

Acknowledgements

My dissertation is dedicated to my mother Charlotte who has dedicated her life to the health care profession and to helping others. She is the first person who taught me how difficult and rewarding working in the health care sector can be. I would also like to thank my dissertation committee members Frank Levy, Joan Fitzgerald, and J. Phillip Thompson for providing guidance and direction throughout my dissertation research. In addition, I would like to thank the following individuals who provided me with feedback on my work as well as support and encouragement: Kevin Anderson, Brian Bosworth, Nolan Bowie, Manuel Castells, Victoria Choitz, Michael Darnell Dawson, Alisa DiCaprio, Sharon Chan Edmiston, Pierre Fallavier, Erin Flynn, Parminder Jassal, Richard O'Bryant, Paul Osterman, and my very good friend Byron Stancil who was always willing to help me when I needed it. I would like to extend a special thank you to the following individuals who, without their help, this dissertation would not have been possible: Cynthia Briggs, Jennifer Frost, Sarah Griffen, Dawn Martin, Michelle Riley, Beverly Sobers, Harriet Tolpin, and everyone else who was willing to allow me to follow them around, interview them, and provide me with information about the health care sector. I would also like to thank all my friends and family who have been supportive over the years. Finally, I could not have completed this dissertation without the love, support, and patience of my wonderful wife Nicole. She was with me through all the ups and downs and continues to be an inspiration in my life.

Politics, Jobs and Workforce Development: The Role of Workforce Intermediaries in Building Career Pathways within Boston's Health Care Industry

By

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**Submitted to the Department of Urban Studies and Planning
On May 26, 2006 in Partial Fulfillment of the
Requirements for the Degree of Doctor of Philosophy in
Urban and Regional Planning**

ABSTRACT

This research study examines the role that workforce intermediaries within Boston play in creating career pathways for economically disadvantaged, under-skilled residents in the local health care industry. Using a case study analysis, this study compares the outcomes of two workforce intermediaries—one which is employer-led and the other which is led by a community development corporation. Despite the proliferation of new workforce intermediaries around the country and the increased amount of funding to support them from the private and public sectors, these institutions are limited in their ability to increase the supply of a skilled workforce and to change the demand-side of the labor market. However, given the current structural holes in the publicly funded workforce development system, workforce intermediaries play a critical role in serving populations who otherwise would have a difficult time entering into the regional labor market.

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CHAPTER ONE: INTRODUCTION

Increased Growth of the Health Care Industry

Over the last decade the demand for skilled workers within the healthcare industry has grown at a steady pace. According to the U.S. Bureau of Labor, both high and low-skilled employment within health occupations is projected to grow from 11.5 million in 2002 to over 15 million in 2012. The rate of growth of new jobs in healthcare occupations is projected to be 30.1%, while the rate of employment growth projected for non-health occupations is only 13.5%.¹

Currently, the health care industry accounts for nearly 14% of the gross domestic product (GDP); and it is estimated that by 2007 the health care sector will account for more than \$2 trillion or 16% of GDP.² The U.S. Bureau of Labor Statistics predicts that between 2002 and 2012 the health care industry will add nearly 3.5 million new jobs, an increase of 30%. The health occupations that are expected to *grow by the largest number of jobs* between 2002 and 2012 are the following: registered nurses (623,000); nursing aides, orderlies, and attendants (343,000); home health aides (279,000); medical assistants (215,000); and licensed vocational and licensed practical nurses (142,000). Although these five occupations are expected to grow by the most number of jobs until 2012, they vary widely in median annual salary and postsecondary education and training requirements. For example, a dental hygienists' median annual salary in 2002 was \$55,320 and requires at least a two-year associate's degree while nursing aides, orderlies,

¹ Martiniano, Robert et al. "Health Care Employment Projections: An Analysis of Bureau of Labor Statistics Occupational Projections, 2002-2012." The Center for Health Workforce Studies. March 2004.

² Chong, Nilda. "A Model for the Nation's Health Care Industry: Kaiser Permanente's Institute for Culturally Competent Care. *The Permanente Journal*. Summer 2002. Volume 6, No. 3.

and attendants had a 2002 median annual income of \$19,960 and only requires short-term on-the-job training (see TABLE 1).

**TABLE 1. National Outlook: Selected Health Care Occupational Projections³
(Jobs in Thousands)**

Health Care-Related Occupations	2002-20012 Projected Growth	2002 Median Annual Earnings	Postsecondary Education & Training
Registered Nurses	623	\$48,090	Associate Degree
Nursing Aides, Orderlies, and Attendants	343	\$19,960	Short-term on-the-job
Home Health Aides	279	\$18,090	Short-term on-the-job
Medical Assistants	215	\$23,940	Moderate on-the-job
LPN/LVN	142	\$31,940	Postsecondary vocational award
Dental Assistants	113	\$27,240	Moderate on-the-job
Medical Records and Health Information Technicians ⁴	69	\$23,890	Associate Degree
Dental Hygienists	64	\$55,320	Associate Degree
Pharmacy Technicians	61	\$22,250	Moderate on-the-job
Emergency Medical Technicians and Paramedics	59	\$24,030	Postsecondary vocational award

This growth in the health care industry is especially visible in the Northeast healthcare corridor. Referred to by many as the center of the nation's healthcare economy, the Northeast's medical corridor stretching from Bethesda, Maryland to Boston has created over 50,000 healthcare jobs since 2000.⁵ At the forefront of this expansion and among the nation's leaders is the Boston metropolitan region. In just the Longwood

³ Ibid 3.

⁴ Medical Records and Health Information Technicians does not include Health Information Administration.

⁵ Leohardt, David. "Northeast Quietly Becomes a Health Care Corridor." The New York Times. December 30, 2002.

Medical and Academic Area (LMA) of Boston, there are over 21 healthcare and academic-related institutions which combined have over 30,000 employees and exceed \$2.5 billion in annual revenues. In order to continue growing and performing at a high level, these institutions have focused on increasing their level of recruitment and retention of skilled healthcare professionals and ancillary employees in order to meet employment demands. The state of Massachusetts' Division of Employment and Training (DET) estimates that between 2002 and 2008, jobs in the health services industry is expected to expand by 20 percent, this is twice as fast as the average for all industries and will generate 66,000 new jobs, with the lion's share being created in the City of Boston.⁶ In Boston alone, home health aides are expected to grow by 51%, followed by medical assistants (50%), physician assistants (43%), medical records/health information technicians (39%), respiratory therapists (36%), surgical technologists (35%), dental hygienists (34%) and biological scientists (31%).⁷ This projection of course assumes that the supply of skilled health professionals will be available. Remarkably, these figures are just for the health services industry and do not include the expected growth for non-healthcare related employment (i.e. food services, security and safety personnel and environmental service jobs).

Shortage of Skilled Health Care Workers

Unfortunately meeting the labor demand in the health services industry is not likely to be solved anytime soon due to a number of demographic and societal factors. According to the American Hospital Association Commission on Workforce for

⁶ Massachusetts Division of Employment and Training. "Massachusetts Employment Projections Through 2008: A Focus on Jobs, the Industries, and the Workforce."

⁷ Massachusetts Division of Employment and Training. "SDA Long-Term Job Outlook Through 2008."

Hospitals and Health Systems (AHA Commission) one of the biggest factors contributing to the labor shortage is the fact that the U.S. labor force has been aging. The median age of the U.S. labor force was 34.8 years in 1978 and had increased to 38.7 years by 1998. By 2008, it is estimated that the median age of the U.S. labor force will be 40.7 years.⁸ This trend is especially prominent in the nursing profession. The median age of a registered nurse in the U.S. in 2000 was 47 years⁹ compared to 1980 when roughly 53% of registered nurses were under the age of 40.¹⁰ As nurses age and eventually retire, many of their positions go unfilled or take a significant amount of time to replace—ultimately costing hospitals and medical clinics hundreds of thousands of dollars in recruitment fees and administrative costs.

Another factor contributing to the difficulty in filling vacant jobs within the health services sector is the fact that the overall U.S. labor force is growing much more slowly than in past decades precisely at a time when the number of jobs in health care is growing. The U.S. labor force is expected to grow by only 1% between 2000 and 2015 which is significantly less than the 2.6% growth between 1970 and 1980.

A third factor contributing to the shortage of and the difficulty in retaining health service employees is that health careers are perceived as less attractive than many other careers. A survey administered by the Health Resources and Services Administration (a division of the U.S. Department of Health and Human Services), found that only 69.5% of registered nurses reported being satisfied in their current position. This number is significantly lower than in other professions. By comparison data from the General

⁸ “Working in the 21st Century,” U.S. Department of Labor. June 2001.

⁹ “The Registered Nurse Population: Findings from the National Sample Survey of Registered Nurses,” U.S. Department of Health and Human Services Administration. 2001.

¹⁰ Ibid 5.

Social Survey of the National Opinion Research Center indicate that from 1986 through 1996, 85% of workers in general and 90% of professional workers expressed satisfaction with their job.¹¹

A final factor limiting the growth of new hospital workers is the fact that too many are stressed out by the current working conditions that exist in many health facilities, including hospitals and nursing homes, this makes it difficult to recruit new employees to the industry and to reduce soaring turnover rates. As the AHA Commission states, "Today, many in direct patient care feel tired and burned-out from a stressful, often understaffed environment, with little or no time to experience the one-on-one caring that should be the heart of hospital employment." Moreover, health care professionals face severe risks to their health on the job. Healthcare workers involved in direct patient care must take precautions to guard against back strain from lifting patients and equipment, exposure to radiation and caustic chemicals, and infectious diseases such as AIDS, tuberculosis, and hepatitis.¹²

The labor shortage crisis has left the health services industry searching for ways to attract skilled workers. One solution has been to recruit immigrant professional health care workers from other countries, including Canada, Ireland, the Philippines and most recently India. This strategy is time consuming (it can take up to six months) and it is also expensive. The process of recruiting immigrant professional nurses can cost hospitals anywhere between \$6,000-11,000 per employee.¹³ This also diminishes the supply of skilled health care professionals in other countries. This an inefficient and

¹¹ "The Registered Nurse Population: Findings from the National Sample Survey of Registered Nurses," U.S. Department of Health and Human Services Administration. 2001.

¹² "Occupational Outlook Handbook 2002-2003." U.S. Bureau of Labor Statistics. 2002.

¹³ Interview with Arthur Bowes, Vice President Human Resources, Spaulding Rehabilitation Hospital Network, December 13, 2002.

unsustainable way to fill the growing demand for higher end health care professionals, and over a long period of time it contributes to the alarmingly high increase in health care costs and inadequately addresses the need to increase the overall supply of skilled health care workers. Finally, this short-sighted strategy does nothing to create career ladder opportunities for entry level incumbent health care workers, nor does it provide the foundation for a workforce development system that could recruit, train, and retain the workers needed to meet the demand for jobs within the industry.

Addressing the Healthcare Worker Shortage

Although there are some serious systemic barriers that limit the supply of skilled health care workers, many scholars and workforce development practitioners argue that there remain some potential solutions to meet the industry's demand. One possible solution is for the health care industry to develop a comprehensive workforce development strategy that focuses on recruitment, training, and retaining under-skilled urban job seekers and entry-level incumbent workers for higher end jobs. Since a significant number of health clusters (i.e. hospitals, medical clinics, biotechnology and pharmaceutical companies) are concentrated within metropolitan areas (i.e. Boston, Chicago, New York, San Francisco and Washington, D.C.), it would make sense for these facilities to tap into the local urban labor market for new employees. There are several reasons for this type of strategy.

According to the spatial mismatch hypothesis central city areas contain a significant number of job-seeking residents who do not have access to the large

number of jobs that are being created in the suburbs. It has been estimated that two-thirds of all new jobs are located in the suburbs, but three-quarters of welfare recipients live in central cities or rural areas (Dreier, Mollenkopf and Swanstrom, 2001). Many reasons help explain this mismatch including racial segregation, investment choices, low-inner city auto ownership, and inadequate public transportation systems linking to job growth centers (Giloith, 1998). Fortunately, the vast majority of metropolitan hospitals, university-run medical clinics and medical laboratories do not relocate from the central city to the suburbs as many firms do. A survey of the top 10 private employers in the largest 20 U.S. cities found that nearly 550,000, or 35 percent, of the 1.6 million people who worked for the top ten private employers were employed by institutions of higher learning and medical facilities (Harkavy and Zuckerman, 1999). Therefore the argument has been made that with the creation of a comprehensive workforce development strategy, health care and health care-related facilities have an opportunity to increase the supply of their workforce by recruiting, training, and retaining central city residents for the abundance of entry level and mid-level health care jobs that go unfilled each year.

An added benefit of a comprehensive workforce development strategy targeting job-seeking urban residents and entry-level workers is that there is the potential opportunity for the development of career pathways. The health services profession has a number of occupations ranging from entry level home health aide jobs (median hourly wage \$8.81) that require very little education to registered nurse (median hourly wage \$25.15) and dental hygienist jobs (median hourly wage

\$28.05) that require at least a two-year associate's degree (see TABLE 2). An individual who has a high school diploma or GED and works as a home health aide could potentially advance along a career ladder to the next position up on the pay scale as a medical assistant (median hourly wage 11.83) if they gained an additional 6 to 24 months¹⁴ of training at a community college or vocational/technical training school. In another example, an individual working as a licensed vocational/practical nurse (median hourly wage 16.33) whose goal is to advance along a career ladder towards becoming a registered nurse, would need to complete at least a two-year RN program leading to a diploma or associate's degree combined with clinical practice in a hospital.¹⁵ These two examples illustrate that there is room for upward job mobility within the health services profession.

¹⁴ The six to twenty-four months of additional training required to become a medical assistant assumes that the individual will be attending full-time. In the case of most entry-level health services workers, they do not have the resources (financial, social support, etc.) to stop working while they attend a community college or vocational/technical training program. Therefore, one can assume that in most cases where individuals need to work that it would take more time to finish these types of training programs.

¹⁵ This again assumes an individual is attending school full-time.

TABLE 2. Median Annual Earnings, Education and Training Requirements for the Largest Occupations in Health Services, 2004.¹⁶

Occupation	Median Annual Earnings	Education Requirements	Training Requirements
Home Health Aides	\$18,324	H.S. diploma/GED or less	None required.
Nursing Aides, Orderlies, and Attendants	\$20,987	H.S. diploma/GED or less	None required.
Medical Assistants	\$24,610	H.S. diploma/GED or equivalent	May be required to take additional training ranging from 6 to 24 months.
Dental Assistants	\$28,329	H.S. diploma or equivalent	May be required to take additional training ranging from 9 to 24 months.
Licensed Practical/Vocation Nurses	\$33,970	H.S. diploma or equivalent	Complete a 12 to 18 month state approved vocation/practical nursing program must be completed; State licensure required.
Radiologic Technologists and Technicians	\$43,350	H.S. diploma or equivalent	Must complete 24-month program in a hospital or school.
Registered Nurses	\$52,330	Two-year associate's degree; 4-year college degree; master's degree	Complete at least a 24-month program leading to a diploma or associate's degree combined with clinical practice in hospitals; Management positions require 4-year college degree, master's degree required to teach or specialize.

¹⁶ U.S. Department of Labor. Bureau of Labor Statistics. *Occupational Outlook Handbook 2006-2007 Edition*.

A comprehensive workforce development strategy aimed at urban residents (especially for those that come from ethnically and racially diverse backgrounds), also recognizes the significant shifts in the demographics of major metropolitan regions. Metropolitan regions across the United States are increasingly becoming more ethnically and racially diverse. Immigrants represented a fourth of all labor growth during the period 1980-2000 and are likely to account for an even larger percentage of the growth over the next 20 years (Holzer and Waller, 2003). This demographic shift is posing new challenges for healthcare providers as the “provision of medical care to culturally diverse patients now relies more heavily on cross-cultural communication than at any other time. Medical care that addresses the cultural needs of diverse populations stands at the forefront of many discussions in the health care industry” (Chong, 2002). The demand is stronger than ever for culturally and linguistically competent healthcare workers who can deliver care to immigrant and minority populations that is compatible with their cultural beliefs, practices and preferred language.¹⁷ In the long-run this could improve patient care and make prevention and awareness programs focused on specific ethnic groups more effective (i.e. diabetes, HIV/AIDS prevention in the African-American community). Thus, hiring workers from immigrant and minority communities could be mutually beneficial for everyone involved—healthcare providers, patients and the community at-large. Many states with large immigrant and diverse populations such as California, New York and Texas have already developed programs to attract more minorities to the medical profession.

¹⁷ Chong, Nilda. “A Model for the Nation’s Health Care Industry: Kaiser Permanente’s Institute for Culturally Competent Care.” 2005. *The Permanente Journal*. Summer 2002. Vol 6. No. 3.

Finally, numerous studies of individual and population health have shown that health burdens experienced by economically and socially deprived urban populations is much greater than those from higher socioeconomic backgrounds. O'Campo and Yonas (2005) argue in their article, "Health of Economically Deprived Populations in Cities" in The Handbook of Urban Health, that "while patterns of disparity differ for various outcomes, a consistent relationship of increased morbidity and mortality has been observed for economically disadvantaged urban populations compared to less deprived counterparts for outcomes such as cardiovascular disease, homicide, mental health, asthma, and premature mortality." Given these facts, workforce development efforts focused on helping the urban poor increase their socioeconomic status would be beneficial in two ways. It would increase their economic opportunity by providing them with wages significantly higher than the federal minimum wage, but more importantly it would provide these residents with health care and dental benefits that many lower-wage jobs do not provide. This could potentially improve the health status of economically disadvantaged urban residents, especially for single-female headed households with young children.

However, it is important to keep in mind that in order for a comprehensive health care workforce development of strategy to be beneficial to both employers and workers, a holistic approach to workforce development must be developed that incorporates both a *supply-side* and *demand-side* strategy. A comprehensive workforce development approach on the supply-side would focus on improving the skills and education of under-skilled job seekers and incumbent workers. It would also make sure that these individuals had access to supportive services such as counseling, child care, case

management, career counseling/coaching, etc. in order to help them successfully complete any pre-employment training and education programs. On the demand-side of the labor market, a comprehensive workforce development strategy would identify the entry-level jobs within the health care sector with the potential for good pay and benefits as well as for upward mobility. It would also focus on changing the work environment to make sure that it is supportive of workers by conducting activities such as mentoring, career counseling, education and training classes, and have clearly defined career pathways.

The Rise of Workforce Development Institutions

Previous efforts to increase the economic opportunities of under-skilled, chronically unemployed workers were quick to adopt workforce development strategies that focused solely on the supply-side of the urban labor market. These strategies had a tendency to only address the “inhibitors of sustainable employment and advancement for many low-income entry level workers: the unavailability of childcare, problems with transportation and housing, the need for skill upgrading, and issues of attitude” (Sutton, 2001). These supply-side strategies are helpful in assisting low-skilled workers find jobs by improving their human capital and expanding their social network, but they have their limitations. As Stacey Sutton argues in her article “Corporate-Community Workforce Development Collaborations,” a supply-side approach “predicates employment opportunities on the behavior of low-income people while neglecting broader policy issues and structural constraints such as employer demand, the changing structure of jobs, discrimination, and structural shifts in the economy. And a [supply-side approach] fails to incorporate employer needs and expectations into the analysis” (p. 1). The lack of

employer involvement in the training and curriculum development in the worker training process can lead to the lack of an organized, collective involvement of those on the demand-side of the labor market (Parker and Rogers, 1999), contributing to an even larger chasm between training providers and employers.

It is important for workforce development practitioners to create strategies for low-skilled, economically disadvantaged job-seekers that also focus on the demand-side of the urban labor market. Demand-side workforce development strategies aim to improve workers' economic opportunities by working with employers to provide livable wages, improve the quality of jobs, and create career advancement opportunities for workers. Therefore, as Sutton and others (Harrison and Weiss, 1998; Parker and Rogers, 1999) have argued, workforce development strategies must go beyond one-dimensional strategies of being either supply-side or demand-side and develop an approach which incorporates *both* supply and demand-side strategies. In other words these strategies must strive to develop a dual-customer approach—meeting both the workforce needs of employers and employees.

From Boston to San Francisco the lack of a steady supply of a skilled labor force coupled with the difficulty in retaining and advancing workers has been an impediment to the healthcare industry's ability to reduce operating costs, improve efficiency, and deliver better patient care. The current political and economic situation in the United States has resulted in limited public dollars earmarked for education and training programs aimed at building the human capital of the nation's health care workforce. Moreover, in major metropolitan areas with

growing populations and shifting demographics (i.e. increase in ethnic diversity, have a significant elderly population, etc.) there is a greater need than ever for skilled health care professionals that possess not only the critical occupational skills, but also have the language skills and cultural competence to meet the increased need in urban areas. The situation has resulted in a competitive environment among employers for skilled health care workers, which in return drives up labor costs, affects patient care, and leads to inefficiencies in the health care delivery system.

As a result, partnerships and initiatives have been created to distribute limited funds towards building the human capital of the nation's health care workforce. Across the country public/private investments have been made on behalf of federal, state, and local government agencies, national and community foundations as well as the private sector to develop and support new workforce development intermediaries. Workforce development intermediaries are generally collaborations, consortia, and networks that consist of employers, community and labor organizations, education and training providers, and/or public agencies.¹⁸ In my dissertation I use the definition of workforce development intermediaries developed by Robert Giloth. Giloth defines workforce development intermediaries as *homegrown, local partnerships that bring together employers and workers, private and public funding streams, and relevant partners to fashion and implement pathways to career advancement and family-supporting employment for low-skilled workers* (2004). These types of intermediaries tend to carry out three main functions:

¹⁸ Jobs For the Future. "Building Effective Intermediaries." 2005. www.jff.org

- Employment training and education;
- Job placement, and
- Work with employers to improve the overall quality of jobs through higher wages and investing in workers' skill development.

