

**UCLA**

**Community Service Projects/Papers**

**Title**

Caregiver Training Initiative Process and Implementation Evaluation

**Permalink**

<https://escholarship.org/uc/item/140018tf>

**Authors**

Matthias, Ruth  
Morrison, Ellen  
Chapman, Susan  
et al.

**Publication Date**

2002-05-01



Contractor: UCLA

*Principal Investigator:  
A.E. (Ted) Benjamin, Ph.D.  
School of Public Policy  
and Social Research*

*Project Director and Co-PI:  
Ruth E. Matthias, Ph.D.*

*Labor Market Analysts:  
Paul M Ong, Ph.D.  
Jordan Rickles, M.P.P.*

*Research Assistant:  
Paula Castro*

Subcontractor: UCSF  
*Principal Investigator:  
Robert Newcomer, Ph.D.*

*Co-Investigator:  
Jonathan Showstack, Ph.D.*

*Co-Investigator and Project Director:  
Susan Chapman, Ph.D.*

*Evaluator:  
Ellen Morrison, Ph.D.*

For Further Information Contact:  
*Dr. Ruth Matthias, Project Director  
School of Public Policy  
and Social Research, UCLA  
3250 Public Policy Building  
Los Angeles, CA 90095-1656  
(310) 825-1951*

## ***Caregiver Training Initiative***

### **PROCESS AND IMPLEMENTATION EVALUATION**

*California Employment Development  
Department*

*May 15, 2002*

*Ruth Matthias, Ph.D.  
Ellen Morrison, Ph.D.  
Susan Chapman, Ph.D.  
A.E. (Ted) Benjamin, Ph.D.*

*This evaluation is supported by the Employment Development Department, California Health and Human Services Agency, through the School of Public Policy and Social Research, the Ralph and Goldy Lewis Center for Regional Policy Studies, UCLA. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the California Employment Development Department or of UCLA.*

# TABLE OF CONTENTS

<b>EXECUTIVE SUMMARY .....</b>	<b>3</b>
A. STUDY DESCRIPTION .....	3
B. EVALUATION PLAN .....	3
C. PRELIMINARY FINDINGS .....	4
<i>Getting Started</i> .....	4
<i>Recruitment</i> .....	5
<i>Training</i> .....	5
<i>Early Departure and Retention</i> .....	6
<i>Future Directions</i> .....	6
<b>I. OVERVIEW .....</b>	<b>7</b>
A. INTRODUCTION .....	7
B. BACKGROUND .....	7
<i>Factors Affecting the Demand for Healthcare Workers</i> .....	7
<i>Factors Affecting the Supply of Healthcare Workforce</i> .....	8
<i>Who Are the Workers?</i> .....	8
<i>What Are the Worksites?</i> .....	9
<i>Where are Healthcare Workers Trained in California?</i> .....	10
<i>Healthcare Worker Training Requirements and Programs</i> .....	11
C. CTI PROJECT DESCRIPTION .....	14
D. EVALUATION PLAN .....	15
<i>Implementation and Process Study Research Questions</i> .....	16
<i>Evaluation Design</i> .....	17
<i>Data Sources</i> .....	18
<i>Limitations</i> .....	20
E. PROGRAM PARTICIPANTS .....	21
<i>Participant Demographics</i> .....	22
<i>Participant Work Histories</i> .....	22
<i>How Participants Heard about the Program</i> .....	23
<b>II. GETTING STARTED .....</b>	<b>25</b>
A. SITE PROPOSAL OVERVIEWS .....	25
<i>Employers' Training Resource Department of the County of Kern</i> .....	25
<i>Greater Long Beach Workforce Development System</i> .....	26
<i>North Bay Employment Connection</i> .....	26
<i>Northern Rural Training &amp; Employment Consortium</i> .....	27
<i>Workforce Development Center at Riverside</i> .....	28
<i>Sacramento Employment and Training Agency</i> .....	29
<i>San Diego Workforce Partnership, Inc.</i> .....	29
<i>Private Industry Council of San Francisco</i> .....	30
<i>San Jose/Silicon Valley Workforce Investment Board</i> .....	31
<i>Workforce Investment Board of Southeast Los Angeles County</i> .....	31
<i>County of Ventura Human Services Agency</i> .....	32
<i>West Hills Community College District and Region 5 – 6 Partners</i> .....	33
B. IMPLEMENTATION ISSUES .....	33
<i>Collaboration Styles</i> .....	33
<i>Time Constraints</i> .....	36
<i>Program Licensure</i> .....	37
<i>Criminal Record Checks</i> .....	37
<b>III. EARLY PROGRAM OPERATION .....</b>	<b>39</b>
A. RECRUITMENT AND ASSESSMENT .....	39
<i>Community Outreach</i> .....	39
<i>Innovative Recruitment Targets</i> .....	41
<i>Recruitment Methods</i> .....	42

<i>Recruitment Challenges</i> .....	46
<i>Assessing Suitability of Potential Participants</i> .....	49
B. TRAINING .....	50
<i>Training Settings</i> .....	50
<i>Student Opinions about Training</i> .....	57
<i>Training Program Dropouts</i> .....	59
<i>Supportive Services during Training</i> .....	60
C. RETENTION .....	67
<i>Case Management and Follow-Up</i> .....	67
<i>Innovations in Case Management and Follow-Up</i> .....	68
<i>Retention Strategies and Programs</i> .....	70
<i>Retention Issues</i> .....	72
<b>IV. PRELIMINARY FINDINGS</b> .....	<b>73</b>
A. GETTING STARTED .....	73
<i>What Works</i> .....	73
<i>Primary Barriers</i> .....	73
B. RECRUITMENT .....	75
<i>What Works</i> .....	75
<i>Primary Barriers</i> .....	76
C. TRAINING .....	77
<i>What Works</i> .....	77
<i>Primary Barriers</i> .....	78
D. EARLY DEPARTURE AND RETENTION .....	79
E. FUTURE DIRECTIONS .....	80
<b>BIBLIOGRAPHY</b> .....	<b>81</b>
<b>APPENDIX A: SAMPLE SITE VISIT GUIDE</b> .....	<b>83</b>
<b>APPENDIX B: PARTICIPANT AND STAFF INTERVIEW GUIDES</b> .....	<b>88</b>
<b>APPENDIX C: BASELINE INFORMATION FORM</b> .....	<b>94</b>
<b>APPENDIX D: CTI PARTICIPANT BASELINE INFORMATION, BY SITE</b> .....	<b>97</b>
<b>APPENDIX E: TRAINING SATISFACTION SURVEYS I AND II</b> .....	<b>102</b>
<b>APPENDIX F: PRELIMINARY FINDINGS--TRAINING SATISFACTION SURVEYS</b> .....	<b>109</b>
<b>APPENDIX G: EARLY DEPARTURE SURVEY FORM</b> .....	<b>115</b>
<b>APPENDIX H: PRELIMINARY FINDINGS –EARLY DEPARTURE SURVEYS</b> .....	<b>119</b>

### **Acknowledgements**

The authors wish to thank the twelve Regional Collaboratives, particularly the CTI program coordinators, whose cooperation was essential to this report. We acknowledge the kind assistance of David Illig, Steve Saxton, and John Milat, whose comments on the earlier draft were immensely helpful. Finally, thanks go to our own staff, Jordan Rickles, Paula Castro, Yukari Matsuyama, and Susan Truong, who have been diligent, patient, and organized as they collect, enter, and analyze program data.

# EXECUTIVE SUMMARY

## A. STUDY DESCRIPTION

The intent of the Caregiver Training Initiative (CTI) is to increase the number of health caregivers in the State of California. This initiative, which is part of the Governor's Aging with Dignity Initiative, has provided \$25 million through competitive grants to twelve Regional Collaboratives statewide for an 18-21 month period from early 2001 through late 2002. The goals of the CTI project are to address urgent workforce shortages through innovative approaches for recruiting, training, and retaining employees in the healthcare industry, and also to enhance the earning potential of health caregivers. The primary participants in the program are Workforce Investment Act (WIA) clients and Welfare-to-Work (WtW) clients.

The Regional Collaboratives selected to participate in CTI are:

- Greater Long Beach Workforce Development
- Employers' Training Resource Department of Kern County
- North Bay Employment Connection
- Northern Rural Training and Employment Consortium (NoRTEC)
- Riverside County Local Workforce Investment Area
- Sacramento Employment and Training Agency
- San Diego Workforce Partnership, Inc.
- Private Industry Council of San Francisco
- San Jose/Silicon Valley Workforce Investment Board
- Workforce Investment Board of Southeast Los Angeles County (SELACO)
- County of Ventura
- West Hills Community College District

## B. EVALUATION PLAN

This report describes CTI's first year of implementation and assesses program activity in recruiting, training and retaining caregivers. Subsequent evaluation analyses will address labor market issues and program outcomes, including the effectiveness of CTI in developing career ladders and improving work environments. A research team from the Ralph and Goldy Lewis Center for Regional and Policy Studies at the University of California at Los Angeles, and the Center for the Health Professions at the University of California at San Francisco is conducting the evaluation.

This process and implementation evaluation report focuses on one objective, "to determine whether CTI strategies were effective in increasing recruitment, training, and retention of caregivers." The analysis uses both qualitative and quantitative data. These have been obtained from site visits to all twelve sites, attendance at collaborative meetings, interviews with CTI staff and CTI participants, telephone conversations, satisfaction questionnaires administered

to program participants (N=245), questionnaires administered to those leaving the program early (N=37), baseline information on participants (N=2,333), and program participant data from the statewide WIA administrative database.

## C. PRELIMINARY FINDINGS

These preliminary findings are reported in terms of (1) what seems to work well, and (2) which barriers have arisen that may impede effectiveness.

### Getting Started

#### *What works*

Collaboratives with certain attributes have fewer problems getting started than those without. These attributes include:

- Previous experience in partnering, where collaborative partners worked together prior to the CTI grant, so that less time was needed initially to organize
- Previous experience working with state licensing boards, so that approval for starting a new training program could be facilitated more quickly
- Strong and effective collaborative leadership, from both the lead agency and the individual responsible for guiding CTI development and implementation
- A positive relationship with the California Employment Development Department Regional Advisor to facilitate swift resolution of problems related to administrative requirements

#### *Primary barriers*

- The short time spans between grant announcement and project start date, and the short time frame for the program, have been challenging. The time frame created challenges for consortia in resolving sub-contract negotiations and approvals, addressing confusion about eligibility and reporting requirements, and creating an infrastructure of courses, instructors and case managers.
- Not all collaboratives embrace collaborating equally. Investment in active and innovative collaboration among partners within collaboratives is uneven, in part due to different pre-existing organizational barriers, different enrollment goals among partners ranging from very small numbers to hundreds, and different stakes in the program based on varying budget shares among local partners.
- Identifying and expunging previous criminal records for clients so they can qualify for certification is a significant challenge. There are problems with delays in getting fingerprint results, misperceptions by CTI participants about the thoroughness of criminal checks, the complexity of the expungement process, and limited effectiveness of

background checks.

## **Recruitment**

### *What works*

- Overall, many types of recruiting efforts have been used. Recruiting has been effective since nearly all collaboratives are on target to meet or exceed their participation goals.
- Several outreach methods are useful in recruiting target groups of participants, including using community-based organizations and unions, developing relationships with employers, marketing through radio and TV, and sharing marketing materials among collaboratives.
- Some collaboratives are successful and innovative in targeting specific, and non-traditional, populations for caregiver training, including migrant farm workers, non-English speaking home care workers, and individuals likely to have prior healthcare experience (Medical Corpsmen, entry-level workers).
- A few of the collaboratives have adapted new applicant screening techniques or expanded their screening efforts to adjust for the unique requirements of caregiving.

### *Primary barriers*

- WtW participants are difficult to recruit and to qualify for training, in part due to social and educational barriers, and in part due to the work-first emphasis at most social service agencies.
- Limited English proficiency is a large barrier in California for low-income individuals who would like to seek caregiver training.
- The shortage of nurse instructors limits the capacity to increase the numbers of individuals recruited and trained.

## **Training**

### *What works*

- From the perspective of many collaboratives, the impact of collaboration on training has been positive since it encourages coordinating regional training resources. The result is a training system that can accommodate students more fully. Also, collaboratives appreciate the flexibility of CTI funding for the provision of support services, viewing it as a positive component of the program.
- From a student perspective, CTI participants overall are highly satisfied with CTI training. Fast-track training is a popular and efficient training approach for some CTI students, and on-the-job training is also very popular. Students are pleased with cash incentives, but these are used infrequently.

- From a staff perspective, students are more likely to stay in the program if they have intensive case management afforded by CTI funds, although we will not know the true impact of case management on retention until after the project ends. CTI staff also are positive about the impact of mentoring services, although these are not as widely used as originally planned in the proposals.

#### Primary barriers

- The most commonly needed training support services are transportation and childcare; availability and delivery of these services varies among collaboratives.
- Some CTI trainees, including WtW clients, or those in rural areas, require more extensive support services in order to complete a training program successfully.

### **Early Departure and Retention**

Although it is too early to comment on the program's impact on retention, some of the collaboratives have implemented features geared to improving retention. These include extensive screening and intensive case management, plus various supportive services during training. Subsequent reports will address retention issues and outcomes within the limits of a short-time window for following workers post-CTI.

### **Future Directions**

In summary, there are not enough health caregivers in California to respond to current demand from the elderly and other populations, resulting in threats to patient safety and compromised quality of care. The percentage of Californians over age 65, over age 85, and over age 95 will increase dramatically over the next two decades. The current critical worker shortage, which is worsening over time, cannot be relieved without a strong and meaningful commitment from the state. Such a commitment is exemplified by two more recent WIA-funded grants, \$10 million to health care facilities to train healthcare workers, and \$60 million for the Nurse Workforce Initiative to increase the number of nurses in the State. Hopefully, findings from these and similar programs will be useful in helping State decision-makers pinpoint key elements of organizational, financial, and operational successes in recruiting, training, and retaining caregivers, so that future programs can most effectively address California's healthcare workforce shortage.



# I. OVERVIEW

## A. INTRODUCTION

This report describes the early experience of collaboratives in the Caregiver Training Initiative (CTI), a statewide program intended to increase the number of health caregivers in the State of California. To address urgent workforce issues, the California Health and Human Services Agency/Employment Development Department selected twelve Regional Collaboratives to provide innovative approaches to recruiting, training, and retaining employees in the healthcare industry, and to enhance earning potential of health caregivers.

This report presents the results of the process and implementation evaluation conducted by an evaluation team of experienced faculty and staff at the Ralph and Goldy Lewis Center for Regional and Policy Studies at the University of California at Los Angeles, and the Center for the Health Professions at the University of California at San Francisco.

The report is organized into four chapters:

- Overview (background on healthcare workforce issues, CTI project description, the evaluation plan, and program participants)
- Getting started (site proposal overviews and implementation issues)
- Early program operation (recruitment and assessment, training, and retention)
- Preliminary findings

## B. BACKGROUND

A recent press release from the U.S. Department of Health and Human Services states that 90% of nursing homes lack adequate staffing, and that this shortage is expected to worsen in the future (Pear, 2002). Media reports frequently reference the “health care crisis” in the United States and even globally, and one part of this crisis is the shortage of entry-level workers. The extent of the problem varies, depending on who is reporting, but overall it ranges from “a serious problem” to “a very serious problem.” How did this crisis come about? Very simply, the demand for health care is rapidly growing, while the supply of workers is not keeping pace. These changes are due to a confluence of factors, some of which have emerged over the past two decades.

### **Factors Affecting the Demand for Healthcare Workers**

The elderly population is growing, and health care delivery is changing, adding to the demand for workers. For example, care of elderly people often was the responsibility of family

members; today, families are burdened with additional employment responsibilities, resulting in limitations on family capacity to provide informal care. Because of expanded Medicare and Medicaid benefits, more people are able to rely on formal as well as informal care supports. In the past couple of decades, we have seen constraints on hospital inpatient and nursing home payments and lengths of stay. Patients discharged while still in various stages of recovery now need more post-hospital care. Finally, technological developments have allowed more sophisticated treatment in outpatient settings and at home.

### **Factors Affecting the Supply of Healthcare Workforce**

While health services demand increases, the relative supply of workers remains too small. There is a “critical shortage of registered nurses” (U.S. General Accounting Office, 2001a; U.S. General Accounting Office, 2001c; U.S. Department of Health and Human Services, 2002), and there is a current shortage of Certified Nurse Assistants (CNAs) nationally and in California (Center for California Health Workforce Studies, 2001; California Department of Health Services, 2001). The shortage is a result of several trends, including low wages and benefits and competing occupations. Because so many competing jobs have higher salaries and lower demands (VanKleunen & Wilner, 2000), the population available for healthcare work is not keeping pace. Younger women, who had very limited career choices in the past, now have many more choices (Carrier, et al., 2000). The labor pool has not grown because interest in nursing as a career is decreasing as the nursing labor force is aging (U.S. General Accounting Office, 2001c). Working conditions are poor too. Workers are exposed to infections, back injuries, and physical violence from residents (Gregory, 2001). As a result, turnover is high, with rates for nurse aides ranging from 38 percent to 143 percent, and for LVNs ranging from 27 to 61 percent (Decker, Dollard & Kraditor, 2001). The large ranges are due in part to different study samples and different formulas for calculating turnover.

### **Who Are the Workers?**

In general, the federal government compiles data on three categories of entry-level healthcare workers: (1) nurse aides, orderlies and attendants; (2) home health aides; and (3) personal and home care aides. These three combined categories also are referred to as the paraprofessional workforce, allied healthcare workers, or direct care workers. Despite distinct definitions, there is considerable overlap among these jobs. Overall, these workers labor in a variety of settings, ranging from hospitals to nursing and group homes, to private homes. These caregivers provide health, personal care, housekeeping and home-management-related tasks for people of all ages with disabilities.

These workers, mostly women, are ethnically and racially diverse. Nationally, about 51% of nursing aides, orderlies and attendants are non-Latino white (hereafter designated as white), 35% African-American and 10% Latino; about 90% are women. For home health aides, 60% are white, 25% African American, and 10% Latino, and 79% are women (U.S. Department of Health and Human Services, 2000). Most workers are, not surprisingly, economically disadvantaged and have low levels of education, and many are coping with family responsibilities. Half of the nursing aides and a third of the home care workers have children under age 18 (Stone, 2000).

In California, about 56% of nursing aides, orderlies and attendants are white, 25% African-American, 13% Latino, and 3% are Asian/Pacific Islander. For workers in the In-Home Supportive Services program (IHSS), 39.5% are white, 14.7% Latino, 9.7% African-American, and 8.0% Asian/Pacific Islander (with 26.6% not reporting) (UCLA Lewis Center unpublished data based on the IHSS data set and the Current Population Survey, 2002).

## **What Are the Worksites?**

### *Home care*

The home care element of the healthcare industry is its fastest growing segment. In 1999 there were more than 7,700 Medicare-certified home health agencies nationwide; over 670,000 people were employed in these agencies (excluding hospital-based, public agency workers and private workers), of whom 326,000 were home care aides and 40,800 were LPNs, or LVNs in California (National Association of Home Care, 2000). These figures underestimate the total number of home care workers, since many are hired privately and thus not counted. Nationally, the June 2000 vacancy rate for nurse aides in home health care was 8 percent (U.S. General Accounting Office, 2001e).

In California, home healthcare services accounted for the employment of 34,400 people in 1998 (U.S. Department of Health and Human Services, 2000), similar to the 1998 state estimate of 23,300 home health workers plus 13,600 personal and home care aides (California Employment Development Department, 2001). An additional 200,000 people provide care under the auspices of California's IHSS program.

### *Nursing homes*

Nationally, nursing homes employ 1,855,000 healthcare workers. About 38% of nursing home workers are personal care, home health and nursing aides, 11% are LVNs and 9% are RNs (U.S. Department of Health and Human Services, 2000). Certified Nurse Assistants (CNAs) are the principal caregivers in these homes. In 1997, CNAs held about 65% of all nursing home direct-care jobs; they averaged 40 minutes of patient care per resident per eight-hour shift, compared with only 14 minutes for LVNs and 10 minutes for RNs (Gregory, 2001). The June 2000 vacancy rate for nurse aides in nursing homes was 16 percent (U.S. General Accounting Office, 2001e).

In California, there are just under 125,000 nursing home workers (U.S. Department of Health and Human Services, 2000) of whom 11,211 are registered nurses. If the California proportions are the same as national proportions, then about 47,500 workers are aides and 13,750 are LVNs. From 1988 to 1998, nursing and personal care facility employment in the state grew by 18%, and in 1998, California employed 0.93 workers per bed compared with the national average of 1.02 workers (U.S. Department of Health and Human Services, 2000). More recently, California legislators enacted a law requiring skilled nursing facilities (SNFs) to meet a 3.2 hours per patient day standard by April 2000; staffing levels have increased significantly, although 33% of SNFs surveyed in 2001 were not in compliance (California Department of Health Services, 2001).

### Hospitals

Nationally, there were almost five million hospital employees in 1998, with about 408,000 hospital employees in California (U.S. Department of Health and Human Services, 2000). This represents 40.2% of this state's health service workforce. Registered nurses comprise the largest proportion of hospital employees --26% of the hospital workforce. LVNs comprise 5% and direct care workers such as aides, orderlies and attendants represent 6% (non-health professions comprise 36%). The number of full-time hospital healthcare workers per capita in California declined from 1992 to 1998 by 3%, compared with no change nationally.

## **Where are Healthcare Workers Trained in California?**

For some entry-level workers, such as home care workers, there are no training requirements. CNAs must have 150 hours of training, and LVN training typically takes 18 months. (Job category variations in training requirements are discussed in more detail below.) Future healthcare workers can choose from various training sites that include facility- or employer-based training, regional occupational programs, adult education programs, and community and four-year colleges.

### Facility-based (or employer-based) training

According to California's Licensing and Certification Program in the Department of Health Services, most training for CNAs is conducted through training facilities such as hospitals or long-term care facilities that employ or make an offer to employ a student during the training period. Based on federal nursing home regulations, these facilities are required to pay training costs and hourly wages while the person is in training. Also, trainees must complete training within four months, or else stop performing patient care duties. (The pros and cons of this type of training are discussed below.)

### Regional Occupational Programs

Regional Occupational Programs (ROPs, or ROCPs, Regional Occupational Centers and Programs) are listed as partners in most of the CTI collaboratives. In California, there are 72 ROPs. They consolidate federal and state education funds to provide entry-level career technical training and workforce preparation for students 16 years and older. They offer comprehensive employment training, support services such as counseling and referrals, and placement for high school students and adults.

### Adult education

The California Public School Adult Education Program provides life-long educational opportunities and support services to adults. These programs provide adults with the knowledge and skills necessary to participate effectively as productive citizens, workers, and family members. Specific to the CTI project, these programs are the primary delivery system of a curriculum in the areas of basic reading, writing and math skills for adults, General Education Development certificates, and English as a Second Language (ESL). In the CTI program, the adult school partners function as main sources for supplemental education or training pre-requisites. With ROPs, they also support many CNA training programs.

### Community colleges

With 2.5 million students, the California Community College system is the largest higher educational system in the world; it consists of 108 two-year public institutions. These schools offer academic and vocational education at the lower division level for both younger and older students, and provide education, training, and services that contribute to workforce improvement. Their functions include remedial instruction, instruction in English as a second language (ESL), adult noncredit instruction, and support services such as counseling and referrals to help students succeed at the post-secondary level. All of the CTI collaboratives include at least one community college as a partner. Most LVN training is through the community college system.

### Four-year colleges

Registered nurse training programs culminating in BS degrees are offered at 26 four-year institutions in California. Thirteen of these are private colleges, and thirteen are part of the California State University System, a network of 23 campuses and 388,700 students. In 1998, about one-quarter of California's nurse graduates received BS in Nursing degrees, with the remainder receiving two-year degrees. About 12,000 RNs were licensed during the fiscal year 1999-2000, according to California's Board of Registered Nursing.

## **Healthcare Worker Training Requirements and Programs**

Table 1 below summarizes the training and licensing requirements for various healthcare worker categories in the state. It includes the position title, required training, licensing mandates, and the necessary qualifications.

Table 1. Training and licensing requirements for healthcare workers in California			
Position	Training	Licensing	Qualifications
Personal and home care aides	No training required, except by some counties for IHSS workers registered under a Public Authority. Some counties offer voluntary basic caregiver training, usually 25-40 hours	No certificate or license.	None specified, except for IHSS workers. IHSS workers must be at least 18 years old, or have a work permit. Some counties request a criminal background check.
Nurse Aides/Asst	A few employers (hospitals, nursing homes) require some training or some experience.	No license or certificate.	None specified
Certified Nurse Assistant	150 hours total, 50 hours classroom +100 hours supervised clinical training	Certificate only (no license). Must complete a competency exam conducted by a state department-approved vendor. Renewal every 2 years with 48 hours of in-service training.	-Must be at least 16 years old. -Health screening and TB test -Criminal background check
Home health aides	65 hours of theory + 55 hours of supervised clinical training, or 40 hours total if combined with CNA	Certificate only. Renewal every 2 years with 48 hours of in-service training, or automatically with CNA renewal.	-Must be at least 16 years old. -Health screening and TB test -Criminal background check
Medical Assistant	In clinics/doctors' offices, or in adult/vocational schools: for 22 weeks to 1 year;	No licensing required, but CMA and RMA are national credentials, and are "desirable"	-H.S. Diploma or GED desirable
Licensed Vocational Nurse	1,530 Total Hours: Theory - 576 Hours; Clinical - 954 Hours *Includes Pharmacology - 54 Hours Program Length: -Full-Time 12-14 Months of Training -Part-Time 18-20 Months of Training	The CA Board of Vocational Nursing and Psychiatric Technicians (BVNPT) are responsible for examination and licensure. The Board contracts with the <u>National Council of State Boards of Nursing, Inc.</u> for the LVN exam (NCLEX). Renewal every two years.	-High school education, or equivalent -Fingerprinting

Position	Training	Licensing	Qualifications
Psychiatric Technician	1,530 Total Hours: Theory - 576 Hours; Clinical - 954 Hours Full-time 12-14 Months or part-time 18-20 months of training	The CA Board (BVNPT) is responsible for examination and licensure of about 450 PT applicants annually. Renewal every two years.	-High school education, or equivalent -Fingerprinting
Registered nurse	Either a two-year community college program, or a four-year college program, combining RN with a BS	License required from the State Board of Registered Nursing. Need to complete 30 hours of continuing education every two years at the time of license renewal.	-High school education, or equivalent -Fingerprinting

Sources: California Health and Human Services Agency, Department of Health Services, Nurse Assistants, Home Health Aides, Hemodialysis Technicians: Certification Facts, 2001; California Board of Vocational Nursing and Psychiatric Technicians, at <http://www.bvnpt.ca.gov/factvn.htm>; California Employment Development Department at <http://www.calmis.cahwnet.gov/file/occguidc>; and California Board of Registered Nursing at <http://www.rn.ca.gov/about/about.htm>

*Personal and home care aides, including IHSS workers*

In California, most home care workers are employed by In-Home Supportive Services (IHSS), an entitlement program for low-income people with disabilities. About 195,000 IHSS users in California receive support to hire someone to provide personal care and domestic services. Several counties in the state have established Public Authorities which then become the employer and assist the providers in obtaining access to training and education. For example, in Los Angeles County, this Public Authority and the Service Employees International Union have joined together to establish a provider skills training curriculum. In general, however, there is little or no training required for IHSS or other home care workers.

*Certified Nurse Assistant/ Home Health Aides*

There are currently about 100,000 CNAs and 786 programs to train CNAs in California. Training is widely available in community colleges, adult education programs, private vocational schools, and Regional Occupational Programs. These are enumerated in Table 2 below. Over 38% of the CNA programs are offered through facilities such as nursing homes or hospitals, with about one-third of the programs offered through ROPs and Adult Education programs. The community college sector offers the smallest proportion of programs (9.2%) but has seen the largest growth, more than doubling in the past five years.

Most Home Health Aide (HHA) training programs are offered in conjunction with CNA training programs. In California, there are about 35,000 certified HHAs. Most of these, about 32,000, have both CNA and HHA certificates. Conversely, about one-third of CNAs also have HHA licenses.

Table 2. Approved CNA training programs in California

	1996	2001	% change over 5 years	% of total programs
Facility-based	323	300	-7%	38.2%
ROPs/Adult Ed	217	252	+16%	32.1%
Community Colleges	34	72	+112%	9.2%
Proprietary	121	162	+34%	20.6
TOTAL	695	786	+13%	100.0%

Source: Licensing and Certification Program, California Department of Health Services, 4/01.

Note: From 1,342 facilities, 102 are unable to train for 2 years because of federal deficiencies.

