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Health Careers for All
Local Evaluation Preliminary Year 2 Report

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Background

Health Careers for All (HCA) is a U.S. Department of Health and Human Services (HHS) Health Profession Opportunities Grant (HPOG) -funded project. The goal of this project is to make healthcare career pathways accessible to low income residents of the Puget Sound area now and into the future, with special attention to recipients of Temporary Assistance to Needy Families (TANF). To achieve this goal, the HCA project supports three different types of activities:

1) ***Career and education navigators*** who partner with other service providers (such as DSHS, WorkSource, housing authorities, and others) to recruit eligible individuals, provide career and education counseling aimed at introducing healthcare as a career option, and support individuals with limited resources into and through the entry level with the ultimate goal of obtaining further training to ascend a career ladder during the life of the grant;
2) ***Creation of additional training options*** to meet the needs of the grant's priority population, as well as other training programs to meet the emerging needs of today's healthcare employers; and
3) ***System integration efforts*** to identify and resolve system barriers that may hamper the grant's long-term goal of establishing sustainable entry points and pathways for career advancement for project participants and for other low income individuals in the future.

The goal of the HCA internal evaluation is to provide ongoing feedback about the project's activities to help guide program development and support sustainability planning.

Methods

Both qualitative and quantitative methods are used to track the progress of the project. In Year 2 these have included:

- Interviews and focus groups with system representative and partners (January to March, 2012). This included 5 individual interviews, 3 group interviews with a total of 6 people, and four focus groups with a total of 33 individuals.
- Intake survey of 108 HCA participants (44 from youth in the summer program and 64 from adult participants)
- Focus groups with five groups of participants totaling 55 individuals
- The HCA database maintained by the TRAC Associates navigators that tracks the progress of the adult participants (n=332)
- Data extracted from the paper files of the adult participants (n=329)

In addition, we began interviews with training instructors and with participants who left HCA without completing. However, that data collection is still in early stages and reports of these perspectives will be deferred until more data have been collected.

Key Findings

CONTEXT

HCA is a complex collaborative project working within multiple large systems to facilitate career entry and progression toward self-sufficiency among the region's TANF recipients and other qualified low income individuals. HCA has developed multiple training directions with many training institutions to accommodate varied career interests and varied education needs for both youth and adults. Participants work with experienced navigators who assess participants, provide career counseling, facilitate entry into training and provide support services as needed to help participants succeed.

Partners, mostly members of an existing system of strong collaborators, are working together to support participants and remove barriers that participants have encountered as they move through the project.

PROGRESS TOWARD PROJECT GOALS

Over the 5 years of the project, HCA is targeted to enroll 920 adults and youth in training and achieve a training completion rate of at least 70%. With more than 400 participants enrolled by the end of Year 2 the project is nearly halfway (47%) to the project-end enrollment target.

By mid -September 2012, 329 adults had enrolled in HCA, reflecting the brisk recruitment process. Nearly all of these entered a training program, at one (or more) of 21 local institutions, including community colleges and private vocational schools. Overall, a few more than half the participants enrolled in HCA-funded cohorts and about one third accessed HCA-funded ITA's for the training.

Sixty adults enrolled in foundational healthcare bridge classes designed to introduce participants to healthcare occupations and basic healthcare vocational content while developing basic math and/or English language skills. About half the participants enrolled in CNA training (the other half went directly into a medical assistant or phlebotomy training cohort or in non-direct care such as medical interpreter or medical office). File review reveals that about half of the participants expressed the long term goal of becoming an RN. As of mid-September, 153 (81% of those whose programs had finished) had completed their training. As of the date of the data snapshot, 117 were still in training, 41 were in job search, 85 were in post-training employment, 29 had exited, and 16 were on hold.[1]

One hundred and seven youth have enrolled in HCA to date. Fifty-eight WIA youth participated in Year 2 HCA-funded cohorts at four King County community college campuses. Sixteen participated in a foundational ("Health Exploration for Youth") class and 49 in summer NA-C cohorts. Fifty-two (89%) of these youth successfully completed.

[1] Updated data for the balance were in the ongoing data entry process at the time of the snapshot.

ADULT PARTICIPANTS[2]

Demographics: Most participants are women (83%); 43% are TANF recipients (45% of the women and 31% of the men); just under half are Black/African American and one third are White/Caucasian; just under half (47%) are immigrants/refugees.

Housing: About 40% live in market rate housing and about 30% live in public housing. About 20% live with relatives. About 13% are unstably housed – in a shelter, couch surfing, or homeless. About one third of participants indicated concerns about paying for their housing. Public housing residents and those in shared housing with non-relatives (6%) were the *least* likely to identify this barrier.

Transportation: About three-fourths of participants have a driver's license – those in market rate housing are more likely to have one; TANF participants who are immigrants/refugees, and those in unstable housing are less likely. Most (78%) of the participants in market rate housing report having a reliable car for transportation to training and work, and about 20% plan to commute by bus. 50%-60% of participants in other relatively stable housing report having a reliable car and others said they would take the bus. *Participants with unstable housing are least likely to have a reliable car (20%-30%) and plan to use public transportation. This may become a significant barrier to attending class and getting to employment regularly for some participants in this group.*

Childcare: Non TANF participants in market rate housing are *least* likely to have identified a stable and reliable childcare option..

Education and skills: About one-third of participants had no education beyond a high school diploma at program enrollment. Another one-third had achieved as much as 3 years of postsecondary education.. About 20% had achieved an AA/AS or more. Immigrant and refugee participants were more likely to have *either* no education beyond high school *or* a post-secondary degree (AA/AS or higher) at program enrollment whereas U.S. born participants were more likely than their immigrant/refugee counterparts to have some post-secondary education but no degree. TANF participants have somewhat less education than those in the second priority group (household income less than 175% of the Federal Poverty Level). Those in the third priority group (household income above 175% FPL) have considerably more education. About 40% of the participants (35% of TANF) have had previous training in the medical field.

Participants who are on TANF, older, without a high school diploma or GED, and/or homeless or living in a shelter are at risk for poor computer skills.

Most participants (70%), especially women, express a preference for hands-on learning.

Employment at intake: About one-third of participants were employed when they entered HCA (10% of TANF participants, 38% of the second priority group, and 91% of the third priority group). Those in each category who were not working had been out of work for about the same length of time on average (13

[2] This report includes a detailed look at adult participants; future reports will look at youth participants in greater detail.

to 14 months). Subsidized housing residents were out of work longer than participants in other housing (18-25 months). Overall, 241 participants reported a median of 3 years of work history. Twelve of these reported no work experience at all and two reported more than 20 years of work experience.

About half of the participants (and 40% of TANF) have had previous experience in the healthcare field (including volunteer work and care for their own family), with 29% overall (15% of TANF participants), indicating healthcare as their most recently job before enrolling in HCA. The proportion of new participants entering with previous training and experience in healthcare has increased in the second year, compared with the first year.

Barriers: The most common potential barriers to success identified by participants at enrollment are financial barriers, including such specific concerns as paying for housing, childcare, and transportation. Some participants reported none of these barriers; some reported more than one. Navigators identified limited or spotty work history as a potential barrier for one-third (37%) of the participants, which may increase the need for externships or other work-based learning experiences. This was **not** a greater challenge for TANF participants than for non TANF participants. Navigators also noted financial and housing barriers.

Immigrants and refugees identified fewer barriers for themselves than did their U.S. born counterparts, and navigators' assessments were aligned with their perceptions.

Commitment to career and training: Participants seem committed and grateful – and eager to get jobs. When asked what prompted their interest in a healthcare career, all subgroups analyzed most often mentioned their desire to serve others. TANF participants and immigrants/refugees were more likely than other groups to mention the professional opportunities available in healthcare.

Participants were asked in a survey whether they would quit their training program if they were offered a good job. Mostly, respondents said they would not. TANF participants and others who identified a financial barrier were less adamant in their answers. Similarly, like other respondents, immigrant/refugees disagreed with the statement "This particular job is not a priority for me; I just need some job." But they disagreed a little less adamantly.

Half of the participants receiving public benefits are afraid of losing them before they are able to financially support their families with wages, as they make progress toward their career goals.

Training programs: A significant proportion of participants have enrolled in CNA training. Initial analysis of the snapshot of data available suggests that CNA training programs are not equally successful in retaining students, nor are students completing these programs equally successful in passing the state exam. Both community colleges and private vocational schools were among the top performers for completions and credentials. Not enough employment data is available to assess graduates' ability to obtain and retain employment by training institution. More analysis on this and other training outcomes will occur in Year 3.

Predicting completion: In a multivariate analysis, participants with more children, (especially those under 5), who see themselves as having more barriers to completion (especially financial barriers), and whom navigators perceive to have a limited or spotty work history, or problems with employers in the past, are most at risk for *not completing* a training program.

SELECTED OBSERVATIONS/RECOMMENDATIONS FROM QUALITATIVE DATA

Data collected through qualitative methods (interviews, focus groups) have been shared with HCA program staff and partners throughout Years 1 and 2 and program improvements/modifications have been made in some areas in response to the data. The intention is to ensure ongoing communication of local evaluation findings to support mid-course refinements. Below is a summary of some observations/recommendations that have been communicated from partners/participants who participated in interviews/focus groups and from evaluators themselves.

Communication and roles

- Increase and improve communication between HCA/ TRAC and the staff of partner agencies as long as TRAC and partner agencies share clients. This could include more informational sessions, cultivating champions within each CSO, an HCA website or newsletter, and a process for reporting back about shared participants. Consider increasing "face time" between navigators and caseworkers, peer exchange opportunities with caseworkers and navigators, joint meetings, and increased navigator presence in CSO offices as warranted by recruitment needs.
- Ensure that navigators have the time to serve their growing caseloads. Participants' needs are diverse and participants require individualized attention, placing a significant demand on the navigators. As the participant group "matures" into subsequent training and job search steps, the demands made of the navigators are likely to increase. Remain vigilant to ensure that in this complex project, roles remain as clear as possible, even if they must be negotiated separately with different partners or training programs. This would include identifying points of contact and clarifying communication needs and procedures.

Participant success

- Ensure that strategies that allow TANF participants to continue training beyond 12 months are clear to navigators and can be clearly presented to participants.
- Consider creating a welcome packet for HCA participants with information they may need immediately or in the future. This could include the WDC's career pathway map, contact information for the navigators, perhaps a "who's who" at the college, support services available from HCA, qualifications for receiving them, and procedures to apply for them, complete with the necessary forms, and other support services that may be available.
- Look for work-based learning strategies to help participants with "limited or spotty work history" overcome it, and to capitalize on the preferred hands on learning style of many of the participants.

- Look for ways to support low-wage workers in healthcare (such as those trained to be CNAs in this project) to secure enough additional support so that they are able to support their families while taking the next training step to advance in their careers.
- Review participants' paperwork to identify barriers that are likely to jeopardize their ability to succeed with their training plans. Look for ways to address those barriers or revise the training plan to accommodate the barrier.
- Consider including computer access questions into the assessment process. Look for ways to help participants whose training programs require computer access get convenient access to computers and to the Internet so that lack of technology does not become an additional barrier. Find training opportunities to improve computer skills for participants that need it (note: participants may not always know when their skills are too low).

System change

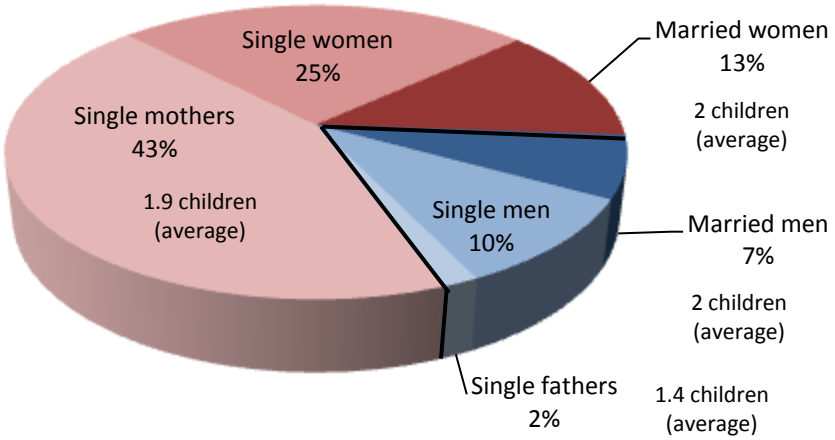
- Continue exploring strategies to work most effectively within TANF policy and eliminate barriers to the greatest extent possible. Be sure best practices are shared across agencies and with navigators.
- Continue looking for ways to raise awareness about the training program among area employers. Seek more ways to encourage employer engagement.
- Study CNA training programs to determine whether they employ "hands-on" teaching methods and whether it makes a difference in student success, and to understand differences in completion and certification rates between training programs (resulting in best practices for serving a TANF or low income population).
- Explore the impact of HCA navigators from the perspective of the colleges.
- Create a navigator best-practices manual with crucial practices, procedures, policies, and philosophies of successful navigators for future generations of navigators.
- Continue to create videos and other means of communicating to various policy-makers the impact of the HCA program on the lives of participants.

Detailed Analysis of Adult Participants

Quantitative

Who participated?

Figure 1. Gender of participants by family type



Overall, 83% of participants are women, and just over half (54%) of the women are single mothers.

Of the men, just over half (54%) are single.

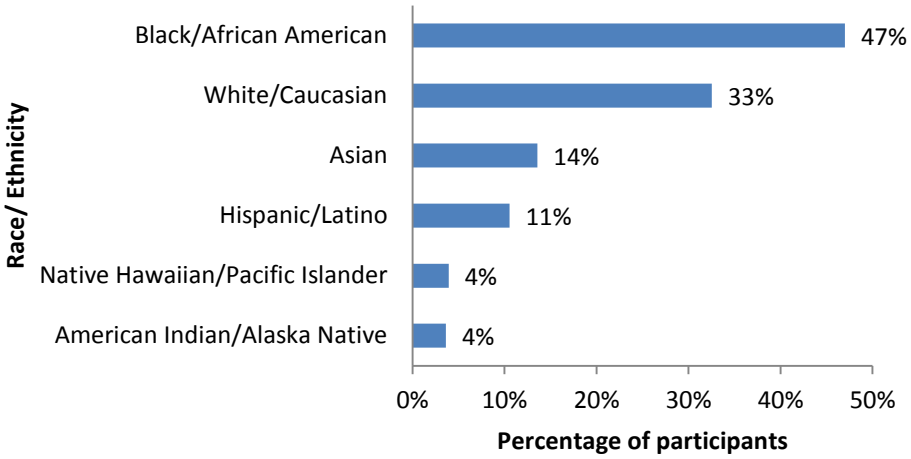
Overall, about 4 in 10 (43%) are TANF recipients – 45% of the women and 31% of the men. Men are more likely to be in the second priority group (household income less than 175% FPL)--59% vs. 45% of the women.

HCA participants range in age from 18 to 79, with an average of 33 (and a median only slightly younger at 31).

Participants live throughout King County, especially concentrated in the higher population areas, with a handful coming from Snohomish and Pierce counties. Appendix I contains a map illustrating the distribution of participants and training programs across the county.

Just under half (47%) of the participants are Black/ African American and one-third are White/ Caucasian.

