for these programs ranged from only 1 employer up to 150 employers, with an average of 39 employer partners per program. This was a change from HPOG 1.0, for which only 60 percent of program operators reported that they engaged employer partners (Bernstein et al. 2016).[32]

[31] The employer partners identified here are based on a separate question from the HPOG 2.0 2017 grantee interviews. The definition considers multiple ways that program operators can partner with employers to actively engage in the program implementation and service delivery. It can include direct involvement in program operations as noted in Exhibit 2-3 but also in other ways to support participants.

[32] This statistic for the earlier study also includes employers that were not directly involved in program operations but interested in the program's success (see Section 1.1.4).

Generally, employers contributed to the program beyond hiring participants. As shown in Exhibit 2-4, the most common roles played by employers were providing job information, offering special hiring considerations for HPOG participants, and participating in career fairs. In all but 1 of the 15 programs, employers played these roles. Partnering employers provided work experiences to 13 programs; advised on or informed curricula, necessary technical/professional skills, or other aspects of the local program to 12 programs; delivered lessons, lectures, or presentations to HPOG participants in 11 programs; provided oversight or advisory board membership in 10 programs; contracted with grantees to provide training and provided financial or physical resources in 8 programs; and hosted field trips in 7 programs.

Exhibit 2-4 Roles Played by Employer Partners in HPOG 2.0 Systems Study Programs

Source: HPOG 2.0 2017 grantee interviews. N = 15 programs.

Twelve of the 15 selected programs participated in a regional workforce or industry partnership to better connect with employers and industry representatives. These partnerships comprised multiple organizations such as government agencies, institutions of higher education, community-based organizations, and employers that developed and coordinated workforce development strategies across a region. Industry partnerships focused on one industry, such as healthcare.

2.3 HPOG Systems Activities

Program operators and their partners undertook a variety of specific activities to support improvements to how the local systems function. Examples of these specific systems activities within the five overall categories are provided in the text box.[33]

[33] See description of these systems activities on pp. 6-7.

Examples of HPOG 2.0 Systems Activities

Collaboration

- **Created a group of partners to better coordinate training and services.** Organizations created a formal initiative that involved multiple organizations in a system, supported by a memorandum of understanding. Organizations also created an informal group of organizations trying to solve specific challenges (e.g., referrals, case management).
- **Created a logic model or theory of change used across partners.** Organizations created a logic model or theory of change across organizations in a system to undergird a larger system strategy such as developing and implementing career pathways.

Improvements to access and quality of training and services

- **Conducted outreach to market healthcare training and careers.** Organizations developed a website or social media campaign to more broadly create interest in healthcare careers. They also met with or presented to high school students or incumbent workers at a medical facility to discuss healthcare career options.
- **Increased capacity for healthcare training and services.** Organizations hired new instructors or case managers that allowed for the expansion of training slots available in a system.
- **Developed new and improved case management practices.** Organizations developed or implemented new assessments to better gauge participant needs. Organizations also brought together case management staff from different organizations to improve coordination for participants co-enrolled in programs.
- **Developed new or improved referral systems.** Organizations developed new policies and procedures, including use of data, for providing referrals across organizations.
- **Developed a curriculum that can be used across partners.** Organizations developed new or enhanced existing curriculum to be used across organizations. The curriculum could be for technical, academic, or professional/workplace skills or a combination of skills (e.g., contextualized learning).
- **Created articulation agreements.** Organizations developed formal agreements to allow students at a higher education institution to transfer credits between institutions or allow credits to be earned for non-credit courses to create pathways for educational advancement within a system.

Employer engagement

- **Conducted outreach to employers.** Organizations coordinated outreach to employers to consolidate communications so as not to overburden employers with requests. Organizations hired a staff person to conduct the outreach.
- **Developed new employer-recognized credentials** (this is also an example of improved quality of training). Organizations worked with employers to develop new or enhance existing credentials to reflect skills that employers needed. The expectation was that employers would hire participants with these credentials.
- **Created a sector partnership with employers.** Organizations created a partnership with employers in one industry to build a pipeline of individuals training for available healthcare jobs.

Data sharing

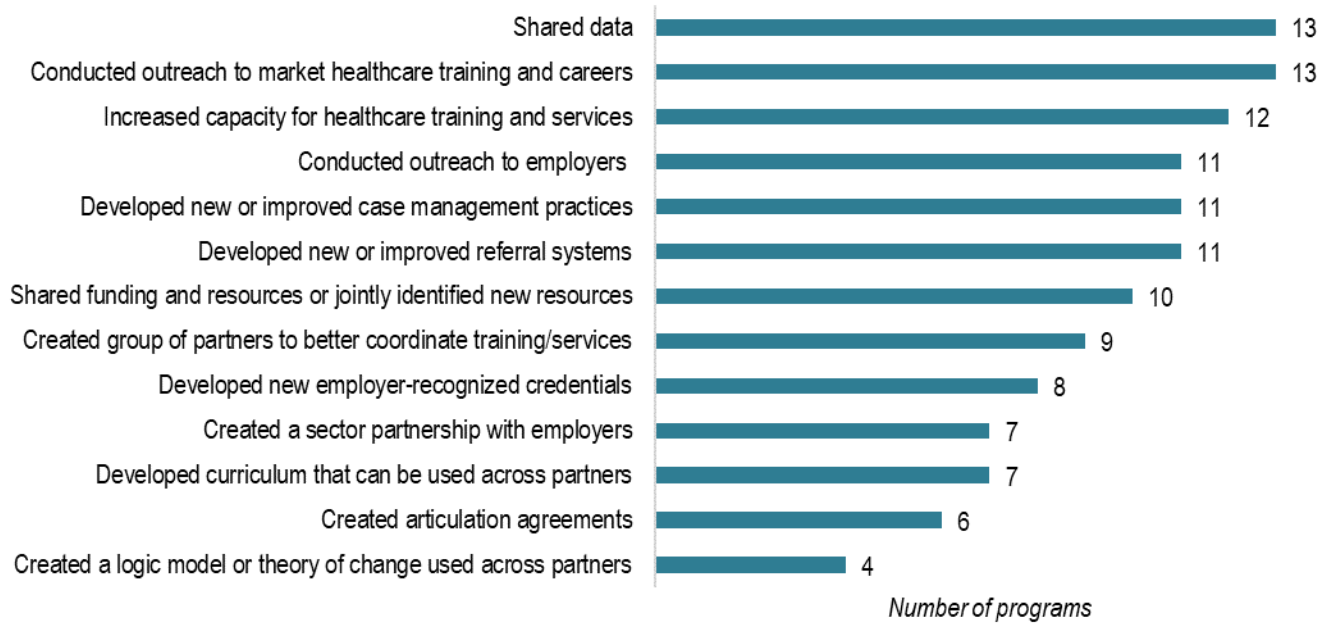
- **Shared data to manage partner relationships and improve coordination.** Organizations shared and used data on participants, employers, and labor market to support continuous improvement and decision-making for healthcare training and services across a system.

Sustaining of programs

- **Shared funding and resources or jointly identified new resources**. Organizations coordinated use of existing funding and resources to more efficiently deploy programs and services. Organizations also sought funding and resources together such as a grant or in-kind contributions from employers.

As shown in Exhibit 2-5, program operators and partners often collaborated to improve their local service delivery system operations. The three most common systems activities program operators and their partners jointly engaged in were data sharing (13 programs), conducting outreach to market healthcare training and careers (13 programs), and increasing capacity for healthcare training and services that HPOG participants and others in need could access in their service area (12 programs). The least common systems activity was development of a logic model or theory of change to guide program implementation and track progress (4 programs).

Exhibit 2-5 Systems Activities Conducted by HPOG 2.0 Systems Study Program Operators and Their Partners



Source: HPOG 2.0 2017 grantee interviews. N = 15 programs.

This chapter provided an overview of the 15 programs, their partners, and their systems activities. The next two chapters summarize the perspectives of operators of these programs and their partners on how local service delivery systems may have influenced HPOG program implementation, and how HPOG program implementation may have influenced local systems.

3. HOW LOCAL SERVICE DELIVERY SYSTEMS INFLUENCED HPOG PROGRAM IMPLEMENTATION

During HPOG 2.0, the local service delivery system context and existing training and support services within which programs and partner organizations operated may have influenced the design and implementation of HPOG programs. One way local systems may have influenced HPOG programs was the strength (or weakness) of the labor market and employer demand affecting healthcare training and employment opportunities in communities implementing HPOG awards. At the time data were collected for this study, the HPOG programs in this study operated in a context of low unemployment and high demand for healthcare workers. Other economic and policy factors, such as poverty, accessibility of work supports, and healthcare policies and regulations, may have enhanced or inhibited HPOG program operators' ability to provide access to high-quality healthcare training and the ability of people with low incomes to participate and succeed in healthcare training and the workforce. Finally, the lack of adequate healthcare training for in-demand occupations and support services for people with barriers to postsecondary education and training and employment within the system may have influenced HPOG program design and implementation.

This chapter describes program operators' and partners' perceptions of how local service delivery systems influenced HPOG program design and implementation, based on the 2019–20 interviews conducted for the Systems Study. This chapter and the next describe the systems in which the 15 HPOG program operators and their partners, which we interviewed, operate.

3.1 Labor Market Context Influencing HPOG Program Implementation

This section presents findings on the perspectives of program operators and their partners about the local economic context. It discusses the strength of the local labor market within these systems and how it may have influenced HPOG program implementation.

At the time of data collection for this study, local labor market demand for healthcare workers was strong and had been increasing since HPOG 2.0 began in 2015, enhancing the need for HPOG-funded training.

Respondents across all 15 systems—program operators and partners—highlighted the high demand for healthcare workers in their community. Among the HPOG program operators interviewed, 14 described strong demand in the healthcare sector across multiple occupations in their local communities. Nearly all described how demand had been increasing over time since the program began. Four program operators who led HPOG 1.0 programs (which ran from 2010 to 2015) indicated demand was stronger in HPOG 2.0 than it had been under HPOG 1.0. This healthcare sector demand was perceived to have had spillover effects into other industries. One workforce system partner organization described how cybersecurity concerns had driven a need for a trained pipeline of medical coders in the community, stating, "All tech giants are engaging us to help people become [medical] coders."

The demand for both entry- and advanced-level workers, especially CNAs, was high, which HPOG programs appeared to consider in designing their training offerings.

Program operators and partners across all systems believed that addressing worker shortages was a pressing need for both entry- and advanced-level healthcare jobs. Fourteen of the 15 program operators described worker shortages at the entry level for CNAs and in more advanced-level positions (e.g., RNs) along the healthcare career pathway. One program operator described a 22 percent increase in projected local growth in healthcare occupations through 2024. Three workforce system partner organizations and one program operator also described signing bonuses offered by employer partners for specific occupations in particularly high-demand fields.

Respondents across all systems indicated that consistent and increasing demand over time had also driven the need for entry-level healthcare workers in their local communities, to which the HPOG programs responded. One program operator described the regional healthcare market as growing "exponentially" and reported that demand for entry-level workers had doubled. As a result of this growth, healthcare training programs in the service area, not only the HPOG programs, considered developing entry-level trainings as part of career pathway programs.

Low compensation for entry-level healthcare jobs may have negatively affected enrollment in HPOG programs and their ability to meet employer demand.

Employer demand for entry-level healthcare workers was high from the start of the HPOG 2.0 grants in 2015 through early 2020, when the research team completed interviews for the Systems Study. However, according to respondents, recruitment and retention of HPOG participants could be challenging due to low pay in the entry-level positions that were a first step in healthcare employment for many potential HPOG participants.

> *"CNAs are only making $10–12 an hour, and their turnover is just ridiculous."*
>
> – HPOG Program Operator
>
> *"Part of the issue with growth in home-based care is that the occupations growing the fastest don't pay enough money."*
>
> – Workforce System Partner

High demand for entry-level workers may have influenced the large numbers of CNA training programs operated by HPOG grantees and their partners, but recruiting participants was difficult. One program operator noted that the lack of competitive wages led participants to not select CNA training, affecting enrollment. Another described how the low unemployment rate during the grant period (prior to 2020) meant that healthcare employers were competing with other sectors that offered entry-level work for higher pay, stating that participants "can make more at McDonalds or Panera Bread." A workforce system partner echoed this observation, describing how "whenever there is a good local economy, people pursue other opportunities."

Respondents in eight systems noted that turnover in healthcare jobs, an important issue within local systems, perpetuated a cycle of increased demand for additional healthcare workers at the entry level. Some saw this turnover as a result of low compensation by employers. In particular, a few respondents described this issue as a problem for positions such as CNAs and home health aides, two of the most in demand but lowest-paying healthcare occupations.

An aging population, geographic differences, and changes to the healthcare infrastructure seemed to be major factors affecting healthcare employment opportunities.