### Medical Assistants

Medical assistants are unlicensed health professionals who do clerical work, simple lab work and clinical tasks under supervision in a medical office or clinic setting. They are trained in doctors' offices and clinics, or they can be trained in more formal settings such as adult/vocational schools or junior colleges. Programs can range in time from 20 weeks to one year, or two years with an AA degree. Licenses can be obtained through national associations, but are not required by the state (although they may be required by malpractice insurance carriers).

### Licensed Vocational Nurse, and Psychiatric Technician

According to the California Board of Vocational Nursing and Psychiatric Technicians, there are 96 accredited vocational nursing schools in the state, and 11 accredited psychiatric technician schools. Most of the LVN programs are in the community college system (N=45), although many (N=23) are part of adult education programs. For example, Los Angeles Unified School District has nine separate LVN programs in adult schools and technology centers. Nineteen programs are in private schools, eight are in ROPs, and one is hospital-based. In 1998 there were about 50,000 LVNs employed in California (U.S. Department of Health and Human Services, 2000).

### Registered Nurse

RNs must be licensed to practice in California by the State Board of Registered Nursing. Two types of Registered Nurse training programs are available in California: two-year community college associate degree programs and four-year bachelor's degree programs. Most community colleges give Licensed Vocational Nurses (LVNs) credit for their basic nursing course work and experience. Currently, there are about 250,000 licensed registered nurses in California, according to the state licensing board.

## **C. CTI PROJECT DESCRIPTION**

The purpose of the Caregiver Training Initiative (CTI) is to recruit, train, and retain health caregivers in the state of California. The goals of the CTI project are to address urgent workforce issues by developing innovative approaches for recruiting, training, and retaining healthcare employees, and also to enhance the earning potential of health caregivers. Twelve statewide Regional Collaboratives were awarded competitive grants for an 18- to 21-month period from early 2001 through late 2002. The primary participants in the program are



Workforce Investment Act (WIA) clients and Welfare-to-Work (WtW) clients. The state's Employment Development Department under the Health and Human Services Agency is administering the \$25 million federally- and state-funded program.

The twelve collaboratives selected to participate in CTI are:

- Greater Long Beach Workforce Development
- Employers' Training Resource Department of Kern County
- North Bay Employment Connection
- Northern Rural Training and Employment Consortium (NoRTEC)
- Riverside County Local Workforce Investment Area
- Sacramento Employment and Training Agency
- San Diego Workforce Partnership, Inc.
- Private Industry Council of San Francisco
- San Jose/Silicon Valley Workforce Investment Board
- Workforce Investment Board of Southeast Los Angeles County (SELACO)
- County of Ventura
- West Hills Community College District

These twelve collaboratives include most of California's 58 counties. From the twelve sites, three were selected as focus sites on which the evaluation team would concentrate more fully: San Jose/Silicon Valley Workforce Investment Board, Greater Long Beach Workforce Development and Employers' Training Resource Department of Kern County. These sites were selected because they are geographically and demographically diverse, and thus more representative of the state as a whole. About nine months into the project, a fourth site, Sacramento Employment and Training Agency, was added to accommodate the need for higher combined enrollment figures at the focus sites.

## **D. EVALUATION PLAN**

This report will describe CTI's first year of implementation and how effective the initiative has been thus far in recruiting, training and retaining caregivers. The focus of the evaluation is outlined in the project's six major objectives. The first objective (highlighted below) will be the centerpiece of this report since it is most pertinent to the initiative's process and implementation. The final report (due October 2003) with its focus on CTI outcomes will address all six objectives. Objectives are:

- To determine whether CTI strategies were effective in increasing recruitment, training, and retention of caregivers;
- To determine whether the CTI can develop and implement effective career ladders for caregivers;
- To determine whether CTI strategies contributed to improved work environments for caregivers and other staff;
- To assess the impact of CTI strategies on the populations in receipt of caregiver

resources;

- To develop a better understanding of the labor market for caregivers including external policy and other factors affecting the market;
- To suggest improvements in the program's design and operation.

### **Implementation and Process Study Research Questions**

The implementation and process questions address the first objective above. The implementation part of the evaluation addresses procedural issues, or how well the program does what it is supposed to do. In other words, is the initiative being implemented as designed? The three implementation questions listed below address issues raised as the Regional Collaboratives initiated each project.

1. To what extent do the funded projects test innovative strategies versus traditional recruitment, retention, and training methods?
2. What barriers were identified to attracting and retaining qualified caregivers? Were these barriers overcome, and if so, how?
3. How well did the Regional Collaboratives contribute to addressing the problem of regional labor shortages in the healthcare industry?

Process evaluations provide information on what a program does, and what effect it is having on those in the program. The process evaluation looks at the formal activities and anticipated outcomes of a program, and also investigates informal patterns and unanticipated interactions. (Often there is overlap, as there is here, between the process and implementation parts of the evaluation.) Answers to the seven process evaluation questions below will describe what the program is and does.

1. How well did the solicitation and competitive selection process identify the best solutions to removing barriers for attracting and retaining qualified caregivers?
2. What efforts have county welfare departments made to increase interest by CalWORKs (California's version of Welfare-to-Work) participants in the healthcare provider and caregiver industry?
3. How effective were the marketing and outreach strategies in attracting eligible participants to begin careers in the healthcare industry?
4. What recruitment methods were most successful/unsuccessful?
5. How well did the Regional Collaboratives do in developing and implementing formal and on-the-job training programs to prepare, hire, and retain qualified caregivers?
6. What assessment processes do county welfare departments and/or employers use to ensure that caregiver occupations would be an appropriate match for the participants' skills, knowledge, abilities, and values?
7. How effective were the training strategies used to prepare participants to advance in the healthcare industry?

## **Evaluation Design**

This process and implementation analysis uses both qualitative and quantitative data. These are obtained from site visits to all twelve sites, attendance at collaborative meetings, interviews with CTI staff and CTI participants, telephone conversations, satisfaction questionnaires administered to program participants (N=245), questionnaires administered to those leaving the program early (N=37), baseline information on participants (N=2,333), and data from statewide administrative data sets.

The final report (due in late 2003), will focus on outcomes, will rely mostly on quantitative data, and will include all participants since it is designed as a post-program report. For that report, we will merge multiple statewide administrative data sets, including WIA, WtW, Employment Development Department (EDD) Base Wage data, and CNA licensing information. Merging CTI participant data from several datasets will strengthen our understanding of participants. We will use matching to construct quasi-control groups (e.g., WIA- and WtW-eligible people) to compare with CTI participant groups.

Because this report focuses on process and implementation (rather than outcomes), and because the program is still enrolling participants, we rely more heavily on qualitative data and descriptive reporting. The only administrative data used for the present report are WIA-based data on CTI participant education and “limited English.” CTI participant information from the Baseline Information Forms (described below) supplements WIA data; both sources provide demographic information for each participant.

### *Focus sites*

One of the evaluation team’s first tasks was to select three collaboratives as “focus sites” for more in-depth study. After consulting with state personnel, we selected Greater Long Beach Workforce Development, Employers’ Training Resource Department of Kern County, and the San Jose/Silicon Valley Workforce Investment Board. These three collaboratives were diverse in terms of location within the state, regional economics, urban versus rural, and multiple versus single-county partners. Late in 2001, we included Sacramento Employment and Training Agency as a fourth focus site; this was in response to a slow startup for two initial focus-site collaboratives, resulting in smaller-than-anticipated numbers of respondents.

Information about the four focus collaboratives (optional for the other eight collaboratives) comes from:

- Follow-up site visits after the initial visit
- Attendance at collaborative meetings by evaluation team members
- Face-to-face interviews with CTI staff and participants
- Training Satisfaction Questionnaire-I administered to program participants (by the collaborative)
- Follow-up Training Satisfaction Questionnaire-II (telephone-administered by UCLA)
- Telephone interviews with program dropouts (conducted by UCLA)

Because initially there were too few dropout interviews, we asked the other eight collaboratives in late 2001 for names and telephone numbers of their dropouts.

In this report, we describe process and implementation for the four focus sites in more depth than for the other sites. In some cases, (more so for focus sites) we identify collaboratives by name. In other cases, especially when identification does not add to the purpose of the discussion, or when several collaboratives are described as a cluster, the collaboratives are not identified by name.

## **Data Sources**

The use of multiple data sources contributes to the richness of the findings. While quantitative data collection is geared to findings that are formal and anticipated, qualitative data sources enable the evaluation team to incorporate informal and unanticipated program patterns. The sources of data specific to this process evaluation are listed below.

### *Site visits and face-to-face interviews*

The evaluation team is using multiple approaches to examine this initiative. For the implementation and process parts of the evaluation plan, we rely in part on face-to-face interviews conducted during site visits and during follow-up visits at the four focus sites. We continue to attend collaborative meetings and have telephone conversations with collaborative members.

We conducted initial site visits to each of the twelve sites and met with key CTI representatives during July and August 2001. We originally planned to visit sites earlier in the spring, but none of the sites were far enough along with the project to accommodate us that early. For each site visit, we prepared a summary site visit guide as a basis for discussion. We sent these to the sites during the week prior to the visit so that each site would be aware of discussion topics. (See Appendix A, Sample Site Visit Guide).

These guides were based on collaborative proposals and contained questions about individual collaborative features. The site-specific questions were followed by general questions concerning assessment methods and recruiting Welfare-to-Work participants. The site interviews covered the following general topics:

- CTI program design, goals, and objectives for the twelve sites
- innovations in recruitment, training and retention, and the level of difficulty associated with each
- marketing and recruitment methods
- assessment processes used to assure a good match
- targeted audience for participation
- barriers to recruitment and training
- clinical and classroom training sites and programs
- efforts to increase interest of WtW participants
- employer outreach
- support systems
- retention efforts
- strengths and weaknesses of the training programs

In addition to the twelve site visits, we conducted 16 in-depth interviews with staff and

participants at three focus sites--San Jose, Long Beach and Kern-- and 13 interviews at the fourth site, Sacramento, despite its later inclusion. Appendix B contains sample participant and staff interview guides. These guides were not rigidly followed, however, since not all questions were applicable to all staff or to all participants.

#### Baseline Information Forms

Data from participant questionnaires are useful for this preliminary evaluation. For this report, we use background data from 2,333 Baseline Information Forms, collected from each participant at all twelve sites. A sample form is included in Appendix C. These completed forms provide descriptive information about current CTI program participants. In the final report, these baseline data will be supplemented with information from the WIA database. The merger of WIA information with baseline information will yield a complete demographic description of the CTI participants. Later, the evaluation team will link program participant data with administrative data such as the EDD Base Wage files. These data merges will enable analysis of comparisons of wages earned and quarters worked.

#### Training Satisfaction Questionnaires

CTI staff at the four Regional Collaborative focus sites administer on-site brief Training Satisfaction-I Questionnaires to participants about three-quarters of the way through the program. This questionnaire provides information about sources of satisfaction and dissatisfaction with the program. As of February 15, 2001, data from 245 CTI Training Satisfaction-I Questionnaires have been analyzed, although findings (presented later) are preliminary. The final report will include training satisfaction information for a larger number of participants.

The follow-up questionnaires, Training Satisfaction-II, are telephone-administered by UCLA about six months after the first questionnaire is administered. This process is just underway. To date, the team has conducted 17 Training Satisfaction-II interviews. The topics covered in both Training Satisfaction I and II questionnaires (included in Appendix E) are:

- demographic information (age, gender, etc)
- previous healthcare work
- assessment of classes and instructors
- usefulness of training
- reasons for participating in the program
- best and worst parts of the program
- future plans (follow-up only)

#### Early Departure Survey

We are conducting a small telephone survey of people who have dropped out of the program. Initially, we planned to ask only focus sites for names and phone numbers of dropouts, but it soon became clear that the focus sites would not yield enough names for a meaningful analysis. This was especially problematic since many of those dropping out of the program were difficult to contact later, due to wrong phone numbers, and other problems. Now, all sites have been asked to supply names and phone numbers of participants who drop out of the CTI program. UCLA evaluators attempt to contact those leaving the program as soon as we receive a list of dropout names and telephone numbers.

The Early Departure Survey is conducted over the telephone, and takes about 10-15

minutes. The topics covered in this survey (Appendix G) are:

- demographic information (age, gender, etc)
- previous healthcare work
- reasons for leaving the program
- what the program could offer to increase retention

So far, there are 37 completed Early Departure Surveys. Responses to these will be discussed in the section on Training (Chapter III-B).

Listed in Table 3 below is a summary of the surveys and questionnaires administered as part of the process and implementation evaluation. (The final report, focusing more on outcomes, will include administrative data as well, not included in this table.)

Table 3. Summary of Surveys and Questionnaires Used for the Evaluation.

	Name of instrument	Mode of administration	Duration	Intervals of administration	Who is administering?
Preliminary findings presented in this report	Staff and Participant In-Depth Interviews (S) and (P)	Face-to-face interviews at four of the sites, supplemented by telephone interviews	30-45 minutes	Most people interviewed only once, unless a follow up is indicated.	UCLA/UCSF will administer but will need info (names, phone #s) from the sites
	Baseline Information Form (P)	Questionnaire; will use this in conjunction with WIA data intake form	5-10 minutes	Once, at program intake	All 12 sites; program intake staff personnel
	Training Satisfaction Form-I (P)	Questionnaire administered by site personnel and sent to UCLA	10-15 minutes	Once, when trainee is about 75% through the training program	Training program administrators at 4 focus sites will hand them out
	Early Departure Survey (P)	Telephone interview conducted by UCLA	10-15 minutes	Either 6 months or 12 months after program starts	UCLA will administer by telephone
...in Final Report	Training Satisfaction Form-II (P)	Telephone interview conducted by UCLA	10-15 minutes	Once, about 6 months after program completion	UCLA will administer but will need info (names, phone #s) from the sites

S=CTI Staff; P= CTI Participants

### **Limitations**

The design of this study poses several limitations. First, there is the challenge of consistent administration of the Baseline Information Forms and Training Satisfaction Questionnaires which are administered by the collaboratives in multiple sites. To minimize inconsistency, the evaluation team instructed each collaborative, both verbally and in writing, how and when to administer these questionnaires. In addition, we have been available by

telephone and email to provide technical assistance to those collaboratives that have had problems or questions (about half did). Generally those questions were readily resolved. The Training Satisfaction-II Questionnaires and Early Departure Surveys are telephone-administered by university staff, so consistency was not expected to be a problem. For the most part, both Baseline Information Forms and Training Satisfaction Questionnaires submitted to the evaluators from the collaboratives have been completed accurately, and responses seem valid.

Second, most of what the evaluation team learns qualitatively about each collaborative's processes and implementation necessarily comes from that collaborative's partners. If partners are hesitant to share information, as could be the case under various circumstances, this could limit our ability to obtain information. There are also problems related to recall bias. When questions pertain to something that happened several months before, staff or student recall can be limited or distorted. We addressed this potential problem in the evaluation design by collecting and validating information from several respondents at each site.

Third, ideally we would like to know about the recruitment pool that responded to CTI marketing and recruitment efforts but that did not enter the program. We do not know how many prospective applicants called the toll-free telephone lines or came to orientations, but did not follow through to enrollment, for whatever reason. Because each site recruited differently, it has been difficult to determine how or why potential applicants were lost to the program. At the end of the CTI program, we will collect available marketing information (e.g., how many CTI phone queries sites had) from each collaborative in an attempt to address this issue.

Fourth, we do not know how many CTI participants would have gone into healthcare work even without CTI. We hope to address this in part by sampling non-CTI CNAs (depending on collaborative and/or CNA testing site cooperation) to determine how they heard about their CNA training program, why they chose healthcare work, their work history, and primary language. This would enable comparison of differences in the experience of workers trained under CTI and others in the worker pool.

Finally (this limitation has more relevance for the outcomes study), it is not feasible to utilize an experimental design with a randomly-assigned control group of non-CTI trainees and an experimental group of CTI trainees. As a result, we do not know if people in the program are more enduring or more effective workers than those without such a program. To address this shortcoming, we will be constructing quasi-control groups of non-CTI WIA and WtW participants who are matched by certain characteristics with the CTI WIA and WtW participants. With this, we hope to compare (cautiously) the progress of these four groups over time.

## **E. PROGRAM PARTICIPANTS**

Before discussing our analysis of CTI implementation and process, we will describe the CTI participants. Descriptions are based on 2,333 participants for whom there were Baseline Information Form data on January 24, 2002. About 30%, or 688 of these are Welfare-to-Work (WtW) clients, and the rest are participants eligible under the Workforce Investment Act (WIA) program. Because the methods of recruiting from these two groups differ somewhat, and because the populations in each of these groups are also different, Tables 3 to 5 below show the program participants' characteristics, based on their WtW versus WIA eligibility status. In

addition, Appendix D has the same information on participants, by site.

### **Participant Demographics**

WIA participants are slightly older than those in WtW, and more are married and divorced (Table 4a). Over half of those in WtW were never married; 40.5% of WIA participants never married. About three-quarters of the WtW participants have children living with them, compared with 60.9% of the WIA participants.

More of the WIA participants report another adult in the home who works full-time (37.7%) or part-time (8.8%) than the WtW participants, although the WtW group report more people on average working part-time. More WIA participants own cars than WtW participants.

Table 4a. CTI Participant Profile, by Eligibility Status (As of January 24, 2002)

	WtW	WIA	Total
Number of CTI Participants	688	1,645	2,333
Mean Age (years)	29.1	31.3	30.7
Marital Status (%):			
Married (and living with spouse)	21.2	31.0	28.1
Separated (or living apart from spouse)	14.7	7.4	9.6
Divorced	7.6	12.6	11.1
Widowed	1.2	1.8	1.6
Never Married	51.5	40.5	43.7
Ref/Unknown	3.9	6.8	5.9
Children Living with You (% Yes)	75.7	60.9	65.2
.....(if yes) Mean number under 5	0.8	0.8	0.8
.....(if yes) Mean number 5-17	1.3	1.2	1.2
Other Adults in Home Work Full-Time (% Yes)	30.6	37.7	35.6
....(if yes) Mean number who work FT	1.3	1.3	1.3
Other Adults in Home Work Part-Time (% Yes)	8.0	8.8	8.6
....(if yes) Mean # who work PT	1.4	1.2	1.2
Own a Car (% Yes)	52.8	61.3	58.8

### **Participant Work Histories**

Questions are included about participant work histories in order to understand their level



of exposure to health caregiving (See Table 4b). One question asks if the participant “regularly cared for someone who is sick, disabled, or elderly,” and about three in ten respond positively. The percentage is higher for the WIA group. Among those who are already caregivers, the proportion of those who get paid is also higher for the WIA group (55.7% versus 39.3%). However, the proportion of caregivers caring for a relative is higher for the WtW group (44.8% versus 33.9%).

More of the WIA group worked in the last week (41% versus 31%), and their mean hours are also higher. More of the WIA group also worked in the past year, well over half. About one in three of all respondents worked in a health-care related job, and again, the proportion is higher for the WIA group. Similarly more of those in the WIA group had some previous training in health care (39.9% versus 30.7%).

In summary, the WIA group has more work experience, more healthcare work experience, and more healthcare training. Fewer of the WIA group have children, but more are living with their spouse. This indicates that overall, those who are WIA-eligible do not have as many challenges as those in the WtW-eligible group. In future analyses, we will include data from the WIA database (not available for analysis at this time) on other demographic characteristics, providing a more comprehensive portrait of CTI program participants.

Table 4b. CTI participant work history, by eligibility status (N=2,333)

	WtW	WIA	Total
Regularly Care for Someone (% Yes)	23.7	30.9	28.8
.....(if yes) Are you paid (% Yes)	39.3	55.7	51.7
.....(if yes) Is it a relative (% Yes)	44.8	33.9	36.5
Worked Last Week (% Yes)	31.4	41.2	38.3
.....(if yes) Mean number of hours	28.9	32.5	31.6
Worked in Past Year (% Yes)	44.5	56.6	53.0
.....(if yes) Mean number of weeks	32.0	34.7	34.0
Health-Care Related Job in Past Year (% Yes)	22.8	34.6	31.1
.....(if no) Health-care job ever (% Yes)	15.7	17.7	17.1
Previous Training in Health Care (% Yes)	30.7	39.9	37.2

### **How Participants Heard about the Program**

In asking participants how they found out about the CTI program, we originally specified a number of possible sources but not the following four: (1) school; (2) career center; (3) employer/at work; and (4) union. We added these categories after looking through more than 700 responses to the “other” category question and determining that there were enough responses for separate categories. We recoded many of the “other” responses into prior categories. For example, if someone wrote “my aunt” in “other,” we recoded it as “someone else.”

Most people heard about the CTI program through “someone else” or from “a county

worker” (See Table 5). Understandably, more WtW than WIA participants heard through their county worker. About three in ten WtW people heard about the program from a case manager or other county worker compared with about half that many for the WIA program participants. About one in ten heard about the program through their school (8% for WtW versus 12% for WIA).

Table 5. Source of information about the CTI program, by eligibility status

	WtW N=688	WIA N=1,645	Total N=2,333
How Heard About the Program (%):			
Newspaper ads	6.95	8.42	8.00
Bulletin boards/posters	2.91	2.63	2.71
Newsletter/ mailing	3.39	5.85	5.15
County worker	30.37	15.75	19.91
Someone else	28.27	30.72	30.02
TV/radio	1.94	2.38	2.25
Brochures	4.04	4.88	4.64
Job fair	0.81	1.09	1.01
Web-site	0.32	0.19	0.23
School	8.08	11.89	10.80
Career Center	2.91	2.31	2.48
Employer/At Work	0.97	3.41	2.71
Union	0.48	1.03	0.87
Other	8.56	9.45	9.20

Media sources were less commonly cited as sources of information about the CTI program. However, it is likely that the “someone else” who told the participant about the program had heard about it through a media-advertised source. Newspaper ads attracted a few more WIA participants than WtW participants (8.4% vs. 7.0%), and the same could be said for newsletters/mailings, brochures, and TV/radio ads. Job fairs and websites had very low responses for both groups. Many more WIA than WtW participants heard about the program from employers (3.4% vs. 1.0%).

## II. GETTING STARTED

The twelve CTI collaboratives faced a range of implementation issues early in the grant period. This section will review the sites' goals, and discuss implementation issues and how they are being addressed. First, the following section provides brief overviews of each of the sites' project plans as stated in their proposals.

### A. SITE PROPOSAL OVERVIEWS

#### **Employers' Training Resource Department of the County of Kern**

##### *Goals*

The approach Kern is pursuing is three-fold—attract, train and retain. “Key areas in this comprehensive service process include marketing services to attract qualified candidates; collaborative services to provide training; and retention services for program sustainability.”

##### *Marketing and Recruitment Strategies*

Marketing and recruitment will be through job fairs, mass media, program website, referrals from LTC and acute facilities (of both applicants and incumbent workers desiring skill upgrade), onsite high school recruitment, promotional materials enclosed with CalWORKs checks, referrals from DHS, direct promotion to farm workers. There are two marketing phases: (1) three healthcare industry specific job fairs in Bakersfield, Visalia and Hanford, and (2) ongoing media advertisement.

##### *Training*

Sites are California College of Vocational Careers and Bakersfield College (weekend, evening, televised classes, and onsite classes). The employers are Delano District Skilled Nursing Facility, Valley Convalescent Hospital, California Care Center, and Emmanuel Parkview Convalescent Center Facility (donating classroom space, equipment, clinical settings). Delano District SNF also pledged \$10,000 to supplement training costs. Supports are childcare, transportation, mentoring, career guidance, work schedule flexibility, English, ESL, math classes (through local adult schools and the Mexican American Opportunity Foundation), and employer incentives (on-the-job training contracts and tax incentives). Training programs are for CNAs, LVNs, RNs and Geriatric Nurse Practitioners.

##### *Retention*

Features are: (1) continued marketing and promotion to encourage new enrollment; (2) trained personnel dedicated solely to this project work with clients to promote completion, certification, job placement; (3) program employer partners committed to hiring CTI trainees (e.g., Delano District SNF committed to hire 10 new CNAs per year); (4) job counseling to be provided to incumbent workers increasing their skills; (5) creation of a Geriatric Nurse Practitioner (GNP) program to reduce demand for lower skilled workers in long term care; (6) tax credits to employers who hire WtW recipients; and (7) \$1,000 to employers who hire and retain eligible CalWORKs recipients for at least 6 months.

## **Greater Long Beach Workforce Development System**

### **Goals**

The general goals at Long Beach are to increase availability of skilled homecare workers in LA County, provide homecare workers with greater access to California's publicly funded job training and educational systems, advance skilled homecare workers to higher wages through advanced training, and build capacity of Service Employee International Union (SEIU) locals to collaborate with the workforce investment system to sustain healthcare career advancement after the grant period ends.

### **Marketing and Recruitment Strategies**

Marketing includes outreach to locate and identify members of the target group, promotion through newspapers and fliers in various languages, presentations, informal meetings, initial group screenings, and established linkages with community-based organizations. The California State University, Long Beach (CSULB) CNA program, SEIU Local 434B Homecare Workers Union, and the CNA Local 399 will serve as bases of recruitment for LVNs. Recruitment also will be conducted through outreach programs from the CSULB Center for Career Studies and a campaign to local healthcare employers.

### **Training**

Training will be offered at Pacific College, the CSULB Center for Career Studies, and Long Beach City College. Highlights include: (1) a newly developed homecare worker training class for 750 new or current IHSS workers; (2) customized Alzheimer's training for participating homecare workers; (3) a consumer training component for IHSS consumers about their rights and responsibilities; and (4) development of a career ladder program combining counseling with advanced training for CNA, HHA, and LVN certification. Other program components are job development to match homecare workers with IHSS consumers, and facilitation of transition to homecare workers Local 399 after advancement. Supportive services include Vocational English as a Second Language (VESL) classes, life skills, and soft skills incorporated into training as needed, and case management performed by the CSULB Center for Career Studies and Long Beach City College. Referrals to other agencies for support will be made as needed. Programs are to train IHSS workers, CNAs, HHAs, and LVNs.

### **Retention**

Retention methods include having additional/continued case management, using job developers and job coaches, encouraging employers to take advantage of tax credits and incentives, and providing graduates with individualized assistance and professional development materials.

## **North Bay Employment Connection**

### **Goals**

The goal is to create a career ladder for incumbent workers from IHSS all the way to RN, with interim steps including CNA, HHA, Psychiatric Technician, Radiology Technologist, and LVN. A related goal of the grant is to develop an administrative and support career ladder for clinical medical assistants, medical records technicians, and transcriptionists. The career ladder

model is also a “work-first” model, and local employers are committed to hiring and training participants.

#### Marketing and Recruitment Strategies

Recruitment methods include: a centralized four-county marketing campaign; a toll-free number and website; promotion of CTI to partners in SKILLS project (DOL project with several healthcare education partners); youth services developed with School-to-Career to provide high school health career pathways; ads in professional journals; and, promotions within professional associations. The collaborative will use methods created by the SKILLS project to increase employers’ knowledge and buy-in.

#### Training

Training sites are the College of Marin, Fairfield-Suisun Adult School, Petaluma Adult School, Santa Rosa Junior College, and the Solano School of Nursing Assistant, Inc. Supportive services include childcare, transportation, books and supplies, mentoring, tutoring, basic skills training (ESL), job readiness, soft skills, and GED preparation. Sonoma Developmental Center and Napa State Hospital operate “20/20” programs, allowing students to work 20 hours per week and attend school/training for Psychiatric Technician Assistants 20 hours per week while earning full pay. Collaborative programs include CNA, HHA, LVN, Psychiatric Technician, RN, as well as other categories like radiology technologist, medical assistant, and medical records technicians.

#### Retention

Case management is provided through welfare departments, One-Stop centers (WIA and other agencies operating employment, training and education services in one location), and with CTI designated funds. Some employers have committed to increasing wages of incumbent workers who complete skill-upgrade training. Resource commitments come from educational providers who offer in-kind donations of instructor time and classroom space.

### **Northern Rural Training & Employment Consortium**

#### Goals

Five goals listed are: (1) to link four WIAs in 16 counties (one county has since withdrawn from the project) to develop a continuum of health occupational education with articulation between educational agencies; (2) to position community colleges to provide RN training; (3) to position ROPs to offer additional training for LVN, CNA, CHHA (Certified Home Health Aide), IHSS, and Direct Care Staff; (4) to position private-sector employer support to provide new career opportunities for caregivers; and (5) to coordinate education and training technology needed to develop, deliver, and implement caregiver programs.

#### Recruiting

Recruitment methods include: print ads in regional and local papers; radio ads; news stories and features for regional and local papers, radio, and TV; informational posters and brochures; direct mail to CalWORKs recipients and other targeted groups; coverage on public affairs radio and TV; coverage on “Jobs: the TV Show;” job forum informational sessions; and detailed information at One-Stops and on One-Stop websites.