Moreover, what distinguishes these new workforce intermediaries from other labor market intermediaries is their explicit focus on low-wage, low-skilled workers (Giloith, 2004). In addition, Giloith argues that workforce intermediaries possess five important attributes:

- 1) Serve a dual-customer model by addressing the needs of employers and less-skilled workers and jobseekers.
- 2) Go beyond job matching, but instead work with employers to improve human resource systems, career ladders, job quality, and overall competitiveness.
- 3) Serve as integrators of funding streams, public and private sector services and programs, and information sources to better serve the needs of jobseekers, workers, and employers.
- 4) Are generators of ideas and innovations about what workers, firms, and communities need in order to prosper.
- 5) Are not single purpose or function organizations, but instead serve multiple purposes.

Intermediaries that are able to possess and implement the above five attributes tend to be more successful at connecting under-skilled individuals to quality jobs and help them increase their economic opportunity over time by assisting them in advancing along a career pathway.

Given the proliferation of new workforce development intermediaries across the U.S., how effective have they been at meeting both the needs of employers and workers? What factors seem to determine which intermediaries are successful and which one's are

not? Over the last several years, a number of evaluations and studies have been released which has analyzed the effectiveness of workforce intermediaries in helping low-income adults find employment and progress along a career pathway. One of the larger evaluations was a national analysis of 11 welfare-to-work intermediaries by MDRC between 1989 and 2002. The National Evaluation of Welfare-to-Work Strategies tracked more than 40,000 single-parent families over a 5-year period (MDRC, 2002). The evaluation examined three types of programs: 1) employment focused approach which emphasized short-term job assistance and focused on helping participants find jobs quickly; 2) education focused approach, which emphasized longer-term education and training before participants entered the job market; and 3) mixed approach, which placed some participants in longer-term training and education before entering the job market and the rest were encouraged to find jobs immediately. The MDRC evaluation resulted in several key findings. The intermediaries that were able to create and implement job advancement strategies for workers and meet the needs of employers provided both pre-employment and post-employment services. In the pre-employment stage, successful intermediaries provided participants with help in choosing a menu of career pathways, they focused on job readiness, retention skills, and basic education (English proficiency and technical training) (Poppe, Strawn, and Martinson, 2004). They also had an aggressive job development and placement component that focused on making connections to employers who were committed to helping employees progress along a career pathway and continue learning while also working (Poppe, Strawn, and Martinson, 2004). In terms of the post-employment services, the most successful intermediaries focused on improving worker retention rates by providing employees with social support

services such as counseling, child care, etc. These intermediaries also helped participants develop a detailed plan about their desired career progression. Most importantly, they provided employees with continued access to education and training that led to an industry required credential (Poppe, Strawn, and Martinson, 2004).

Another national analysis of workforce intermediaries was conducted by the National Network of Sector Partners with input from Jobs for the Future and the Aspen Institute in late August and early September 2002. The National Network of Sector Partners conducted a survey of 243 workforce development intermediaries serving a number of industries around the country. The top three industries served were health care (25%), information technology (22%), and manufacturing (19%). In order to be counted as a workforce development intermediary by NNSP, all intermediaries had to serve two primary customers (employers and workers), primarily worked with low-income or low-wage individuals, provided a menu of services and created and managed a mix of funding streams, and provided an investment in the longer term career advancement of those is served (Marano and Tarr, 2004). The study found that intermediaries that were able to serve a dual customer (employers and workers) and provided investment in the longer term career advancement of participants generally outperformed other workforce development organizations. For example, 55% of individuals that were placed in jobs exceeded \$9.50 an hour, 29% reported being placed in jobs paying \$11.00 or more an hour, and 66% of intermediaries reported job retention rates for individuals above 50 percent 6 months after they received employment services and training. In other studies such as the evaluation of the Job Training Partnership Act (JTPA) found that the average wage at placement was \$8.27 per participant (Grubb, 1995; Marano and Tarr, 2004) and

studies on sectoral programs at the Aspen Institute found average hourly wages of \$9.67 (Rademacher, 2001; Marano and Tarr, 2004). Finally, among those intermediaries that tracked employer outcomes 34% reported increased retention, 32% reported having lower training costs, and 22% improved the promotion rates of employees (Marano and Tarr, 2004).

There are also various types of workforce intermediaries. The NNSP evaluation consisted of workforce intermediaries that were led by workforce boards, educational institutions, economic development organizations, one stop career centers, etc. A significant number of workforce intermediaries are led by community-centered nonprofit organizations (i.e. community organizations, community colleges, etc.) and have adopted a job-centered economic development approach to workforce development. This strategy is concerned about making firms more productive, increasing workers' skills, and improving job quality. In the book Jobs and Economic Development, Giloth proposes a job-centered economic development strategy that focuses on identifying and accessing good jobs for low-income communities, networking among employers, building career ladders, enabling job retention, and advocating policies in support of livable wage jobs (Giloth, 1998). For him, job-centered economic development “suggests the formulation of a new ‘social contract’ among business, government, labor, and community around access to good jobs and the need for more integrated labor market policies and institutions at all levels of government and the economy” (Giloth, 1998). Unlike, regional skill alliances that tend to be industry-driven, workforce development intermediaries with a job-centered economic development approach focuses on job quality and the possibilities for moving people out of poverty (Fitzgerald and Leigh,

2002). An example of a job-centered economic approach to workforce and economic development is the Regional Manufacturing Training Collaborative (RMTC) in Chicago. The RMTC is an alliance of non-profit training providers, neighborhood economic development groups, employer associations, community colleges, a university-based research consortium, and other organizations interested in connecting economically disadvantaged communities with industries in order to develop a manufacturing training system that provides career pathways and living wage jobs.¹⁹

A job-centered economic development approach to workforce development could also apply to the health care industry by first identifying where the good quality jobs within the industry are using a number of factors such as pay, education requirements, projected growth, potential for upward job mobility, safe working conditions, and so on and so forth. Health care providers could partner with local nonprofit community organizations, labor, educational institutions, and others to develop a workforce development program that focuses on providing job training, education, and the necessary social supports that would enable economically disadvantaged residents to access quality health care occupations.

In contrast to workforce development intermediaries led by nonprofit organizations are intermediaries that are employer-led. It has been argued that workforce development intermediaries led by employers tend to focus on improving the education and skills of their employees in order to meet their immediate workforce development needs. They accomplish this by forming partnerships up with institutions of higher education, training vendors, social support agencies, public sector agencies, and nonprofits. Historically, employers have been reluctant to invest in any forms of training

¹⁹ Regional Manufacturing Training Collaborative. 2003. <http://www.chicagolandrmtc.org/index.html>

and educational resources for their low-earning, less-educated entry-level employees.²⁰ However, in sectors where the demand for skilled workers is high, such as in health care, more employers have been willing to divert resources for training and education targeted at their entry-level frontline health care workers.

The case can be made that a workforce intermediary led by a community organization is more likely to be more connected to economically disadvantaged residents with limited skills. Therefore, this type of intermediary will be most effective at meeting the workforce needs for those job seekers and frontline incumbent workers who need it most. But these intermediaries may not have developed a strong relationship to employers that is necessary to place low-skilled workers into jobs and help them advance their careers.

On the other hand, the argument can be made that an employer-led workforce intermediary is the most effective at meeting both the supply- and demand-side of the labor market because employers control access to the jobs and have a greater understanding of the skills and education needed in the workplace. Many workforce development scholars feel these are the most critical elements in helping low-skilled workers gain access to entry-level occupations with upward job mobility, such as those within the healthcare industry.

In her latest study on career ladder programs for low-income, low-skilled workers, Joan Fitzgerald (2006) has found five features that greatly improve a career-ladder program's chances of success:

- 1) A workplace environment that minimizes hierarchy and values communication;

²⁰ Conway, Maureen, Amy Kays Blair and Catherine Gibbons. 2003. "Investigating Demand Side Outcomes: Literature Review and Implications." The Aspen Institute. Washington, D.C.

- 2) An educational component designed to be supportive of the adult students who may lack confidence;
- 3) A partnership that benefits all groups involved in creating the program;
- 4) Devoted staff who champion the program; and
- 5) Career pathways that are clearly delineated for workers and clearly recognized by employers.

As workforce intermediaries continue to grow in numbers, they are increasingly moving beyond just placing economically disadvantaged adults in jobs, they are focused on developing career pathways. In the case of the health care sector, it is still unclear just how far an individual can progress along a career pathway.

Workforce Intermediaries in Boston

Boston, Massachusetts is an example of where the local government in conjunction with the state, have passed public policies to support the creation and sustainability of workforce development intermediaries. The public and private sectors have teamed up to make coordinated financial investments in these intermediaries with the goal of creating local workforce delivery systems that lead to long-term economic benefits for low-income, unemployed, and underemployed individuals.²¹ For example in 2004, national and local foundations, the Commonwealth of Massachusetts and the City of Boston launched SkillWorks (formerly called the Boston Workforce Development Initiative). SkillWorks is a \$5 million grants initiative that is aimed at enhancing the employment opportunities for economically deprived Boston residents by changing the way employers hire and promote entry-level workers from Boston's neighborhoods and

²¹ Jobs for the Future. 2004. www.jff.org

to raise the income level and standard of living for immigrants and other low-income residents.²² Among the first round of grant recipients were—the *Boston Health Care and Research Training Institute* (Training Institute) managed by the Jamaica Plain Neighborhood Development Corporation (JPNDC) in partnership with Fenway Community Development Corporation (FCDC) and Mission Works and *Partners in Career and Workforce Development (PCWD)* managed by the Community Benefits and Human Resources departments of Partners HealthCare System Inc.. The intermediaries are remarkably similar in their goals. For example, both intermediaries are focused on the following:

- *Serving dual customers—job seekers/incumbent workers and employers;*
- *Providing frontline incumbent workers with the education and training they need to move into professional careers in healthcare;*
- *Offering pre-employment training for neighborhood residents entering the workforce;*
- *Offering career counseling, case management, and adult basic education classes (computers, math, science concepts, ESOL, etc.) to participants; and*
- *Partnering with post-secondary educational institutions, non-profit organizations, and government agencies.*

Despite their similar goals the Training Institute and PCWD differ a great deal in the following areas:

- Approach to workforce development—the Training Institute is focused on a job-centered approach that identifies good jobs with an opportunity for

²² Massachusetts General Hospital Press Release. “Partners Healthcare awarded Workforce Development Grant.” December 12, 2003.

residents to progress along a career pathway. In addition, the Training Institute has adopted a human capital development approach to workforce development that focuses on helping participants gain education and skills before entering the labor market. PCWD has a labor market approach to workforce development that is focused on moving participants into jobs quickly with minimal education and skills training.

- Connectedness to economically disadvantaged, low-skilled Boston residents.
- Organizational structure and capacity

As a community development corporation, JPNDC's mission is to be an advocate for marginalized, economically deprived populations living within the greater Jamaica Plain neighborhood of Boston. Over its twenty-year history JPNDC has provided local residents with various services and economic opportunities such as assistance in obtaining affordable housing, connecting them to quality jobs, and supporting entrepreneurial activities. This has enabled JPNDC to gain legitimacy within the community as an organization dedicated to improving the lives of community residents.

Consistent with this history, JPNDC has worked hard to incorporate their mission into the design and development of the Training Institute. JPNDC has adopted a job-centered economic development approach to workforce development. This strategy, as I mentioned earlier, focuses on identifying and accessing good jobs for low-income residents, improving the workplace environment, networking among employers, building career ladders, increasing job retention, and advocating for policies that support livable wage jobs (Giloith, 1998; Fitzgerald and Leigh, 2002). JPNDC has formed close partnerships with the Fenway Community Development Corporation (FCDC) and MissionWorks to increase the service area to recruit low-income, low-skilled residents into their Pre-Employment and Incumbent Worker Training Programs. FCDC and

MissionWorks play a major role as neighborhood service providers, recruiters, employment specialists, and serve as pre-employment education centers. Since these community organizations have been deeply embedded in the local community for some time, they have strong ties to local residents, making it easier to recruit low-income and immigrant residents into the Training Institute. More importantly, by establishing a network with other community organizations, JPNDC is able to increase their staff capacity to manage and operate the Training Institute, which would be nearly impossible for them to do on their own.

Unlike the Training Institute, PCWD is an employer-driven intermediary that is managed by the Community Benefits Department within the Partners Healthcare System, a network of healthcare providers. The Community Benefits Department is charged with overseeing and running the daily operations of PCWD. Since PCWD is sponsored and managed by a network of employers, the program's approach to workforce development is predominately from the demand-side of the labor market. In other words, PCWD emphasizes meeting the workforce needs of its employer-based network by focusing on developing the careers and education of their employees.

PCWD also differs from the Training Institute in regards to their connections to economically disadvantaged, low-skilled Boston residents. Since PCWD is managed by a group of employers, it does not have the same institutional linkages to the local community as does the Training Institute. Instead, the leadership of PCWD has to rely on outside partner organizations such as the WorkSource Staffing Partnership and Project HOPE/Transition-To-Work to assist in the recruitment and screening of economically disadvantaged, lower-skilled residents.

Research Question(s)

Over the last decade labor market trends such as global competition, new technologies, and increased pressure from capital markets have widened the income gap between higher skilled technical workers and those workers with lower skills (Osterman 2004). Moreover, these labor market trends have severely weakened the old system of career advancement through internal labor markets, creating the need for new labor market institutions that can address career mobility across all income and skill levels, but especially for those individuals with the least amount of skills and economic opportunities (Kazis, 2004). As a result, politicians, policy analysts, and practitioners are supporting the growth and development of workforce intermediaries as potential solutions to improving labor market outcomes for low wage, low-skilled individuals. These workforce intermediaries such as the Training Institute and PCWD, attempt to increase economic opportunities for poor, low-skilled individuals by creating local workforce development systems that focus on the development of partnerships that emphasize employer engagement, job quality, advancement opportunities, and better integration of services (Kazis, 2004).

However, research evidence suggests that workforce intermediaries' attempt to build effective local workforce development systems largely fail because they do not satisfy the needs and aspirations of both job seekers/workers and employers. In many instances "low-wage and low-skilled workers are not supported on career paths that help them reach economic self-sufficiency, and businesses do not obtain a sufficient number of job-ready employees who can perform productively, acquire needed skills, and reduce turnover rates by remaining on the job" (Giloith, 2004). A significant part of the problem

lies in the difficulty in building the necessary institutional relationships among the various actors in the coordination and integration of multiple programs. Another part of the problem is in the actual ability of workforce intermediaries to design and implement strategies to help lower-wage, lower-skilled individuals advance along a career pathway.

In my dissertation I attempt to answer the following questions:

- What were the conditions that led to the creation of both the Training Institute and the Partners in Career and Workforce Development intermediaries? How have local politics and policies played a role in the creation and/or expansion of these intermediaries?
- Given that the Training Institute and PCWD intermediaries differ in their organizational structure, staffing capacity, approach to workforce development, and connectedness to the local Boston community, which of these intermediaries is most effective in helping low-wage job seekers/workers advance along a career pathway and in meeting employers' workforce needs? What factors may explain differences in the intermediaries' effectiveness?²³
- How much can workforce intermediaries such as the Training Institute and PCWD improve a workers' skill level. How far can a worker expect to advance along a career pathway? Are the career pathways set by workforce intermediaries realistic?
- How effective are the Training Institute and PCWD in changing the demand-side of the labor market (i.e. improving job quality, changing the workplace environment, providing support services to workers, etc.)
- Since the Training Institute and PCWD consist of numerous partners with diverse interests (employers, community organizations, educational institutions, government agencies, etc.), how have these partnerships been able or not been able to sustain themselves over time? What strategies are being implemented to ensure the program is sustainable?

These are all important questions for several reasons. First, workforce intermediaries are increasingly being developed and expanded in order to complement

²³ Please see Research and Design Methodology section in this chapter to see what measures I will use to define a workforce intermediaries' effectiveness.

and in some cases compete with the existing publicly funded workforce development system. Therefore it is important to understand the historical, political, economic, and institutional factors that have led to the rise of new workforce intermediaries.

Second, given the amount of resources and growing political support for the creation of these new intermediaries, few studies have attempted to examine how effective they are in helping economically deprived, low-skilled job seekers and workers advance along a career pathway as well as meet the needs of employers. More importantly, it is still unclear why one type of workforce intermediary is more effective than another at bridging the gap between the supply- and demand-sides of the labor market and in creating real structural change. My dissertation research sheds light on these key factors and strategies that are the most effective at helping under-skilled job seekers and entry-level incumbent workers access quality jobs and meet the needs of health care employers. I also attempt to uncover how far, on average, an individual that participates in the Training Institute or PCWD can expect to increase their skills and progress along a career ladder.

Third, new workforce intermediaries consist of diverse institutional partners (i.e. employers, educational institutions, community organizations, etc.), this requires building a great deal of civic capacity—the networks, relationships, and institutions connected and mobilized around a common set of ideas, issues, and objectives (Stone,1998; Giloth, 2004). As Richard Kazis argues, “promoting advancement sometimes requires more than skill in developing trust. Sometimes it takes the will and the power to negotiate with individual employers, industry associations, service providers, and public agencies for performance standards—and changes in both policy and practice—that put career

advancement first” (2004). This is why, through my research, I make an effort to understand how diverse organizations, such as those that make up the Training Institute and PCWD, are able or not able to form coalitions and sustain themselves in order to accomplish public purposes (i.e. build human capital, develop training programs, implement economic development strategies, etc.).

Finally, my research questions are important because the results from my dissertation could potentially better inform and influence the way policy makers redesign local workforce systems. Several workforce development practitioners have suggested that federal workforce development policies should be more flexible in order to support a broader menu of services for economically disadvantaged and socially deprived individuals at the local level (i.e. career counseling, basic skills enhancement, technical assistance to improve employer human resources, housing assistance, medical care, etc.). They also contend that federal workforce policies should direct more financial resources to states to provide technical assistance monies to strengthen performance and achieve continuous improvement of local workforce systems and intermediaries (Marano and Tarr, 2004). My dissertation research can address many of these concerns.

Research Design

In order to answer my research questions I conducted a descriptive case study analysis of the Boston Health Care and Research Training Institute and the Partners in Career and Workforce Development intermediaries.

Case Study Unit of Analysis

As part of my case study analysis I focused on two units of analysis—the workforce development intermediaries themselves (organizational structure and capacity, approach to workforce development, inter-organizational relationships, sustainability, etc.) and the two intermediaries’ workforce development outcomes for both the workers and employers. In the first phase of my analysis, I analyzed the conditions that led to the creation of the two workforce intermediaries and how they are trying to strengthen the local workforce development system. The second phase of my analysis examined how effective the Training Institute and PCWD were at helping low-income individuals advance a long a career pathway and in helping healthcare employers meet their workforce needs. I also sought to understand how these new workforce intermediaries strive to institutionalize their activities in an effort to create an effective workforce development system (see **FIGURE 1**).

FIGURE 1. “Process-Outcome” Framework for Workforce Intermediaries*

<p>Workforce Intermediaries’ Activities</p>	<p>Workforce Intermediaries’ Outcomes</p>
<ul style="list-style-type: none"> • Creation of partnership • Sustainability of partnership 	<ul style="list-style-type: none"> • Satisfaction of self interests of partners • Institutionalization of partnership
<p>Workforce Development Activities</p>	<p>Workforce Development Outcomes</p>
<ul style="list-style-type: none"> • Design activities (i.e. pre-employment programs, educational courses/programs, career coaching, etc.) • Implementation of joint activities <p align="center">Process</p>	<ul style="list-style-type: none"> • Impact on helping low-income individuals advance along a career pathway • Impact on meeting healthcare employers’ workforce needs • Institutionalization of activities leading to an effective workforce system <p align="center">Outcomes</p>

Time →

*Framework adapted from Robert K. Yin’s “Life Cycle Framework for Evaluating Educational Partnerships.” 1993.

Measurements to Define an Effective Workforce Intermediary:

- Number of individuals completing the Training Institute and PCWD's Pre-Employment Training Program and/or taking advantage of pre-employment services (i.e. resume writing workshops, job interviewing skills, ESOL classes, etc.);
- Number of pre-employment participants obtaining jobs within the health care sector;
- Starting hourly wage of Pre-Employment Training Program graduates;
- Number of promotions and wage increases over a 2-year period;
- Work retention rates after 2-years;
- Types of occupations pre-employment participants obtained within the health care industry;
- Average cost to provide educational and training services to each participant.

Case Study Selection Criteria

I chose the Boston Health Care and Research Training Institute and Partners Career and

Workforce Development intermediaries as case studies using the following criteria:

- Both workforce intermediaries consist of a partnership among employers, post-secondary educational institutions, community organizations, employers and others;
- Both workforce intermediaries' are focused on helping low-income and entry-level incumbent workers (primarily focused on Boston residents) advance along a career pathway within the healthcare industry. In addition, they are focused on serving the employment needs of healthcare employers;

- Both workforce intermediaries provide a comprehensive approach to workforce development by offering job seekers/workers pre-and post-employment training, career coaching, career planning, exposure to health careers, etc; and
- Both receive public and private funds to support the development and sustainability of a local workforce development system.
- Both workforce intermediaries are located in Boston, Massachusetts.