Respondents across the 15 systems thought that the aging population contributed to increased labor market demand across healthcare occupations. One employer partner described how "with [changing demographics] has come an increased demand for home care. Caregiving services allow families to keep their properties and not move older generations to nursing homes." Several respondents described this need as more urgent in states with a large number of retirees and elderly residents. According to a community college partner, "Boomers don't want to go to nursing homes, so home care is growing."

> *"Pay discrepancies between urban and rural markets may be a factor [in employer demand]. Rural workers are more willing to travel to [pursue] urban positions due to higher pay rates, and healthcare facilities in rural areas struggle to stay open."*
>
> – HPOG Program Operator

According to respondents, geographic differences in demand for healthcare workers and pay may have affected programs in rural areas, driving workers to pursue opportunities in urban areas. Some respondents described how the small pool of trained healthcare workers has led to challenges in meeting employer demand in those areas. One program operator noted that lower wages in rural areas could also be a factor in employers' ability to find trained healthcare workers.

Some respondents also highlighted how healthcare employment opportunities may actually be decreasing in rural areas. Many program operators and partners described a shift from networks of smaller independent and family-owned healthcare providers to larger, more consolidated healthcare and hospital systems. This shift may have led to fewer job opportunities in rural areas, because large healthcare providers are mainly located in urban and suburban areas. One training provider partner described how "the job demand is typically with the larger providers. In a rural area, you run out of options quickly."

Most HPOG programs responded to the increasing employer demand by training new healthcare workers.

Respondents in 10 systems felt that the largest contribution of the HPOG programs to employers was helping to address increased demand for healthcare training by developing training courses that reflected worker and employer needs.[34] As one program operator stated, "We've understood that because the economy is at low unemployment, [HPOG] is about getting individuals into the current occupations we've identified as growing and being able to support them." A community college partner working with this program commented, "I think [HPOG] used criteria so they knew where jobs were and where students would have a greater chance of being able to obtain employment. They went to the workforce board to obtain information on high-growth, high-demand jobs." Another community college partner described how providing a

> *"The most important contribution of HPOG to the system is filling vacancies. Number two is improving retention rates. We also help employers create value for the folks they have. We have less poaching going on now."*
>
> – HPOG Program Operator

[34] Although respondents' perceptions indicated that HPOG programs addressed employer demand, the programs had not detectably increased employment and earnings by the 5th quarter for participants after program enrollment compared to what would have happened without HPOG (Klerman et al. 2022).

qualified pipeline of employees to meet local demand was the biggest way HPOG met the needs of employers. A program operator in an area with very low unemployment commented that "HPOG has been good for the overall employment situation and for employers."

HPOG programs appeared to respond to local demand by increasing the number of training slots and combining healthcare training with intensive supports to serve both employers and a new pipeline of healthcare workers.

Program operators across all systems described how healthcare training programs already existed in their local communities prior to the implementation of HPOG 2.0. However, some respondents pointed out that existing programs were not a feasible or realistic option for many of the individuals in HPOG's target population due to the lack of wraparound supports (such as case management and transportation benefits) that more intensive programs like HPOG provided. One HPOG program operator described celebrating the number of individuals served by the program, because "the volume is so much larger than other efforts. It's all valuable work, but [HPOG] just feels different." A community college partner commented that HPOG was probably making the biggest impact for individuals who would not be able to access education and training opportunities otherwise because of the expense.

> *"This is the level of work that it takes to be successful—you need the wraparound supports. We are working even harder to serve people because we have the budget to provide a lot of supportive services, whereas community colleges just cover the tuition and walk through the door with a career path in mind. Our lens is a little bit different. It tends to be very difficult for people in this area to find funds for training. Some people are paid for by a church. They really have to be creative and find the right help."*
>
> – Community College Partner

According to respondents, the HPOG program provided fully funded education and wraparound support services for participants that were not readily available in most cases via existing training programs in their communities. One partner described how "HPOG brings resources to the community for employed and unemployed individuals to help them enter an industry where they can find a job that creates an opportunity for a long-term career. Because of the pipeline and the model, it has been a positive impact on our … economy because of the opportunity for TANF and unemployed individuals."

In some systems, employer demand seemed to influence the design and implementation of HPOG training and program components.

Respondents in five systems indicated that program operators and partners created and adapted specific training and program components in response to employer demand. For example, one program operator said, "We added phlebotomy as a training for our medical assistant class because we are finding some classes need additional add-ons to make students more employable and marketable." Another community college partner described the value of the HPOG training provider's instructors staying in close communication with employers and providing participants the opportunity to use the most up-to-date technology in their clinical rotations.

> *"[The college] created wings at their campus that look just like a current hospital facility and have all equipment necessary to operate like a hospital."*
>
> – Community College Partner

A few respondents also noted that HPOG programs included work-based learning opportunities in the curriculum in ways that aligned with employer demand and addressed the skill needs of students. One community college partner implemented a hybrid model of course delivery to be responsive to the need for new surgical technology program graduates in the local area. Through the HPOG partnership, participants completed the surgical technology program online through remote lab locations and only needed to be on site for final testing and graduation.

> *"Without prior experience, students can complete training but are less likely to get hired. Adding on the work-based component, employers get to test students out and are more willing to take a risk on them."*
>
> – HPOG Program Operator

3.2 Social and Policy Contexts Influencing HPOG Program Implementation

In addition to the local labor market context, the social and policy contexts within local service delivery systems may have influenced HPOG program implementation. Barriers to education and employment success for people with low incomes may include a lack of education and training opportunities, a lack of work and training supports (e.g., transportation and child care), the cost of training, inadequate educational preparation for college and careers, challenges balancing work and family commitments with training, poor mental health or substance abuse, and basic needs that are unmet (e.g., housing or food insecurity). Supports needed for people with low incomes to succeed in education and training may include transportation, child care subsidies, academic/basic skills training, flexible course scheduling, and emergency funds. This section presents findings on the perspectives of program operators and their partners across the 15 systems about these local contextual factors and how they influenced HPOG program implementation.

People with low incomes could face structural barriers to participating in healthcare training, which shaped HPOG programs' approaches to service provision.

People with low incomes can face structural barriers to engage in training that can improve their economic circumstances and mobility (Gordon and Dew-Becker 2008; Hacker and Pierson 2010; Jacobs and Dirlam 2016; Loungani and Ostry 2017; Reardon and Bischoff 2011). They may lack access to high-quality training institutions and programs and support services, creating barriers to educational attainment and employment (Turner et al. 2014). Many study respondents noted that these challenges could make it difficult for individuals with low incomes to participate in healthcare training and jobs.

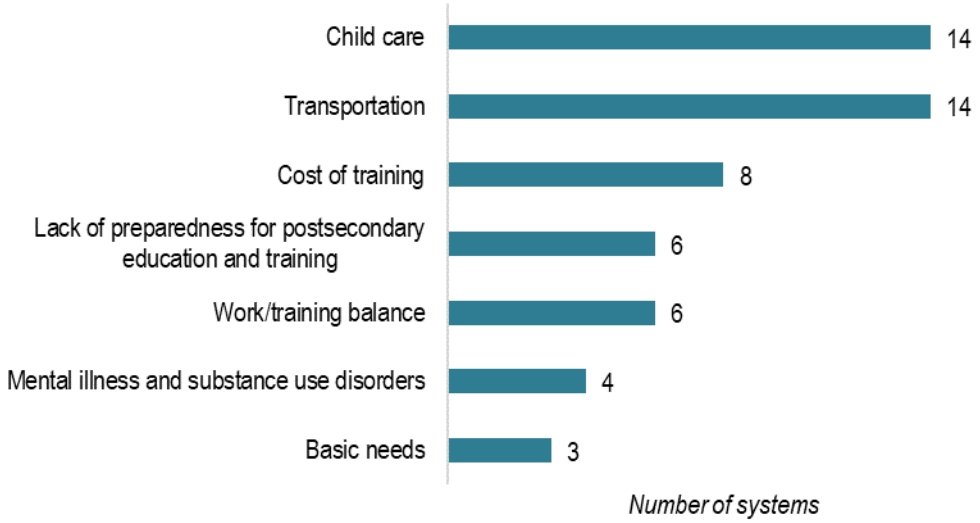
> *"Trying to recruit [low-income people] and getting them to commit and see the long game is so hard when they have scarce capacity and live crisis to crisis."*
>
> – Community College Partner

Respondents in all 15 systems noted that these barriers to success influenced the support services offered by HPOG programs. As shown in Exhibit 3-1, barriers included a lack of child care and transportation, inability to afford healthcare training, lack of preparation for postsecondary education and training, challenges in balancing work and training, and difficulty meeting basic needs, which HPOG programs addressed through their support services.[35] One partner, who noted that the challenges are systemic, said "I think our [system's]

[35] More information on the frequency of these and other barriers to success for HPOG participants can be found in Klerman et al. (2022).

gaps [in services] are in the fact that people have so many barriers.… It's the road to healthcare that causes a problem, not being in the healthcare field."

Exhibit 3-1 Barriers to Participation in Healthcare Training Reported by HPOG 2.0 Systems Study Program Operators



Source: 2019–20 interviews with HPOG 2.0 program operators and partners. N = 15 systems.

People interested in training often needed child care and transportation assistance, which the HPOG programs could help address.

As shown in Exhibit 3-1, respondents in nearly all systems mentioned difficulty accessing child care as a major barrier to succeeding in healthcare jobs, and often identified it as the biggest gap in the local system. These respondents noted the difficulty of finding *affordable* child care in particular. One program operator remarked, "You spend all this time training them and they get out there and can't make it because child care costs are so unbelievable." Two partners noted that few facilities offered child care during nontraditional work hours, which parents often needed to be able to work healthcare shifts. Another partner mentioned that child care subsidies were often unavailable or insufficient to cover the cost of care. Respondents said that many HPOG programs tried to address child care needs for participants, but it was difficult to meet many participants' needs due to limited funding, eligibility restrictions, and misalignment of child care availability with course schedules.[36] Thus, the issue remained across these systems.

Transportation to training and work was identified as a major barrier by respondents in 14 systems. Some urban areas lacked sufficient public transportation routes for participants to get to jobs or training. Respondents in one system noted that it could take one or two hours and multiple buses for a participant to travel from her home to her job, and that public transportation was

> *"[Low-income] people live in areas where the jobs aren't … and the transit system doesn't go there."*
>
> – Community College Partner

[36] All HPOG 2.0 programs offered child/dependent care assistance, but only 5 percent of participants requested it (Roy et al. forthcoming).

nonexistent if the participant lived in the suburbs. In another urban system, the program operator noted that the lack of public transportation to the main medical center meant that participants had to drive their cars, but that the cost of parking was unaffordable. He said, "They can't afford not to work, but they can't afford to work, either." In two rural systems areas, respondents said that public transportation was not available at all, and that paying for a car and gas posed a significant financial barrier. Two respondents noted that transportation was an acute challenge for home health workers, who are required by some states to drive a personal vehicle to patients' homes to protect the patients' privacy.[37]

The costs of existing training seemed to lead HPOG programs to make support for the costs of attendance broadly available to participants.

As shown in Exhibit 3-1, respondents in eight systems said the high cost of healthcare training deterred participation. Many respondents noted that tuition supports were available in their systems prior to HPOG. However, these supports did not always cover the additional costs associated with healthcare training, including background checks, drug tests, textbooks, and equipment. Respondents noted that the HPOG programs helped to address the costs of attendance by making tuition and other financial supports widely available to participants for the grant-funded training courses.

Addressing the challenge of individuals with low basic skills appeared to have influenced the HPOG program offerings.

In six systems, respondents noted that some participants lacked a high school credential, which was required for enrollment into some HPOG training courses. Some respondents stated that even participants who had a high school diploma or passed the Test of Adult Basic Education and the General Education Development test sometimes still struggled in college-level courses and needed basic skills/adult education first.[38] Two respondents believed this problem's roots lay in the failures of the local K-12 school systems to prepare students for higher education. To help people with low basic skills succeed in HPOG training courses, respondents noted that HPOG programs offered adult education courses, test preparation, boot camps, and contextualized learning, as encouraged by ACF (2015).

> *"It seems that education is what's lacking for the majority of our clientele … I'm talking about high school education. People don't qualify for trainings if they don't have a high school diploma, and a lot of people don't have the math and reading skills."*
>
> – Community Based Organization Partner

Respondents seemed unsure of how well HPOG programs responded to other systemic barriers.

Respondents pointed to several other barriers to participating in healthcare training and jobs faced by people in their communities that may have influenced HPOG program implementation. These barriers included the difficulty of balancing work and training (six systems), the lack of

[37] All HPOG 2.0 programs offered transportation assistance, and 49 percent of participants received it (Roy et al. forthcoming).