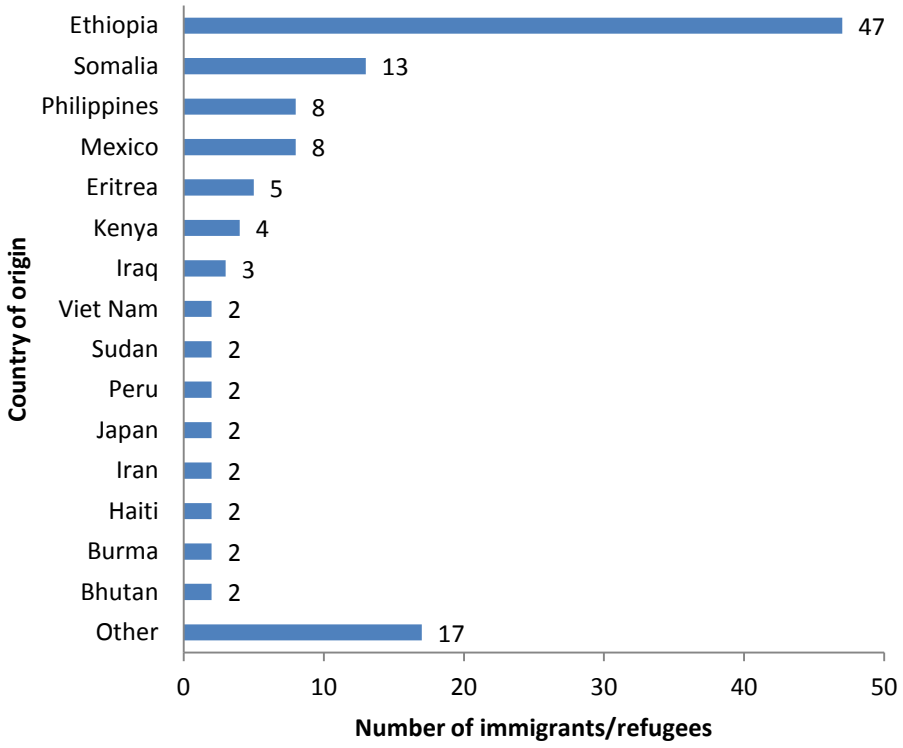
Figure 2. Race/ Ethnicity of Participants



Based on multiple indicators[3], not quite half (47%) were born in another country.

Of the 158 deduced immigrant/ refugees, country of origin was available for 121. This information for these 121 is summarized in Figure 3.

Figure 3.
Country of origin of immigrant or refugee participants



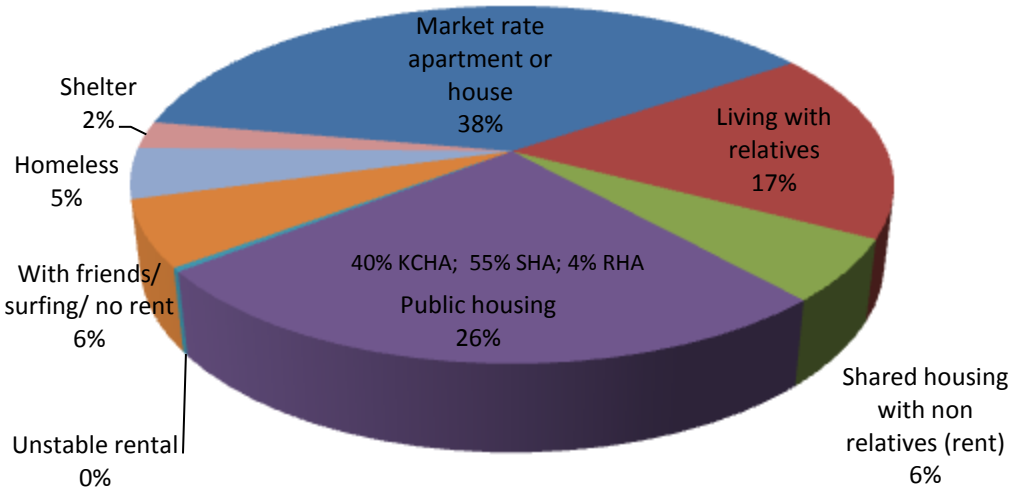
The 17 from an "other" country were from: Cambodia, Congo, Egypt, El Salvador, Gambia, India, Korea, Laos, Pakistan, Senegal, Somoa, Taiwan, Thailand, Tonga, the United Kingdom, Ukraine, and Venezuela.

A higher proportion of the participants who were born outside the U.S. are men (26% of this group are men, compared with 10% of the U.S. born participants), and married (30% vs. 12%). Fewer are single parents (34% vs. 57%). They are about as likely to be TANF recipients, more likely to qualify as the second priority group (less than 175% FPL – 55% vs. 41%) and less likely to qualify in the third priority group (5% vs. 15%).

The date of arrival was available or could be estimated for 118 immigrant/ refugee participants. These participants had been in the U.S. for an average of 4.4 years before enrolling in the HCA project. However, the median length of time in the U.S. is about 2 years, meaning that half have been in this country for just over 2 years – and 30% have been here for less than a year. Fifty-two were indicated as having Limited English Proficiency.

[3] Not asked directly in any form, so deduced from multiple factors, including having a green card, a passport indicating another country of origin, LEP or taking an ESL class, reported healthcare experience abroad, ORIA co-enrollment, previous work experience in another country, identification of bilingual skills as something to offer a healthcare employer

Figure 4. Housing status at intake



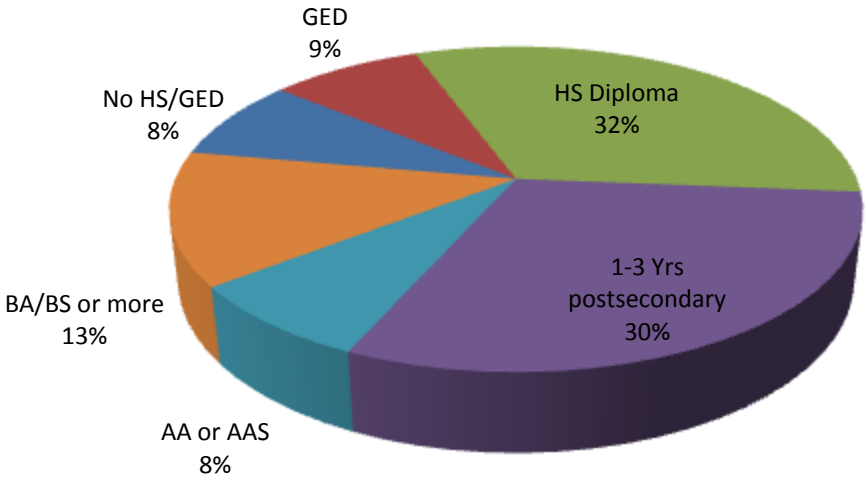
The distribution of housing status has remained fairly stable since the first year, with slightly more living in subsidized[4] housing and slightly fewer living with relatives or in unstable housing. (Some of the increase in public housing representation may be due to improved data quality.)

TANF recipients are less likely to be living in market rate apartments (25%), and are more likely to be in subsidized housing (36%), or homeless (8%) or living in a shelter (4%). Men are more likely to be "couch surfing" (14%) or homeless (12%). Immigrants/ refugees and U.S. born participants had similar housing patterns, unless they were noted as having Limited English Proficiency. Those individuals were more likely to be homeless (10%) or in a shelter (6%). The participants who were homeless or living in a shelter were older than other participants, and those who were staying with friends and "couch surfing" were younger.

Figure 5 shows that about one third of the participants have a high school diploma only and half have attained some postsecondary education.

TANF participants are more likely not to have completed high school or a GED (15%) and those in the third priority enrollment category (household

Figure 5. Educational Attainment at Intake

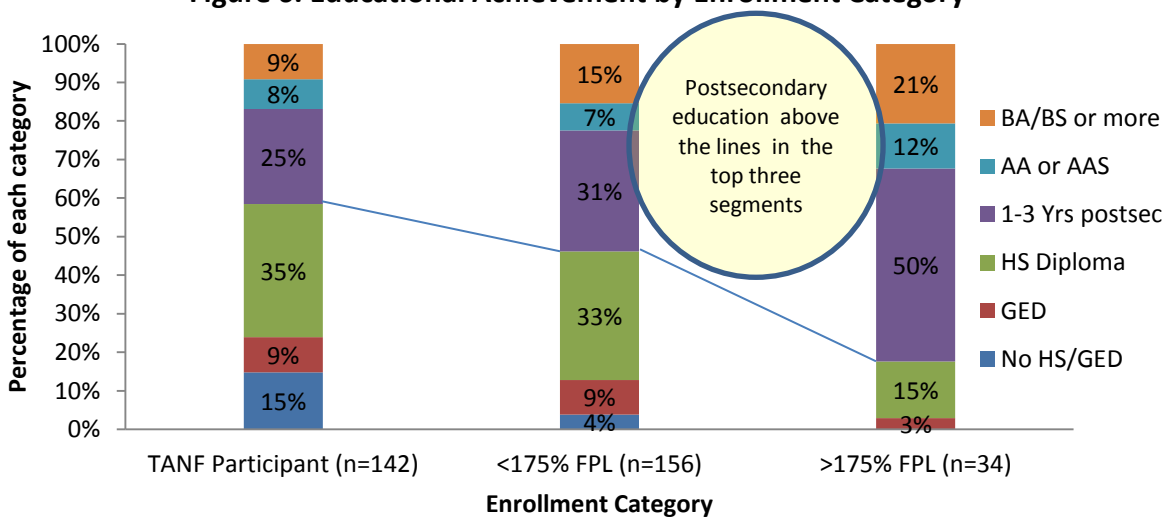


[4] KCHA, SHA, and RHA = King County, Seattle, and Renton Housing Authorities

income greater than 175% FPL) are more likely to have attended some postsecondary (50%). These findings are illustrated in Figure 6.

Figure 6 is complex, but rich with information. Each bar represents one of the enrollment categories (TANF, <175% of FPL, or >175% of FPL). Each bar, representing 100% of one of the enrollment categories, is divided into segments representing the percentage of participants in that enrollment category who have achieved a given "highest" level of education. So, for example, of the 142 TANF participants who provided educational information, 15% (the bottom segment) have not completed high school or a GED. Nine percent (the second segment – red) have completed a GED (and no more) and 35% (the third segment – green) have completed no more than a high school diploma. Now scanning across at the other bars, it is quickly evident that the second priority group seems roughly similar to the first one, but many in the third priority group have achieved more than a high school diploma or GED.

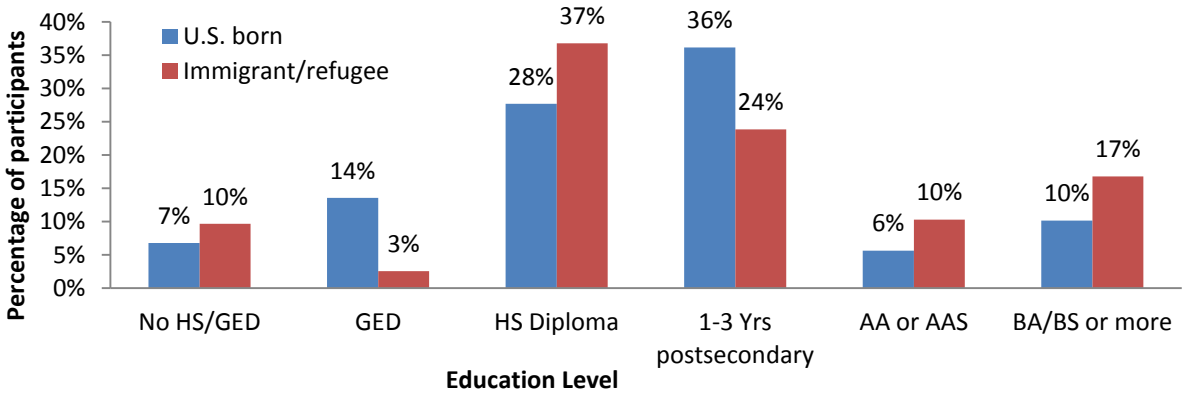
Figure 6. Educational Achievement by Enrollment Category



Men are overrepresented in the higher education categories (11% reported a Bachelor's degree and 17% a two-year degree) and underrepresented in the lower education categories (2% did not complete high school or a GED and 2% completed a GED only).

Figure 7 shows that participants born outside the U.S. are more likely to have a two- or four-year college degree (27% vs. 16%) and more likely to have a high school diploma.

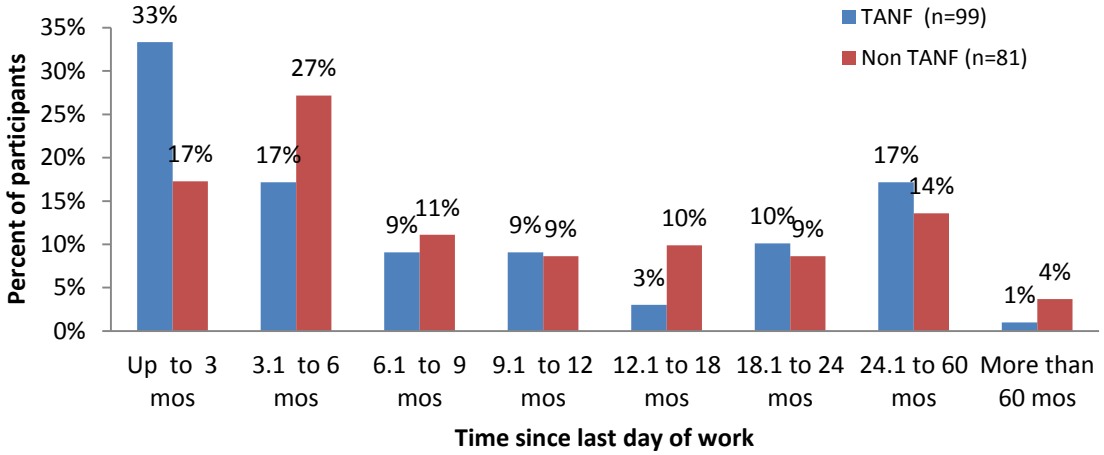
Figure 7. Educational Achievement by Place of Birth



Thirty-one percent of the participants were employed when they entered the HCA project. Those who were not employed had been out of work for an average of 13-14 months. Twenty percent had been out of work for more than two years. Participants reported an average hourly wage of $12.27, with a quarter reporting less than $9 per hour, half reporting less than $10.50 per hour and the top quarter reporting at least $14.75 per hour. (Note that some of the wages reported were earned in other countries and were much lower than U.S. wages. Specifically, 5% of the participants reported earning no more than $1 per hour.)

Ten percent of the TANF participants were employed at intake, compared with 38% of the second priority group and 91% of the third group. Those in each category who were not working had been out of work for about the same length of time on average (13 to 14 months). Figure 8 shows some differences in patterns between TANF and non TANF participants. For example, one-third of TANF participants have been out of work for three months or less, and of the non TANF participants who are not working, about one-fourth have been out of work for three to six months. Participants in the first two priority groups earned about the same amount per hour at their last or most recent job ($11-$12) and worked about the same number of hours per week (30-32). Participants in the third group earned more per hour ($17.70) and worked more ours (37.7).

Figure 8. Length of time out of work for TANF and non TANF participants



The employment pattern for men and women was similar, except that men worked more hours per week in their most recent job (35.7 vs. 30.8).

People who lived in KCHA-subsidized housing had been out of work an average of 25 months, compared with those in SHA-subsidized housing who had been out of work for an average of 18 months. Those not living in public housing had been out of work for an average of 12 months. KCHA and SHA residents were somewhat less likely to be employed when they entered HCA (22% vs. 34%) but that difference did not reach statistical significance.

