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Findings from the Tribal Health Profession Opportunity Grants Process and Outcomes Evaluation in **Pathways to Careers in Health Care**

Michael Meit  
*NORC at the University of Chicago*

Carol Hafford  
*NORC at the University of Chicago*

Catharine Fromknecht  
*NORC at the University of Chicago*

Noelle Miesfeld  
*NORC at the University of Chicago*

Emily Phillips  
*NORC at the University of Chicago*

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# **Pathways to Careers in Health Care**

Christopher T. King  
Philip Young P. Hong  
*Editors*

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W.E. Upjohn Institute for Employment Research

300 S. Westnedge Avenue

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# 5

## Findings from the Tribal Health Profession Opportunity Grants Process and Outcomes Evaluation

Michael Meit  
Carol Hafford  
Catharine Fromknecht  
Noelle Miesfeld  
Emily Phillips  
*NORC at the University of Chicago*

Shortages in the health care workforce in the United States have created high demand for well-trained health professionals in underserved communities (National Center for Health Workforce Analysis n.d.). These shortages have been particularly critical in American Indian/Alaska Native (AI/AN)<sup>1</sup> communities, who struggle to retain quality medical providers.<sup>2</sup> At Indian Health Service facilities (IHS) the average physician turnover rate is 48 percent compared to 6.8 percent on average across the United States (American Medical Group Association 2014). To address tribal community workforce shortages while providing employment opportunity for low-income AI/AN individuals, the Health Profession Opportunity Grants (HPOG) program included five tribal grantees out of a total of 32 national grantees to provide education and training opportunities for Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals. In 2010, Administration for Children and Families (ACF) awarded the five Tribal HPOG 1.0 demonstration projects to tribal organizations and tribal colleges: Blackfeet Community College (BCC) in Browning, Montana; Cankdeska Cikana Community College (CCCC) in Fort Totten, North Dakota; College of Menominee Nation (CMN) in Green Bay, Wisconsin; Cook Inlet Tribal Council, Inc. (CITC) in Anchorage, Alaska; and Turtle Mountain Community College (TMCC) in Belcourt, North Dakota. The intent of these demonstration projects was to pro-

vide eligible individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand (Administration for Children and Families 2010).

This chapter begins with an overview of some unique aspects of implementing grant programs with AI/AN communities, including a brief history of evaluation with tribal communities and a summary of key components for designing and conducting a culturally responsive evaluation. Next, we share key research questions of the Tribal HPOG evaluation and the methods for data collection and analysis. Following that we provide an overview of the five Tribal HPOG grantees, along with a description of the unique program models and structures that the grantees used to implement their programs. Lastly, we describe the main outcomes across the five grant programs, including the total number of participants who enrolled in the programs, completed health care trainings, and obtained employment, as well as program challenges and stakeholder satisfaction.

## **EVALUATION IN TRIBAL COMMUNITIES**

Research review policies to oversee research and program evaluation in AI/AN communities are important in that they protect tribes and tribal members from harmful research, ensure maximum benefits are gained from the research, and establish tribes' authority as sovereign nations to control research conducted on their lands (Sahota 2009). Research and evaluation studies must be designed in collaboration with the tribal entities that are implementing the program, while at the same time presenting the results objectively. Policies and institutional structures for research review are significant both in light of and as a result of the historical trauma and history of AI/AN communities. Government policies over the past centuries have resulted in removal of AI/ANs from their homelands, prohibition of cultural practices, and removal of children from homes (Pacheco et al. 2013; Struthers and Lowe 2003). Additionally, there is mistrust of the scientific community, given unethical research practices that have been implemented in AI/AN communities (Burnette et al. 2011; Cochran et al. 2008; Pacheco

et al. 2013). Further, researchers should be aware that they are sometimes described as “drive-by,” “mosquito,” or “helicopter” researchers (Johnston-Goodstar 2012, p. 110), referring to those who come into the community only to conduct research and leave or to conduct research that does not benefit the community (Cochran et al. 2008).

Given the history and context of research in AI/AN communities, researchers should be careful to implement research methods to address concerns of the study participants, such as using a community-based participatory research (CBPR) approach (Caldwell et al. 2005), which treats communities as “equal partners at all stages of a research project” and is a “philosophy about how research should be conducted so that community needs are prioritized” (Sahota 2010, p. 1). While the CBPR principles remain the same, they can be implemented using varying strategies across research projects, depending on the needs of the community members and researchers and the overall resources of the research project itself (Sahota 2010). One common component of the CBPR approach is the use of an advisory group to oversee research projects in AI/AN communities. Advisory groups comprised of community members can ensure that the perspective of the community is represented and that the research is relevant to its members (Johnston-Goodstar 2012; Quigley 2006).

In addition to working with an advisory group, other common processes for research design and review in AI/AN communities include review by a federally registered institutional review board, the enforcement of research-specific codes within tribal laws, or review by a tribal ethics review panel. In the absence of an established research review committee that was formed specifically for reviewing research on a regular basis, tribes can form research review consortiums, collaborate with an existing community committee that wants to be involved in research review, and/or rely on their tribal governance (e.g., tribal council) to review and approve research study participation and protocols as the need arises (Sahota 2009). The AI/AN community should be in control of their own review process because they are sovereign nations (Bowman 2006). To ensure that these processes are adhered to, nontribal researchers must recognize that each tribe is unique and should work with the collaborating tribe to determine the appropriate processes, protocols, and reviewers that are relevant to their study (Harding et al. 2011).

Similar approaches for research, including the use of a CBPR approach, are recommended when conducting research among urban AI/AN populations. However, there are unique considerations when working with AI/AN populations living in urban settings versus on reservation lands (Yuan, Bartgis, and Demers 2014). For example, urban AI/ANs do not typically live in localized urban neighborhoods, creating challenges when defining community and garnering community support, and multitribal urban AI/AN communities often have diverse perspectives. Additionally, there is often no single entity that represents the community, as there is no sovereign government elected by the community that can form partnerships on behalf of its members. Researchers should be proactive in addressing the concerns of AI/AN populations regarding research and should consider the differences between populations living in urban settings or reservation lands when conducting research with urban AI/AN's (Yuan, Bartgis, and Demers 2014). Key principles in conducting work with AI/AN communities include acknowledgment of historical experience with research, recognition of tribal sovereignty, understanding of the tribal community and its leaders, and planning for extended time lines to provide time for obtaining tribal approval for conducting research (LaVeaux and Christopher 2009).

Guided by these principles, the Tribal HPOG evaluation team worked to design and conduct an evaluation that was collaborative in nature, respectful of tribal cultures, and responsive to community history and norms.

## **DESIGNING AND CONDUCTING A CULTURALLY RESPONSIVE EVALUATION**

The first step in designing an evaluation that is culturally responsive to tribal ways of life is for researchers to establish trust and demonstrate respect for tribal research partners, cultural beliefs, tribal institutions, and tribal sovereignty (Harding et al. 2011; Oetzel et al. 2015; NCAI Policy Research Center and MSU Center for Native Health Partnerships 2012). The tribal evaluation team encouraged engagement and

consensus building with stakeholders in a number of ways. Importantly, the evaluation team built relationships with the Tribal HPOG grantees using dedicated small teams to work exclusively with each of the grantees in order to build and maintain trusted relationships. Each team was led by a senior researcher, who worked with their designated grantees for the duration of the evaluation. The teams engaged with the grantees through in-person meetings, regular telephone calls, and joint conference presentations.

Throughout the five-year evaluation, the Tribal HPOG evaluation team sought input from partners, advisors, and, most importantly, the Tribal HPOG grantees. The team included tribal partners at the National Indian Health Board and Red Star Innovations, a tribally owned small business. In addition to the core evaluation team, project activities were guided by a technical work group comprising tribal researchers and experts in AI/AN higher education, public health, and health care workforce development research. Tribal grantees and the evaluation team collaboratively designed evaluation components. The tribal grantees reviewed drafts of the evaluation plan and participated in evaluation webinars, and the evaluation team sought permissions from tribal councils and/or tribal institutional review boards as required by tribal grantees.