Case Study Timeframe

I examined both case studies over the course of 24 months during the period of January 1, 2004-December 31, 2005. During that time I collected training and employment data. I collected qualitative data and quantitative data at various points in time over the 2-year period in order to gain an understanding of how the two intermediaries evolved over time. In addition, this enabled me to measure the program's improvement over time with regards to their implementation of strategies and outcomes.

Methodology

In order to collect multiple sources of data about the Training Institute and PCWD's Pre-Employment and Incumbent Worker Training Programs, I used several case study methods to collect evidence. They consisted of the following:

- Documentation

I collected relevant documents related to the two programs such as copies of memorandums of understanding among organizational partners, program proposals for funding, study reports, etc. This allowed me to better understand the history of the programs, reasons for being created, how they were created as well as the roles and responsibilities of each organizational partner.

- **Archival Records**

I collected and analyzed archival records such as program employer and employee survey data administered by the programs, minutes to meetings (curriculum committee meetings, steering committee meetings, etc.), employee retention and promotional rates, number of employees participating in the program; etc. This enabled me to measure how well the programs are effective at meeting their desired outcomes.

- **Interviews, Surveys, and Focus Groups**

Since my primary unit of analysis is each workforce intermediary, I conducted in-depth interviews with a total of 46 key personnel from employers, education and training providers, community partners, government agencies, and social service agencies. I also interviewed several workforce development practitioners around the country that are specifically managing or developing health care workforce intermediaries. Here is a breakdown of who I interviewed:

11-Employers

10-Staff members from both the Training Institute and PCWD

12-Organizational partner staff members

4-Hospital administrators

5-Workforce development specialists

4-Community college staff members

I also conducted an additional 4 interviews with Training Institute and PCWD site directors after 1-year into the program. All interviews lasted between 45 minutes to 2 hours. During my interviews I attempted to understand why organizations are partners in the intermediaries, what they expect to get out of it, the challenges of maintaining/developing this type of organizational structure, etc. My interviews with local and regional government agency officials helped me to understand the barriers and challenges to developing local workforce development systems aimed at helping low-income individuals advance along a career pathway.

In addition to interviews, I conducted surveys and focus groups with a total of 22 pre-employment individuals from both the Training Institute (12 participants during a focus group) and PCWD (10 surveys of pre-employment participants).

- Direct Observation

When possible, I made site visits to each intermediaries' organizational meetings, training classes, career planning and coaching sessions, etc. over the two-year period. This enabled me to witness first hand how these partnerships function and operate.

Hypothesis

The rise of new workforce intermediaries has academicians, policymakers and practitioners questioning how well these intermediaries are able to help meet the workforce needs of both workers/job seekers and employers. More importantly researchers, including myself, are interested in understanding how well these intermediaries perform and what factors might help explain why some perform better than others. Based on previous studies, some researchers have attempted to develop early theories about the characteristics of successful intermediaries. Among the most popular ideas that explain the key factors of successful intermediaries was advanced by Giloth (2004) and Kazis (2004) which argue that the most successful workforce intermediaries are those that are able to carry out three important tasks:

- 1) They have an *entrepreneurial focus* on outcomes like long-term job retention, wage progression, and career mobility;
- 2) They *are able to network and partner* across supply, demand, educational, financial/funding, and spatial dimensions of regional labor markets; and
- 3) They have the *ability to learn and adapt* as market conditions and opportunities change.

Based on these three characteristics it appears that the Training Institute and PCWD are both likely to be successful in meeting workers' and employers' workforce needs. For

example, as a community-led intermediary, the Training Institute's core mission is to improve the job retention, wage progression and overall career mobility of low-skilled, low income Boston residents. As a result, the program is likely to have created social support mechanisms for low-income job seekers/workers by connecting them to the necessary educational and social services (i.e. childcare support, transportation, family/individual counseling, etc.) in an effort to assist them in their transition to jobs within the medical profession. In addition, the Training Institute has developed a job-centered economic development approach to workforce development which I discussed earlier.

PCWD on the other hand is also likely to be entrepreneurial in their approach to recruiting/retaining workers, creating monetary incentives for workers who perform at a high level and in the way they create career mobility opportunities for workers. However, the fact that PCWD is managed by a healthcare employer network will likely limit how far they are willing to extend themselves or think "outside the box" when it comes to attracting, retaining and promoting low-income, low skilled workers compared to JPNDC's Training Institute. Instead PCWD is likely to focus on the traditional recruitment and retention strategies that are focused and geared towards meeting employers' financial bottom line instead of developing additional, and sometimes expensive, social service support services such as childcare, transportation services, work readiness courses, etc that are necessary to help many entry-level workers succeed in the beginning. Moreover, PCWD's approach to workforce development is centered more heavily on the demand-side of the labor market which has a tendency to consider employers' needs over the needs of workers.

In terms of networking and partnering across supply, demand, educational, financial/funding, and spatial dimensions of the regional labor market, both the Training Institute and PCWD are also likely to do a good job. The Training Institute and PCWD have established partnerships with local and regional institutions such as community colleges, community organizations, social service agencies, private firms and government entities in order to develop a holistic approach to workforce development. However, it is more likely that the Training Institute will be more successful than PCWD at creating partnerships across the regional labor market simply because the Training Institute has less resources than PCWD. As a result, this requires JPND to establish close partnerships with other outside institutions to ensure that the program is sustainable both financially and programmatically. This is likely to be quite different for the PCWD program because it has significantly more resources (financial, staffing, institutional, etc.) than the Training Institute. Therefore, PCWD is likely to be more insular and develop fewer outside partnerships. The program is likely to rely on its employers for programmatic support with regards to curricula, training methods, financial support, staffing, etc. This is not unusual for large organizations with a significant amount of resources; they do not need to look beyond themselves for support the way organizations with less capacity do.

Finally, I believe both the Training Institute and PCWD will also be effective at learning and adapting to changes in the labor market. However, this is the one area where I think PCWD will have a distinct advantage over the Training Institute. Since PCWD is managed by healthcare employers, it is feasible that they will be aware and sensitive to any changes in the labor market caused by internal or external factors such as

increased demand for certain types of workers due to demand shifts for specific types of medical procedures or by technological innovations in the field that place greater emphasis on specific types of skills while decreasing the need for others. It is highly probable that the Training Institute relies on employers for information about the latest changes in the labor market with regards to skill and occupational demand so that they can adjust their training program accordingly.

Despite the fact that both the Training Institute and PCWD intermediaries are likely to be successful at helping low-income job seekers/workers advance along a career pathway and in meeting the needs of employers, it is more likely that the Training Institute will do the better job. The Training Institute's strong connections to social service agencies and educational providers as well as their core commitment to help low-income, under-skilled residents improve their economic and social conditions are likely to make the major difference in the outcomes between the two programs. It is my hope that my dissertation will shed light on this issue and help influence the policy debate around local workforce development systems for low-skilled, low-income residents.

Chapters to Follow

Chapter Two describes the four structural and political factors that created the conditions that helped to support the development of the Boston Health Care and Research Training Institute and the Partners Career in Workforce Development intermediaries. **Chapter Three** covers the history of the Boston Health Care Research and Training Institute. It includes history on how the Training Institute evolved over time, how it is designed to work, how it actually works, and the Training Institute's

outcomes. **Chapter Four** describes the history of the Partners in Career and Workforce Development program. Just like with the Training Institute, I cover the evolution of the program, how it is designed to work, how it works, and PCWD's outcomes. In **Chapter Five** I provide a cross-comparison analysis between both case studies. This includes how the Training Institute and PCWD were able to help entry-level incumbent workers and under-skilled, economically disadvantaged job seeking Boston residents obtain jobs within the health care sector and advance along career ladders and lattices. In addition, I examine how well each intermediary was able to meet the occupational demands of health care employers. In this chapter I will also examine how each intermediary was able to implement their workforce strategies and take steps at developing long-term sustainability. Finally, I conclude by providing policy recommendations as to the ways in which the existing workforce development system might be improved in order to be more efficient and effective at increasing the skills, education, and economic opportunities of lower-skilled, economically disadvantaged individuals and suggest future areas of academic research in this field.

CHAPTER TWO STRUCTURAL AND POLITICAL FACTORS: THE EMERGENCE OF HEALTH WORKFORCE DEVELOPMENT PROGRAMS

How did Boston, a city with just under 600,000 residents, become one of the first cities in the nation to have not just one, but two, workforce intermediaries exclusively focused on the health care industry? This did not happen by an accident or coincidence. Instead welfare reform, the federal Workforce Investment Act, a tight labor market, and political pressure by state and local elected officials contributed to the conditions that made it possible for the creation of both the Boston Health Care and Research Training Institute (Training Institute) and the Partners in Career and Workforce Development (PCWD) programs.

From Welfare to Work

During the mid-1990's welfare reform became a hot button issue that both Democrats and Republicans debated vociferously. Republicans argued that the time had come for the Aid to Families with Dependent Children (AFDC) welfare program to be reformed and place greater responsibility on the individual for increasing their economic opportunities, conversely some in the Democratic Party argued that any significant changes in the welfare system would lead to greater number of children and families living in poverty. The Commonwealth of Massachusetts was at the forefront of this debate. So much so that on November 1, 1995, a year before the federal government passed sweeping welfare legislation with the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the state legislature of Massachusetts, at the

insistence of then Governor William F. Weld, passed new legislation that changed the previous welfare system and resulted in the creation of the Transitional Aid to Families with Dependent Children (TAFDC) program, a time-limited welfare assistance program with stringent work requirements, operating under the state Department of Transitional Assistance (DTA). It became clear that Massachusetts' new welfare reform legislation was designed to shift individuals off the state's welfare assistance program and to put "work first" under the new Full Employment Program (FEP). As one assistant commissioner in charge of overseeing the FEP initiative stated, "The cornerstone of the reform is work. It doesn't matter how you get there. This program is just a small piece of the puzzle."¹ Under the TAFDC law, an individual receiving cash assistance is only able to receive cash benefits for 24-months during a 60-month time period. TAFDC also requires all able-bodied recipients with school-age children (six years or older) to participate in the Full Employment Program (FEP). FEP was designed to provide TAFDC recipients with paid work experience and on-the-job training necessary to obtain unsubsidized employment. Recipients participating in FEP receive a subsidized wage in lieu of TAFDC cash benefits and food stamps and are subject to FEP criteria in accordance with the Commonwealth of Massachusetts regulations.²

Under the initial FEP plan, the state offered employers who hired welfare recipients a one-year wage subsidy: \$2.50 an hour for nine months, \$1.50 for the last three months. An additional \$1 an hour was placed in a trust for the employee to collect at the end of the year. In the beginning of the program, the Department of Transitional

¹ Ibid 2.

² Commonwealth of Massachusetts 106 CMR 208.000: Department of Transitional Assistance. http://www.mass.gov/Eeohhs2/docs/dta/g_reg_208.pdf

Assistance was overly ambitious and set an original goal of placing 2,000 welfare recipients across Massachusetts in jobs within just 8 months. However, after eight months FEP had only placed 128 recipients in jobs across the entire state. The results in Boston were equally dismal. In the city of Boston the goal was to create 320 new jobs for welfare recipients during the same eight month time period, but in reality the city was successful in placing only 5 individuals in jobs.³ Some argued that the initial success of FEP was slow because many welfare recipients lacked the education and skills necessary to land a job. In addition, many employers were apprehensive about hiring welfare recipients.⁴

TAFDC was also designed to emphasize post-employment services and other supports (i.e., childcare and short-term skills development) to make it easier for welfare recipients to transition from welfare to employment, with the goal of helping them to become economically self-sufficient (Kaye et al, 2001). This political shift at the state level was significant not only because it focused on the needs of families transitioning off welfare and low-income families in general, but it forced the state agencies in charge of implementation to consolidate and streamline responsibilities in order to encourage more formal collaboration among programs serving families, workers, and children (Kaye et al, 2001). This was a significant factor in fostering multi-sector partnerships (employers, community organizations, government agencies, educational institutions, etc.).

³ Grunwald, Michael. "Welfare Job Plan Unfulfilled As Deadline Nears," in The Boston Globe. June 14, 1996. City Edition. Metro/Region; Pg. 1.

⁴ Ibid 2.

The Emergence of WIA and the Consolidation of the Workforce Development System

In addition to welfare reform, Massachusetts was also one of the first states to consolidate their workforce development system and one-stop career center network. In 1996, Boston opened two career centers as part of Massachusetts' participation in the US Department of Labor's One Stop Implementation Project. A year later Boston's third career center opened. Boston's career centers were built around four central principles— 1) universal access; 2) service integration; 3) customer choice; and 4) accountability. More importantly, Boston's career centers developed a single, unified management structure that created partnerships between the private not-for-profit community based organizations and public agencies.⁵

The streamlining of Massachusetts' workforce development system was further enhanced with the passage of the federal Workforce Investment Act (WIA) of 1998, which superseded the Jobs Training Partnership Act (JTPA). WIA was designed to better coordinate the nation's employment and training programs, provide state and local flexibility, and promote increased accountability in jobs programs (Skillman, Sadow-Hasenberg, and Hart, 2004). Under WIA, states and local service delivery areas were mandated to provide workforce planning in partnership with business, elected officials, labor, and other key partners through workforce investment boards (WIBs). WIA also required every state to be subdivided into workforce development areas and to provide workforce services such as job search assistance, assessment, and training for eligible adults, dislocated workers, and youth to be delivered through one-stop centers in each area (Skillman, Sadow-Hasenberg, and Hart, 2004).

⁵ Boston Private Industry Council. 2006. www.bostonpic.org/adult

In Massachusetts, the passage of WIA resulted in state officials developing a workforce investment system that was built on and guided by a partnership between the public and private sectors as well as between state and local stakeholders (Massachusetts Department of Workforce Development, 2006). The Department of Workforce Development (DWD) (formerly named the Department of Labor and Workforce Development) was designated as the state level agency responsible for the oversight of WIA funds received from the U.S. Department of Labor Employment and Training Administration. Workforce investment boards and one-stop career centers became the core of the state's service delivery for job development and placement, training referrals and placements, and employer outreach on workforce development services (Massachusetts Department of Workforce Development, 2006).

One distinction that separated Massachusetts from other states was the fact that the state workforce development system and cash assistance programs were highly integrated very early on. For example in Boston, individuals seeking TAFDC assistance were required to apply through a Department of Transitional Assistance office. If an applicant qualifies for TAFDC, a case worker reviews the applicants educational background, skills, work history, and job references before processing the application. If TAFDC recipients are subject to the work requirement, they are referred to one of the three one-stop career centers (Boston Career Link, JobNet, and The Work Place), which have contractual agreements with the Department of Transitional Assistance to provide employment assessment, job search assistance, employment services to welfare recipients, and referrals to other employment and training programs (Kaye et al, 2001). Boston is unique in that its one-stop career centers do not actually provide any job

training, instead they contract out to local employment and training organizations. This consolidated workforce development system places greater responsibility on local government agencies, employers, and community organizations to bear a larger burden of the responsibility in helping welfare recipients transition off welfare and into work.

The new welfare legislation placed an enormous amount of pressure on state agencies and local jurisdictions across Massachusetts to come up with a comprehensive strategy to help thousands of welfare recipients who faced time limits to transition off welfare and into full employment, none the less, it was the passage of WIA that provided flexible funding to the state and local areas (i.e. Boston) to reach this goal. WIA funding, in combination with welfare-to-work funds which were already flowing into Massachusetts, were the catalysts in creating a more integrated workforce development system focused on helping adults, dislocated workers, and youth gain access to employment services and training. In the City of Boston, it was Mayor Thomas M. Menino, the city council, elected state representatives, the Mayor's Office of Jobs and Community Services (JCS), and the Boston Private Industry Council (the local workforce investment board) who led the effort in helping to support these workforce development efforts, especially programs exclusively for the city's most economically disadvantaged residents.

The Boston Private Industry Council (Boston PIC) and the Mayor's Office of Jobs and Community Services (JCS) played a key role in creating partnerships among employers and community-based organizations to assist former welfare recipients with their transition off public assistance and into employment. Under WIA, the Boston PIC and JCS (a department of the Boston Redevelopment Authority that dispenses private and

public funds and services to Boston residents), became responsible for overseeing the workforce development system. As Skillman, Sadow-Hasenberg, and Hart stated, “Business, labor, and community organizations must be represented on state and local WIBs. The mandated membership of the WIBs is intended to increase the likelihood of serving the two main customers of the new Workforce Investment System: local businesses and individuals seeking employment” (2004). This is precisely the role of the Boston PIC which works in partnership with JCS to develop Boston’s local WIA plan—to provide strategic direction to the publicly funded workforce system, determine funding decisions, and measure the system’s effectiveness in meeting the employment and training needs of individuals and the workforce needs of employers in Boston.⁶ Founded in 1979, the Boston PIC is a long-time employer-led intermediary. The PIC’s mission is “to strengthen Boston's communities and its workforce by connecting youth and adults with education and employment opportunities that prepare them to meet the skills demands of employers in a changing economy” (Boston Private Industry Council, 2006). In keeping with their mission, the Boston PIC has partnered with education, labor, the community, and government agencies to provide oversight of public workforce development programs.⁷ Moreover, as an intermediary, the Boston PIC strives to play four interrelated roles:

- 1) convenes local leadership around education and workforce priorities,
- 2) brokers employer partnerships,
- 3) connects youth and adults with education and employment opportunities, and
- 4) measures program impact, as well as quality and scale.

⁶ Boston Private Industry Council. 2006. www.bostonpic.org

⁷ Ibid 5.

In 1998 the Boston PIC in partnership with JCS and the Economic Development and Industrial Corporation, received a 4-year, \$11.3 million dollar grant from the Department of Labor to fund welfare-to-work training programs in Boston. This was significant because it was the first substantial amount of welfare-to-work funding made available to employer sponsored training initiatives and community service programs. The U.S. DOL welfare-to-work grant helped the Boston PIC and JCS strengthen their position and clout locally among the business community because it allowed these organizations to be more than just intermediaries and conveners of local partnerships. The Boston PIC and JCS proved they could also bring in federal dollars to support workforce development activities. As a result, it was easier to get the “buy-in” from employers who were initially skeptical about hiring former welfare recipients, let alone to get involved with workforce development programs exclusively focused on welfare recipients. Suddenly, with federal dollars to subsidize local welfare-to-work programs and WIA-related activities, it made it easier for local WIBs and workforce intermediaries to bring employers to the table as partners, and in some instances, have them take the lead in managing welfare-to-work training programs. As a long-time employee of the Boston PIC told me, “Workforce development partnerships in Boston are galvanized around funding streams, which tend to include the Boston PIC. This is why I am always paying attention to what funding is available at the federal, state, and local level.”

As the fiscal agent of the U.S. DOL grant, the Boston PIC solicited proposals from both public and private organizations interested in developing, managing, and implementing welfare-to-work programs. Given the mounting political pressure from

elected officials at both the state and local level to place TAFDC recipients in jobs, the Boston PIC and JCS made it a mandate that any group receiving a grant had to commit to training and placing at least 20 welfare recipients into jobs within just four months. Among the organizations that received funding were two health care welfare-to-work employment training programs—one led by the Jamaica Plain Neighborhood Development Corporation (JPNDC) and Fenway Community Development Corporation (FCDC) and the other led by Partners HealthCare System Inc, a nonprofit coalition of health care providers (including some of Boston’s largest health care employers). Since JPNDC and FCDC were both actively involved in local workforce development efforts independent of each other, the two community organizations decided to consolidate their efforts and developed a welfare-to-work program called Steps to the Future. The Steps to the Future welfare-to-work training program originally focused on placing participants in frontline occupations within the hospitality and health care industries. However, JPNDC/FCDC quickly discovered that the hospitality industry employment was unstable due to fluctuations in the economy. Moreover, the industry provided few opportunities for upward job mobility, especially for under-skilled workers (I will discuss this in further detail in Chapter 3). Based on these factors JPNDC and FCDC switched the focus of Steps to the Future and decided to exclusively target the health care industry.

The PIC grant awarded to Partners HealthCare System funded a welfare-to-work program called Project RISE (Reaching Individuals Striving for Excellence). Project RISE was a comprehensive training program that focused on placing participants in entry-level health care jobs. According to Partners HealthCare, Project RISE was created to address two main challenges—to respond to the organization’s concerns about the

effects of Massachusetts welfare reform on community members and to meet Partners' system-wide need to fill entry-level positions with job-ready applicants.⁸

Both Steps to the Future and Project RISE welfare-to-work training programs were successful in establishing partnerships with Boston's health care employers, community organizations, social service providers, and government agencies. These two programs were the first large scale health care workforce programs in the City of Boston and laid the foundation for what would later evolve into two distinct workforce development intermediaries focused on the health care industry—the Boston Health Care and Research Training Institute and the Partners in Career and Workforce Development programs.