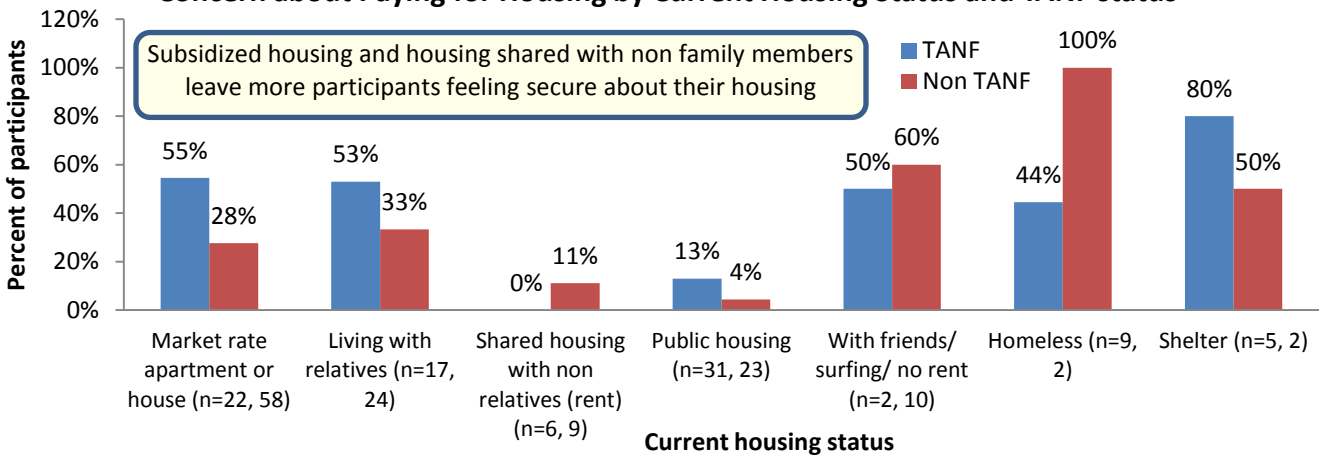
Immigrants/refugees were very similar to their U.S. born counterparts in rate of current employment (31%) and length of time out of work (13.4 months), but earned less per hour on average ($10.34 vs. $13.81). Importantly, some of this disparity may be due to the reporting of wages earned in other countries.

In addition to the above information collected in the Access database, when available, we extracted work history information from the case files, including years of work experience and the highest wage report. Overall, 241 participants reported a median of 3 years of work history (including 12 who reported no work experience at all and two with more than 20 years of work experience). The median top hourly wage reported was $11.28, with 22 people reporting less than $1 per hour (from employment in other countries) and 18 reporting a top hourly wage of at least $25. Analysis of work history and top wage shows that most of the difference between groups – priority enrollment groups or housing status groups is associated more with the low wages immigrants and refugees reported earning in the countries they left. When this factor is removed from the analyses, differences between these groups disappear so that participants living in subsidized housing or TANF participants have about the same work history and wage history as participants in other living situations and non TANF participants.

Participants' potential barriers to success

As part of the assessment process, participants complete a self-assessment form, writing in responses to questions about barriers. About one-third (32%) indicated a concern about housing, with significantly more people who were not in subsidized housing expressing this concern (37% vs. 10% of KCHA, SHA, or RHA residents). Not surprisingly, those who are homeless, living in a shelter, "couch surfing" or living with relatives were the most likely to express this concern (55%, 71%, 58%, and 41%, respectively). Additional analysis shows that TANF and non TANF participants express different levels of concern about their housing stability, depending on their current housing status. Figure 9 illustrates this finding.

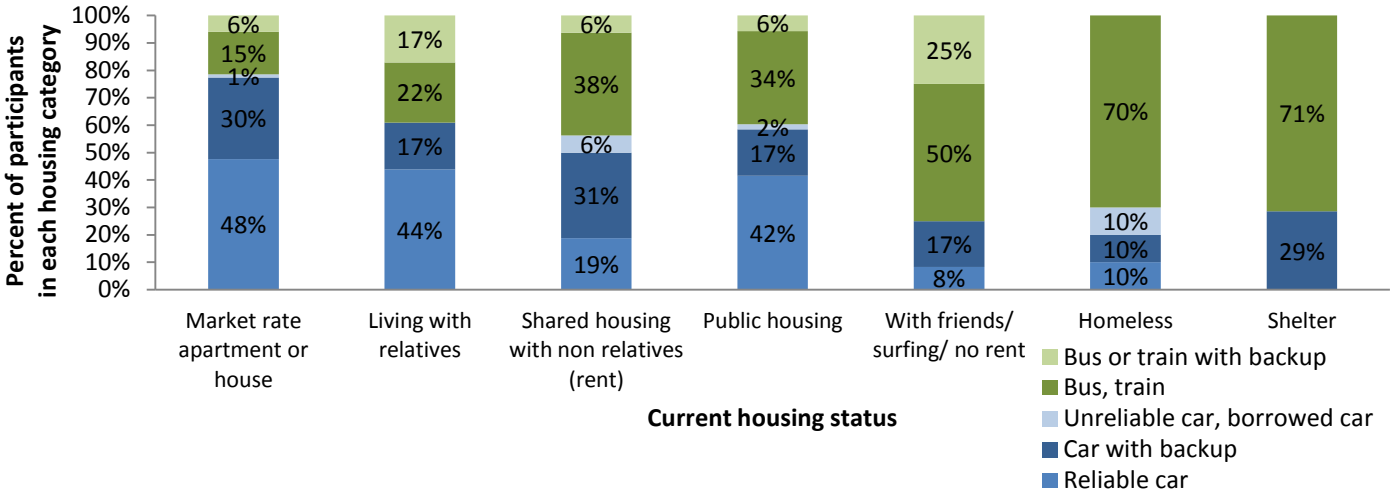
Figure 9.
Concern about Paying for Housing by Current Housing Status and TANF status



This figure shows fairly pervasive concern about ability to pay for housing. Considerably fewer of those living in public housing expressed a concern about their housing. Interestingly, the other group expressing less concern is those living in shared housing in which they share rent with a non-relative. Although these numbers are small, this finding may be worth examining further as a relatively stable option for those with low income and without access to public housing.

Participants were asked to describe their mode of transportation to training and work, as well as back up plans. Many provided their state driver's license or identification card, which was photocopied and inserted in their files. Overall, 72% of the participants have valid driver's licenses. Those living in market rate housing are more likely to have a driver's license (82%), and those who are couch surfing, homeless, or in a shelter are less likely (54%, 39%, and 50%, respectively). TANF participants are less likely to have a driver's license (66% vs. 77%), as are immigrants/refugees (67% vs. 77%). Further analysis of the relationship between having a driver's license, TANF participation, and country of origin shows that three of these groups (Non TANF, both those born in the U.S. and those born elsewhere, and TANF participants born in the U.S.) are equally likely to have driver's licenses (77%). TANF participants who are also immigrants/refugees are less likely to have driver's licenses (53%).

Figure 10. Transportation Plans by Current Housing Status



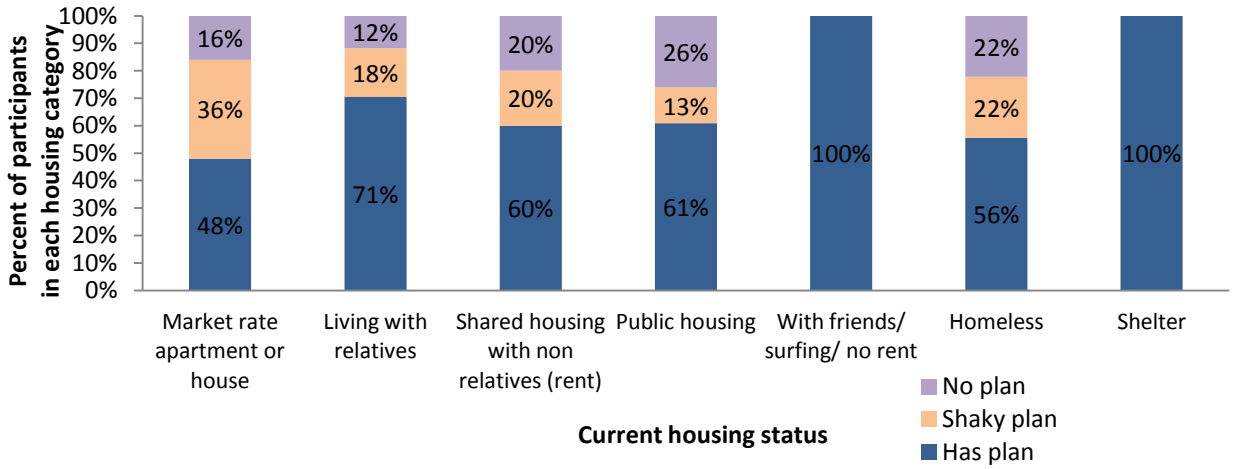
Transportation plans described by TANF and non TANF participants were similar. Figure 10 shows responses by current housing status. Most (78%) of the participants in market rate apartments or houses report having a car; and some of these articulated a back-up plan. About 20% of this group plans to commute by bus to training or work. Fifty to sixty percent of those in the other relatively stable housing categories (with relatives, subsidized housing, shared housing) also reported having their own car for transportation, and the others discussed their plans to take a bus.

Those without housing stability (couch surfing, homeless, living in shelters) are least likely to have a reliable car (20%-30%) and they plan to use public transportation. Future analysis may show that the combination of unstable/ likely inconsistent housing along with reliance on public transportation may make it particularly difficult for certain participants to succeed.

The case files also contained information about childcare plans. Responses were coded as "Has Plan," "No Plan," and "Shaky Plan." Shaky plans were those that relied on favors from friends or extended family who were not otherwise responsible for the children. Figure 11 shows the proportion of each housing group coded with each category of childcare plan. (Those without children do not appear in this figure or the next one.) Figure 11 shows that participants living in market rate housing may have the

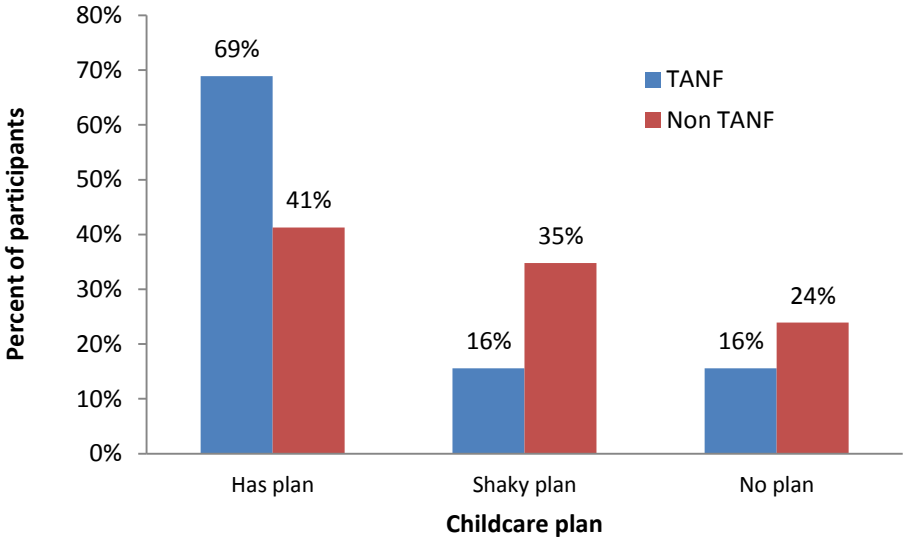
least robust plans for caring for their children while they attend training or work. Participants living in market rate housing have concerns about paying for housing, and are least likely to have a solid plan for childcare.

Figure 11. Childcare Plans by Current Housing Status



Non TANF participants living in market rate housing are the least prepared for childcare with only one-third of these participants reporting a solid childcare plan, compared with two-thirds of the TANF participants in market rate housing. Figure 12 shows that overall, TANF participants are most likely to have a solid childcare plan in place. Analysis may show that childcare may become too great a challenge for individuals attempting to attend training without childcare support.

Figure 12. Concern about Paying for Housing by Current Housing Status and TANF status



Overall, participants identified an average of 1.3 barriers for themselves (actual responses ranged from 0 to 6), while navigators identified an average of 1.4 barriers for the participants (again, ranging from 0 to 6).

Interestingly, even though TANF participants may be more secure in their housing and childcare, they identified significantly more barriers than non TANF participants (1.7 vs. 1.0), a pattern also observed in the navigators' assessments (1.6 vs. 1.2), but not reaching statistical significance.

Women identify more barriers for themselves than men (1.4 vs. .9) and navigators do so more strongly (1.6 vs. .8). Interestingly, those born outside the U.S. identify *fewer* barriers for themselves than do their U.S. born counterparts (1.1 vs. 1.5 barriers) and the navigators see it the same way, even if the difference did not reach statistical significance (1.2 vs. 1.6 barriers).

One of the most frequent barriers identified by participants was a "financial barrier that could impact their ability to complete training," coded as "yes" for 18% of the participants. Further analysis to better understand the concerns were inconclusive. Men and women were about as likely to identify the financial barrier; TANF and non TANF participants responded similarly; those with and without a solid childcare plan responded similarly; those with and without children responded similarly; those with and without a limited or spotty work history, according to the navigator responded similarly. Analysis of housing status provided a surprising (but not statistically significant) result: those without housing (homeless, living in a shelter) were less likely to identify financial barriers (0% and 18%, respectively). In contrast, those in (potentially insecure) housing were more likely to identify a financial barrier (22% of those in market rate housing or living with relatives, 25% of those "couch surfing.") This finding suggests a possible "inoculation" hypothesis in which people who have already endured a financial crisis so extreme that it led to homelessness, when compared with their counterparts who have so far avoided that outcome, may find it less concerning (possibly because they found and know they can count on the "safety net" of food banks and shelters to help them survive). If so, those with more work experience and more earnings in the recent past might express more concern about their financial well-being. This analysis shows that those identifying a possible financial barrier had a longer work history (5.1 years vs. 3.6) and earned a significantly higher wage prior to entering HCA ($14.67 vs. $10.77). Additionally, immigrants and refugees are significantly less likely to identify a possible financial barrier (14% vs. 25%).

Navigators completed a checklist of potential barriers facing their customers. The percentage of customers for which the navigators identified each of these barriers is illustrated in Figure 13. The most common, limited or spotty work history, was identified for 37% of the participants, pointing to the need for internships or some sort of work experience as part of the training program. Program staff report that virtually all of the HCA health care training includes a work-based learning component (clinical/externship/practicum). TANF participants were no more likely than non TANF participants to have a limited or spotty work history, nor were those born outside the U.S., compared with U.S. born participants. Women were much more likely to have this barrier (41% vs. 17%) as were participants in certain housing categories, especially those living with others without paying rent (couch surfing or living with relatives), as well as those in public housing or shelters. Curiously, those who were homeless at the time of enrollment in HCA were the least likely to be identified as having a limited or spotty work history.