The evaluation team also sought regular input from tribal partner organizations and the project technical working group; both provided guidance on incorporating culturally appropriate methods in the evaluation. The evaluation team engaged with the working group through annual meetings to review findings to date and discuss any needed revisions to the evaluation research questions and approaches. In addition, the working group members and tribal partners provided feedback on the evaluation plan and reviewed the data collection instruments for cultural appropriateness.

To ensure that the evaluation was conducted in an ethical manner and adhered to human subjects and community protections, the evaluation team consulted with and obtained approvals from tribal council and/or tribal institutional review board, as well as approval from NORC's institutional review board. To underscore mutual obligations, the evaluation team and each tribal grantee entered into a memorandum of understanding that specified the objectives of the evaluation,



respective roles and responsibilities relative to the evaluation, the scope of information requested during data collection, how the information would be used, and the terms of data privacy.

The evaluation included annual site visits to each of the five tribal grantees, which served as an important component to understanding barriers to and facilitators of implementing and evaluating the program in tribal communities. The site visits included interviews with grantee staff, grantee partners, and program participants; informal tours of educational institutions and employment partners; and observations of the geographic location, physical terrain, and local infrastructure. The trips were two to five days in duration, depending on the program model type and whether the grantee had implementation partners in multiple cities. In addition to collecting qualitative data, these site visits served as an opportunity to continue building a relationship between the evaluation team and the grantee. While communication via email and phone occurred throughout the year, the time spent in person during the site visit was invaluable.

The evaluation team shared evaluation design protocols and outcome reports with the grantees throughout the evaluation. In year 1, the grantees provided feedback on the evaluation plan to ensure that the research questions were meaningful and data were collected in a culturally respectful manner. Grantees also reviewed evaluation products to ensure information about their program was accurately conveyed and that the interpretation of the findings reflected tribal culture and local context. These products included site visit reports summarizing findings from the annual site visits and site-specific practice briefs developed in year 4. Grantees also reviewed the Tribal HPOG Program Evaluation final report (Meit et al. 2016).

Finally, the evaluation team provided technical assistance throughout the course of the evaluation to build grantees' capacity to participate in the Tribal HPOG evaluation activities. This included conducting needs assessment calls with grantees, offering technical assistance during in-person site visits, and responding to grantee requests over the course of the grant period. The evaluation team reviewed grantee performance data related to participant enrollment, health care training completions, and participant employment prior to the in-person site visits in preparation for data quality discussions. The purpose of the data quality discussions was to ensure that program outcomes were accu-

rately reported into the HPOG Performance Reporting System (PRS), the federal management information system for the HPOG program. The evaluation team worked with the PRS team to provide technical assistance to the grantees as necessary.

## **KEY RESEARCH QUESTIONS AND METHODS**

The evaluation studied the structures, processes, and outcomes of the Tribal HPOG 1.0 grantees and addressed three key evaluation questions. Table 5.1 presents these evaluation questions, as well as the related subquestions in distinct focus areas that were developed after a review of the literature on workforce development and AI/AN higher education.

The evaluation team used both qualitative and quantitative methods to address the study's research questions. During annual site visits to the Tribal HPOG programs, the evaluation team collected a majority of the qualitative data. Data collection protocols consisted of focus groups with students currently enrolled in the program and interviews with grantee and partner administrative staff (e.g., program directors, managers), program implementation staff (e.g., instructors, service providers), and local employers. Prior to site visits, all members of the tribal evaluation team participated in a comprehensive full-day training to ensure culturally sensitive and consistent administration of data collection protocols. Following the annual site visits, the team conducted telephone interviews with students who successfully completed their training program as well as students who did not complete their program. Additional qualitative methods included review of grantee documents, grant applications, semiannual reports, training program curricula, and outreach and recruitment materials. The team conducted content analysis using NVivo software to identify common themes across the tribal grantee programs that corresponded to the key research questions. The team disseminated major outcomes and findings in the annual evaluation reports and practice briefs.

To supplement qualitative information, the evaluation team obtained quantitative data on participant enrollment, training completion and employment, along with demographic information, from the PRS. The

**Table 5.1 Tribal HPOG Evaluation Questions and Subquestions**

	Evaluation question(s)	Subquestions
Structures	What frameworks and relationships did the Tribal HPOG grantees create to implement training and service delivery?	<ul style="list-style-type: none"> <li>• What is the program type (i.e., academic instruction, on-the-job-training, apprenticeship, other)? Was the program incorporated within, or as an extension of, an existing program?</li> <li>• What is the administrative structure of the program?</li> <li>• How are local and/or regional partners and the community engaged?</li> <li>• What is the program curriculum (i.e., academic lectures, field practicum training manual)? In what ways was the program designed or modified for tribal populations?</li> <li>• What are the qualifications of program implementation staff?</li> <li>• Does the training program address skills and competencies demanded by the local health care industry?</li> <li>• How did the social, economic, and political context of the community influence program design and implementation?</li> </ul>
Processes	How were training and support services delivered?	<ul style="list-style-type: none"> <li>• What support services are offered with the program and how are they incorporated?</li> <li>• Were strategies used to engage participants' families, and if so, why and how?</li> <li>• What recruitment strategies were utilized? Were these strategies effective?</li> <li>• What orientation strategies were utilized? Were these strategies effective?</li> <li>• How are program data collected and used? Are data used for program management decisions, performance monitoring, or program correction?</li> <li>• Was the program implemented as intended?</li> <li>• Was effective instruction delivered?</li> </ul>

Outcomes	What outcomes did participants achieve? Was health care workforce capacity enhanced in tribal communities?	<ul style="list-style-type: none"><li>• Did participation in the program result in a professional or industry recognized certificate, degree, or licensure? Why or why not? What factors are associated with receiving a certificate, degree, or licensure?</li><li>• Did program participants enter a job or provide a community service in related occupations?</li><li>• Did participation in the program result in any employability-related outcomes (e.g., increased life skills, self-efficacy, confidence, reduced use of income supports)?</li><li>• Did the program help fill vacancies in the tribal health care workforce? Are participants serving tribal populations?</li><li>• Are key program stakeholders satisfied with the program?</li></ul>
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PRS was designed for both performance management and program evaluation. The tribal evaluation team coordinated with the PRS team to obtain data from the PRS for all of the Tribal HPOG grantees.

## **IMPLEMENTATION OF THE TRIBAL HPOG PROGRAM**

This section provides background information on the tribal community, grantee organization, HPOG program, and key elements of implementation and partnerships for each of the five Tribal HPOG 1.0 grantees.

### **Blackfeet Community College (BCC)**

BCC is a community college on the Blackfeet Indian Reservation in Browning, Montana. Chartered in 1974 by the Blackfeet Tribal Business Council, BCC is a fully accredited tribal college. Its mission is to provide the Blackfeet Nation and surrounding community with access to quality educational programs. The college offers an array of educational programs that integrate the Blackfeet culture and language into curricula and prepare students for achievement in higher education and meaningful employment.

The BCC HPOG program, known as the Issksiniip Project, provided scholarships and training opportunities in health care fields to Blackfeet community members; AI/AN students at BCC, the grant's lead entity; and Blackfeet and AI/AN students at its five partner institutions across the state.<sup>3</sup> The target populations for the scholarships were those eligible for TANF, individuals who left high school before graduating, low-income individuals, and single mothers with children. The training opportunities available through the Issksiniip Project included programs in nursing, pharmacy, nutrition, social work, dentistry, medical coding and billing, and other allied health professions.