[38] The Test of Adult Basic Education and the General Education Development tests are two assessments used to award a high school equivalency credential for those without a high school diploma.

services for people with mental health and substance use disorders (four systems), and the lack of available supports to help meet other basic needs (three systems). Respondents emphasized that these barriers were particularly difficult challenges, but they were unclear about how well HPOG programs responded to them.

The availability of state and local resources and funding could affect HPOG's and other training providers' ability to meet individuals' needs.

Respondents in all 15 systems indicated that HPOG leveraged other funds and community resources to share the cost of trainings or supplement the wraparound services that HPOG could offer. The landscape of these funds and resources also determined the accessibility of healthcare training for low-income individuals who were not in HPOG. However, the availability of these resources varied by the local context in which the HPOG programs operated.

Respondents in a few systems noted having access to adequate funding sources other than HPOG to pay for healthcare trainings. Commonly cited funding sources included student financial aid, Pell grants, WIOA training vouchers, and other public and private workforce grants in the community.

> *"If [the state] would focus more deliberately on shorter-term training programs, that would be good.…They're not recognizing that there are lots of entry points to get into nursing. They're very short-sighted."*
>
> – Community College Partner

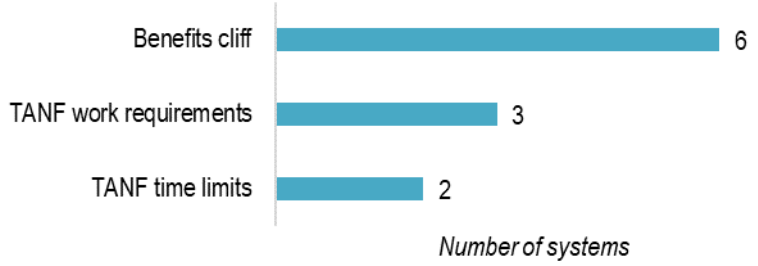
However, other respondents reported that although there was insufficient funding to serve all low-income individuals who were interested in training, HPOG filled that gap. In particular, respondents in five systems noted that Pell grants did not support short-term, noncredit training programs for entry-level healthcare jobs. This lack of support often made healthcare training unaffordable for low-income individuals. Respondents also noted the additional difficulty posed by restrictions that prevented WIOA funding from being used to cover short-term trainings. Two partners said that fluctuations in WIOA funding from year to year made it difficult to leverage in general.

Respondents perceived that the robustness of the nonprofit sector and initiatives also affected HPOG programs' ability to provide the wraparound supports that many individuals needed to participate in healthcare training and jobs. All HPOG program operators mentioned referring participants to community-based organizations for services they could not provide, such as mental health and domestic violence services. Respondents in two systems noted that a major strength of their local service delivery system was the robustness and coordination of services offered by community-based organizations. And in three systems, funding from local anti-poverty initiatives was used to pay for services like child care and vision care for HPOG participants. However, not all systems believed they had adequate resources in their community. As one partner stated, "A lot of the [HPOG award] money supports the cost of the courses and instructors. What the funding doesn't address is the peripheral steps to completing [participants'] education."

Public assistance policies appeared to make it more difficult for HPOG programs to provide training and access to healthcare jobs.

Respondents in 10 systems indicated that certain public policies could make it challenging for program operators and partners to implement HPOG programs. Respondents in 8 systems noted that public benefits receipt policies deterred low-income individuals from participating in healthcare training and jobs (Exhibit 3-2) and training providers from offering high-quality, accessible training. Issues mentioned explicitly were public program benefit cliffs and TANF work requirements and time limits.

Exhibit 3-2 Policies and Regulations Posed Barriers to HPOG 2.0 Program Implementation



Source: 2019–20 interviews with HPOG 2.0 program operators and partners. N = 15 systems.

Respondents in six systems pointed to the "benefits cliff" as a major impediment to the recruitment and retention of people with low incomes in HPOG. The "cliff" effect refers to the sudden and often unexpected decrease in public benefits that can occur with a small increase in earnings, which can cause families to lose critical economic supports (Birken, Moriarty-Siler, and White 2018). Thus, individuals receiving public assistance may be concerned about losing benefits that support their family, such as Medicaid (public health insurance), once they find employment. Respondents noted that the earnings of entry-level healthcare workers were often right near the cliff, and that their additional income often was not enough to compensate for losing benefits, which could make it difficult to keep their jobs.[39]

> *"They may go into CNA and make enough money that it's one dollar too much for them to keep their housing or to keep their cash benefits, so they don't want to go to work, but they only have so much time that they're allowed to be in training before they lose those benefits. They need a longer time, or there needs to be a better transition process."*
>
> – HPOG Program Operator

> *"Training isn't considered work … so if they decide to go through training with us, they lose their benefits, and their benefits help with their livelihood."*
>
> – HPOG Program Operator

Respondents in three systems emphasized that TANF work requirements were a major barrier for TANF recipients to engage in HPOG or other training. Typically, TANF recipients have to be engaged in work, a state-approved training program, or other approved activities to receive TANF benefits. In some cases, state or local TANF rules focused on "work first" policies, and participation in training would not count toward their required work hours. Thus, HPOG training

[39] For more detail on benefits cliffs and the experiences of HPOG participants, see "Navigating Benefits Cliffs in HPOG" at https://www.acf.hhs.gov/ofa/news/navigating-benefits-cliffs-hpog.

courses did not meet the participants' TANF work requirements. In a state that recently allowed education and training to be counted toward TANF work requirements, the program operator said, "It's really taken the burden off that participant that they can spend some time training. This helps people move toward family-sustaining wages. We were struggling to get TANF [participants]. Now there are more."

Respondents in two systems noted the challenge of time limits on receiving TANF benefits. Federal TANF policy limits benefit receipt to a maximum of five years. However, states and local areas can reduce this time limit. A challenge noted by a few respondents was that benefits sometimes expired in the middle of training, leaving participants with no other income source. Program operators said time limits could make it significantly harder to serve TANF recipients, either because the possible loss of benefits deterred them from participating or because the actual loss of benefits caused them to struggle to stay enrolled in training.

Healthcare regulations, such as requirements for clinical placements and background checks, could make it challenging for HPOG programs to provide training and access to jobs.

Respondents in five systems mentioned several ways in which healthcare regulations, intended to ensure quality and safety in the healthcare workplace, posed challenges to delivering high-quality, accessible training. These challenges included state and federal regulations on the content of healthcare trainings and reduced flexibility in designing and approving curricula, which could slow the adoption of new or enhanced HPOG training courses.

Respondents also noted that regulations on the delivery of clinical experiences, which are a required part of many of the healthcare trainings provided by HPOG, posed challenges. One employer partner respondent who worked at a long-term care facility mentioned that the employer wanted to provide its own HPOG training courses, but healthcare regulations precluded assisted living and residential care facilities from offering them. Two program operators mentioned that the high number of clinical hours that some training courses required made it difficult to find employers willing to offer placements because of a lack of staff resources to oversee the on-the-job training.

Regulations in the healthcare industry could pose barriers to participation in HPOG trainings and access to jobs after program completion. Respondents in three systems expressed concern about regulations and employer practices that exclude people with a criminal record from entering the healthcare field. Respondents noted that some employers were starting to remove restrictions as demand for healthcare workers grew and as social perceptions of individuals with past criminal legal system involvement changed, but that more work was necessary on this front.

> *"Federal and state governments could look at changing whether criminal justice records should keep you out—it's hurting low-income folks and the industry."*
>
> – HPOG Program Operator

Federal rules on data privacy may have hindered HPOG implementation.

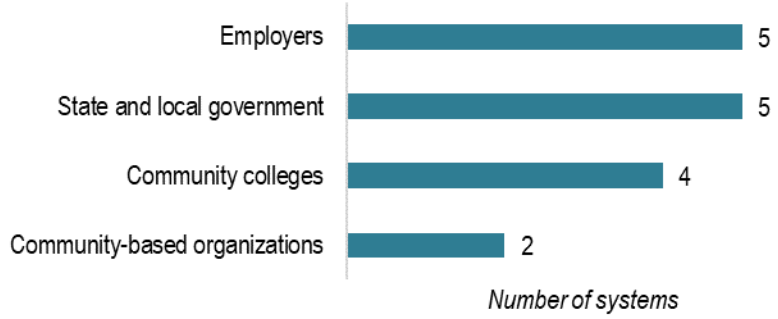
Respondents in five systems described concerns with sharing data. The most common concern among respondents was protecting individual program participant data governed by the Family Educational Rights and Privacy Act. These respondents noted that student information privacy rules could be a challenge to sharing data among program operators and partners. One partner said that these guidelines constrained data-sharing efforts, saying we "can't share concrete data without specific permission." Some respondents voiced concerns about protecting individual-level data on participants, and others shared strategies for how they overcame this challenge. Some respondents indicated that they elected to share aggregate data or work with participants to obtain consent to help mitigate concerns in protecting individual program participant data. Several respondents expressed concerns over restrictive data-sharing agreements that inhibited their ability to share data across HPOG program partners and operators for program management.

> *"Our willingness to share data with other organizations depends on [the] purpose of data [collection and their use] and if sharing would compromise the integrity of the participants' [private information]."*
>
> – HPOG Program Operator

Career pathways existed before the HPOG programs, but barriers to accessing them remained during HPOG 2.0.

As discussed in Chapter 2, ACF encouraged HPOG 2.0 programs to develop and enhance healthcare career pathways, which provide an articulated career ladder. Respondents in 10 systems indicated that healthcare career pathways were present in the local system prior to HPOG 2.0. Career pathway initiatives or programs may have been part of HPOG 1.0 or separate efforts such as state-led initiatives. Respondents in 5 systems commented that employers led most existing career pathway initiatives, but that state and local government agencies, community colleges, and community-based organizations also contributed to these initiatives (Exhibit 3-3).

Exhibit 3-3 Sponsors of Existing Career Pathways in HPOG 2.0 Systems



Source: 2019–20 interviews with HPOG 2.0 program operators and partners. N = 15.

Respondents in three systems described state-level initiatives focused on getting high school students and adults into healthcare career pathways. One local healthcare employer indicated that his company was considering a pipeline starting in high school. The employer already had a program in place that provided an opportunity for high school juniors and seniors to be exposed to healthcare careers and was considering an affiliation agreement with high schools to allow

students to come to a hospital or clinic on their campus to observe procedures. Another partner noted that the local workforce steering committee created a career pathway map of healthcare opportunities at the local community college and produced a video describing career pathways.

As will be described further in Chapter 4, respondents generally agreed that career pathways made it easier for individuals to advance in the healthcare field. However, these pathways were not always fully built out or funded, especially for lower-level positions. One partner noted, "Healthcare has traditionally not really had career pathways at [lower] levels … you're typically considering middle skills or higher. For CNAs, there is no bridge program to give people credit for being a CNA that overlaps with the next program." Another partner said of home health aides, "There's no real career ladder in long-term care because career advancement from home health aide is not paid for in the system."[40]

Additionally, respondents in four systems noted that even when career pathways existed, they remained elusive to many low-income individuals who lacked the financial means to progress along them. Many of the financial challenges discussed above, such as the high cost of healthcare training, insufficient financial supports for training, low wages in entry-level positions, and trade-offs that low-income people often have to make between school and work, made following a career pathway extremely difficult.

> *"For folks who are low income or living in poverty, it's very challenging to make the move from CNA to the next level because you can't quit your job and go back to school."*
>
> – Community Based Organization Partner

[40] Evidence from recent research on the extent to which HPOG participants complete training at one level and then complete a second, higher-level training indicates this pattern is rare (Klerman, Litwok, and Morris 2022).

4. HOW HPOG 2.0 PROGRAM IMPLEMENTATION INFLUENCED LOCAL SERVICE DELIVERY SYSTEMS

HPOG 2.0 program operators worked with their partners to increase collaboration, improve access to and the quality of training and support services (including developing and implementing career pathways), engage employers, share data, and sustain training and supports beyond the end of the grant. These five overarching systems activities (discussed in Chapter 1) can improve how local service delivery systems function to support healthcare training for people with low incomes and meet employer demand. This chapter describes how the 15 program operators and their partners believed the HPOG programs influenced the systems in which they operated.

4.1 Improving Collaboration among Organizations in the System

Collaboration among organizations in systems is a critical systems activity (Bernstein and Martin-Caughey 2017). A goal of collaboration is for organizations across a system to share a vision or coordinated approach to serving workers and employers and to effectively work together to solve problems and share best practices. The HPOG program operators and partners interviewed revealed different levels of collaboration across their local service delivery systems. They also described coordination activities such as regular meetings, informal contact as needed, and sharing participant information. In some cases, respondents could not be sure if increased collaboration or certain coordination activities were a direct result of HPOG, as systems often had several healthcare workforce–related initiatives happening simultaneously.