Figure 13. Potential Barriers Identified by Navigators

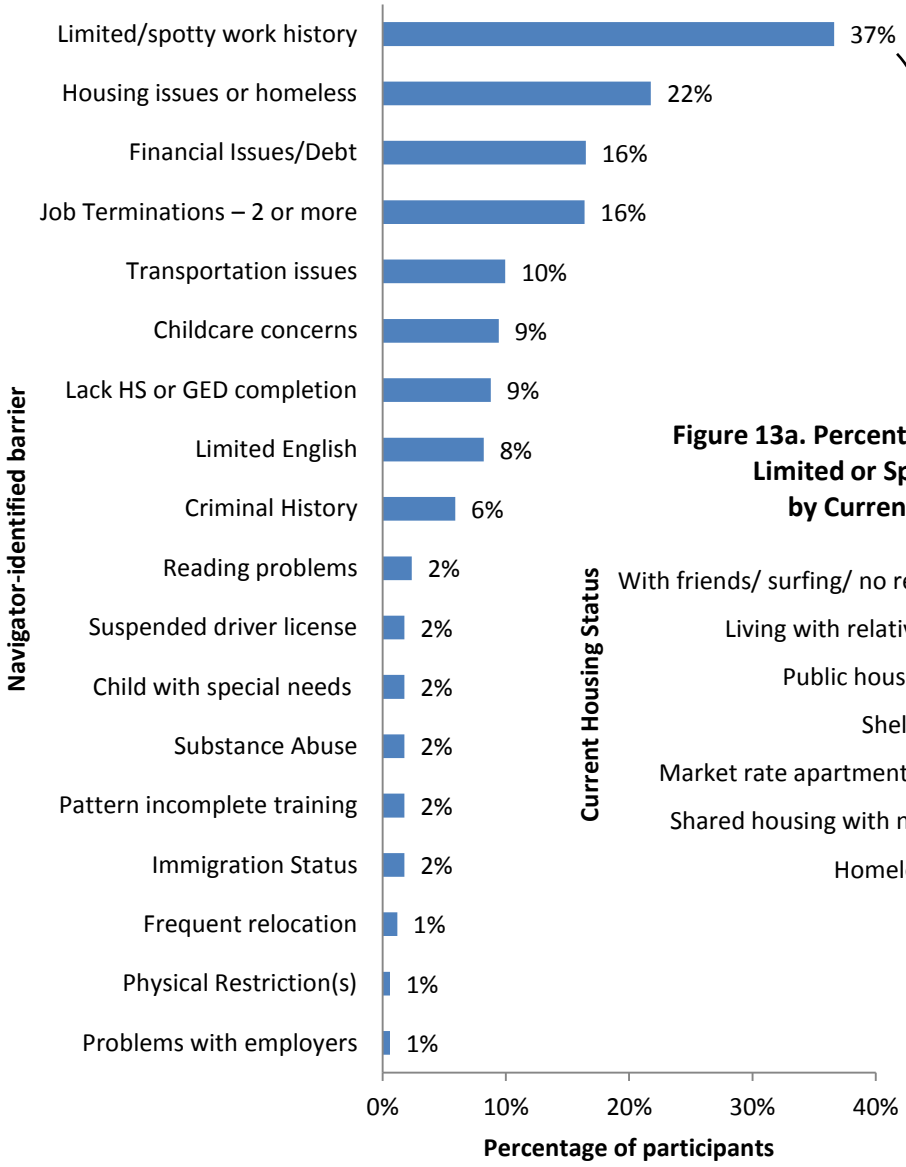
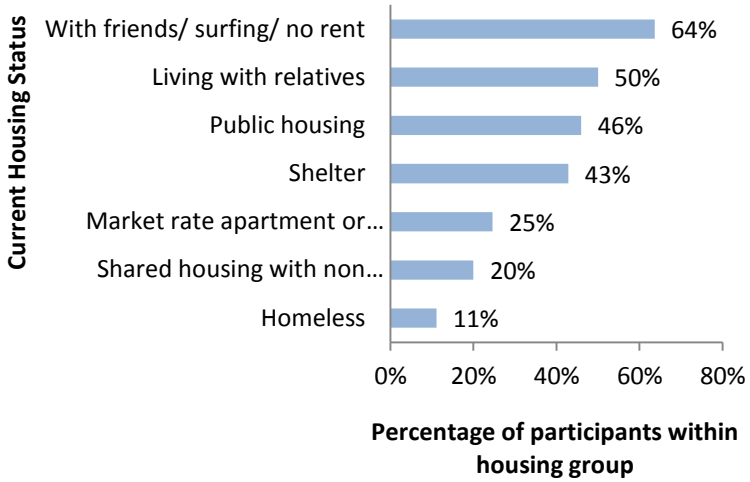


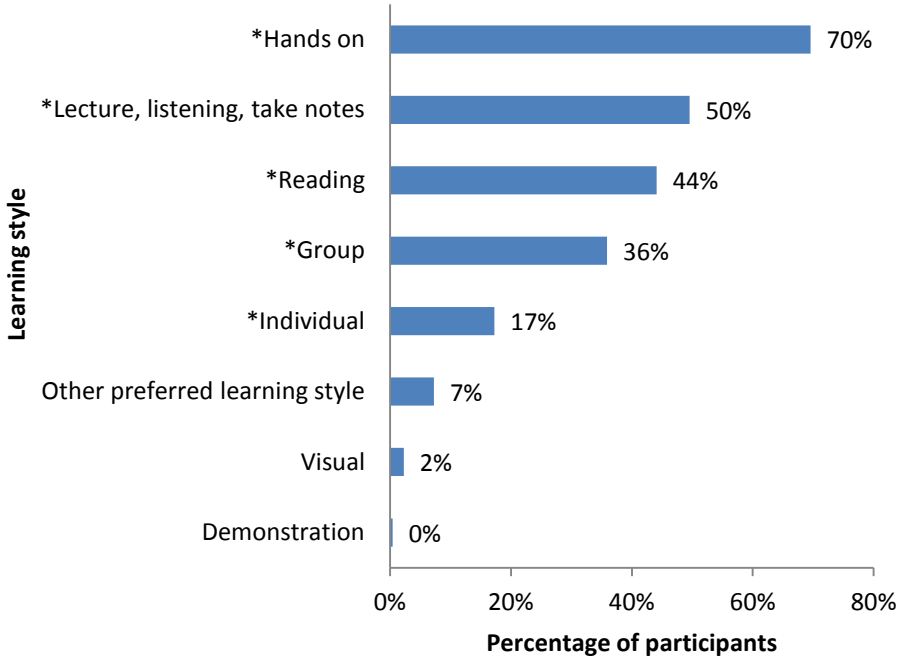
Figure 13a. Percentage Identified as Having a Limited or Spotty Work History, by Current Housing Status



Learning Experience

Participants were also asked to indicate whether they had experienced any learning difficulties in school (9% said they had) and to describe their preferred learning styles.

Figure 14. Preferred Learning Style



Analysis of the top five preferred learning styles shows that women are significantly more likely to prefer "hands on" learning (75% vs. 49%); TANF participants are somewhat *less* likely to prefer individual learning activities; and immigrants and refugees are more likely than others to prefer lectures (57% vs. 41%) and are less likely than others to indicate "hands on" (52% vs. 89%). Those with more education were more likely to prefer both lectures and individual learning styles. It may be important to note that those learning styles with an asterisk (*) in Figure 14 were suggested as part of the question, "What is your preferred style of learning? (*e.g., reading, lecture/oral delivery*, *hands-on, individual, group)"* Thus, the frequency of the appearance of five learning styles mentioned in the question can reasonably be compared, but the frequency of any of those five should not be compared with the frequency with which others are written in (such as "Visual" or "Demonstration").

The assessment form attempted to determine the participants' computer literacy. Nearly all participants reported having an email account and knowing how to search for jobs on the Internet. About one-third (35%) have taken an online course. Participants were asked to rate their skill with the different programs with Microsoft's Office suite. For each participant, we counted the number of programs (from none to five) for which s/he indicated "good" skill or better. Responses varied, ranging from less than "good" skill with any Office program (16%) to at least "good" with all five (25%).

Participants were also asked to indicate whether they know how to perform 18 different computer functions. About two-thirds indicated "Yes" to all 18 items. Analysis shows a "digital divide" between TANF and non TANF participants, by housing status, by educational achievement, by being Caucasian, and by age. Participants were not asked about their computer and Internet access.

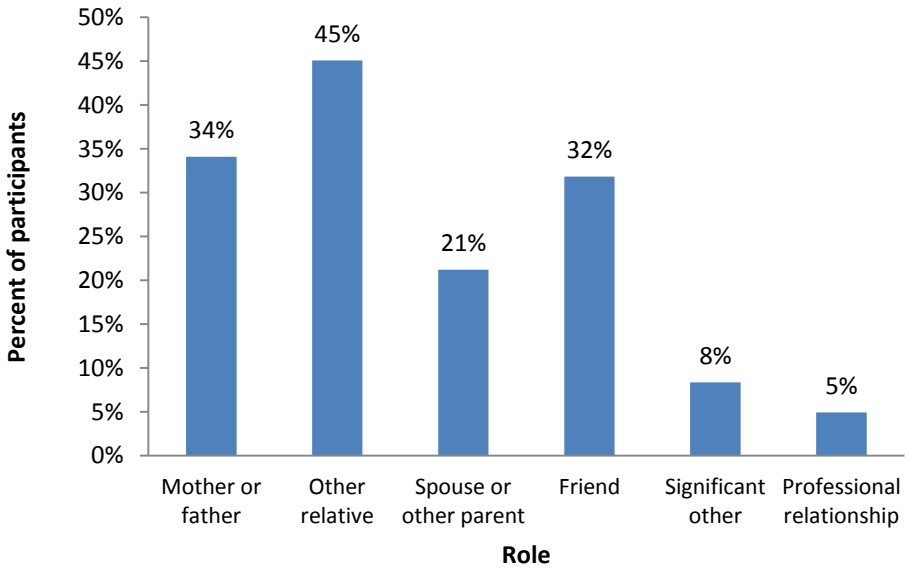
- TANF participants were less likely to indicate that they were skilled at all 18 computer tasks (55% vs. 73% of non TANF participants), were somewhat less likely to have taken an online class (29% vs. 40%), and had "good" skills with fewer programs in the Office suite (2.4 vs. 2.8);

- Older participants tended to have "good" skills with fewer Office products;
- Overall, immigrants/refugees had the same level of skill as their U.S. born counterparts. However, among the participating immigrants and refugees, Caucasians had at least "good" skills with significantly more Office products (3.5 vs. 2.4) and were significantly more likely to be able to perform all 18 computer tasks (93% vs. 59%).
- Those with more education had "good" or better skills with more Office products; were more likely to be able to perform all 18 computer functions (from 45% among those without a high school diploma or GED to 78% among those with a four year degree); and were more likely to have taken an online course (from none without a high school diploma or GED, to 27% of those with a GED, up to 52% of those with a four-year degree).
- Those who live in a shelter were least likely to be skilled in all 18 computer functions (43%), up to less than 60% among the homeless participants, those living with relative, and those in public housing. Those paying rent/mortgage more likely to have all 18 skills (69% in shared housing; 74% in market rate), and all the "couch surfers" noted that they have all 18 skills. Proportion of participants who have taken an online follows the same housing gradient, with 14% of those in a shelter saying they had, up to 27% of the homeless participants, and 31% of those in public housing. About 40% of the other housing groups have taken an online course.

These findings indicate that the groups that are traditionally "digitally" disadvantaged are also digitally disadvantaged in this project. Future analysis may show that this gap merits additional attention.

To facilitate tracking, participants were asked to provide contact information for others who would always know how to reach them. Participants provided information for an average of 1.6 people. In addition to gathering the contact information, who the contact person is was coded into relationship categories (yes/no). Whether one friend or three friends were named, the Friend category was coded as "Yes." Thus the percentages in Figure 15 do not indicate how many parents were named or how many other relatives, simply that 34% of the participants named at least one parent, 45% named at least one other relative (usually a sibling or an aunt or uncle), and 32% named at least one friend. Others named

Figure 15. Who can always reach you?



their spouse or sometimes the other parent of their child. A surprisingly small percentage named a boyfriend or girlfriend and a few named their caseworker or other professional relationship.

- Women identified more contacts than men (1.7 vs. 1.5) and were more likely to name a parent (37% vs. 23%) but otherwise had a pattern similar to the men.
- Participants who were born outside the U.S. identified fewer contacts than their U.S. born counterparts (1.6 vs. 1.7), were much less likely to include their parents (15% vs. 53%), and more likely to name a friend (37% vs. 26%), a professional relationship (8% vs. 2%), and fewer supportive people or organizations (1.5 vs. 2.7).
- TANF participants are similar to non TANF participants except that they are more likely to name a professional relationship (9% vs. 2%).
- The pattern by housing status is complicated and is illustrated in Figure 16.

Figure 16. Who Can Always Reach You by Housing Status

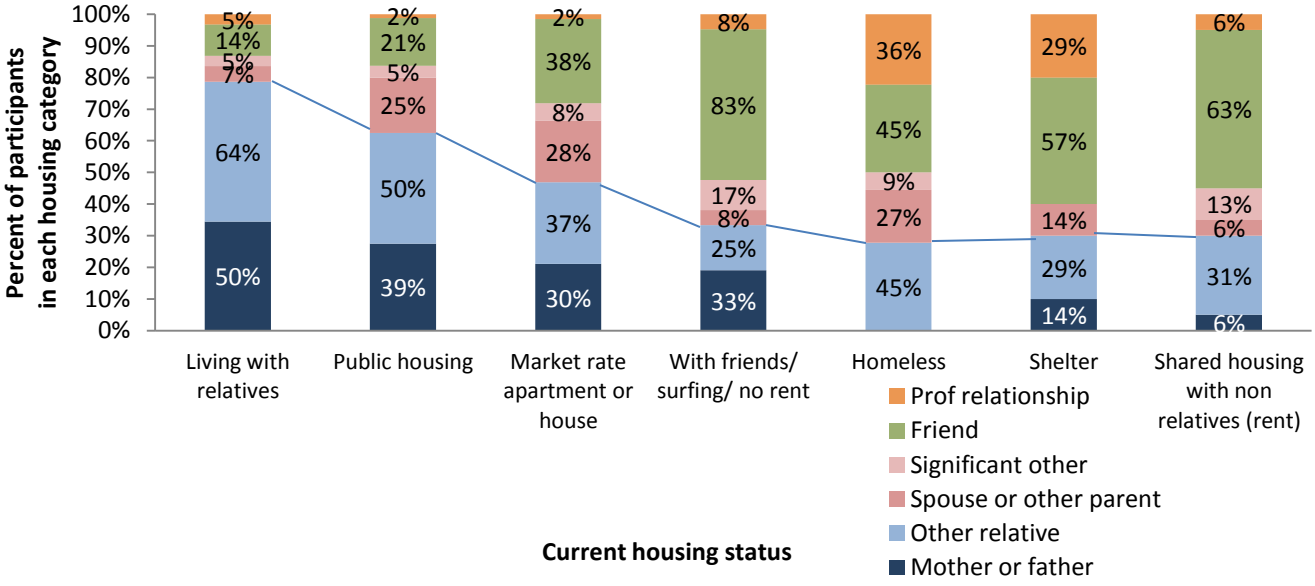


Figure 16 is a more complex stacked graph than those presented above. Note that the percentages within each bar add to more than 100%. This is because participants generally provided more than one name, often in more than one category. However, this graph still shows the relative prevalence of the different relationship roles and that prevalence can be compared across housing categories.

This figure shows a great difference in the prevalence of most roles as someone who will always be able to reach the participant, depending on housing situation. This suggests that housing is related to relationships. For example, those who share rent with non-relatives were least likely to name relatives as people who could always reach them. Only six percent of this group named their parents, and only about one-third named other relatives. At the other end, those who are living with relatives were very likely to name parents and other relatives as people who would always be able to reach them. Those in public housing are also more likely to name family members in this capacity. Those who are not stably housed (couch surfing, homeless, in a shelter) are less likely to name relatives. Interestingly, as the

likelihood of naming relatives decreases, the likelihood of naming someone in a professional capacity increases. These findings raise the issue of the relationship between social support and functioning.

