HPOG Health Profession Opportunity Grants
OFFICE OF FAMILY ASSISTANCE

Abt ASSOCIATES

Agile During a Pandemic: How HPOG 2.0 Programs Responded to COVID-19

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OPRE Report 2022-71 | March 2022

KEY FINDINGS

The COVID-19 pandemic affected HPOG 2.0 enrollments and healthcare employment opportunities from March through December 2020. Overall enrollments and new employment in healthcare declined after the onset of the pandemic compared to 2019. While they began to improve, they remained below pre-pandemic levels.

In response to the changes brought on by the COVID-19 pandemic all 38 non-Tribal HPOG 2.0 programs implemented adaptations. Key programmatic adaptations include:

- Programs increased their reliance on social media for outreach and transitioned to online and contactless enrollment procedures.
- Programs shifted from in-person to online basic skills assessments, over time staff were certified to administer basic skills assessments on-site.
- Programs adapted to support their own staff with new technologies and through peer learning.
- Programs provided increased case management services and technological supports in response to evolving participant needs.
- Programs applied safety measures for in-person learning and provided additional supports to help participants adjust to online learning as healthcare training activities were paused, waived, or shifted to virtual settings.

Contents

Introduction

The spread of COVID-19 in early 2020 changed almost all aspects of life in the United States and across the world. Communities imposed stay-at-home orders and encouraged social distancing,[i] all while health and safety guidelines changed rapidly. While healthcare workers were on the front lines of the pandemic response, the supply of new workers declined as many healthcare training providers closed or substantially reduced their operations during the initial months of the pandemic.

This included HPOG 2.0 programs, which train participants for in-demand healthcare jobs. Enrollment in 38 non-Tribal HPOG 2.0 programs—and the healthcare training they support—declined during the pandemic. As the pandemic unfolded, **local HPOG 2.0 programs adapted their procedures to continue activities while protecting their staff, students, and partners.**

This brief focuses on **how the COVID-19 pandemic affected implementation of HPOG 2.0 programs in five areas**[ii]:

1. participant **enrollment**,
2. **basic skills** assessments,
3. **healthcare training** offerings,
4. participant **supports**, and
5. HPOG 2.0 **staff supports**.

The brief examines changes programs adopted during the first 10 months of the COVID-19 pandemic and distinguishes between the initial crisis response period (approximately March–June 2020), when state and local guidelines were rapidly changing and HPOG 2.0 staff were quickly pivoting service delivery, and the later adaptation period (approximately July–December 2020), when programs were implementing longer-term responses to the pandemic.

SECTION 1

How Programs Operated Before the COVID-19 Pandemic

HPOG 2.0 programs began a five-year grant period in September 2015.[iii] Programs operated in different ways, but all provided similar services, delivered mostly in person.

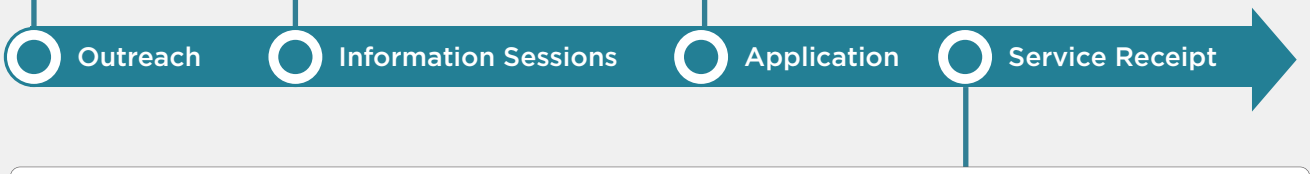
HPOG 2.0 PROGRAM ENROLLMENT PROCESS

Outreach:

To enroll new participants, programs conducted direct outreach to their target populations and also worked with other community organizations, which referred or helped identify interested applicants.

Information Sessions and Application:

The intake process involved in-person information sessions about the HPOG 2.0 program and working in the healthcare field, as well as an application to screen for eligibility. Applicants typically had to bring paper eligibility or screening documentation to the program office.[iv]



Service Receipt:

Training and Support Services. HPOG 2.0 programs provided a range of healthcare training options, from Certified Nursing Assistant (CNA) training courses lasting only a few weeks to longer training courses for technical or nursing positions. Healthcare courses often required hands-on training activities and also sometimes a workplace clinical or externship. For some occupations, students who completed training also needed to pass an in-person certification or licensing exam before they could work.

Because the HPOG 2.0 target population often faces high barriers to education or employment, programs offered financial help with tuition as well as support services, such as case management or coaching, academic or career counseling, and employment assistance. Programs also provided personal and logistical supports, such as transportation and childcare assistance, intended to help participants attend training and other in-person program activities.

SECTION 2

How Programs Adapted to the COVID-19 Pandemic

HPOG 2.0 program activities were largely unchanged for the first four years of the grant period. However, by March 2020 when the United States declared a state of emergency, programs were forced to rethink how to deliver services. By May 30, 2020, all but a few states and territories had issued stay-at-home orders or advisories.[v] The type and duration of restrictions varied and had differing effects on local operations.

This section describes the challenges HPOG 2.0 programs experienced while adjusting to guidance on COVID-19 precautions and how they adapted to those challenges. In each of the five topic areas of the brief, we highlight the following key themes:

- **Addressing participant concerns**
- **Developing alternate modes of service delivery**
- **Reinventing roles of local program staff**
- **Creating alternatives to meet training & employment requirements**
- **Adapting to reduced partner activities**