The relationship among Boston's health care employers, community organizations, government agencies, social service providers, institutions of higher education, labor unions, etc. was further strengthened when, in 2000, the Boston Public Health Commission and the Boston PIC facilitated a series of meetings and discussions with health care employers about the mismatch between the health care industry's employment needs and the supply of workers in the Boston region (Boston PIC, 2002). In the fall of 2001, with funding from the U.S. Department of Labor, the Boston PIC formed the Boston Health Care Consortium, a consortium which included more than 50 members representing health care employers (from acute care, extended care, home health care, and community health centers), health care professional and trade associations, state and local workforce development agencies, organized labor, community-based organizations, community and neighborhood organizations, and post-

⁸ VHA Health Foundation Inc. 2000. "Welfare-To-Work: Strategies for Health Care Workforce Development." Annie E. Casey Foundation. Baltimore, MD. Pg. 82.

secondary institutions that offer health sciences certificates and degrees (Boston PIC, 2002). The goal of the Consortium was to identify past and current strategies that were aimed at alleviating the health care labor shortages within Boston's health care industry. The Consortium discussed ways to improve health career focused school to career models, pre-employment skills training programs for adults, and retention and skills upgrading programs for incumbent health care workers. The Boston Health Care Consortium provided the first real opportunity for diverse health care-related organizations and professionals from the public, not-for-profit, and private sectors to come together to express their ideas, share information, and develop strategies to address the health care workforce employment demands and challenges. It also helped build relationships and trust among disparate organizations and professionals.

Addressing the Health Care Industry's Employment Demands in a Tight Labor Market

Some scholars and workforce development practitioners have argued that the Workforce Investment Act of 1998 has been a catalyst for helping to alleviate health care workforce shortages by pooling additional resources from both the private and public sources. Moreover, they contend that the timing of WIA legislation mandating the participation of employers on state and local WIBs provided a window of opportunity for the involvement of the health care industry in workforce planning because the industry was beginning to experience a workforce shortage crises" (Skillman, Sadow-Hasenberg, and Hart, 2004). Finding a solution to this crises is what motivated many health care employers to participate in the workforce development system (Skillman, Sadow-Hasenberg, and Hart, 2004).

This argument sounds rather logical and I am certain that in other metropolitan and rural areas around the country this may have indeed been true. However, in the City of Boston the situation was slightly different. Boston's health care sector never experienced a severe health care workforce shortage in comparison to other regions. Instead, the health services industry experienced only a modest growth in overall employment and workforce shortages were only moderate between 1993 and 2000. According to a labor market analysis conducted by the Northeastern University Center for Labor Market Studies (CLMS), Massachusetts' health care employment levels rose 299,200 in 1993 to 325,100 by 2000, an increase of just 25,900 jobs or 8.7%, a growth rate that was less than one-third the rate of the service sector during the same time period. In Boston between 1993 and 1997, the health care industry grew at a rate of 4.7% (3,279 jobs) compared to the health care industry growth in the Boston suburbs at 11.3% (12,898 jobs) (CLMS, 2002). Much of the health services growth in the suburbs of Boston was in non-hospital settings such as home health care, extended care facilities, and physicians' offices. Between 1997 and 2000, the City of Boston's health care employment grew at steady, but moderate 4.4% (3,226 jobs), while the Boston suburbs and the state overall experienced health care declines of 6.5% (8,275 jobs lost) and 0.7% (2,139 jobs lost) respectively (Boston PIC, 2002) (see TABLE #3 below). Much of the decline in health services employment throughout the state and within the Boston suburbs was in non-hospital settings, many of the same facilities that were responsible for the rapid growth during the mid-1990s (CLMS, 2002).

TABLE #3:

Trends in Employment Levels within the Health Services Industry in Selected Geographic Areas in Massachusetts, 1993-1997 and 1997-2000

Geographic Area	1993	1997	Absolute Change	Relative Change
Massachusetts	299,228	327,288	28,060	9.40%
City of Boston	70,097	73,376	3,279	4.70%
Balance of Boston Labor Market Area (LMA)	114,267	127,165	12,898	11.30%
Balance of State	114,864	126,747	11,883	10.30%
Geographic Area	1997	2000	Absolute Change	Relative Change
Massachusetts	327,288	325,149	-2,139	-0.07%
City of Boston	73,376	76,602	3,226	4.40%
Balance of Boston Labor Market Area (LMA)	127,165	118,890	-8,275	-6.50%
Balance of State	126,747	129,657	2,910	2.30%

Source: Center Labor Market Studies, Northeastern University. "The Health Services Industry in the Greater Boston Area: Analysis of the November 2001 Job Vacancy Survey."

Despite the modest job growth within the health services industry, the CLMS study did find that some occupations within specific health care sectors did experience workforce shortages. The CLMS researchers were able to classify most of the 25,900 jobs created in the state of Massachusetts between 1993 and 2000 into five health care sectors: hospitals, nursing homes and personal care facilities, home health care services, medical and dental laboratories, and community health centers. This revealed the following:

- Between 1993 and 2000 almost all of the City of Boston's employment gains were concentrated in the hospital sector, which added more than 5,500. Hospital employment accounted for half of the City's health services employment. The largest vacancies among hospitals were in nursing (medical surgical nurses at 22%, CNAs at 9%, and RNs at 6%)

- Extended care facilities experienced persistent shortages in direct care workers, particularly in nursing (LPNs and RNs); and
- Home care agencies, medical and dental laboratories, and community health centers did not experience any significant shortages.

Overall, Boston's health services industry experienced only a moderate job vacancy rate of 3.8% between 1993-2000 with the majority of workforce shortages concentrated in nursing (LPN and RN), psychologist/counselor, and medical and technologist occupations (CLMS, 2002).

Since the majority of workforce shortages were concentrated in mostly highly skilled occupations (requiring post-secondary education/training) there must be other factors that explain why Boston's largest health care employers became deeply involved in workforce development intermediaries targeted at increasing the supply of the frontline, entry-level health care workforce. One factor that explains this is that, during the late 1990s and into 2000, Boston was experiencing an upswing in the economy, largely driven by the information technology sector, which resulted in a record number of jobs being created. Between 1992 and 2000, Boston gained over 120,000 new jobs and reached an all-time high of just over 700,000 total jobs (Boston Redevelopment Authority, 2000). During the same time period, Boston's unemployment rate declined from a high of 8.6% during the recession year of 1991, to a record low 2.9% in 2000 (BRA, 2000). The City's average unemployment rate in 2000 was one percentage point lower than the national rate and only 0.2 percentage points higher than the state average.

Although these were encouraging economic indicators, health care employers were concerned about some startling labor force trends with regards to the future supply

of the health care labor force. During the rapid expansion of Massachusetts' economy during the 1990s, the state experienced only a 0.7% increase in the labor force or the equivalent of roughly 21,000 workers, which was well behind the U.S. labor force growth rate of 12.2% for the same period (CLMS, 2002). In addition, there was a significant decline in the labor force growth rate when compared to the previous two decades which experienced a growth rate of 15.2% (1980s) and 17.9% (1970s) (CLMS, 2002). Even more startling was the fact that the number of degrees awarded below the bachelor's level in health sciences had declined 37% overall and the total number of health sciences degrees awarded by all post-secondary institutions between the academic school years 1994-95 and 2000-01 in the state declined by 12%, from 12,024 to 10,611. Greater Boston area post-secondary institutions awarded 41.8% fewer associates-level health sciences degrees during this time. The occupations most affected by statewide declines in associates level health sciences degrees in both absolute and relative terms were RN (-33.3%); physical therapy (-62.5%); medical assistant (-60.3%); radiologic technologist (-58.3%); and psychiatric/mental health services technician (-41.3%) (CLMS, 2002).

These numbers, in combination with a tight labor market help to explain another reason why health care employers may have gotten involved in local welfare-to-work efforts. However since late 2001, the economy in both Boston and the state of Massachusetts has softened quite a bit. The economy is no longer experiencing a tight labor market. The economy suffered a downturn after the terrorist attacks of September 11, 2001 and as recent as December 2005, the unemployment rate for the City of Boston was 4.7%, up significantly from the record low of 2.9% five years earlier. After 2001, the Boston economy softened and there was no longer a tight labor pool. In fact, health care

employers have stated that competition for jobs within the health services industry has, and continues to, increase. During my interviews with health care employers they often stated that competition for jobs within the hospitals and research laboratories is strong. One Partners HealthCare System administrator summed it up best when she said, “Competition for health care jobs in Boston is fierce. Partners jobs generally receive a high volume of applications, even for entry-level positions. It is not uncommon for some positions to receive over 100 applications.” Another health care administrator explained to me that competition for jobs is especially strong within the Longwood Medical Area (LMA) because of the fact that these institutions emphasize teaching and research. He stated, “[Institutions within the LMA] are more interested in research, so they prefer well-educated workers. Competition for federal research grants and research results are so strong that even the administrative assistants have master’s degrees from top universities. Often times, there is tension between local residents and students with B.A.’s who want to get work experience before applying to graduate or medical school. This is especially the case in Boston.”

In addition to the increased competition for jobs within the health services industry, state labor trends suggest that jobs are requiring more skills, education, and training. State health care occupational projections estimate that among the jobs which are projected to grow significantly between 2000 and 2010, most will require additional skills, post-secondary education and/or training, and also require occupational/industry certification. According to the latest health services employment data for Massachusetts, only a handful of jobs requiring less than post-secondary training are expected to grow at any significant level between 2000 and 2010. Among the *health care practitioner and*

technical occupations listed under the standard occupational classification (SOC) system, only pharmacy technicians and dietetic technicians require less than an associate's degree. These two occupations are projected to experience an average growth rate of only 2.2% and 1.9% respectively between 2000 and 2010. When analyzing the *health care support* occupations under the SOC system, the outlook is only slightly more encouraging. Six of the top ten health care support occupations with the highest average growth rates between 2000 and 2010 require less than post-secondary education and training. They are medical assistants (4.1%), home health aides (3.5%), physical therapist aides (3.4%), occupational therapist aides (2.8%), dental assistants (2.7%), and veterinary assistant and laboratory animal care takers (2.3%) (see TABLE #4).

One can see from the occupational data that there appears to be only modest projected growth among health care occupations that require less than post-secondary training in the state of Massachusetts between 2000 and 2010. Only medical assistants, home health aides, and dental assistants are expected to have any significant increase in the *absolute number of jobs created* within the state over this 10-year period. Moreover, the majority of health care occupations expected to grow during this period require at a minimum post-secondary vocational training, which is beyond the educational levels of a significant portion of the Training Institute and PCWD's Pre-Employment Training Program participants.

TABLE #4: Top Ten Health Care Support Occupations Sorted by Average Growth Rate

Occupational Title	2000 Estimated Employment	2010 Projected Employment	Average Growth Rate	Absolute Change	2004 Average Wage	Education/Training
Medical Assistants	5,757	8,593	4.1%	2,836	\$14.75	Moderate-on-the-job training (1-12 months)
Home Health Aides	14,161	20,069	3.5%	5,908	\$11.10	Short-term-on-the-job training
Physical Therapist Aides	735	1,023	3.4%	288	\$12.50	Short-term-on-the-job training
Physical Therapist Assistants	1,637	2,237	3.2%	600	\$19.47	Associate degree
Occupational Therapist Aides	251	341	3.1%	90	\$15.23	Short-term-on-the-job training
Occupational Therapist Assistants	843	1,110	2.8%	267	\$18.30	Associate degree
Dental Assistants	6,165	8,062	2.7%	1,897	\$16.48	Moderate-on-the-job training (1-12 months)
Massage Therapists	821	1,041	2.4%	220	\$19.26	Post secondary vocational training
Veterinary Asst. and Lab. Animal Caretakers	2,052	2,588	2.3%	536	\$13.40	Short-term-on-the-job training
Medical Transcriptionists	1,716	2,096	2.0%	380	\$17.72	Post secondary vocational training

Data Source: MassStats, 2006. www.massstats.detma.org

Overall, an analysis of the health care labor market between the early 1990s and 2000 showed that Massachusetts, and Boston in particular, never experienced a severe health care workforce shortage. The health services sector grew at a moderate rate and even declined between 1997 and 2000 in Massachusetts, except for in the City of Boston. The data did reveal that some occupations such as nursing, health technicians and technologists, and among psychologists and counselors experienced workforce shortages. The vast majority of these occupations require extensive post-secondary education, training, and certification. Labor market projections suggest that the occupations with the

most opportunity for growth and higher pay will be those that require at least post-secondary education, training, and certification (i.e., medical records and health information technicians, dental hygienists, cardiovascular technologists/technicians, respiratory therapists, etc.) Given all of this, there must be an additional explanation as to why the largest health care employers (mainly research and teaching hospitals) in Boston have been willing to spend so much time, money, and resources in partnering with community organizations to support workforce development programs targeted at the City's most economically disadvantaged and under-skilled residents, especially when competition for these jobs is already strong.

Politics Matter: Building Connections between Boston's Health Care Sector and Its Economically Disadvantaged Neighborhoods

The health services industry is one of the largest employment sectors in Boston. The City's health services sector represents more than one out of six city jobs, employing 103,835 people employed in 2003, and includes all employment in Boston's 22 inpatient hospitals, 25 community health centers, nursing homes and community, family, and child services agencies (The Boston Foundation, 2004). Six of the top ten largest private employers in Boston are hospitals and medical centers—Massachusetts General Hospital (#1), Beth Israel Deaconess Medical Center (#3), Brigham and Women's Hospital (#4), Children's Hospital Boston (#6), New England Medical Center (#7), and Boston Medical Center (#9). Overall, the health services and related industries account for 40.5% of the total jobs provided by Boston's largest employers.⁹

The largest agglomeration of teaching hospitals, medical clinics, research laboratories, and health care-related firms are located within the Longwood Medical and

⁹ Boston Redevelopment Authority. 2001. "Health and Medical Services Fact Sheet."

Academic Area (LMA). As I briefly mentioned in Chapter 1, the LMA is a densely built environment comprised of 21 institutions built on a 213-acre site adjacent to the Fenway and Mission Hill neighborhoods of Boston and the Town of Brookline. On any given day more than 37,000 employees and approximately 15,000 students come into the LMA. Federal research grants awarded to LMA institutions have grown precipitously since the early 1990s. For example between 1991 and 2001, National Institutes of Health (NIH) awards more than doubled for the LMA institutions from \$302 million to \$722 million. During roughly the same period, square footage growth in the LMA has increased more than 26%.¹⁰ More recently, development proposed, approved or under construction in the area between 2001 and September 2003 included approximately 4 million square feet of research, academic and medical space, including residence halls, academic support space, patient and research facilities, and parking.¹¹

¹⁰ Medical Academic and Scientific Community Organization, Inc (MASCO). 2006. www.masco.org

¹¹ Ibid 9.



The rapid growth of buildings within the LMA over the years has forced institutions to look for available land in the surrounding communities adjacent or in close proximity to the LMA, such as Mission Hill, Roxbury and Jamaica Plain. Increased development within the LMA and into the surrounding communities has been an extremely controversial and contentious issue between community residents and LMA

institutions. Residents living in neighborhoods contiguous to the LMA often complain about the increased development by LMA institutions. Residents argue that the development within and surrounding the LMA is contributing to increased housing costs, traffic congestion, and gentrification. More importantly, a high percentage of the residents living in the Fenway-Kenmore, Jamaica Plain, and Roxbury neighborhoods are under-skilled, economically disadvantaged residents. These residents have protested to city officials, local state representatives, city council members, and LMA administrators that they are being pushed out of the area due to development and say that they would be less likely to oppose most development projects if residents from their communities were getting a proportion of the newly created jobs. A veteran Mission Hill (an area of Jamaica Plain that is adjacent to the LMA along Huntington Avenue) community advocate told me that a job developer at the local community center had been trying to get Mission Hill residents jobs within the LMA several years ago but was unsuccessful. She expressed the frustration that so many from this community feel, “Residents are already connected to the LMA area because they go there for services and health care. However, many have a difficult time getting employment in the LMA. There are roughly 10 residents employed by LMA institutions! That’s why Mission Works is working so hard to place residents within the Longwood Medical Area.”¹²

¹² Mission Works, is a free-standing, community-based non-profit located within a 535-unit public housing complex. The goal of Mission Works is to provide services that helps residents move towards economic self-sufficiency.

TABLE # 5: 2000 Census Data of Boston Neighborhoods Surrounding or in Close Proximity to the Longwood Medical and Academic Area (LMA)

	Fenway-Kenmore*	Jamaica Plain	Roxbury	Boston
Population	36,191	38,074	55,663	589,141
White (non-Hispanic)	24,505 (67.7%)	19,369 (50.9%)	2,520 (4.5%)	290,972 (49.4%)
Black/African-American	2,698 (7.5%)	6,842 (18.0%)	36,454 (65.5%)	146,958 (24.9%)
Hispanic or Latino	3,003 (8.3%)	8,642 (22.7%)	13,995 (13.0%)	85,199 (14.5%)
Asian/Pacific Islander	5,074 (14.0%)	2,537 (6.7%)	355 (0.6%)	44,563 (7.5%)
Native American	80 (0.2%)	200 (0.5%)	493 (0.9%)	2,581 (0.4%)
Percent Foreign Born	21.3%	22.9%	20.8%	25.8%
Median Household Income	\$25,356	\$41,524	\$27,133	\$39,629
Poverty Rate	37.3%	20.9%	27.1%	19.5%
Unemployment Rate	11.4%	5.5%	11.6%	7.2%
Percent H.S. Graduate or less	21.6%	35.0%	63.0%	45.1%

*Significant student population in this area which may account for some of the data such as household income, poverty rate, and unemployment rate

Apparently Boston residents' complaints did not fall upon deaf ears. In recent years, elected officials from the state and local level have begun monitoring how much LMA medical institutions and other medical organizations around Boston contribute to efforts that create economic opportunities, improve the quality of life, and enhance the overall well-being of Boston's residents, especially the most impoverished. In 2001, the Massachusetts Attorney General's Office began requiring all health maintenance organizations (HMOs) and non-profit acute care hospitals to prepare annual community

benefit reports that document the status of their community benefits programs and initiatives. According to the Attorney General's Office, "the availability of such information enables hospitals, HMOs and communities to work together to identify and address critical unmet community needs, and facilitates replication of best practices" (Massachusetts Office of the Attorney General, 2006). The idea behind the Attorney General's Office is to make HMO and hospital data transparent. All of the data collected from community benefit reports is placed in a publicly searchable online database allowing any Massachusetts resident to monitor the level of community involvement and investment by hospitals and HMOs.

Boston's Mayor Menino and several local state representatives have also openly supported health care workforce development programs, especially the Boston Health Care and Research Training Institute and the Partners in Career and Workforce Development programs. Boston's Mayor Menino has been particularly concerned about the lack of economic opportunity and health disparities between Boston's higher educated, higher income residents and those residents with very little formal education and/or skills. In 2003, a period during which Boston suffered an economic downturn, Mayor Menino and The Boston Foundation announced a five-year, multi-million dollar workforce development initiative (SkillWorks). The SkillsWorks initiative ended up providing a substantial amount of funding to support the workforce development efforts of the Training Institute and served as seed money to launch the Partners in Career Workforce Development program. During the press conference to announce the SkillWorks initiative, Mayor Menino cleverly named Brigham and Women's Hospital President, Dr. Gary Gottlieb, to chair the Workforce Development Committee of the

Boston Private Industry Council.¹³ By appointing such a powerful hospital administrator to chair the local workforce development committee for the Boston PIC, the Mayor sent a message to others that connecting residents to health care jobs was a priority. Mayor Menino further made his point by telling the audience and media that were present, “I believe in the people of Boston. If we give them the tools they need to compete in the city’s knowledge-based economy, they will rebuild our economy. We have invested a lot in workforce development over the past ten years and it is our responsibility to continue to support our workforce at a time when they need it most.”¹⁴ This occasion would mark the beginning of Menino’s efforts to place a greater responsibility on health care employers to do more to connect Boston residents to jobs.

Mayor Menino took several concrete steps to make certain that his efforts to encourage health care employers to hire local residents, especially those residents in adjacent communities to the LMA, were taken seriously. During the month following month after the press conference to announcing the SkillWorks workforce development initiative, the Boston Redevelopment Authority, the Office of Jobs and Community Services, and the Boston Transportation Department, under the guidance of the Mayor, announced the beginning of an 18-month planning process for the Longwood Medical and Academic Area (the “LMA Master Plan”). The development of the master plan for the LMA required the participation of city agencies, LMA institutions, and area residents. During the 18-month interim period preceding the completion of the LMA master plan, a set of interim guidelines were released by the Boston Redevelopment Authority for the purposes of “governing development, preventing ad hoc growth in the LMA, and control

¹³ Boston Redevelopment Authority. January 15, 2003. Press Release: “Mayor Menino, The Boston Foundation Announce Workforce Development Plan.” www.cityofboston.gov/bra/press

¹⁴ Ibid 12.

growth in a fair and equitable manner” (BRA, 2003). Under the new *LMA Interim Guidelines* report, all development in the LMA would have to go through the organization’s development review process.

Prior to the release of the *LMA Interim Guidelines*, each institution was responsible for developing their own master plan. With the creation of the *LMA Interim Guidelines*, the control over development was taken out of the hands of LMA institutions and placed it into the hands of the City. More importantly, this was an opportunity for Mayor Menino to exert his political power, allowing him to directly influence the type of development being built within the LMA, create affordable housing and employment opportunities for local residents, and find ways to better integrate the activities and services provided by LMA institutions into the fabric of the surrounding neighborhoods. For instance, in the *LMA Interim Guidelines*, development was tied to workforce development, making Boston the first city in the country to tie real estate development to job development.¹⁵ The report clearly stated that institutions or developers contemplating development within the LMA would be required to present to BRA and JCS workforce development staff, as part of the development review process, “an assessment of current and projected workforce needs, and to work with BRA/JCS staff to formulate a workforce development plan to address those needs” (2003). This required developers/institutions to provide the following:

- Data on the number and percentage of current employees who are Boston residents, and the types of positions they hold;
- Current and projected staffing needs; and
- A description of the institution’s existing workforce development activities.