HPOG programs seemed to spur new collaboration among partners.

Respondents from 10 systems commented that the HPOG program was responsible for new collaboration or coordination activities in their healthcare systems. For example, one workforce development board partner described the shared vision of HPOG partners as enabling them to come together and coordinate to change their programs from short-term trainings to longer-term training pathways. A training partner commented that the program operator kept existing partners working together and built new relationships with partners. The partner believed these relationships never would have happened without HPOG. One community college partner said, “It’s about all working together to find an opportunity for people who wouldn’t typically have the opportunity.”

HPOG programs appeared to bolster existing efforts at collaboration.

Respondents from eight systems noted that although HPOG was not necessarily the cause of new collaboration or coordination, it increased collaborative efforts that were already taking place. This bolstering effect was particularly evident with programs in which

> *“I think our HPOG program has improved collaboration across the system. I think us reaching out to employers made a big difference. I was going to their doors and knocking at the beginning of HPOG 1.0 to create partnerships.”*
>
> – HPOG Program Operator

the partners had worked together prior to the start of the grant period, such as for the nine program operators and their partners that were part of HPOG 1.0. For example, one program operator described how they began collaborating to offer training and services for participants as part of their HPOG 1.0 program. They built on those established partnerships to really focus on building their healthcare workforce during HPOG 2.0. One local workforce system partner said, "I think the momentum was already there in terms of collaboration before the HPOG partnership came together. I think [HPOG] reinforced the benefit of collaboration versus competition. The fact [that] you have these organizations working together functionally has helped from an organizational standpoint because the individual staffer sees that this is something that can be done."

In some systems, HPOG programs did not appear to create new opportunities for collaboration due to competition among partners.

Respondents from five systems reported a lack of cohesion across their system and that collaborative efforts occurred only between certain organizations or within certain smaller partnerships. Respondents cited causes such as competitiveness among both training providers and employers, competing priorities, and bureaucracy as prohibitive to systemwide coordination. One employer partner noted how competition can hinder collaboration across the system: "In terms of how healthcare employers work across the [local service delivery] system, when it comes to [our organization], we come together as a united entity. When we leave the organization, it's unfortunate that there's a [home health] agency on every corner. It's very competitive, and we're not as united as we should be when we walk away from the HPOG table. Our patients would be happier, and we would have less turnover if we collaborated with other agencies."

HPOG program operators and their partners participated in a variety of collaborative activities.

Respondents across all of the systems mentioned specific collaborative activities, such as employer engagement, discussing or sharing training program curricula, sharing best practices for serving HPOG participants, getting partner input, and grant writing. These respondents described the modes of collaboration and coordination that supported such activities (Exhibit 4-1). The most common collaboration activity used already-established system meetings, such as healthcare industry partnership meetings or workforce development system meetings, to discuss HPOG programs (14 systems). The second-most common collaboration activity was one-on-one collaboration in which individuals from partner organizations contacted each other directly to share information, such as how to meet the needs of a particular participant or to discuss job openings (13 systems). Other collaboration activities included holding regularly scheduled meetings specifically about HPOG for all partners or a subset of partners (12 systems); referring HPOG staff or participants to each other's programs, services, or job openings (11 systems); conducting outreach and recruitment for HPOG programs (7 systems); and co-locating HPOG staff at partner organization locations to streamline program operations, such as recruitment and participant support (4 systems).

Exhibit 4-1 Mode of Collaboration and Coordination in HPOG 2.0 Systems

Source: 2019–20 interviews with HPOG 2.0 program operators and partners. N = 15.

4.2 Improving Access to and the Quality of Healthcare Training and Support Services

Another goal of HPOG was to provide an opportunity for people with low incomes to access healthcare training and support services, as discussed in Chapter 1. This goal included making training and services visible and accessible to people with barriers to employment and making more healthcare training available in the community. Improved access could also include increasing the awareness of training or increasing the availability of training to people with low incomes. Improving the quality of healthcare training and services could include tailoring programs to employers' workforce needs, building career pathways (will be discussed in Section 4.3), and ensuring wraparound support services to help participants succeed. Overall, respondents believed many HPOG participants would not have been able to access healthcare training and enter healthcare jobs without HPOG. Respondents were generally more focused on discussing access to training versus quality of training and support services, even when asked about both.

Respondents thought HPOG increased access to healthcare training, particularly in rural areas.[41]

> *"The most important contribution HPOG has made to the healthcare delivery system is to provide the funds to students who otherwise wouldn't be able to go through a program."*
>
> – Training Provider Partner

Respondents from all 15 systems believed HPOG increased access to healthcare training for individuals who otherwise might not have been able to enroll and persist in a healthcare training program. Respondents in four systems reported that the HPOG programs addressed the challenge of increasing the accessibility of training in rural areas. Two factors that contributed to their success, according to respondents from two systems, were finding and retaining healthcare educators and offering enough clinical placements. One workforce system partner described how lack of instructors constrained the regional system's ability to provide required

[41] The HPOG 2.0 Short-Term Impact Report found 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).

hands-on training prior to certification: "We could use a lot more CNA training in this region, but it's very difficult for other training providers to hire a qualified CNA trainer. Even some of our local institutions have a limit on the number of RNs and LPNs they can [accept in training] because of the difficulty of finding qualified nurse educators."

Respondents considered random assignment, a part of the National Evaluation's Impact Evaluation, a barrier to training access.

As described above, the HPOG 2.0 National Evaluation is studying whether and how HPOG affected participants' education, employment, earnings, and other outcomes over time. Eligible applicants to HPOG were randomly assigned to a group that could participate in the local HPOG program (the treatment group) or to a group that could not participate in the program (the control group). Control group members did not have access to HPOG, but they could access other programs and resources for which they were eligible.[42] Respondents from 11 systems, including program operators and partners, identified random assignment as a barrier to access for some participants, as other programs and supports outside of HPOG were not sufficient to support entry into training for all individuals assigned to control groups. Respondents also noted how disappointing and confusing it could be for candidates who qualified for HPOG but were not randomized into the treatment group. A community-based organization partner commented, "The challenge for HPOG is randomization. People expect us to help them when they come in, and that makes it hard for us. They wonder: We're in the same family and same situation, so why does only one of us get services?"

Some respondents thought that HPOG improved the quality of training and services and participants' experience in healthcare training.

Respondents from five systems reported that HPOG increased the quality of healthcare training in their system in some way. Most comments focused on how HPOG-funded training met the needs of specific employers and therefore led to employment. A few mentioned improvement in specific components of training courses. For example, one workforce development board partner mentioned that HPOG created a more streamlined process for enrolling people in training courses and connecting them to support services. In addition, some community college partners thought that they themselves were increasing the quality of training for HPOG participants. One respondent noted that their simulation lab, developed with HPOG funding, was designed to increase the quality of the hands-on component of their training courses. Another community college partner thought having access to an employment specialist for participants was particularly important for improving the quality of the program because HPOG participants were able to get jobs after graduating.

[42] For more information on this aspect of the evaluation, see Klerman, Judkins, and Locke (2019).

Some respondents indicated that the main contribution of HPOG was the wraparound support services, but it was still difficult to overcome barriers to education and employment success.

Program operators and their partners in seven systems commented that the biggest contribution of HPOG to their healthcare delivery system was the wraparound supports that helped participants complete their programs and transition to the workforce.[43] Reasons cited included HPOG's provision of support services and staff, such as navigators, as well as financial assistance. A training partner noted, "I've talked to HPOG participants who said if it weren't for HPOG, they don't know how they would have gotten to the next level. The case managers are critical in helping them navigate resumes and professional development."

> *"They [HPOG staff] talk about financial aid options and transportation methods and can help [participants] with bus passes. With child care, they talk about their plan while the person is doing classes and how they can help. The new employment specialist has also been doing a really good job with my graduates when I couldn't work with them. They help with finding jobs, working on resumes, and prepping for interviews."*
>
> – Community College Partner

HPOG participants, as well, continued to face challenges because support services could not always overcome the complex barriers that many individuals faced in their personal lives. Once participants finished training and entered the workforce, respondents noted that they often lost access to critical wraparound services like child care and transportation, making it harder for them to work and retain employment. In addition, some respondents also noted that individuals who may have been eligible for an HPOG program may not have participated because they thought some barriers made completion of healthcare training and holding a healthcare job extremely difficult.

4.3 Informing the Development and Use of Career Pathways

Developing and using career pathways are other ways HPOG programs could help improve access to and the quality of healthcare training and services because they connect people to training and employment in an industry or occupation with opportunities for advancement (Eyster and Gebrekristos 2018). ACF (2015) required that HPOG programs develop and enhance healthcare career pathways.

Chapter 3 discusses the existence of career pathways and pathways activities in healthcare systems beyond HPOG programs. This section describes how HPOG program activities expanded the role of career pathways in systems. Respondents varied in their descriptions of what healthcare career pathways looked like within HPOG, as well as the relationship between HPOG and building healthcare career pathways. In some cases, it was not clear whether HPOG directly led to the development of new career pathways or the strengthening of existing ones, as some program operators and partners were already participating in career pathways activities prior to the grants.

[43] Klerman et al. (2022) found that treatment group members received more career-related and caseworker services than control group members.

HPOG programs created, strengthened, or made use of career pathways.

Respondents from 12 systems felt that the HPOG programs created or strengthened healthcare career pathways in some way. This included moving participants through various partners' education, training, or support service programs, as well as HPOG staff supporting participants to move to higher levels of training and education beyond HPOG-funded programs. One training partner thought the pathway in nursing occupations was well articulated: "If you do CNA through [community college partner], then move to our LVN [licensed vocational nurse] mobility program, then get associates RN [registered nurse], and then MSN [master's in nursing], that pathway is clear."

Respondents from nine systems described career pathways between specific occupations that were supported by HPOG. For example, several respondents mentioned CNA to LPN as an important step for HPOG participants.

Respondents described challenges related to creating career pathways for healthcare occupations.

Respondents in five systems noted some challenges related to the development of career pathways through HPOG. For example, several respondents shared that some organizations, such as the public workforce system or local government, touted career pathways as a goal or initiative across industries, but these respondents did not see the model succeed in helping people advance in healthcare. Others cited that difficulty getting employers involved in the HPOG program was a challenge to supporting participants' advancement in a healthcare career pathway, as discussed in the next section.

In addition, although some respondents described how HPOG supported clear pathways between particular occupations, others stressed a lack of connections. For example, one respondent mentioned that there was no clear bridge in her system to move from CNA into LPN training beyond one partnership that had not yet been brought to scale. Finally, three respondents mentioned that competition between employers for entry-level workers and among healthcare training and service providers for public funding could interfere with collaboration across organizations to build pathways across their systems.

4.4 Engaging Employers and Industry and Supporting Their Hiring Needs

ACF (2015) encouraged HPOG grantees to partner with employers to support program design and implementation. Employers and industry are often a focus of system activities, which the organizations within a system support by advocating for improved job quality, encouraging employers to provide funding for training, and providing technical assistance to employers.[44] Program operators and partners described the ways HPOG programs built relationships with employers, including how employers engaged with HPOG and program participants and how HPOG was used as a hiring pipeline for employers.

[44] Bernstein and Martin-Caughey (2017).

HPOG programs appeared to facilitate increased collaboration with employers within the system, but some respondents thought employer partnerships could be stronger.

According to respondents from five systems, the HPOG programs helped to increase collaboration between healthcare employers and organizations within the system. Collaboration could be directly as part of HPOG activities or partnerships or indirectly through the involvement of HPOG partners who already had established relationships with certain employers. One program operator described how its HPOG partners coordinated with employers and industry through job fairs, an event for veterans, advisory committees, and direct one-on-one coordination with specific employers as needed. An employer partner remarked, "The most important contribution of HPOG has been bringing the providers and employers together to make that communication, and education and marketing of all the possibilities for training available. HPOG has brought a lot of people together that may not have been in the same room before."

Respondents in a few systems described their desire for stronger systemwide industry partnerships to increase the quality of the training and help ensure employers across the system hired program graduates. These respondents recognized that their current one-on-one relationships with employers may only address specific employer needs. They would rather develop industry partnerships with multiple employers involved to develop systemwide strategies for healthcare training and hiring. One program operator noted a discrepancy between the expected intensity of employer engagement in the HPOG program and actual employer engagement. The program operator expected employers to provide feedback in curriculum development, but employers focused more on hiring recent program graduates. Respondents from two systems suggested that there may have been challenges in having the right people at the table, either from the organization's leadership team or from employer partners.

> *"A goal is getting feedback from our employers to keep us abreast of what's going on in labor market demand. Engaging them at a deeper level is the ultimate goal. We have honest conversations about who they'll hire. We're making projections: we ask them to tell us about what jobs will look like in six months or a year from now so we can create training programs for when new jobs come up in the future. We haven't been able to do that but [we] want to."*
>
> – HPOG Program Operator

Program operators engaged employers through multiple channels.