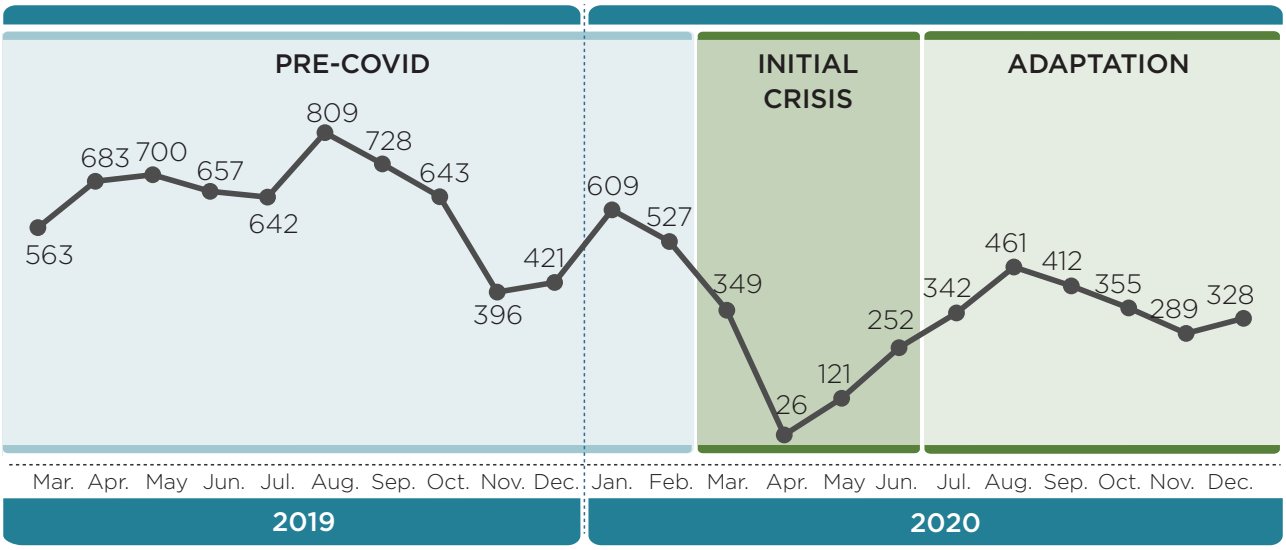
HPOG 2.0 PARTICIPANT ENROLLMENT

In response to shutdowns, stay-at-home orders, and declining enrollment, programs shifted to social media platforms for marketing and outreach, and transitioned to online and contactless enrollment procedures.

HPOG 2.0 participants attend healthcare training courses, typically at community colleges or other training providers. Enrollment into HPOG 2.0 programs usually peaks just before the start of fall and spring semesters (August/September and December/January), with a slower yet steady pace of enrollment at other times of the year (for training not on a semester schedule). Consistent with data from other years, enrollment into HPOG 2.0 was high in January 2020. However, by March 2020, COVID-19 had brought new enrollments to a near halt. As localities were placed under stay-at-home orders, programs closed offices and could no longer conduct in-person recruitment or screening for HPOG 2.0. (Exhibit 1).

HPOG 2.0 enrollments plummeted during the initial crisis response period, then increased during the adaptation period, but overall enrollment remained lower than in 2019.

Exhibit 1. Number of HPOG 2.0 Enrollments



Source: PAGES. N = 10,313 participants enrolled between March 1, 2019, and December 31, 2020.

Starting in March 2020, many HPOG 2.0 programs suspended new enrollments while they developed procedures to conduct intake and enrollment remotely. This included adapting eligibility and intake procedures to accommodate social distancing or stay-at-home orders. As a result, enrollments during the initial crisis response period were lower than the same time period a year earlier. Enrollments picked back up in May 2020 after programs were able to start enrolling participants remotely (described below). However, by June 2020, monthly enrollment was only about a third of the level observed in June 2019. The COVID-19 pandemic continued to suppress enrollment through fall 2020. Though enrollment increased slightly at the start of the 2020-21 school year, it declined thereafter.

Addressing Intake and Enrollment Challenges

Programs experienced enrollment challenges throughout the pandemic period covered by this brief. During the initial crisis response period, program factors such as staff reductions or limited support from referral partners likely contributed to low enrollments. Participant challenges also played a role, according to staff, such as concerns over working in healthcare and aversion or obstacles to online learning. Programs addressed these challenges in several ways:

SPOTLIGHT:
Adjusting to Remote Recruitment

▶ Problem:

A community-based HPOG 2.0 program and its recruitment partners had to close their offices to in-person meetings.

▶ Context:

Prior to the pandemic, the program relied heavily on in-person activities to recruit new participants. Each week, the program held an orientation session and open enrollment days at its office for potential applicants to drop in without an appointment to learn about HPOG 2.0.

▶ Adaptation:

The program held orientations online with adjustments, such as **revising presentations to be more easily read on smaller screens, increasing the frequency** of orientation sessions (to four per week), and **varying the time of day it held** sessions. The program also **created a social media presence** with **QR codes to informational flyers** and links to directly sign up for an orientation session. These adjustments allowed the program to recruit at a similar level to that prior to the pandemic.

> **[We] have been using [a digital signature software], and have received great feedback from [participants] and colleges about it. It's been really good for our [participants] because when a form requires multiple signatures, it can just be emailed to the people who need to sign it rather than requiring the [participant] to go to each person directly to ask for an ink signature. It's reduced the amount of effort for them and also reduces their [COVID-19] exposure points.**
>
> —HPOG 2.0 PROGRAM STAFF

Responding to reduced support from referral partners.

Traditional referral partners closed or began working remotely because of the pandemic, reducing the number of new referrals. In response, some HPOG 2.0 programs **reached out to past applicants** who had not completed the enrollment process to inquire whether they were interested in moving forward with their application. Several programs also **expanded their outreach and marketing efforts via social media platforms** instead of relying as heavily on community referral partners. A few HPOG 2.0 programs shifted their focus from recruiting new applicants to **retaining as many existing participants** as possible.

Allowing for remote intake and contactless document collection.

During the initial crisis response period, programs found new ways to conduct activities typically done in person. Some programs began allowing participants to **submit** their completed forms and eligibility documents **by mail** or through **contactless drop-off.** Other programs modified intake to allow applicants to **e-sign documents** and **submit them digitally**, eliminating the transfer of paper. Programs also limited physical contact by switching to **virtual information sessions**.

Though programs continued to enroll new participants, programs found that remote intake often took longer and required more individual back-and-forth, especially compared to the group intake sessions common before the COVID-19 pandemic. To overcome this challenge, a few programs developed an **online version** of their introductory healthcare orientation workshop so they could continue to conduct **introductory intake sessions in a group setting**.