The Issksiniip Project provided financial assistance and extensive support services using a case management model that included mentoring, tutoring, academic advising, referrals to public assistance and behavioral health programs, and career development, such as job shadowing and career fairs. BCC formed partnerships with several educa-

tional institutions across Montana to provide scholarships and training opportunities to eligible students. Project partners were Salish Kootenai College (Pablo), University of Montana Missoula (Missoula), Montana State University Bozeman (Bozeman), Great Falls College–Montana State University (Great Falls), and Montana State University Billings (Billings). At each academic institution, students applied their Issksiniip Project scholarship to a variety of health profession training programs (Meit, Hafford, et al. 2015).

### **Cankdeska Cikana Community College (CCCC)**

CCCC serves the people of the Spirit Lake Nation and the surrounding communities near Fort Totten, North Dakota. Chartered in 1975 by the Spirit Lake Tribal Council, CCCC is a fully accredited tribal college. Its mission is to provide “opportunities that lead to student independence and self-sufficiency through academic achievement and continuation of the Spirit Lake Dakota language and culture.” CCCC offers a variety of academic programs, including associate’s degree programs and certificates.

The CCCC HPOG program was titled “Next Steps: An Empowerment Model for Native People Entering the Health Professions.” It provided scholarships and training opportunities in health care fields to students at CCCC as well as to students at partner institutions across North Dakota. The training opportunities available through Next Steps included programs in nursing, nutrition and wellness, medical coding and billing, and other health professions.

Next Steps provided financial assistance as well as academic and social support services that enabled students to pursue training and promoted completion of training programs. A critical component of the program model was the use of mentors to empower students and help them achieve their goals. CCCC partnered with three other tribal colleges in North Dakota—United Tribes Technical College in Bismarck, Fort Berthold Community College in New Town, and Sitting Bull College in Fort Yates—which, along with CCCC, served as the point of entry for most students in Next Steps. In general, students began their education at one of the four tribal colleges and, after graduating with an associate’s degree in a health profession, could continue their training at a four-year university, such as the University of North Dakota in Grand

Forks, for a bachelor's or master's degree. Through CCCC's partnership with the Recruitment/Retention of American Indians into Nursing (RAIN) Program at the University of North Dakota, a dedicated mentor served at each of the four tribal college sites, along with a fifth mentor to offer outreach support to the Next Steps students enrolled in other colleges and universities throughout the state (Meit, TenBroeck, and Miesfeld 2015).

### **College of Menominee Nation (CMN)**

Populations of Menominee Nation, neighboring tribal nations, and surrounding communities in Wisconsin attend CMN. The main campus is located on the Menominee Indian Reservation in Keshena, and a second campus is located in Green Bay. Chartered in 1993, CMN is a tribally controlled and accredited community college. It offers students a range of options to pursue higher learning, including baccalaureate and associate's degree programs, technical diplomas and certificates, and continuing education opportunities.

The CMN HPOG program targeted individuals from the Menominee Reservation, other area reservations, and regional rural and urban communities who are unemployed, underemployed, low-wage workers, displaced workers, or incumbent workers, as well as TANF recipients. The CMN HPOG program offered a nursing career ladder that allowed students to progress from the pre-nursing level through the registered nurse level. The program served a range of students, from those seeking immediate employment to those who were working toward a more advanced nursing certificate, licensure, or degree.

The CMN HPOG program offered academic and social support services to students. Academic support services included academic counseling, advising, supplemental lab instruction, tutoring, and career placement support. Social support services include case management, as well as financial assistance to help cover transportation, housing, and child care costs. The program was implemented at both the Keshena and Green Bay campuses (Meit, Meyer, et al. 2015). CMN developed partnerships with several state and local agencies, including Bay Area Workforce Development, Green Bay; Fox Valley Workforce Development, Appleton; Workforce Development Area-Workforce Investment

Board; Community Resource Center, Keshena; local health care and long-term care providers; and the Department of Transit Services.

### **Cook Inlet Tribal Council, Inc. (CITC)**

CITC serves Alaskan Native and other American Indians within the Municipality of Anchorage and throughout the Cook Inlet Region. The AI/AN population in Anchorage is not reservation based but includes people from rural Native villages and regions across Alaska who have migrated to the Anchorage metropolitan area. Established in 1983, CITC is a nonprofit tribal social service organization. It administers Tribal TANF within the municipality of Anchorage and serves as a one-stop service center, which provides a range of support services to low-income AI/AN job seekers in one location.

The CITC HPOG program provided health professions training to Alaska Natives and other Native Americans who live in Anchorage and the Cook Inlet region who receive Tribal TANF or who are low-income. The tribal council partnered with the Alaska Vocational Technical Education Center to provide academic instruction to program participants through offering certified nursing assistant, licensed practical nursing, registered nursing, medical billing and coding, and medical office assistant training programs.

CITC led the recruitment and screening of HPOG participants and provided support services, including rental assistance, gas cards or bus passes, child care assistance, food cards, tuition and textbook payments, and equipment for students to complete their required practical experience in a clinical setting. It partnered with the Alaska Vocational Technical Education Center to provide academic training and the South Central Area Health Education Center to deliver the orientation for program participants and expose them to health care professions through job shadowing experiences at local medical facilities (Meit, Gilbert, and Fromknecht 2015).

### **Turtle Mountain Community College (TMCC)**

TMCC is located within the boundaries of the Turtle Mountain Indian Reservation in Belcourt, North Dakota. Founded in 1972, it is a tribally controlled and accredited college. The college primarily serves



the educational needs of the Turtle Mountain Band of Chippewa Indians, but enrollment is open to any person who is pursuing higher education. TMCC offers a variety of associate's degrees and certificate of completion programs, as well as four-year degrees in education.

The TMCC HPOG program was called "Project CHOICE: Choosing Health Opportunities for Indian Career Enhancement." The goal was to create educational opportunities for TANF recipients and other low-income individuals through health profession training programs located at TMCC. Project CHOICE offered students a variety of programs: the Clinical/Medical Lab Technician Program, which included a certificate program in phlebotomy; the Pharmacy Technician Program; the CNA Program; the Licensed Vocational Nursing Program; and the Health Information Management Program.

Project CHOICE provided a range of support services to TMCC students to address both academic and social support needs. These services included reimbursement for transportation mileage and child care costs, financial assistance for tuition and other training expenses, tutoring, access to technology, and job placement and employability services. Project CHOICE established local and state partnerships with Job Service North Dakota, North Dakota Department of Commerce, North Dakota Department of Human Services, and the North Dakota State Office of Apprenticeship (Meit, Knudson, et al. 2015).

### **Incorporating Native Culture into Curricula**

All of the Tribal HPOG 1.0 grantees served American Indian and Alaska Native populations. Some of the programs adapted or modified their health care training curricula to be culturally relevant and to align with the specific needs of their student population. The importance of incorporating tribal culture and language is noted in the mission, vision, and values of all of the Tribal HPOG grantees.

Culturally tailored curricula are a central component of the tribal colleges as a whole. Two of the Tribal HPOG 1.0 grantees designed a specific cultural component for the health profession programs. For the Quality Service Provider program, CCCC designed a curriculum that incorporated Native Elder Care, which was developed in collaboration with the National Resource Center on Native American Aging.<sup>4</sup> CMN's nursing program was structured around the five principal clans of the

Menominee People (Bear, Golden Eagle, Wolf, Crane, and Moose), which recognizes each clan as having a duty, that no one duty is more important than the others, and that no one can be successful in isolation. Every course that was integrated into the nursing program was designed to address these teachings. Program administrators and staff explained that the curriculum design instills cultural sensitivity into the practices of the students.