¹⁵ Greenberger, Scott. March 14, 2003. *The Boston Globe*. “City Pushes Local Jobs at Longwood.” Section: Metro/Region; Pg. B1. 673 words.

Moreover, the Workforce Development section within the *LMA Interim Guidelines* stated that institutions or developers may submit proposals to the BRA requesting that a portion of the development funds be placed into the Neighborhood Jobs Trust, which is used to train new workers for positions within a proposed project. The BRA/JCS workforce development staff in evaluating proposals looked for the following:

- A firm commitment for a specific number of jobs offering adequate pay and benefits;
- A high degree of institutional involvement in the design and implementation of the training program;
- A substantial commitment of in-kind resources from the institution; and
- A commitment to hiring a specific number of Boston residents.

The *LMA Interim Guidelines* also blatantly stated that it was expected that an LMA institution's workforce development plan would include an increased investment in the Boston Health Care and Research Training Institute "to ensure that this new health care career-ladder initiative continues to grow after the initial start-up grants from the City and State have expired." If LMA institutions did not make investments in the Training Institute they had the option of making investments in the following:

- Establishment of other career-ladder training models, which could, for example, build upon successful school-to-work or welfare-to-work programs piloted over the past several years by Boston health care institutions and training providers (i.e., Partners in Career and Workforce Development program led by Partners HealthCare Systems Inc.);
- Establishment of intensive, on-site English as a Second Language (ESL) classes for current employees, preparing them for career-ladder job training programs

while at the same time increasing the pool of bilingual employees (especially designed for recent immigrants to Boston); and/or

- Investment in the City's English for New Bostonians initiative, or the Adult Literacy Initiative, which fund the expansion of ESL and literacy services citywide (programs targeted at helping increase the language and literacy skills of immigrants in Boston, who increasingly comprise a larger percentage of Boston's population and labor force).

In addition to all of these guidelines, LMA institutions and developers wanting to construct buildings exceeding the BRA baselines of 75' or 150' (depending on location and type of building), would have to provide more benefits to the public. For instance, in early 2003 Joslin Diabetes Center had plans to build more than 1 million square feet for a research center and apartment building within the LMA. After resistance from Boston city officials, elected state and local leaders (i.e. state representative Jeffery Sanchez and Boston City Council Member Michael Ross), and community residents, Joslin was forced to reduce their proposed project under the new LMA interim planning guidelines.

Joslin's revised plan included only 490,000 square feet of development instead of 1 million, 150 apartment units instead of 160, a 29-floor tower instead of 37, and 350 parking spaces instead of 357.¹⁶ Despite Joslin's significantly reduced development plan, the organization still faced resistance from BRA staff and others who demanded that more affordable housing and jobs be developed for local residents. Finally in May 2003 the BRA gave final approval for Joslin Diabetes Center to build their proposed research center and apartment complex. However, as part of the agreement with the BRA to allow Joslin to construct a building taller than the specified LMA interim guidelines, Joslin agreed to increase its current investment in workforce development in Boston from

¹⁶ Palmer Jr., Thomas C. April 11, 2003. *The Boston Globe*. "BRA Postpones Longwood Project Vote Traffic Issues at Diabetes Center's Complex Are Cited." Section: Business; Pg. D3. 718 words.

\$160,000 to \$330,000 between the fall of 2003 and late 2007.¹⁷ Joslin also agreed to provide more affordable housing units within its proposed apartment complex. In a *Boston Globe* article that ran shortly after city planners approved Joslin's development proposal, Joslin Diabetes Center president, C. Ronald Kahn told the *Globe* that, "The city insisted on the housing. We need lab space so we can accept more research grants and increase our staff by about 60 percent in the coming decade, to respond to the growing epidemic of diabetes with research, diagnosis, and patient care" (*The Boston Globe*, 2003). Apparently, this deal was worth it to Joslin's because the organization's president also stated that the institution was eager to expand at its current prominent location within the LMA to be near colleagues at Harvard Medical School and 16 other affiliated institutions.¹⁸ The desire to be in close proximity to world-class research institutions and other medical facilities is a driving force that allows the BRA and other city agencies to negotiate and demand so much from LMA institutions. It would be unlikely that the City of Boston would be able to demand the same from employers in another industry such as manufacturing or information technology, largely because it is easier for these institutions to relocate to regions with lower operating costs (i.e., rent, wages, taxes, etc.).

The second major step Mayor Menino took in encouraging Boston health care employers to invest and support workforce development initiatives came in the fall of 2005. The Mayor announced that the City of Boston was providing \$1 million in public and private funds to provide grants to help fight racial and ethnic health disparities. The Boston Health Disparities Project is a ten point strategic plan to eliminate the health disparities that exist between Boston's white and minority residents. The Disparities

¹⁷ Ibid 14.

¹⁸ Diesenhouse, Susan. July 26, 2003. *The Boston Globe*. "City's RX for Medical Area: More Housing Joslin's \$225m Complex to Have Apartments, Labs." Section. Real Estate; Pg. D12. 691 words.

Project calls for a wide range of strategies to improve the health outcomes of Boston residents (i.e. data collection and quality improvement, patient education, neighborhood investment, etc.). The Health Disparities Project even focuses on improving the diversity of the health care workforce and increasing job security for poorer residents. To date, four efforts have been funded to increase the opportunities for Boston's minority residents to enter the health care field. Two grantees have been funded to create one-year intensive dual certification and bridge programs for Boston Public School's high school students or recent graduates from Boston Public Schools interested in pursuing a health-related profession. The other two have received planning grants for activities to implement city-wide plans to increase admission and enrollment of minority students in universities involved in healthcare.¹⁹

Conclusion

In this chapter I have demonstrated that there were several structural and political factors that contributed to the development and support of health care workforce development programs in Boston. In the mid-1990's welfare reform was successful in placing work first, which led to the distribution of millions of federal dollars that went to support state and local efforts to help TANF recipients transition from welfare to work as well as for workforce development initiatives and programs. By the late 1990s the Workforce Investment Act legislation helped to reorganize and streamline Massachusetts' workforce development system. Under WIA, state and local WIBs were required to include employers on their boards. This federal requirement in combination

¹⁹ Boston Public Health Commission. 2006. Boston's Health Disparities Project. www.bphc.org/disparities

with additional government administered WIA funds helped get the “buy-in” of employers, especially in local jurisdictions such as Boston. Coincidentally, by the time welfare reform and WIA legislation was being implemented, Massachusetts was experiencing an economic boom driven largely by the information and technology sector. This resulted in record low unemployment levels and a tight labor pool in Boston, which got the attention of health care employers and motivated them to be apart of state and local workforce development efforts. However, after 2001, Boston’s economy experienced an economic downturn and unemployment rose. Today, competition for health care jobs remains strong and Boston’s health care employers have continued to invest in health care workforce development efforts targeted at the City’s most economically disadvantaged, and under-skilled residents. This is, in large part due to the political pressure from state and local elected officials. The Mayor of Boston has been successful in linking real estate development within the Longwood Medical Area to the development of jobs and other public benefits. In addition, he has called on health care employers to provide more funding for workforce development efforts which directly support programs such as the Boston Health Care and Research Training Institute and Partners Career in Workforce Development programs.

In the next two chapters, I will show that, although structural factors and political pressure may have led to the conditions that helped create and provide ongoing support for the development of the Training Institute and PCWD, it has been the leadership, structure, flexibility, and social networks of these organizations that has helped Boston’s most economically disadvantaged residents obtain jobs within the health care sector.

CHAPTER THREE: A CASE STUDY OF THE BOSTON HEALTH CARE AND RESEARCH TRAINING INSTITUTE

In this chapter I provide a historical and descriptive case study analysis of how the Boston Health Care and Research Training Institute (Training Institute) was created and how the intermediary has evolved over time. I argue that the Jamaica Plain Neighborhood Development Corporation (JPNDC) and the Fenway Community Development Corporation (FCDC) along with their community partners have taken a job-centered economic development approach to workforce development by connecting under-skilled residents to entry-level positions within the health care industry. The Training Institute has had limited success in changing the demand-side of the labor market, however it has been able to encourage employers to become more proactive in the development of career pathways, work on creating a more supportive work environment for entry-level employees, and to invest their own money into the Training Institute. Over time, the relationship between employers and JPNDC/FCDC has evolved from a partnership to a business-client relationship, which has resulted in employers demanding more services from the Training Institute. In the last section of this chapter I conclude by examining how well the Training Institute has been able to help their Pre-Employment Training Program participants obtain jobs within the health care sector. In addition, I provide an analysis of the outcomes for incumbent workers who participated in the Training Institute's Incumbent Worker Training Program.

Overview

The Training Institute officially began in 2002 as a partnership between 8 major employers in the health care and research sector. The original partnership included the Boston Private Industry Council, a labor union, four community organizations, and two community colleges. Since its inception, the Training Institute has evolved immensely. Today, the workforce intermediary is comprised of 28 partners—11 employers (including all the largest health care employers within the Longwood Medical and Academic Area), 17 organizations of higher education, a health care industry association, a labor union, the Boston PIC, social service agencies and community organizations. Managed by JPNDC in partnership with FCDC and the Mission Hill Network, the Training Institute provides workforce development training, education and social service support to under-skilled, economically disadvantaged individuals who reside primarily in the Fenway, Jamaica Plain, Mission Hill, and Roxbury neighborhoods of Boston. More specifically, the Training Institute provides education and training programs to individuals who fall into one of the following categories:

- Pre-employment job seekers with limited English or education;
- Entry- and mid-level workers lacking the language skills, education, and training needed to move into higher paying health care occupations; and
- Hospital supervisors who would like assistance in learning how to improve their management skills.

The Training Institute has the following long-term goals:

- To improve the ability of entry-level workers to advance economically;
- To improve the efficiency of healthcare employers by improving retention and filling vacancies in nursing and other allied health professions;
- To build a career ladders model that will be replicable by other health care employers that are not currently members of the Training Institute, and that will lead to greater collaboration among employers;
- To create a permanent Training Institute in the Longwood Medical and Academic Area that will institutionalize career development opportunities for entry level workers, and will provide employers with a steady source of qualified workers in areas of skill shortages; and
- To develop a system that facilitates the hiring of neighborhood residents, especially from the neighborhoods surrounding the Longwood Medical and Academic Area (LMA).

History

Over the last two decades Boston has experienced a precipitous increase in ethnic minorities. In 1980 Boston's population was 68% white. By 2000 Boston, had become a majority minority city with ethnic minorities totaling 50.5% of the population. In 2000 the three largest ethnic minorities in the city were Blacks/African-Americans (23.8%), Latinos (14.4%), and Asians (7.5%) (U.S. Census, 2000). Immigration has largely been responsible for the demographic shift in Boston. In 2000, 1 out of every 4 Boston residents was foreign-born with the majority of new comers from the Americas.¹ A significant number of immigrants settling into Boston's neighborhoods have been non-English speaking, under-skilled individuals. For example in the neighborhood of Jamaica Plain, immigrants from Latin America and the Caribbean have struggled to learn English and obtain jobs skills needed to gain entry into the local labor force.

¹ City of Boston, Mayor's Office of New Bostonians. 2006. "New Bostonians' Demographic Report." http://www.cityofboston.gov/newbostonians/pdfs/dem_report.pdf

The growth of immigrants posed new challenges for the Jamaica Plain Neighborhood Development Corporation (JPNDC), which is located in the heart of the diverse and immigrant-rich Boston neighborhood of Jamaica Plain. Until the mid-1990's JPND C was primarily a developer of affordable housing and it focused on community development and organizing. However, the rapid increase in immigrants and economic changes in the neighborhood, including rising housing costs and business development led JPND C to focus more attention on creating economic opportunities for local residents. JPND C decided to engage local residents in a strategic planning process in order to better understand residents' needs and help them improve their economic opportunity. During this process, JPND C surveyed local residents and found that the vast majority of them expressed a need for jobs, day care services, and access to education. The findings from the planning process motivated the staff of JPND C to think creatively about strategies the organization could implement which would help local residents increase their employment opportunities and become economically self-sufficient. For example, in 1996 JPND C's board of directors commissioned a feasibility study to see if the organization could play a significant role in enhancing the economic opportunities of Jamaica Plain residents. According to a report released by The Rockefeller Foundation in 2003, the central question that JPND C's board attempted to answer was, "How does a community-based workforce development strategy serve both the needs of residents and those of employers? How does it develop the necessary relationship of trust with both business people who do the hiring and residents who need support services, education, training, jobs, and advancement opportunities" (2003)?

It was no coincidence that JPNDC's strategic planning process occurred during the national debate about welfare reform. As I mentioned in the previous chapter, the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 reformed the federal welfare system. The new changes to the welfare system placed an enormous amount of pressure on state and local government agencies, the business community, and nonprofit social service agencies such as community-centered organizations to help Boston's most economically disadvantaged residents find adequate employment—jobs that had the potential to provide the poorest residents and their families with a livable wage and upward job mobility that could lift them out of poverty. JPNDC, like many other local community organizations, soon found themselves strategizing on how they could play a significant role in local workforce and economic development, something they had done little of in the past.

The economic, political, and demographic changes provided JPNDC with a window of opportunity to improve the organization's capacity for workforce and economic development. In 1996, JPNDC began planning workforce and economic strategies and launched a program called 'Jobs for Jamaica Plain,' which focused on helping residents improve their skills and find jobs as well as assisted them with housing, child care, and other support services. A year later JPNDC also developed the Small Business Development Program, a program that provides technical assistance, educational workshops, and financial support to small businesses. Soon after the Jobs for Jamaica Plain and Small Business Development programs were up and running, JPNDC applied for and successfully received a U.S. Housing and Urban Development Community Block Grant to further enhance the organization's capacity for workforce and

economic development. Then, in 1998, the Boston Private Industry Council in partnership with the Mayor's Office of Jobs and Community Services along with the Economic Development and Industrial Corporation received a four-year \$11.3 million U.S. Department of Labor (DOL) grant to fund welfare-to-work job training programs in Boston. JPNDC and FCDC teamed up to develop Steps to the Future, a welfare-to-work job training program. As I discussed earlier, Steps to the Future was a pre-employment job training program that targeted TANF recipients. Under the City of Boston's guidelines, the goal of the Steps to the Future program was to place 20 Boston TANF recipients in jobs within four months.

Almost a year after Steps to the Future had begun, the Bank of Boston (which was bought by Fleet Bank and later bought by Bank of America in 2004) decided to formally sponsor an incumbent career ladders program geared towards helping individuals with limited skills and economic resources advance along a career ladder. JPNDC and FCDC teamed up again and were successful in obtaining funding from the Bank of Boston to launch "Bridges to the Future," a career ladders pilot project targeting the health care sector. Unlike the Steps to the Future program, Bridges to the Future (Bridges), was a much larger program and focused exclusively on incumbent health care workers within the LMA. The Bridges to the Future partners were Beth Israel Deaconess Medical Center (BIDMC) and Children's Hospital Boston. Later Harvard Medical School, Harvard School of Dental Medicine, and New England Baptist Hospital joined the partnership. Although health care employers had been engaged in their own internal workforce development efforts, Bridges to the Future was the first program of its kind to create a

partnership between a significant number of health care employers and local community organizations.

The Bridges program was a three year, \$80,000 a year project that focused exclusively on two outcomes—the retention and career advancement of entry-level under-skilled employees in occupations such as medical administration, food service, and environmental management services. In the early stages of the program, an advisory committee comprised of academics, policymakers, and workforce development practitioners was established to help develop workforce strategies, map career pathways, and agree on the skills that would be the foundation for training pre-employment participants. This model proved to be instrumental in designing a program that was relevant to both the needs of health care employers and local residents, especially during a tight labor market with record low unemployment. Bridges staff met with employers every month for 7 months from February to September 2000 in order to be sure all partners fully understood each other’s perspective and how the program was to be implemented. As one former Bridges staff member told me, “It took until September 2000 for employers to finally get it! For employers to finally understand what Bridges was all about.” Most employers thought the Bridges program was simply a job training program to fill the frontline occupational needs and enhance the skills of entry-level employees. Many employers had very little experience dealing with a workforce intermediary so they were not sure in the beginning how the program was supposed to function.

Employers eventually came to realize that the Bridges program was not just about training entry-level employees, but was also focused on creating career pathways and

improving job quality. It was about restructuring the demand-side of the labor market. This was different from the previous job training models which focused primarily on helping residents get jobs. Instead, a clear goal of the Bridges program was to help entry-level workers improve their job and language skills so that they could move-up or transition into other occupations within the hospital. The second objective of the program was to help employers fill job vacancies and reduce turnover rates. One administrator at Beth Israel Deaconess Medical Center told me,

“At the time the Bridges program was developed, Beth Israel Deaconess Medical Center had a group of front-line workers that we felt could benefit from Bridges. BIDMC was looking for people with promise, we had just went through a merger and needed someone to come in and help us with thinking around workforce development issues. BIDMC liked the product of Bridges. The curriculum was well thought out, the retention strategy made sense. The whole program made sense....the Bridges program was seen [by BIDMC administrators] as a potential solution to BIDMC’s retention and training problem with entry level employees. Bridges was a small and the safe thing to do.”

Another hospital administrator in the human resources department at Children’s Hospital Boston stated, “Children’s had skilled shortage issues at the time the Bridges program was launched, so Children’s felt that it was important to develop career ladder, promotion, and retention opportunities.” Both of these statements by hospital administrators demonstrate their commitment to being a part of the Bridges program because it met their workforce needs or at least had the potential to do so. More importantly, Bridges involved employers at the beginning of the planning and design process which helped them understand how in working together, the program could meet

both the needs of employers and workers. The extensive planning and design process also helped to break down some cultural barriers that existed between employers and community organizations. The Bridges program was Boston's first large scale effort between community organizations and the City's health care employers to work together in order to establish a career ladder pipeline. Prior to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and the Workforce Investment Act of 1998, few nonprofit community organizations were involved in large scale workforce development activities.

Although the Bridges program was a fairly modest pilot project, it trained roughly 50-60 individuals a year for three years. More importantly, Bridges had the backing of Boston's mayor, Thomas Menino, who was determined to find ways for welfare-to-work recipients and other economically disadvantaged individuals to have access to economic opportunities. For example, at the official kickoff event to start the Bridges to the Future program, Mayor Menino attended the ceremony along with the CEO from every participating hospital, which raised the level of the program's profile not only around the city and but within each participating hospital.

By the time the Bridges program's funding was almost depleted, the Commonwealth Corporation (a nonprofit Massachusetts based workforce consulting and research agency), along with other state education and training agencies, pooled together their resources to create the Building Essential Skills through Training (BEST) Initiative. The BEST Initiative was a state-wide initiative with the following goals:

- Eliminating redundancy and combining federal and state dollars into a single effort

- Involving workforce development experts at the local level to participate in the initiative
- Creating career ladders in various sectors
- Defining promising practices
- Providing sector employers with effective ways to improve their productivity and the skills of their workers.