By the start of the adaptation period (July 2020), many programs were able to switch to a **mix of in-person and virtual intake** allowing applicants who preferred to interact in person to do so if they followed safety procedures.

In-person intake was often done by appointment and required applicants to complete COVID-19 screening questions and a temperature check before entering the office. Staff wore personal protective equipment such as face masks, frequently sanitized shared spaces, and separated people with Plexiglas acrylic dividers. Staff also modified their office spaces, following maximum capacity thresholds to allow for social distancing.

Throughout the period, whenever COVID-19 infection rates were on the rise, programs readjusted their intake and enrollment procedures to close their office to the public, either completely or for a few days per week, restrict access to appointment only, or shift back to entirely remote intakes.

Overcoming participant concerns about digital platforms.

Programs helped participants who feared submitting personal documents online or did not have the technology to do so. A few programs **opened their offices for participants to drop off materials** but continued to meet with participants remotely. For one program, this included allowing participants to come to the office so they could **videoconference** with staff from the lobby, using a program computer and Wi-Fi, while staff remained in another part of the building.

SPOTLIGHT: Virtual Programming to Boost Rural Enrollment

▸ Problem:

Participants from rural areas faced barriers to participation in HPOG 2.0 programming given regulations for in-person gatherings and challenges with transportation and childcare, which were exacerbated by the COVID-19 pandemic. Difficulty attending required in-person programming deterred potential enrollees from applying to the HPOG program.

▸ Context:

An HPOG program run by a state agency required new participants to attend an in-person "boot camp" shortly after enrollment, which provided contextualized basic skills training to prepare them to pursue healthcare training. Before the pandemic, boot camp was offered in person at several technical schools.

▸ Adaptation:

The program began implementing a **virtual boot camp** so that enrollees could participate in the program remotely and limit in-person contact and the need to travel. The virtual boot camp was offered in **one- or two-week formats** to make it less burdensome. Staff noted that virtual boot camps increased enrollment by allowing **rural participants to complete** these courses from home, even using their cell phones.

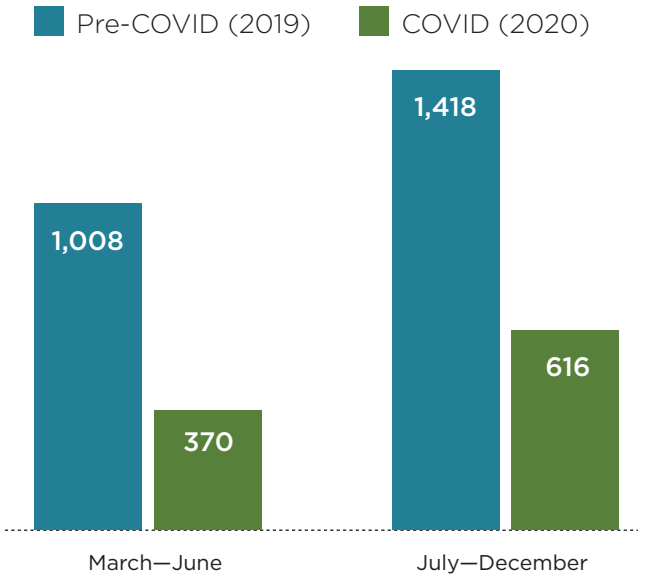
BASIC SKILLS ASSESSMENTS

To adjust to challenges with in-person basic skills testing, programs shifted to online basic skills assessments, and staff trained to become certified proctors.

As part of the intake process, most HPOG 2.0 programs require participants to complete basic skills assessments so any needs are addressed before or alongside participants' healthcare training. To address these needs, some participants take basic skills training as a precursor to healthcare training, and therefore new basic skills training enrollments (Exhibit 2) mirrored the downward trend seen in new program enrollments during the initial crisis response period. Then, around the start of the adaptation period (July 2020), the number of participants enrolling in basic skills training began to increase as programs accommodated intake and enrollment via virtual settings, alternative testing, and adult basic education changes.

The number of participants who **started any basic skills training declined sharply** during the **initial crisis response period** compared to the same months in 2019. During the adaptation period, the counts **increased slightly relative to the initial period** as programs adjusted.

Exhibit 2. Number of Participants Starting Basic Skills Training



> **The adult skills assessments (CASAS) were difficult to transition remotely, as students completing the assessment online need to have a registered laptop. [We] reverted back to paper assessments, which the students completed and mailed in. When students start working with their [adult basic skills] instructors, they retake the assessment (informally) through [a virtual meeting platform]. The instructor then assesses if the students really [have] proficiency.**
>
> **—HPOG 2.0 PROGRAM STAFF**

Reimagining Basic Skills Assessments

The ability to complete basic skills assessments was hindered by the closure of testing sites and the inability to conduct in-person testing. Programs responded to this challenge by:

Finding alternative modes to administer basic skills assessments.

Programs were challenged to find alternatives to in-person testing for basic skills and other intake assessments. This challenge was especially acute for programs that administer the Tests of Adult Basic Education (TABE)—a math and reading assessment tool—which traditionally requires in-person proctoring. One program tried to adjust to this challenge by **administering the TABE online.**

Programs using Comprehensive Adult Student Assessment Systems (CASAS), another common basic skills test, found it could not be completed virtually; one resorted to having participants mail in paper tests. Over time, some staff were able to become **certified proctors** to administer the assessments, such as CASAS and WorkKeys, in person in socially distanced settings.

Administering alternative assessments.

Other programs' adult basic education partners closed due to the pandemic. To address this challenge, during the initial crisis response period programs looked for **alternative tests** that did not require in-person proctoring or shifted to accepting practice test results.

HEALTHCARE TRAINING OFFERINGS

Many training activities were paused, waived, or switched to virtual formats. Programs implemented safety measures for in-person training and provided supports to help participants adjust to online learning. To overcome the suspension of clinicals, states issued temporary waivers and programs adopted online simulations or added new clinical partners. Shutdown of licensing exam administration centers prompted a few programs to get certified as state testing locations.