Tribal HPOG grantees that were tribal colleges developed culturally tailored programming to facilitate academic success. For example, BCC formed a society program on campus to aid in student academic success, which incorporates elements of Blackfeet cultural heritage. Both faculty and students were assigned to one of 17 societies whose names represent important figures in Blackfeet culture. Each society was composed of individuals from different departments at the college, which fostered community building campuswide. TMCC's organizational mission was to provide educational and research opportunities in which the cultural and social heritage of the Turtle Mountain Band of Chippewa is present in the curricula. Some of the programs offered at the college incorporated Native teachings into the curricula. In addition, staff at TMCC remained in contact with American Indian Student Services at other universities to create a support network for students who wished to pursue education opportunities off the reservation. Those partner universities included the University of North Dakota's RAIN Program and North Dakota State University's Native Research Center.

### **Recruitment and Enrollment Strategies**

Tribal HPOG 1.0 grantees used many different recruitment strategies to market their programs to potential students. All five grantees developed promotional materials, such as brochures and flyers, at the beginning of the HPOG programs to assist with recruitment efforts. Some grantees also advertised the HPOG program in local newspapers or on local radio, which are important communication venues in tribal communities. Word of mouth was the most effective recruitment tool for reaching potential students, with students, instructors, and community members relaying information to family and friends.

Grantees also reached out directly to students and accepted referrals from instructors. For example, TMCC notified all of the current

students about the HPOG program when it began. BCC and its college and university partner sites advertised programs on their websites and through student listservs. Some grantees mailed information directly to their current nursing students. At CCCC and its partner sites, mentors informed students and other eligible individuals about the HPOG program. The RAIN Program at the University of North Dakota also provided information to RAIN students who qualified for the HPOG program.

HPOG grantees also accepted referrals from human service and workforce development organizations, including those that administer TANF and promote job training in their communities. Some HPOG programs were more successful than others in obtaining referrals from these organizations. CITC had success with internal referrals from its TANF caseload, particularly clients who visited the Alaska's People Center, the career development center at CITC, as these individuals were in the process of seeking training or employment. TANF case workers at CITC referred both new walk-ins as well as existing clients to the HPOG program if they expressed an interest in health care. BCC also had success recruiting HPOG students through case managers and career counselors at Blackfeet Manpower, a one-stop center that administers the TANF program in Browning, Montana. Although CMN had set up a referral process to recruit potential students from the TANF program at the local Community Resource Center, several did not pass background checks (for example, because of a felony) and were not eligible for the program.

Other recruitment strategies used by HPOG grantees included attending job and career fairs to reach out to potential students, marketing the program to those already enrolled in home health aide classes, and holding information sessions about the HPOG program, especially to reach potential students who had not considered pursuing higher education. Four out of five grantees (the exception being CCCC) conducted outreach at local high schools, with the goal of building a pipeline for health care training and professions.

In addition to modifying recruitment strategies established in the first year of the grant, and trying new recruitment approaches to determine what worked best, grantees also needed to adapt their recruitment strategies based on the year of the grant. Grantees were encouraged to enroll students who would complete their training programs prior to

the end of the grant in September 2015. Therefore, in the later years of the grant period, grantees focused primarily on enrolling students in short-term training programs, such as the certified nursing assistant (CNA) program. In addition, some grantees recruited students who were already enrolled in health care training programs and met the eligibility requirements to enroll in the HPOG program if they were on schedule to graduate prior to the grant ending.

### **Orientation Strategies**

All five Tribal HPOG grantees offered a formal orientation for newly enrolled HPOG students to introduce them to the program and program staff, and to convey program expectations. Four of the five grantees hosted one- to two-day group orientations with HPOG students prior to the start of their training programs. One grantee, CCCC, had students meet one-on-one with their assigned mentors to learn about the HPOG program instead of offering a group orientation. Similar topics were covered at each grantee's orientation, including expectations around attendance, punctuality, grades, and professionalism. At BCC and TMCC, students were required to sign contracts or letters of commitment stating they understood and would meet program expectations. Most grantee orientation processes evolved over the course of the grant period. For the most part, grantees expanded the length of orientation to include additional content. The biggest change to orientation overall was the addition of activities focused on employment and job readiness, such as sessions on soft skills and assistance with résumé development. CITC and BCC also began inviting current or past HPOG students to the orientation to share personal testimonies about the program and answer students' questions.

### **Support Services**

All the grantees provided a variety of support services designed to help students overcome barriers to pursuing their education and to comprehensively address the students' basic living needs. Support services typically fell into one of three categories: academic, social, and employment. Table 5.2 lists all services provided to HPOG participants by Tribal HPOG grantees. Many of the HPOG students said that they

**Table 5.2 Support Services Offered by Tribal HPOG Grantee**

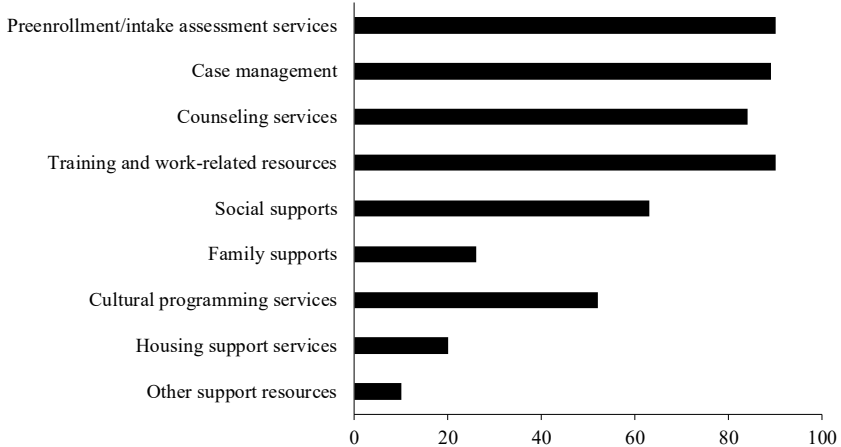
Support services	Tribal HPOG Grantees				
	Blackfeet Comm. College	Cankdeska Cikana Comm. College	Cook Inlet Tribal Council	College of Menominee Nation	Turtle Mountain Comm. College
<b>Academic services</b>					
Tuition and fees	✓	✓	✓	✓	✓
Books	✓	✓	✓	✓	✓
Tutoring	✓	✓		✓	✓
Academic counseling	✓	✓			✓
Exam/certification fees	✓	✓			✓
Exam review materials	✓		✓		✓
Lodging for exam					✓
Uniforms	✓	✓	✓		✓
Other training supplies	✓	✓	✓		✓
Computers	✓	✓			✓
<b>Social services</b>					
Child care	✓	✓	✓	✓	✓
Transportation	✓	✓	✓	✓	✓
Food	✓	✓	✓		✓
Rent assistance	✓		✓	✓	✓
Utilities assistance	✓			✓	
Internet access	✓			✓	
One-time emergent needs	✓	✓		✓	✓
Financial literacy	✓			✓	✓
<b>Employment services</b>					
Career counseling	✓	✓			
Life skills training	✓	✓			✓
Résumé/cover letter	✓	✓	✓	✓	✓
Job searching	✓	✓	✓		✓
Interview preparation	✓		✓		✓
Financial assistance for moving for employment	✓				✓

SOURCE: Key informant interviews and participant focus groups during annual site visits.

could not have completed their degree program without the aid of the support services, specifically the social support services, such as transportation and child care. Tribal colleges are experienced in securing financial assistance for their students in the form of grants and scholarships, but most of those programs only cover academic costs. HPOG was unique in its ability to cover academic and social services, such as child care and transportation. Additionally, Tribal HPOG grantees assisted program graduates with obtaining their certifications by providing gas money for travel to the testing site, lodging if needed, test registration fees, and study materials. Support services also included job readiness and employment assistance, ensuring that graduates had career readiness skills such as résumé writing, job searching, and interview techniques.

Figure 5.1 shows the percentage of Tribal HPOG participants who received each type of support service as identified in the PRS. The most commonly received support services included preenrollment and intake assessments (90 percent), case management (89 percent), training and work-related resources (90 percent), and counseling (84 percent).