According to the Commonwealth Corporation, “The BEST Initiative was designed to support industry-driven partnerships that address the workforce development needs of Massachusetts businesses by building workers' skills through education and training. With this initiative, the state's adult education and job training agencies joined together to support regional proposals that give front-line workers a foundation of skills to achieve career mobility, while reducing persistent job vacancies in key sectors.”²

An In-Depth Look at the Boston Health Care and Research Training Institute

Program and Focus

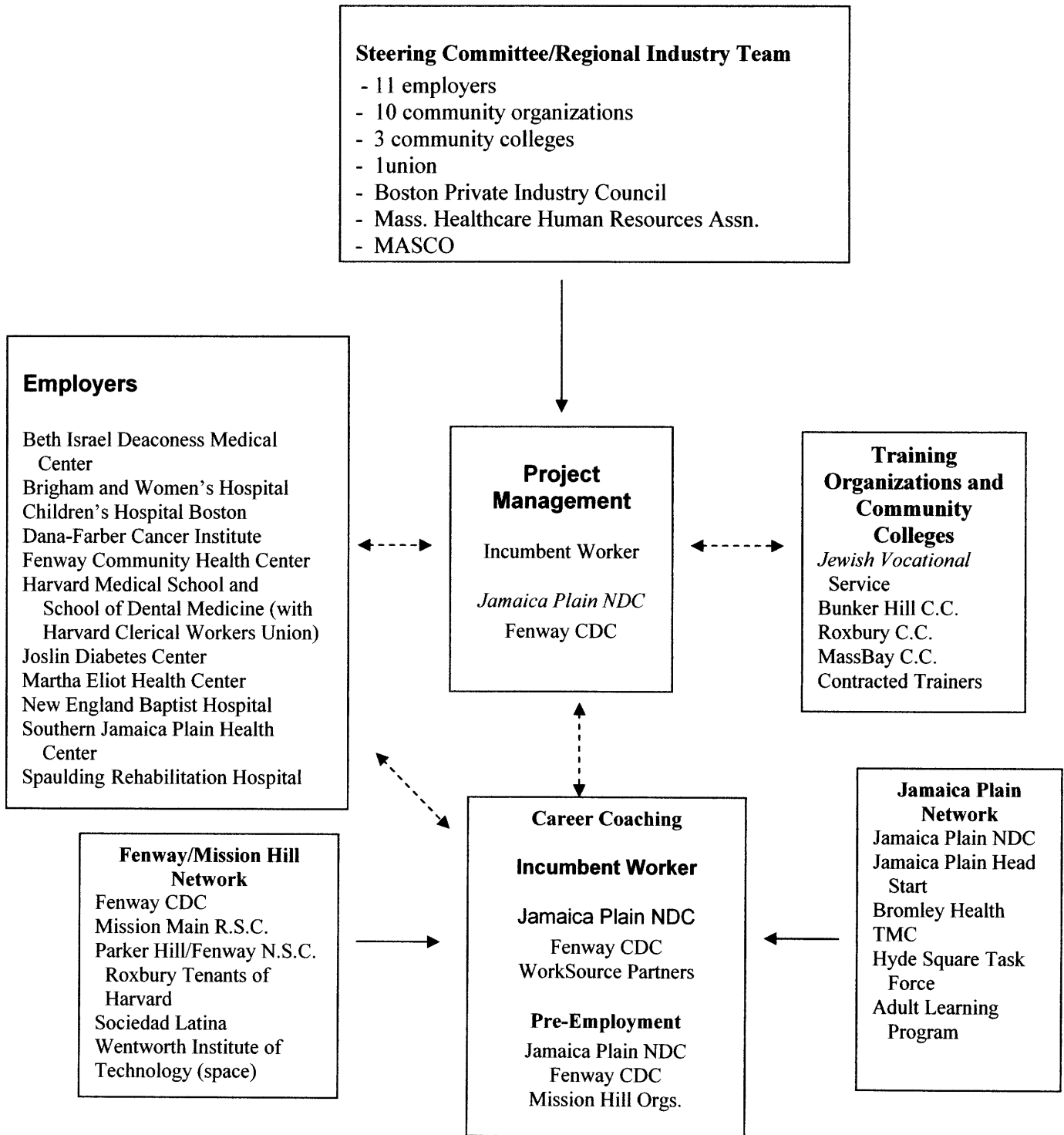
In April 2002, JPNDC and FCDC’s joint proposal was selected as one of six regional sites to be a part of the BEST Initiative. They received a half-million dollar grant to create the Boston Health Care and Research Training Institute (Training Institute). This grant allowed JPNDC and FCDC to build upon their experience with the Bridges program by expanding the original number of five partners under the Bank of Boston funded program to 15 partners under the BEST Initiative. In 2003, the Training Institute received a five-year grant from SkillWorks (formerly known as the Boston

² Commonwealth Corporation. 2005. <http://www.commcorp.org/cwi/programs/best/projects.html>

Workforce Development Initiative), a \$15 million dollar workforce development initiative focused on building the skills of low-skilled, under-employed, entry-level workers in Boston.³ The SkillWorks Initiative is funded by a major consortium of public and private funders, known as The Boston Funders Group for Workforce Development which includes contributions from the City of Boston, the Commonwealth of Massachusetts' Governor's Discretionary Workforce Investment Act grant, and nine Boston-based and national foundations: The Boston Foundation, Bank of America Private Bank, the Annie E. Casey Foundation, The William Randolph Hearst Foundations, The Hyams Foundation, The Robert Wood Johnson Foundation, The John Merck Fund, Rockefeller Foundation, The Paul and Phyllis Fireman Foundation, the State Street Trust Community Foundation, and United Way of Massachusetts Bay. Under this new funding structure, the Training Institute has an annual operating budget of about \$650,000 and has expanded to include 28 partners representing employers, social service agencies, education and training providers, community organizations, a labor union, an industry association and the Boston Private Industry Council (see FIGURE 2 below).

³ The SkillWorks Initiative has a goal of raising \$25 million dollars. As of February 2006, the SkillWorks Initiative had raised \$15 million dollars towards workforce development efforts in Boston.

**FIGURE 2. Boston Health Care and Research Training Institute
Organizational Structure⁴**



⁴ Figure 1. Developed by Jamaica Plain Neighborhood Development Corporation. 2005

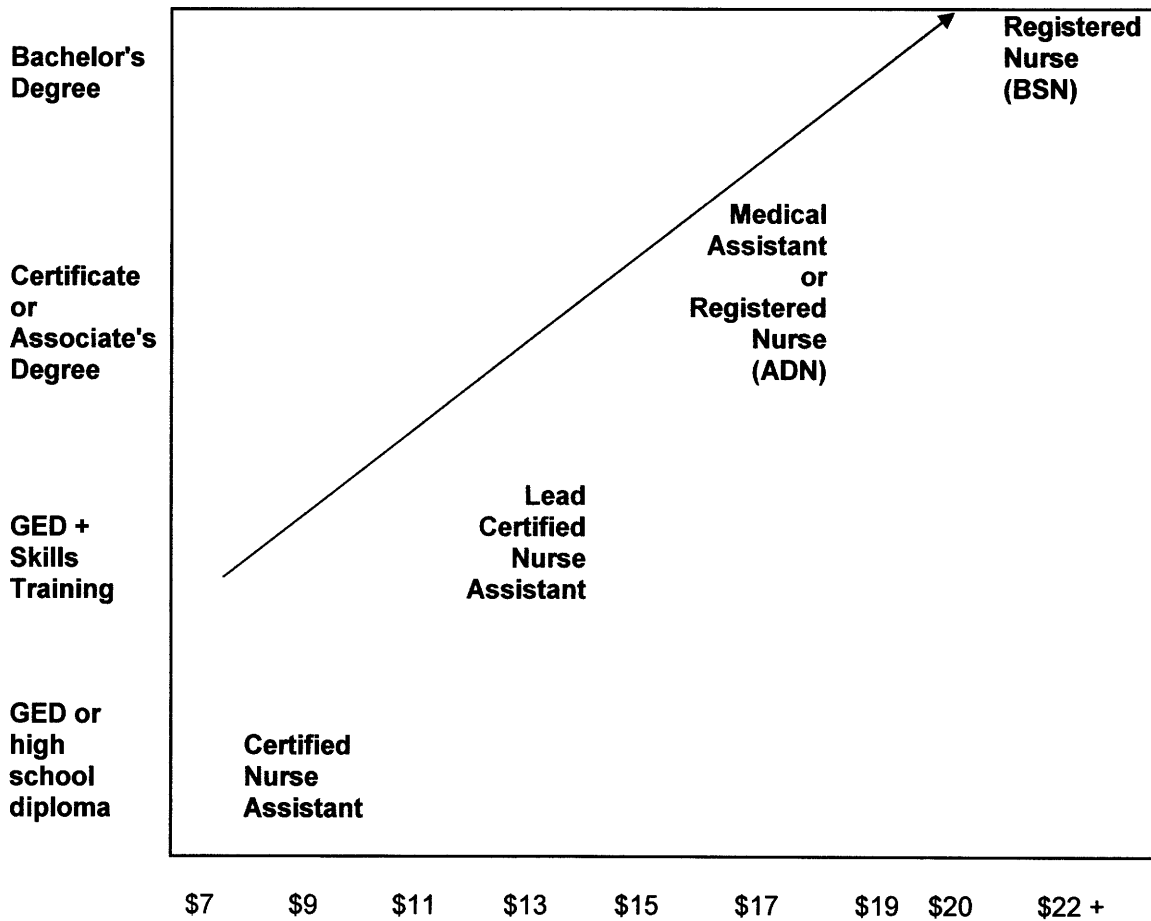
The primary goal of the Training Institute is to provide local Boston neighborhood residents and entry-level employees with skill training, education, and career support programs in the health care and research sector. The Training Institute is available to any resident with limited skills and work experience and/or a low education. In order for entry-level incumbent workers to participate in the program they must be an employee at one of the 11 health care employers who are members of the Training Institute.

Participants of the Training Institute are trained for jobs along three career pathways:

- 1) Administration—which begins with Medical Records Clerk and progresses to Unit Secretary or Patients Account Representative to Administrative Associate or Billing and Coding to finally a management position.
- 2) Patient Care—which begins with being a Certified Nurse Assistant (CNA) then progresses to Lead CNA on to Medical Assistant or Registered Nurse (associate degree in nursing) and finally on to a Registered Nurse with a bachelor's of science in nursing (BSN).
- 3) Technology—which begins with Central Sterile Supply as Lab/Animal Assistant then progresses to Assistant Radiology Technician which progresses to Surgical Technician or Radiologic Technologists to finally a Medical Technologist or Lab Technologist.

The goal of the Training Institute is to assist workers in their advancement along an education and training continuum. The hope is that as an employee gains more education and training they are able to advance along a career pathway into a new occupation that requires more responsibility and pays a higher salary.

Example of a Training Institute Career Pathways Model: Patient Care



The assumption in this model is that an employee beginning as a certified nurse assistant with only a GED or high school diploma will be able to participate in the Training Institute's skills courses and eventually progress to a lead certified nurse assistant. Over time, this same individual could enroll in one of the Training Institute's partner community colleges (i.e., Bunker Hill Community College) and take enough courses to earn a certificate or associate's degree in nursing. For those who are motivated and have the opportunity, it is assumed that they can continue their education and training and eventually earn a bachelor's degree as a registered nurse. The problem with a career pathways model such as this is that it is unrealistic. It takes entry-level employees years

to advance along a career pathway. Based on data I collected of 94 training institute pre-employment participants, only 10 received promotions over a two-year period (11%). On the incumbent side, my analysis of 240 incumbent workers revealed that only 23 individuals (10%) who completed Training Institute courses received a promotion to a higher level job over a four-year period. Most promotions were modest where an individual advanced from an administrative assistant I position to administrative assistant II position.

A major reason why so few incumbent workers are able to advance along a career pathway is because it simply becomes too difficult for workers to enroll in a community college degree or certificate program and earn a degree in a timely manner. For an individual working full- or part-time and who is enrolled in a community college degree or certificate program, it can take several years to progress along a career pathway. Even under the best circumstances, it will take an individual who is both working and enrolled in a one or two-year community college certificate or degree program at least twice as long to complete the program. With the consideration of time, it could realistically take an individual with limited education and skills who is working in an entry-level position several years to make any significant progress along a career pathway leading to higher wages.

How Training Institute Operates

The Training Institute has three major components: the Pre-Employment Training Program, the Incumbent Worker Training Program, and curriculum development.

Pre-Employment Program

The pre-employment component of the Training Institute tries to focus on a number of factors that will help participants successfully complete the program and find a job within the health care sector. The Training Institute Pre-Employment Training Program emphasizes a human capital development approach to workforce development that focuses on providing participants with education and skills training before they begin looking for a job. This is the opposite of many other training programs, such as PCWD's Pre-Employment Training Program which focuses on moving people quickly from job readiness training into employment (I will discuss this in Chapter 4). During the 12-week pre-employment training, the Institute tries to provide participants with an intensive training experience. The Institute provides a mix of on-the-job training opportunities as well as classroom instruction which focuses on hard and soft skills and basic education (math, reading, writing, English literacy). Finally, the Training Institute Pre-Employment Training Program attempts to introduce workers to a number of career pathways or raise awareness of the disparate health careers by working with each participant to develop a long-term career plan. I will discuss all of this in more detail.

The pre-employment component of the Training Institute is available to local residents with limited education, skills, and work experience. Generally, an employment specialist working for the Training Institute sends out mailings, post fliers, and makes announcements at community meetings and organizations in order to recruit individuals to the program. Once an individual has expressed interest in enrolling in the Training Institute, they are assessed as to whether they are a good fit to succeed in the Pre-Employment Training Program. As part of the assessment individuals are interviewed by

a Training Institute staff member (usually an employment specialist) who gathers information and evaluates their personal situation including family life, socioeconomic status, and work history. In addition, the interviews help Training Institute staff assess the individual's career goals, professional interests, mental health, and level of motivation. Level of motivation is especially important. According to 70% of the employers and social service support staff that I interviewed (12), motivation is a key factor in determining the success of an individual. As one career coach told me, "The most successful employees tend to be those who are motivated and ambitious. The employees I tend to get are happy and confident."

As part of the recruitment process, employment specialists also screen for an individuals' skills set, their employability (work history, motivation, personality, etc.), basic competencies, and conduct a Criminal Offender Record Information (CORI) check, which is required under Massachusetts state law.⁵ In addition, they are given a Test of Adult Basic Education (TABE) which allows the Training Institute to assess a perspective participants' writing ability, reading comprehension, and math skills. If an applicant scores above the sixth or seventh grade level on the TABE and performs well during their interview, the Training Institute will help the perspective participant apply for an available job among one of their 11 employer partners. More often than not, job seekers are encouraged to participate in the Training Institute's 12-week Pre-Employment Training Program. Increasingly, the Training Institute similar to PCWD, is moving towards upgrading the requirements for participants to enter into the Pre-Employment Training Program. The Institute each year is beginning to require participants to score

⁵ Anyone who is found to have been committed of a crime in the CORI search is ineligible to participate in the program.

higher on the TABE tests. In the beginning of the program, an individual could enter into the program with a 6th grade score on the TABE. Now the trend is towards taking individuals that score at the 8th grade level.

As I previously mentioned, the Training Institute's Pre-Employment Training Program was developed by JPNDC with a human capital development approach to workforce development. JPNDC's training attempts to provide participants with a comprehensive array of skills (hard and soft), competencies (computer and software), and basic education. For example, the first six weeks of the 12-week training program focuses on developing the students' hard skills (i.e., computer skills, math skills, science skills, etc.). Four weeks into the 12-week course, students begin an 8-week internship with an employer. This requires them to spend three days a week at their internship and the remaining two days a week in the classroom. Internships are a key component of the pre-employment training, but the number of internships available to Training Institute participants varies from training cycle to training cycle. In several instances, employers have been slow to provide internships to Training Institute participants because there are a number of other training programs that request internships as well, such as PCWD.

While the students are completing their training and internships, Training Institute staff begin the process of trying to match participants with jobs. This involves identifying a potential job, contacting the employers, helping participants set up interviews, and assisting them with their interviewing skills. These are all important factors in helping participants gain employment. The students that I conducted a focus group with explained that without this additional help, they would have had a hard time

finding a job. More than 50% (7) had applied to several jobs without any success before they enrolled in the Training Institute (they did not even get an interview).

Once students complete the 12-week skills training course and are hired by a Training Institute employer, they are tracked by an employment specialist for 90 days. The employment specialist helps them get acclimated to their new job and work conditions. However, many of the employment specialists are overloaded with heavy case loads. Some are managing 30-60 cases per month. This makes it difficult for them to realistically spend quality time with each participant and provide them with customized support. After this 90 day period expires, the incumbent worker's file is transferred from the employment specialist to a career coach who takes over the responsibility of assisting them with their career progression. The career coach monitors their progress including the documentation of any wage increases or promotions. The career coach also serves as the intermediary between the employee and their supervisor/manger. If a supervisor or manager is having a problem with an employee, they can either address it directly with the employee or opt to contact the career coach who will address the issue (I will expand on the importance of career coaches later on in this chapter). Finally, four to six months into their job, the Training Institute makes sure that employees are paired up permanently with one of their career coaches. The Institute also lets the incumbent workers know by way of a letter that they are now eligible for the Training Institute's incumbent training programs. Even though career coaches are available to help them develop a career plan, the most motivated employees take advantage of the service because career coaches, like employment specialists, have limited time to assist all participants with their career plans.

Incumbent Worker Program

The Incumbent Worker program is geared towards entry-level employees working at one of the consortium's hospitals or community health centers. The Incumbent Worker component of the Training Institute attempts to help workers advance along a career pathway in patient care, administration, or technology. The Training Institute has a two-pronged approach to identifying incumbent workers for their training services. First, the Institute works closely with supervisors and managers from each participating hospital, research laboratory, or community health center to identify employees who would make good candidates for additional skills training. This usually works well, but there are occasions when supervisors and managers are ambivalent about recommending valued and capable workers to participate in the Training Institute's Incumbent Worker Program. In many entry-level occupations it is difficult to find staff to fill vacant positions. So once a good, dependable worker is hired, unit supervisors and managers prefer not to lose that employee to another department or to give them work release time to take courses. The issue is one that Training Institute staff and hospital administrators are trying to address. One attempt is to make sure that positions are backfilled. Once an employee gains enough training and progresses to another position in a different department, the Training Institute tries to identify other employees to fill that position. Overall, the Training Institute is trying to create a pipeline for workers within the hospitals and research laboratories. Unfortunately, as I discussed earlier, helping employees advance along a career ladder has proved to be very difficult and results have

been slow to materialize. Over a two-year period, only 10 individuals from the pre-employment training program received promotions.

Advertising is the second strategy through which the Training Institute attempts to identify incumbent workers to participate in the program. The Training Institute posts fliers around the hospitals and makes announcements in various medical departments about the training courses. If a worker expresses interest, they contact their supervisor and manager, and under the agreement with the hospitals and JPNDC/FCDC, employees are allowed release time to attend Institute courses. The Institute makes every effort to offer courses that are flexible for workers' schedules but, in some cases, workers need to be released from duty in order to attend class.

The courses offered to incumbent workers by the Training Institute include, but are not limited to, the following:

- Administration Skills;
- Business Writing;
- Computers I: Introduction to Windows;
- Computers II: Email and Internet;
- Computers III: Introduction to Microsoft Word;
- English (English 090 and English 102-Freshman English II);
- GED ;
- Effective Communication Skills;
- ESOL I—Beginner and ESOL II—Intermediate;
- General Science;
- Patient Care;

- Psychology 101;
- Math 090;
- Nursing Prerequisites (Anatomy & Physiology);
- Pre-Technologist Training;
- Pathology Lab Assistant;
- Science (General); and
- Supervisory Skills;

Training Institute courses range anywhere from two weeks to five months depending on the number of hours per each class session. Computer courses are generally the shortest, lasting only two weeks, while the Patient Care and GED courses can last several months. The Training Institute hires outside training vendors to lead course instruction (i.e., Jewish Vocational Service or one of the community college instructors). All courses are taught by an experienced and/or licensed educational professional. In order to make the program's courses accessible to as many workers as possible, most courses are offered within the LMA. For those courses that are not taught within the LMA, they are taught at Bunker Hill, Massachusetts Bay, or Roxbury Community Colleges or at the Wentworth Institute of Technology (which only provides space). In general, individuals do not have a problem accessing these institutions because most are easily accessible via the Massachusetts Bay Transportation Authority's public transportation system. The typical enrollment in Training Institute courses range anywhere from 12-15 individuals in the Pre-Technologist Training course to roughly 30 people enrolled in Pre-College courses. During the Fall and Spring 2005 Training Institute course schedule, the average class size

was 13 individuals. Over time, employers have continued to demand higher skilled employees with a breadth of knowledge in a number of subject areas (i.e. computers, writing, communication skills, etc.). This has led the Training Institute to offer more courses (much more than PCWD) to meet the demands of employers. I will discuss this further in the next section.

Curriculum Development

One of the major challenges for any workforce development training program is making certain that the courses and skills training they provide to pre-employment and incumbent workers meets the needs of the employers. In addition, workforce development institutions have to make certain that the courses and skills training they provide are able to keep pace with structural changes within the labor market. In the health care profession, technological innovation is changing the nature of work, increasing the level of skills and computer literacy required for practically all health care occupations which range from medical administrative office assistant to physicians. Brigham and Women's Hospital, a hospital with over 12,000 employees and numerous specialty clinics, is constantly at the cutting-edge of innovation. During an arranged private tour led by a Brigham and Women's human resource staff member, several department supervisors and managers explained how technology was changing the workplace. During a part of the tour, we stopped by the Center for Women and Newborns (CWN), where the unit supervisor described the new Electronic Medication Administration System (eMAR) that the hospital is implementing. The eMAR system is a mobile computer database application that can more efficiently identify the patient and

their medical staff, monitor the dispensation of prescription drugs against the patient's profile, and maintain other sensitive patient information. The eMAR system relies on Bluetooth-enabled wireless bar-coded readers that link up to personal computers sitting on mobile carts which are used by most health workers who provide direct patient care. This system is also used by health care workers who are responsible for managing patients' medical records and patient hospital admissions. This new computer database system requires the majority of health care workers employed by Brigham and Women's Hospital to be proficient in computers and have a higher level of computer literacy than in past years. As one independent training instructor who works closely with the Training Institute and PCWD programs stated:

“Several years ago hospital HR staff and department supervisors used to tell me they just wanted an employee who could show up on time and have a positive attitude. It didn't even matter if they had a high school diploma! Now everything has changed because of technology. In order to be a part of the Training Institute or PCWD, you have to have a high school diploma or GED and you must be proficient in computers. This has also made my job as an instructor harder. I always have to update my courses constantly to stay up with the [technological] changes.”

The training instructor statement, illustrates one of the significant challenges facing the Training Institute. In order to continue providing employers with employment and training services, the Training Institute has to continually re-invent itself to keep up with the technological changes in the health care industry. One way the Training Institute has attempted to meet this challenge is through the creation of the Curriculum Development Committee, which meets every two weeks to discuss, develop, and implement the Institute's core curriculum. The Curriculum Development Committee

consists of employment specialists, employers, and education and training providers. The multi-sector membership of the Curriculum Development Committee is crucial in assisting the Training Institute with the design of courses that are relevant to the health care industry's needs. The Committee has allowed employers to provide feedback on what courses they would like to see offered for pre-employment and incumbent workers. Employers consistently pressure the Training Institute to offer higher level and advanced courses in areas such as science and math. There is always a constant pressure put on the Training Institute by employers to provide higher quality classes that will better prepare workers for wide-variety of occupations within the health care sector. This issue has led the Committee to develop a core curriculum that workers can take sequentially from the beginner to advanced levels. The hope is that this will allow the least skilled participants an opportunity to raise their skill levels gradually and that the more skilled participants will be able to enroll in higher level courses. One example of this is that with computer skills training. In an attempt to respond to the growing demand among health care employers for increasingly more computer literate employees, the Training Institute developed a core set of computer courses—Computer Skills I, II and III. These computer courses begin with an introduction to computers and Microsoft Windows (Computer Skills I), then progresses to learning how to use e-mail and the Internet (Computer Skills II), and finally finishes by teaching participants how to use Microsoft applications such as Excel and Word (Computer Skills III). In order to stay relevant and be a resource for employers, the Training Institute has increased the number and breadth of courses that it provides. The Institute now offers 30 courses in various subject and skill areas.