Respondents in 10 systems described a range of ways employers were involved with programs, including direct engagement with program participants, co-creating curricula, and financial support. One program operator, for example, emphasized that the feedback processes for employers in program design helped its HPOG program develop employees with the skills the employers needed and whom they would hire. Respondents in 7 systems noted that program operators led various regular meetings with employers. They referenced using these meetings to better understand employer needs (such as being sent applicants who matched the job description well), to ask employers to inform curriculum development, and to gain insight into employers' hiring practices and onboarding processes. One program operator noted that these meetings helped clarify what was working and what was not. They also used the meetings to

understand how skill needs were changing so program operators could make sure participants would qualify for available jobs.

Respondents in 11 systems described how employers supported participants' entry into the healthcare workforce by participating in job fairs or mock interview events. At these events, HPOG program participants could learn what is needed to work in the industry, have one-on-one interactions with employers, and take advantage of tours and job-shadowing opportunities. One program operator highlighted the role of employers in helping identify job opportunities for participants: "They helped us with looking up job titles when students apply for jobs. They let us know which of our occupational trainings will serve their different job titles."

HPOG programs worked with employers to provide work-based learning experiences beyond clinical placements.

Although respondents in all 15 systems reported partnering with employers for work-based learning opportunities, respondents from 6 systems highlighted more extensive work-based learning opportunities for HPOG participants.[45] They noted that opportunities extended beyond clinical placements to externships and other on-the-job training.[46] Respondents in two systems indicated that such opportunities benefitted the hiring pipeline for employers. One respondent highlighted how such experiences led employers to hire those who were placed at their agency or facility because the employer knew these participants personally and knew they were well-trained. Another partner referenced specific job offers that stemmed from HPOG participants completing clinical work: "The students have job offers before they graduate through relationships built through doing the clinical work."

> *"[The employer] has trainings on site in the evenings from 6:00-9:00. It uses an apprenticeship model with learning on the job. With the human resources representative coming into your classroom, [participants] get a one-on-one conversation.... It customizes the workforce experience of our HPOG participants."*
>
> – HPOG Program Operator

HPOG program operators encouraged employers to provide support to their current employees in HPOG-funded trainings.

Respondents in six systems explained how HPOG programs worked with employers to offer supports for their current employees (i.e., incumbent workers), to participate in healthcare training. These supports included stipends to go back to school or take employer-paid courses. These respondents described efforts to encourage employers to help their own employees who participated in HPOG programs persist in and complete training. One program operator described how its program vetted employer partners to identify "high-road employers" with upward job mobility and tuition reimbursement to connect program participants to employers that would support them.

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[45] The HPOG 2.0 Implementation Study Report indicates that 68 percent of HPOG programs offered work-based learning (Roy et al. forthcoming). This discrepancy may be due to the respondents' understanding of work-based learning and selection of programs for this study.

[46] A clinical placement is a supervised and structured, hands-on learning experience in a healthcare setting to master needed skills and competencies for a given occupation. An externship is a work-based learning experience that is embedded in the curriculum for a training program to allow students to obtain work experience.

Respondents in five systems noted that HPOG supported incumbent worker training efforts to improve the skills of current employees. One respondent highlighted how providing such incumbent worker training was valuable for fostering the broader relationship between employers and the HPOG program.

Respondents thought that some HPOG programs tailored training courses to meet employers' needs.

Building a pipeline of skilled workers was a goal of the HPOG Program. Several respondents described how local HPOG programs customized training curricula to meet employers' needs and how employers reported that the program served as a hiring pipeline for them, generating strong candidates. Respondents in six systems highlighted how their HPOG programs adjusted occupational trainings based on employer feedback. One described how their partnership with employers was designed to be a long-term solution by "ascertaining employer needs in the long term, then work[ing] … [with] training providers to make sure they understand [the] need, then execute from there." One respondent mentioned working with employers to create tailored program placements. Employer partners also highlighted their experience providing feedback for curriculum development for the HPOG program. Although respondents' comments were generally positive, one community college partner commented that the stringent guidelines for program accreditation decreased its flexibility to customize to employer needs.

> *"An example of a time I provided input on the curriculum [involved] a new policy coming out where they wanted home health aides to be able to administer medicine. We talked with HPOG about what employers look for in terms of different skill sets, like the importance of knowing how to deal with Alzheimer's."*
>
> – Employer Partner

Most employers believed that the HPOG program model provided a strong pipeline for new workers.

Employer respondents in 13 systems described how the HPOG program was a hiring pipeline for employers. One employer referenced the high-quality training HPOG participants received. One program operator said that employers specifically asked about its HPOG program graduates: "When we have participants that complete the CNA, LPN, or the RN program, our partner employers will call and want to know when graduation is and which of them are our participants, and some of them are even approaching them at graduation and offering them positions."

Three employer respondents described how the HPOG program was able to effectively track and support employee retention among HPOG participants after they graduated from the program, and they reported that hired HPOG participants had strong retention at their employers. Two emphasized the active role that the HPOG program took in this process, describing how HPOG staff checked on employee retention with employers after program participants graduated.

> *"We are able to hire [HPOG program participants] because we know their ethics and style and don't always need to interview them, so it's been an easy way to hire. Even if we don't have a vacancy, when we do, we make an effort to hire HPOG participants."*
>
> – Employer Partner

HPOG programs seemed to help participants overcome barriers to employment and become skilled healthcare workers whom employers wanted to hire.

Respondents in four systems described how the HPOG program made participants more hirable by providing them with relevant occupational and basic skills. A community-based partner commented that they saw "concrete evidence that [the HPOG program] made individuals more hirable."

Respondents in five systems described how the HPOG program changed their ideas of who was hirable. One employer highlighted how the inspiring stories of HPOG program participants who lived in shelters and were hired successfully were able to change employers' perspectives: "I think when you consistently get success stories from [the HPOG program operator], it breaks biases you may have or stereotypes toward low-income individuals or people living in shelters. I think that's really important. Look how many people I've hired who came from these backgrounds that are now productive members of the workforce. It's been an awakening for me personally and professionally." Other respondents emphasized that HPOG can support these participants through their journey because the program operator "provides tremendous value in terms of increasing coordination. Then you find the people who fell through the cracks and figure out why." Despite these successes, two respondents noted that some employers still wanted to hire the ideal worker instead of providing on-the-job training, and another recognized that negative attitudes employers have about participants, many of whom receive public benefits, are difficult to change.

> *"I think HPOG has started a conversation…. Usually when I'm at a meeting, it's about barriers students face, which generates conversation about how the types of barriers they have affect the types of jobs they have. Transportation and child care are huge barriers. If you're a home health aide, you can't take an Uber or cab to a person's home because of privacy concerns. Little things like that we don't know about are things our customers face every day and become barriers. Employers are starting to think about how to help work through those things."*
>
> – Workforce Partner

Some HPOG programs experienced difficulty engaging large employers.

Respondents in four systems described the challenges associated with building employer partnerships with organizations that were large and decentralized. Notably, respondents in three systems mentioned that hospitals present particular challenges because of their large and decentralized organizational structure, many components of which may be located outside of the region where the HPOG program was operating. One program operator detailed these challenges: "We have three major hospital systems, and two are owned by regional entities now. That makes it hard to partner. All the smaller clinics are under larger umbrellas instead of being independent employers, so it's harder to get one-on-one partnerships when we have to go through a massive HR system. We aren't unable to partner, it's just harder to partner."

4.5 Encouraging Data Sharing for Decision-making

In support of program operations, Federal oversight, and evaluation activities, HPOG 2.0 programs collected data on HPOG participants, their program activities, and their outcomes to improve program performance and evaluate program effectiveness. HPOG programs often had to work with their partners to collect participant data. The advantage of sharing data is that it can

support joint decision-making, not only to improve program performance but also to improve future sharing and use of data across the system (Bernstein and Martin-Caughey 2017). HPOG encouraged data sharing in several ways. Local HPOG programs were required to track participant characteristics, activities, and outcomes in the HPOG 2.0 Participant Accomplishment and Grant Evaluation System (PAGES). Program partner activities were reported in PAGES as well. Program operators and partners could use the data for program management and reporting, as well as to improve the quality of training and services and strengthen collaboration. Data sharing could be new to some program operators and their partners. Few program operators and partners created formal data sharing arrangements, with more using existing agreements or informally sharing data. However, as discussed in Chapter 3, rules protecting student privacy could make data sharing challenging. This section discusses how program operators and partners shared data and to what end.

Data sharing through HPOG could be valuable to enhancing partnerships across the system and coordinating system strategies.

Respondents in three systems explained that they leveraged shared data to manage partner relationships and improve coordination between partners. Some respondents used data sharing to tackle questions of program capacity to ensure programs continued to meet participants' and employers' needs. Respondents in two systems noted that shared data were a resource that could ease staff reporting burdens and reduce duplication of efforts across partners. One program operator said that the data it pooled with its partners suggested that it needed to increase staff capacity to deliver services.

Respondents in the same three systems described how sharing data at partner meetings could help support joint decision-making on program performance. As one respondent said, "At the advisory board presentations, [the HPOG program operator] gave lots of data. There is lots of information about the value of assessments, economic impact, enrollment and graduation statistics, number served, and success in the workforce." The aggregated data on participants were especially valuable for understanding participant outcomes and challenges and how the program operator and partners could improve their programs and services to support them.

Respondents in two systems described how HPOG partners shared data for strategic planning efforts and to improve program development. Two other respondents indicated that they used shared data primarily to understand participant characteristics—to describe the participant population, who they were, and to meet their needs. These respondents highlighted how shared data can advance key pieces of the HPOG program by responding to participant needs and by building strategic industry-wide collaborations to improve workforce training for low-income populations.

Arrangements for sharing data varied.

Respondents in six systems indicated that they shared data for HPOG without a formal data-sharing agreement. Three respondents in these systems said they developed data-sharing agreements or memoranda of understanding with program partners. One partner commented, "If there is [a memorandum of understanding] in place, we are able to share data on HPOG participants or other aspects of program management to improve coordination across the

healthcare system." One respondent described a challenge in obtaining the authority to make data sharing possible in the workforce development system, which data-sharing agreements can help alleviate.

Sharing data for HPOG could improve case management across the system.

Respondents in five systems highlighted how data sharing through the HPOG program helped improve case management of participants. Respondents in six systems said that they used shared data to guide participants to services and track progress and outcomes. Several respondents described the types of outcomes they tracked in their data systems, using demographics, employment, enrollment, completion of training, referrals to other services, and career trajectories of participants as key metrics.

PAGES seemed to support some data sharing across program operators and partners.

Respondents in a few systems highlighted the value of PAGES. One partner described how PAGES provided a point of connection: "All of our partners have access to PAGES.… HPOG has supported data sharing on participants. It's awesome that we have a database we're all hooked up to." One program operator said, "We share from PAGES data to create new partners, strengthen participation, or show overall impact on our community." A few respondents mentioned the data system as a resource for sharing data, although two acknowledged that it was not sufficiently flexible for day-to-day tracking of participant activities and engagement.

Data sharing efforts for HPOG were often piecemeal.

Program operators in six systems described disparate, sometimes ad hoc, data-sharing activities. One program operator described its data-sharing strategy in this way: "When our partners ask, we provide data on participants. If someone gains employment, we let the partner where they're co-enrolled know that happened." Another program operator said, "Each individual organization in the system collects its own data. We collect information on hiring and retention that we don't share, but there is some information we do share." Three respondents indicated that data were often siloed, as partners may maintain their own data systems.

HPOG was sometimes part of existing systemwide data-sharing efforts, so it did not increase data sharing in the system.

Respondents in four systems highlighted how organizations already shared data across the local service delivery system. Some indicated that data sharing happened through the course of administering workforce programs as part of regular reporting. They noted that they shared data with funders, such as agencies that administer WIOA and TANF services. One community-based service provider noted, "In terms of data sharing, we're obligated to report employment data to [local social service agency], so we keep track of participants."

A few respondents described local workforce systemwide data-sharing efforts that gave partners access to one harmonized data system in which they could see other partners' data on participants. Such widely shared data systems appeared to be less common across HPOG partnerships, with only two program operators indicating that they and their partners used such systems. Two respondents mentioned that HPOG was a participating partner in the system but was not a catalyst of these efforts. Depending on the HPOG partnership, different partners led systemwide data-sharing efforts.