Entering the HCA program

Participants have been enrolling in the HCA project since the end of March 2011. Figure 17 shows the weekly cumulative enrollments since that date. The two lines show the enrollment of TANF participants, the lower (blue) line and non TANF participants, the top (red) line.

Figure 17. Cumulative HCA Enrollments by TANF Participation

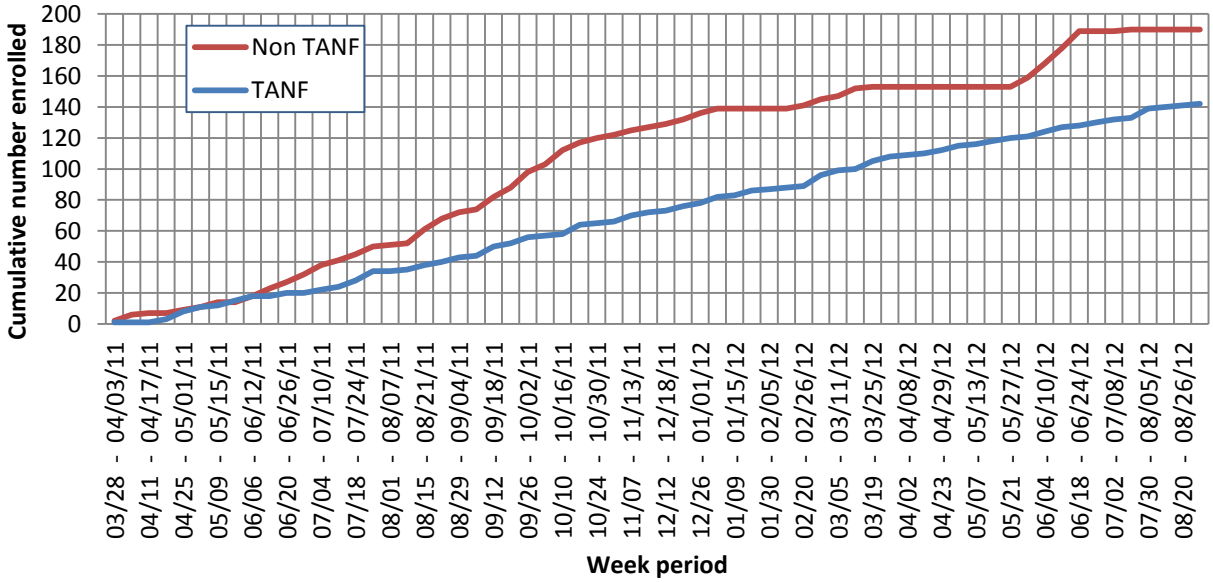
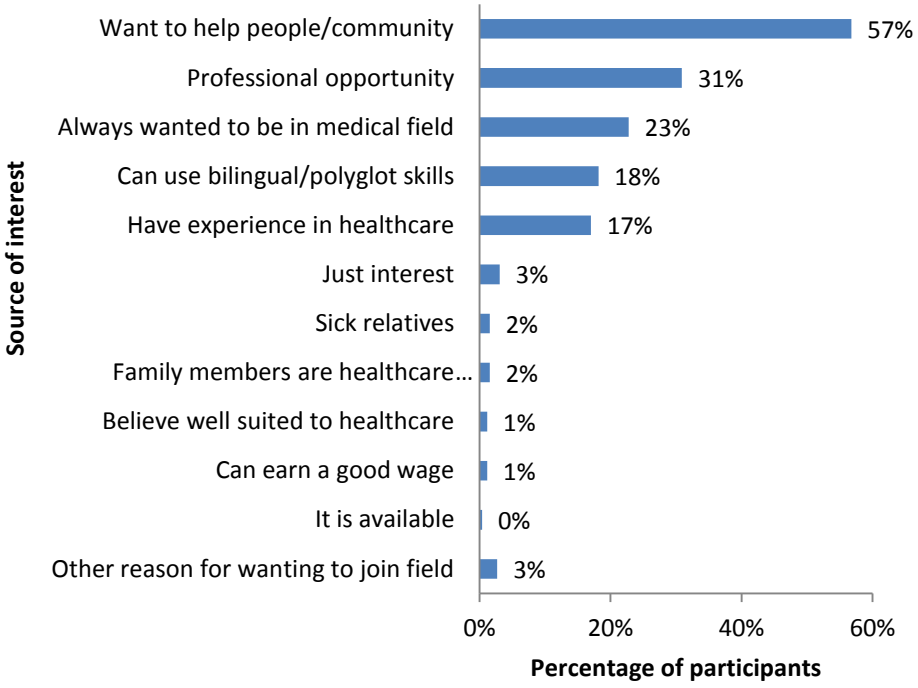


Figure 18. What prompted your interest?



Participants were asked in an open ended question what prompted their interest in a healthcare career. Responses were coded into the categories displayed in Figure 18. The most common is a desire to help people or to help their community. Interestingly, this reason was also given by 57% of the participants a year ago. About the same

percentage also indicated that they were attracted to the professional opportunity and more are noting that they always wanted to be in the medical field (up from 8% a year ago). Although the overall pattern was consistent for all groups (that is, wanting to be of service to others was the most commonly mentioned reason in all the subgroups), some of the subgroups were more likely to give some of the responses. For example, the immigrants and refugees were much more likely to mention their language skills (36% vs. 0%). They were also more likely to appreciate the professional opportunities available in healthcare (37% vs. 24%). This group was less likely to say that they always wanted to be in healthcare (16% vs. 30%).

TANF participants focused somewhat more than non TANF on the career aspect of healthcare, mentioning more often the professional opportunities of a healthcare career (38% vs. 26%), and the availability of a good wage for the work (3% vs. 0%).

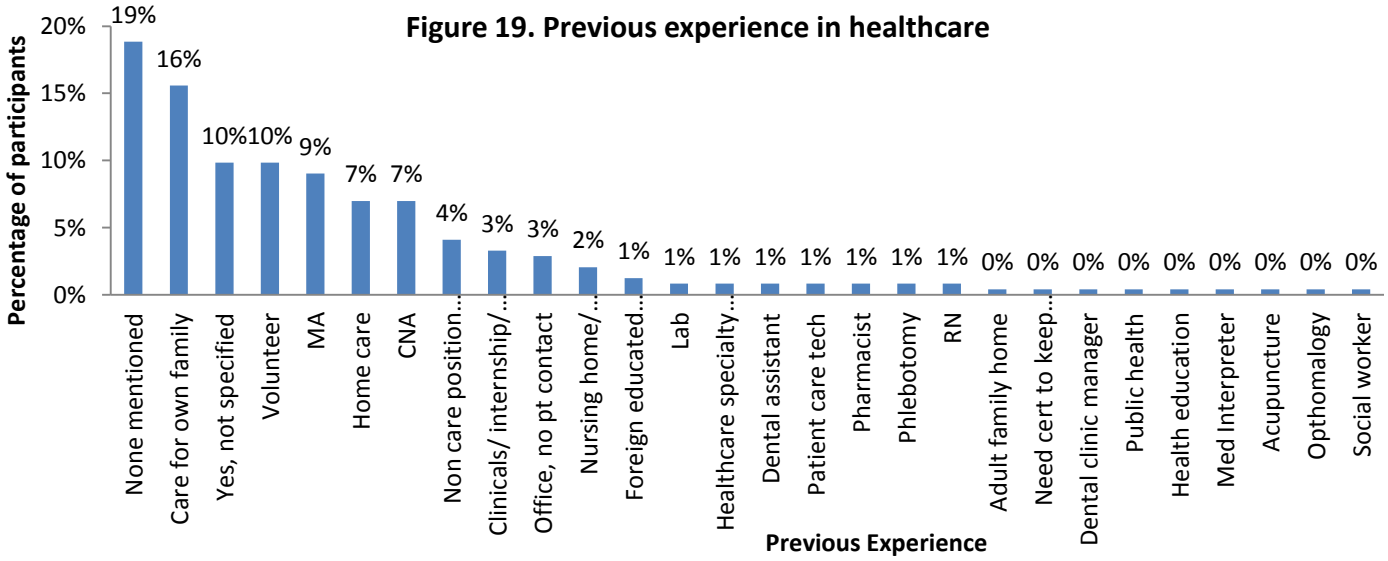
No differences were found based on educational achievement, housing status, or gender.

Previous experience in healthcare

Participants were asked to describe past work experience in a healthcare field, including volunteer work, externships, and homecare experience. Additionally, some completed past employment forms that supplied this information. Based on these sources, 42.5% of the participants have had previous training in the medical field and 49% have had previous experience in the healthcare field, 29% in their most recentl job before enrolling in HCA. All of these values have increased since last year. TANF participants were significantly less likely to report any of this previous experience. They were less likely to have had previous training in the medical field (35% vs. 48%), less likely to have experience in a healthcare field (40% vs. 55%), and less likely to have been most recently employed in a healthcare field (15% vs. 37%).

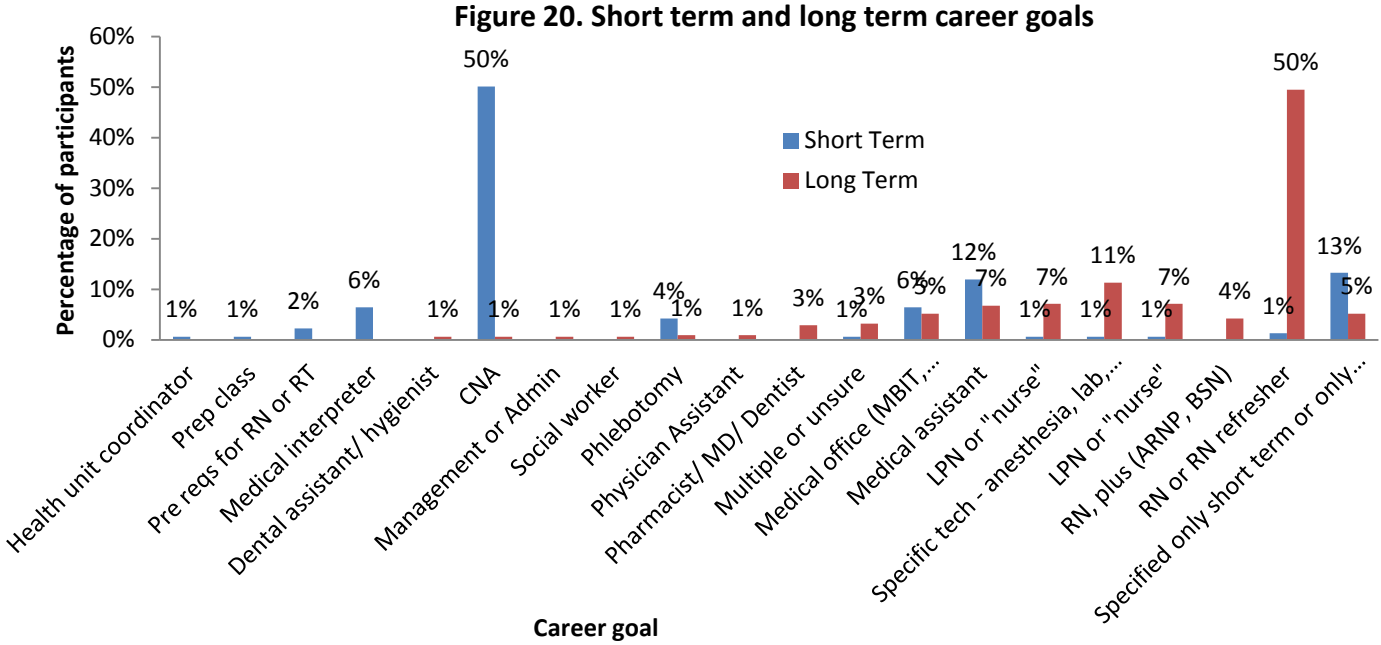
Figure 19 summarizes responses coded from the 244 files with available data. About one-fifth did not mention any experience, 16% described caring for family members and 10% described their volunteer work. Ten percent did not specify their experience. Others named a variety of positions, most frequently MA, CNA, and Home Care.

Figure 19. Previous experience in healthcare



Participants were asked to indicate their short and long term career goals on several forms. Responses were combined to produce the following graph, dominated by a short term CNA goal and a long term RN goal. Only one percent also specified CNA as their long term career goal, setting the stage for career progression over the period of the grant. The percentage identifying RN as their long term goal has also declined somewhat from 68% among the first year participants.

Figure 20. Short term and long term career goals



The training process

Of the 329 individuals with file reviews and electronic data from TRAC Associates, 86 were enrolled in school when they entered HCA[5]. Thirty mentioned basic skills (ESL, ABE, GED, developmental education) or foundational training. Twenty-two were in a healthcare certificate program, such as CNA, Medical Interpreter or MA. Fourteen were in or preparing for longer term training. Figure 21 provides details.

Figure 21. Educational program when enrolling in HCA

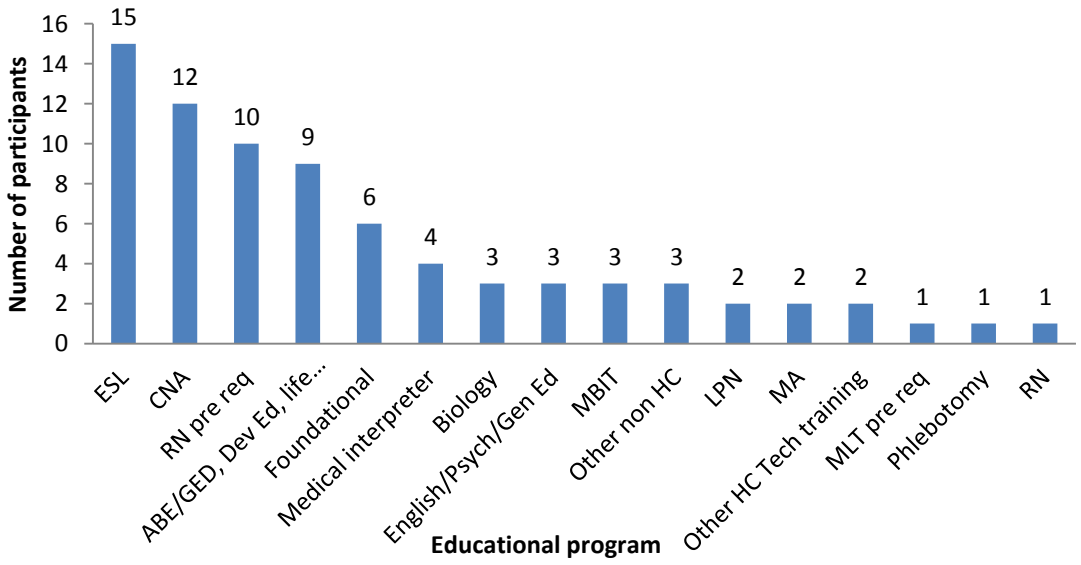
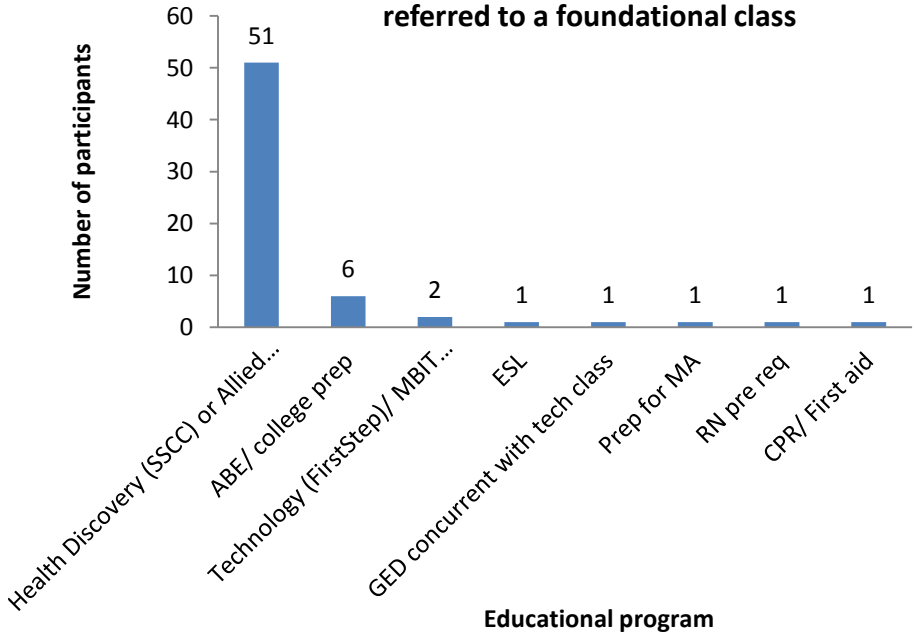


Figure 22. Some participants were referred to a foundational class



Sixty-four participants were referred to a foundational class, most of these to Health Discovery at SSCC or Allied Health Core at RTC. Program staff report that additional participants attended a foundational class at North Seattle Community College and at Green River Community College, indicating that this figure under reports the number of participants who have enrolled in a foundational class. Two participants were referred to technology

[5] This may be an overestimate as some may have indicated mistakenly their upcoming training program.

training. Figure 22 details the other referrals.