### Training

Educational providers include ROPs, College of the Redwoods, Yuba College, Butte College, Feather River College, Lassen College, and Shasta College, and a consortium led by Mendocino College. Supportive services are not stated in the proposal. The programs include a distance learning component. Training will be for IHSS workers, CNAS, HHAs, LVNs and RNs.

### Retention

Methods for retention are not stated explicitly in the proposal, although case management is mentioned.

## **Workforce Development Center at Riverside**

### Goals

This site proposes to use three models for employer-based customized training: (1) a consortium of healthcare providers serving seniors in skilled, long-term, and residential facilities, and also at home; (2) a single large corporate-based model; and (3) an acute care hospital-based model.

### Recruiting

Recruitment methods include radio and newspaper public service announcements in Spanish and English; outreach by community-based organizations (Foster Success, Coachella Valley Housing Coalition, United Farm Workers of America, EDD's Migrant Seasonal Farm Worker Outreach Program, ESL providers, education providers); fliers; California Career Videos in English and Spanish at electronic kiosks; job fairs; and referrals from providers and educational sites. The collaborative intends to recruit workers from dietary, laundry, and housekeeping and pay them to upgrade their skills.

### Training

The training sites include Community Access Centers, Mount San Jacinto College, Palm Springs Adult School, California Nurses Educational Institute, ROP, College of the Desert, Copper Mountain College, the Marine base at Twentynine Palms, and Marriott International. Supportive services include life skills support (parenting, financial management, self esteem, family/marital); soft skills training (attendance, personal grooming, interrelationships on the job); childcare; transportation assistance; LEGACY MENTORS peer volunteer program; ESL/VESL classes; and other support services as needed. Training programs are for CNA, HHA, LVN, Geriatric Nurse Aide, and Restorative Nurse Aide positions.

### Retention

To address retention, Riverside proposes using continuous outreach activity among all community-based organizations and a bi-annual awards program celebrating successes of participants and acknowledging high referral rates from community organizations.

## **Sacramento Employment and Training Agency**

### *Goals*

The stated goal of this program is to recruit, train, and place 420 CalWORKs recipients and underemployed incumbent healthcare workers as CNA, HHA, and IHSS workers in local hospitals, SNFs, and private homes. Another goal is to advance 75 entry-level employees to LVN, psychiatric technician, or RN positions.

### *Marketing and Recruitment Strategies*

The site will use multilingual brochures, posters at key locations, public service announcements and “other electronic media campaigns,” mass mailing to 9,000 IHSS workers, and monthly recruitment orientations by educators and employers. All One-Stop staff, Sacramento Valley Organizing Community (SVOC) participants, and SEIU Local 250 workers will conduct outreach to recruit participants into training. Employers will recruit incumbent workers for advanced training.

### *Training*

Training will take place at Los Rios Community College, Sacramento County Office of Education ROP, Grant Joint Union High School District Adult Education, Sierra College, and the Yuba Community College District. Supportive services include pre-vocational training and pre-employment skills, life skills/soft skills, academic remediation, GED preparation, childcare, transportation, counseling, and case management (with financial incentives for case managers). Programs will include IHSS, CNA, Psychiatric Technician, LVN, and RN training.

### *Retention*

Methods for retention include a Resource Referral System; Individual Development Accounts for CalWORKs recipients; mentoring/job coaching; follow-up counseling on job retention and upgrade opportunities; continuing education; financial assistance (car loans, uniforms, alumni association); and case management (with financial incentives for case managers).

## **San Diego Workforce Partnership, Inc.**

### *Goals*

The stated mission of this collaborative is, “to work together to implement innovative, effective, and culturally competent recruitment, training, placement, and career development strategies that will meet San Diego’s growing need for quality health care.”

### *Marketing and Recruitment Strategies*

The site will have an 800 telephone number as a single point of contact for CTI: a health industry exhibit for job fairs; conferences and community events; color brochures in English, Spanish, and Tagalog; bench, kiosk, and bus shelter ads; radio public service announcements; PowerPoint presentations; and an online CTI component at Workforce.org. They intend to inform potential participants of caregiver training opportunities, work with career centers to conduct intake and refer participants into appropriate training programs, produce a master brochure, and schedule outlining specifics of different training programs. Comprehensive

Training Systems will do most of these tasks.

### Training

Training sites are Grossmont Union High School District Health Occupations Center, Grossmont Community College, El Cajon Valley High School, Golden Hill Health Careers Academy, Comprehensive Training Systems, San Diego Job Corps, American Red Cross, and Health Education Consultants. Supportive services include childcare, transportation, soft skills/work readiness training, ESL, VESL (Vocational English as a Second Language), mental health services, substance abuse treatment, “second chance” tutoring for participants who fail the CNA test; and coaching/mentoring services. Participants needing additional support will be referred to San Diego-Imperial Counties Labor Council. Partners will train participants as CNAs, LVNs, RNs, Medical Assistants, and other types of direct care staff including IHSS workers.

### Retention

Retention components are the “Earn as You Learn” Program during employer-based training. The program offers enhanced services in mentoring, soft skill training certification, and work readiness coaching where mentors/preceptors receive small incentive stipends.

## **Private Industry Council of San Francisco**

### Goals

The proposal identifies six goals: (1) training for greater levels of skill and professionalism; (2) vocational ESL; (3) training toward movement along a career ladder; (4) creating support networks; (5) providing respite care for incumbent workers; and (6) providing needs-based training stipends, transportation, childcare, and other support services.

### Marketing and Recruitment Strategies

Strategies include program recruitment materials in several languages (English, Spanish, Russian, Chinese, Tagalog, Vietnamese), public service announcements, ads and newspaper stories. Project staff will identify “other outreach venues and techniques” and Local 250 will advertise in its monthly magazine, through its website, and with fliers.

### Training

Training sites are City College of San Francisco, Skyline College, San Mateo Union High School District Adult and Community Education, and San Mateo County Office of Education/ROP. Supportive services include VESL, job readiness, basic remedial education, peer and job site support, job search skills, case management, needs-based payment, childcare, and transportation. Programs include training for CNA, HHA, LVN, RN, Psychiatric Technician, and Emergency Medical Technician.

### Retention

Retention activities include job placement, re-placement, retention, and skills and job upgrade services.



## **San Jose/Silicon Valley Workforce Investment Board**

### *Goals*

This site will focus on recruiting and providing services to new and incumbent workers at lower skill levels, providing training, support services, and follow-up to ensure career growth opportunities.

### *Marketing and Recruitment Strategies*

Marketing tasks include developing a website to promote CTI; creating marketing materials to promote CTI to job seekers, employers, and providers; developing a standardized screening tool for providers throughout the system; developing standardized outcomes for job seekers and incumbent workers; conducting a community audit to assess the current status of regional continuum of care; and, developing a Caregiver Career Opportunity Continuum Ladder. Recruitment will be done through county social service agencies, including six county CalWORKs programs, nine regional Workforce Investment Boards (WIBs), four county Public Authority IHSS Registries, six county area SEIU Locals, and community-based organizations serving special populations.

### *Training*

Training sites include Mission College and Evergreen Valley College. Supportive services include: basic literacy; VESL; safety training; job readiness/job search skills; childcare; transportation assistance; purchase of uniforms and other supplies; criminal clearance; housing support; assistance in obtaining a driver's license; mental health counseling; domestic violence counseling; coverage of fingerprinting costs; consumer credit education; and, emergency payments for rent or other one-time expenses. Types of training programs are not specified, with the exception of IHSS worker training.

### *Retention*

The San Jose collaborative proposes to work with participating employers and employees during the first 180 days of employment. It also proposes to implement an Emergency Assistance Program, Regional Mentoring/Peer Services, and continued job development and placement services. The collaborative will offer IHSS workers access to an expanded Registry including referrals and continued training opportunities. Public Authorities will continue to work with less-than-full-time IHSS workers to increase hours.

## **Workforce Investment Board of Southeast Los Angeles County**

### *Goals*

This site's goals are to facilitate ongoing upward mobility for individuals unaccustomed to educational and career advancement through integration of training and employment.

### *Marketing and Recruitment Strategies*

These strategies include contacting WtW CNA grads to elicit interest in advanced training; obtaining referrals from LTC facilities, acute facilities, and welfare caseworkers; broadly distributing fliers in English, Spanish, and Vietnamese; and making announcements on "electronic kiosks" in libraries, malls, government buildings and other settings.

### Training

Training sites are Cerritos College and Technical College. Supportive services include ongoing VESL classes (Cerritos College); job readiness seminars (grooming, dress, punctuality, introductory computer and Internet research classes); “Urban Village” suite of support services at DPSS-GAIN facilities; free childcare; and, payment for uniforms and benefits. The collaborative will refer participants to opportunities offered by other public agencies, educational institutions, organized labor, and employer groups. Proposed programs include CNA and HHA certificate programs and LVN and psychiatric technician licensing programs.

### Retention

SELACO will contribute case management, and oversight of employment planning, training, and supportive services. They will offer guaranteed unsubsidized entry-level jobs, and there will be supervision/mentoring of new hires and performance-based training for incumbents.

## **County of Ventura Human Services Agency**

### Goals

There are four goals: (1) to increase wages and benefits for IHSS workers; (2) to assist IHSS workers in their ability to organize collectively to develop a degree of professionalism; (3) to coordinate referral systems for new job opportunities; and (4) to provide training programs which upgrade current workers.

### Marketing and Recruitment Strategies

The Business and Employment Services Department (One-Stop) will identify potentially eligible WIA and WtW applicants, refer them to the program, and assist in enrollment. The Adult Services Program Division will identify existing workers and recruit new applicants. In-Home Supportive Services Program will refer applicants for training and will provide clinical experience, and the WIB will identify employer needs and assist participants in the transition from training to non-subsidized employment.

### Training

Training sites are Adult Schools (Oxnard, Simi Valley, Conejo Valley, Regional Occupation Program) and Community Colleges (Ventura, Moorpark). Supportive services include enhanced instruction and tutoring, academic remediation, career assessment prior to enrollment, payment of all program expenses (e.g., certification tests, uniforms, equipment), a paid internship program, and “necessary supportive services.” Training programs are for nurse aide, CNA, HHA, LVN, and medical assistant positions.

### Retention

The Business and Employment Services Department will coordinate placement, employment upgrade, and follow-up services for participants. The program will encourage providers to take advantage of tax incentives. These are extensions of current One-Stop activities.

## **West Hills Community College District and Region 5 – 6 Partners**

### **Goals**

The five goals are to: (1) develop open-entry, pre-allied health preparatory programs; (2) implement a pilot program to recruit and train participants as Psychiatric Technicians in preparation for a new state mental hospital currently under construction in Coalinga; (3) expand existing CNA and LVN training programs; (4) develop a distance learning program for rurally isolated areas; and (5) develop a transportation system to transport rural trainees.

### **Marketing and Recruitment Strategies**

The marketing campaign includes highway billboards, cinema big screen ads, TV commercials, radio ads (English, Spanish, Hmong), a 1-800-4-Health Hotline (English, Spanish, Hmong), college and adult school publications, and public service announcements. They will also use traditional marketing through the local welfare system and WIA One-Stops. High schools will be encouraged to adopt a pre-allied health educational track. Employers will be asked to refer under-qualified applicants to CTI, and will be invited to serve on advisory committees, join strategic planning meetings, and visit training programs.

### **Training**

The providers are West Hills Community College, Fresno Adult School, Fresno ROP, CSU Fresno, Clovis Adult School, Merced College, Merced ROP, Hanford Adult School, Caruthers Adult School, Selma Adult School, and Golden Plains Adult School. Adult schools will develop a fast track open-entry pre-allied health program, with teachers serving as mentors and career ladder advisors. There will be entry-level training in multiple languages, and distance learning programs. Supportive services include an Articulation Coordinator to facilitate moving adult school graduates into community college programs, three vans to provide transportation for rural trainees, and childcare provided by existing sources. Programs include Psychiatric Technician (pilot program), CNA, and LVN.

### **Retention**

The State of California will lend technical support to assist individuals applying for positions at the new state mental hospital. Employers are in need for such workers, and continued participation is anticipated

## **B. IMPLEMENTATION ISSUES**

All twelve collaboratives outlined detailed program plans in their proposals, but actual implementation posed various challenges. During the initial phases of the grant, collaboratives had to face, to a greater or lesser degree, issues relating to collaboration styles, time constraints, criminal record checks, and program licensure.

### **Collaboration Styles**

Using human services collaboration to improve the quality and availability of social services is an important concept (Sandfort, 1999), but working to develop agency collaborations

is complex and long-term, and requires certain conditions and opportunities (Bardach, 1999). For example, for a collaborative to thrive, it must confront bureaucracies usually inhospitable to interagency collaboration. The collaborative must also build negotiating skills and tools, and develop trust among the partners. To sum up, collaboration is “a mutually beneficial relationship between two or more parties who work toward common goals by sharing responsibility, authority, and accountability for achieving results” (Chrislip and Larson, 1994).

All collaboratives faced challenges in identifying and working toward “common goals” during the grant implementation period. While all twelve collaboratives, as well as participating counties and organizations within each collaborative, share the general goals of recruiting, training, and retaining healthcare workers, the “level of mutually beneficial relationships” varies a lot from one collaborative to the next. Unique features within each CTI collaborative have resulted in twelve different approaches to collaboration. Most notable are differences in pre-CTI relationships and in geography.

Some counties and agencies had pre-existing working relationships, while others had never partnered before, and had to learn about other agency or educational programs at the same time they were fostering new relationships, assembling a grant application, and then starting a new program. Previous relationships were advantageous to those collaborating on proposal work. This was more noticeable because there was less than two months between release date and due date of the state’s Solicitation for Proposals. The same counties and agencies had similar advantages for implementing their proposals more efficiently.

The collaboratives vary widely too, in terms of geography. Three collaboratives are single-county based: South East Los Angeles, Long Beach (Los Angeles County), and San Diego. For each of these, new partnerships were formed between county and non-county agencies in order to respond to the CTI proposal. The remaining nine collaborative partnerships span both county and agency lines. County partnerships range from two counties (San Francisco and San Mateo in the San Francisco Private Industry Council site) to sixteen counties (Northern Rural Training & Employment Consortium, reduced to 15 counties after Glenn County withdrew from participation). Other geographically-related differences are urban versus rural, ethnicity, economics, and population size. There are also differences relating to the kinds and numbers of partners and type of administration. While eleven collaboratives are administered through Workforce Investment Boards (Workforce Investment Boards, or WIBs, administer WIA-related activities), one collaborative is administered by a local community college district.

Not surprisingly then, each of these unique collaboratives interprets “collaboration” differently. At one end of the spectrum, participating counties in one collaborative divided the grant dollars based on county population and each “partner” county accepted an enrollment goal representing its share of the total. In that collaborative, only small subsets of the counties participate in face-to-face meetings, and partners engage in little to no sharing of best practices or marketing materials. At the other end of the spectrum is the non-WIB-based collaborative, West Hills Community College, which has strong relationships with its new partners. Sub-committees meet reasonably frequently and/or communicate electronically to share information and insights. Most of the remaining collaboratives fall between these two extremes. Usually, the collaborative’s fiscal agent/WIB with the highest enrollment goals takes the lead in creating infrastructure and developing marketing materials. The lead agent communicates with its smaller partners but has limited or no involvement in the partner operations.

Partner enrollment goals affect the degree of collaboration. With only one exception (West Hills), enrollment goals in multi-county collaboratives are determined by each county's population. Therefore, a large urban county may have an enrollment goal in the hundreds while its smaller rural county collaborative partner may have an enrollment goal of ten individuals. Clearly the infrastructure development, marketing, and case management goals are not "common" between those two collaborative partners. One rural administrator with an enrollment goal of 20 individuals stated, "Although [urban county partner] has offered to share marketing materials with us, we don't use them. We can't market. We don't have the classroom capacity. People straggle in here and there and we try to match them up to an upcoming class."

The distribution and amount of CTI dollars also affects how much partners collaborate. Twenty-five million dollars is an impressive figure, especially given the total enrollment goal of 5,000 participants. When that number is divided by the 46 participating counties, based on population (more going to more densely populated counties), and multiple agencies within each county, it becomes far less pivotal in providing incentives to motivate. WIB directors, balancing WIA funds and other agency-specific grants in the millions of dollars, may not see investing many hours in changing the healthcare training infrastructure as justifiable, given a "small" \$100,000 or so allotment for CTI, described by one WIB director as "less than a crumb." WIB directors also are accustomed to thinking in terms of enrollment and performance goals. The critical performance criterion for a WIB is to meet the enrollment numbers, regardless of grant money available.

#### *Collaboration case study*

The San Jose/Silicon Valley (SJSV) collaborative, an evaluation focus site, eventually was able to "share responsibility, authority and accountability for achieving results." This is the only collaborative in which multiple urban and rural counties are partners. Three urban counties—Alameda, Contra Costa, and Santa Clara—have partnered with three rural counties—Monterey, San Benito, and Santa Cruz. Representatives from these counties began meeting face-to-face and communicating electronically soon after the state's release of the Solicitation for Proposals. Members educated one another about their different areas of expertise and their concerns about the healthcare workforce, as related to the proposal. Several meetings were held before the group selected a fiscal agent for the grant. Unlike some other multiple-county collaboratives, three of the prospective partners had the administrative capacity to administer large grants.

But after the grant was awarded, four difficulties plagued early implementation. First, leaders within large counties, accustomed to acting without the benefit of group decision, found it difficult to determine whether they should be taking action or waiting for a group decision on the action. Second, the large number of complex organizations involved in the collaborative, including but not limited to WIBs, CalWORKs offices, SEIU, and Councils on Aging, each had complex contract procedures. Activity was stalled for months as the partners waited for contract approval. Third, even though the grant award was as large as other collaboratives, each county's share was small in comparison to other training program dollars. For many partners, the relatively small award and small enrollment goals resulted in the CTI grant having low priority. Finally, the designated grant coordinator was at a lower administrative level within the SJSV WIB and had not been involved in the proposal process, so was faced with the task of learning about CTI quickly while trying to give direction to a large group of strong, experienced partners.

Several months into the grant period, CTI enrollments were so low in the SJSV collaborative that representatives from EDD met with SJSV WIB leaders to voice concern. The WIB leaders responded quickly, hired a new project coordinator, and effectively “turned the grant around.” The initial high level of interaction between the partners was revived due in large part to the efforts of a workforce consultant engaged to insure that the collaborative meets its stated proposal goals. The revived partners are working toward creating infrastructure both to work together on future projects and to invest in long-term strategies for healthcare workforce issues.

**Time Constraints**

Without exception, each grantee faced multiple challenges due to the swift turnaround time from grant announcement until anticipated grant start date (see Table 6 below). Collaboratives had about 40 days to implement their proposals. To add to their burden, they had to spend 40% of the grant, the WtW dollars, in four months. Only one collaborative met that goal, so they were all relieved by the May 2001 announcement that the WtW deadline had been extended.

Table 6. CTI Program Timeline

Activity	Date
Solicitation for Proposals released	September 21, 2000
Proposal due date to EDD	November 13, 2000
Award announcement date	January 21, 2001
Anticipated program start date	March 1, 2001
All contracts and sub-contracts approved	Not yet completed (from several months to over a year)
Deadline for WtW monies to be expended	June 30, 2001 (on 5/11/01, extended to end of CTI program)
Anticipated program completion dates	September to December, 2002

One of the most common problems involved sub-contracts. Many collaboratives discovered that it took a very long time to draft, negotiate, finalize, and approve their sub-contracts with participating organizations, especially when a city or county board needed to approve them. Thirteen months after the anticipated start-date of the grant there were CTI sub-contractors who still had not signed contracts. In a few instances, some of the sub-contracting counties and organizations in a collaborative could proceed with program activities without benefit of a signed sub-contract. However, where contracts were required, few agencies or institutions were willing to expend effort without contracted assurance of payment. Depending on the anticipated role of the partner(s) who could not proceed, these delays made a more or less significant impact on the progress of the grant.

Another set of issues faced by all of the collaboratives concerns confusion about grant requirements. In general, CTI collaborative personnel were familiar with either WIA or WtW regulations, but rarely both. Questions about different types of eligibility, dual-eligibility, and reporting requirements resulted in numerous emails, phone calls, and meetings with EDD administrators, and became the topic of grantee meeting discussions and a technical assistance website. Collaboratives stated that this confusion cost valuable startup time.

The anticipated length of the grant continues to pose problems for the sites. All grantees note the difficulty in attempting to create infrastructure for CTI, only to anticipate breaking it down in 18 months--or less, given the contract-related delays described above. As described in later sections of this report, developing a specific focus on healthcare training is a new venture for most of the collaboratives, and it takes time and energy to mobilize healthcare resources. Collaboratives are aware that the need for healthcare workers will continue for many years, but they are equally aware that CTI grant support is for a relatively short period.

### **Program Licensure**

In some of the collaboratives, educational providers needed to receive approval from state licensing boards to add or change instructional programs. Meeting this requirement was sometimes a lengthy process. While in one collaborative, the application for adding a Psychiatric Technician curriculum was quickly approved, in another collaborative that same approval took many months. When asked about the quick approval process, the CTI administrator at the former collaborative replied that she had experience with the people at the licensing board and knew the “right” people to contact. Another collaborative applied to condense its LVN curriculum into a 12-month program and was told that the LVN board had no knowledge of a governor’s initiative to promote and increase healthcare training. While timing is certainly an issue in getting these programs approved, there also appear to be political and communication barriers in facilitating the start-up or modification of these training programs.

### **Criminal Record Checks**

California Health and Safety Code 1337 requires that certified nurse assistants obtain criminal record clearance upon certification and then biannually to maintain certification. To enforce this legislation, every individual who applies for certification or licensure in a healthcare position must submit to a fingerprint test that is processed by the California Department of Justice. If individuals have juvenile or adult convictions, they may apply to have these convictions sealed and destroyed, reduce felonies to misdemeanors, or receive a letter of pardon from the Governor. For practical purposes, all of these avenues lead to expungement (deletion) of records that could otherwise prevent certification or licensure in the healthcare field.

The processes by which the State of California identifies previous criminal records for healthcare worker certification candidates and by which those candidates can delete or expunge previous convictions create significant challenges to the CTI program. The issues are complex, but the challenges for CTI fall into the following categories:

#### **Timeliness**

According to CTI administrators, the waiting time for fingerprint results sometimes is as long as six to eight months. Students in short-duration training programs, such as CNA training, must sometimes work on a probationary status for months before their records are cleared. Students often are not fingerprinted until late in the course, to save the expense of fingerprinting applicants who might drop out. We interviewed one CNA graduate who had lost her job when the original fingerprint test was determined to be smudged, through no fault of her own. The

turnaround time for results of the repeated test left this individual jobless for three months. Part of the problem is due to severe staff shortages. DHS receives thousands of fingerprint clearance requests not only from CNA applicants, but also from the Department of Justice, and each request requires personal review.

#### Screening issues

CTI program directors state that the requirements of a criminal background check and drug testing are described thoroughly in every CTI orientation meeting. In fact, a couple of sites reported that during the orientations, as many as half of the audience left during the first break following these announcements. At one site in particular, instructors, students, and graduates described the large amount of class time wasted on “283B discussions,” referring to Form 283B on which applicants must declare previous criminal convictions. Given the limited available training capacity, instructors lamented the loss of class time as well as valuable student slots going to students who thought they could “slip through the cracks” and not have their criminal records exposed.

#### Complexity of expungement process

A number of CTI applicants have juvenile criminal records that prevent them from participating in the program, but it is possible for these records to be expunged, or sealed, through a legal process. A legal action is brought to the court where the conviction occurred, and a request is made to have the criminal conviction reversed, set aside, or dismissed. The process applies to most misdemeanor and felony cases. However, participants with limited education can be intimidated by expungement application requirements, due to the costs and the demands of negotiating a complicated legal system and completing substantial paperwork. Writing an explanation of the circumstances surrounding their conviction and how circumstances have changed, gathering letters of reference, and completing the application form can be daunting tasks. One WIB has monthly seminars on record expungement, run by a retired judge, and available for CTI applicants. All of the sites offer some sort of assistance with this process, but there are wide variations in the level of usage.

#### Limitations of background checks

While the justification for criminal background checks on those entering the healthcare field is strong, the actual practice is inconsistent. Only crimes prosecuted in California are subject to review, so someone with a serious criminal record in another state would not be identified in California’s background check system.

An interview with a DHS official revealed that the only option for a broader criminal record check would be to require two sets of fingerprints, submitting one set to the FBI. This would cost more and take longer. That system is still not foolproof, since not all states submit criminal records data to the FBI. No state has reciprocity with any other state in terms of sharing criminal records data. Even if California has reciprocity with other states for licensure, if an out-of-state applicant applies for a California license, the criminal background check includes only crimes prosecuted in California, and not crimes from the applicant’s home state.



### III. EARLY PROGRAM OPERATION

#### A. RECRUITMENT AND ASSESSMENT

Recruitment of participants is a central task of the CTI collaboratives. Their work has produced innovative activity and highlighted some important issues. Recruitment activities discussed in this section include:

- Community outreach
- Innovative recruitment targets
- Recruitment methods
- Recruitment challenges
- Assessing suitability of potential participants

Recruitment and suitability assessment are not new to CTI grantees. Prior to the CTI grant, organizations that are now CTI grantees recruited participants into educational, training, and employment-focused programs. They created recruitment campaigns and screened applicants for suitability. The evaluation team sought to identify recruitment and assessment approaches that were new to the grantee, new to the healthcare field, or both. The team also sought to identify differences in recruitment and assessment that resulted from the collaboration of CTI grantees across county and agency lines. In other words, what was the influence of collaboration, and what was new regarding the healthcare workforce?

#### **Community Outreach**

Many collaboratives are working to build relationships within the community. This includes developing affiliations with healthcare providers, high school districts, community-based organizations, faith-based organizations, and local unions.

#### *Healthcare provider communication*

An outreach approach common to all twelve CTI sites is to implement or enhance communication with healthcare employers. Competing employers are joining forces with some of the CTI collaboratives to address critical workforce shortages. This union enhances on-the-job-training (OJT) opportunities and promotes CTI training opportunities to entry-level and auxiliary workers on site. While most CTI grantees interact exclusively with providers in their region, one grantee seeks to increase awareness at the health care executive level over a wider geographic area by making presentations at professional meetings. In Riverside, employers are cooperating with the development of a registry of providers available by date for clinical rotations. In this collaborative, a coalition of 25 in-home residential care and skilled nursing facilities worked with the Workforce Investment Board (WIB) for about a year before CTI began. In the West Hills collaborative, Atascadero State Hospital offers weekend employment

and housing to Psych Tech students during their 12-month course of study. Still others offer 20/20 programs (full-time pay for 20 hours of work, 20 hours of study per week) for existing workers to upgrade their skills. Long-term care providers and state hospitals are the most consistent participants in these new arrangements, but acute care facilities are involved as well. Kaiser-Permanente acute-care facilities, for example, are partners in several CTI collaborative programs. Some collaboratives include many more facilities than others, but the number of engaged facilities has no impact on total collaborative enrollment figures.

Formal ongoing communication with healthcare providers reflects a departure from “business as usual” for Workforce Investment Boards (WIBs), for whom the traditional focus is on the needs of the individual job-seeker. It is also a departure for the one non-WIB collaborative, West Hills, where the traditional focus had been on attracting students to fill pre-determined course offerings regardless of industry workforce shortages. Prior to the CTI grant, both the WIB and non-WIB collaboratives admittedly had limited knowledge of the healthcare industry, even while having expertise in workforce development or education across many fields. Both types of collaboratives find this new form of communication and cooperation with industry to be a positive, even exhilarating, experience. On the other hand, there are two collaboratives where a handful of long-term care facilities do not welcome CTI promotional materials on their job sites. According to CTI staff, facility administrators are concerned about their current workers who might leave for better jobs after attending training classes.

The WIB collaboratives perceive healthcare employers to be much more flexible and creative regarding timing and location of training alternatives, than community college “educational providers” who often are wedded to weekday schedules and on-campus classes. The traditional community college format is to offer weekday classes taught by full-time faculty on campus during a semester schedule. Many community colleges have extensive evening programs, but these are usually non-credit adult classes such as language, cooking, and computer skills courses taught by non-faculty instructors. The college’s rationale for such evening programs is to increase revenues by utilizing empty classrooms and relatively low-paid instructors during off-hours. In order to enhance training opportunities, some CTI collaboratives attempted unsuccessfully to negotiate with community colleges for either evening/weekend schedules or provider-site training using the colleges’ full-time faculty and equipment. However, the cost involved in either attracting qualified instructors willing to teach off-hour courses or taking both faculty and equipment off site during the day made these suggestions unattractive to the colleges. Because community college tuition costs are state-determined, colleges cannot legally recoup those losses by charging higher fees.