Fewer participants started a healthcare training during the pandemic than during the same months in 2019, although the seasonal trend was similar to the previous year (Exhibit 3). The number of participants starting healthcare training declined in April 2020, around the time that many stay-at-home orders were put in place, then spiked before the fall semester (August 2020).

Participants starting and completing healthcare **training followed similar seasonal trends** during the pandemic as they did prior to the pandemic, **but at lower rates**. The number of participants starting a healthcare training in September 2020 **declined** compared to the same period in 2019.

Similarly, fewer participants completed training during the pandemic as compared to 2019 (Exhibit 4); this also followed the same seasonal trends, with the most completions occurring toward the end of the spring and fall semesters (May and December).

Exhibit 3. Number of Participants Starting Healthcare Training

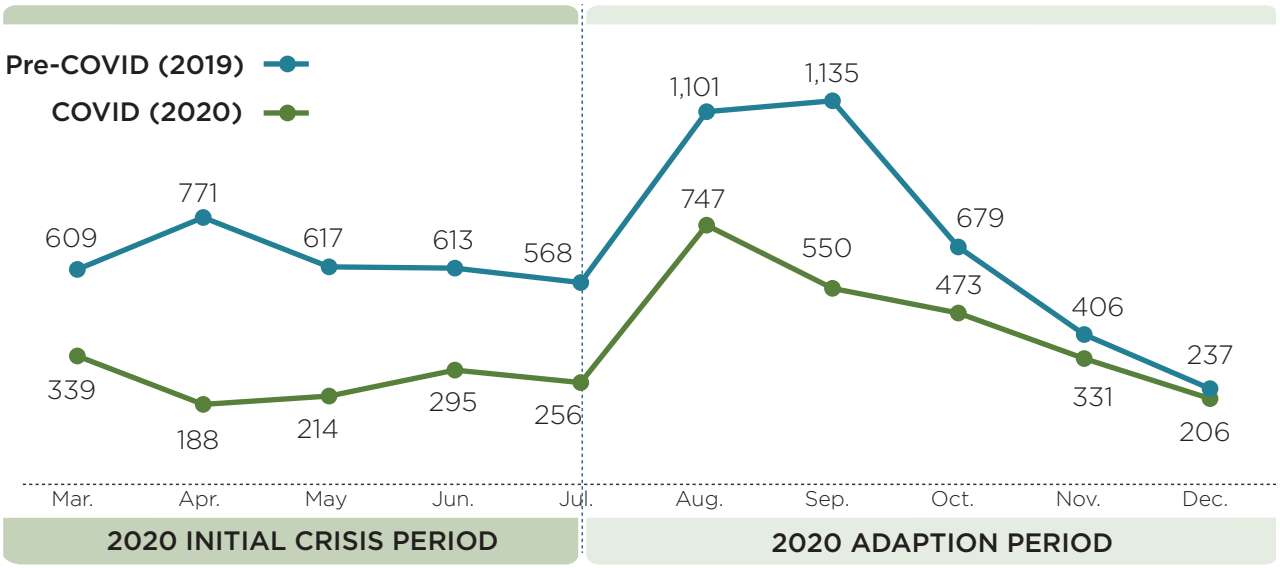
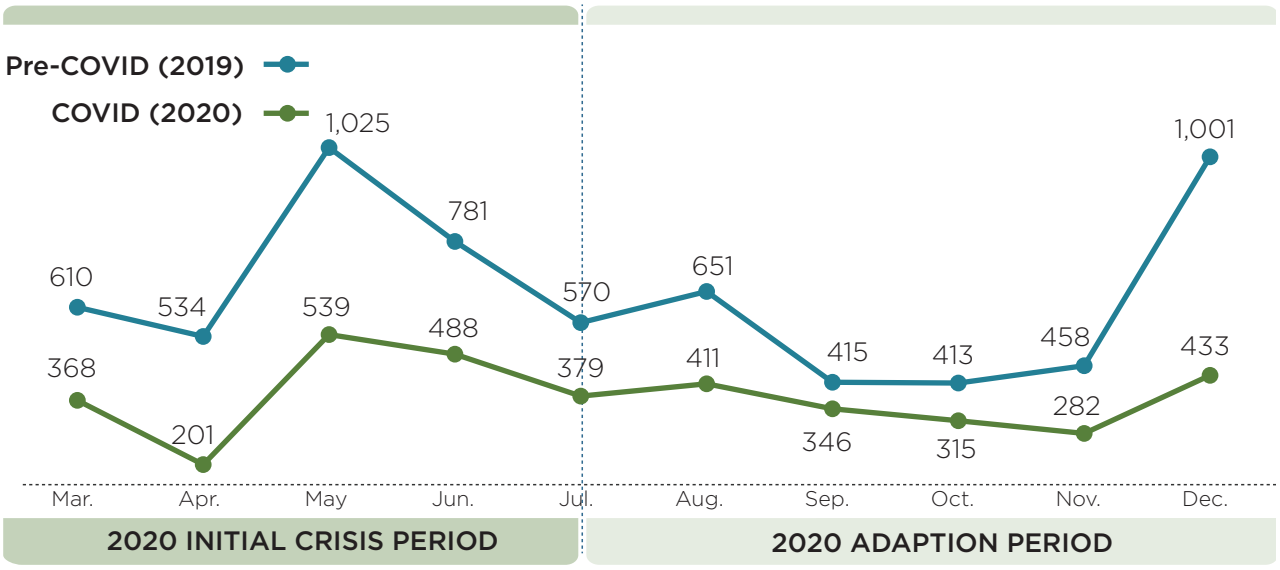


Exhibit 4. Number of Participants Completing Healthcare Training



Source: PAGES. N = 36,477 participants enrolled between September 1, 2015, and December 31, 2020.

> **Due to COVID-19 disruption, externship cancellations have negatively impacted healthcare training completions for those enrolled in [Certified] Nursing Assistant, EKG, Patient Care Tech, Pharmacy, and Phlebotomy [training programs].**
>
> **—HPOG 2.0 PROGRAM STAFF**

Adapting Healthcare Trainings and Clinical Offerings

During the initial crisis response period, many healthcare training courses were suspended or delayed. In response, training providers transitioned courses to online learning platforms to accommodate social distancing or stay-at-home orders. Programs and states took other important steps to adapt to pandemic conditions:

Finding alternative ways to fulfill clinical and externship requirements.