Most participants attended an entry level training program, depending on a combination of interest and qualifications on the part of the participant, and the availability of a cohort or individual training account funding on the part of the program.

Figure 23. Entry level classes

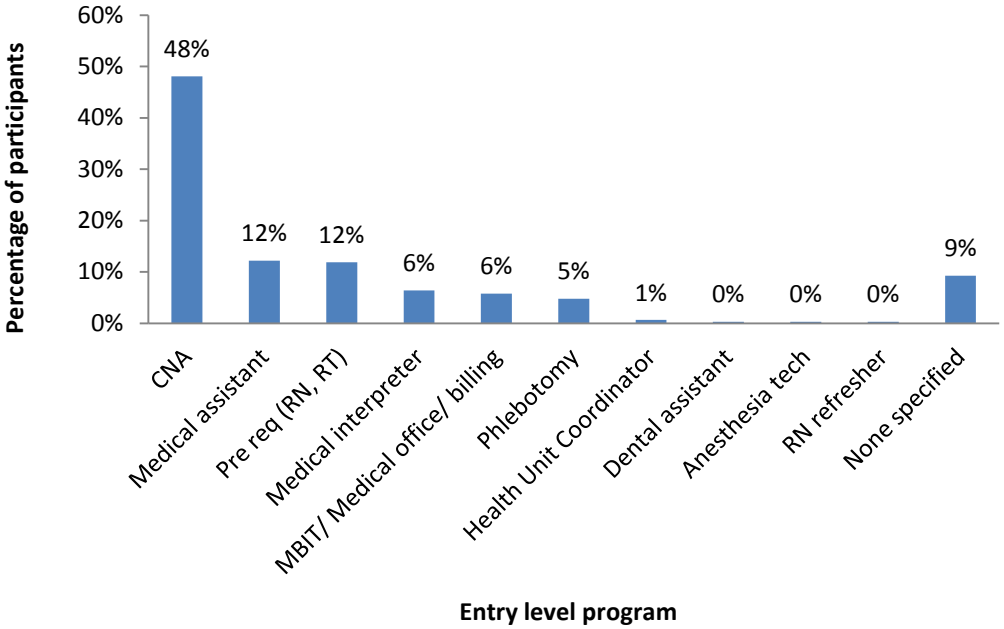


Figure 23 shows that about half of the HCA participants in the first two years enrolled in CNA training as their entry into the healthcare field. The other half went directly into a medical assistant or phlebotomy program (11%), or in a direction involving less direct patient care such as medical interpreter or medical office (12%).

HCA has enrolled participants in a large number of training programs geographically distributed around the county and even into Pierce County. Appendix I contains a map that illustrated the location of the training programs, overlaid with the distribution of home ZIP codes of the participants.

An important goal of the HCA program is to facilitate and support the movement of participants up the healthcare career ladder, rather than simply accumulating a large group in entry level jobs. Figure 24 illustrates the different pathways through healthcare training and employment traveled by the first 329 adults in the program. This figure is based on information available in the TRAC database and navigators' informal notes as of 9/14/12, and should be considered more an illustrative snapshot in time than the source of hard numbers.

Despite the preliminary nature of the data, this figure shows that participants are engaging in training and moving from training into employment, and sometimes back for more training. Other participants are moving straight through a training track. Just over half (53%) of the training has been through cohorts and 23% through HCA-funded ITAs. The balance has been funded through other sources. Cohort funding is more likely in the earlier phases of training, decreasing from 55% of the initial training programs to 51% of the second training step and 36% of the third.

Figure 24. Movement through training to employment and sometimes, back

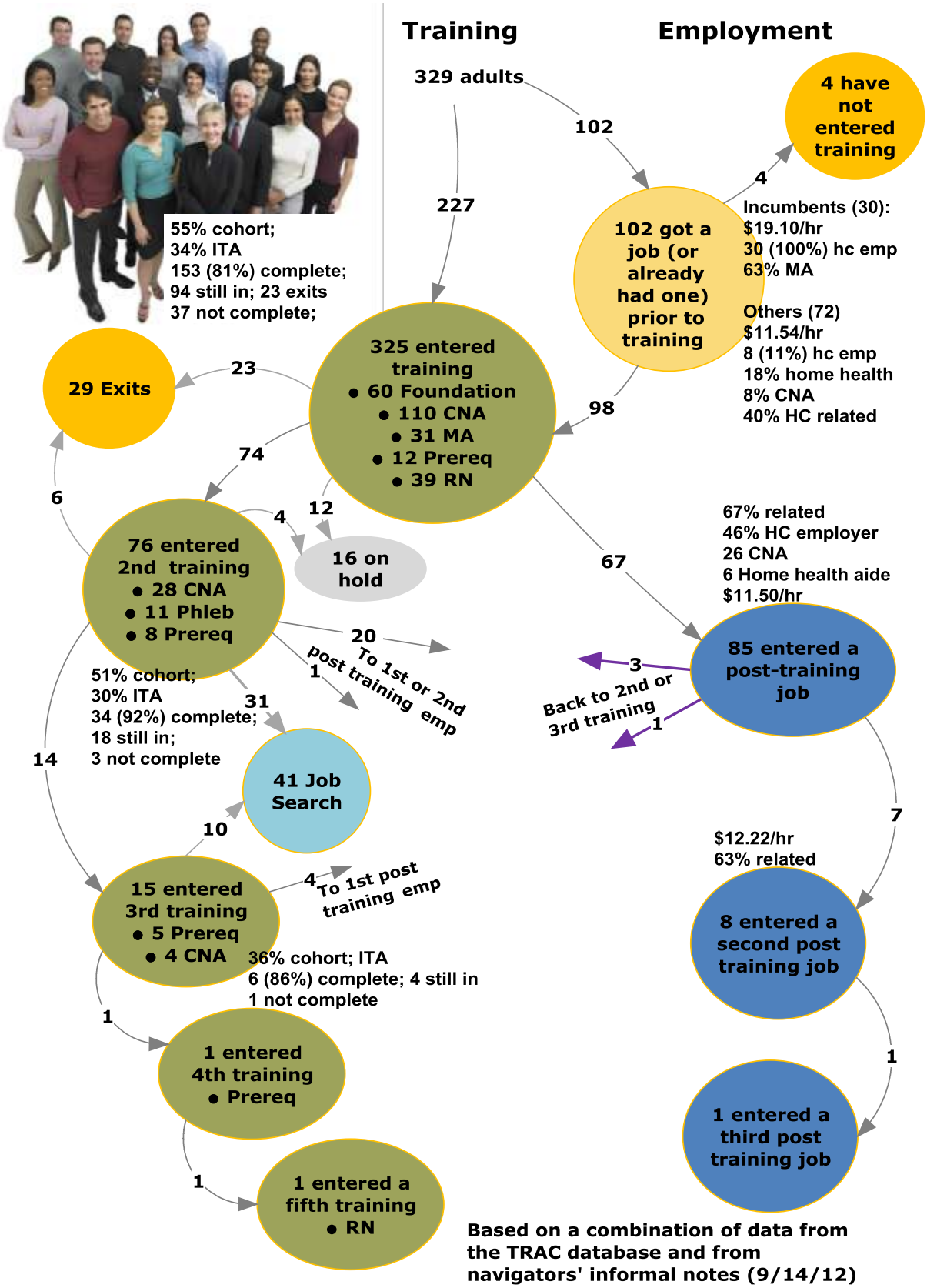
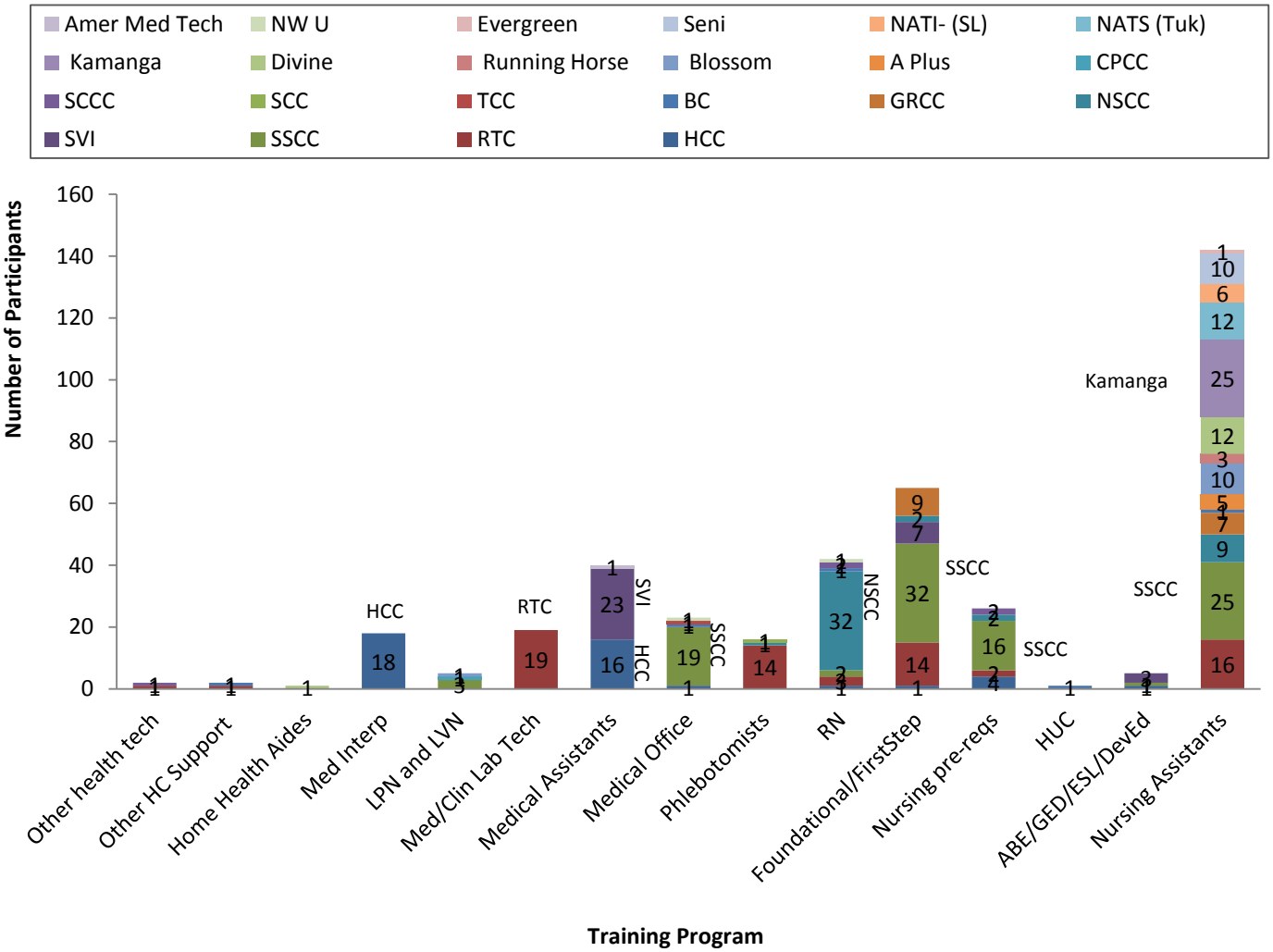


Figure 25 shows the training institutions that participants attend, by the occupation. Reflecting the large number of participants who have enrolled in CNA training, the far right bar is the tallest and shows which schools they have attended to learn to be nursing assistants. This graph shows that HCA is using a variety of training resources.

Figure 25. Number of participants in each program at each school



A preliminary look at completion and credential outcomes points at some issues to track. For example, out of the 142 enrolled in CNA training programs, 105 (74%) have completed. (Some participants are still in progress and some failed to complete.) Of the 105 who have completed their CNA training program, 56 (53%) have received their NAC credential. This percentage may go up as more actually attempt (or in some cases re-attempt) the certification test. When the data entry is completed, the number of participants in each program is sufficient, and a better understanding of each program is achieved, we will compare completion and certification rates across training providers.

Who completes training or gets a job?

One important reason for gathering quantitative data from paper files and electronic sources is to search for factors that might predict outcome, that is, factors that might be the answer to the questions, "Who completes training?" And, "Who gets a job?" A multivariate approach was used in which all the potentially predictive factors are used together, combining them into a single, optimally predictive function. When the intention is to classify participants into different known groups, Discriminant Function Analysis (DFA) is a useful technique. At the exploratory stage of data analysis, it is sometimes instructive to permit the statistical program to select the factors one at a time to maximally separate the groups. This is a stepwise approach, fraught with methodological limitations but still useful in trying to develop a model. With a stepwise approach, it is particularly important to view the resulting model with caution; rather to consider it information to be added to other knowledge and tested when more data become available.[6]

One hundred eighty-five participants had either completed all trainings (n=151) or not completed any training (n=34). Many potentially predictive factors were "offered" to the program to discriminate the participants into their correct group. including demographics (sex, age, immigrant/refugee, race/ethnicity, education including previous training in healthcare, and technology skills) circumstances (housing, transportation, age of children, childcare plan, LEP, criminal history, social support, TANF/non TANF, employment status and history, including time out of work and previous experience in healthcare), participant self-report items (reason for interest in healthcare and barriers) navigator assessment of barriers, and factors related to the first training program (duration of training program and cohort/ITA).

Applying DFA, using these factors to classify participants according to training completion retained 79: 18 who did not complete and 61 who did. (The other 106 were eliminated because of missing at least one of discriminating variable). The resulting model was tested by removing the variables that did not contribute to the discriminating function, returning another 34 to the analysis.