**Figure 5.1 Participants Receiving HPOG Support Services across Tribal HPOG Grantees (%)**



NOTE: N = 2,270. Participants who received more than one type of support service may be represented in more than one category, but only once within each category.

SOURCE: Performance Reporting System, 2015.

## Academic Support Services

Academic support services were similar among all grantees. Tribal HPOG grantees provided financial assistance for tuition and fees, textbooks, exam and certification fees, uniforms, and other training supplies. Three of the grantees—BCC, CCCC, and TMCC—provided laptops and tablets for students that did not have them. TMCC HPOG staff believed that tablets would improve students' access to technology and textbook content via e-books. The staff shifted away from traditional textbooks to combat the rising costs. A few instructors expressed concern about this change, indicating that some of their textbooks were not available as e-books. Tribal HPOG grantees also covered the costs of transportation, lodging, and meals for students during clinical training periods and trips to state testing facilities for their health professions certification exams.

Nonfinancial academic supports included mentoring, academic counseling, tutoring, remedial classes, and additional lab hours. Most of these academic services were offered by the colleges and available to all students, regardless of HPOG affiliation; however, one of the secondary implementation sites of BCC made a concerted effort to create a support community specifically for HPOG students. At Great Falls College-Montana State University, tutoring and academic services for HPOG students were housed at the Issksiniip Center, which was established exclusively for BCC HPOG students and provided a quiet, lounge-like atmosphere for students to do homework, have tutoring sessions, and meet with classmates.

## Social Support Services

*Social support services* refers to financial assistance for nonacademic needs of the students. Among all Tribal HPOG grantees, transportation and child care were the most widely used and appreciated nonacademic services. Depending on the grantee, financial assistance covered housing (security deposit and first month's rent), child care (payment to a licensed provider), transportation (gas cards or mileage reimbursement), and food (meal provision or payment). Over the years, some of the grantees modified eligible uses of funding, depending on the needs of their HPOG students and the amount of other funding streams

that could be leveraged. All the grantees also used financial assistance to cover unique emergent needs, such as car repairs, temporary housing, and driver's license assistance. Grantees also referred students to social service organizations in the community to access TANF, employment assistance, and mental health services.

In addition, some grantees provided counseling or other one-on-one support services. For example, at BCC, counseling services were offered to students for academic issues and nonacademic issues, such as grief or family relationships. At CCCC, students also received individualized assistance from the mentors, such as arranging child care or transportation to class and checking in with a phone call or text message.

Grantees provided other types of social support services as student needs were identified. For example, the CITC HPOG program offered transitional assistance for up to one year after program completion. However, in the later years of implementation, staff discussed the possibility of reallocating some of these funds by reducing the amount of time graduates could receive assistance. Program staff believed that while this assistance was useful for the program graduates, one year was more time than needed for participants to stabilize themselves. BCC provided support after graduation to students who planned to continue their education at another institution. Additionally, BCC provided transportation funds for support related to moving for employment and financial assistance to purchase supplies such as uniforms, textbooks, or tablets.

### **Employment-Related Services**

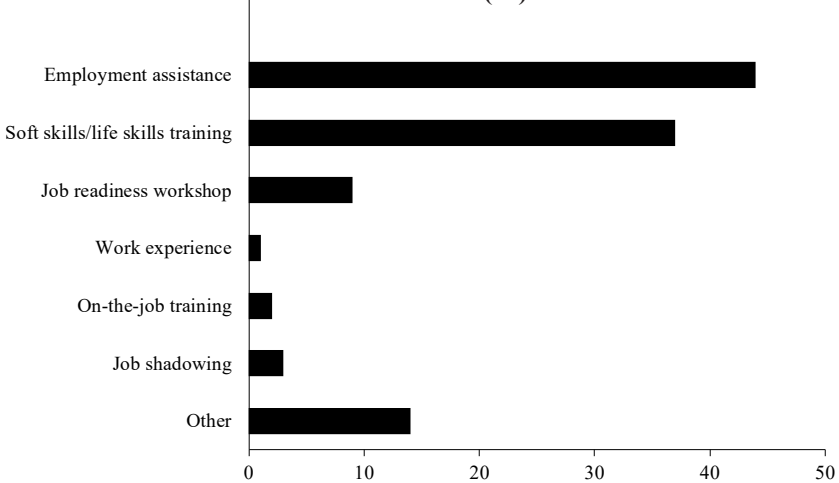
While grantees had employment-focused components and services from the beginning of their programs, employment-related support services became a more central component of the Tribal HPOG programs during the final two years of implementation. BCC, CITC, CMN, and TMCC all hired additional staff to focus on employment assistance during the second half of the grant period. The smaller grantees, CMN and TMCC, did not identify the need for employment services until year 3. At the end of the program, all the grantees reported that they should have identified the need for employment-related services at the beginning of the grant period.



Generally, employment services included career counseling, job searching and placement assistance, and job retention services. Figure 5.2 shows the percentage of Tribal HPOG participants enrolled in employment development activities throughout the five-year grant period. The two most common employment development activities among participants were employment assistance (44 percent of participants), such as assistance with searching for jobs, completing applications, and developing résumés, and soft skills/life skills training (37 percent), which includes training to develop skills such as self-confidence and ability to get along with others and work in a team.

Grantees used existing employment assistance services offered by their partners through a process of referral or collaboration. For example, CITC referred students to employment-related services at the Alaska’s People Center, also housed at CITC. At CMN there was a class dedicated to showing students how to access the Job Center of Wisconsin website, upload their résumés, and navigate the website to apply for employment upon completion of the program. In Montana, BCC

**Figure 5.2 Participants Enrolled in Employment Development Activity across Tribal HPOG Grantees (%)**



NOTE: N = 2,270. Participants who engaged in more than one type of activity may be represented in more than one category, but only once within each category.

SOURCE: Performance Reporting System, 2015.

partnered with Benefis Health System to provide job shadowing for HPOG students prior to beginning their training programs. Not only did this opportunity help students learn about their fields, it also gave them exposure to a potential employer; some BCC students were employed at Benefis.

Grantees also developed their own programs to enhance their students' job search skills. In year 4, TMCC held an employability boot camp to support students' transition to employment and help build connections with employers outside the local area. The boot camp also taught soft skills (attitude, professionalism, how to present oneself), which were identified by program staff as an area for improvement among the HPOG students. In the final year of the program, BCC developed an initiative to boost employment among their HPOG graduates across all implementation sites. The initiative, which was run by the job developers, was called the "Where are you now?" campaign, and its mission was to reach out to past students to learn what they had accomplished since graduating and to help with finding jobs. At some of the secondary implementation sites for BCC—MSU-Bozeman, for example—HPOG students used existing student support services to gain job readiness training or life skills coaching. The services included a career coach who was available to work with all students at the university but was highly involved in the Native studies program.

Job retention services were offered in the form of transitional funds for individuals establishing themselves in a new job and moving, if necessary. As stated earlier, CITC provided financial assistance for one year following program completion. CCCC implemented a system to provide funding for HPOG graduates who secured employment and were required to move; the funding decreased gradually over time. The financial assistance could be used for transportation and child care costs.

## **Retention Strategies**

The main retention strategies grantees used included extensive screening processes, implementing systems for accountability, and support services. Both CITC and TMCC cited the thorough screening processes they implemented as a key to retention, as it allowed them to identify dedicated, motivated individuals who would be committed to completing the program. Grantees also conducted academic assess-

ments at intake to ensure that prospective students had the required reading, writing, and math skills to be successful in their training programs. Once enrolled in HPOG, grantees implemented systems designed to ensure accountability for HPOG students. Three of the grantees—CCCC, BCC, and TMCC—required students to submit attendance and grade reports to their mentors or retention counselor on a weekly or biweekly basis. This strategy enhanced students' accountability to the program while allowing mentors and HPOG program staff to recognize issues and respond to challenges before they escalated.