Training Institute's Organizational Structure

As I previously mentioned, the Training Institute has evolved considerably over the last four years. It has expanded from a modest workforce development intermediary serving a few employers and neighborhoods in Boston to a rather large intermediary with many partners and programmatic areas. As a result, the Training Institute has developed seven operating components or divisions in an attempt to operate more efficiently and effectively. They include the following (also refer back to Figure 2):

- Project Management
- Steering Committee
- Employers
- Training and Education Organizations
- Career Coaching
- Community Network Component: Fenway/Mission Hill Network and the Jamaica Plain Network

The Training Institute's ability to grow rapidly within such a short period of time has had both positive and negative consequences for the workforce intermediary. From a positive perspective, the growth of the Training Institute has allowed the intermediary to increase its economies of scale and train a larger segment of metropolitan Boston's population. Annually, a total of about 325 individuals enroll in Training Institute pre-employment and incumbent courses. This is up from the beginning of the Institute when only about 200 individuals enrolled in courses each year. The precipitous growth of the Training Institute has helped it secure a foothold in the hospitals and research laboratories, developing a niche for itself. Although several structural and political factors contributed

to the conditions that made an intermediary like the Training Institute possible, it has been the repertoire of creativity, advocacy, and political acumen of its founders that has helped the intermediary remain sustainable thus far and impact the way health care employers develop career pathways. For example the staff of the Training Institute has discovered that employees tend to get promoted and do well on the job when they have supportive managers and supervisors. They then developed 4-step strategy to identify, recruit, and retain supportive hospital managers and supervisors. This included meeting with HR to encourage more supervisors and managers to get involved with the Training Institute, they also made an attempt to understand the issues and concerns that supervisors/managers have and figured out ways to address them, and Training Institute staff created marketing materials with testimonials from supervisors that had a positive experience with the Institute. Finally, Training Institute staff set up meetings with hospital CEO's and COO's encouraging them to send out letters with marketing materials to encourage managers and supervisors to participate in the Training Institute.

The rapid growth of the Training Institute has also led to several negative consequences. First, there is some question as to whether or not the community organizations in charge of managing the Training Institute—JPNDC and FCDC, have gone beyond their mission of serving residents of Jamaica Plain and Fenway neighborhoods. Second, the growth of the Training Institute has put tremendous amounts of pressure and strain on JPNDC's staff and its partner organizations, which has led to burnout and high employee turnover. Finally, some argue that the rapid growth of the Training Institute has led to the sacrifice of the quality of its skills training curriculum. Reducing the Training Institute's ability to prepare pre-employment workers for jobs

within the health care sector and provide incumbent workers with the necessary skills to progress along a career pathway. I will explore each of these issues in further detail in the following sections.

Project Management

The Training Institute is managed by JPNDC in partnership with FCDC and the Mission Hill Network (The Project Management Team). The Project Management Team's primary task is to make sure that the Training Institute's partners are in constant communication with each other on all aspects of the training programs. This Team plays an important role as the broker among all partners in the Training Institute. The real driver of the Training Institute is the director. The director has been around since the beginning of the Training Institute and has over a decade of experience in building workforce development programs. She was one of the lead designers and implementers of JPNDC's earlier training programs—Steps to the Future and Bridges to the Future. The director's early involvement with these programs allowed her to build strong relationships with health care employers, community organizations, educational institutions, city agencies, and local politicians.

Many are concerned that the director's charismatic personality and dedication to the Institute is a big reason why the intermediary has been so successful at keeping all partners at the table. They point to the fact that the director has been able to bring in grant money from national and local foundations and most recently, been successful in negotiations with employers to get them to invest annually in the Training Institute. The director has been working with the Aspen Institute to develop a return on investment

formula that shows each employer how much the Training Institute has saved them in operating costs based on improved employee retention rates, increased productivity, training and educational costs, etc. If the director steps down, many think this will hurt the future development and sustainability of the Institute. The director has been with the Institute since its inception and has been able to gain the trust and respect of employers which has allowed her to be successful during negotiations.

Many members of the Training Institute also credit the director for being an advocate on behalf of entry-level employees and by working with employers to develop a career pathway. For instance, the director led discussions with employers to develop a Career Exploration Support Group for employees. The Support Group would provide an opportunity for employees to develop an understanding of what a career path is, what type of investment is required to develop a career, and give basic information on careers available within the health care field.⁶ In the past, the director has also negotiated with employers to allow managers and supervisors to participate in the Training Institute's courses and has encouraged employers to allocate more time for managers and supervisors to serve as mentors for entry-level employees.

Despite the director's ability to play a significant role in driving the agenda and get outcomes for the Training Institute, some hospital HR staff and employees argue that they fear that the Institute may be growing too fast and is moving beyond its mission and core work. This feeling was captured well by an HR staff member, which stated, "One problem people have with the Training Institute is that it is expanding too rapidly and losing lots of quality along the way. Employers feel the program is offering too many

⁶ Information based on the Boston Health Care and Research Training Institute's Career Exploration Support Group Curriculum Outline. 9/23/2005.

classes and programs and it is hurting the quality of the product. Not too mention, Training Institute staff feel overly strained as well.” This is a real challenge for the Institute. The program has expanded rapidly over the years and is struggling to strike a balance between the core focus of the Institute and how large can the intermediary be and still be effective at meeting the needs of employers and workers.

Steering Committee

JPNDC, FCDC (in partnership with the Mission Hill Network) are responsible for the day-to-day operations of the Institute, however the Training Institute’s Steering Committee is responsible for making decisions that affect the long-term direction of the intermediary. The Steering Committee is responsible for deciding Training Institute expansion, financial planning, strategies for retention and advancement, just to name a few. The Steering Committee consists of 28 members representing every organization involved with the Institute. The Committee is chaired by the director of the Training Institute and meets on a quarterly basis. These meetings are critical in establishing relationships among the disparate program participants, charting out the future of the Training Institute, and in addressing the intermediary’s concerns and challenges. These meetings are also an opportunity to share and monitor the latest data on employee outcomes. In many ways, the Steering Committee is the ‘checks and balances’ of the Training Institute. The Committee ensures that all partners are held accountable. This is very different from other types of partnerships where each participating organization is usually only responsible to its board of directors or outside financial contributors, and otherwise, has few ways of holding its partners accountable.

Each Steering Committee representative is expected to be present and participate fully in the quarterly meetings. An agenda for each meeting is sent out in advance by a staff person at JPNDC. The agenda items usually include an update, which often includes course enrollment numbers, graduation rates, curriculum development, etc. In addition, the quarterly meetings are designed to be interactive and often include time for small group breakout sessions that require partners to openly discuss challenges, successes, and solutions. For example, in one particular meeting that I attended, Steering Committee members were asked to discuss ways in which the Training Institute could improve the rate in which employees were promoted. This issue was raised in the Steering Committee meeting when Institute staff discovered that some hospital and research laboratory supervisors and managers, with high worker shortages were reluctant to promote employees or recommend them for additional training for fear of losing them to another department.

Overall, Steering Committee meetings allow each partner to express their thoughts, concerns, and ideas. The meetings can at times become tense over particular issues such as urging employers to do more to provide internships to Training Institute pre-employment participants or having hospital managers and supervisors spend more time on Institute related issues or programs. These meetings also are important because they help to build trust among employers, community organizations, educational institutions, training providers, social service agencies, and city government. Each organization has its own culture, internal language, and way of doing things. Without constant face-to-face interactions, these differences would be more difficult to overcome. Instead, over time, the Steering Committee meetings have helped all partners of the

Training Institute to try and find common ground around mutual interests. Many employers expressed that, in the initial stages of the partnership, they felt that the Training Institute was too process-oriented and that it took too long to get anything done. However, most employers feel that JPNDC and other community groups have made an effort to be more responsive and efficient in meeting their needs and concerns.

The Steering Committee meetings also provide a forum and opportunities for political maneuvering. Based on my observations at numerous Steering Committee meetings, each partner comes to these meetings with their own agenda. For instance JPNDC tries to encourage employers to improve the quality and quantity of health care jobs for Training Institute participants, makes their case as to why employers should continue provide financial support to the Institute, and develops new ways to enhance wrap-around social services for economically disadvantaged residents, etc. The employers also have their own agendas—improving the quality and content of courses offered, increasing the education and skills of the health care workforce, and reducing the time and costs associated with the Training Institute, to name a few.

Employers

Employers play a significant role in the Training Institute. In the beginning of the Institute's development, employers were encouraged by Mayor Menino and other elected officials to be a part of this workforce intermediary. In addition, multiple funding streams from the federal, state, and local governments as well as support from foundations made it less risky for employers to participate. They were not required to make any substantial initial financial investments towards the development of the

Training Institute. Given these circumstances, employers had less of a stake in the Training Institute when compared to JPNDC, FCDC, and the Mission Hill Network.

As a result, JPNDC and the other community organizations worked hard to develop a job-centered economic development strategy for the health care industry. JPNDC and their community partners worked with employers to identify potential career pathways for entry-level employees, stressed job retention, and job quality, and generally advocated for individuals that who completed skills training through the Institute. They essentially engaged employers every step of the way in the development of the Institute. These efforts paid off and the Training Institute became the primary health care workforce intermediary in Boston and soon began to develop a name for itself. The Training Institute convinced employers to agree to provide incumbent workers with release time to attend courses. They also had employers to agree to send hospital supervisors to training courses to teach them how to be more effective managers. Along the way, JPNDC and their neighborhood partners have played a significant role in getting employers to take chances on employees they may have otherwise never hired.

However, the relationship between health care employers and JPNDC/FCDC along with their community partners has changed dramatically from when the Institute first began. As the initial grants and other sources of funding that went to support the Institute ran out, JPNDC turned to employers for financial support. Over the last two years the level of funding from employers has increased significantly. In 2005, over \$400,000 was contributed by employers to support the Institute's pre-employment and incumbent worker educational and training efforts. Now that employers are contributing more money to support the operations of the Institute they now see the relationship

between JPNDC and their community partners as a business relationship. A Children's hospital administrator closely involved with the Training Institute since its inception stated, "We have to make a decision on a continual basis if we are having our needs met." Employers have expectations as to what they want in terms of services provided. Another hospital administrator at Beth Israel Deaconess Medical Center stated that they now view their relationship with the Training Institute as a vendor-employer relationship rather than a partnership. "Beth Israel Deaconess Medical Center is the client and the Training Institute is providing a service. They offer a menu of services and we want to pick what we want."

The new employer-vendor relationship and the fact that many employers are now paying the Institute for the training services they receive has many employers wondering what services they can offer internally and what services they should contract out to a private education or training vendor. A human resources staff member at Brigham and Women's Hospital (BWH) explained that the hospital sometimes provides contracts to outside vendors in addition to the Institute to provide contextualized training. She said, "We need to work smarter and more efficiently. When deciding who to go with we ask, 'Who can provide this [training] service? Colleges? Outside Vendors? Us?' Then we make a decision on who to contract with for training services." It is clear that the Training Institute no longer has the leverage when negotiating with employers that they once had when they were providing educational and training services to employers nearly free of charge. They now have to be more responsive to employers' needs, which limits JPNDC and their partners' ability to influence structural change on the demand-side (i.e., improving quality of jobs, changing the work environment, providing additional support

to workers, etc.). Of course JPNDC and their community partners still have the support of Mayor Menino and other political leaders which is critical but, in a free market economy, this support can only go so far in getting employers to comply with JPNDC's demands and the needs of Boston's most disadvantaged adults.

Training and Educational Organizations

The training and education organizations participating in the Institute are another key element of the intermediary. Training vendors such as Jewish Vocational Service (JVS) and institutions of higher education such as the local community colleges (Bunker Hill, Massachusetts Bay, and Roxbury Community Colleges) are hired on a contractual basis to provide customized courses for the Institute. Training and education providers work closely with the Institute Project Management Team to develop courses that are relevant to industry needs and enhance the skills of participants. Due to the changes in the health care sector, which is partly being driven by technological innovation, training, and education, training providers have to be in close contact with human resource personnel, hospital supervisors and managers, and workforce development specialists.

The community college partners sometimes feel ambivalent about the Training Institute. Community Colleges view themselves in competition with workforce development intermediaries such as the Training Institute and PCWD. Many community colleges argue they are in a better position to serve under-skilled individuals than other types of training providers. For example in the greater Boston metropolitan area, a number of community colleges provide health care-related certificates and associate degrees. Their courses are accredited through a national accrediting association and their

degrees and certificates are portable—meaning the credits earned can be transferred to another community college within Massachusetts or in another state. Moreover, when a community college graduate applies for a job, employers have some way of measuring the quality, rigor, and overall curriculum of a particular certificate or degree program.

This is not always the case with the Training Institute. Many of the courses that participants take do not allow participants to earn college credit that builds towards an associate degree or certificate. Also, it is difficult for health care employers, who are located outside the LMA or are not affiliated with the Training Institute to determine the quality of these courses. These employers have no way of comparing the quality of courses an individual completed. Furthermore there is no objective, agreed upon standardized rating system that can help employers determine the level of training an perspective employee received. This is an important issue because community college administrators and instructors point to the fact that millions of public dollars are being diverted to workforce development intermediaries, money that community college officials say could help them hire more faculty and improve the quality of health care-related courses (this is an issue I will go further into in Chapter 5). The faculty shortage within the health care industry is one of the reasons why there is a shortage of health care professionals, especially in nursing.

The lack of qualified faculty to teach courses creates a backlog of students waiting to enroll into health care certificate and degree programs with high occupational shortages such as health information technology and registered nursing. Community college administrators also contend that increased funding can also help them to develop a comprehensive health care career educational pathway that begins at the certificate

level for lower-skilled individuals and ends with an associate degree in registered nursing or an equivalent health care profession. Unfortunately, the lack of funding at the federal, state, and local levels has made it virtually impossible for most community colleges in Massachusetts and around the country to offer a comprehensive health care education curriculum, with the exception of Northern Virginia's community college system, which has a community college entirely dedicated to medical education.

The Northern Virginia Community College Medical Campus offers associate degree programs in a number of occupations such as dental hygienists, emergency medical services technician, health information technologist, medical laboratory technologist, nursing, physical therapist assistant, radiography-diagnostic imaging, and respiratory therapist. They also offer educational certificates in fields such as computerized tomography, surgical technology, mammography, and magnetic resonance imaging just to name a few.

JPNDC and their community partners have been trying to resolve some of the tension that exists between community colleges and the Training Institute by developing an education and training system that is complimentary rather than competitive. The Training Institute is providing education and training courses to a significant segment of the population who are not ready for community college coursework. An overwhelming majority of constituents are economically disadvantaged immigrants, single mothers, TANF recipients, the elderly, and disabled. Many of these individuals are unable to enroll in courses at the local community college because they can not afford to do so and/or because they need to work full-time and take care of their children. As a result, the Training Institute is more able to meet their immediate educational and training needs

compared to community colleges. JPNDC's staff contend that the Institute courses are free, flexible, and are offered in short modules (mostly ranging in length from 5 to 10 weeks), which helps entry-level workers take a menu of courses. For those individuals who are not desperate to find employment immediately, they can enroll in the Training Institute's 12-week Pre-Employment Training Program.

In the Training Institute model, the community colleges' role is to target those individuals who have a higher level of skills—math, reading, writing, science, etc. and get them to enroll in college. JPNDC, FCDC, and the Mission Hill Network are responsible for raising the skills of individuals who need significant developmental education (English language skills, basic math, reading and writing, etc.) so that they can obtain employment. Aside from providing some courses on a contractual basis for the Institute, community colleges are not directly involved in helping these individuals enroll in college to further their education, until after they have gained some work experience and raised their skills level. This is an important distinction between the Training Institute and PCWD. In PCWD, post-secondary education is a key piece of the intermediary and is promoted throughout. The overarching goal of PCWD is to develop an environment within the workplace that stresses a continuum of education and training and provides a supportive environment that allows workers to advance along a career ladder or lattice. The staff of PCWD has been in negotiations with community colleges to provide courses that are aimed specifically at Partners' entry- to mid-level incumbent workforce. I will discuss this in more detail in the next chapter.

Career Coaching

The career coaches work closely with every partner involved with the Training Institute—employers, education/training providers, community organizations, employees, and the Project Management Team to make sure incumbent workers are aware of the courses and resources available to them. Career coaches also help incumbent workers better communicate with employers and understand workplace culture and expectations as well as connect them to any social services (child care, transportation, etc.) they may need. Career coaches are also advocates for their clients and are often the difference that determines if an individual is hired or fired. Many health care employers are reluctant to hire the type of population who participates in the Training Institute. They sometimes view these individuals as a “work in progress” or feel like they may need special attention or services, which many employers would prefer not to have to address. It is the career coaches that step in to reassure employers that they are around in case problems arise. This sentiment was best echoed from a career coach at FCDC. She stated that her job is to “do a lot of listening to human resource staff. I need to listen to their complaints and concerns. I need to make them feel like I will be there if there is a problem....I try to send employers the best workers. Trust is important. Reputation and trust is very important. You have to view this as a business.” In one situation a career coach had an employee who was showing up to work with hygiene problems and he would often fall asleep on the job. After a week of this behavior, the employee’s supervisor contacted his career coach. The career coach quickly intervened and discovered that this particular employee was working two jobs. He would work the night shift at a distribution warehouse and in the morning he would go to his job at the hospital. His day and night

shifts left him with little time to sleep, shower, and put on a fresh set of clean clothes. After hearing all of this, the career coach contacted the employee's supervisor at the distribution warehouse and worked out a deal that allowed the employee to leave work earlier in order for him to have enough time to shower and change clothes before starting his shift at the hospital. This example is illustrative of the challenges that career coaches must deal with on a daily basis. The career coach in this specific situation was able to take a sensitive and uncomfortable issue that the employee's hospital supervisor was reluctant to address and make it work for all parties involved. Without the assistance of the career coach, this employee would likely have been terminated.

Career coaches not only work hard to build positive relationships with employers, they also have to work hard to encourage, motivate, and solve workers' problems. 75% of the career coaches who I interviewed (3 out of 4) described the challenge of setting realistic expectations for their clients. A JPNDC career coach told me that "not every resident [Boston participant in the Training Institute] can perform up to the standard that they want to. It's important to challenge them, but also to be realistic." In some cases language is a barrier that holds some residents back from advancing to a higher paying occupation, especially for immigrants. In many instances they already have obtained a formal education in their home country and do not want to start out in entry-level positions within the hospital, such as environmental services where they mop floors and take out hazardous waste everyday. It is the career coaches that explain to them that obtaining better English language and communication skills can help them have more opportunities later to advance into occupations better suited for their particular set of skills and education.

Community Networks

The community networks of Jamaica Plain, Fenway/Mission Hill, and their partners are the foundation of the Training Institute. It is the community network of organizations—community development corporations, social service agencies, and community outreach programs that help recruit, retain, and support the economic advancement of local residents. Many residents need assistance with child care, family counseling, work readiness skills (resume writing, interviewing skills, etc.), financial assistance, and subsidized housing. It is the community network of agencies and organizations that are the primary resources that assist and support residents' needs. Without this community network, many training participants would not be able to complete the 12-week Pre-Employment Training Program and successfully find a job.

Each community organization and social service agency continues to be involved as a partner in the Training Institute because they share a common cause. These organizations are interested in helping economically disadvantaged residents transition off public assistance, increase their economic opportunities, obtain more education, and become self-sufficient. They have come to understand that the Training Institute is the entity that can help each organization leverage resources, especially during a time where fewer federal dollars are set aside to fund workforce development and social service programs. As an intermediary that has a disparate group of partners, the Training Institute has been successful in obtaining large, multi-year grants from foundations, government agencies, and the private sector. Although JPNDC is the fiscal agent of the Training Institute, a portion of the grant dollars are distributed among the all partners of

the Institute which supports the day-to-day operations of the intermediary. This enables each organization to use that money to support Training Institute activities such as career coaching, case management, counseling, etc.

It appears that building community networks and networking in general are important factors in helping intermediaries become effective and sustainable. In the case of the Institute, JPNDC has been able to leverage the networks they have built with other community organizations to increase its base of support (social and political). This base of support includes JPNDC's community partners and all of their constituents (i.e. neighborhood residents) as well as local community leaders and elected officials. This network plays a critical role in helping the Institute have leverage when negotiating with employers. Employers understand that as a community development corporation that is well-connected, JPNDC can contact the Mayor's office and the office of other elected officials (i.e. city council members and state representatives) that will place pressure on them to hire more neighborhood residents.

Networking across organizations and building up a social and political base of support is important for all intermediaries. JPDC has a clear advantage over PCWD in this area because the organization is rooted in community organization, activism, and advocacy. PCWD does not have the same history and lacks the organizational capacity (i.e. staff) and network (ties to other community organizations) in order to place demands on employers to hire neighborhood residents the same way that the Training Institute has been able to do over the years.

Training Institute Participant Outcomes

To this point, my primary discussion and analysis has been on the operation and function of the Training Institute. In this section, I will shift my attention to the Training Institute participants—both the pre-employment and incumbent workers. I will assess the Institute’s performance in helping workers increase their education and skills level, obtain a job within the health care sector, and calculate the average cost per participant. I will also explain, based on employment data, how far an individual can advance along a career ladder or lattice once they have participated in Training Institute’s courses.