Both analyses correctly classified 72% of the participants, significantly better than what would be expected by chance (50% correct classification). The stability and effectiveness of the function when the dataset is increased by 40% increases confidence in the model. The four factors creating the discriminating function are:

[6] One requirement for any approach to using predictors to differentiate completers from non-completers, those who obtained a credential from those who did not, or those who obtained employment from those who did not is that the groups must be clearly and correctly defined. Before we can explore the data to find out what the difference is between a completer and a non-completer, for example, we must clearly know who the completers and non-completers are. This is particularly challenging in this project because a person who has not received his/her credential this week and is in the "no credential" group this week, may change groups next week when s/he passes the exam. This analysis will be more accurate once participants have "settled" into their group, however, it won't be as useful for this project at that time. So these findings are presented, not as the final word on classifying participants, but as the best information circumstances will permit now for the program managers and implementers to draw meaning from as possible. Once this model is developed with confidence, *then* it could be used to attempt to identify completers and non completers in advance.

- Number of children 0-5 (as this goes up, likelihood of completing goes down)
- Navigator-identified problems with employers (those with problems were less likely to complete)
- Navigator-identified limited or spotty work history (those with this barrier were less likely to complete)
- Participant-identified financial barriers that might impact ability to obtain/maintain employment or training (those with such a barrier were less likely to complete)

The discriminating function also correlated with number of children overall, and the number of barriers identified by the participant (the more of either, the less likely to complete), and less strongly with education and knowledge of Microsoft Office (lower attainments were associated with lower likelihood of completing).

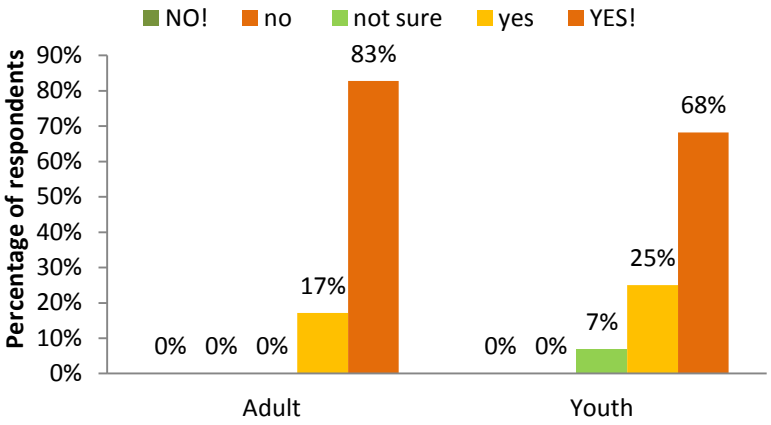
In summary, participants with more children, (especially those under 5), who see themselves as having more barriers to completion (especially financial barriers), and whom navigators perceive to have a limited or spotty work history, or problems with employers in the past are most at risk for not completing a training program.

The same predictive factors were used to try to discriminate employment after training. According to the data and navigators' hand count, 92 participants have obtained employment after receiving training, and 131 have not. The analysis included 90 participants (46 not employed and 44 employed). The other 95 were missing at least one discriminating variable. This analysis was unable to predict employment any better than by chance.

Participant intake survey

The Participant Survey contains questions intended to identify participant commitment to their goal, and their expectation of success, along with their preferred coping strategy. If these items or scales could be administered to participants near their enrollment with HCA and then help predict probable outcomes, it could be used to plan services and improve outcomes. 108 Participant Surveys have been completed, 64 by adults, mostly during focus groups (MAs at SVI, Phlebotomists at RTC) or distributed by an instructor (RN Pre-Reqs at NSCC), and 44 by youth in the 2012 summer programs. These data may prove useful as the participants continue through their training programs to completion, state exams, and employment. Until then, it will be used to describe the population.

Figure 26.
Reaching this goal is my absolute top priority

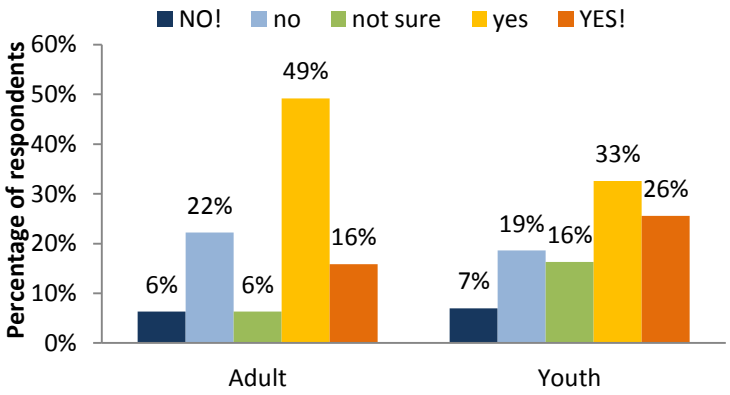


Respondents were first asked to articulate their long term goal. This question may have been placed in a way to make it easy to overlook as many respondents did not reply. Of the adults who did respond, four indicated a goal of becoming a nurse, in addition to the 30 in the NSCC program, two want to be a medical lab technician, two a physician's assistant, one a surgical tech, one a medical assistant, two want to be doctors, two are open to various opportunities in healthcare and one is interested in home health. Youth goals are somewhat more ambitious and include becoming a doctor or dentist (8), a nurse (or 1 each also is considering physical therapist or radiologist) (12), a pharmacist (1), a psychologist (1), or a veterinarian (1).

Figures 26 through 33 illustrate responses to nine questions intended to elicit commitment, confidence, and concerns about completing the training program. Youth and adults are displayed separately on each graph. Most of the adults consider reaching their goal a top priority; youth are less extreme.

Figure 27 reflects diverse interests among the respondents. These responses may predict whether participants will overcome barriers.

Figure 27. I have many different interests and this is just one of them



More than half the adult respondents were adamant that they would not quit their training program if a good job came along. TANF participants still tended to answer negatively but they were less adamant, possibly reflecting the determination expressed in the focus groups to get off TANF. Youth were not at all adamant in their responses to this item.

Those who noted a financial challenge that might impact their ability to obtain or maintain employment or training were also disagreed a little less strongly with this statement.

Figure 29 shows that the adults strongly disagreed that this particular job is not a priority – they just need a job and youth also disagree, but not as strongly. Respondents who were born outside the U.S. also disagreed, but not as strongly as their U.S. born classmates.

Figure 28. I am committed, but if offered a different, good job before I finish, I'll take it

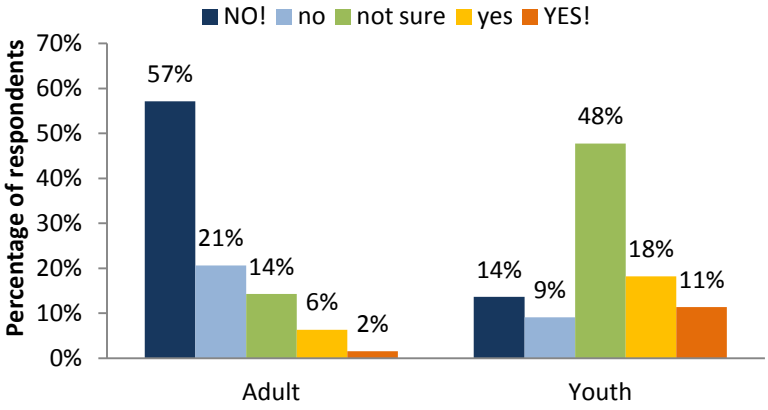


Figure 29. This particular job is not a priority for me; I just need some job

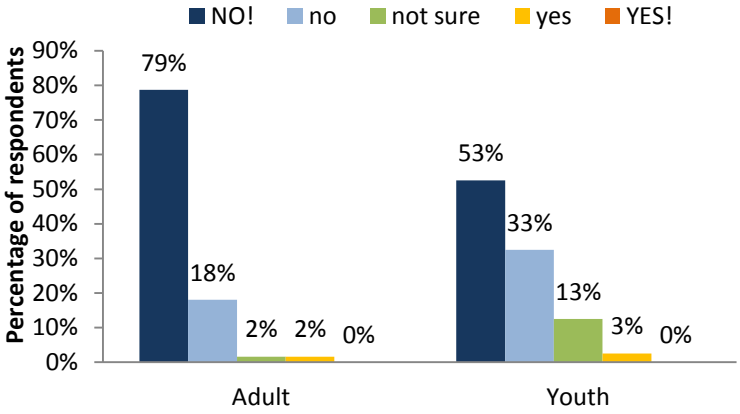


Figure 30. I am just doing this to keep my housing or cash benefits

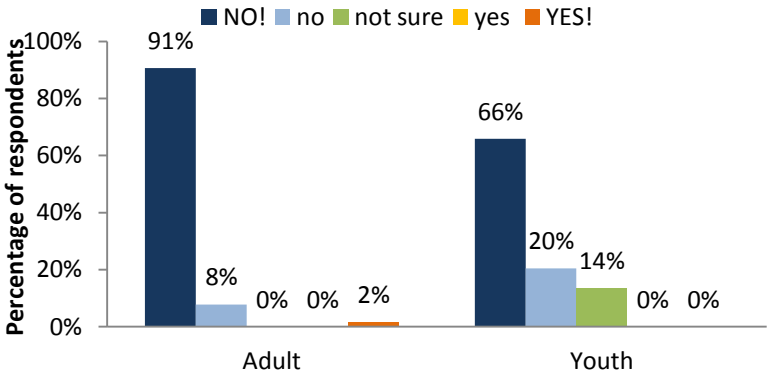
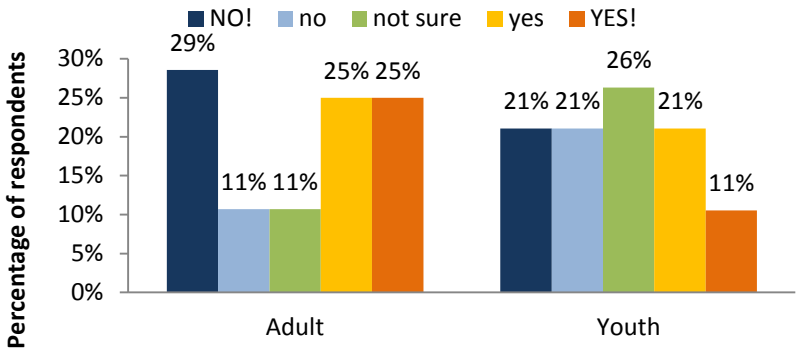


Figure 30 shows that most adults strongly disagreed that their purpose in being in the training was to keep their benefits. In a curious finding, men disagreed a little less strongly (but statistically significant), and those who did not have stable housing – couch surfers in particular – were less adamant in their negative response.

Figure 31. As I make progress toward my goal, I'm afraid I'll lose my benefits before I'm ready



no benefits: 65% (adults) 50% (youth)
food: 17% (adults) 33% (youth)
housing: 12% (adults) 25% (youth)
childcare: 13% (adults) 0% (youth)

Only 65% of the adults and 50% of the youth reported receiving any benefits, and Figure 31 shows that those who do vary in their concern about losing their benefits as they earn more money, but before they are ready to be self-sufficient.

Figure 32. I will work as hard and as long as necessary to reach this goal

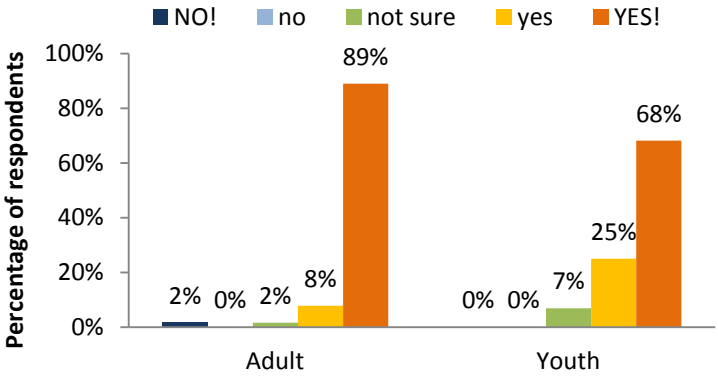


Figure 32 shows that adults are adamant in their commitment to work hard to reach their goal. Youth are somewhat less adamant.

Figure 33. I've always wanted to have a job where I could help people

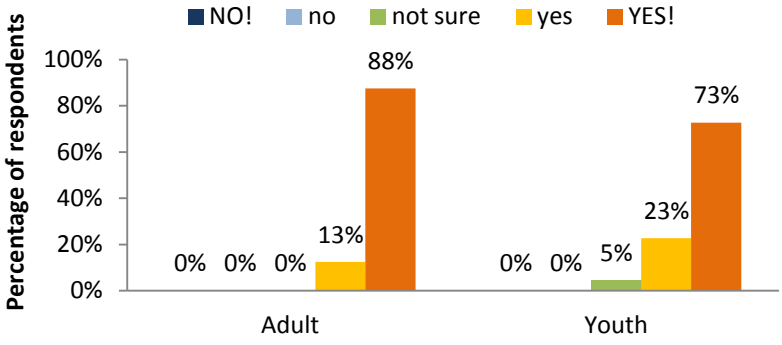


Figure 34 shows that the adults, more than the youth, are certain that they will reach their goals. When more completion and employment data become available it will be interesting to see if any of these items predict actual outcomes.

Figure 34. How likely is it that you will reach your long term goal?

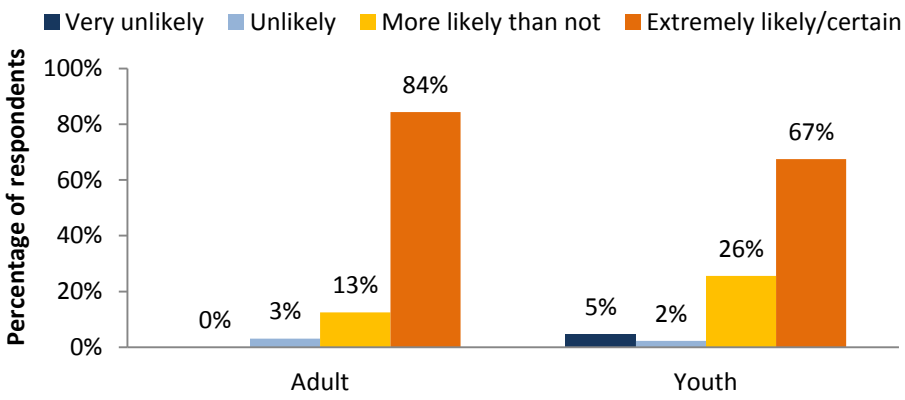


Figure 35. Prevalence of different coping strategies

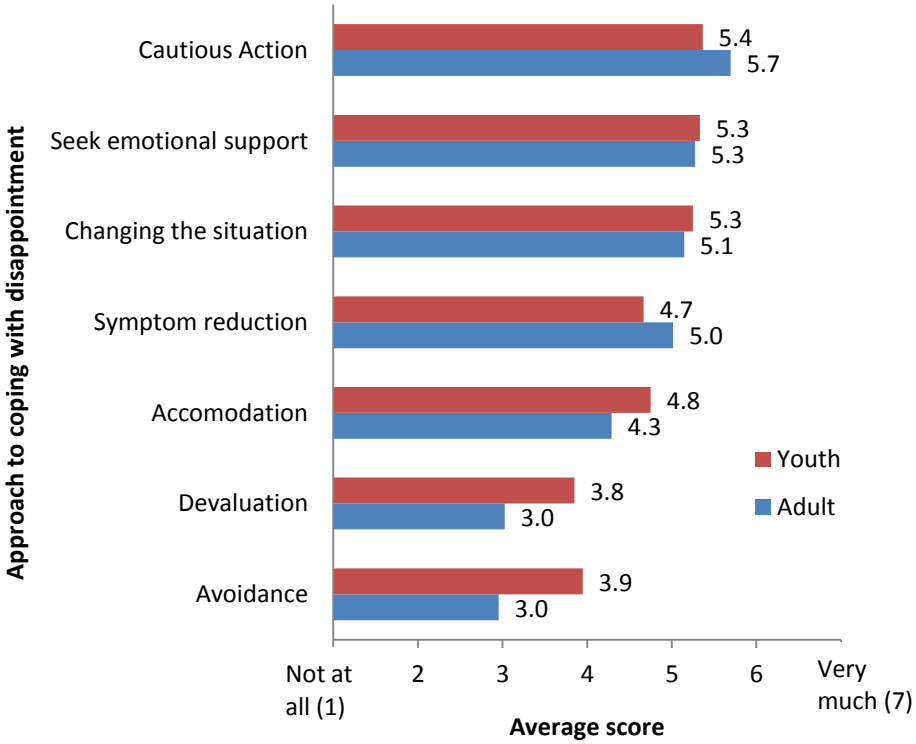


Figure 35 illustrates the prevalence of the different approaches for coping with life problems. Youth may be more likely than adults to avoid problems (not think about it, turn attention away) and they may be more likely to use devaluation of the problem (decided the problem isn't so serious after all).