Training providers for certain healthcare training occupations that require direct patient care, such as phlebotomy and nursing, had to suspend classes until they could safely accommodate the required in-person clinicals or externships. Clinicals and externships are often completed in long-term care and nursing facilities—residents of which were highly vulnerable to COVID-19. In response to this challenge, a few programs adopted **online simulation programs** (such as PersonAbility) in lieu of in-person clinicals. However, even during the adaptation period, some HPOG 2.0 programs continued to report that clinicals and externships were still on pause altogether, causing participants' training to be disrupted.

Applying to become state testing locations.

Healthcare is a credentials-oriented field. Students completing training often must demonstrate proficiency to an established credentialing body and receive official licensing or certification before they can work in the field. This process often requires in-person, proctored testing.

Many external organizations stopped offering proctored licensing and certification examinations during the initial crisis response period and into the adaptation period. More than half of programs mentioned no or limited availability of exams and, once exams resumed, there were significant delays due to testing backlogs. The inability to complete a licensing or certification exam negatively affected participants' ability to enter healthcare employment. In response, some programs applied to become **state testing sites or have staff become certified proctors**. During the adaptation period, testing facilities began to reopen but operated under the CDC-recommended guidance of social distancing and reduced capacity, which resulted in long wait lists for licensing and certification exams.

> **The community colleges are not offering in-person classes. Three training providers are offering remote training options. A dental assistant program is offering in-person dental assistant courses, but the class size is significantly reduced: six people instead of 12. For CNA, most training providers have stopped or rescheduled training. [Testing] sites are not offering testing through the end of May [2020], and they may push that deadline back again. Not many trainings are available, so a lot of folks have put their trainings on hold, or they are trying to come back at a different time.**
>
> —HPOG 2.0 PROGRAM STAFF

States issuing temporary waivers for clinicals and licensing exams.

Some states offered **temporary alternatives or state licensing waivers**. A number of programs reported that state- or employer-level policies allowed program completers to be hired without passing their clinicals or their licensing or certification exams. This was especially common for CNAs and Registered Nurses (RNs). For example, the State of Virginia exempted students from in-person clinicals for CNAs, Licensed Practical Nurses (LPNs), and RNs, allowing them to complete case studies and virtual trainings instead. Louisiana similarly waived the licensure requirement for LPNs and RNs, but not for CNAs.

Offering alternative learning models to balance participant needs.

To help participants balance employment, family responsibilities, and training demands, one program transitioned online courses to an **asynchronous learning** model, meaning participants could complete lessons on their own time, when it was most convenient for them.

Expanding partnerships to support clinical and externship capacity.

As programs continued to adjust to life during the pandemic, some training programs **expanded partnerships** to include new agencies willing to **offer externship opportunities** while implementing safety procedures such as limiting the number of students allowed in labs so they could safely socially distance. Programs that were unable to continue offering clinicals or externships instead started or expanded training for **other healthcare occupations that did not require a clinical or externship**, such as Medical Billing and Coding, which requires less patient contact. A few programs also considered **adding new trainings related to COVID-19**, such as Contact Tracing, although many did not do so.

Implementing safety measures to resume in-person learning.

Programs that were able to resume in-person instruction during the latter half of the initial crisis response period and into the adaptation period did extensive planning. In-person instruction required implementing safety measures such as **limited time in class or reduced class sizes** to allow for proper social distancing and other CDC-recommended precautions such as the use of **personal protective equipment, regular cleaning/ sanitation, and temperature checks** for all individuals entering the campus.

As the adaptation period continued and people became more comfortable with the safety guidelines, a few training providers began to offer fully in-person instruction for the summer or fall semester. However, the ability to continue in-person instruction became uncertain as another wave of rising COVID-19 cases began in late 2020.

Providing additional supports to help participants adjust to online learning.

Online instruction had been rare in healthcare training before the pandemic. Some participants had limited experience with computers in general and might not have had the technology or reliable internet service needed to engage in online learning at home.

To help accommodate different learning styles and abilities, programs created **hybrid training offerings** to allow students to attend some sessions in person and some online.

Hybrid offerings varied by type of healthcare occupational training. Some trainings allowed for clinicals, labs, or licensing and certification exams to be completed in-person whereas traditional coursework was completed online. Programs also addressed challenges related to lack of technology by providing participants with access to laptops and Wi-Fi, as described in the "Participant Supports" section below.

SPOTLIGHT: Helping Students with Digital Literacy

▶ Problem:

Students struggled with online learning platforms.

▶ Context:

A college-based HPOG 2.0 program provided students with digital literacy support prior to the pandemic, including support with computer programs and how to convert Word documents into PDFs. But this support did not include instruction on how to navigate online learning platforms.

▶ Adaptation:

The HPOG program developed a new **"Online Learning Support Specialist"** position offering participants additional **digital literacy and IT support** above and beyond the standard supports offered prior to the pandemic. Students receive guidance on how to use the technology for online classes, such as how to "stitch together" and upload video files.

PARTICIPANT SUPPORTS

To respond to changes in participant needs, where feasible, programs resorted to online delivery of support services, provided intensive case management services, and expanded technological supports.

HPOG 2.0 programs offer a range of support services—such as academic, personal, logistical, and employment assistance—designed to help participants enter and complete healthcare training and ultimately gain employment. Programs adapted HPOG support services in a variety of ways to meet changing needs during the pandemic.

Assessing Participant Needs

During the pandemic, HPOG 2.0 programs pivoted to assessing participant needs through **virtual town halls** and **online surveys**. Some programs used generalized surveys for an overall assessment of the needs of the participants they serve, whereas other programs used targeted surveys to identify individual needs.

Most programs found participants' needs shifted during the pandemic. For example, before the COVID-19 pandemic, providing transportation assistance (i.e., gas cards or public transit assistance) was a popular support that participants used to get to classes and clinicals. During the COVID-19 pandemic, instruction was delivered online, and participants no longer needed to travel for classes. However, the shift to online courses presented new needs for technological support. Childcare assistance was another commonly cited need, given that schools and childcare centers were closed or had limited capacity.