Grantees also noted that the support services offered by the HPOG program were key to student retention. Often the provision of a support service was seen as the difference between students staying in school or leaving their training program. Grantees reported that both social support and academic services were important for student retention. Students often shared how important the support services were to their success, for example, as described by a participant: "This whole program is life changing for me. I don't know if I would've come back to school. I always wanted to be a nurse, but financially, being a single mom, there is no way I could have done it without this program. This program just makes me want to go, go, go. . . . I can't believe I am here and done and it is all because of this program supporting me through it all. It has completely changed my life."

Although all grantees noted that these strategies improved student retention, they did have students who were unable to complete their training programs. According to grantees, some students did not complete their programs because of academic challenges with the course material. Personal challenges and family issues were also frequently cited as a contributing factor for students who did not complete their training programs.

### **Honoring Family**

The Tribal HPOG grantees, particularly the tribal colleges, created an environment that welcomed and honored their students' extended families' structure and recognized the importance of familial involvement and support (HeavyRunner and DeCelles 2002). Involving families in the Tribal HPOG 1.0 program varied across grantees. While not a separate component of most of the implementation plans, all the Tribal

HPOG 1.0 grantees organized at least one family event per year and generally encouraged families to support and participate in their family member's HPOG education. For example, secondary implementation sites for BCC hosted family-centered events, such as powwows and Native American Day celebrations. All HPOG students and graduates were invited and encouraged to bring family members to share in the events. Other grantees also invited families to graduation and other recognition ceremonies. During holiday dinners, luncheons, and other events hosted at the college, HPOG staff used the opportunity to inform families about the importance of creating a supportive environment for their family member to pursue an education. Over time, some grantees saw an increase in students who brought their family members to those events, and staff welcomed and encouraged their participation. In addition, HPOG staff, especially the case managers, helped make family accommodations on a daily basis so that students could attend class, such as helping to find babysitters, sending reminders to students about class schedules and tests, and checking on availability of transportation.

The academic clan and society distinctions in the nursing program at CMN and collegewide at BCC, respectively, also emphasized familial and community support. As mentioned previously, CMN's nursing program instilled the cultural teachings of the five principle clans of the Menominee People and BCC incorporated figures of Blackfeet culture into the names of 17 societies composed of students, staff, and instructors. Both of these examples demonstrate how grantees structured academic programs using cultural elements to build a sense of community around a shared identity. According to the BCC staff members, engaging families increases the likelihood that students will receive support at home. Family members of BCC participants were invited to orientation, seminars, and campus visits so they could become familiar with the staff and setting where the students' training occurred. One of BCC's secondary implementation sites, Salish Kootenai College, hosted a family night every year that was arranged by the student senate to which the HPOG students were invited. In addition, the college offered orientation for families to coincide with student orientation, during which families learned about student responsibilities and experiences, such as long study hours and increased stress during exam times. Some students at other colleges expressed the desire for more organized family engagement to help family members cope with the demanding

education and work schedule. Many students noted that they were the first in their families to pursue higher education, and family members were “both proud and worried when students [left] home.” This sentiment was echoed by a staff member who said that some family members “pull back” as the student becomes more immersed in her education, and this is what a family-focused educational component would address.

An unanticipated benefit was the effect that HPOG seemed to have on the perception of education in the home. During focus groups conducted by the evaluation team and in conversations with Tribal HPOG 1.0 staff, many HPOG students described the interactions that they had with their children, working on homework together and forming an expectation that education should be a priority. Students reported that they took it upon themselves to include their children in their education. Some parents studied with their children to create an environment at home that placed an emphasis on education and support. Students noted that they were able to show their children that it was possible to pursue an education and find employment. Though this was reported by a subset of HPOG participants, the effect on families may have implications for a majority of HPOG students, over half of whom reported having at least one dependent child.

## **TRIBAL HPOG OUTCOMES**

Over the five-year grant period, 2,270 students were enrolled in HPOG among all five Tribal HPOG 1.0 grantees. Final outcome data were calculated from the PRS in September 2015. At intake, the majority of participants were female (87 percent), never married (61 percent), and had one or more dependent children (64 percent). Nearly half of participants (47 percent) were below the age of 30. Approximately two-thirds of participants were AI/AN. Nearly half of participants (44 percent) had one to three years of college or technical school, and 43 percent of participants were high school graduates or equivalent. Many of the participants were low-income. At intake into the HPOG program, 41 percent of participants were in households with annual incomes below \$10,000, and another 20 percent of participants were in households

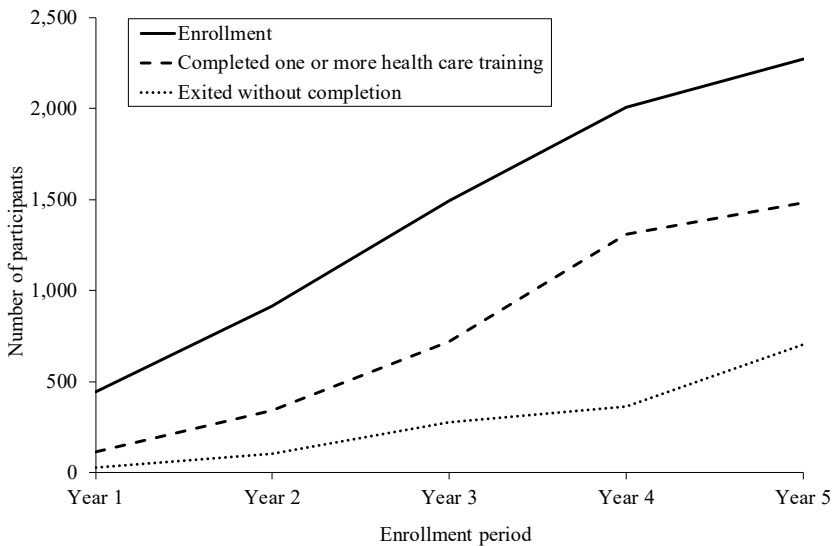
with incomes between \$10,000 and \$19,999. In addition, 16 percent of the Tribal HPOG 1.0 participants were TANF recipients at intake.

### Educational Attainment

By the end of the grant period, 1,483 out of the 2,270 enrollees (65.3 percent) had completed one or more health care trainings. There were 433 participants who started a second training program, of which 238 completed the second training. There were 703 participants who exited without completing a training program (31 percent).<sup>5</sup> The remaining 4 percent had neither completed a training program nor exited the program. Figure 5.3 shows the cumulative Tribal HPOG program enrollment, training completion, and exits without completion.

Across the Tribal HPOG 1.0 grantees, the health care training program with the most enrollees was the CNA program; this program also had the highest percentage of completers among training programs

**Figure 5.3 HPOG Enrollment, Health Care Training Completion, and Exiting without Completion**



NOTE: N = 2,270  
 SOURCE: Performance Reporting System, 2015.

(79.6 percent) (Table 5.3). The program with the second-highest completion rate, at 75 percent, fell under the Miscellaneous Community and Social Service Specialist Standard Occupational Classification system, which included programs such as behavioral health aide and diabetes specialist. CNA programs, typically three to eight weeks long, were among the shortest training programs offered by grantees, which may help explain the higher number of completions. The programs with the lowest completion rates were the emergency medical technicians and paramedics (24.8 percent completion rate), pharmacy technician (28 percent completion rate), and the diagnostic-related technician (25 percent completion rate, though there were only four total enrollees in this

**Table 5.3 Number of Tribal HPOG 1.0 Participants Who Enrolled in and Completed Each Training Program (Listed by Most to Least Number of Participants Enrolled)**

Training programs (SOC)	Number enrolled	Number completed	Percent completed
Nursing assistant, aide, orderly, attendant	1,170	931	79.6
Licensed practical and vocational nurses	351	205	58.4
Misc. community and social service specialist	175	131	74.9
Registered nurses	172	101	58.7
Medical records and health information technician	157	95	60.5
Emergency medical technicians and paramedics	129	32	24.8
Misc. health care support occupation	103	49	47.6
Home health aide	37	15	40.5
Pharmacy technician	25	7	28.0
Phlebotomist	24	15	62.5
Medical assistant	8	5	62.5
Diagnostic-related technician	4	1	25.0
All other SOCs <sup>a</sup>	107	56	52.3

<sup>a</sup> Other SOCs include health practitioner support technologists and technicians, clinical laboratory technologists and technicians, physical therapist assistants and aides, miscellaneous health diagnosing and treating practitioners, miscellaneous health technician and technicians, and counselors.