West Hills, the community college non-WIB collaborative, uses the CTI grant as a catalyst for building communication and articulation across county, agency, and adult school/community college lines. In general, these new communication lines with healthcare providers are perceived by CTI grantees as enduring recruitment tools. Their value also extends into training and retention, described later in this report.

### *High school pipeline development*

Four of the twelve grantees use CTI funds for long-range recruitment efforts by reaching into high school School-to-Career programs, commonly referred to as health care pipeline development. Building relationships with high schools, as with healthcare providers, is new for most CTI grantees. Similar to provider relationships, these relationships are perceived as

enduring recruitment tools. The work of these four diverse CTI grantees is increasing awareness among high school students and is an investment in future recruiting efforts. The efforts range from making presentations to high school students or counselors to one aggressive program that offers LVN prerequisite courses in high school using additional funds from another source. The key challenges to a pipeline strategy are time and uncertainty. In a short time-frame program such as CTI, pipeline development activities will not produce high numbers of healthcare workers. Only a handful of students participating in CTI-sponsored pipeline activities will have graduated from high school by the time the CTI grants conclude. Also, pipeline programs are still relatively new and lack evaluation data on their levels of success in directing youth to healthcare careers.

#### *Community- and faith-based organization involvement*

To enhance recruitment, three of the collaboratives have working relationships with community-based and faith-based organizations. These sites meet with organization leaders, give presentations to staff and volunteers, and provide information on application requirements and procedures. Armed with this information, staff and volunteers in these organizations refer potential participants and assist in the application process. Community- and faith-based organizations use their knowledge of their service community to locate potential candidates who may not come forward otherwise. These organizations also provide additional support to program participants during and after training.

#### *Union partnerships*

Although most collaboratives have some experience with organized labor, partnering with healthcare worker unions is new for some. Six of the sites have healthcare worker unions as partners, and two sites include other union-partners in their efforts to recruit and train workers. The most common outreach efforts by unions include surveying IHSS workers about their interest in skill or position-upgrade training, and including CTI fliers in union mailings. Most of the healthcare worker union partnerships, specifically with SEIU, focus on IHSS worker training. One collaborative established a contract with its local union (SEIU) that delegated all recruiting efforts to the union. At this site, the union is actively involved in recruitment; it hires people to phone its member homecare workers, tell them about the CTI program, and invite them to ongoing orientation sessions. (Only union members are contacted.) One local union promotes CTI in its monthly newsletter and on its website in addition to participating in flier distribution.

### **Innovative Recruitment Targets**

#### *Non-English speaking home workers*

Although the expressed focus of CTI is to increase the number of healthcare workers in California, closely related goals include increasing worker retention and quality of care provided by healthcare workers. Four CTI grantees are reaching out to limited- or non-English speaking home care workers. These grantees provide skills training that offer the promise of both enhanced quality of care and increased job satisfaction and retention. Participants also learn about other healthcare positions for which they could be eligible with some amount of training. Classes are taught in English, Spanish, Chinese, and Russian, since many of these workers are family members or are part of tight-knit non-English speaking neighborhoods in which English proficiency is not a requirement for employment. (Tests and licensing/certification are not required for IHSS home care workers). Focus site interviews indicate that training courses have

been well-received and well-attended.

#### Potential upgrade candidates

Two sites tried to identify potential candidates by tapping their WtW databases for CNAs, an effort that required some on-site computer expertise. The intent was to target low-income healthcare workers who might benefit from assistance in pursuing LVN training. There were difficulties with this strategy. First, the sites seemed to have some problems in generating the CNA/WtW list. Apparently WtW databases are set up for specific administrative uses, and are not easily adapted for broader purposes. Second, the process did not result in as many potential recruits as hoped. Staff at one collaborative told us that many of these WtW-linked CNAs had already completed LVN training. We will be able to address this more fully when we merge WtW database information with CNA licensing information.

#### Migrant worker family members

Two rural sites are working with the United Farm Workers and EDD's Migrant Seasonal Farm Worker Outreach Program to recruit family members of migrant workers for healthcare training. In addition to cultivating a new source of healthcare workers, such training allows migrant worker families more financial stability, the potential for upward mobility, and the motivation to become both linguistically and culturally involved in their local communities. Some family members of migrant workers have healthcare backgrounds in their native countries, but because they are unable to pass English-only certification exams, they are not allowed to practice in the United States. The CTI grantee approach provides training to limited-English speakers as personal caregivers while offering ESL and other basic skills classes that open the door to advancement.

#### Marine medical corpsmen

The Riverside collaborative targeted soon-to-be-discharged medical corpsmen from the nearby Twentynine Palms U.S. Marine base. These corpsmen would take intensified classes that would prepare them quickly to challenge the LVN state licensing exam. (Military personnel with medical experience are allowed to take the LVN exam without first taking LVN coursework.) This innovation has the potential not only to abbreviate LVN training time, but also to keep discharged medical corpsmen in the healthcare field by providing relatively easy access to healthcare positions after discharge. This strategy was very popular among corpsmen and was progressing well until the events of September 11, 2001, which resulted in corpsmen being transferred to other locations, having tours of duty extended, or voluntarily re-enlisting.

#### Foster-care youth nearing emancipation

One collaborative specifically targets foster-care youth nearing emancipation, with an additional two collaboratives planning to target this group. A fourth collaborative met with the Community Youth Corps in its area, but has not proceeded from there. The aim is to provide alternatives to these youth while increasing the number of young people in the healthcare workforce pool. The collaborative leading in this approach already has a successful workforce development program, Foster Success, that targets foster youth.

### **Recruitment Methods**

Population density, ethnic heritage, economic climate, and enrollment goals all vary

across as well as within the twelve collaboratives, and these differences are reflected in recruitment methods. For example, the West Hills collaborative, which incorporates a geographically large, primarily rural area has a high-budget public awareness marketing campaign. This includes highway billboards, Spanish TV station interview spots, Spanish radio station public service announcements, movie theater ads in targeted neighborhoods, multi-lingual toll-free telephone hot lines, a dedicated website, and newspaper ads in addition to the posters, brochures, fliers, and career fairs used by other sites. NoRTEC, the collaborative in which each participating county is small and each county's enrollment goals are low, engages in very little CTI-specific recruitment. Yet another site, Sacramento, has had overwhelming responses to small efforts to promote the program, something they attribute to the recent economic downturn. Sacramento had to scale back its original recruitment plans because it did not have the capacity to meet demand for training.

Recruitment methods used by the twelve sites are, in general, standard methods:

- Fliers, brochures, and posters placed in One-Stops and healthcare facilities or mailed to WIA/WtW participants
- Career fairs
- Public service announcements
- Press conferences
- Newspaper ads

A critical issue in marketing is the appropriate balance between a broad public awareness approach and an approach specifically targeted to potential participants. On the one hand, the public awareness approach has the potential to reach large numbers of people quickly. On the other, large-scale campaigns are expensive and can generate interest among many who are not qualified, and this requires much more screening time. Both West Hills and Kern, who used large-scale campaigns, had to staff hotlines in multiple languages in order to respond to hundreds of queries. Some collaboratives who used more focused recruitment initially had fewer participants, although one of the WIB partners in the San Jose collaborative exceeded its enrollment goals simply by inserting a sentence in the local adult school catalog CNA course description that scholarships for the course were available through the WIB. The Southeast Los Angeles collaborative filled its WtW slots quickly by concentrating efforts on WtW case managers. According to data collected at baseline, about 80% of the participants here heard of the CTI program from a county worker, compared with 30% for all collaboratives.

We uncovered relatively few examples of methods that were new to the grantee or new to the healthcare field. A handful of collaboratives, however, identified some benefits attributable to collaboration, described below.

#### *Effective collaboration*

One CTI grantee, West Hills, devoted a large portion of its budget and a great deal of creativity to developing a large-scale public awareness campaign. What is unique about this campaign is that it is truly a collaborative effort. A committee including partners from both adult schools and community colleges made all decisions on the program's plan, design, and implementation. When the committee selected billboard ads as recruitment tools, those ads were placed throughout the geographic region. When movie theater ads were selected, committee members discussed choices of movie theaters that would reach the target audience most effectively.

Another site, San Diego, hired an advertising agency that began its work by running focus groups in order to develop materials that reflect the comprehensive services of CTI. When the focus groups began, some members of the collaborative were not pleased, and there were differences of opinion about how the advertising should work. Some members wanted bus ads and billboards but these were unrealistic in terms of cost. Members deferred to the “experts” and were “happier later” after marketing began and it appeared that the focus groups paid off, the marketing team’s approach was right, and recruitment efforts were successful. While the West Hills collaborative used its own partners to determine a recruitment plan and San Diego contracted an outside group, both collaboratives demonstrated a collaborative approach that sought to identify the most effective types and locations of ads for their target populations.

Other than these two sites, we did not witness a lot of collaboration in marketing efforts. Most collaboratives used their WIB in-house marketing departments that applied recruitment methods usually under the direction of the collaborative director. In a few collaboratives, the urban center/fiscal agent CTI team developed marketing materials that were shared with the smaller counties; materials could be revised to suit each county. In the remaining collaboratives, partners “did their own thing.” Those collaborative partners with higher enrollment goals conducted most marketing activity; those with low goals were able to meet their quota without marketing. San Jose is developing healthcare career marketing materials with the intent of sharing them throughout the six participating counties. These materials, however, will be published after CTI enrollment goals are met. Collaborative partners are developing plans to market to the provider community, to increase interest in and support of career ladder incentives.

#### Leveraging exposure

In general, grantees avoid radio and television ads due to their high costs and limited exposure, although public service announcements are used by a few collaboratives. One grantee is developing a new approach for gaining free and ongoing TV exposure. The West Hills recruitment team identified a particularly popular Spanish station morning TV talk show host to run a human-interest story interview about the growing demand for healthcare workers. In addition to increasing public awareness about increased training opportunities, the collaborative would gain the host’s ongoing support. The collaborative also is pursuing this strategy with two radio stations that conduct interviews at school sites and could provide ongoing references and support to CTI at no cost.

Another collaborative, administered by the Employers’ Training Resource of Kern County, has a strong and extensive marketing component. Many of its approaches are similar to those used by other collaboratives, but some are unique. Kern used its own WIB-based marketing department to prepare a large marketing “package.” The department produced a videotape, “Careers in Kern,” that was aired on the local channel when the CTI program started. Because the WIB produced its own tape, there was virtually no cost to CTI for the service. Copies of the tape were distributed to training providers and to local high schools with health career academies.

Kern’s CTI advertises in various newspapers, and because this is a largely rural area, they are targeted by geographic location. For instance, if a job fair is held in Mojave, only papers serving Mojave are used to advertise. (However, most of the media market is in Bakersfield.) Marketing focuses on particular classes, so that potential participants will hear or read about a

class along with a specific date, time, and place. The collaborative runs radio announcements with several stations, including a Spanish radio station, and television announcements on five different local channels. These advertise upcoming job fairs, as well as CTI training orientations and starting dates. Interestingly, when participants at this collaborative were asked (on the Baseline questionnaires) how they heard about the CTI program, almost 16% checked the “TV/radio” response, a much higher proportion than the other sites. Additionally, the collaborative is using an upcoming “Public Health Week” to full advantage. It is incorporating CTI elements into special job fairs, forums at the One-Stops, and a recognition luncheon where the CTI program was nominated as a “Public Health Hero” to be honored for its contribution to the health of county residents.

The collaborative is spending much less on marketing than budgeted. Much of the marketing budget (\$250,000) was earmarked for job fairs, but because marketing targeted to specific classes was so effective, they were able to cut back on job fairs, billboards, and other high-cost items and save money. “Reverse referrals” also work well; this means that participants are directly referred to the program, from WtW case managers, for example. Another cost-effective approach involves sharing across collaboratives. Marketing department personnel from Kern visited West Hills and were able to use some of the artwork and materials developed for the West Hills CTI program. The concept of sharing marketing materials across the entire state has great potential. Collaboratives could save time (in at least one case, valuable startup time) and money if materials could be produced at a central location and then shared.

#### *Incorporating technology*

CTI grantees exploit existing technologies and take advantage of some new technologies to recruit participants. These technologies are appropriate for a low-income, low-education target audience, in large part due to the existence of One-Stop Centers. These statewide networks of centers are WIA-funded, and provide comprehensive employment, education, and training services in one location. They also provide access to high-tech information-sharing resources. The One-Stops we visited have many computers with Internet access and offer assistance in Internet use through classes and technical support personnel. One county has a CTI PowerPoint presentation loaded onto each of its One-Stop’s desktop computers. Job seekers with an interest in healthcare careers can view the presentation to see an in-depth description of CTI opportunities. Another collaborative’s advertising team developed a PowerPoint presentation shown at One-Stops, to case managers, and at client orientations. Four sites have CTI-dedicated toll-free information lines manned by multilingual operators. The same four sites have CTI-dedicated websites or website pages. Based on early findings, a very small proportion of participants (0.2%) learned about the program through a website, so in terms of marketing website effectiveness is limited. Two collaboratives have county-sponsored electronic kiosks located in public buildings and high-traffic areas to promote CTI or healthcare careers in general to potential recruits.

Overall, marketing techniques (whose effects admittedly are difficult to separate from a downturn in the economy) seem to be successful in bringing people to the programs, since no collaborative is complaining about a lack of potential participants.

## **Recruitment Challenges**

### *Caseworker education and recruiting WtW clients*

All of the CTI grantees have developed some approach to educate WIA and WtW caseworkers about CTI opportunities. These approaches range from brief presentations and fliers, to more intensive caseworker education efforts intended to “convince” WtW caseworkers of the CTI program’s value. It is important to remember that WtW caseworkers and WIA case managers, even if they operate under the same One-Stop roof, represent different agencies with different priorities. WtW caseworkers are employed by the county welfare system, which reports to the state’s Department of Social Services. Because of welfare reform legislation, every welfare recipient is “on a time clock” to find sustainable work. The urgency of that time clock contributes to a “work first” mandate in many California counties, so that caseworkers’ primary goals are to secure work placements for WtW participants. Training, under WtW, is emphasized less, regardless of its potential or cost. Yet, WtW case managers have a lot of autonomy in terms of deciding whether a person can or cannot go into job training rather than entering work immediately. While WtW case managers are employees of county social service departments, WIA case managers work for federal Department of Labor and California Employment Development Department programs that are more familiar with and more supportive of training as a means to self-sufficiency. It is difficult to know what impact WIA and WtW cultural differences have on participants because WIA and WtW participant groups are different when they enter the program. Also, WtW case managers are not an entirely homogeneous group, nor are WIA case managers.

In one single-county collaborative, the county contracts with private agencies for CalWORKs services, and case managers receive a financial bonus for placing participants in employment and nothing for placing participants in training. In another collaborative, a WtW manager described her unit’s caseworkers as feeling that they were applying favoritism when making a training placement, and that anyone with an interest in health care could “get away with” going into training, while others had to continue to search for a job. It is important to note that WIA and WtW agencies are relatively unfamiliar with “industry-specific contracts” such as CTI. The same manager described as a nightmare a prior industry-specific contract, one intended to increase the availability of truck drivers (described as “just as desperate a need as the healthcare industry”). The effort required to identify individuals appropriate for truck driver training and to overcome caseworker values about equal treatment left the unit well under its contracted target.

Recruitment challenges arise not only because the goals of WtW caseworkers and WIA case managers differ from one another, but also because the goals of both of these groups differ from the goals of the CTI grant. For both WtW and WIA caseworkers, goals are to assist clients in finding employment, while the CTI grant’s goal is to fill an industry need. Because a large part of this need is for entry-level workers, WIA and especially WtW populations are logical targets for recruitment, but providing those populations with gainful employment is a side benefit of the grant, not its primary purpose. While it appears on the surface that these perspectives are complementary, the differences in outcomes can be significant. For example, if a client reports an interest in healthcare training to a WtW or WIA caseworker, that worker will, under the best of circumstances, attempt to locate immediate training opportunities and begin the process of assessing the client for suitability. From the perspective of the caseworker, in order for caregiver training to be a feasible choice for this client:



- The client must have enough basic math, science, and English proficiency to qualify for caregiver training. Otherwise, the client will be referred to basic skills classes and/or other employment opportunities. WtW clients especially cannot afford to be without employment while they complete the work necessary to qualify for caregiver training.
- The client must have a clean criminal record. If there is a known criminal record the caseworker may provide referral assistance to the client for expunging the record, but would simultaneously encourage other employment, due to the lengthy expungement process.
- Training classes must be available to clients with often-limited transportation. Clients in rural areas cannot always rely on public transportation and caseworkers frequently report that their clients' cars are unreliable.
- Training classes must be scheduled to begin within a reasonably short time-frame following a client's application. If the only training site has a four-month waiting period, the client probably will be referred to employment.

From the perspective of finding employment, caseworker decisions result in placing thousands of WtW and WIA clients into gainful employment. From the perspective of the healthcare industry, thousands of potential caregivers are being lost to other industries.

Sometimes there is a lack of coordination between the social services department and those overseeing the CTI program. For example, one 27-year old student told us that she was being sanctioned (e.g., losing financial benefits) for participating in the training. She felt that it was worth the loss, however, because the program is free, and she does not like the CalWORKs environment. She proudly states, "I want to be independent. [This program]... is giving me the opportunity to do what I want, a career in health care." (It is not clear why this student is being sanctioned. Perhaps the problem is due to a caseworker who cannot justify the time required to train a WtW client, or perhaps the client is unclear about the actual circumstances.) Our interviews reveal poor ongoing communication between some of the WtW clients and their caseworkers, probably exacerbated by high turnover among caseworkers.

The work-first culture among WtW caseworkers is one of several factors that may partially explain low WtW enrollment to date. One collaborative, SELACO, successfully and quickly enrolled its targeted number of WtW participants, but here there were strong pre-existing working relationships between the WtW unit and the CTI grant coordinator. As mentioned above, 80% of this collaborative's participants heard about the program from their "county worker." The San Jose/Silicon Valley collaborative also is exceptional. Contra Costa County's social service department does not pursue a work-first imperative, but rather "family first" and "preparation for self-sufficiency" imperatives that result in promotion of training and sophisticated screening, including screening family members before placing an applicant in training. Another partner in the collaborative, Alameda County, has a subcontract with SEIU Local 250 in Oakland to do all CalWORKs recruitment. This union sponsors the Shirley Ware Educational Center that offers a wide range of training opportunities. Despite a slow startup, this collaborative has already exceeded its WtW enrollment goals.

### English proficiency

In order to receive certification or licensure, healthcare workers in California must pass written examinations in English. While there are compelling reasons for English-only examination requirements, it is likely that these requirements prevent significant numbers of Californians who might otherwise be capable caregivers from pursuing healthcare careers. Approximately 40% of California's population is of Hispanic or Asian ethnicity, and based on Department of Education statistics, approximately 25% of K-12 students in California have limited English proficiency. Even though some of the CTI collaboratives produced fliers about the program in Spanish and other languages, they report losing potential recruits during orientation sessions when they announce that all but non-certified home care worker jobs require English proficiency. These losses are common to all collaboratives. Individuals are encouraged to enroll in English as a Second Language (ESL) and Vocational ESL classes, but reaching adequate proficiency levels could take as long as two years. Thus, most of these individuals are excluded from CTI. We do not know how many potential applicants are excluded, since many would probably not even apply. Currently, 7% of WIA and 10% of WtW participants have "limited English" skills (based on WIA data for 2,828 participants), but these are participants who have been screened.

### Lack of training capacity

Also contributing to the shortage of healthcare workers in California is the shortage of instructors to train healthcare workers. Every collaborative described difficulties in attracting faculty. One significant problem is that nurses, particularly RNs, are able to make much higher salaries doing clinical work than teaching, so there is competition for their time. (In general, CNA instructors are LVNs, and LVN instructors are RNs.) This results in a shortage of instructors, mentioned earlier. One administrator stated that they could have many more students if they could find the teachers. Another said that one county relies on the existing supply of available instructors, but that supply is dropping noticeably. Elsewhere, finding instructors is more difficult in the summer months.

This shortage discourages some collaboratives from recruiting too many applicants, only to have to turn them away or tell them that they must wait in some cases up to three months before the next class begins. Educators tell us that enrollment in community colleges always increases during economic downturns and recessions. Interest in free training follows suit, and some CTI program coordinators have reduced outreach efforts because they do not have the capacity to respond. The extent of the problem varies among the collaboratives, and is more serious at the RN and LVN levels, but it is an often-mentioned theme.

### Reluctance of healthcare providers to assist in recruitment efforts

Although communication and collaboration with healthcare providers are recruitment tools used in most collaboratives, two of the collaboratives report that some of their healthcare providers regard CTI recruitment as a threat. These employers do not allow CTI fliers on the job site and do not promote the program to their staff. They are concerned about losing low-wage workers to training programs from which they might not return. It must be emphasized that this is the exception, since, in most cases, employers embraced the CTI wholeheartedly. One explanation is that these are both rural areas so there is a stronger attachment to the worker, and less confidence in long-term training benefits. Another explanation is that this is due merely to employer idiosyncrasies. The issue highlights the need for educating employers and securing their commitment, and the importance of helping employers fill vacated entry-level positions.

## **Assessing Suitability of Potential Participants**

Screening is part of the intake process for employment and training. Both WtW and WIA caseworkers use standardized screening instruments to match clients with opportunities and determine areas of vulnerability or needs for educational assistance. For the most part, screening instruments determine an applicant's intellectual capacity to perform certain tasks. Collaboratives use a wide range of standardized tests to screen for basic knowledge in math, science, reading comprehension, and composition skills. The innovations we sought in our site visits and interviews were those that more specifically targeted healthcare interests, or that targeted suitability, in other words, intellectual and emotional characteristics associated with good caregivers.

### *Assessment innovations*

With two exceptions, all of the CTI grantees rely exclusively on "packaged" assessment tools, the most common being the Test of Adult Basic Education (TABE), the Comprehensive Adult Student Assessment System (CASAS), and Interest Determinations, Exploration, and Assessment System (IDEAS). These measures are not specific to health care, rather they focus on general knowledge and interests as well as suitability for training. In addition to these tools, one collaborative uses its own brief "Caregiver Training Initiative Interest Survey," that focuses on healthcare interests.

One exception is the Sacramento collaborative. This site has used the CTI grant as an opportunity to design a set of innovative healthcare-specific assessment procedures, referred to as the "CTI Suitability Assessment Procedures and Criteria." This set of procedures includes TABE, IDEAS and other packaged assessment tools, but also assesses the candidate's potential social/emotional "fit" with caregiving. As part of the assessment process, the applicant must interview and shadow a caregiver, and write a brief essay on reasons for pursuing this training. (In some cases, however, time constraints lead sites to forego the shadowing and interviewing.) The applicant also must sign a statement of commitment to participate actively and cooperate with program requirements, and must complete a checklist identifying barriers that may interrupt training, such as childcare or transportation issues.

Instructors in the Sacramento program are very supportive of the screening process, claiming that when accepted students are more aware of what to expect, they are less likely to drop out during the training period. The Sacramento collaborative has shared its assessment procedures and criteria packet with other collaboratives, but most have not been willing to adopt new assessment techniques in the middle of the program.

Contra Costa County, a partner in the San Jose/Silicon Valley collaborative, uses an in-depth screening process adapted for healthcare careers. Applicants take standardized tests and answer specific suitability questions about the demands of healthcare jobs, applicant expectations, and the expectations and demands of the applicant's family. According to the coordinator for healthcare careers (a CTI-created position), questions relate to abuse, family stress issues, demands for childcare, and home duties, all of which can interfere with training and shift work. Contra Costa County used this approach prior to CTI, and now is sharing it with its collaborative partners. A sub-committee of the partners is discussing using this as a starting

point for a collaborative-wide screening approach.

### Assessment challenges

The greatest challenges to successful assessment in the CTI program include incorporating (1) the significantly different requirements involved in health-related caregiving work, and (2) the likely differences in how WtW and WIA eligible individuals will match those requirements. Unlike many other jobs or training programs to which caseworkers refer applicants, licensed or certified healthcare positions require written English proficiency and a basic understanding of math and science. These positions require drug testing and a criminal background check. They require shift work, often night shift work for new employees. They can require heavy and sometimes unpleasant physical labor. They include some risk of injury or infection. But perhaps most importantly, if a worker completes training and remains in health care, he or she must be emotionally able to care for elderly, ill, and disabled patients and manage the loss of patients. We hear from new and experienced workers alike that being a caregiver is exhausting work. The goal of a CTI assessment cannot be solely to measure competence for training. The primary challenge is to assess likelihood that once trained, the worker will remain in health care, whether staying at entry level or moving up a career ladder. Even with standardized assessment procedures, interviews reveal that WtW and WIB screening processes can vary by caseworker. Offices adopt standards but each caseworker makes individual adjustments based on time and subjective assessment about the client.

Across the collaboratives, administrators state that many CTI applicants, particularly WtW applicants, have English proficiency problems and poor academic preparation in math and science. In addition, they are more likely to have previous criminal convictions. Although they may be more willing to accept employment with some amount of risk, shift work, heavy physical labor and unpleasant labor, there is no reason to believe that they are any more likely than the population at large to have the emotional capacity to be caregivers.

## **B. TRAINING**

### Training Settings

Training is at the core of the CTI program. In one sense, the training element of the CTI program is “nothing new,” since training programs for healthcare providers have been operating for many years in many settings. But in another sense, CTI enables existing healthcare provider training programs to be enhanced, expanded, and integrated so that the result is more graduates with more effective training. In this section, we will describe training settings, including collaborative program descriptions, training issues, and innovations. In general, most of the descriptions in this section were obtained from site visit interviews.

### Description of collaborative-based training programs

Most of the sites go well beyond training entry-level workers. All except one include LVN training, and five sites have instituted RN training as part of the CTI program (Table 6). Five collaboratives offer pre-CNA training; in Long Beach, NoRTEC, and San Francisco this training focuses on IHSS workers. Three sites offer psychiatric technician training. This

training is an integral part of the West Hills program since a new psychiatric facility is under construction there. The “other” category includes, for example, emergency medical technicians and medical assistants. The numbers (reported by the sites as of February 5, 2002) in each type of training show that over half of the CTI participants are in CNA programs, and almost 20% are in LVN programs. Collaboratives vary a lot in terms of enrollee distribution among types of programs. For example, 97% of San Diego collaborative trainees are in CNA programs, compared with only 27% in Long Beach. Whereas some collaboratives focus on two or three programs, others, like San Francisco, North Bay, and West Hills have enrollees in diverse “other” programs such as pharmacy technician, medical assistant, medical office, and physical therapy assistant.

SITE	IHSS/Pre-CNA	CNA/HHA	LVN	RN	Psych Tech	Other	Total
Kern		329	46	12			387
Long Beach	77	40	33				150
NoRTEC	34	129	125	17			305
North Bay		60	16	21	41	34	172
Riverside	18	97	68				183
Sacramento		248	44	2	15		309
San Diego		248	8				256
San Francisco	81	63	28	2		117	291
San Jose		37					37
SELA		224	47				271
Ventura		26	13			16	55
West Hills	12	302	157		45		742
Total N	222	1,772	585	54	101	424	3,158
Total %	7.0	56.1	18.5	1.7	3.2	13.4	100.0

\*This is an interim count, as of 4/5/02, based on collaborative self-reports to EDD.

### *Enrollees*

All proposals provided total numbers of anticipated enrollees, and all but one of the collaboratives should meet those goals, despite late starting times for some. The exception is Long Beach, which had one of the highest proposed target goals, over 1,200 trainees, most of them IHSS workers. There are two major reasons for the low enrollment here: (1) the IHSS workers are not interested in training that will not lead to higher pay, and (2) the program relies on SEIU for recruiting, and initial contract problems delayed that process for about a year. Long Beach is not alone in having low IHSS enrollment. Of the three proposals that included numbers of participants targeted for each specific type of training, the actual numbers are on track for CNA and LVN, but lower than targeted for IHSS and pre-CNA training. (Reasons for low numbers of IHSS trainees will be discussed in more detail below.)

### *Training providers*

Collaboratives vary in terms of types and numbers of training providers used. Table 7 lists the training providers for each collaborative. Most collaboratives use at least four or five training providers, with a few collaboratives dependent on only two or three providers. All the

collaboratives rely on the community college system; most have two or more colleges as part of their partner group. NoRTEC, largely rural, includes seven colleges. In general, urban collaboratives are less likely to be dependent on numerous training providers. One exception is Sacramento where there are many training providers in each category. In some cases, such as Sacramento and San Jose, there is overlap between the private training providers and employer-based providers, since these are not mutually exclusive categories.