> *"Without [HPOG program], I think there will be a direct impact on my program and participants… Those participants would not otherwise have access to education. [The HPOG program] takes away a huge barrier. Once the funding ends, it will be a whole different strategy in terms of case management and resource referral in terms of inspiring my participants to engage in education because they will be entering the community college setting having to fund their own education."*
>
> – State Government Agency Partner

4.6 Supporting Sustainability of Healthcare Training and Services in the System

Sustaining HPOG training and supports beyond the end of the HPOG 2.0 grant funding was an important component of project planning and collaboration. In general, respondents across all systems agreed that HPOG programs allowed systems to better serve individuals with low incomes in ways that would not have been possible without the grant program. Workforce system partners also indicated that continuing to provide support services was a critical program component for sustained impact. ACF indicated its intent to provide technical assistance to support sustainability of the programs in the FOA. Program operators and partners perceived a variety of ways in which HPOG activities would help sustain healthcare training for individuals with low incomes in their respective systems. Respondents described sustainability as critical to meet the ongoing demand for trained healthcare workers in their communities. However, they expressed concerns about their ability to continue HPOG program components past the grant period without other sources of funding.

The training and services developed or improved under HPOG were likely to continue in some form beyond the grant period.

Respondents from nine systems indicated that some of the training and services offered through HPOG would continue beyond the life of the grant. Some respondents from organizations that were not training providers but that served individuals with low incomes in need of job training indicated that they were actively looking for other subsidized healthcare training opportunities for their clients. One program operator was considering developing its own in-house healthcare training program. Respondents included program operators and partners that were not previously focused on healthcare workers but planned to continue healthcare training and services as a result of HPOG.

Respondents from two systems indicated that they planned to continue all components of their HPOG programs at a similar level using other funding sources. Operators and partners from other systems indicated that they would continue doing similar work but on a smaller scale. Some respondents described funding goals for sustaining specific HPOG staff, including program directors, career navigators, and program coordinators. Such plans reflect some

systems' emphasis on keeping the program structure developed under HPOG and working closely with participants with barriers to training and employment in order to help them succeed.

In some instances, new and enhanced collaboration developed under HPOG will be sustained.

As discussed in Section 4.1, collaboration was an important but challenging activity for designing and implementing HPOG programs. In fact, eight systems had no respondents who believed collaboration across organizations developed under HPOG would be sustained. A few respondents specifically noted the difficulty of institutionalizing coordination across a local system beyond specific initiatives or the efforts of individual entities.

However, respondents from the remaining seven systems reported that increased collaboration and coordination across various organizations that resulted from HPOG would be sustained beyond the end of the grant. Some respondents also indicated that ongoing collaboration would be important for sustaining healthcare training or services for individuals with low incomes. For example, one community-based partner commented, "In terms of strategies for sustaining progress, some of the connections we've made with the hospital systems can develop into career paths that the hospitals themselves will want to support."

Program operators and partners described a variety of collaboration and coordination activities that would be sustained beyond the HPOG award period. These activities included the following:

> *"It's been a deliberate effort on our part in HPOG 2.0 to bring partners to the table. We do this through the lens of sustainability. We went into HPOG 2.0 planning for the end. The biggest impact of HPOG 2.0 on the community has been getting a lot of major players in the workforce space to the table and collaborating together."*
>
> – HPOG Program Operator

- holding regular meetings with representatives from various organizations, including workforce development agencies and social services organizations;
- discussing with their HPOG partners how the program or parts of the program could be sustained or continued at some level after the grant period; and
- continuing to make referrals between organizations offering different programs and services, continuing to use the peer learning resources generated by HPOG, and benefiting from general improvements to various healthcare system processes resulting from HPOG programs.

Some program operators and partners indicated that HPOG helped them determine what works best for their healthcare training programs and enabled them to work more closely with employers to meet their needs. This understanding resulted in relationships that would be sustained beyond the grant. "We've been helping fill the needs of employers, and I think we've been doing a pretty good job," one respondent reported. "They trust that we can send them qualified employees who will excel for them in the workforce." A few respondents indicated that employer partners will want to support training efforts now that they have seen the benefits for meeting their labor demands.

Overall, respondents from the seven programs who thought that collaboration would continue indicated that their HPOG program created many opportunities to connect and that these opportunities would last beyond the end of the grant. A training partner said its staff felt comfortable picking up the phone and reaching out to the program operator if something was not working. A community-based organization partner also thought opportunities to build trust across organizations, like a roundtable at which everyone speaks, were important to the success of the collaborations. One program operator thought the collaboration generated through the HPOG program would continue in the long run: "[HPOG partner] meetings will continue even when the grant ends. We've been doing that from day one. We share everything that's going on in our programs, good and bad, and give each other ideas to make it better. We also support each other in writing grants."

Respondents in some systems noted that HPOG helped establish policies and processes that support long-term efforts to provide healthcare training, job opportunities, and support services to people with low incomes.

Respondents in four systems noted that program operators and partners were able to make changes to the WIOA eligibility requirements and work requirements tied to receipt of public assistance benefits (e.g., TANF and the Supplemental Nutrition Assistance Program) to increase the number of people who qualified for subsidized job training. As one program operator explained, "There are times when our local policies were in the way from a WIOA standpoint. When certain situations would come about and a person couldn't get approved, we were able to take those examples to the [workforce] board and get some of those policies removed. That wouldn't have happened without HPOG referring people to us. That increased the efficiency and efficacy of our enrollment process." Another program operator noted that although the HPOG program did not lead to new, dedicated funding sources for healthcare training in its community, local WIOA eligibility requirements were changed so that a participant did not have be a laid-off worker to qualify for training. Consequently, this program operator said, "We went from only being able to fund 3,000 people to 7,000."

Participation in HPOG also led a few workforce systems partners to change their internal program policies in ways that will continue to support sustained training for individuals with low incomes after the end of the grant period. For example, one partner commented, "We have an internal policy that we won't interview CNAs until they pass a state board exam, but for [the program operator] we waive that because they have such a high pass rate [on the licensing test]."

Finally, one program operator described how state policy surrounding enhanced nursing licensure had been changed recently to enable RNs and LPNs to have one multistate license. While not a change directly brought on by the HPOG program, the program operator expected the new policy would have a sustained impact on students' job prospects after they complete their training in nursing: "It is an extra fee, but if [participants] pay to be in the Compact, then they can practice in, I believe, 25 different states, and that's huge, because not only do we serve our students here, we have a population and nursing program … at [a nearby] military base, and they're always deploying to other places…. It will be tremendous for those students

because for them it has been a terrible barrier to move to another state and then have to go sometimes through a number of hoops [to meet licensing requirements]."

HPOG programs could not be fully sustained without new sources of funding.

Respondents from 10 HPOG systems indicated that they would not be able to continue providing training and support services for individuals with low incomes at all or at the same level without additional funding.

However, respondents from 14 systems indicated that they had already identified or were intentionally working to identify other funding sources that would allow them to continue their HPOG programs at some level or sustain at least some components of their programs (see box to the right). One adult education partner described the need for a funding leader: "If the HPOG grant money goes away, we'd need employers sponsoring their own training or hiring individuals [to demonstrate] that they're willing to invest in training. Finding the one larger entity willing to stand behind this effort and be a leader is what we're lacking in our area."

Potential Sources for Sustaining HPOG Identified by Respondents

- WIOA Title I
- Vocational Rehabilitation
- State and local funding
- Community college–based initiatives
- Scholarships
- Pell grants and other student financial aid programs
- TANF
- Employer-sponsored training and other private funding
- Foundation funding
- Other grant programs

Respondents in six systems noted the importance of data in gaining funding and support for continuing HPOG. Several respondents stressed the importance of using HPOG data on participant outcomes to advocate for funding from state legislators, local government leaders, and private funders like foundations and employers. One program operator said, "I'm always planning for the future and thinking about how to do things differently, and that data is key for how to focus efforts and plan for new opportunities."

5. CONCLUSIONS

The Systems Study for the HPOG 2.0 National Evaluation explored how 15 selected HPOG program operators and their partners conducted systems activities that may have improved or hindered how the larger service delivery system functioned. The study also explored how the local labor market and social and policy contexts within the systems in which the programs operated not only influenced the design of the HPOG programs but may have hindered their ability to be responsive to the needs of participants and employers. This chapter summarizes the findings and provides implications for future initiatives.

5.1 SUMMARY OF FINDINGS

The sections below summarize the findings with respect to the System Study's three overarching research questions.

5.1.1 What Were the Local Service Delivery Systems in Which HPOG 2.0 Programs Operated?

The study examined the key components of 15 selected HPOG programs, the partners and employers they engaged and their roles, and their systems activities. The program operators represented a variety of organizations—community and technical colleges and other educational agencies, local workforce development boards, and community-based organizations—mostly serving urban areas but also in rural and suburban locations. Almost all programs focused on providing CNA training, an entry-level, lower-paying occupation, but most programs connected these occupations to a well-defined career pathway to support advancement.

The 15 HPOG 2.0 program operators partnered with over 290 organizations (including employers actively engaged with program operations and service delivery), most commonly community and technical colleges, community- and faith-based organizations, state government agencies, and American Job Centers, to implement their programs. The partners typically played multiple roles, most often providing occupational training, basic skills and other nonoccupational training, and referrals to services.

The main difference observed between HPOG 2.0 programs that did and did not receive funding under HPOG 1.0 is that *all* HPOG 2.0 programs, not only those in this study, reported having employers involved in the programs beyond hiring participants. For HPOG 1.0 programs, this was true for only 60 percent of the programs. In addition, the nine programs included in this study that received HPOG 1.0 funding often built on relationships with system partners established under their first grant. Otherwise, few differences in systems activities between programs that received HPOG 1.0 funding and those that only received HPOG 2.0 were observed.

Given employment goals, all program operators worked with employers on hiring trainees. In addition to hiring, employer partners worked with program operators to help ensure participants' employment success. They engaged with as few as one employer to as many as 150, with an

average of 39 employer partners per program. Employers most commonly provided job information, offered special hiring considerations for HPOG participants, and participated in career fairs. This appears to be more employer engagement than was present for HPOG 1.0. However, the perceived strength of these partnerships varied, with both program operators and partners acknowledging the difficulty of engaging employers.

Program operators and partners worked together to design and implement HPOG programs and engaged in systems activities that may have improved how their systems functioned. More than two-thirds of program operators indicated that they and their partners shared data, conducted joint marketing and outreach to potential applicants and employers, increased access to training, developed referral systems, and shared funding and resources or worked together to identify funding. Less common systems activities, such as establishing sector partnerships, employer-recognized credentials, and articulation agreements to support advancement, were related to developing career pathways.

Collaboration among program operators and partners was perceived to be critical to HPOG success. Program operators and partners had regular meetings on HPOG but also actively participated in meetings with community leaders and through industry partnerships. Program operators and their partners sometimes met as a group to address systemwide issues (e.g., recruitment to training, case management) that would not only help the success of the HPOG program but could be implemented across the system. In addition, some program operators and their partners worked together to find funding and other resources to sustain the HPOG program. However, not all attempts at collaboration were successful. Competition for resources, competing priorities, and bureaucracy were named as barriers to collaboration.

5.1.2 How Did Local Service Delivery Systems Influence the Implementation of the HPOG Programs?

The overall context for the systems in which the HPOG program operated—the local and regional labor markets, various social factors, and the policy context—was perceived to influence the HPOG program design. Program operators and partners widely reported that the need for trained healthcare workers, especially entry-level workers, rose in their service areas since the start of their grant. Respondents thought increased demand was driven by an aging population and geography. Overall, program operators and partners reported that HPOG programs responded to employer demand by developing a pipeline of skilled healthcare workers in their service areas. But there was concern among partners that these jobs, primarily CNAs, were low wage and low quality and may not offer a path to more advanced training and higher wages, causing high turnover. Program operators and partners had mixed opinions on whether career pathways did or did not succeed at connecting people in entry-level jobs to more advanced ones. Findings from other reports show that the HPOG 2.0 programs had difficulty realizing the goal of career pathways to help participants take more advanced steps in their education and employment.[47]

[47] See Peck et al. (2019) and Klerman et al. (2022) for more information.

Program operators and partners generally thought that the unmet needs in their local systems influenced the HPOG program design and implementation, but their views varied concerning HPOG's success at addressing systemic barriers to healthcare training and employment. Some respondents noted the difficulty in addressing long-standing barriers to success in training and employment. These barriers, which HPOG programs often addressed, included limited access to high-quality K-12 education providing preparation for college and careers, a lack of postsecondary education and training opportunities in the community, insufficient work and training supports (e.g., transportation and child care), challenges balancing work and family commitments with training, poor mental health, substance abuse, and basic needs that are unmet (e.g., housing or food insecurity). However, other respondents thought that HPOG addressed these systems barriers to some degree by providing intensive supports, which often included child care, transportation assistance, academic support, and career counseling. Other respondents noted challenges with the cost of training and balancing work, family, and school. Some program operators and partners thought that the needs in their community were too high for HPOG programs to address.