NOTE: N = 2,270.

SOURCE: Performance Reporting System, 2015.

program). It was reported that the low completion rate for emergency medical technician may be due to difficulties with taking and passing the licensure exams.

Participants expressed how completing their training program and earning a degree impacted their outlook toward the future and their potential to support their families: “[Earning my degree] has given me the feeling that I now have my future secured. It taught me that hard work pays off and there are programs out there to help us Natives in completing our goals and making a better life for our families. It feels good knowing that I can do more for my daughters and family.”

### **Employment Outcomes**

Two measures of employment outcomes among Tribal HPOG 1.0 participants were calculated. The first measure was participants’ employment status at intake and whether they became employed at any point after intake.<sup>6</sup> At program intake, 65 percent of participants (1,468) were unemployed, 20 percent (458) were employed in a non–health care field, and 15 percent (134) were employed in a health care field. Almost half of the participants who were unemployed at intake became employed at some time after intake, most of them obtaining health care–related employment. Of those who were employed in health care at intake, 39 percent experienced a wage increase at some point after intake.

The second employment outcome measure is average wages and full-time equivalents earned, or annual earnings calculated based on the equivalent of one employed person working full-time (40 hours per week x 52 weeks = 2,080 hours per year), by participants who gained employment after intake (Table 5.4).<sup>7</sup> The average hourly wage among all occupations was \$15.47, which is about \$32,000 annually for a full-time employee. Average hourly wages ranged from \$10.58 (\$22,000 annually) for Home Health Aides to \$27.58 for Miscellaneous Health Diagnosing and Treating Practitioners (\$57,000 annually). Within the nursing professions, CNAs averaged \$12.34 an hour (\$25,600 annually), LPNs averaged \$18.13 an hour (\$37,700 annually), and RNs averaged \$22.72 an hour (\$47,200 annually). All the occupations listed in Table 5.4 had annual full-time equivalent earnings that exceeded the 2015 federal poverty level for a family of three in the contiguous 48 states



**Table 5.4 Wages of Tribal HPOG 1.0 Participants**

Occupation (SOC)	Number employed	Average hourly wage (\$)	Annual full-time equivalent earnings (\$)
Nursing assistant, aide, orderly, and attendant	468	12.34	25,657.47
Licensed practical and licensed vocational nurse	107	18.13	37,720.70
Miscellaneous community and social service specialists	77	13.64	28,367.42
Registered nurse	65	22.72	47,266.88
Counselors	53	13.49	28,057.63
Medical records and health information technician	48	14.36	29,875.30
Miscellaneous health care support occupations	36	14.11	29,340.71
Medical assistant	24	15.29	31,801.47
Home health aide	24	10.58	22,003.80
Emergency medical technicians and paramedics	16	12.49	25,977.90
Miscellaneous health diagnosing and treating practitioners	9	27.58	57,361.78
Phlebotomist	6	14.96	31,109.87
Pharmacy technician	6	14.82	30,829.07
Health technologists and technicians, misc.	6	13.63	28,340.00
Health practitioner support technologists and technicians	5	15.02	31,241.60
Clinical laboratory technologists and technicians	4	16.10	33,477.60
Physical therapist assistants and aides	3	16.33	33,973.33
Diagnostic-related technologists and technicians	3	14.33	29,813.33

NOTE: N = 960. Includes Tribal HPOG 1.0 participants who were employed at any time after program intake, including during enrollment, at program exit, or at follow-up. Only includes participants that had an SOC and wage recorded in the PRS. If more than one employment record, the most recent record is reported.

SOURCE: Performance Reporting System, 2015.

and District of Columbia. Excluding the home health aide, wages for the occupations exceeded the federal poverty level for a family of four in the contiguous 48 states and District of Columbia. Alaska has higher federal poverty levels. In Alaska, approximately half of the occupations listed had annual full-time equivalent earnings that exceeded the federal poverty levels for a family of four, and all but one (Home Health Aide) exceeded the federal poverty level for a family of three (Assistant Secretary for Planning and Evaluation 2015).

During qualitative interviews, the grantees reported that students increased their soft skills, such as how to communicate effectively and dress professionally, through job readiness activities and trainings offered by grantees, which made them more employable. Students also reported increases in their soft skills during focus groups. Grantees reported that most students retained their employment, and some students were promoted within their places of employment. Several Tribal HPOG 1.0 graduates advanced to the role of director of nursing at their respective places of employment.

Although many students across the five Tribal HPOG 1.0 grantees completed one or more training programs and became employed, some grantees experienced challenges that prevented them from reaching their employment-related goals. During program planning and implementation, grantees reviewed labor market data to identify workforce needs and aligned their training programs to meet these demands. However, these data focused more broadly on opportunities in the larger region or statewide, rather than at the local level; for some grantees in smaller communities there were limited employment opportunities. This was a particular challenge for the more rural grantees (TMCC, BCC, and CCCC) where there were fewer medical facilities in the local community. Although in some cases employment opportunities existed outside the local community, many students were unwilling or unable to move for employment.

As discussed with grantees and students in the programs, there are several reasons graduates did not want to or were unable to leave their communities to seek employment. The importance of family connectedness is very strong on the reservation, and moving away from home and family members for a job would not always lead to an improved quality of life. For example, many students at BCC reported that they had never left the reservation and home before; they reported experiencing culture shock as well as racial discrimination when they moved to urban areas. The absence of their extended family and support system added to the hardships students faced when attending college and living away from home. Grantee staff also reported that the cost of moving and the additional expenses associated with living off the reservation (e.g., higher rent, child care) were barriers to students moving away from the reservation for employment. For example, housing costs in some areas of

North Dakota increased during the oil boom on the Bakken Formation because the influx of workers seeking lucrative jobs increased housing demand. CCCC, TMCC, and BCC offered financial support for a period of time to lessen the cost burden on graduates willing to move; however, they found that this was not enough of a motivator because challenges were still too great for many to move off the reservation.<sup>8</sup>

### **Program Satisfaction**

Among all five grantees, program staff, instructors, and students reported that they were satisfied with the Tribal HPOG 1.0 Program. Many students mentioned that they would not have been able to complete a program without both the social and financial support of HPOG. They appreciated the support services offered to them, which helped lessen the barriers to completing their programs. According to one participant, “It helps a lot. I wouldn’t have made it through college without it. Everyone was so caring, my teachers and such, they all still keep in contact with me.” Students said that the program helped them become more self-sufficient and better able to take care of their families. One student reported, “This program . . . gave me an opportunity to have the job skills to never be dependent on public assistance again. It does so much for me personally and financially so that I can take care of my son and myself [as a single mom].” Another student said the program “increased my self-esteem [and] gives me a sense of accomplishment.”

Program staff also reported a high level of satisfaction with the program. For instance, staff at BCC commented on how the program has been beneficial for students of all ages: “The way the students trust in Issksiniip to turn their lives around, not just younger, but the older generation are going back to school because of Issksiniip, because some barriers are removed. Issksiniip has [also] helped the older generation.”

Staff at TMCC commented on how the Tribal HPOG program has had a positive impact on not just the students but their families as well: “Taking people off welfare means not just a lot to that person but also to their kids. It sets an example and motivates them to be like their parent.”