SITE	Community College/Cal State Coll.	Private	ROPs/ Adult School/HS	Employer-Based	OJT	Distance Learning
Kern	CerroCoso, Bakersfield C		Bakersfield, Delano	-thru the Adult School		
Long Beach	CSULB, LB City C	Pacific College	Some referrals for remedial academics			
NoRTEC	C. of Redwoods, Butte, Feather River, Yuba, Mendocino, Shasta, Siskiyou	Senior Residential Care Industry, several hospitals	Several ROPs, Ukiah AS			Yes, working on course development
North Bay	C of Marin, Santa Rosa JC, Napa Valley C	Sonoma Red Cross; Solano School of Nursing,	Fairfield-Suisun AS, Petaluma AS	Sonoma Dev. Ctr, Napa State Hospital + others	20/20 programs plus others	
Riverside	Mt. San J, Riverside CC, C of the Desert	CNEI, Marriott, ITA providers	Palm Springs A.S.	MSJC/VHS, RCC/Plott Marriott	yes	
Sacramento	Los Rios CC, Yuba CC, Sierra	Gramercy Court, Bruceville Terrace, Sunbridge, Heritage, Homestead, Horizon, Asian Comm. NH	Grant Adult, SCOE ROP, San Juan USD, 49er ROP	SEIU Local 250; Sutter Hospital, Royal Oaks, Mission Carmichael, Folsom Convalescent	yes	
San Diego	Grossmont CC	Golden Hills Academy and K Shea, LTC	El Cajon + Grossmont HS	Kennon & Shea, Brighton	Kennon & Shea, Brighton	
San Francisco	City C of SF, Skyline C, Canada C, San Mateo C	11 organizations	San Mateo HS Adult Ed+Office of Ed.		Jewish Home for the Aged	
San Jose	Evergreen Valley C, Mission C,	SEIU trains at private hospital worksites	Mount Diablo Adult Ed	Working with Valley Medical	Yes	Monterey-One-stops
SELACO	Technical College	St. Francis				
Ventura	Moorpark College, Ventura College		AS: Oxnard, Simi Valley, Conejo; Tech Dev Ctr (Ad Ed)			
West Hills	West Hills CC, Merced College		ROP: Fresno, Merced. AS: Central, Fresno Clovis, Golden Plains, Hanford		Dept. of Mental Health@ Atascadero	In development

\*Table compiled from site visit interviews, and sent to all collaboratives for editing

### Issues related to training

Several issues relevant to training are important to describe in more detail. These include on-the-job training, employer-based training--pros and cons, IHSS worker training, and cooperation and competition.

#### *On-the-job training.*

Some of the collaboratives use on-the-job training (OJT), which is very attractive to students. Classroom training is provided at the same facility as the clinical training, and students are paid for full-time work while in training. Six collaboratives included OJT programs in their proposals. Three of these, as well as three others, have OJT programs. One collaborative never started OJT because the organization "had a shortage of personnel to supervise the trainees." The OJT programs are offered through classes at employer-based facilities, but these classes are limited in size and number. As of April 2002, the number of OJT participants ranged from 9 to 62 per collaborative, totaling 128 in CNA training at five collaboratives, and 37 in psychiatric technician training at two collaboratives.

The North Bay collaborative has several employers operating "20/20" programs, which are variations of OJT. These programs enable students to work 20 hours per week, attend school and training for 20 hours per week, and still earn full pay. Here, two employers, a developmental center and a state hospital, focus on psychiatric technician assistants and a third, a local hospital, offers security guards the 20/20 program to train to become phlebotomists. Most of this collaborative's partners feel that paid training is the best approach for providing student support. This is important because it provides income and because it resolves the problem of students getting release time from work. Paying students while they work is a "huge advantage," according to one collaborative director.

Administrators admit that the demand for on-the-job training is greater than the supply of classes. The need is especially apparent among lower-income workers who cannot survive on reduced hours and income while attending a training program. One collaborative is "flooded with calls for the LVN program" but many of those interested cannot participate because they also need to support themselves during training. Even CNA candidates have difficulties living on a reduced income during a relatively short training period. As one administrator stated, "Barriers exist because people cannot support themselves while in training."

#### *Employer-based training-- pros and cons.*

Employer- or facility-based training has other advantages, besides its ready access to potential or actual future employers, and income stability. Facilities such as nursing homes or hospitals can be more flexible in scheduling training courses, since they are not restricted by community college-style course schedules where classes are "blocked." Unlike more-structured and rigidly-scheduled community colleges, employers can offer training classes at any time they want, and can gear class schedules to the schedules of potential students who are employed. One collaborative administrator is very pleased with their flexibly-scheduled program. Because this local program offers a night class, Welfare-to-Work people are "pouring in the door."

An excellent example of flexibility is at one employer-based training program site where CNA/HHA classes are modular. Each class presentation for the theory-related instruction is self-contained, so a student can start anytime and attend full-time or part-time. This allows students to work full-time or manage family responsibilities while taking courses. Each student must

complete 19 modules totaling 80 hours before starting 128 hours of clinical work, which also can be part-time.

CTI collaborative staff members report other problems from rigid scheduling. For example, clients may not be in a position to wait when schools offer classes only once every six months, or even once every three months. This is particularly the case for WtW clients who are under strict time limits, and whose case managers are not always eager to have an idle client when that client could be working. According to one collaborative, the weakest part of their CTI program is “the challenge of timing recruitment to coincide with the beginning of classes.” Because some classes are based on academic quarterly or semester schedules, people may be recruited, but then be lured away by other opportunities while waiting for the classes to begin.

In addition to scheduling freely, employer-based trainers can screen very effectively if they recruit from their cadre of current workers. One site is addressing the problem of retention preventively by soliciting referrals to CTI from the healthcare employer. Retention is much less a problem since the trainee is first, hand-picked, and second, motivated by the promise of a higher salary upon completion of the training course.

On the other hand, employer-based training can be more expensive than other training. Total cost may range from \$4,000 to \$6,000 per person. There are critics who fear that such training provided by long-term care facilities is more work-based than training-focused. Also, as discussed earlier, a small number of employers are wary about doing anything that would mean losing workers from their facility as workers upgrade their skills and move to better jobs. An administrator at another site mentioned that some agencies are hesitant about upgrading positions. To compensate, educators may consider helping with “backfilling,” that is, with filling in the lowest level jobs that are vacated when employees move up the career ladder.

#### *In-Home Supportive Services (IHSS) worker training*

Most of the collaboratives included IHSS workers in their proposals, to varying degrees. Some sites use IHSS workers as a recruiting base for CNAs, whereas other sites have training programs specifically for IHSS workers. The purpose of the IHSS training, or homecare worker training, is not as clear as for other CTI training programs. There is no likely increase in salary for this group, and the hours spent in training are not directly applicable to further training (such as CNA training) to move the participant up the career ladder faster. One of the collaboratives stated that they have problems filling slots in the IHSS training program because the IHSS workers do not see the advantages of training. At another collaborative, the feeling is that few participants want the IHSS training because they are more interested in CNA certification. As mentioned earlier, all collaboratives are having problems filling their IHSS slots. On the other hand, one site states that IHSS training “enhances skills and confidence” and presents it as a means for getting people used to the idea of going back to school and furthering their education. The research team will be able to explore this hypothesis in the outcomes analysis.

One major factor in the IHSS training programs is the presence and influence of the Service Employees International Union (SEIU) in California. In general, SEIU shares the primary goals of CTI, since the union wants to improve the working skills and conditions of healthcare workers, particularly those working in private homes. In general, the union is a strong and positive influence, bringing people into the program and even running its own training program under the auspices of CTI. At one collaborative, though, the union’s role was initially



problematic as major delays in recruitment stemmed from delays in finalizing an SEIU contract, and from further delays caused by difficulty resolving who would control the training dollars.

### *Cooperation and competition*

Cooperation within collaboratives has resulted in some positive changes for training programs. One urban collaborative mentioned that the CTI grant brought together all the county community training programs, and they now have developed agreements and published a joint caregiver career catalogue. Programs working together allow more flexibility in scheduling, location, and class type for students. One administrator stated, the “newly forged partnerships between colleges and agencies have resulted in [staff] being re-energized and more positive,” as well as having more customized programs and lower costs. Another collaborative stated that they are trying to bring long-term care providers and trainers into one working group. They were surprised to discover that by working together, they can “expand the numbers.” CTI staff are well aware of the need for and benefits of collaboration. An administrator at the non-WIB collaborative said, “The schools are now working together, but WIA [the WIB] needs to join in too.”

The Riverside collaborative established a registry of beds used for training. This enables all of the training sites to know where and when beds are available. The site reports that this is a highly effective and low-cost use of collaborative resources. In San Francisco, a joint “Caregiver Catalog” was developed; another site similarly set up a “master calendar” that lists all the health caregiver classes plus schedules. This calendar is distributed to all case managers so that they can refer students to classes that match their schedules.

At one collaborative, the community colleges were not cooperating fully with the adult schools. To address the problem, this collaborative hired an “articulation coordinator” who works aggressively to establish articulation agreements between the partnering educational providers. Because of this work, the adult school graduates can move more easily into the community college programs. Community colleges at another collaborative said that they could not expand their nursing programs because they did not have access to clinical sites for training. As a result of the CTI, these colleges were able to work with an educational consultant who helped them design on-site training programs with employers. To accommodate the students, some faculty had to change schedules and go to the employment site.

Despite positive changes, there is still competition among training programs within some collaboratives. Collaboratives are selective about which schools/training programs participate in CTI since not all training programs in each locality are included. Therefore, it is possible for training programs in the collaborative to compete with neighboring programs not in the collaborative. At one collaborative, we heard that “a lot of the adult schools see this program as competition,” especially if they offer the same program.

One collaborative mentioned that training programs at the local skilled nursing facilities (SNFs) and other employers seem unintentionally to be siphoning people away from the CTI program. The collaborative is trying to determine how to bring these providers together so they can cooperate, and also to establish a new model for training that will continue when CTI funding ends. As mentioned earlier, some SNFs are interested in upgrading worker skills, but worry that these upgraded workers might then leave. Another site stated that because long-term care facilities can easily offer their own CNA training (all they need is a director of staff

development), it is more difficult for the collaboratives to bring all the trainers together.

### *Innovative training approaches*

Although the approaches described below are not new to the educational realm, they are approaches generally not used prior to the CTI program.

#### *Distance learning.*

Four rural collaboratives included distance learning components in their proposals, focusing on entry-level through RN positions. Implementation varies. At one site, the administrators stated that CTI gives them “an opportunity to get involved in things like distance education, which we otherwise wouldn’t have done.” At this site, a community college is developing non-clinical programs on-line, such as gerontology and pharmacology (all RN). Nonetheless, some of the LVNs who want to upgrade have to drive 1.5 hours one way for their clinical training, which is a severe hardship for single parents. Another site hopes to have at least one program by the spring or summer of 2002. They are discussing an agreement to share resources across and within the adult schools and community colleges in order to implement distance learning. A CTI consultant at another collaborative described a problem with incompatible telephone lines, so distance learning came to a complete standstill there. In summary, distance learning is fully operational at only one collaborative, but because clinical training must be on-site, distance learning is only a partial solution for isolated areas.

#### *Fast-track training*

One collaborative in particular is very pleased with its “fast-track” training program. If students meet certain academic eligibility criteria they are admitted to the fast track program that does on-site training at the worksite. An employer hires 15 students who complete the CNA in 5 weeks, as opposed to the usual 16 weeks. Each day has 4 hours of class followed by 4 hours of work. However, even with the fast track, a student has to be in a living situation where he/she can survive for 5 weeks with reduced income.

The collaboratives incorporate fast-track programs at different levels. One collaborative uses this approach in an adult school by offering concurrent fast-track classes to students who have the ability and interest. At the same site, a program is underway to develop a one-year fast-track RN program in conjunction with the Cal State University system; this is still in the planning stages.

#### *Intensive case management*

Because of CTI funding, collaboratives are able to offer comprehensive individual case management. Many collaboratives fund special CTI case managers whose role is to focus on CTI enrollees, and be available to help them during the training period. The case manager often functions as a parent-figure, someone available to offer advice, consolation, and assistance to a group of students with diverse needs and concerns. Most collaborative directors feel that this is a positive part of the program, stating that when more attention is paid to the students, satisfaction increases, class absences decrease, and retention increases. Whether this is true is unclear. While satisfaction levels are high, as discussed below, retention results will not be available for some time.

The goals of intensive case management are positive, but interviews reveal that in practice the “intensity” varies. In one site that covers a large urban/rural area, case managers are

assigned students by zip code. While the initial logic of that approach seems strong, the outcome is that case managers whose offices are in low-income neighborhoods are overwhelmed by their caseloads, while caseloads elsewhere are light. At other sites, caseworkers focus on new cases, so they spend much of their day driving from client site to client site. Most participants interviewed referred to their case managers as attentive and supportive, but some stated that their managers did not return their calls.

### *Upgrading facilities*

Many collaboratives use CTI funding to furnish and upgrade teaching space. This is more complex for clinical instruction, where classrooms have high equipment needs, such as mannequins, hospital beds and equipment, and working bathrooms. One teacher, pleased to now have a classroom with beds, sinks, and a kitchen, says, “I will be able to do things that I would have liked to do before. It is giving me the tools; it makes a huge difference to teach in that environment.” Without this equipment, she would have to teach these skills later at the clinical sites, and she believes that by the time students get to the clinical practice, they should already have those basic skills.

West Hills had the most expansive plans for facility upgrades, with \$650,000 allocated in its proposal budget to convert about 5,000 square feet of existing space into classrooms, computer labs, and skills labs. At the time of our site visit, two pre-fabricated classrooms had been placed on site, and remodeling was underway.

### *Other-language training*

Several sites offer training in Spanish. This is useful because in many situations, trainees who are Spanish-speaking are needed to work in homes where the client is Spanish-speaking, as well as in some nursing homes that have a majority of Spanish-speaking clients. One site proposed to focus on farm workers, so that at least one family member would have skills for non-seasonal work. At one private facility, training is offered in Spanish, with medical terminology offered in English (because the CNA certification exam is English-only).

In another training program, both Spanish and Chinese bilingual instruction are available for a slightly higher fee. Students attend one class taught in their native language, then the same class taught in English. Textbooks are in both languages. This method is used for about the first 40 hours of theory, with remaining theory taught in English only. Translation is offered on an as-needed basis. According to the program liaison, most students in this program pass the CNA exam the first time, and virtually all pass the second time.

## **Student Opinions about Training**

The two sections below are discussions of student opinions about training, based on responses to 245 completed Training Satisfaction Questionnaires, and on 29 face-to-face interviews with students and staff. The interviews are more general than the questionnaires, so students are free to discuss topics not covered in the questionnaires, such as their preference for clinical over classroom training. The questionnaires are overwhelmingly favorable about satisfaction with training, and the face-to-face interview findings similarly are positive. Both questionnaires and interviews reveal that many of these students are interested in further healthcare training.

### Training satisfaction feedback from questionnaires—interim findings

As part of the CTI program evaluation, students at the four focus sites complete Training Satisfaction Questionnaires. As mentioned earlier, someone not directly related to the educational program administers these questionnaires on-site, when participants are about three-quarters of the way through the program. This ensures that they will have been in the program long enough to provide meaningful evaluations.

Appendix F presents detailed findings from the analyses of questionnaire results. (The Training Satisfaction Questionnaire is in Appendix E); these are summarized briefly below. Topics covered in the questionnaire include classes and instructors, flexibility of time and location, usefulness of training, course materials, further desired training, and the best and worst parts of the program.

In general, participants are highly favorable in their assessment of their programs. More than 90% of students agree that the instructors make the material easy to understand and care about the students. Overall, more than 90% are satisfied. Three-fourths feel the program is sufficiently flexible. Many students mention plans for further training; many in the CNA program mention moving into an LVN program at some time. When asked about the best part of the training program, students frequently mention clinical experience and working with people, in addition to personal benefits, such as improved self-esteem and increased skills and knowledge. When asked about the worst part of the program, students have little to say. Many say “nothing,” while others mention problems related to disorganization in program start-up, and to personal issues, such as adjusting to earlier hours.

### Training satisfaction feedback from interviews with students

The evaluation team also is conducting face-to-face interviews with program staff and participants. Twenty-nine have been completed so far. Listed below are training issues mentioned by program participants during face-to-face interviews.

- Similar to Training Satisfaction Questionnaire findings, students interviewed are positive about the CTI program. Overall, they view the training program experience as rewarding. Students are grateful for the opportunity that CTI brings and seem to be motivated to continue studying.
- In one collaborative, some students wanted training to go faster, but courses have to accommodate slower students. So faculty developed a system where more advanced students were asked to become quasi-teaching assistants in order to help their classmates. The result is a deeper commitment to the courses, with a positive impact on everyone.
- There is some lack of understanding of CTI as a “program.” During the interviews, when participants and faculty are asked about the program they think about free classes, books and uniforms. Not all instructors teaching CTI participants are fully acquainted with CTI, and student knowledge of the program appears to be limited to information provided by instructors and perhaps case managers. (This lack of information has little bearing on the program, but it does affect how the evaluators ask questions about “the CTI program.”) In one case, wider knowledge of CTI would have been useful; a CNA graduate was considering moving elsewhere in the state and was unaware that CTI could

possibly assist her with her LVN training goal. She understood the CTI assistance to be a one-time opportunity for CNA training only in her community.

- Students find the training environment to be supportive. Many interviewees commented on the helpful and friendly class environment. Similarly, Training Satisfaction Questionnaire analysis reveals that almost 90% agree or strongly agree that the instructors “care about the students in their classes.”
- Most CTI participants interviewed are aware of career ladder concepts. Most want to go into registered nursing, but see their possibilities in different ways. Some trust they will succeed through hard work, studying at night and paying with their savings. Others feel that without assistance from a program like CTI, they will have few possibilities.
- CNA students and graduates state that they prefer clinical training to classroom/theory time and often wish they had more clinical time before starting employment. Some also feel that they would like to have experience working on different shifts before beginning employment.
- Clinical training allows students to become acquainted with the facilities where they are receiving training, so that they have a first-hand understanding of working conditions at these facilities.

### **Training Program Dropouts**

One important evaluation component is the Early Departure Survey, a survey of trainees leaving the program before completion. Initially the evaluation team asked the three focus sites to submit lists of dropout names and telephone numbers so that they could be telephoned and surveyed about their reasons for leaving. This approach yielded few names, and locating former participants was difficult. For this reason, in late 2001 the evaluation team asked all twelve sites to provide lists of people leaving the program. As of February 2002, the team had conducted 37 Early Departure Surveys. Response information, by participating collaborative, is shown in Table 8. One collaborative informed us that they had no dropouts, and the rest had not sent lists at the time of this report, so this is not a complete count of total dropouts. The final report will include dropout information from each site, as well as analyzed response rates.

Table 8. Early Departure Survey Response Information

	Names Received	Complete	Active	Unable to reach*	Lost**
North Bay	16	9	0	3	4
Long Beach	5	2	0	0	3
Kern	30	19	0	6	5
San Diego	8	6	2	0	0
San Jose	1	0	1	0	0
Ventura	3	1	2	0	0
<b>TOTAL</b>	<b>63</b>	<b>37</b>	<b>5</b>	<b>9</b>	<b>12</b>

\* multiple calls with no answer

\*\* wrong number, number not in service, person no longer at number, etc.

Findings from Early Departure Surveys are summarized below, with more detailed findings presented in Appendix H. These findings are very preliminary, and the sample is so small, that conclusions can be tentative, at best. The most commonly cited reasons for early departure from CTI training relate to lack of time. Students have problems with the training schedule, the workload, or attendance requirements of the program. Students often have to combine classes and jobs with time conflicts such as taking and picking up children from school, or the program is just too far away from their homes. Some students complain about the intensity of the program. They state they would prefer classes three times a week instead of every day, or fewer hours per day, giving them more time for homework and family activities. They frequently mention the program's lack of flexibility about absences. Sometimes students miss class because they or their children become ill, or they have transportation problems. Once they miss a few classes, they are forced to leave the program, losing all previous effort invested in the program.

At least six students identified as "Early Departures" did not complete the Early Departure Survey because follow-up discussions with the collaboratives indicated their departure was not of their own choice, and the questions therefore were not applicable. At least two of these students failed the course work, and another student had a problem with the teacher. One student was released due to a substance abuse problem, and another was released because she allegedly stole money from a classmate. One student was asked to leave the class about four weeks after the program began. The reason given was that there were 18 students in a class that could accommodate only 15 students. She was told that the program would call her back, but has not yet been called and is not sure why she was the one chosen to leave.

### **Supportive Services during Training**

All of the collaboratives offer Welfare-to-Work students services available under the WtW program. These services include: (1) basic employment services such as assessment and/or case management, job readiness and placement, and participant work activities like on-the-job training; (2) post-employment services, like job retention services, counseling, mediation with employers, and workplace mentors; and (3) other supportive services such as transportation and childcare assistance, substance abuse treatment, and mental health services.

In California, services for WIA-eligible adults include general services and supportive services designed and administered through local Workforce Investment Boards (WIBs). General services include job search and placement assistance (including career counseling), labor market information, initial assessment of skills and needs, information about available services, and follow-up services to help customers keep their jobs once they are placed. Supportive services include transportation, childcare, dependent care, housing, and needs-related payments necessary to enable an individual to participate in WIA-authorized activities. These supportive services are not available to all WIA-eligible people, since they usually are based on financial need. A case manager oversees supportive service assignment, which can vary depending on that manager's subjective determination of an individual's need.

The CTI program stipulates that participants who need supportive services will have services covered by other programs or WtW or local WIA-formula funds first, and then by CTI

grant funds. In the CTI program, childcare, transportation, remedial programs, soft-skills and life-skills training usually are covered through WtW and local WIA-formula funds. CTI state-level grant funds allow collaboratives slightly more flexibility, so that they can, for example, buy books, uniforms, and shoes, or pay for motel rooms.

*Description of collaborative-based supportive services*

Table 9 lists the range of supportive services offered to CTI participants by collaborative, and how services are provided. This report will not discuss specifically all supportive services presented in the table, but will summarize those that are more innovative, such as mentoring, and those that respond to collaborative variation, such as childcare and transportation. The kinds and amounts of supportive services offered to students are diverse. The diversity is driven in large part by different kinds of needs among the collaboratives (discussed in the next section). Furthermore, within collaboratives, needs can vary from county to county, and thus types of support offered can vary from county to county.

At some of the collaboratives, most supportive services are available through the WIB, usually at One-Stop centers. One collaborative offers many of its supportive services through its partner community-based organization. Many collaboratives have drawn from numerous sources, such as unions, adult schools, and the employers themselves, to put together a package of services that would help CTI students complete their training. The collaboratives appreciate being able to use CTI grant funds to cover items not usually covered by WtW or WIA formula funds, or by other agencies, such as books and uniforms, shoes, fingerprinting, lodging, and tuition. Sites consider this “flexibility in funding” to be a great plus in providing effective training.

Table 9. CTI Supportive Services, by Site, and Who Provides Them\*

SITE	Childcare	Transportation	VESL/ ESL	Life/soft skills	Mentors	Tutoring/ remedial	Other
Kern	WtW (WIB contracts w/ locals)	WtW (WIB contracts w/ locals)	ESL –several classes	Incorporated in curriculum	Informally w/ liaison/case manager	By training provider if students don't pass exam	
Long Beach	WtW	WtW	Referrals to community resources	At One-Stops already	Through SEIU	From training partners	Books, shoes, equipment, physical exams, tuition
NoRTEC	Through county referral agency	Mileage reimbursement, car repair, tires					Books, supplies, uniforms, shoes; lodging
North Bay	WtW	Marin: \$3/day	Napa-AS, Educational Resource Center		Napa-AS		Books, shoes, uniforms, medical equipment e.g. stethoscope, tuition, physical exams
Riverside	Through WIB, CalWORKs	WIB, Sunline, CalWORKs	Adult school and WIB, C of the Desert	WIB	Office on Aging	WIB	
Sacramento	Child Action; CalWORKs for WtW; CTI pays 2 or 3 months	Gas vouchers, bus passes provided	One-stops, Adult Ed, SETA service providers		Plans for SVOC (CBO); not started yet	Covered by CalWORKs Los Rios Comm. College, Grant Adult	Rental aid, utilities, food, clothing, TB tests, fingerprinting, supplies, uniforms, books, other emerg. aid
San Diego	Labor Council pays for non-WtW; only for emergencies	Labor Council pays for non-WtW; only for emergencies		Offered by Labor Council and CTS: senior mentors for WtW	Senior mentors for WtW do soft skills— used very little	Offered by Health Educational Consultants	
San Francisco	Through PIC/WIB	Through PIC/WIB	CBOs	CBOs	CBOs	.by several agencies	Case mgmt; books, uniforms supplies, background checks, fingerprinting
San Jose (services vary by county)	Mostly WtW funding	Mostly WtW; contract for IHSS workers	Through CBOs and Adult Schools	CBOs and Adult Schools; some One-Stops		Through CBOs and Adult Schools	Emergency rent payment; counseling
SELA	WtW and DPSS	WtW and DPSS	Offered by training vendor and online	One-Stops	One-Stops	One-Stops	Uniforms paid through CalWORKs



SITE	Childcare	Transportation	VESL/ ESL	Life/soft skills	Mentors	Tutoring/ remedial	Other
Ventura	WtW and WIA, if qualified based on financial need	WtW and WIA if qualified	At some training sites			At some training sites	
West Hills	Relatives; WHCCD sliding-scale childcare; WtW	3 vans to pick up students; driven by students	ESL: Adult schools; VESL: all teachers			Available through Nurse/Tutor	Books, supplies, physical, Live Scan screening

\*Table compiled from site visit interviews, and sent to all collaboratives for editing

### Issues related to supportive services

There are areas of implied need that relate directly to supportive services, and these merit more discussion. They include childcare service needs, transportation needs, and pre-training preparation needs.

#### *Childcare service needs*

Needs for childcare vary among individual counties and collaboratives. From the “CTI Participant Baseline Information, by Site” table in Appendix D, we see that only 32.4% of participants in the San Jose collaborative have children, compared with over 87% of SELACO participants and over 75% of Riverside participants. Although it is the exception, one up-scale county stated that it had seen little need for childcare, since many of their students are very young. Also, there are differences between the childcare needs of WIA and WtW participants. Because more WtW participants have children (76% vs. 61%), more have needs for childcare.

While each collaborative has payment mechanisms in place for childcare (either through WtW, or WIA, where cost usually is based on income), the way childcare is implemented differs. Some collaboratives are very active in locating childcare services. For example, a couple of WIB-based sites have childcare facilities available on-site; this type of arrangement makes more sense in denser urban areas where there are more potential users of a facility. Other collaboratives make the money available but the participant must locate the childcare services. Most collaboratives make this task easier by having some sort of referral mechanism, such as a roster of available providers, or a childcare referral agency. A couple of collaboratives offer only minimal assistance. At one of these, we heard that if the clients don’t ask for childcare, they do not volunteer assistance. At another, the philosophy is that the participants have to fend for themselves after the CTI program, so in preparation they need to start now and work out their own childcare arrangements. Another important issue is the need for sick-child childcare. Most childcare facilities do not take sick children, and that often results in parents missing classes.

#### *Transportation needs*

Differences in transportation needs among the collaboratives are reflected in percentages of those who have cars (See Appendix D). Based on 2,333 participant responses, car ownership varies from 26.4% in San Francisco to 80.9% in Ventura. NoRTEC, largely rural, is higher than most others (77.9%); nevertheless, 22%, or 38 participants are without cars in an area with a limited public transportation system.

Transportation is essential to participation in CTI. All twelve collaboratives pay for

transportation-related items in one way or another. In rural areas, people have fewer transportation options so other accommodations are needed. One 21-year old mother of three informed us that it takes two hours by bus for her to get to class. In Fresno County, we heard that transportation is one of the most common reasons (along with spousal abuse) for dropping out of the program. Sometimes teachers will pick up students on their way to class, if they live nearby. Car pools are used too. A unique transportation solution at another collaborative was the purchase of three vans to transport students from their homes to their clinical sites. Some of the students themselves are hired as van drivers, and in this way can earn extra money while in school. Many sites pay for mileage reimbursement, gas vouchers, car repairs, and even new tires. One collaborative helped a participant with car loans (through the community-based organization), and another rural collaborative hired a bus to take students to get their fingerprinting. In more urban areas, solutions differ. Collaboratives most commonly assist students by offering them bus passes. One county offers transportation support of \$3 per day per client.

Beyond transportation, several of the rural collaboratives use CTI funding to pay for lodging. One collaborative pays for motel rooms, about two nights a week, so that student commuting time can be greatly reduced. The students are required to be in training at 6 AM, so without motel vouchers, they would have to wake up around 3 AM and would have problems getting through a day of training. One collaborative pays for a small apartment available during the training period. This is shared by a group of students from more remote areas of the region.