Program operators and partners also reported that other contextual factors in the system, such as policies and regulations, could hinder HPOG program implementation. Public policies on when benefits would end because of increased income, work requirements, and time limits could hurt recruitment and retention of participants. Additionally, regulations in the healthcare industry, although typically intended to ensure quality and safety in service delivery, could pose barriers to participation in HPOG trainings and access to jobs after program completion. Finally, program operators and partners noted that data privacy regulations could restrict data sharing to track HPOG participants' progress and performance.

5.1.3 How Did the Implementation of the HPOG Programs Influence How Local Service Delivery Systems Functioned?

The HPOG programs influenced local service delivery systems through increased collaboration with partners, including employers, increased access to and the quality of training and support services, employer engagement, data sharing, and sustainability. Overall, program operators and partners believed that the HPOG program spurred new collaborations or enhanced existing ones among organizations in the system. Some respondents thought that the collaboration helped to improve issues in the system, such as case management, service capacity, and referral processes. But others did not think HPOG programs increased collaboration, mainly due to competition within the system.

Program operators and partners across all 15 local service delivery systems emphasized that HPOG improved systems by increasing access to healthcare training for people with low incomes and barriers to employment, including those living in rural areas. Respondents strongly agreed that HPOG increased the quality of training and services, mainly by ensuring that participants had the support services they needed to complete their programs and find a job in healthcare. Some program operators and partners thought HPOG also increased the quality of healthcare training by creating or enhancing career pathways, but others did not think the HPOG career pathways actually helped people advance in healthcare.

A major component of HPOG was engaging employers to help build a better pipeline of healthcare workers. Program operators and partners engaged employers during HPOG 2.0 by having them serve as advisors on curriculum and credentials, supporting HPOG participants' entry into the healthcare workforce by providing work-based learning and other job-preparation experiences (e.g., mock interviews), and hiring participants. HPOG also helped to change employers' negative perceptions about participants and may have helped employers see participants as qualified for jobs. Most employers interviewed thought the HPOG program model provided a strong pipeline for new healthcare workers.

Data sharing among organizations in a service delivery system for healthcare training helped improve how their system functioned by providing a tool to make joint decisions and improve program performance. Many program operators and partners noted that new data sharing occurred for tracking participant progress and outcomes as a part of HPOG, and some indicated that it helped to improve services such as case management. However, respondents noted that piecemeal efforts and privacy restrictions sometimes impeded development of new or improved data-sharing processes and systems that would last beyond the grant.

Finally, HPOG could help support the sustainability of healthcare training and services in the system after the grant ended. Program operators from nine systems thought that some training and service components of their HPOG program would last beyond the grant, with respondents from two systems saying that the HPOG program would fully continue. But HPOG programs needed new sources of funding to continue, with nearly all program respondents saying they had identified new funding sources. Some respondents noted that collaborative activities and policies and processes that would support access to healthcare training and support services for participants would be sustained beyond the grant period.

5.2 Implications for Future Initiatives

As shown in Exhibit 5-1, this study offers numerous implications for future initiatives that support sustainable local and regional healthcare training for people with low incomes and that are responsive to the needs of workers and employers. These implications are mainly directed at policymakers at all levels of government and other funders. They may also be useful to practitioners seeking to improve their local service delivery systems.

Exhibit 5-1: Implications of the Systems Study Findings for Policymakers and Practitioners

Study Findings	Implications for Policymakers and Practitioners
The HPOG 2.0 programs appeared to be an inflection point for new or enhanced **collaboration** within the system. No one program operator in this study could bring about change alone. Partners took on various roles in directly supporting HPOG program implementation. However, according to some respondents, there may have been organizations in the system that did not become involved with the HPOG programs due to competition.	Continuing to encourage new partnerships and leveraging and strengthening existing partnerships with a variety of organizations could be helpful for improving access to, and the quality of, healthcare training for people with low incomes.
Local program operators and partners perceived that offering robust support services helped **improve the quality of healthcare training and services**. Ensuring provision of and access to a rich array of support services may be among HPOG's most valuable contributions to the	Providing a robust set of wraparound support services through grant-funded training programs, with types and intensity of services tailored to the needs of participants, could help improve

Study Findings	Implications for Policymakers and Practitioners
system, according to respondents, because they addressed barriers to training (and employment thereafter) for people within these systems. However, these provisions could be an expensive component of program operations. Further, evidence from HPOG 1.0 through six years and HPOG 2.0 through 15 and 30 months suggests that these programs provided support services and training and that led to more training (Klerman et al., 2022; Peck, Litwok, and Walton 2022). However, the training was overwhelmingly short and, at least to date, not sufficient to substantially increase earnings. Perhaps more intensive set of remediation/basic skills training and support services (including stipends) is needed to raise earnings.	persistence and completion of training and address systemic barriers to completing training and advancing beyond entry-level credentials and jobs.
The presence of **articulated career pathways** did not appear to help support advancement in healthcare careers. Program operators and partners thought HPOG supported the development of new or enhanced healthcare career pathways. However, many respondents were skeptical that the use of the career pathways model in training programs would actually help participants move beyond entry-level healthcare jobs like CNA. Well-defined career pathways may serve as a guide towards future opportunities, but these pathways alone are not enough to overcome barriers to participating in more advanced training. More intentional strategies to help people advance beyond an entry-level healthcare position may be needed.	Encouraging a greater focus on advancement in healthcare careers could help improve access to and the quality of training in the systems.
Nearly all HPOG 2.0 programs **engaged multiple employers** that played different roles to support participant success in the workforce. Although challenges persisted with employers' negative perceptions about HPOG participants and varying strength of the partnerships, employers seemed to be more consistently involved in HPOG 2.0 than in HPOG 1.0 programs.	Continuing to encourage and emphasize strong employer relationships, especially industry-wide or sector partnerships, could help ensure that healthcare training is responsive to employer needs, shifts employer perceptions about participants in programs for people with low incomes, and supports participant advancement.
Data sharing for improving healthcare training and local systems seemed to be a more limited aspect of HPOG. HPOG encouraged data sharing for managing the HPOG programs, but it did not always support systems activities such as building cross-system processes and strategies. Program operators and partners acknowledged limits to data sharing caused by piecemeal approaches or challenges with accessing data due to privacy concerns or other data-sharing restrictions.	Setting expectations about data sharing to guide program and systems efforts for grantees could support improvements in healthcare training and services across the system, although federal and state data privacy requirements may continue to hinder data sharing.
Reflecting the intent of the grant, HPOG program operators and partners planned to **sustain the programs**, including the training and services, in some form. Most had identified or were working to identify new sources of funding to do so. Some program operators and partners were less confident that the partnerships developed under HPOG 2.0 and the policies and processes implemented (e.g., support services, referrals, case management) would last beyond the grant. The degree to which they had considered sustainability as a part of their grant activities varied. Sustainability at the time of data collection (in the fourth year of the six-year grant period) was not guaranteed.	Supporting successful sustainability for future initiatives may take guidance and technical assistance from funders after the grants ends.

These implications for future initiatives are based on the perceptions of HPOG 2.0 program operators and their partners. Taken together with findings from the broader HPOG research and evaluation portfolio (Appendix A), these observations may guide policymakers and practitioners

as they develop and improve future initiatives to provide healthcare occupational training that is responsive to the needs of workers and employers.

APPENDIX A: 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)

ACF awarded 32 five-year grants in 2010, with 18 grantees receiving extensions into early 2016. A research team oversaw development and operation of a management information system called the Performance Reporting System (PRS) used by all grantees.

HPOG Implementation and Outcomes Research. 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/opre/report/descriptive-implementation-and-outcome-study-report-national-implementation-evaluation.
- The systems change analysis is available here: https://www.acf.hhs.gov/opre/report/systems-change-under-health-profession-opportunity-grants-hpog-program.
- The final report on the implementation research is available here: https://www.acf.hhs.gov/opre/report/final-report-national-implementation-evaluation-first-round-health-profession.

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/report/tribal-health-profession-opportunity-grants-hpog-program-evaluation-final-report.

HPOG 1.0 Impact Study. For 23 of the 27 non-Tribal grants, the research team conducted an experimental study—the HPOG 1.0 Impact Study—to assess the impacts of the HPOG Program. 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 also participated in another OPRE-sponsored evaluation of career pathways programs begun in 2007, the Pathways for Advancing Careers and Education (PACE) project.

- *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 random assignment 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/report/health-profession-opportunity-grants-hpog-10-impact-study-interim-report-program.

- *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 randomization. The report is available here: https://www.acf.hhs.gov/opre/report/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 randomization. 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 the HPOG 1.0 Impact Study and PACE project participants and will describe outcomes approximately **10 years** (pending additional funding) after randomization 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, early impacts, three-year, and six-year impacts of the nine programs in the PACE project are available here: https://www.acf.hhs.gov/opre/project/pathways-advancing-careers-and-education-pace-2007-2018.

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 were Tribal organizations and 27 non-Tribal. HPOG 2.0 was extended an additional 12 months, ending September 2021. ACF 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 data, PAGES data, and other administrative data to assess outcomes for 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 could access HPOG 2.0 services 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 baseline survey upon entering the study. The evaluation is assessing short-term impacts (about 15 months after random assignment), intermediate-term impacts (about 36 months after random assignment), and longer-term impacts (about 66 months after

random assignment). The evaluation is also assessing the effectiveness of the HPOG 2.0 Program before and after the COVID-19 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 27 non-Tribal HPOG 2.0 grants:

- **HPOG 2.0 Descriptive Evaluation.** The research team is conducting implementation, outcomes, and systems studies as part of the Descriptive Evaluation. 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 non-Tribal HPOG 2.0 grantees participated 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** includes 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.

More information on all of these research activities is available here: https://www.acf.hhs.gov/opre/project/career-pathways.

APPENDIX B: HPOG 2.0 SYSTEMS STUDY DESIGN

This appendix presents an overview of the HPOG 2.0 Systems Study Design. It includes the research questions, data sources, program and partner selection, data collection and analysis, and study limitations of the HPOG 2.0 Systems Study. More detail is available in the design report (Werner et al. 2018) and in the analysis plan (Werner et al. 2019) for the Descriptive Evaluation.

Research Questions

The HPOG 2.0 Systems Study addresses three overarching categories of research questions to describe: the local service systems in which HPOG 2.0 programs operated, how the systems may have influenced HPOG implementation, and how the HPOG programs may have influenced the systems in which they operated. The detailed research questions, the responses to which are based on the perspectives and experiences of 15 program operators and a selection of their partners, are as follows:

What were the local service delivery systems in which HPOG 2.0 programs operated?

- What were the major local programs and program operators for postsecondary training in healthcare at the time HPOG 2.0 was implemented?
- What organizations made up the local service delivery system? What roles did they play in the system? To what degree were the organizations involved in HPOG operations? If some were not involved, why not?
- How did organizations in the system interact? To what degree did they collaborate on efforts beyond HPOG?
- To what degree and in what ways were employers involved in programs and activities to support healthcare training?
- How did systems differ across HPOG programs?

How did local service delivery systems influence HPOG programs?

- What external factors, such as local economic conditions and state and local policy, may have influenced the availability of postsecondary training and higher-quality jobs in healthcare to low-income populations?
- Has the development and use of career pathways models by organizations in the healthcare training system influenced the implementation of the local HPOG program? If yes, how so? If no, why not?
- How did the general availability of community resources and funding support or hinder full implementation of all planned HPOG trainings and other services? How did it help or hinder the local HPOG program to be successful in training low-income individuals for healthcare jobs?

How did HPOG program implementation influence local service delivery systems?

- Did HPOG programs change access to and the quality of healthcare training for low-income individuals in their communities? If so, what activities led to this change? If not, why?
- Did HPOG programs inform the development and use of career pathways models in their systems? If yes, how so? If no, why not?
- Did HPOG programs improve coordination among service delivery partners in their local systems? If so, what activities led to this change? If not, why?
- Did HPOG programs lead to improvements in how organizations in the system engage employers and industry as a part of training efforts? If so, what activities led to this change? If not, why?
- Did HPOG programs help to meet employer needs for healthcare workers? If so, what activities led to this change? If not, why?
- Did the emphasis on employer and industry partnerships for the HPOG 2.0 awards change the intensity of activities and engagement of employers and industry for those HPOG 2.0 programs that were also involved in HPOG 1.0 award activities? If so, what activities led to this change? If not, why?
- Did HPOG programs lead to improvements in sharing and use of data for improving program design and implementation? If so, what activities led to this change? If not, why?
- Did HPOG programs lead to efforts to scale and sustain healthcare training and support services? If so, what activities led to this change? If not, why? What policies, practices, or funding have been put in place to support continued implementation of HPOG programs beyond the grant period? If none, why not?
- How did efforts to improve systems by HPOG program operators and their partners differ between newer programs (HPOG 2.0) and longer-term programs (HPOG 1.0 grantees awarded an HPOG 2.0 grant)?