Local employers near TMCC described the program as mutually advantageous because students were provided experience at clinical sites and then they were able to fill open positions when they graduated. Local employers near CCCC were pleased with the performance

of HPOG graduates. One employer stated, “[I would] definitely want to hire other Next Steps graduates in the future.”

### **Building Native Health Care Workforce Capacity**

All five grantees reported that they had been successful in training AI/AN students to enter health professions and to address workforce needs locally. They spoke about the importance of having skilled AI/AN health care providers serving AI/AN people, especially in the direct care professions. A local employer near CCCC remarked on the benefit of training and hiring Native Americans: “They are more sensitive to social issues and the clients that they serve, and the historical perspective of how we arrived here.”

Providing culturally sensitive care according to Native beliefs and traditions has many benefits for patients, including greater adherence to medical advice, increases in health care-seeking behavior, and more successful patient education (Lehman, Fenza, and Hollinger-Smith 2004). It is also beneficial for AI/AN individuals to receive services provided by people of their cultural background. For example, a study by the Seattle Indian Health Board found that AI/AN elders saw many benefits to having an AI/AN provider, such as feeling more at ease during the visit and a better ability of the provider to understand the patient (Urban Indian Health Institute 2004).

At the start of the program, each grantee identified health care workforce needs in their communities, in various regions, and throughout the state in order to offer training programs with the most potential for employment. Over the course of the grant period, grantees identified additional needs of local employers and opportunities to train more students in the areas of most need. By assessing local workforce needs, three grantees adapted to changing circumstances and added new programs during the grant period. CCCC recognized the large need for medical coders in North Dakota, so they started the Medical Coding program. Staff reported that many times medical coders can work remotely, thus eliminating their need to move away from home to find employment. BCC added two new programs, Medical Billing and Coding and Phlebotomy, to meet the needs of the local workforce. The Medical Billing and Coding students completed practicums at the local IHS hospital and reported that they had found job opportunities even

before completing their programs. In the middle of the grant period, CITC changed their Medical Billing and Coding program to a Medical Office Assistant program. This change occurred for two reasons: 1) CITC discovered that most Anchorage-area health facilities were outsourcing medical billing and coding to contract entities in the lower 48 states, thereby limiting employment opportunity, and 2) CITC recognized that a more general office assistant program would provide skills that could be useful in a variety of office settings. Staff report that most of the Medical Office Assistant students have found local employment in health-related office settings.

Employers from each grantee area reported being pleased with the Tribal HPOG 1.0 graduates that they hire. Several grantees maintained relationships with employers in their community who had hired HPOG graduates. For example, CITC has a relationship with the Alaska Native Medical Center, which is committed to hiring all of the CNAs that are trained through the CITC HPOG program. Several CITC Medical Office Assistant graduates are also working in the human resources department at Alaska Native Medical Center. CCCC built a network of employers to link students with employment across the state. One employer reported using this network to find CNAs to work across their several health care campuses. CCCC has used the network to send information about the Tribal HPOG program to 18,000 employers across the state.

## CONCLUSION

All five Tribal HPOG 1.0 grantees established programs that led to health care training completion and employment. They built on existing resources to enhance administrative structures and offer additional academic programs to facilitate training and create opportunities for employment in the health care professions. Partnerships were key to implementation of HPOG programs in grantees' communities, particularly for grantees that partnered with multiple secondary implementation sites or training partners. Partnering with additional academic institutions allowed grantees to expand their geographic reach and the types of academic training programs offered to HPOG students. Grantees also formed partnerships with employers in their communities and regions.

These relationships helped facilitate employment for HPOG graduates as employers became aware of the HPOG program and training that students received.

Over time, grantees adapted program offerings to meet student demand and local health care workforce needs. Other grantees modified academic programs to better align with employment opportunities in the community.

Grantees implemented structures to administer two of the primary Tribal HPOG program components: academic programs and support services. While faculty provided academic instruction, staff such as case managers or support service specialists assessed student needs and delivered services as appropriate. When possible, grantees leveraged resources available from other programs to help support participants. Program staff and students reported that the comprehensive academic and social support services were vital to student success in their academic training programs.

Over the grant period, grantees implemented streamlined processes for recruitment and screening of participants. Word of mouth was reported as the most effective method for recruitment, although grantees employed a variety of strategies. Screening processes not only allowed grantees to confirm prospective participants' eligibility but also enabled them to identify dedicated students who met academic readiness requirements. In addition, grantees developed formal orientation processes to inform students about the services provided through HPOG and program expectations regarding attendance, grades, and job readiness skills. The program processes established over the course of the grant period appeared to enable smooth implementation of Tribal HPOG programs.

By establishing processes for the assessment and distribution of support services to students, grantees addressed students' needs throughout the duration of their training programs. All grantees had designated staff to assess student need and coordinate support services, although the staff members responsible for this function varied across grantees.

Educational attainment and employment were the key participant outcomes assessed. Over the five years of the Tribal HPOG 1.0 Program, a total of 2,270 students were enrolled across the five Tribal HPOG grantees. With the support of the Tribal HPOG program, 63.5

percent of students completed one or more health care training programs between September 2010 and September 2015.

After completing a health care training program, graduates often sought employment, although some elected to continue their training. Because grantees could only support students who could complete their training programs before the end of the grant period, HPOG students who enrolled in the earlier part of the grant period had greater opportunities to continue training toward more advanced degrees, such as CNA to LPN to RN.

Among participants who completed and exited the program where employment status was known, 69 percent were employed at exit (85 percent of those participants were employed in health care), and 31 percent were unemployed. All grantees trained AI/AN students to enter health professions. Qualitative data collected from students and employers show that many students were able to gain employment locally, building the Native health care workforce capacity in their communities.

Stakeholders, including program staff, instructors, and students, reported satisfaction with the Tribal HPOG 1.0 Program. Many students noted that they would not have been able to complete a program without both the financial and social support services offered. In describing their satisfaction with the program, many stakeholders commented on the broader influence of Tribal HPOG, noting that graduates serve as role models within their families and communities.

## Notes

1. The words *American Indian/Alaska Native* (AI/AN), *Native American*, and *Tribal* are used interchangeably throughout the chapter.
2. Testimony of the National Indian Health Board Oversight Hearing on Indian Country Priorities for the 114th Congress, Senate Committee on Indian Affairs, January 28, 2015. National Indian Health Board. <https://www.indian.senate.gov/sites/default/files/upload/files/1.28.15%20SCIA%20Witness%20Testimony%20%20Stacy%20Bohlen%20-%20NIHB.pdf> (accessed January 28, 2019).
3. In the Blackfeet language, *Issksiniip* means “a way of knowing” or “the concept of gaining knowledge.”
4. Qualified service providers are individuals or agencies that have agreed to provide services to clients who receive services funded by the North Dakota Department of Health.

ment of Human Services. For additional information see <https://www.nd.gov/dhs/services/adultsaging/providers.html> (accessed March 15, 2019).

5. Program exit is defined by each grantee, but generally indicates the participant is no longer receiving HPOG services.
6. “After intake” includes while enrolled in the program, at program exit, and at follow-up. If a participant is marked as “employed” at any of these times, they are included as having gained employment after intake. If a participant is employed at intake, and is also marked as employed at any of the times mentioned above, they are included as employed.
7. Average wages/full-time equivalents are calculated for participants who are employed after intake (which includes while enrolled in the program, at program exit, at follow-up) and who have an SOC and wage recorded in the PRS. If multiple wages/SOCs are recorded, signifying wage increases or different types of employment at different times, the most recent employment record that has both a wage and SOC is used.
8. Assistance for costs associated with moving for employment differed from the transitional assistance that grantees provided. Moving assistance provided support to students who were physically moving off the reservation to pursue work elsewhere, usually in a city. Moving assistance included rental deposit, moving costs, gas cards, and child care assistance to help participants while they were settling in a new location away from family and friends.

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