*Need for pre-training preparation*

Based on education data obtained from 2,828 program participants identified in the WIA-based data set, a substantial number of program participants are not high school graduates, as depicted in Table 10 below. Around 28% have less than a high school education. About half have a high school degree or GED, and almost 22% have some education beyond high school. Thus, about one quarter of this group of CTI participants are not high school graduates; many of these could have some problems with academic coursework.

Table 10. Educational levels for WtW and WIA CTI Program Participants

	<u>WtW</u> (N=624)	<u>WIA</u> (N=2204)	<u>Total</u> (N=2,828)
<u>Educational Levels (%)</u>			
Less than high school	48.6	22.7	28.4
HS Grad or GED	41.4	52.3	50.0
Post HS Education	9.6	20.0	17.7
College Graduate	0.5	5.0	4.0

There are significant differences between the WIA group and the WtW group in spite of the fact that all participants are screened to ensure minimum educational levels at program entry. Over twice as many in the WtW group compared with the WIA group have less than a high school education (48.6% versus 22.7%). While about 5% of the WIA group have a college degree, only 0.5% or three people in the WtW have one.

WtW students have more needs than the WIA students, and here pre-training is valuable.

Many WtW participants have lower reading and math scores, as well as other barriers to training. Interviews with CTI personnel suggest that this group has self-esteem problems and lacks basic skills such as punctuality and budgeting money. As described by one teacher, some students have problems with organization and with time management. They are not used to getting up early every day, going to bed early, and keeping cars filled with gas. The teacher added, "They need a net of support; they need more than nurse skills." One much-admired instructor said, "the teacher has to be there" for the WtW participants. She stated that the teacher really has to become involved with students' lives, to support them, to help them, and to encourage them so they can increase their confidence. Despite the fact that WtW students could benefit from pre-training preparation, they are not likely to receive this preparation if it means extra training time. Because their "welfare clock" is ticking, they are, for example, excluded from training programs that have extra prerequisites.

As a whole, many CTI students need additional educational support. For these students, supplementary training is available in the areas of remedial reading, math, soft skills such as attendance, being on time, personal grooming, interrelationships on the job, and life skills such as parenting, financial management, self esteem, and family and marital relationships. The advantage of supplemental training is that it facilitates inclusion of students who, for a variety of reasons, may have dropped out of the traditional educational system. They now have a second chance to accomplish something important to them and to society. The hope is that those with the ability will now have the opportunity. While some students will not succeed even with remedial work, CTI experience thus far suggests that many will. Our interviewing to date suggests that few people have left the program because of academic problems.

One faculty person talked about students needing to work on soft skills, and mentioned "getting to work early" as one hard-to-learn skill. Along a parallel line, many students responding to the Training Satisfaction Questionnaire state that the hardest thing about the program is "getting up in the morning." Despite this "problem," these students seem very happy with the program and pleased with the direction of their lives.

One CNA student interviewed was a woman in her late 40s who had to take remedial math and reading coursework. Consequently, due to these additional classes she is at school all day. This is a woman who also is raising two foster children with the help of her daughter, and she worries about childcare for them since the program does not cover their childcare. Despite this, she says of the program and the extra classes, "It is helping me. It is fine." In spite of having a family to worry about, and having to take remedial classes, she wants to continue the program and get her LVN degree. She is very proud of the fact that she has received two "A"s so far. On another positive note, one instructor has a high regard for CTI student quality. According to her, the CTI group of WtW students has a higher level of math and reading skills and seems to be less needy and less vulnerable than WtW students in other courses.

#### *Innovative supportive service approaches*

There are some innovations in the way CTI participants receive supportive services. For example, in San Diego, the administrative arm of the CTI is developing a directory to be given to each CTI participant, listing available resources. The collaborative also trains employers to be aware of available social services. According to administrators at one collaborative, many of their privately-operated training providers had not needed this information before because prior to the CTI program they had not served such low-income populations.

Another innovative kind of support is mentoring, which can take several forms. One form is job-specific mentoring, where someone who completes the training program and has some work experience becomes a mentor for students who are in training. In one collaborative there are plans for a “legacy mentors” peer volunteer program set up with a contract between the WtW and Office on Aging to recruit retired LVNs as mentors. The collaborative’s goal is to expand this to include WIA, with a focus on healthcare professionals, especially CNA to LVN. The mentors also would do follow-up work with participants. In San Francisco, SEIU has set up their own mentorship program. To prepare mentors, they provide three days of training that emphasizes health, safety, and problem solving, and includes focus groups to discuss problems and career advancement. This, however, is for SEIU members only, and mentors chosen are leaders in the union.

More commonly, collaboratives report that mentors are available through adult school or vocational education programs, in which the mentor falls under the realm of an educational counselor. In addition, there are mentors who could be classified as “informal mentors” such as the case manager or classroom instructor who takes on the role of a support person. In individual interviews, CTI staff report that relationships that are more personal and offer more support to the students are important factors in meeting students’ needs, and ultimately, keeping them in the program. One single-mother student described her case manager as someone who got clothes for her daughter, helped her when she was sick, got food, and always showed concern for the student and her daughter. She said of her case manager, “whatever I needed, she did.” Along the same lines, one teacher told us that “some people don’t have breakfast, and we here do something in order to get food for them, and sometimes for their kids.”

As one WtW student states, “It is the first time I am getting help from every direction...caseworker, [Career] Center...everybody.” Now, she says she has much more confidence in herself. Another student says that her teacher gives students life lessons. The teacher herself had been a welfare recipient, and is now an LVN. As such, this is mentoring at its best, since students observe firsthand someone with a similar background who has succeeded. One 24-year old CNA student is very appreciative of the fact that the teachers are respectful, and treat the students as equals. She states, “I like it because I feel they respect me. It makes me feel like more of a person.” While informal mentoring is not necessarily innovative, and its effectiveness in increasing retention has not been determined, the unique feature is that CTI provides resources to support more case manager time and/or more teacher time with the students, and students are appreciative.

For many participants, this is the first time they have received special, individualized attention. It seems to be an important resource, relating to their sense of self-worth and possibly to retention. In one county, federal vocational-education funding is used to pay a monitor who calls students and their WIA case managers immediately if they miss class, if their grades fall, or if there are any other problems. According to school administrators, this intensive counseling has been so effective in increasing retention they are using it in all of their vocational programs. (This particular program benefits CTI participants but is not CTI-funded.)

## C. RETENTION

One goal of the CTI evaluation is to learn about factors that enable, encourage, and facilitate the retention of newly-trained CTI workers. Studies of workforce turnover show rates of up to 100% per year in some long-term care facilities. From the worker perspective, reasons for turnover include low pay, heavy workload, lack of recognition, and problems with supervisors. From the management perspective, high turnover rates also are caused by lack of soft job skills, family difficulties such as the need for childcare, family illness, and transportation problems. The CTI evaluation study will address some of those retention factors included in the interviews of early departures, face-to-face interviews at the focus sites, and the training satisfaction survey administered during training and at follow-up approximately six months later. On the basis of administrative data, further studies of whether the CTI trainees remain in the healthcare workforce beyond six months, one year, or two years will be important to the ultimate outcomes of this training initiative.

### **Case Management and Follow-Up**

Long-term follow-up and support may be a key to retention. At each of the site visits collaborative plans for follow-up services were discussed. Because enrollment and training were just underway in many collaboratives, they could present only follow-up plans. Most plan to provide conventional follow-up services available to any WIA or WtW client. The evaluators will monitor these activities for the duration of the program at the focus sites and, to the extent feasible, at the other sites.

The most common retention or follow-up service offered to a CTI participant is individual case management, typically based on WIA and WtW models. Case management services are likely to differ in the non-WIA model collaborative, West Hills. At the time of the site visit West Hills was still in discussions with their local WIB regarding the provision of case management.

#### *Who provides case management and follow-up services?*

Who provides case management and follow-up may be an important factor in predicting success in retaining CTI participants in the healthcare workforce. The case managers may be welfare caseworkers (most common), counselors, or specialists such as the vocational counselors used in Sonoma County. The use of vocational counselors as case managers may be beneficial because they are better trained in skills assessment and career coaching. Several CTI collaboratives have contracted with outside vendors for case management and retention services.

The background and credentials of the person providing case management services vary within each CTI collaborative as well as across collaboratives. One educational coordinator, for example, voiced concerns that case managers are not trained to cover the range of issues presented by CTI students. Pregnancy, spousal abuse, financial crises, car breakdowns, and both child and student health crises are not uncommon problems faced by low-income students. In this coordinator's assessment, case managers have neither the training nor the resources to provide meaningful assistance.

### *What services are provided?*

The content of case management services varies from collaborative to collaborative and from case manager to case manager. At the initial site visits, we collected information from all twelve collaboratives about their current case management or plans for implementing a case management program. From that information, we know that a wide variety of case management models are used with the CTI participants. From further interviews at the focus sites we have more in-depth knowledge of case management services which confirms that a variety of case management models and services are provided to CTI participants. There is insufficient information to date to assess the quality of case management and its impact on participant retention, although we have anecdotal reports from interviews. For example, some CTI staff mentioned that the intensive case management offered by the program leads to a decline in the drop out rate. While most interviewees spoke very favorably of their case managers, a few complained of their inaccessibility.

The Sacramento collaborative plans to offer more intensive case management services to CTI participants, including preparation of an Individualized Service Plan with career goals for each client. Because Sacramento is a focus site, we plan to collect further information on the effectiveness of this tool in retention of participants in the healthcare workforce.

### *Setting, frequency, and length of follow-up services*

The duration of case management services provided to CTI participants at follow-up will vary by collaborative and even within each county in the multi-county collaboratives. The range of post-program case management services reported by the collaboratives during the site visits is from six to eighteen months after training. The frequency of contact between the case manager and the client varies in the CTI programs from weekly, monthly, quarterly, or on an as-needed basis.

## **Innovations in Case Management and Follow-Up**

Contra Costa County has developed or is in the process of developing several innovative approaches to case management and follow-up of CTI participants. Those innovations include hiring a healthcare specialist case manager/training coordinator so that someone with specialized knowledge about the healthcare workforce is available to other case managers, trainees, and graduates of the CTI program. In addition, the county has a 24/7 on-call paging system for case managers (for all clients) so that needs for emergency assistance can be addressed. These relatively new innovations in case management are expected to enhance long-term retention of CTI participants. The evaluators will address the effectiveness of these programs in the final report.

Another innovation is a newsletter for CTI participants in Solano County. The newsletter focuses on job retention issues, and is mailed to all clients who complete the training program. It contains information and tips about retention as well as workshop offerings on retention-related issues such as improving one's credit, financial management, and staying motivated.

The transition to employment is a key aspect of the CTI program. Building partnerships with employer organizations is a strategic objective of most of the collaboratives. Some of these county, educational, and industry partnerships were created with CTI funding; other partnerships

had a long history prior to CTI. With the current healthcare workforce shortage, most employers seem eager to join forces with training efforts and to provide financial and in-kind support. As discussed earlier, several of the CTI collaboratives have employers who are involved actively in the marketing and pre-training recruitment efforts.

Collaboratives vary in terms of how they form relationships with employers as partners. This is reflected in the fact that some of the collaboratives listed only WIBs as partners, whereas others were much more expansive. Employer relationships range from formal collaborative membership, to secondary partnerships serving as clinical training sites. Regardless of formal partnership arrangements, all collaboratives have close working relationships with local employers. The numbers range from a couple of employers to a dozen or so. Thus far, our analysis has not found any relationship between the number, or kind, of employer relationships and employability of participants.

#### *Varied employer involvement*

Because employers were key drivers in the development of the CTI program, their level of participation in the collaboratives is an important component of the evaluation. (As more participants complete the program, employer interviews and follow-up Training Satisfaction Questionnaires will provide further information on this topic for the final report.) From the initial site visits, we observed that employer enthusiasm, motivation and direct participation in the regional CTI efforts is mixed. Employer involvement and interest in working with the CTI collaboratives seems to be related to the severity of regional workforce shortages and how desperate employers are to find new employees or potential employees. Where shortages are severe, some employers compete with each other (through wages) for these newly trained employees. Thus, the atmosphere in some collaboratives is not conducive to employers working together or being together at the same table. On the other hand, from an employee perspective, this is not altogether bad, since one consequence may be higher wages for workers.

#### *What commitments employers expect from CTI trainees*

In the SELACO collaborative, employers initiated "contracts" or agreements for continued employment for LVN students after training. Employers are reluctant to fund or support the training program for these LVNs without some type of commitment from the students. These contracts are developed and negotiated between the employer and the student without any involvement of the collaborative agency. The length of commitment varies and the formality of the agreements also varies. Whether such contracts are legally binding remains to be seen in the long-term; the students involved are still in the training program.

#### *When transition to employment occurs*

The transition to employment may occur in two ways. It can happen prior to or during the training experience, or it can happen after training is complete. For the former type of transition, some CTI participants are employed at the beginning of their enrollment in the program. In collaboratives where there is active involvement and support from employers, these participants receive various forms of on-the-job and paid training. One example is the 20/20 work/training program, supported by several employers working with the CTI. For the latter type of transition, which applies to most of the CTI participants, transitions to work occur after training and require follow-up with the participant and/or employer to determine employment details.

### *Ease of finding a job after training*

In today's environment with a shortage of healthcare workers, finding a job is nearly effortless. For most of the CTI trainees, getting a job in health care has not been difficult. Many trainees have job offers or firm commitments before completing their training. At this time, we are not able to report on the quality of the jobs CTI participants obtained, whether their wages improved from pre-training, and whether wages were competitive with other similar positions in the market. We will analyze this information using state-supplied databases, and will report findings in the CTI Final Report.

### *Employer and employee incentives*

Several collaborative proposals discussed the possibility of offering employer tax incentives for CalWORKS clients. Under the federal Taxpayer Relief Act of 1997, the Welfare to Work Tax Credit is available to employers who hire long-term CalWORKs recipients. Tax credit can be obtained for employees working a minimum of 400 hours, ranging from 35 to 50% of the first two years' qualified wages. Besides federal tax credits, state tax credits (Enterprise Zone Hiring Credits) also are available for employers of CalWORKs recipients. Eligibility must be established for the job seeker before the offer of employment, and all paperwork must be submitted to EDD.

Most employers with CTI have chosen not to take advantage of the opportunity. First, employer tax incentives may not be needed in the current job market where employers are eager to hire any CTI trainee. Also, barriers reported by site administrators include employer apprehensions about opening up books for an outside agency audit, and the amount of paperwork required. SELACO is one collaborative using tax credits. There, a small number of nursing home facilities use the tax incentive money to provide bonuses to CNAs, rewarding attendance on the job. Employees with perfect attendance for 30 days receive a \$100 bonus, and for 90 days of perfect attendance, they receive \$300. Employers find that this incentive program works well because the reward program focuses on their real goal of workforce retention.

Incentives for CTI students are used infrequently. One training site offers a cash bonus, up to \$300, for students who stay on the job for a given period of time. The employee does not receive the cash until she or he has completed the required number of months or hours on the job. This has been very well received by trainees, and merits further scrutiny with future retention analyses.

## **Retention Strategies and Programs**

Increasing retention in employment is a central goal of the CTI program and a challenge with the entry-level healthcare workforce. Given the relatively short program timeframe, collaboratives will be able to follow participants for only a few months to a year, at most, after clients complete training. To the extent that qualitative data from the focus sites and labor market data allow, we will address retention as one outcome measure in the final report.

### *Instructors contribute to retention*

Based on interviews with program participants, the instructors themselves seem to be a retention tool. They play an important role in student perceptions of classes and in their evaluation of the training experience. As discussed earlier, students constantly refer to teachers



as giving them support and teaching them much more than CNA technical skills. Beyond being instructors, they serve as role models and sources of support encouraging students to be persistent and to pursue their goals. In this sense, it is reasonable to view instructors as very relevant “retention tools” who prevent students from dropping out and encourage them to continue and to set future goals.

#### *Increased wages as a retention strategy*

A key retention strategy identified by several collaboratives is to promote increased wages and benefits, and generally to address the work environment, particularly for entry level, low-wage healthcare workers. Collaboratives with active union participation, particularly San Francisco, include these goals in the CTI program agenda. One collaborative mentioned an employer who promised clients higher wages, about \$2 more per hour, upon completion of training. Other collaboratives with less direct union involvement seem not as committed, or at least not as vocally committed, to wage and benefit improvement as a key to retaining workers. Again, the statewide administrative databases we receive during the course of this evaluation will allow us to examine wage increases for the CTI participants, and determine whether a strong union presence has a positive influence on wages and earnings.

#### *Continuing education as a retention strategy*

Some collaboratives express the belief that continuing education is the key to retaining newly trained workers such as CNAs, psychiatric technicians, and licensed nurses. Some collaboratives are working with educational partners to develop continuing education programs, although specifics on these efforts are not available yet. One collaborative plans to pay for lost time from work so that workers can focus on career advancement training.

#### *Pre-employment job awareness as a retention strategy*

It is a common assumption that greater understanding of the nature of healthcare employment and greater awareness of the reality of the work environment are related to longer retention in the healthcare workforce. At least two of the collaboratives require potential CTI participants to attend a job club. There they investigate the labor market and job functions of healthcare providers, including a site visit to a long-term care facility and interviews with employees. Another collaborative requires a pre-training visit to a long-term care facility. The administrators state that this is an effective and important “weeding out” process.

#### *Career coaching and mentoring*

Career coaching and mentoring after training are offered or planned to be offered by several collaboratives. Mentoring will be provided by recent training program graduates, retired or current workers, SEIU members, and union stewards. At this time, mentoring and career coaching activities are still in the planning stage at most sites. At least one site, the SELACO collaborative, initially intended to contract with an outside vendor for mentoring and retention services. This contract was not implemented because the vendor lead time for starting services for a new client was determined to be too long. SELACO decided to keep case management services in-house and is providing these services through the One-Stop centers. We will report further on these activities in the Final Report.

#### *Providing ongoing supportive services as a retention strategy*

One collaborative has suggested that providing ongoing support services such as childcare following training would be a good use of CTI funds. While this may be an option,

program restrictions on use of funds may limit the possibility of this as a long-term retention aid.

### **Retention Issues**

As stated earlier, retention of workers in the long-term care workforce is a key goal of the CTI program. The outcomes related to retention of CTI participants in the healthcare workforce are an important component of the evaluation. To the extent that we can evaluate this important component of retention, we intend to provide further analysis in the final report. Longer-term follow up of case management as a factor in retention also should be a key component of future studies.

## IV. PRELIMINARY FINDINGS

This chapter reports findings based on our analysis to date of CTI project activities described in detail in the previous chapters. As indicated, these findings are trends identified by the analyses to date, and in some instances, can be interpreted as preliminary promising practices. Our final evaluation report will include a fuller analysis of the effectiveness of collaborative efforts to recruit, train, and retain health caregivers in California. These preliminary findings are reported in terms of (1) what seems to work well, and (2) which barriers have arisen that may impede effectiveness.

### A. GETTING STARTED

Given the variation in population density, demand for caregivers, and organizational partners comprising the twelve collaboratives, it is not surprising that the grantees differ in their pace and approach to program implementation. The following findings relate to getting started in building collaboratives and implementing the CTI program.

#### What Works

*Collaboratives with certain attributes have fewer problems getting started than those without.*

These attributes include:

- Previous experience in partnering, where collaborative partners worked together prior to the CTI grant, so that less time was needed initially to organize
- Previous experience working with state licensing boards, so that approval for starting a new training program could be facilitated more quickly
- Strong and effective collaborative leadership, from both the lead agency and the individual responsible for guiding CTI development and implementation
- A positive relationship with the EDD Regional Advisor to facilitate swift resolution of problems related to administrative requirements

#### Primary Barriers

*1. The short time span between grant announcement and program start date, and the short time frame for the program, have been challenging to the grantees.*

The key time-sensitive factors are:

- Confusion about the program, especially eligibility and reporting requirements. The short time between award announcement and program start date (under six weeks) required collaborative staff familiar with only one program (WIA or WtW) to learn about the other program. Many local CTI administrators were confused about eligibility, reporting, and performance measures for CTI. These issues were eventually resolved, but in some cases resolution happened many months after the grants began.
- Sub-contract negotiation and approval. Negotiation and approval of sub-contracts often take many months to complete, especially when city or county boards have to approve contracts. Some collaboratives require numerous sub-contracts, for each county partner as well as for each agency partner.
- Concerns over creating an infrastructure of courses, instructors and case managers for a short-lived grant. The CTI grant allows for personnel expenditures, but many CTI partner agencies and organizations cannot easily hire staff only to terminate them after eighteen months. Further, while community colleges and adult schools can use grant monies to expand capacity and invest in equipment, they hesitate to make that investment if the demand will terminate with the grant.

***2. Not all collaboratives benefit from collaborating, and the investment in active and innovative collaboration among partners within collaboratives is uneven.***

The key barriers to active and innovative partnering are:

- Organizational barriers. In all but a few cases, grantees formed new partnerships in order to develop their collaboratives. Few county Social Service Departments and Workforce Investment Boards had prior collaboration experience. Counties that joined or formed collaboratives for the purpose of the CTI grant often had not worked previously with other CTI partners for well-founded reasons — their populations, industries, provider communities, and workforce needs differed. In cases where major partners, such as neighboring counties, did have previous experience collaborating, grant start-up proceeded more smoothly.
- Significantly different enrollment goals among collaborative partners. Because CTI enrollment targets vary significantly by county and within each collaborative, there is wide variation in the investment made in the CTI by the partners in the collaborative. A county with a goal of only several participants does not have to revamp recruiting or training as much as a county with a goal of several hundred.
- Small percentage of total budget that CTI grant represents for partnering agencies. By the time the CTI dollars are split among many counties and/or agencies, some consider their share to be too small to do anything except meet minimum enrollment goals.

### ***3. Identifying and expunging previous criminal records for clients so they could qualify for certification is a significant challenge.***

All CNA and HHA applicants must have criminal record clearance, a challenge for all of the CTI collaboratives. Key issues in clearing past criminal records are:

- Timeliness of receiving fingerprint results. Collaboratives report delays in getting results of fingerprinting back from the state, where students must be cleared through the Department of Justice and the Health and Human Services Agency.
- Misperceptions by CTI participants concerning the thoroughness of the identification process. Both instructors and students report that some CNA students falsely report no criminal background on application forms. This means that some will receive training but not receive their certificates.
- Complexity of the expungement process. CTI staff members report that many potential candidates have criminal records, but they may be able to expunge, or erase, their records to qualify for healthcare employment. The expungement process, however, can be both costly and lengthy.
- Limitations of background checks. Only crimes prosecuted in California are subject to review, so out-of-state criminal records will not be identified in California's background check system. A lengthier and more expensive review process is to submit fingerprints to the FBI, but not all state records are in the FBI database.

## **B. RECRUITMENT**

Recruitment and suitability assessment are not new to CTI grantees. Prior to CTI, collaboratives recruited participants into training programs, created recruitment campaigns, and screened applicants. The evaluation team has sought to identify recruitment innovations in CTI programs, both in terms of approaches used and groups targeted.

### **What Works**

#### ***1. All of the collaboratives are on target to meet or exceed their participation goals.***

Though some collaboratives started up slowly, at this time it appears that almost all will reach or exceed their anticipated numbers of participants, so recruitment efforts overall are adequate.

#### ***2. Several innovative methods seem useful in reaching target groups of participants and building relationships with the community.***

- Reaching out to community-based organizations to assist in marketing and identification of potential candidates
- Partnering with healthcare unions

- Building relationships with healthcare providers/employers
- Fostering interest in caregiving careers among high school students
- Leveraging exposure by promoting community interest stories for local television and radio programs
- Incorporating both existing and emerging technology into marketing programs, such as toll-free hotlines, websites and pages, and electronic kiosk ads
- Collaboratives sharing marketing materials with each other

**3. Several collaboratives are targeting specific and non-traditional populations for caregiver training.**

- Non-English speaking home care workers for skill upgrades
- Potential upgrade candidates identified from CNA/WtW databases
- Migrant worker family members
- Marine medical corpsmen
- Foster youth nearing emancipation

**4. Not everyone is suitable for healthcare work. Some collaboratives have developed innovative and comprehensive assessment procedures targeted toward assessing suitability for healthcare work.**

While all collaboratives are familiar with suitability assessment tools and with the WIA and WtW populations, they are not as familiar with the difficulties of assessment in the healthcare field. Unlike many other occupations, caregivers must be proficient in English, have no previous criminal convictions, submit to drug testing, and be able to manage both physical and emotional work challenges. One collaborative developed an assessment process to determine applicant fit with the physical and emotional demands of caregiving. Partners in some other collaboratives use more informal and personal screening approaches.

**Primary Barriers**

**1. On average, WtW participants are more difficult to recruit and qualify for training.**

The WtW participants face more barriers than do members of the general population in seeking healthcare training. The key barriers are:

- Lack of English proficiency
- Lack of basic math and science knowledge
- Lack of “soft skills”— professional dress and attitude, timeliness
- Transportation problems
- Childcare problems
- Criminal records
- Substance dependency
- Domestic violence

**2. The emphasis on “work first” limits the flow of potential CTI applicants.**

CalWORKs caseworker commitment to “work first” diminishes the importance of training and presents obstacles in making referrals to training programs. Caseworkers are keenly aware of the time limitations for every WtW client. If training is not available immediately at a location easily accessible to the WtW client and if the client has any other barriers to overcome,

such as those listed above, caseworkers are very likely to require the client to seek work instead of training.

***3. Limited English proficiency is a significant barrier in California for low-income individuals who would like to seek caregiver training.***

A large and growing number of low-income Californians do not speak or read English well enough to complete English-only training courses or certification exams. Lack of English proficiency means that many potential participants need more preparation/assistance to qualify for certified caregiver training. We have identified only one bi-lingual training program for CNAs and HHAs in the state, a private school in San Francisco.

***4. The shortage of nurse instructors limits capacity to increase the numbers of individuals trained.***

Effective training begins with qualified instructors, and an expanded healthcare workforce requires an expanded pool of nurses and others to train them. Developing this instructor pool is a challenge for many sites and will require specific attention in current and future program design.

***5. In areas with severe shortages of workers, some LTC facilities are less cooperative with recruitment because they fear losing valuable workers, even if only in the short-term.***

In an industry faced with worker shortages, employer behavior may be determined by short-term self-interest at the expense of longer-term societal goals. Retaining current workers, however limited their formal training, supercedes encouraging career path choices that may lead workers to leave for better jobs. Employers are both crucial and challenging partners.

## **C. TRAINING**

Training is at the core of the CTI, and the evaluation team has identified what seem to be several features of successful training programs. The evaluators pay particular attention to training support services, including innovations in the creation or use of support services, and success and challenges in their use.

### **What Works**

***1. The effect of collaboration has been positive on organizing and coordinating regional training resources.***

In general, the overall impact of the collaborative effort on the training programs is positive. Especially in urban areas, collaboration has resulted in less competition and more efficient use of resources. Administrators state they are better able to meet student needs because of CTI's cooperative atmosphere. Collaborative-wide training programs can provide more flexibility and offer students more training options.

***2. Overall, CTI participants are highly satisfied with CTI training.***

Nine of ten students are satisfied or very satisfied with the overall quality of the program. There are also high levels of satisfaction with instructor preparation, class presentations, level of difficulty, usefulness of classes, how much instructors care about the students, how much they

help them, program flexibility, location, and ability to practice skills on real people.

**3. *Fast-track training is a popular and efficient training approach for some CTI students.***

Several collaboratives have developed a fast-track option for the most promising trainees. For students who are well prepared and able to adapt, this means that training can be completed in a fraction of the time required for regular programs. It is not appropriate for all students, since it is, as its name implies, fast-paced.

**4. *On-the-job training is very desirable from a student perspective.***

On-the-job training is beneficial to students who need income while they are in training, and who are not able to give up a full-time salary. Because many of those targeted for CTI training are primary family wage earners, increasing the numbers of those paid during training should be strongly considered for future initiatives.

**5. *Students like cash incentives for training, but they are not widely used.***

One site has a CTI-funded incentive program, in which participants are given cash incentives as they complete various stages of training. They receive \$100 when CNA certification is complete, with another bonus after working for a healthcare employer for six months. These incentives are very popular at that site. At another site, one employer agreed to offer a \$2/hour wage increase for all incumbent workers who complete CNA training.

**6. *Case management is an important component of the training programs.***

The importance of intensive case management, possible with CTI funding, is acknowledged by students and staff alike. Students report that for the first time they are being treated with respect, and many talk about improved self-esteem and a stronger commitment to the program. Staff report that case management helps prevent behaviors (e.g., missing classes) that lead to program non-completion.

**7. *Many sites proposed to develop mentoring resources, but few have done so.***

Formal mentoring, where a volunteer-like person (usually someone who has completed CNA or LVN training) is assigned to act as a mentor to the student, is used by only one collaborative. Informal mentoring is more common in this program, where someone is available to assist in addressing the diverse needs of these participants.