Adjusting Support Services in Response to Changing Participant Needs

The changes to daily life—including the additional stressors brought on by the pandemic—led to changes in participant needs. Programs acknowledged participants' changing needs by:

Addressing participants' mental health needs.

For some, the pandemic exacerbated existing mental health challenges. Local HPOG 2.0 program staff described a high incidence of depression and anxiety among participants during the pandemic. Case managers and counselors shifted to i**ntensive case management**. To help participants stay focused and motivated, staff incorporated active listening skills into online check-ins with participants. During these check-ins, staff provided emotional support, assessed evolving needs, shared practical resources, and referred participants to appropriate services.

Participants grappled with the challenges of preparing to work at the frontline while also raising children or living in multi-generational homes. Participants feared getting sick themselves, but also feared spreading the virus to their children, partners, parents, and others at home. Video conferencing or online **virtual peer support** enabled students to connect with one another and talk though these concerns.

> **Maintaining these relationships via remote platforms is a new challenge for program staff to meet…we needed to connect with our participants emotionally, especially in times of anxiety and uncertainty. [Case managers] began making an additional weekly contact with participants with COVID-19 related resources, words of encouragement, inspirational quotes, etc. This is separate from the usual weekly contact that is focused solely on training progress and training needs.**
>
> —HPOG 2.0 PROGRAM STAFF

Supporting participants with multiple responsibilities.

Some participants could not work due to the additional responsibilities of children at home during the pandemic. Programs continued to provide participants with **emergency assistance** for childcare, but participants often had trouble finding open childcare centers or the facilities had limited capacity. Additionally, programs offered **virtual workshops** to help students adapt to the realities of the COVID-19 pandemic.

Types of Virtual Support Workshops Offered

- Education about the COVID-19 virus, safety, and well-being practices for participants.
- Online training etiquette covered proper attire and strategies for controlling distractions during classes.
- Communication tips focused on how to stay connected with supervisors and instructors.
- Tips on studying and testing online at home.
- Time management strategies for parents juggling their own training and their children's education.

Shifting to virtual support services.

Programs replaced in-person participant check-ins with **virtual check-ins**. Coaching, tutoring, self-care classes, and job-readiness skills workshops offered through **online conferencing platforms** became the sole delivery mode for several programs. In addition to routine check-ins, programs offered employment assistance remotely. Programs offered **virtual** reviews of resumes, soft-skills training, elevator pitches, tips on professional attire for video conferencing, and telephone and video interview prep. Programs also offered **online employment workshops, virtual job fairs, employer information sessions**, and other employer events.

Moving into the adaptation period, some programs continued virtual coaching but also began to reinstate in-person meetings. When in-person meetings were offered, programs followed local guidelines and state health measures to ensure the safety of both participants and staff.

Expanding technology supports for online learning.

Especially at the beginning of the pandemic, participants had not planned to complete courses online and many faced challenges, including low internet bandwidth or even lack of internet access. One program reported that students worked out of campus parking lots to access reliable Wi-Fi.

As the adaptation period continued, programs expanded supports to help students become more comfortable with online learning and the technology it requires. Programs directly **supplied laptops, tablets, computer accessories, printers, or internet services** (such as hotspots). Some programs referred participants to partners and vendors that **provided technology** to those with low incomes.

SPOTLIGHT: Shifting to Socially Distanced Job Fairs

▸ Problem:

The pandemic made it difficult for programs to connect participants with employers. Programs needed to rethink their strategies.

▸ Context:

Before the pandemic, programs held events with employers, hosted employers on site to connect with HPOG 2.0 participants, and held in-person job fairs.

▸ Adaptation:

One program organized a **virtual hiring fair with employer booths**. The virtual platform provided greater flexibility for participants and removed travel constraints. Participants were able to hear firsthand about employer safety precautions, which reduced participants' fears of entering a healthcare occupation during the pandemic. Another program held **drive-through job fairs**. Job seekers could **text "JOBS"** to receive an application link for positions in their area.

Creating new technology support staff roles.

To ease students' discomfort with online learning, staff took on additional responsibilities to assist students with effective use of technology. Some programs developed entirely **new positions,** such as specialists to help students practice skills required for successful online learning. These staff helped students navigate different online learning platforms and use new computer software.

Expanding community resources.

Several programs compiled (or updated) **comprehensive lists of community resources** for participants. Programs included local services ranging from public benefit offices to food pantries and financial resources for housing costs. Instead of providing participants with grocery store gift cards, some programs shifted to offering online assistance, such as grocery delivery service. Case managers followed up with participants to confirm receipt and understanding of available supports.

HPOG 2.0 STAFF SUPPORTS

As staff transitioned to telework and engaged with participants remotely, programs purchased new technologies to support them and ensure secure communication. Staff also participated in peer learning with other HPOG 2.0 programs.

Prior to the COVID-19 pandemic, staff had access to typical human resources supports. However, with the shift to telework and the extra demands created by the stay-at-home orders, some staff began to feel overwhelmed. In response to these challenges, programs began to offer additional supports.

Facilitating Secure and Supportive Remote Work Environments

Providing new technology to facilitate telework and virtual service delivery.

Several programs described purchasing **new technology** (such as cell phones and computers) or d**ocument-sharing digital platforms**. One program purchased headsets for its staff to ensure the privacy of participants while staff took calls from home. As most of the HPOG 2.0 services and trainings went virtual, staff had to assist participants with technology more than ever before, so programs provided training to staff to help them support participants.

Responding to staff anxieties and health needs.

Programs realized staff were increasingly anxious about lack of personal protective equipment (such as disinfecting wipes and facemasks), returning to offices, reduced staff capacity, staff vacancies and turnover, and difficulties training new staff remotely.

Program directors grew concerned for their staff's health and safety, including their mental health. Regular **mental-health check-ins** with staff and **increased flexibility**, such as allowing staff to continue to work from home, were steps programs took to support staff in these unprecedented circumstances. Some programs found the pandemic brought their staff closer together.