Data Sources

The main data source for the Systems Study is one-hour semi-structured interviews with 15 program operators and 3 to 7 of their partners conducted from October 2019 to February 2020. The research team members conducting the interviews asked the same set of open-ended questions to both program operators and partners to allow for analysis across a consistent set of topics. The team members covered all topics in the guides but did not ask all questions, depending on the knowledge and role of the respondent and the time available.

The study also uses additional data sources for information on the 15 programs, including grantee and partner telephone interviews conducted in 2017 for another part of the HPOG 2.0 National Evaluation,[48] grant applications, and aggregate data from the management information system on HPOG 2.0 participants. The 2017 telephone interview data provides descriptive

[48] The National Evaluation team conducted these telephone interviews HPOG 2.0 program representatives and key partners in summer 2017 as part of the evaluation's Implementation Study, which is another component of the Descriptive Evaluation.

information on the programs, such as types of occupational training, partner types and roles, and use of defined career pathways. The analysis of these data is presented in Chapter 2, which describes the programs, their partners, and their systems activities.

Program and Partner Selection

The team used a purposive sampling strategy to identify 15 HPOG 2.0 programs that would reflect the variety of types and intensity of systems activities. Selecting across those variations allowed the team to explore a range of experiences and perspectives on activities and partnerships that may have contributed to or hindered systems development and improvement. The team selected programs with a range of types of systems activities, including some with extensive and some with more limited systems activities. Programs with few partners or systems activities were intentionally excluded from the sample.

Using data from the 2017 telephone interviews, the team first categorized the 38 programs by three primary selection criteria:

- partner organizations involved in HPOG program implementation (types and number)
- systems activities implemented by the program (types and number)
- employer engagement by the program operator (number of employer partners and whether the lead organization is part of a local workforce or industry partnership)

The team then categorized the 38 programs by program characteristics, which were the secondary selection criteria:

- HPOG 1.0 grantee/program operator[49]
- expected program enrollment
- types of occupational training
- lead organization type
- target population(s)
- presence of a well-defined career pathway
- type of geographic region served by the program (urban, suburban, rural, or mixed)

For each HPOG 2.0 program selected for the study, the research team interviewed the program operator staff person most knowledgeable about the program's efforts at collaboration with partners. During that interview, the research team members discussed which among the program's partners were highly involved and which partners were less involved and why. At the end of the interview, the team members asked the program operator to identify informants for 3 to 7 of the program's partners to be interviewed, including a mix of highly and less involved partners. The team also asked the program operator to identify employer and industry representatives who served as partners to ensure the study captured these perspectives.

[49] Fourteen of the 27 non-Tribal grantees that were part of HPOG 1.0 also received grants under HPOG 2.0.

Program operators recommended 80 partners, and the team interviewed 76 partners, with 4 declining to participate.

Data Analysis

The research team analyzed the qualitative interview data, supplemented by results from the 2017 grantee telephone interviews, using descriptive and thematic analysis. The data analysis to address the first set of research questions described the 15 programs and systems included in the study, using the systems interviews and the additional data sources noted above. The data analysis to address the second and third sets of research questions drew themes from the program operator and partner interviews and identified trends and patterns across the interviews.

The unit of analysis for the first set of research questions in the Systems Study is the program. For the second and third sets of research questions, the unit of analysis is the system in which the selected HPOG 2.0 programs operated. The team conducted the analyses to conceal the identities of the respondents and the programs. The team promised confidentiality to respondents to encourage them to speak freely. The underlying data rely on the recollection and knowledge of the respondents and present their perspectives on the study topics.

Study Limitations

There are several limitations to the Systems Study:

- Specific goals and activities of HPOG 2.0 do not directly support or require a focus on systems activities (OFA 2015). Thus, the research team had to ensure that the study goals and terms were clear to respondents.
- This study does not seek to draw causal inferences about whether the HPOG program changed the local system or the local system changed the HPOG program. Rather, it provides descriptive data to inform these questions. The study relies on the perspectives of the respondents, which are highlighted throughout the report. The findings, thus, are only suggestive and designed to illuminate how interactions between program operators and partners may have supported or hindered HPOG program implementation and how HPOG programs may have influenced the local system.
- There are limits to the generalizability of the study findings. The study does not include all programs and partners, so the findings do not represent all systems activities or partner collaborations in HPOG 2.0 programs. However, the team purposively selected HPOG programs based on the criteria described above to represent the spectrum of programs, that is, those programs with varying intensities of systems activities, partnerships, and employer engagement.
- The findings described in this report may not reflect the changed economic conditions and healthcare training landscape, as the data collection occurred prior to the onset of the COVID-19 pandemic in early 2020, when unemployment rates were very low.

REFERENCES

Bernstein, Hamutal, Lauren Eyster, Jennifer Yahner, Stephanie Owen, and Pamela J. Loprest. 2016. *Systems Change under the Health Profession Opportunity Grant (HPOG) Program*. OPRE Report 2016-50. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/opre/report/systems-change-under-health-profession-opportunity-grants-hpog-program.

Bernstein, Hamutal, and Ananda Martin-Caughey. 2017. *Changing Workforce Systems: A Framework for Describing and Measuring Systems Change*. Washington, DC: Urban Institute. https://www.urban.org/research/publication/changing-workforce-systems.

Birken, Brittany, Erin Moriarty-Siler, and Roxane White. 2018. *Reducing the Cliff Effect to Support Working Families.* Washington, DC: Aspen Institute. https://ascend.aspeninstitute.org/reducing-the-cliff-effect-to-support-working-families/.

Cordero-Guzman, Hector. 2014. "Community-Based Organizations, Immigrant Low-Wage Workers, and the Workforce Development System in the United States." New York: Baruch College at the City University of New York.

Epstein, Zachary, and Maureen Sarna. 2021. The Healthcare Workforce During COVID-19: Results from an Environmental Scan. OPRE 2021-104. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/opre/report/healthcare-workforce-during-covid-19-results-environmental-scan.

Eyster, Lauren, Christin Durham, Michelle Van Noy, and Neil Damron. 2016. *Understanding Local Workforce Systems*. Washington, DC: Urban Institute. https://www.urban.org/research/publication/understanding-local-workforce-systems

Eyster, Lauren, and Semhar Gebrekristos. 2018. *Fulfilling the Promise of Career Pathways: Strategies That Support Career Advancement*. Washington, DC: Urban Institute, October. https://www.urban.org/research/publication/fulfilling-promise-career-pathways-strategies-support-career-advancement.

Gordon, Robert J., and Ian Dew-Becker. 2008. "Controversies about the Rise of American Inequality: A Survey." NBER Working Paper No. 13982. Cambridge, MA: National Bureau of Economic Research. https://www.nber.org/papers/w13982.

Hacker, Jacob S., and Paul Pierson. 2010. "Winner-Take-All Politics: Public Policy, Political Organization, and the Precipitous Rise of Top Incomes in the United States." *Politics & Society* 38 (2): 152–204. https://doi.org/10.1177/0032329210365042.

Jacobs, David, and Jonathan Dirlam. 2016. "Politics and Economic Stratification: Power and Resources and Income Inequality in the United States." *American Journal of Sociology* 122 (2): 469–500. https://doi.org/10.1086/687744.

Klerman, Jacob Alex, David Judkins, and Gretchen Locke. 2019. *Impact Evaluation Design Plan for the HPOG 2.0 National Evaluation*. OPRE Report 2019-82. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/opre/report/national-and-tribal-evaluation-2nd-generation-health-profession-opportunity-grants-1.

Klerman, Jacob Alex, David Ross Judkins, Sarah Prenovitz, and Gretchen Locke. 2022. *Health Profession Opportunity Grants (HPOG 2.0) Short-Term Impact Report.* OPRE Report 2022-37. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/opre/report/report-health-profession-opportunity-grants-hpog-20-short-term-impact-report

Klerman, Jacob Alex, Daniel Litwok, and Tori Morris. 2022. *Occupational Training for Jobs That "Pay Well": Patterns from the Health Profession Opportunity Grants (HPOG)*. OPRE Report 2022-98. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/opre/report/occupational-training-jobs-pay-well-patterns-health-profession-opportunity-grants-hpog

Loprest, Pamela, and Nathan Sick (2018). *Career Prospects for Certified Nursing Assistants: Insights for Training Programs and Policymakers from the Health Profession Opportunity Grants (HPOG) Program*. OPRE Report 2018-92, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, US Department of Health and Human Services. https://www.acf.hhs.gov/opre/report/career-prospects-certified-nursing-assistants-insights-training-programs-and.

Loungani, Prakash, and Jonathan D. Ostry. 2017. *The IMF's Work on Inequality: Bridging Research and Reality.* Washington, DC: International Monetary Fund. https://blogs.imf.org/2017/02/22/the-imfs-work-on-inequality-bridging-research-and-reality/.

Mikelson, Kelly S., Neil Damron, and Pamela Loprest. 2017. *Health Profession Opportunity Grants 2.0: Year One Annual Report (2015–16)*. OPRE Report 2017-45. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/ofa/report/health-profession-opportunity-grants-20-year-one-annual-report-2015-16.

OFA [Office of Family Assistance], Administration for Children and Families. 2010. Health Profession Opportunity Grants to Serve TANF Recipients and Other Low-Income Individuals. Funding Opportunity Announcement (FOA) HHS2010-ACF-OFA-FX-0126. Washington, DC: U.S. Department of Health and Human Services.

OFA [Office of Family Assistance], Administration for Children and Families. 2015. Health Profession Opportunity Grants to Serve TANF Recipients and Other Low-Income Individuals. Funding Opportunity Announcement (FOA) HHS-2015-ACF-OFA-FX-0951. Washington, DC: U.S. Department of Health and Human Services. https://www.acf.hhs.gov/ofa/grant-funding/hpog-20-funding-opportunity-announcements.

Peck, Laura R., Daniel Litwok, Douglas Walton, Eleanor Harvill, and Alan Werner. 2019. *Health Profession Opportunity Grants (HPOG 1.0) Impact Study: Three-Year Impacts Report*. OPRE Report 2019-114. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/opre/report/health-profession-opportunity-grants-hpog-10-impact-study-three-year-impacts-report.

Peck, Laura R., Daniel Litwok, and Douglas Walton. 2022. Health Profession Opportunity Grants (HPOG 1.0) Impact Study: Six-Year Impacts Report. OPRE Report 2022-45 Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/sites/default/files/documents/opre/hpog-impact-study-six-year-impacts-report-feb-2022.pdf.

Reardon, Sean F., and Kendra Bischoff. 2011. "Income Inequality and Income Segregation." *American Journal of Sociology* 116 (4): 1092–1153. https://doi.org/10.1086/657114.

Roy, Radha, Tanya de Sousa, Jillian Ouellette, and Carly Morrison. 2022. *Agile during a Pandemic: How HPOG 2.0 Programs Responded to COVID-19.* OPRE 2022-71. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/sites/default/files/documents/opre/hpog-programs-respond-covid-mar-2022.pdf.

Roy, Radha, Robin Koralek, Nayara Mowry, and Emily Roessel. Forthcoming. *Health Profession Opportunity Grants (HPOG 2.0) Implementation Study Report*. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, US Department of Health and Human Services.

Turner, Margery Austin, Peter Edelman, Erika Poethig, and Laudan Aron, with Matthew Rogers and Christopher Lowenstein. 2014. *Tackling Persistent Poverty in Distressed Urban Neighborhoods: History, Principles, and Strategies for Philanthropic Investment*. Washington, DC: Urban Institute. https://www.urban.org/sites/default/files/publication/22761/413179-tackling-persistent-poverty-in-distressed-urban-neighborhoods.pdf.

Werner, Alan, Robin Koralek, Pamela Loprest, Lauren Eyster, and Gretchen Locke. 2018. *National and Tribal Evaluation of the 2nd Generation of Health Profession Opportunity Grants (HPOG 2.0): Descriptive Evaluation Design Report for the National Evaluation*. OPRE Report 2018-07. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, US Department of Health and Human Services.

https://www.acf.hhs.gov/opre/report/descriptive-evaluation-design-report-national-evaluation.

Werner, Alan, Robin Koralek, Pamela Loprest, Lauren Eyster, and Gretchen Locke. 2019. *National and Tribal Evaluation of the 2nd Generation of Health Profession Opportunity Grants (HPOG 2.0): Descriptive Evaluation Analysis Plan for the National Evaluation*. OPRE Report 2020-92. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, US Department of Health and Human Services. https://www.acf.hhs.gov/opre/report/national-and-tribal-evaluation-2nd-generation-health-profession-opportunity-grants-hpog.