**8. *The flexibility of CTI funding to provide support services is a strong component of the program.***

Most supportive services for CTI participants are offered through the local WIBs. However, many of the collaboratives supplement these with additional services from a wide range of partners, including CBOs, unions, Offices on Aging, and adult schools. The flexibility of CTI funding helps in purchasing, for example, books, uniforms, fingerprinting, and tuition.

## **Primary Barriers**

**1. *The most commonly needed training support services are childcare and transportation.***

Childcare is important for both WIA and WtW participants although it may be more important for WtW clients because more of them have children. Our data indicate that 75.7% of the WtW clients have children living with them, compared with WIA clients, where 60.9% have



children. These services are sometimes offered erratically; one site did not offer childcare unless clients asked specifically.

**2. *Transportation is an important support service, especially for clients living in rural areas.***

One of the more rural sites is innovative in its use of CTI funds to secure several vans used to transport students from remote areas to classes. Another collaborative uses gasoline vouchers, and many use bus passes. Two rural collaboratives offer overnight accommodation for students so that they will not have to drive several hours each day to attend classes. It is unclear how students would get to classes without these special accommodations.

**3. *Some CTI trainees may require more extensive support services in order to complete a training program successfully.***

First, although childcare and transportation are available for all CTI participants, a small number left the program because they needed more comprehensive services. For example, 5 of the 37 people interviewed in the Early Departure survey indicated they needed more help with childcare. At one site, childcare was available at the One-Stop center, but at most collaboratives, participants had to make their own arrangements. Eleven participants reported scheduling problems and fourteen had family or personal problems. It is possible that some of these issues could have been addressed if more and different kinds of supportive services were available.

## **D. EARLY DEPARTURE AND RETENTION**

Retaining newly trained healthcare workers in the workforce is a key goal of the CTI program. It is too early to know, however, if caregivers trained in this program will remain in the healthcare field. The entry-level healthcare workforce is characterized by annual turnover rates of up to and (in some cases) beyond 100% in many long-term care facilities. CTI has devoted significant resources toward recruitment and training of new workers, but this is only part of the solution to the workforce shortage that the Initiative aims to address. Keeping workers in the workforce beyond the training program will be important to the program's success.

The literature on the long-term care workforce indicates that many factors, including the work environment, wages, and the state of the general economy, have an impact on long-term care workforce retention. The labor market analysis component of this evaluation should reveal useful insights about CTI participants and non-participants in terms of their short-term experience in the workforce.

In the evaluation process, it will be especially challenging to assess worker retention due to the relatively short length of the program and the inability to follow clients for more than a few months or a year at most after training is completed. Monitoring and assessment over a longer time period, such as two or three years, would improve our ability to understand the forces affecting retention in the field. Within these constraints, the impact of CTI on retention will be assessed as an outcome measure in the final report.

## **E. FUTURE DIRECTIONS**

Almost all CTI collaboratives are expected to meet or exceed their goals for numbers of caregivers trained. For maximum program success, it is important that most of these caregivers remain in the healthcare field. We recommend further research that combines secondary data analyses, surveys, focus groups, and interview methodologies to better understand caregiver retention. We also recommend support of pilot studies that assess different approaches to increasing retention. For best results, such studies would need to include long-time caregivers in the field as well as recent graduates.

In summary, there are not enough caregivers in California to respond to current demand from the elderly and other populations, resulting in threats to patient safety and compromised quality of care. The percentage of Californians over age 65, over age 85, and over age 95 will increase dramatically over the next two decades. The current critical worker shortage, which is worsening over time, cannot be relieved without a strong and meaningful commitment from the state. Such a commitment is exemplified by two more recent WIA-funded grants, \$10 million to health care facilities to train healthcare workers, and \$60 million for the Nurse Workforce Initiative to increase the number of nurses in the State. Hopefully, findings from these and similar programs will be useful in helping State decision-makers pinpoint key elements of organizational, financial, and operational successes in recruiting, training, and retaining caregivers, so that future programs can most effectively address California's healthcare workforce shortage.

## BIBLIOGRAPHY

- Bardach, E. (1999). Getting Agencies to Work Together: The Practice and Theory of Managerial Craftmanship. Washington, D.C.: The Brookings Institution.
- California Department of Health Services (2001). Nursing Staff Requirements and the Quality of Nursing Home Care: A Report to the California Legislature. Sacramento, CA: DHS, Licensing and Certification Program.
- California Department of Social Services (2001). In-Home Supportive Services: Examining Caseload and Costs during State Fiscal Year 1996-97 through 1998-99. Sacramento, CA: California Department of Social Services, Research and Development Division. Available at <http://www.dss.cahwnet.gov/research/pdf/IHSS.pdf>
- California Employment Development Department (2001). The Quest for Caregivers: Helping Seniors Age with Dignity. Sacramento, CA: Employment Development Department, Labor Market Information Division.
- Carrier, B., Eyman, B.D., Bakewell, E., Meengs, L. & Shapiro, L. (2000). Challenges in Recruiting, Training and Retaining a Workforce for Safety Net Hospitals and Health Systems. Washington, D.C.: National Association of Public Hospitals and Health Systems.
- Center for California Health Workforce Studies (2001). Trends, issues, and projections of supply and demand for nursing aides and home health care aides: California fieldwork. San Francisco: University of California, San Francisco.
- Chrislip, D. & Larson, C. (1994). Collaborative leadership: How citizens and civic leaders can make a difference. San Francisco: Jossey-Bass.
- Decker, H., Dollard, J., & Krador, K. (2001). Staffing of Nursing Services in Nursing Homes: Present Issues and Prospects for the Future. Seniors Housing & Care Journal, 1: 3-26.
- Gregory, S.R. (2001). The nursing home workforce: certified nurse assistants. Available: [http://research.aarp.org/health/fs86\\_cna.html](http://research.aarp.org/health/fs86_cna.html) Washington, D.C.: Public Policy Institute, AARP.
- National Association of Home Care (2000). Basic Statistics about Home Care. Online: <http://www.nahc.org/consumer/hcstats.html>
- Pear, R., (2002, February 18). 9 of 10 Nursing Homes in U.S. Lack Adequate Staff, a Government Study finds. The New York Times, section A, pp. 11
- Sandfort, J. (1999). The structural impediments to human service collaboration: Examining welfare reform at the front lines. Social Service Review, 73: 314.
- Stone, R.I. (2001). Who Will Care for Us? Addressing the Long-Term Care Workforce Crisis. Washington, D.C.: The Urban Institute and the American Association of Homes for the Aging.

U.S. Department of Health and Human Services (2000). HRSA State Health Workforce Profile: California. Rockville, MD: National Center for Health Workforce Information and Analysis. Bureau of Health Professions.

U.S. Department of Health and Human Services (2001). The registered nurse population: national sample survey of registered nurses – March 2000. Preliminary findings. Washington, D.C.: Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing.

U.S. Department of Health and Human Services (2002). Press release: Bush administration promotes careers in nursing: Survey shows critical shortage of nurses. Washington, D.C. HHS Press Office, February 22, 2002.

U.S. Department of Labor (2001). Lost-work time injuries and illnesses: characteristics and resulting time away from work in 1999. Press Release, Bureau of Labor Statistics, March 28, 2001.

U.S. Department of Labor. Occupational Outlook Handbook, 2000-2001 Edition. (2001). Washington, D.C.: U.S. Department of Labor.

U.S. General Accounting Office (2001a). Health workforce: ensuring adequate supply and distribution remains challenging. Testimony before the Committee on Energy and Commerce, U.S. House of Representatives, August 1, 2001. Washington, D.C.: U.S. General Accounting Office.

U.S. General Accounting Office (2001b). Long-term care: Baby boom generation increases challenge of financing needed services. Testimony before the Committee on Finance, U.S. Senate, March 27, 2001. Washington, D.C.: U.S. General Accounting Office.

U.S. General Accounting Office (2001c). Nursing workforce: emerging nurse shortages due to multiple factors. Testimony before the Committee on Ways and Means, U.S. House of Representatives, July 2001. Washington, D.C.: U.S. General Accounting Office.

U.S. General Accounting Office (2001d). Nursing workforce: multiple factors create nurse recruitment and retention problems. Testimony before the Committee on Governmental Affairs, U.S. Senate, June 27, 2001. Washington, D.C.: U.S. General Accounting Office.

U.S. General Accounting Office (2001e). Nursing workforce: recruitment and retention of nurses and nurse aides is a growing concern. Testimony before the Committee on Health, Education, Labor, and Pensions, U.S. Senate, May 17, 2001.

Van Kleunen, A. & Wilner, M.A. (2000). Who will care for mother tomorrow? *Journal of Aging & Social Policy*, 2/3.

Wilner, M.A. and Wyatt, A. (1998). Paraprofessionals on the Frontlines: Improving Their Jobs – Improving the Quality of Long Term Care. A conference background paper prepared for the American Association of Retired Persons Long Term Care Initiative. (September 10-11 1998).

## **APPENDIX A: SAMPLE SITE VISIT GUIDE**

## **Private Industry Council of San Francisco**

### **Summary of Proposal Goals**

#### **General: Identified Training Needs**

Training for greater levels of skill and professionalism

Vocational ESL

Training toward movement along a career ladder

Creating support networks

Providing respite care for incumbent workers

Providing needs-based training stipends, transportation, childcare, and other support services

#### **Recruit**

Recruitment Methods: Program recruitment materials in several languages (English, Spanish, Russian, Chinese, Tagalog, Vietnamese); Public service announcements; newspaper stories; ads; Project staff will identify “other outreach venues and techniques”; Local 250 will advertise in its monthly magazine, through their website, and fliers

#### Key Actors:

WtW: WtW and WIA vendors/program operators; One Stops; community, cultural, and religious organizations/associations

IHSS Workers: Public Authorities outreach; unions; private registries

Targets: IHSS workers (especially non-family members with limited or no English skills); CalWORKS recipients; low skilled workers in healthcare facilities; other WtW eligibles; other unemployed and underemployed

#### **Train**

Sites: City College of San Francisco; Skyline College; San Mateo Union High School District Adult and Community Education; San Mateo County Office of Education/ROP

Key Actors: Arriba Juntos (VESL, job readiness); Self-Help for the Elderly (soft skills; support, case management, VESL); Jewish Vocational Services

Support: VESL, job readiness; Not specified in text of proposal, but graphic on page 6 includes: Basic remedial education, peer & job site support, job search skills, case management, needs-based payment, childcare, transportation

Programs: CHHA, CNA, LVN, LPT, EMT, RN

Employers/Clinical Training Sites: SF IHSS Consortium; Adult Day Services Network; On Lok Senior Health Services; Jewish Family and Children’s Services; Kaiser Permanente; Aunt Ann’s Home Care; The Magnolia; Millbrae Serra Convalescent Hospital; Pacific Nursing and Rehab Center; Ralston Village

#### **Retain**

Key Actors: Not specified in text of proposal

Methods: Not specified in text of proposal, but graphic on page 6 includes: Job placement, re-placement, retention, skills and job upgrade service

**Private Industry Council of San Francisco  
 Caregiver Training Initiative  
 Initial Site Visit, July 23, 2001**

Evaluation Team Members: Ruth Matthias, Susan Chapman, Ellen Morrison, Arnab Mukherjea  
 EDD Representative:

Program Personnel Participating in Site Visit:

<u>Name</u>	<u>Title</u>

Project Actual Start Date:

Recruit N:

Timelines, Progress to Date:

<b>Recruitment Methods</b>	
Program recruitment materials in several languages (English, Spanish, Russian, Chinese, Tagalog, Vietnamese)	Copies of materials?
Public service announcements	Any yet?
Newspaper stories	Any yet?
Ads	Any yet?
Project staff will identify "other outreach venues and techniques"	Describe?

Local 250 will advertise in its monthly magazine, through their website, and fliers	Copies of ads? Website address? Sample flier?
Targets	
IHSS workers (especially non-family members with limited or no English skills)	Status?
CalWORKs recipients	Status?
Low skilled workers in healthcare facilities	Status?
Other WtW eligibles	Status?
Other unemployed and underemployed	Status?

<b>Sites</b>	
City College of San Francisco	Enrollment? Issues?
Skyline College	Enrollment? Issues?

San Mateo Union High School District Adult and Community Education	Enrollment? Issues?
San Mateo County Office of Education/ROP	Enrollment? Issues?
Additional sites (please specify)	Enrollment? Issues?
<b>Training Programs</b>	
CHHA	Enrollment? Issues?
CNA	Enrollment? Issues?
LVN	Enrollment? Issues?
LPT	Enrollment? Issues?
EMT	Enrollment? Issues?
RN	Enrollment? Issues?

<b>Employers/ Clinical Training Sites</b>	
SF IHSS Consortium	Status?
Adult Day Services Network	Status?
On Lok Senior Health Services	Status?
Jewish Family and Children's Services	Status?
Kaiser Permanente	Status?
Aunt Ann's Home Care	Status?
The Magnolia	Status?
Millbrae Serra Convalescent Hospital	Status?
Pacific Nursing and Rehab Center	Status?
Ralston Village	Status?
Additional employers/sites (please specify)	Status?

<b>Support</b>	
VESL	Participation? Feedback?
Job readiness	Participation? Feedback?
Basic remedial education (not specified in text of proposal, but included in graphic on page 6)	Participation? Feedback?
Peer & job site support (not specified in text of proposal, but included in graphic on page 6)	Status?
Job search skills (not specified in text of proposal, but included in graphic on page 6)	Participation? Feedback?
Case management (not specified in text of proposal, but included in graphic on page 6)	Status?
Needs-based payment (not specified in text of proposal, but included in graphic on page 6)	Average cost per student? Total cost?
Childcare (not specified in text of proposal, but included in graphic on page 6)	Average cost per student? Total cost?
Transportation (not specified in text of proposal, but included in graphic on page 6)	Average cost per student? Total cost?



**Retain**

## Timelines, Progress to Date

Improving working conditions, wages	Status?
Ongoing recruitment to encourage continuing enrollment	Status?
Job placement, re-placement, retention (not specified in text of proposal, but included in graphic on page 6)	Status?
Skills and job upgrade services (not specified in text of proposal, but included in graphic on page 6)	Status?
Other?	Status?

## Additional General Questions for All Sites

## 1. Recruitment assessments

- a. What are some of the assessment measures (formal and otherwise) used to determine whether caregiver occupations are the most suitable for the applicants?
- b. Who does these assessments (e.g. the welfare department, the employer, CTI staff)?
- c. Are these assessments based on participants' skills? \_\_\_\_\_ knowledge? \_\_\_\_\_ abilities \_\_\_\_\_ values? \_\_\_\_\_

## 2. CalWORKs participants

- a. What kinds of special efforts, if any, do you or your staff make to include CalWORKs participants?
- b. How are they recruited?
- c. Is the training different? \_\_\_\_\_ If so, how?
- d. Are there any other additional incentives that non-CalWORKs people do not receive?
- e. Overall, do you have any idea whether CalWORKs clients do better or worse than others in terms of staying in the program, finding jobs, etc?
- f. Overall, how effective was the initiative in transitioning the CalWORKs participants into caregiver occupations?

## 3. What do you perceive to be the key innovations of this project?

## 4. So far, what do you think are the most positive parts of the program?

## 5. So far, what are the parts of the program with which you are having the most difficulty?

## 6. How are you addressing these difficulties?

## 7. Have you started working on any plans to obtain other funding sources for the program, or do you think the program will end when the funding ends?

## 8. What information or other support from EDD, the evaluation team, or other sources would increase the likelihood of success or sustainability of your project?

**APPENDIX B: PARTICIPANT AND STAFF INTERVIEW  
GUIDES**

**UCLA School of Public Policy  
Caregiver Training Initiative  
Qualitative Interview for Participants**

**ID #** \_\_\_\_\_

1. Date of interview:
2. Place of interview:
3. Interviewer name:
4. Interviewee name:
5. Gender:
6. Age:
7. Training program/certificate:

## Qualitative Questions for CTI Participants

### **Background**

1. What was your previous job (before starting this training program)?  
Are you still working there? How satisfied are/were you with it?  
How are the hours?  
How is the pay?  
How are your co-workers and boss?

### **CTI personal goals**

1. What were your personal goals and objectives in going into this training program?
2. Why are you interested in this kind of training?

### **Recruitment Methods**

1. How did you find out about this program?
2. [If they worked before] How did you find your last job?
3. Have you had job training before? How did you find it? How was it?
4. *WtW clients only*: Were you encouraged by your WtW caseworker to participate on this program? How?

### **Innovations in recruitment, training and retention, and the level of difficulty associated with each**

1. Before you got in the training program, did you have any problems, like delays with time, or money issues? What?
2. When you started your training, did you have any problems? What?
3. What do you think would be the best way to get more people into the program? Like what?
4. What did (or do) you like most about the program? Why?
5. What did (or do) you like least about the program? Why?
6. Is there anything else the staff or teachers could do to make your training better? Like what?
7. Did you have any problems that made it difficult for you to stay in the program or to do the work? What problems? What did you do about those problems? Did the people from the program offer you help? What kind of help? Was it helpful?
8. Did you ever think about dropping out of the program?  
[If yes] Why did you want to drop out?  
Why did you decide to stay in the program?
9. [If you have been involved in other CalWORKs training programs] How does this compare with other CalWORKs programs you have experienced? What is better? What is worse?

### **Assessment processes used to assure a good match**

1. How much choice did you have about the kind of training program you went into?  
How much choice did you have about your schedule?  
How much choice did you have about your training location?  
How much choice did you have about the kind of certificate/license/degree you are getting?
2. Are you happy with your kind of program, or would you rather be in a program that gives you a different kind of license or certificate? Would you rather be in a different location? .... or have a different schedule?
3. Do you think the staff did a good job finding the right kind of training program for you (in other words, finding a program for you that meets all of your needs)?

### **Strengths and weaknesses of the training programs**

1. What is/was the most useful part of the training program for you?
2. ...the least useful part?
3. How well do you think the training program [is doing/did] in preparing you for a healthcare job?
4. Because of the program, do you think now it will be easier to move up to the next step, like... (LVN, RN, etc....)? Why?
5. Overall, how satisfied are you with this training program? Why?
6. If you could change one thing about the training program, what would it be?

### **Supplemental assistance**

1. What kinds of extra help (e.g. childcare, transportation, loans, books, uniforms, etc.) did you get from the program?
2. If this extra help had not been given to you, what would you have done? (e.g. not started training, found extra help somewhere else, etc)
3. What help would you like to have had that you did not get?
4. *If he/she received supplemental assistance.* How will you manage when this assistance is no longer provided?

### **After the program**

1. Would you like to go back to school later for more training? Describe.
2. Are there any personal issues that may be problems for you in finding and/or keeping a job? What?

**UCLA School of Public Policy  
Caregiver Training Initiative  
Staff Qualitative Interview**

**ID #** \_\_\_\_\_

1. Date of interview:
2. Place of interview:
3. Interviewer name:
4. Interviewee name:
5. Gender:
6. Age:

## **Qualitative Questions for CTI Staff**

### **CTI program design, goals, and objectives for each site**

1. What CTI's programs goals and objectives do you think are the most important?
2. To what extent do you think these goals are being met?
3. If you were starting this program all over again what, if anything, would you change about the way the program is designed to make it more effective?
4. If you were starting this program all over again, what parts of it would you definitely use again? In other words, what were the best parts of the program?

### **Innovations in recruitment, training and retention, and the level of difficulty associated with each**

1. What were the innovations (or new approaches) that your site used to recruit people into the program?  
How difficult has it been to recruit people? How well did the program do in recruiting?  
What else do you think your program could have done to help recruit people?
2. What were the innovations (or new approaches) that your site used to train people in the program?  
How difficult has it been to train people? How effective has the program been in increasing the numbers of trained caregivers?  
What else do you think your program could do to train more people in caregiving?
3. What were the innovations (or new approaches) that your site used to keep people in the program?  
How difficult has it been to keep people in the program? How effective has the program been in keeping people until they finish?  
Is there anything else that could have been done to help keep people in the program?

### **Barriers to recruitment and training**

1. In your opinion, what seem to be the major barriers to finding enough qualified people for the program?
2. What seem to be the biggest barriers to training people for the healthcare field?

### **Efforts to increase interest of CalWORKs participants**

1. What special efforts have been done at your site to bring more CalWORKs clients into the program?
2. Which of these seemed to work well, and which didn't work well?

### **Assessment processes used to assure a good match**

1. What types of assessment methods are used by your site's program to place people?
2. Do you think that the methods used are good in terms of finding the best placements for people?

### **Strengths and weaknesses of the training programs**

1. What do you think are the strongest parts of the training programs?
2. ...the weakest parts?

## **APPENDIX C: BASELINE INFORMATION FORM**



**Caregiver Training Initiative  
Baseline Information Form**

FOR INTERVIEWERS ONLY

Date \_\_\_/\_\_\_/\_\_\_ Site \_\_\_\_\_ Interviewer Name \_\_\_\_\_

1. Client Name \_\_\_\_\_  
Last First MI

2. Date of Birth \_\_\_/\_\_\_/\_\_\_

3. Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

4. Eligibility status (Check all that apply).

- a. Non-custodial parent
- b. Former foster youth (age 18 to 24)
- c. Youngest TANF-eligible child within 12 months of age 18
- d. Barriers to employment (e.g. HS dropout, limited English, teen parent/pregnant, disabled)
- e. On TANF for at least 30 months
- f. Low-income custodial parent
- g. WIA participant

START of INTERVIEW (*Interviewers-- please read starting here. Special directions in italics don't need to be read.*)

Your responses will be used to help us evaluate this training program and will be entirely confidential. You can refuse to answer any of these questions. Completing this form will take about 10 minutes.

5. What is your marital status? Are you...

- 1. Married and living with your husband or wife
- 2. Separated or living apart from your husband or wife
- 3. Divorced
- 4. Widowed
- 5. Never married
- 9. Refused/don't know

6. Do you have children living with you in your home?

- 1. Yes
  - (If yes) How many of these children are under age 5? \_\_\_\_\_
  - (If yes) How many of these children are age 5 through 17? \_\_\_\_\_
- 2. No
- 9. Refused/don't know

7. Do you regularly help take care of someone who is sick, disabled, or elderly?

- 1. Yes
  - (If yes) Are you paid for this?  1. Yes  2. No  9. Refused/don't know
  - (If yes) Is that person a relative?  1. Yes  2. No  9. Refused/don't know
- 2. No

9. Refused/don't know

8. How many hours, if any, did you actually work last week at all paid jobs? \_\_\_\_\_ hours

(99=refused, don't know)

9. During the past 12 months how many weeks did you work (for pay) at least 20 hours a week? Include paid vacation and sick leave as work. \_\_\_\_\_ weeks

NOTE: If respondent not sure, please ask for an approximate number.

NOTE: 12 months=52 weeks. (99=refused, don't know)

10. During the past 12 months, were any of your jobs (for pay) health-care related (e.g. nurse, nursing assistant, nurse's aide, home health aide, home care aide)? Do not count those obtained through your current training program. NOTE: "Current training program" refers to the healthcare training program that is part of the Caregiver Training Initiative (locally named \_\_\_\_\_)

1. Yes  2. No  9. Refused/don't know

(If No...)Have you ever worked in a health care-related job?  1. Yes

NOTE: For pay, since age 18

2. No

9. Ref/ DK

11. Before this CTI program, have you had any specialized training in the health care field?

1. Yes

2. No

9. Refused/don't know

12. How many adults age 18 or older (besides yourself) in your household in the last week.....

(a) ...worked for pay at a full-time job, that is, 35 hours a week or more? \_\_\_\_\_

(b) ...worked for pay at a part-time job, that is, less than 35 hours/week? \_\_\_\_\_

(99=refused, don't know)

13. Do you own a car?

1. Yes

2. No

9. Refused/don't know

14. How did you first hear about the CTI training program?

1. Newspaper ads

6. TV, radio

2. Public bulletin boards (posters)

7. Brochures or other marketing materials

3. Newsletter or direct mailing

8. Job Fair

4. A county worker told me

9. Web-site

5. Someone else told me

10. Other (describe)

15. (Optional) What made you decide to take part in the training program?

---

16. Training Site Location

(street) \_\_\_\_\_ (city) \_\_\_\_\_

**APPENDIX D: CTI PARTICIPANT BASELINE INFORMATION,  
BY SITE**

**CTI Participant Profile, by Site (As of January 24, 2002)**

	Total	Kern	Long Beach	North Bay NORTEC	Riverside
Number of CTI Participants	2,333	220	104	175	176
WIA Participant (% Yes)	70.5	74.6	83.7	80.0	67.6
Mean Age	30.7	29.9	37.1	34.3	31.3
Marital Status (%):					
Married	28.1	27.7	21.2	34.3	21.0
Separated	9.6	9.1	7.7	4.0	19.9
Divorced	11.1	14.6	19.2	22.3	11.4
Widowed	1.6	0.5	4.8	1.7	2.3
Never Married	43.7	42.7	46.2	36.0	42.1
Ref/Unknown	5.9	5.5	1.0	1.7	3.4
Children Living with You (% Yes)	65.2	69.1	47.1	62.3	75.6
(if yes) Mean number under 5	0.8	0.9	0.7	0.4	0.9
(if yes) Mean number 5-17	1.2	1.3	1.3	1.2	1.6
Regularly Care for Someone (% Yes)	28.8	24.1	56.7	41.7	35.8
(if yes) Are you paid (% Yes)	51.7	35.9	79.7	68.5	60.3
(if yes) Is it a relative (% Yes)	36.5	52.8	27.1	24.7	20.6
Worked Last Week (% Yes)	38.3	28.2	51.9	61.1	48.9
(if yes) Mean number of hours	31.6	29.5	32.3	33.6	36.5
Worked in Past Year (% Yes)	53.0	51.4	67.3	77.1	73.9
(if yes) Mean number of weeks	34.0	32.6	38.9	36.1	35.9
Health-Care Related Job in Past Year (% Yes)	31.1	23.2	59.6	52.6	39.2
(if no) Health-care job ever (% Yes)	17.1	16.6	24.3	36.0	19.2
Previous Training in Health Care (% Yes)	37.2	30.9	51.9	57.7	36.9
Other Adults in Home Work Full-Time (% Yes)	35.6	45.5	31.7	45.1	26.0
(if yes) Mean number who work full-time	1.3	1.2	1.7	1.3	1.3
Other Adults in Home Work Part-Time (% Yes)	8.6	9.6	12.5	12.6	5.2

**CTI Participant Profile, by Site (As of January 24, 2002)**

	Total	Kern	Long Beach	North Bay	NORTEC	Riverside
(if yes) Mean number who work part-time	1.2	1.2	1.3	1.0	1.1	1.0
Own a Car (% Yes)	58.8	63.2	65.4	76.0	77.9	58.5
How Heard About the Program (%):						
Newspaper ads	8.00	25.46	12.75	2.56	8.77	5.85
Bulletin boards/posters	2.71	1.39	2.94	0.00	2.92	2.34
Newsletter/mailling	5.15	2.78	2.94	1.28	20.47	0.00
County worker	19.91	15.74	7.84	23.08	14.62	42.11
Someone else	30.02	22.22	26.47	29.49	23.39	28.07
TV/radio	2.25	15.74	0.00	0.00	3.51	0.00
Brochures	4.64	2.78	3.92	0.00	2.92	1.75
Job fair	1.01	0.00	0.98	0.64	1.75	2.34
Web-site	0.23	0.46	1.96	0.00	0.00	0.00
School	10.80	6.02	1.96	14.10	7.60	2.92
Career Center	2.48	2.31	13.73	0.00	2.92	1.75
Employer/at work	2.71	0.46	2.94	16.67	2.92	9.36
Union	0.87	0.00	17.65	0.00	0.00	0.00
Other	9.20	4.63	3.92	12.18	8.19	3.51

Source: CTI Baseline Form

### CTI Participant Profile, by Site (cont'd)

	SELACO	SETA	San Diego	San Francisco	San Jose	Ventura	West Hills
Number of CTI Participants	249	114	179	106	34	47	757
WIA Participant (% Yes)	52.6	77.2	84.4	70.8	17.7	89.4	64.9
Mean Age	28.6	29.3	29.5	38.5	40.0	29.7	28.2
Marital Status (%):							
Married	8.8	22.8	29.6	34.9	35.3	40.4	33.0
Separated	7.6	15.8	10.1	10.4	8.8	8.5	8.5
Divorced	2.4	7.0	13.4	8.5	8.8	8.5	7.7
Widowed	0.0	0.0	1.1	3.8	11.8	0.0	1.2
Never Married	57.8	43.0	40.8	37.7	35.3	42.6	46.8
Ref/Unknown	23.3	11.4	5.0	4.7	0.0	0.0	2.9
Children Living with You (% Yes)	87.6	66.7	50.8	59.4	32.4	53.2	65.3
(if yes) Mean number under 5	0.9	0.8	0.7	0.4	1.1	0.8	0.8
(if yes) Mean number 5-17	1.3	1.3	1.1	1.1	0.6	0.8	1.2
Regularly Care for Someone (% Yes)	6.4	17.5	27.4	41.5	38.2	25.5	27.2
(if yes) Are you paid (% Yes)	56.3	10.0	32.7	65.9	38.5	33.3	40.8
(if yes) Is it a relative (% Yes)	18.8	50.0	53.1	25.0	46.2	66.7	44.2
Worked Last Week (% Yes)	10.8	27.2	26.6	38.7	32.4	40.4	42.5
(if yes) Mean number of hours	26.9	32.9	27.4	30.0	26.6	22.5	32.4
Worked in Past Year (% Yes)	29.3	52.6	45.3	58.5	26.5	78.7	45.8
(if yes) Mean number of weeks	28.2	28.3	28.3	28.5	34.7	31.5	36.8
Health-Care Related Job in Past Year (% Yes)	11.2	29.0	22.4	42.5	14.7	38.3	30.1
(if no) Health-care job ever (% Yes)	7.6	21.3	14.6	24.5	20.0	18.5	14.9
Previous Training in Health Care (% Yes)	14.5	28.1	39.1	38.7	14.7	55.3	40.3
Other Adults in Home Work Full-Time (% Yes)	7.3	29.8	48.6	28.3	8.8	66.0	42.9
(if yes) Mean number who work full-time	1.2	1.3	1.2	1.1	1.3	1.4	1.3
Other Adults in Home Work Part-Time (% Yes)	2.0	10.5	4.5	3.8	11.8	14.9	11.4

### CTI Participant Profile, by Site (cont'd)

	SELACO	SETA	San Diego	San Francisco	San Jose	Ventura	West Hills
(if yes) Mean number who work part-time	1.8	1.3	1.4	1.3	2.3	1.1	1.2
Own a Car (% Yes)	37.4	61.4	48.6	26.4	55.9	80.9	60.8
How Heard About the Program (%):							
Newspaper ads	1.63	6.25	9.32	4.76	20.59	0.00	5.95
Bulletin boards/posters	0.00	4.46	0.00	0.95	5.88	0.00	5.49
Newsletter/mailing	0.00	6.25	4.35	6.67	0.00	0.00	6.86
County worker	79.59	8.04	7.45	4.76	11.76	10.87	4.27
Someone else	2.86	46.43	34.16	53.33	55.88	19.57	37.50
TV/radio	0.00	0.00	0.62	0.00	0.00	0.00	1.22
Brochures	0.00	9.82	3.73	8.57	5.88	2.17	8.23
Job fair	0.41	3.57	0.62	0.00	0.00	0.00	1.07
Web-site	0.00	0.00	0.00	0.00	0.00	0.00	0.30
School	13.88	5.36	26.71	0.95	0.00	52.17	10.98
Career Center	0.41	4.46	6.21	3.81	0.00	6.52	0.61
Employer/at work	0.00	1.79	0.62	2.86	0.00	2.17	0.15
Union	0.00	0.00	0.00	0.95	0.00	0.00	0.00
Other	1.22	3.57	6.21	12.38	0.00	6.52	17.38

Source: CTI Baseline Form

## **APPENDIX E: TRAINING SATISFACTION SURVEYS I AND II**



## **TRAINING SATISFACTION SURVEY -- I**

This is an anonymous form used to assess this caregiver training program and to improve future training.