Expanding participation in program office events and peer networking.

HPOG 2.0 staff participated in **peer affinity group calls** organized by the Office of Family Assistance. The calls were organized by job title (e.g., Program Director, Case Manager, Employment Specialist), which helped staff learn from other HPOG 2.0 programs around the country and adopt promising practices that had already been implemented elsewhere. One OFA Program Specialist was particularly impressed by how cooperative and thoughtful staff were across grantees, reporting that staff would reach out to other programs and share advice and ideas after the peer affinity group calls.

SPOTLIGHT: Supporting Program Staff

▸ Problem:

Like workers throughout the economy, HPOG 2.0 staff had to quickly adjust to a "new normal" in their own work lives while simultaneously offering emotional support to HPOG 2.0 participants.

▸ Context:

Prior to the pandemic, staff would conduct informal check-ins with one another while in the office or socializing.

▸ Adaptation:

One program began the process of becoming a "trauma- informed sanctuary organization" that **starts each day with a meeting**, asking staff how they are feeling, what their goals are, and reviewing whom to turn to for support. This process helped the program **bring staff together**.

SECTION 3

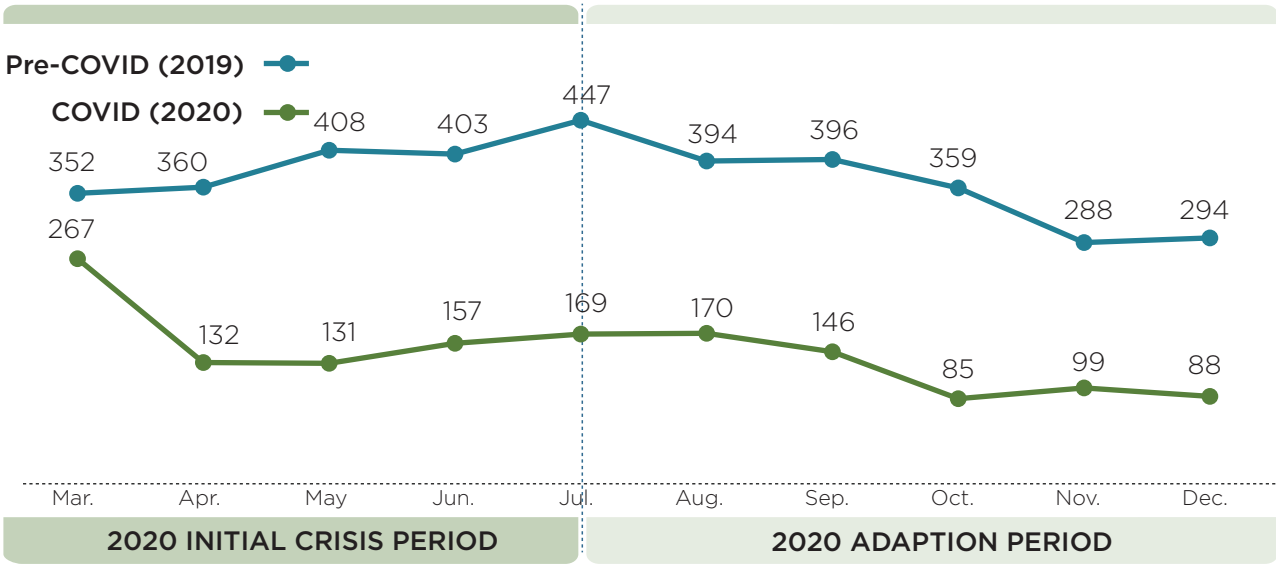
Participants Entering the Healthcare Workforce During COVID-19

The labor market contracted sharply, and demand for healthcare services and employment shifted. In reaction, some programs sought to direct program participants to new employment opportunities related to COVID-19. However, new employment in healthcare saw a sharp decline in the early months of the pandemic.

As described in the previous section, HPOG 2.0 programs adapted operations to continue helping participants complete training and prepare to enter the workforce. However, the COVID-19 pandemic had widespread effects on the healthcare labor market.[vi] This section describes HPOG 2.0 participants' entry into healthcare employment during a volatile period for the sector.

The number of participants **starting employment in healthcare in March through May 2020 declined sharply compared to 2019**. Employment began to improve during the adaptation period but remained well below pre-pandemic levels.

Exhibit 5. Number Employed in Healthcare



Source: PAGES. N=36,477 participants enrolled between September 1, 2015, and December 31, 2020.

During the initial crisis response period, there was a sharp drop in HPOG 2.0 participants starting employment in healthcare (Exhibit 5). Sluggish demand for healthcare workers during the initial crisis response period was a key theme reported across HPOG 2.0 programs as employers imposed delays in hiring, hiring freezes, or layoffs and furloughs. A decline in elective health procedures resulted in a decline in staffing needs in smaller healthcare practices. Assisted living facilities were hesitant to bring in new employees given high risks for seniors.

HPOG 2.0 staff were hopeful about employers accepting waivers to allow participants to start work without certifications or licenses (i.e., temporary unlicensed Nursing Assistants and Aides). However, staff found employers reluctant to hire participants who were trained during this time, worried about the lack of in-person skills training.

The number of HPOG 2.0 participants employed in healthcare increased slightly in June 2020 from prior months, and remained steady during the adaptation period, but at a lower rate than the previous year.

At the same time, most program staff discovered new employment opportunities related to COVID-19 for **Contact Tracer, Facility Monitor, and Sanitation Staff**. However, they also reported that the number of applicants for these positions far exceeded the demand (especially for Contact Tracer), and that few HPOG 2.0 participants were hired for these positions. Multiple programs considered offering Contact Tracing training, but quickly realized the market was already flooded.

> **[The State was] bombarded with [Contact Tracer] applicants so quickly that they shut down the application process. Heard they had 300 open positions, and they probably had 3,000 people apply. Counties were trying to fill those positions as soon as possible to move forward with the reopening phases.**
>
> —HPOG 2.0 PROGRAM STAFF

SECTION 4

Conclusion

After four years of programming (2015-2019), the spread of COVID-19 required staff to quickly transform well-established HPOG 2.0 program operations. Staff had to adjust their intake and enrollment procedures, basic skills training, healthcare training, and support service delivery. The overall HPOG 2.0 Program saw a sharp decline in new enrollments from March through June 2020, compared to the same period in 2019.