A few differences emerged between demographic groups. Participants born outside the U.S. were more likely to cope by accommodating to their circumstances (adjusting expectations, adjust standards). This aligns with the earlier findings that they are more likely to acknowledge that they are participating in the training because they need a job and that they are somewhat more attracted to the career opportunities available in healthcare rather than a strong affinity for working in healthcare more often expressed by their U.S. born counterparts.

TANF participants were less likely to say that they cope by relieving their tension (relaxing, getting it off their chest). It may be worth introducing HCA participants to relaxation techniques and other stress reduction strategies, especially as classes become more demanding making life more complex.

In a possibly related finding, analysis with a very small sample size suggests that those who cope with disappointment by seeking emotional support are more likely to complete their training program.

Summary of System and Partner Interviews and Focus Groups

Data collected through qualitative methods (interviews, focus groups) have been shared with HCA program staff and partners throughout Years 1 and 2 and program improvements/modifications have been made in some areas in response to the data. Below is a summary of some observations/recommendations communicated from partners (as presented at the time they were collected) who participated in interviews/focus groups and from evaluators themselves. Those partners include:

- Employment Security Department
- DSHS
- King County Housing Authority
- Renton YouthSource (WIA youth staff)
- Seattle Housing Authority
- Seattle Youth Employment Program (WIA youth staff)
- WDC Staff
- Workforce Training Board
- TRAC supervisor and navigators

Perceived HCA Strengths with Potential Best Practices

- The HCA program **has exceeded expected outcomes** so far, especially in terms of program referrals and retention.
- Focus **on self-sufficiency**, and is geared toward building skills and experience, linked with job opportunities.
- Preexisting **strong system collaborations** and partnerships have enabled Washington State to establish strong systems provide the foundation for the HCA. Co-location is common, and several partners share in e-JAS which facilitates feedback from the college to the DSHS case workers.
- **Experienced navigators** help low-income individuals with limited educational experience and guide participants up a career ladder in healthcare, helping to coordinate resources across agencies so the participants receive the necessary supports (childcare, housing, and food), career counseling and guidance about the healthcare labor market, as well as support to overcome obstacles during the assessment, training, and job search process.
- Funding for **financial support to participants,** without which their progress may be stalled.
- Purchase of **training cohorts** increases the capacity to serve this disadvantaged population.
- **Development of courses** specifically for individuals who are interested in a healthcare career but may not be ready to start at the entry level (e.g., Health Discovery at SCCC, Allied Health Core at RTC, Healthcare Bridge at SVI)

- An **incumbent worker program** with employers to select employees in entry level positions to promote through a sponsored ADN program to nursing positions. Employers agree to work with staff so their work schedules can accommodate class schedules.

Perceived HCA Challenges:

- **Complex:** HCA is extremely complex with many levels. It focuses on meeting regional demand for various healthcare workers in a way that offers the workers an advancement pathway, in multiple locations around the region, working with multiple referral sources. It targets diverse participants, most with some type of barriers. This complexity is set within a regional economic recession which affects hiring practices. Although program managers, navigators, and partners have become more familiar with the program components over the first two years and have developed strategies to increase efficiency, the overall HCA program remains ambitious, multi-faceted, and complex.
- **High demand:** Program demand has at times exceeded capacity in many aspects of the program. The second year goal for enrollments is almost met less than halfway into the second year. In some cases, this can result in 1) frustration among partners about access to the program; 2) the inability to place new enrollees in training immediately, possibly disrupting momentum toward self-sufficiency or leaving potential TANF participants in need of "countable activities" while waiting.
- **TANF limitations:** TANF recipients are limited to 60 months of benefits and 12 months of vocational education. When participants earn a certificate, TANF policy considers them "job ready" and they are expected to enter into job search, rather than continue their education. This can create a challenge or barrier to the critical HCA goal of moving participants *beyond* the entry level positions. DSHS staff are able to support some extended training while complying with the policies, and new approaches are being developed, creating a need for ongoing communication. It was also noted, however, that CSOs are not all uniform in their interpretation of policies, and caseworkers also differ in the amount of flexibility they are willing to extend. Additionally, some navigators reported challenges with the e-JAS system.
- **UI time limitations:** Unemployed job seekers at or near the 99 week mark are not able to enroll in the HCA because they would not have time to complete the training while still receiving benefits.
- **Cliff effects:** As participants' income increase, they begin to lose their cash benefits and other work supports, often before they are able to financially support their families, potentially creating a disincentives to advancement
- **ITAs for TANF only:** Although temporarily reserving ITAs for TANF recipients helped reduce some of the TANF policy barriers described above, non DSHS case managers believe that it rendered training inaccessible for others (including TANF exhaustees), particularly those with limited English proficiency. The private schools are more accessible for LEP participants, but because of the temporary restriction by HCA, they were accessible only to current TANF recipients during that time period.

- **Feedback and updates:** All referring agencies want to know the outcome of their referrals, including how many enrolled, how many completed, how many were placed. In addition, they want to know how many spots are available, whether the training programs already full or out of funds (so they should stop referring). They want to know whether their referrals making a difference.
- **Economy/Labor Market:** Some partners expressed concern that placement goals would not be achieved, due to reduced demand or slow hiring for some occupations, like CNAs and LPNs.
- **Different philosophies across agencies:** DSHS regulations require parents to participate in "countable" activities at a minimum level to maintain benefits. This creates a different way of interacting with the parent than the philosophy of the HCA program, which encourages focus on giving the parent the "room" to take responsibility for the process that will get them to self-sufficiency, while requesting support along the way. It is important for the different assumptions and implications to be mutually understood and respected to optimize the interactions of the two systems.
- **Role Uncertainty.** Different interviewees had different ideas about which role (i.e., navigator, case manager, or WorkSource specialist) was responsible for which task (e.g. monitoring, enrolling, job search assistance).
- **Client monitoring:** Without feedback from the navigators to the referral source about the participation of their shared clients, case managers or case workers may not be aware of the individual's activities/progress. It is difficult to tell where the communication process breaks down and what the appropriate expectations are. Navigators and caseworkers don't always have shared expectations of what navigators will document (and may be influenced by their experiences with other contracts).

Perceived Program Gaps

- Some interviewees were concerned about the low numbers of veterans in the HCA program.
- Some interviewees reported concern that those with very low education levels did not have access to the program (e.g., low CASAS scores, long ramp to CNA training).
- Determining the most efficient approach and appropriate agency to lead job search. There is a need to have more employers lined up ready for placement or internships.
- Connecting students with learning disabilities and IEPs with learning disability programs (like Access at Highline Community College).
- Follow-up processes: an interviewee asked if there is a system in place to follow-up with participants post-placement, or early exit. Program staff note that this is part of the navigator process.

System Partners Recommendations

- **Increase/Improve Communication**
    - **Second round of introductory presentations:** have the navigators go out and do presentations with supervisors present supporting the program. Bring fliers; prepare to explain and "sell" the program, including the steps to take training beyond the first

level. Extend presentations to all partner agencies, including those who were not involved in the first round of presentations.
    - **Create champions:** It is important to re-message the program to try to create more champions for the program. Share the promotional video and post an article with success stories to increase enthusiasm and referrals
    - **Create an HCA website or newsletter:** where partners could get updated information, and learn about program emphases
    - **Reporting:** DSHS caseworkers ask navigators to send regular emails or enter notes and status updates into e-JAS for TANF clients to enable caseworkers to track and ensure adequate participation.
    - **As appropriate, increase navigator presence at offices** to meet with potential participants and to update staff on changes in the program. Build relationships and trust between the navigators and case managers/caseworkers.
    - **Caseworker peer exchange:** Host an HCA retreat and/or joint meetings with caseworkers from partner agencies; determine where there are best practices. Consider convening a panel of participants who can talk with the staff about their successes and challenges.
- **Entry level:** consider an entry level lower than CNA because for some individuals with low education, CNA is too big a step.
- **Employers:** raise awareness about the HCA program among area employers so they are looking for people with certifications produced through HCA and will give them priority in the hiring process.
- **Experience:** consider a longer term internship or OJT– at the training facility or at a healthcare facility – to help overcome the lack of experience barrier.

Additional Suggestions from the Evaluators

- Continue to build on the program's many strengths; celebrate and promote its success.
- Clarify roles and responsibilities for all partners. Consider co-creating a process map that includes partner agencies to make sure all key tasks are assigned (e.g., employer engagement, attendance and participation documentation, job search activities). There may be a need for different process maps for each partner agency. This may occur as part of the HCA retreat/joint meetings suggested above. Be sure that staff at all levels (especially caseworkers and case managers at partner agencies) are involved in the role clarification process, and that partner agencies have the capacity to fulfill any new tasks assigned. Once roles and responsibilities are clarified, communicate expectations to all staff and partners.
- After clarifying roles and responsibilities, compare the results with the existing navigator model. As necessary, develop and communicate job descriptions for the navigators, using the input from system partners. Consider using the curriculum under development by the National College Transition Network (NCTN) and Accelerating Opportunity to help define the role of the navigator http://professionalstudiesae.worlded.org/ao.html

- Referring interviewees who were most satisfied with the process reported their navigators were on site weekly and engaged in interacting with participants and staff, facilitating workshops or making announcements in others' workshops, and putting information on the calendar. Strike a balance between the need for staff and customer support within the context of limited navigator resources and heavy case load.
- Consider asking DSHS management to more fully train front-line case workers in strategies to working effectively within the TANF participation requirements and vocational educational limitations. It might be helpful to create case studies illustrating how this can work effectively for the HCA program. Consider creating a pamphlet describing the DSHS policies that navigators are trying to satisfy.
- Communicate updated labor market information to navigators and partners to keep abreast of changes in demand, so that they can appropriately counsel participants.
- Consider negotiating some flexibility in the colleges' admission requirements for nursing students. If the nursing student is not required to work as a CNA as part of the nursing education, the requirement to achieve the CNA certification could be waived, eliminating the premature "job ready" trigger which can create a barrier to advancement for TANF recipients.

Summary of Focus Groups with Participants

Methods

The purpose of the current report is to relay the participants' voice.

The evaluators conducted focus groups with five groups of participants and participant surveys:

1) Phlebotomy cohort at Renton Technical College (February 14, 2012 – n=16)
2) Medical interpreter cohort at Highline Community College (March 28, 2012 –n=16)
3) CNA students who had completed training via HCA-funded Individual Training Accounts (ITA) (April 12, 2012, n=4)[7]
4) Medical Assistant (MA) cohort at Seattle Vocational Institute (SVI) (May 8, 2012, n=17)
5) Medical Business Information Technology (MBIT) cohort at South Seattle Community College (SSCC) (May 18, 2012, n=3)[8]

The purpose of the focus groups was to gather information and feedback from the participants about their introduction to the HCA project; their interactions with the project, the navigator, the training program; challenges they're facing; strengths of the program; areas for improvement; and their future plans.

[7] Many HCA participants have received training through ITAs. This small number will be supplemented by additional focus groups in year 3.

[8] The MBIT class differed from the others in that the class comprised cohorts from two different programs (HCA and Seattle Jobs Initiative). Participants from both cohorts attended the focus group and care was taken to separate comments from the two sources. Perspectives of the non HCA participants will be included here when useful, clearly identified.

Program participants were asked to complete a brief participant intake survey asking about their career goal, steps to achieve the goal, commitment to the goal, anticipated barriers, needed support, and coping strategies. This survey was provided both in paper and online.

Key Findings

The four groups of focus group participants were in different stages of their training process. The groups were similar in their gratitude (for the opportunity, and the navigator and program support) and their willingness to work hard to improve their lives and succeed. They differed somewhat in the challenges they faced:

- The CNAs were working or assumed they would find work upon certification. However, CNA wages are often too low to support a family, so CNA graduates may feel the need to work long hours or multiple jobs, leaving no time for the next step in training
- The CNAs who received their training by ITA seemed less aware of training programs, each stumbling onto HCA through an unlikely route. These individuals seem not to be well connected to a support system and may be unaware of some of the support available to them, and how to better understand the impact on their finances.
- The medical interpreter students were extremely positive about their training experience but concerned that the training would not lead to employment. Several planned to continue training in a healthcare field, guided into another cohort by the navigator and somewhat better prepared to succeed in it because of their intensive medical interpreter training.
- The phlebotomists were concerned about the course's compressed time frame when they expected *more* time to master the topics. They were also well aware of the next step in training that is available to them, however several expressed frustration due to uncertainty about whether they would be able to pursue the next training step and still retain their TANF benefits.
- Participants, especially those in cohorts, reported bonding with their classmates and providing mutual support during the program.
- MA students appreciated the compressed time frame of the MA program, although they struggled to fit the program's substantial demands for attendance and especially, homework into their already busy lives. They seemed aware of the next steps in their career progression and how they would take those steps.

Participants made several recommendations

- Make the HCA program or navigators easier to find via WorkSource centers or colleges, with brochures available for people who are unaware of programs.
- Navigators should better understand participants' financial situations and help the participant develop strategies for how to maintain training even if a support gives out.
- Find a way to advise potential medical interpreters with multiple qualifying languages which language to focus on based on labor market demand.

- Clarify strategies that will allow TANF recipients to continue training beyond 12 months if their caseworker cannot simply make an exception, and lay these strategies out clearly to participants.
- MA students made several suggestions to help students like themselves successfully manage the depth and volume of material in a relatively compressed timeline, including making an audio version of the MA textbook available, subsidizing home internet access, and encouraging SVI to provide wireless Internet access in the building.

The evaluator also identified some suggestions:

- Consider creating a welcome packet for HCA participants with information they may need immediately or eventually. This could include the WDC's career pathway map, contact information for the navigators, perhaps a "who's who" at the college, support services available from HCA, qualifications for receiving them, and procedures to apply for them, complete with the necessary forms, and other support services that may be.
- The social support, accountability, and cohesion benefits of a cohort in a single term program can also be achieved in any class, depending on the community-building motivation and skills of the instructor – cohorts can be built from the individuals who enroll in a class.
- Labor Market Information often changes rapidly. Consider developing additional ways to communicate changes to the navigators so they can make appropriate recommendations to students in selecting training and career options. Also, make sure they have accurate information about career pathways so they can provide guidance regarding next steps.

Appendix I: Location of participant home ZIP codes and training programs