Today's Date: \_\_\_/\_\_\_/\_\_\_      Location/Site \_\_\_\_\_

1. Your age \_\_\_\_\_

2. Gender? " 1. Male      " 2. Female

3. What is the highest grade of school that you have completed (check one)?

" 1. 8<sup>th</sup> grade or less

" 2. Some high school (grades 9, 10, 11 and 12)

" 3. High school diploma (completed grade 12)

" 4. General Educational Development diploma (GED)

" 5. Technical or trade school

" 6. Some college or 2 year degree

" 7. College graduate with 4-year degree

4. In the past two years, have you worked for pay in any of the following healthcare settings? Do not count work that's part of this training program. (CIRCLE THE APPROPRIATE NUMBER ON EACH LINE.)

	<u>Yes</u>	<u>No</u>	<u>Refused/ don't know</u>
a. Hospital	1	2	9
b. Nursing home	1	2	9
c. Residential care/assisted living facility	1	2	9
d. Home health care	1	2	9
e. Other (specify) _____	1	2	9

5. Why did you decide to take part in this training program? (CIRCLE THE APPROPRIATE NUMBER ON EACH LINE.)

	<u>Yes</u>	<u>No</u>
a. My caseworker recommended the program	1	2
b. Someone else recommended the program	1	2
c. I wanted to get a certificate or a degree	1	2
d. I wanted to improve my job skills	1	2
e. It's something I am personally interested in	1	2
f. I had no choice because of my welfare program.	1	2
g. I liked the idea of becoming a health care worker	1	2
h. It was the only training program available to me.	1	2
i. Other _____	1	2

6. Which of the above is most important? # \_\_\_\_\_

7. How much say did you have about what kind of training you would be getting in this program?  
 " 1. A lot " 2. Some " 3. Hardly any " 4. None

8. USING THE SCALES BELOW, CIRCLE THE NUMBER THAT BEST DESCRIBES HOW YOU FEEL SO FAR ABOUT THE TRAINING PROGRAM.

		<u>Strongly Disagree</u>	<u>Disagree</u>	<u>Not sure</u>	<u>Agree</u>	<u>Strongly Agree</u>
a.	The instructors are well prepared.	1	2	3	4	5
b.	The class presentations are well planned and organized.	1	2	3	4	5
c.	The instructors explain the material so that it is easy to understand.	1	2	3	4	5
d.	The classes are much too difficult.	1	2	3	4	5
e.	What I am learning will be useful to me in my health care work.	1	2	3	4	5
f.	I am never able to ask questions when I need to.	1	2	3	4	5
g.	I am satisfied with the help given me by instructors.	1	2	3	4	5
h.	The instructors care about the students in their classes.	1	2	3	4	5
i.	The program has not covered all of the things I need to know for a healthcare job.	1	2	3	4	5
j.	The program has enough flexibility to meet my needs (e.g. night classes, telephone help).	1	2	3	4	5
k.	I would prefer a program located somewhere else.	1	2	3	4	5
l.	I am not able to practice the new skills I'm learning with real people	1	2	3	4	5
m.	Because of this program I will be able to earn more money in my next job.	1	2	3	4	5
n.	Overall, I am satisfied with this training program.	1	2	3	4	5

9. Would you recommend this program to a friend?  
 " 1. Yes " 2. No " 3. Maybe " 9. Refused/don't know

10. What further training would you like in this area or a related area?

---



---

11. What has been the best part of the training program?

---



---

12. What has been the worst part of the training program?

---

---

---

13. What is your training program goal?

- " 1. Certified home health aide (HHA or CHHA)
- " 2. CNA (Certified Nurse Assistant)
- " 3. LVN or LPN (Licensed Vocational/Practical Nurse)
- " 4. Technician (e.g. Psychiatric, Radiologic, Emergency Medical, or EMT)
- " 5. RN (Registered Nurse)
- " 6. Other \_\_\_\_\_

**If you agree, we may call you in 6 months or so to ask similar questions about your satisfaction with your training. We would like to know if your feelings about the program change later on. If you are willing to be re-contacted, please write your name and phone number below. If you do NOT wish to be contacted, do not write in this box.**

**Name (please print)** \_\_\_\_\_

**Phone Number (Daytime)** ( \_\_\_ \_\_\_ ) - \_\_\_ \_\_\_ - \_\_\_ \_\_\_

**(Evening)** ( \_\_\_ \_\_\_ ) - \_\_\_ \_\_\_ - \_\_\_ \_\_\_



5. Why did you decide to take part in this training program? (CIRCLE THE APPROPRIATE NUMBER ON EACH LINE.)

	Yes	No	Refused/ don't know
a. My caseworker recommended the program	1	2	9
b. Someone else recommended the program	1	2	9
c. I wanted to get a certificate or a degree	1	2	9
d. I wanted to improve my job skills	1	2	9
e. It's something I am personally interested in	1	2	9
f. I had no choice because of my welfare program.	1	2	9
g. I liked the idea of becoming a healthcare worker	1	2	9
h. It was the only training program available to me.	1	2	9
i. Other _____	1	2	9

6. USING THE SCALES BELOW, CIRCLE THE NUMBER THAT BEST DESCRIBES HOW YOU FEEL ABOUT THE TRAINING PROGRAM.

		Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree
a.	The instructors were well prepared.	1	2	3	4	5
b.	The instructors explained the material so that it was easy to understand.	1	2	3	4	5
c.	I did not learn new things in this training program.	1	2	3	4	5
d.	The classes were much too difficult.	1	2	3	4	5
e.	What I learned is useful to me in my health care work now.	1	2	3	4	5
f.	I find the things I learned in training hard to remember.	1	2	3	4	5
g.	I often refer back to things I learned in my training.	1	2	3	4	5
h.	My work is much easier now because of the training I had.	1	2	3	4	5
i.	The training procedures and equipment were outdated.	1	2	3	4	5
j.	The program did not cover all of the things I need to know for a healthcare job.	1	2	3	4	5
k.	Because of this program I am able to earn more money in my job.	1	2	3	4	5
l.	Overall, I was satisfied with this training program.	1	2	3	4	5

7. Would you recommend this program to a friend?

- " 1. Yes      " 2. No      " 3. Maybe      " 9. Refused

8a. Do you think you will go on for further training in a health field at some time?

- " 1. Yes      " 2. No      " 3. Maybe      " 9. Refused



8b. (If yes or maybe..) For what?      " 1. Certified Nurse Assistant

" 2. LVN or

" 3. RN

" 4. Other \_\_\_\_\_

9. What further training would you like in this area or a related area?

---

---

---

10. What was the most helpful part of the training program?

---

---

---

11. What was the least useful part of the training program?

---

---

---

**APPENDIX F: PRELIMINARY FINDINGS--TRAINING  
SATISFACTION SURVEYS**

**Results from the Training Satisfaction Survey**

As part of the evaluation for the CTI program, Training Satisfaction Questionnaires were administered at the three focus sites. Since the fourth focus site was only recently added, the results of the questionnaires do not include that site. As of February 1, 2002, data were compiled and entered for 245 participants. The section below summarizes the findings from this survey, to date. Of the 245, 197 were in CNA training, 40 in IHSS home care provider training, and 6 were in LVN programs.

*Who are the survey respondents?*

Most of the students (91.4%) were female, with a mean age of 31.4, and a range from 18 to 70 years old. About one in five had less than a high school diploma and about 30% had some education beyond high school (See Table 1).

Table 1. Educational attainment for CTI survey respondents

1.2%	8 <sup>th</sup> grade or less
20.2%	Some high school (grades 9, 10, 11 and 12)
37.9%	High school diploma (completed grade 12)
6.2%	General Educational Development diploma (GED)
5.8%	Technical or trade school
26.3%	Some college or 2 year degree
2.5%	College graduate with 4-year degree

Regarding prior work experience, 56.9% had not worked for pay in a healthcare setting in the past two years. About one in five had worked in home health care with somewhat fewer experienced in residential care (Table 2).

Table 2. % working for pay in a health care setting\*

	<u>Yes</u>
Hospital	5.7%
Nursing home	9.0%
Residential care/assisted living facility	18.1%
Home health care	22.6%
Other	10.1%

\*Note: Categories are not mutually exclusive.

*Reasons for participating in the program*

When given a list of reasons for being in the program, the majority of students indicated personal interest in this area or wanting to get a degree and/or improve their skills (See Table 3). Most (89.4%) said that it was something in which they were personally interested, or that they liked the idea of being a healthcare provider (86%). When asked which reason was most important, over a third said they were personally interested in the area. One in five wanted to get a degree, while one in six wanted to improve job skills. Far fewer stated that they felt they had no choice or that they were doing it just because someone else recommended it. While 87% felt



they had a lot or some say about the kind of training program they entered, 13% felt that they had hardly any or no say at all (Table not shown).

Table 3. Reasons for participating in the training program, and which reason was most important.		
Reasons	<u>Yes*</u>	<u>Most Important?</u>
My caseworker recommended the program	11.1%	0.8%
Someone else recommended the program	31.1%	0.8%
I wanted to get a certificate or a degree	84.8%	22.4%
I wanted to improve my job skills	79.7%	17.1%
It's something I am personally interested in	89.4%	34.7%
I had no choice because of my welfare program.	1.7%	0.4%
I liked the idea of becoming a healthcare worker	86.0%	10.2%
It was the only training program available to me.	4.9%	0.0%
Other	12.1%	4.5%
Missing	---	9.0%
*Note: These response categories were not mutually exclusive. The “most important” response categories were mutually exclusive		

*How satisfied were students with the training program?*

In response to questions pertaining to various aspects of the training program, such as the instructors, the courses, class topics, and program flexibility, CTI participants were quite favorable in their responses (Table 4). When asked about their overall satisfaction, an impressive 90.6% of students strongly agreed or agreed that they were satisfied with the program. Another indicator of satisfaction is the question about whether the person would recommend the program to a friend. About 93% said they would and only 1.3% said they would not (not shown).

The evaluation team had no control over the environment in which participants completed these forms, although we did ask that they be collected by someone affiliated with CTI only, and not with the training program. For the final report, we will be able to compare these responses with the responses from the follow-up satisfaction survey. The follow-up survey is administered about six months after the first survey, at which time most students will have completed all coursework. Those responses may be less biased by the environmental setting (i.e., the instructor is not standing nearby), although possibly more biased by the amount of time that has passed since their training.

Table 4. Satisfaction with various aspects of the training program.					
	<u>Strongly Agree</u>	<u>Agree</u>	<u>Not sure</u>	<u>Disagree</u>	<u>Strongly Disagree</u>
The instructors are well prepared.	57.9	24.8	4.5	7.4	5.4
The class presentations are well planned and organized.	45.7	37.2	4.1	8.7	3.7

	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
The instructors explain the material so that it is easy to understand.	60.1	31.7	2.9	3.3	2.1
The classes are much too difficult.	2.5	4.6	4.6	43.9	44.4
What I am learning will be useful to me in my healthcare work.	73.9	23.2	0.4	0.8	1.7
I am never able to ask questions when I need to.	2.9	5.4	3.7	25.3	62.7
I am satisfied with the help given me by instructors.	58.3	31.4	4.1	4.1	2.1
The instructors care about the students in their classes.	61.4	27.4	5.0	2.5	3.7
The program has not covered all of the things I need to know for a healthcare job.	2.9	9.1	10.4	34.9	42.7
The program has enough flexibility to meet my needs (e.g. night classes, telephone help).	38.6	37.3	14.1	5.8	4.1
I would prefer a program located somewhere else.	2.9	9.7	10.5	34.5	42.4
I am not able to practice the new skills I'm learning with real people	2.1	4.9	4.5	41.2	42.4
Because of this program I will be able to earn more money in my next job.	48.1	32.9	16.0	2.5	0.4
Overall, I am satisfied with this training program.	60.0	30.6	4.5	2.5	1.2

When participants who were in CNA programs were asked about further training, they stated interest in LVN programs. Some also indicated that they would like to get their RN degrees. People also mentioned specialty programs such as EMT, acute hospital care, and phlebotomy. Overall, it appears that the majority of students responding are thinking about career tracks, which is an important goal of the program.

Further training students would like....

- 
- "None. I'm satisfied" (CNA student)*
  - "LVN program" (CNA student)*
  - "more training in computer"*
  - "LVN training—RN too"*
  - "would like to see a surgical tech class or even ...EMT class"*
  - "phlebotomy"*
  - "LVN, RN, then physical therapist"*
  - "LVN course"*
  - "I would like to move up to a RN or LVN in the future. But for now I'm going to stick with the CNA position"*
  - "EMT/ paramedic"*
  - "I would like to become RN and maybe obstetrician" (23-year old female)*

When asked about the best part of the training program, student comments were diverse. Probably the most frequent positive comment was that students loved the clinical work and getting hands-on experience with the patients/residents. Another theme was that they felt that they were doing something useful, something that was helpful to others. Many students mentioned the teachers who were very helpful to them, who were understanding and who encouraged them throughout the program. Personal benefits were mentioned often, and these included learning new things and improving self-esteem.

The best part of the training program...

*"I love it all. Enjoy working/helping people"*

*"it was so well given the test and finals were easy"*

*"going to clinical, working with residents. It was a great experience for me".*

*"hands-on experiences with people/patients; understanding their needs and being able to assist"*

*"clinical training" (listed by several respondents)*

*"[instructor] ...helping us get through this class. She...helped me".*

*"the material and information is a lot better than it was 20 years ago when I took this class"*

*"overall program has been great. Had wonderful instructors"*

*"being able to help real patients in a facility and the hands-on learning"*

*"learning new thing[s] every day"*

*"the best part of the training program is clinical and being able to work close to residents and to meet their needs"*

*"working with the residents"*

*"my self-esteem has improved through my interactions"*

Regarding the "worst part of the training program," most of the students had very little negative to say about the training program. For the most part, the criticisms of the program centered on specific instructors, lack of organization, and equipment/supplies problems. The rest of the negative comments seemed to focus on personal issues, like adjusting to a new routine, or becoming attached to the residents with whom they worked, and then having to leave them.

The worst part of the training program?

---

*"I was working full-time (9 hours a day) and got taking my CNA class. I got behind [in] my studies".*

*"getting used to coming back to school"*

*"[instructor] not prepared and made the class more stressful than it needed to be"*

*"some of the more outspoken and rude students"*

*"maybe having classmates under 20 years of age and all that comes with that" (female in her 40s)*

*"lack of organization; not getting things/equipment on time"*

*"leaving the residents"*

*"some of the students in class being extremely immature and disrespectful. In future, I would highly recommend the instructors screen potential students and choose who they want"*

*"our particular class had no equipment of our own to use during class time.... the equipment that was there didn't work or was in poor condition"*

*"no complaints except leaving the clinical site"*

*"having to say good bye to our residents"*

*"I think the class should have been a little longer"*

*"instructors lack of understanding to personal conflicts at home"*

*"lack of sleep, coming everyday"*

*"a lot of disagreements among instructors that conflicted with the students learning"*

*"nothing" (mentioned by many)*

**APPENDIX G: EARLY DEPARTURE SURVEY FORM**

**CAREGIVER TRAINING INITIATIVE EVALUATION-- EARLY DEPARTURE SURVEY**

This is an anonymous form used to determine why people enrolled but did not attend, or left the program early. Most interviews will be telephone-administered.

Today's Date: \_\_\_/\_\_\_/\_\_\_ Location/Site of interviewee \_\_\_\_\_  
 Name of Interviewer \_\_\_\_\_

*"Hello. I am \_\_\_\_\_ from UCLA [or UCSF]. We are conducting a survey of people who were interested at one time in the Caregiver Training Initiative [or local name \_\_\_\_] but then did not complete the program. We are hoping to learn more about the reasons people leave the program before finishing it, so that we can change the program to better meet people's needs. The interview will take about 15 minutes. Your participation in the study is completely voluntary. Of course, all of your responses will be entirely confidential and your name will not be on the questionnaire. Also, your answers will IN NO WAY affect any governmental services you may be currently receiving. Your participation is very important to this study, and would be much appreciated. Are you willing to answer our questions? ...Thank you. If there are any questions you do not wish to answer, please let me know and I will go on to the next question."*

1. How old are you? \_\_\_\_\_
2. (Ask only if verification needed.) And you are.. " 1. Male " 2. Female
3. What is the highest grade of school that you have completed (check one)?
  - " 1. 8<sup>th</sup> grade or less
  - " 2. Some high school (grades 9, 10, 11 and 12)
  - " 3. High school diploma (completed grade 12)
  - " 4. General Educational Development diploma (GED)
  - " 5. Technical or trade school
  - " 6. Some college or 2 year degree
  - " 7. College graduate with a 4-year degree

4. In the past two years, have you worked for pay in any of the following healthcare settings? (CIRCLE THE APPROPRIATE NUMBER ON EACH LINE.)

	Yes	No	Refused/ don't know
a. Hospital	1	2	9
b. Nursing home	1	2	9
c. Residential care/assisted living facility	1	2	9
d. Home health care	1	2	9
e. Other (specify) _____	1	2	9

5. Were you encouraged by anyone in your county welfare department to consider enrolling in the caregiver training program?
  - " 1. Yes
  - " 2. No
  - " 9. Refused/don't know

6a. Why did you decide not to take part in the Caregiver Training program? Was it because

you...*(Check all that apply)*

- " 1. Found a job/decided to work?
- " 2. Couldn't afford to be in the training program?
- " 3. Didn't have the time?
- " 4. Were not interested in home care or health care?
- " 5. Needed more help with childcare?
- " 6. Had family or personal problems?
- " 7. Had scheduling problems?
- " 8. Found the training program too stressful?
- " 9. Were injured or became ill?
- " 10. Had language problems?
- " 11. Had problems with transportation?

6b. Which best describes when you left the training program?

- " 1. I never started the program. [SKIP TO #7].
- " 2. I started the program but dropped out early on, in the first week or two. [GO TO 6c]
- " 3. I started the program and dropped out later, after a couple of weeks. [GO TO 6c]
- " 4. Other? \_\_\_\_\_

6c. [FOR THOSE WHO STARTED BUT DID NOT COMPLETE THE PROGRAM...]

Why did you decide not to finish this training program? Was it because you...

*(Check all that apply).*

- " 1. Did not like the classes?
- " 2. Did not like the patient-care work?
- " 3. Found the classes to be too hard?
- " 4. Did not have time for the homework?
- " 5. Did not like the instructor?
- " 6. Wanted to be in a different kind of program? (Specify) \_\_\_\_\_
- " 7. Other (Specify) \_\_\_\_\_

7. If this training program were offered again, at a later date, would you enroll then?

- " 1. Yes      " 2. No      " 3. Maybe      " 9. Refused

8a. Is there anything the program could have done to help you stay in the program?

- " 1. Yes      " 2. No      " 3. Maybe      " 9. Refused



8b. (If "Yes" or "Maybe" to #8a) What would have helped you to stay in the training program?

*(Check all that apply.)*

- " 1. More on-the-job training?
- " 2. Less time in the classroom?
- " 3. More money for participants?
- " 4. More help with personal problems like childcare?

- " 5. More help with transportation?
- " 6. More tutoring help with course work?
- " 7. Classes and/or training closer to your home?
- " 8. More interesting classes?
- " 9. Better prepared instructors?
- " 10. Different scheduling?
- " 11. Nothing.
- " 12. Other? \_\_\_\_\_

9. Would you recommend this program to a friend?

- " 1. Yes      " 2. No      " 3. Maybe      " 9. Refused

10. In the next six months, do you plan to have a job as a health care or home care worker?

- " 1. Yes      " 2. No      " 3. Maybe      " 9. Refused

11. Is there anything else you would like to tell me about this program?

---

---

---



**APPENDIX H: PRELIMINARY FINDINGS –EARLY  
DEPARTURE SURVEYS**

## **Early Departure Survey Preliminary Findings**

At this time, there are only 37 completed Early Departure Surveys, so it is too soon to make generalizations about this group. However, the results presented below should give some indications about the characteristics of those leaving the program early. Fourteen interviewees were admitted to, but never started the program. The remaining 23 people started the program but dropped out during the program.

The education levels for those who left the program are similar to those in the program based on WIA data on 2,828 program participants (see Table 1). There seem to be similar proportions of people with less than a high school degree in the Early Departure group as in the entire group. Surprisingly, there are larger proportions of people with education past high school for the Early Departure group.

<b>Table 1. Educational level</b>	Early Departures (N=37)	Total group (N=2,828)
8 <sup>th</sup> grade or less	0.0	3.7
Some high school (9 <sup>th</sup> through 12 <sup>th</sup> )	29.7	24.7
High school diploma/ GED	35.1	50.0
Technical or trade school	2.7	22.7
Some college or 2-year degree	29.7	(more than HS)
College graduate 4-year degree	2.7	

Regarding work experience (See Table 2) about one in five had had some prior experience in a hospital or nursing home, respectively, and one in four had worked in a residential care facility. When asked if they were encouraged to participate in CTI by someone in the county welfare department, 21.6% said that they were (table not shown).

<b>Table 2: Work for pay in the past 2 yrs</b>	<b>%</b>
Hospital	18.9
Nursing Home	18.9
Residential Care/Assisted living facility	24.3
Home health care	16.2
Other	5.4

All respondents were asked why they decided not to take part in the program (Table 3). About a third gave finance-related reasons (i.e., decided to work, or couldn't afford program). Those departing said they could not afford it or they had found a job and decided to work instead of being in training. Most of the reasons were personal, such as not having the time, childcare problems, family/personal problems scheduling problems, or too much stress. Only 5.4% (or two people) said that they discovered they were not interested in the subject matter. It is interesting that despite childcare and transportation assistance offered at all the sites, these were

still problems for a few of the people.

**Table 3: Why did you decide not to take part in the CTI program?**

Reason*	%
Found a job/decided to work	21.6
Couldn't afford to be in the training program	13.5
Didn't have the time	37.8
Not interested in home care or health care	5.4
Needed more help with childcare	13.5
Had family or personal problems	37.8
Had scheduling problems	29.7
Found the training program to be too stressful	8.1
Were injured or became ill	8.1
Had language problems	5.4
Had problems with transportation	5.4
Others	5.4

\*Note: Categories are not mutually exclusive.

As mentioned earlier, fourteen interviewees were admitted to, but never started the program. The 23 people who started but did not complete the program were asked why they decided not to finish (Table 4). Most said they did not have time for the homework. Only a handful said they did not like the classes, patient care work, or the teacher. Most of these problems, again, were personal rather than program related. The “other” category included personal or family situations (7 people), too much work (3 people), health problems (3 people), scheduling (1) and problems with the exams (1).

**Table 4: Why did you decide not to finish program?**

Reason	%
Did not like the classes	4.2
Did not like the patient-care work	4.2
Found the classes to be too hard	12.3
Did not have the time for the homework	29.2
Did not like the instructor	4.2
Wanted to be in a different kind of program	0.0
Other	58.3
Personal or family situations	30.4
Too much work	13.0
Health problems	13.0

When the 37 respondents were asked if they would like to come back into the program at a later time, over three-fourths (78.4%) said they would, 10.8% said maybe they would, and 10.8% said they would not (table not shown). Along the same lines, a very high proportion said that they would recommend the program to a friend (94.6%). Nobody said they would not recommend it.

When asked if there was anything the program could have done to help them stay in the

program, almost half the respondents said that there was nothing. When asked, “what would have helped you stay in the training program,” 13.5% mentioned a different scheduling arrangement, and a similar proportion mentioned more flexibility with absences and times (Table 5). Three people (8.1%) agreed that more money would have helped and three people would have preferred less demanding and/or fewer or shorter classes. In general, based on a very small sample, with the exception of providing different scheduling and more tutoring (which many collaboratives reportedly offer) there was little the CTI program could do to help.

<b>Table 5: What would have helped you to stay in the training program?</b>	<b>%</b>
Nothing	45.9
More on-the-job training	0.0
Less time in the classroom	2.7
Less demanding/fewer or shorter classes	8.1
More money for participants	8.1
More help with personal problems like childcare	0.0
More help with transportation	0.0
More tutoring help with course work	5.4
Classes and/or training closer to your home	2.7
More interesting classes	0.0
Better prepared instructors	0.0
Different scheduling	13.5
More flexibility with absences and timing	13.5
More help with studying (study group)	5.4
Other	8.1

Table 6 below shows the relationship between those who say they plan to be working in health care in 6 months with those who had worked in a healthcare setting sometime in the past two years. A total of 21 people, or 57% of the sample said that they plan to continue working in health care, while 5 more, or 13.5%, said maybe they would work in health care. Since some people had worked in more than one setting, we merged the data (last two rows) to compare those who had worked in any healthcare setting with those who had not. Of the 18 people with prior experience, three were not planning to continue working in health care. Of the 19 people without experience, eight were not planning to continue working in health care. When more data are available, we will be able to calculate statistical significance, but for now it is clear that more of those with prior experience plan to continue working in the field.

**Table 6. Relationships between whether person plans job in health care in future and whether they worked before in health care.**

Healthcare job in next 6 months?		Yes	No	Maybe	Total
<u>Worked before in...</u>					
.Hospital?	Yes	5	1	1	7
	No	16	10	4	30
Nursing Home?	Yes	6	1	0	7
	No	15	10	5	30
Residential Care?	Yes	9	0	0	9
	No	12	11	5	28
Home Care?	Yes	5	1	0	6
	No	16	10	5	31
Any of the above?	Yes	14	3	1	18
	No	7	8	4	19