The challenges and uncertainty brought on by the pandemic required programs to become more agile to adjust to the changing conditions on the ground. As discussed in the sections above, HPOG 2.0 programs implemented several promising adaptations that staff felt would be worth sustaining after the pandemic ends or in a future round of HPOG. These promising long-term adaptations included:

- Providing greater **variety in the modes of support service delivery and healthcare training offerings**—such as virtual, hybrid, and asynchronous training models—that allow participants to complete training or other program requirements on a more flexible schedule.
- Expanding the **capacity of technology support staff**, who are critical to successful and seamless provision of online learning and support service delivery.
- Offering more **frequent case management and peer support groups**, which HPOG 2.0 staff believe go a long way in helping participants overcome challenges.

This brief is a first look into program implementation adaptations during the first 10 months of the COVID-19 pandemic. This brief is part of ACF's effort to learn more about how HPOG programs and participants fared during the pandemic. Additional efforts include a follow-up study of HPOG participants who enrolled in the program after the onset of the COVID-19 pandemic, to support assessments of the effectiveness of the HPOG 2.0 Program before and after the pandemic.

About HPOG

The Health Profession Opportunity Grants (HPOG) Program was administered by the Office of Family Assistance (OFA) in the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services. HPOG supported local programs that provided education and training to Temporary Assistance for Needy Families (TANF) recipients and other low-income adults for occupations in the healthcare industry.

In September 2015, ACF awarded a second round of grants (HPOG 2.0) to 27 non-Tribal organizations across 17 states. Some grantees operated multiple local programs under a single grant bringing the total number of non-Tribal HPOG 2.0 programs to 38.

Participants in HPOG 2.0 are mainly single women in their 20s and 30s, many with dependent children. At the time they enrolled, more than half had some college education, about one-third had a professional license or certification, and about one-quarter were already in school.

Data and Methods

For this brief, the team reviewed data routinely collected for the National Evaluation, including notes from monthly evaluation monitoring calls with local HPOG 2.0 Program Staff, participant-level data on program enrollment and activities, and grantees' performance reports submitted to the OFA in April 2020 and September 2020. The team also spoke with OFA's HPOG 2.0 Program Specialists and observed OFA-sponsored peer affinity group calls where staff from local programs discussed challenges and adaptations during the pandemic.

This brief analyzes trends in intake, enrollments, and healthcare training entries and completions; programs' operational adaptations; and overall themes about how the pandemic affected HPOG 2.0 programs.

Because this effort did not include systematic data collection for the purpose of informing the brief, the findings are limited in scope and level of detail. The analysis did not explore how findings vary by the impact of the COVID-19 pandemic in a location.

National Evaluation of the HPOG 2.0 Program

This brief was developed under the HPOG 2.0 National Evaluation.[vii] The HPOG 2.0 evaluation is a key component of the Office of Planning, Research, and Evaluation (OPRE)'s broader Career Pathways Research Portfolio.

Endnotes

[i] The Centers for Disease Control and Prevention (CDC) advised individuals to leave six feet of distance between non-household members and to wear a protective face mask. To contain spread of the virus, many states issued stay-at-home orders, shut down public spaces, and restricted travel and work for all but "essential" activities. Many employers asked non-essential employees to work from home; some furloughed or laid off employees.

[ii] See Responding to the COVID-19 Pandemic: Tribal HPOG 2.0 Grantees' Program Adaptations | The Administration for Children and Families (hhs.gov) for an examination of how the Tribal HPOG 2.0 grantees adapted their programs in response to the COVID-19 pandemic.

[iii] In late February 2020, ACF invited all HPOG 2.0 grantees to prepare applications for another year of program funding – extending activities from September 2020 through September 2021. However, at the beginning of the initial crisis response period in March 2020, grantees had not yet been notified whether their programs could continue beyond September 2020. Before ACF's announcement, grantees might have already started ramping down their enrollment activities or their support for longer-term trainings. By late spring 2020, all grantees were notified of their extensions and awardees were expected to continue their programs at current levels of service and support.

[iv] Some HPOG 2.0 programs required an assessment of basic skills at the intake step to determine an applicant's eligibility for the program; other programs assessed basic skills after program eligibility was determined. Intake sessions and the application process also included an overview of the National Evaluation during which participants consented to participate in the evaluation.

[v] For more information, see https:/ /www.cdc.gov/mmwr/volumes/69/wr/mm6935a2.htm#F1_down (last accessed April 20, 2021).

[vi] For a broader view of the healthcare labor market during the COVID-19 pandemic, see *The Healthcare Workforce during COVID-19: Results from an Environmental Scan*, https://www.acf.hhs.gov/opre/report/healthcare-workforce-during-covid-19-results-environmental-scan

[vii] ACF supports a multifaceted research and evaluation strategy to assess the success of the HPOG 2.0 Program. Local HPOG 2.0 programs are being evaluated using an experimental design in which eligible program applicants are assigned at random either to a group that can receive HPOG 2.0-funded services (treatment group) or to a group that cannot (control group) so that outcomes for each group can be compared. In early 2020, the COVID-19 pandemic began severely affecting grant activities. Study member recruitment became much more difficult due to lockdowns and social distancing requirements, and training opportunities became more limited as training providers shifted to remote learning. In response, the research team worked with ACF and grantees to modify the treatment-to-control group random assignment ratio from 2:1 to 3:1. This change allowed more individuals to receive HPOG services. The random assignment ratio change was fully implemented in December 2020 and remained in effect through the end of the grant period in September 2021.

SUGGESTED CITATION

Radha Roy, Tanya de Sousa, Jillian Ouellette and Carly Morrison. (2022). *Agile During a Pandemic: How HPOG 2.0 Programs Responded to COVID-19*. OPRE 2022-71. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

SUBMITTED TO

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Administration for Children and Families
U.S. Department of Health and Human Services
Contract Number: HHSP233201500052C

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