Pre-employment Job Seekers

In conducting a demographic analysis of those individuals who enrolled in the Training Institute’s Pre-Employment or Incumbent Training Programs, ESOL classes, or utilized pre-employment services (i.e. resume writing, interviewing skills, job readiness preparation, etc.), it is clear that there is a distinct difference between the pre-employment job seekers and incumbent workers. Let me first begin with a descriptive analysis of the pre-employment job seekers. Based on training program enrollment data, the Training Institute’s overall pre-employment population is among, what many would consider to be the “hardest to employ.” A profile of the average Pre-employment Training Program participant would be a 33-year old, unemployed, single woman who has two children. They are likely to be an underrepresented minority (black or Latino), receive financial assistance from the federal and/or state government, have a high school education or less, and have an annual household income in the range of \$10,000 - \$24,999 a year. It

appears that the Training Institute is indeed serving, what many would call the truly disadvantaged. Let us take a closer look at the demographic profile of program enrollees.

As of February 2005, JPNDC had collected data on 125 Pre-Employment Training Program enrollees dating back to January 1, 2004. As expected, almost all of the program participants have been Boston residents (96%) and primarily women (82%). The average age at the time of enrollment was 33.7 years and 86% of all enrollees were ethnic minorities. Blacks and Latinos each represented 40% of the enrollees (80% total between the two ethnic groups); while whites represented only 5% of the total participant population. Fifty-four percent of the enrollees spoke a first language other than English. The most popular languages among the non-English speakers were Spanish (72%), Chinese (8%), Russian (4%), and French/Creole (3%).

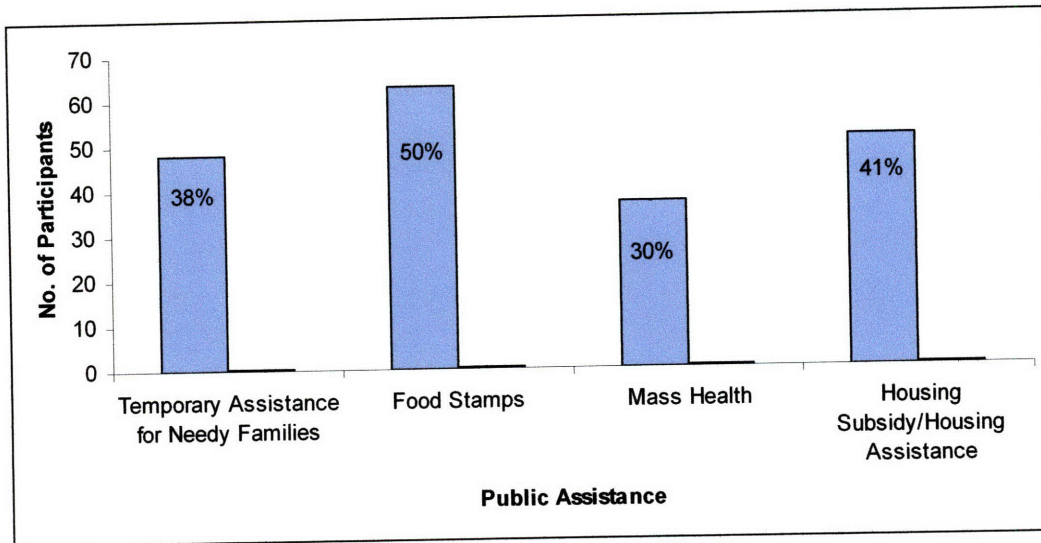
An analysis of the participants' socio-economic status reveals that the majority of participants had an annual median household income well below the City of Boston's average of \$39,629.⁷ Not surprisingly, 55% of Training Institute pre-employment enrollees earned less than \$25,000 a year and 38% received welfare through the Temporary Assistance for Needy Families (TANF) program. Moreover, 41% also reported receiving housing subsidies or housing assistance and half all participants reported receiving food stamps (see TABLE #6). Among the participants who were employed (22 individuals) at the time they enrolled in the Institute's Pre-Employment Training Program had an average hourly wage of \$9.90.

The educational attainment for the group was fairly low. Only 2% of the enrollees had earned a 4-year undergraduate degree, while 49% had a high school education or less (see TABLE #7). Sixty-one percent of participants were single and

⁷ Boston's annual median household income of \$39,629 is based on the 2000 U.S. Census.

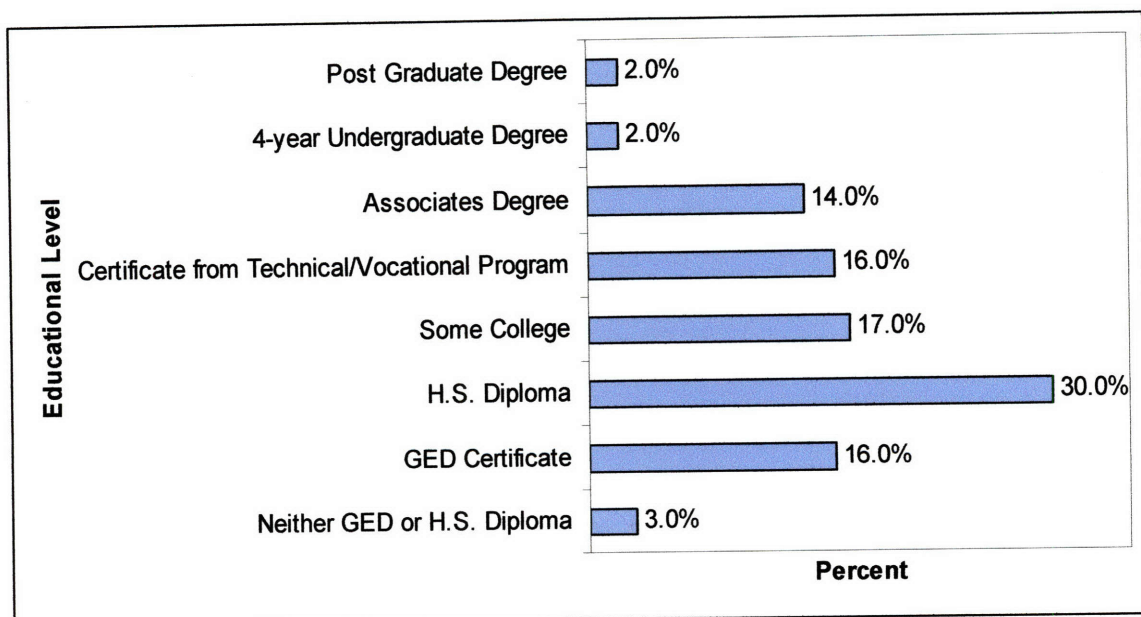
six out of ten participants reported being the sole or primary wage earner for their household, 47% and 23% respectively. Finally, the average number of children under 18 years of age living at home was 1.96 and the average household size of was 2.56.

TABLE #6: Percent of Enrollees Receiving Public Assistance*



*Several participants reported receiving more than one of these public assistance benefits.

TABLE #7: Highest Educational and Certification at Enrollment



Given the demographic background of Training Institute pre-employment participants, how well has the Training Institute been able to help economically disadvantaged, under-skilled Boston residents obtain jobs within the health care sector? Using training and outcome data provided by JPNDC on their Pre-Employment Program participants and others they provided employment services to from January 1, 2004 to December 31, 2005, I was able to conduct my analysis. Over the two year time period, the Training Institute provided training and employment assistance to 164 individuals—94 completed the 12-week Pre-Employment Training program, 45 were walk-ins who used the Institute’s employment and training services, and 25 individuals completed ESOL courses (see Table #8 Percent of the Training Institute’s Pre-Employment Participants Obtaining Employment in the Health Care Sector). Overall, the Training

TABLE #8: Percent of the Training Institute’s Pre-Employment Participants Obtaining Employment within the Health Care Sector

	Number of Participants	Obtained Employment with T.I. Health Care Employer	Obtained Employment Elsewhere	Total Percent Employed
12-week Pre-Employment Training Program	94	37 (39%)	17 (18%)	33.0%
Walk-ins who Utilized Pre-Employment Services	45	18 (40%)	8 (8.5%)	58.0%
Individuals Completing ESOL Courses	25	2 (8%)	6 (6%)	32.0%
Total	164	57 (35%)	31 (19%)	54.0%

Institute has placed 54% of its pre-employment participants in jobs. However, the Institute has not been as successful in placing pre-employment participants in health care

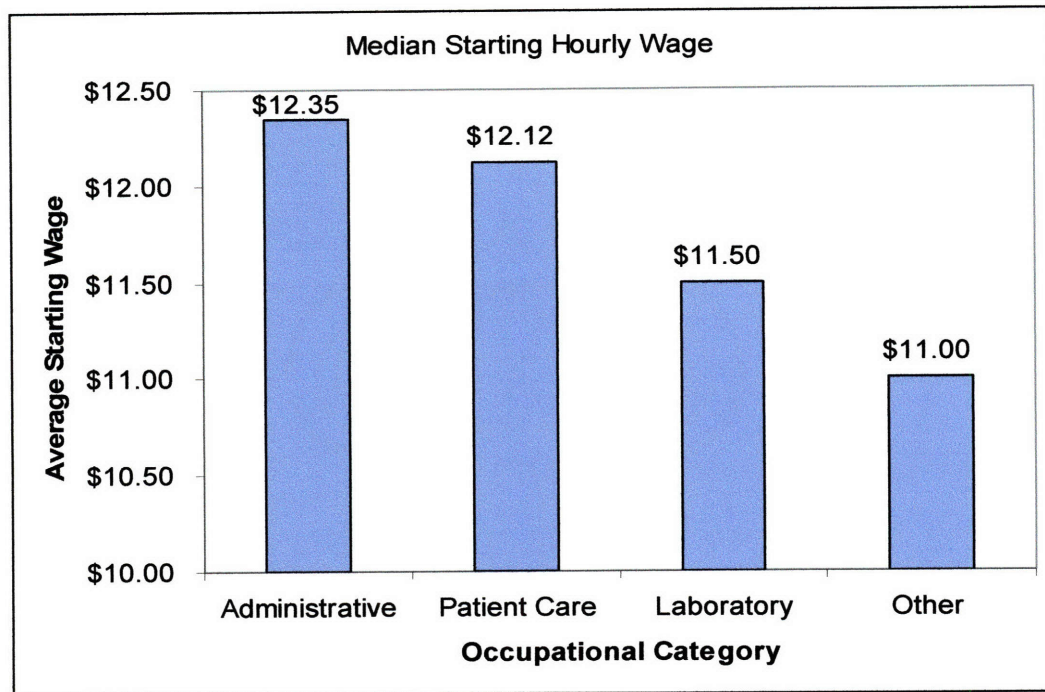
jobs, which is the primary mission of the intermediary. In total the Training Institute placed 57 of its pre-employment participants in health care jobs (~35%). For those individuals who completed the Institute's 12-week Pre-Employment Training Program, only 37 individuals out of 94 ended up with jobs in the health care sector (39%).

How did Training Institute participants who obtained jobs within the health care sector fair? In order to answer this question I first analyzed employment data for all 57 individuals who obtained a job with an Institute-affiliated health care employer. Among those who were hired, the overall retention rate after two years was 89%. For the 11% of workers that were terminated, all lost their jobs within the first six months of employment and one was terminated after just one week on the job. The average starting wage for the group was \$12.28 (median starting hourly wage was \$12.00), which was significantly higher than the pre-employment average hourly wage of \$9.90.

The same number of Training Institute pre-employment participants were hired in administrative positions (administrative assistants, medical records, etc.) as they were in laboratory technology-related positions (animal laboratory technologists, radiology technology assistants, etc.) (17 in each for a total of 60%). Patient care occupations was the second most popular occupation at 26% (medical assistants, certified nursing assistants, etc.), while all other health-care related occupations (primarily nutritional services/food service occupations) comprised just 14% (8 individuals) of all hires. When I disaggregated the data, there was a difference in the average starting hourly wage between occupations. The highest average starting wage for those who were hired in administrative positions was \$13.32 (median \$12.35). Patient care-related occupations paid the second highest average starting hourly wage at \$12.45 (median \$12.12).

Laboratory technology-related occupations and all other hospital-related occupations had an average starting hourly wages of \$11.59 (median \$11.50) and \$11.50 (median \$11.00) respectively (see TABLE #9).

TABLE #9: Median Starting Hourly Wage for All Health Care Training Institute Pre-Employment Hires



Assuming that an individual who worked full-time earned the overall average starting hourly wage of \$12.28, their average annual income would be slightly over \$25,500 a year. Finally, it is worth noting that there was a difference in the median starting hourly wage between residents who completed the 12-week Pre-Employment Training Program (\$12.00) and residents who walked-in off the street for employment assistance (\$11.47). Unfortunately, the numbers were too small to conduct a statistical analysis to see if the difference in median starting hourly wages between the two groups was merely random or if the difference was statistically significant, so I checked to see if there was a difference in the types of jobs pre-employment training participants obtained versus those

walk-in participants that only utilized training services. There appeared to be a difference in the types of jobs between the two groups. Pre-employment participants were more likely to be hired across administrative, patient care, laboratory, and other health care-related occupations while walk-in participants were mostly concentrated in entry-level administrative and patient care positions (patient care assistant) which tend to pay a lower salary. One reason that may explain the difference in jobs between the groups has to do with the fact that the Training Institute has a well-defined career track with administrative, patient care, and laboratory technical positions. Therefore, graduates of the Pre-Employment Training Program are likely to be hired in one of those occupations. Moreover, each pre-employment participant completes an 8-week internship which provides them with on-the-job experience which could also translate into a slightly higher starting salary.

Incumbent Workers

As I mentioned earlier, the demographics of Training Institute incumbent workers varies from those of the pre-employment group. As of February 2005, the Training Institute had provided training to 208 incumbent workers employed within Boston's health care industry. Nearly 80% of the incumbent workers were female and 59% were Boston residents, a significant difference from the 96% of pre-employment participants who were Boston residents. In terms of race and ethnicity, the majority of incumbent workers who enrolled in training classes through the Training Institute were black (34%), followed by non-white Hispanics (25%), whites (12%), and Asian or Pacific Islanders (8%). Similar to the pre-employment participants, the majority of incumbent workers

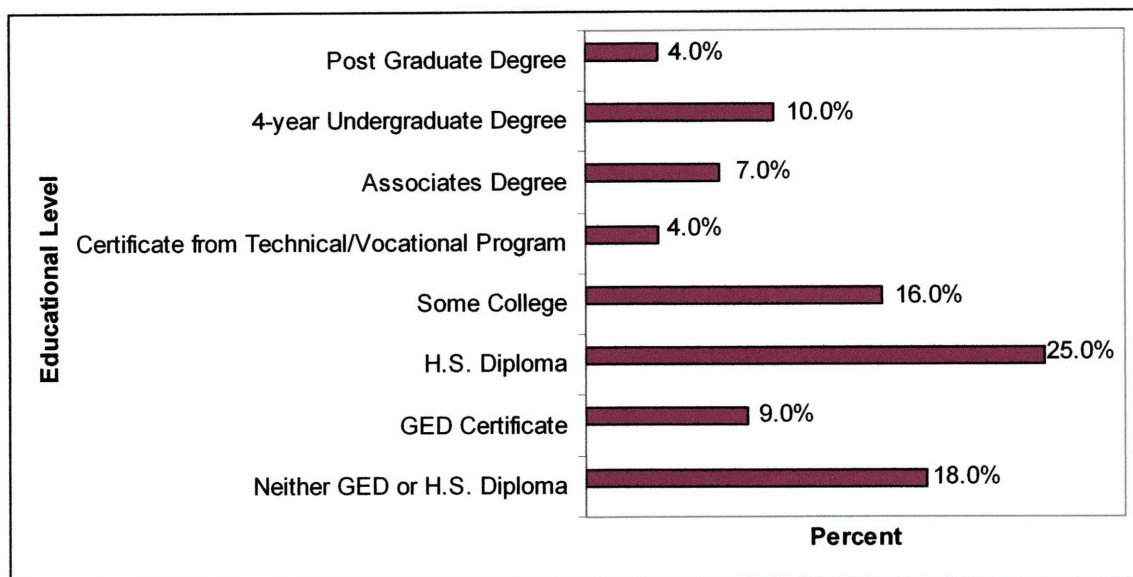
who enrolled in Training Institute classes spoke a primary language other than English (53%). The most popular language spoken among the non-English speakers was Spanish (44%), French/Creole (19%), Chinese (5%), and the remaining 21% spoke a number of other languages.

In terms of age, education, and income, the incumbent workers' average age was 38, roughly 4 years older than the average age for the pre-employment enrollees. The incumbent workforce participating in Training Institute courses included a significantly older group. About 43% or 89 workers were over the age of 41 compared to 33% (41) for the pre-employment participants. Surprisingly, more than half of the incumbent workers who enrolled in Training Institute courses had a high school diploma or less (52%) compared to 49% for the pre-employment group. One would expect that the incumbent workforce would be more educated because they already had jobs. When measuring the number of associate degrees earned, incumbent workers did not fare as well as the pre-employment group either. Only 7% of incumbent workers had earned an associates degree (15 individuals) compared to the pre-employment group at 14% (17 individuals). However, a higher percentage of incumbent workers had earned a 4-year undergraduate or post graduate degree compared to the pre-employment participants (see TABLE #10).

Finally, when analyzing the incumbent workers' annual household income as a group, the distribution was split down the middle. Roughly 43% of incumbent workers had annual household incomes of \$24,999 or less, while 42% of the group reported earning \$40,000 or more. This dichotomy in annual household incomes might suggest that many of the incumbent workers seeking additional skills training from the Training

Institute are either younger and are just entering the workforce or they are older workers who need to maintain/improve their skills. In terms of marital status, among those that responded, One-third of incumbent workers reported being married and the average number of children under the age of 18 living at home for all incumbent workers was 2.3. No incumbent workers reported receiving any public assistance and 83% reported being the sole or primary wage earner, a clear distinction compared to the pre-employment group.

TABLE #10: Highest Educational Level and Certification at Enrollment in Training Institute Courses for Incumbent Workers



One of the questions I am attempting to answer through my dissertation research is, how far can an individual progress along a career ladder or lattice after participating in the Training Institute’s employment and training courses. Specifically, I want to understand the factors that may influence a person’s ability to advance within the health care sector. I was able to obtain employment, wage, and retention data on the incumbent

workforce (from January 1, 2001 to April 8, 2005) from JPND. I received data on 406 incumbent workers who have participated in Training Institute skills courses. Between January 2001 to April 2005, 406 incumbent workers have participated in the Training Institute and 362 were still employed as of April 2005 for an overall retention rate of 89%. A subset of the employment data included the hourly wages of the incumbent workers, the number of courses they completed, wage increases, and promotions. This data includes 240 individuals and was based on employment data collected from six health care employers, all of whom are members of the Training Institute. The average wage for all incumbent workers who enrolled in Training Institute courses was \$12.47.⁸ Seventy-six percent took just one course, 15% completed two courses, and the remaining 9% of incumbents completed three courses or more. Among all incumbent workers who took courses through the Training Institute, roughly 55% (131 participants) were at Children's Hospital Boston, the second most was Beth Israel Deaconess Medical Center with 55 workers (23%) taking part in Institute courses. Almost half of all incumbent workers (46%) who participated in the Training Institute received a merit wage increase. The highest wage increase was \$3.99 and the lowest was \$0.17 and the median merit wage increase for all incumbent workers was \$0.60 over a 4-year period. Finally, 10% (23 individuals) of the incumbent workers who participated in training received a promotion. Although this data appears to be promising, one cannot assume that skills training courses provided through the Training Institute helped workers achieve merit wage increases or promotions.

⁸ Did not have wage data for all 362 incumbent workers, this data is based on 208 workers.

Conclusion

As one begins to uncover and understand the inner workings of the Training Institute, they eventually realize that it is a complicated and dynamic workforce intermediary. Managed by the community organizations of JPNDC and FCDC in partnership with the Mission Hill Network, these organizations developed a job-centered economic development strategy at the inception of the Training Institute that was focused on linking local residents to jobs within the health care sector. Overall, the jobs that pre-employment participants were hired for paid an average hourly wage of \$12.28 compared to the average wage of \$9.90 when residents first began the Training Institute's Pre-Employment Program. Among the pre-employment participants who were hired, only 10 individuals (17%) received a promotion and few have advanced along a career pathway. Furthermore, a cost benefit analysis of the Training Institute revealed that the annual cost per participant is about \$2,000, while the annual cost of a PCWD participant is about \$1,350. At this point it is not clear if the results have paid off, only time will tell if workers are able to progress along a career pathway (I will discuss the intermediary's effectiveness in detail in chapter 5).

JPNDC and FCDC were also, with the help of outside political pressure and federal/grant funding, able to change the demand-side of the labor market. JPNDC and FCDC were able to convince employers to take a more active role in the Training Institute's activities. Employers responded by providing classroom space within the LMA, allowing workers to take leave time in order to attend Institute courses, and encouraged managers and supervisors to attend supervisory skills training courses. JPNDC and FCDC have also encouraged employers to begin developing well-defined

career pathways for their entry-level workforce, especially for under-skilled workers in administrative, patient care, and laboratory technology-related occupations. All of these changes on the demand-side of the labor market have been significant in helping under-skilled, entry-level workers begin advancing along a career progression, while they also have the opportunity to gain valuable training and career planning assistance along the way.

Despite JPNDC and FCDC's ability to negotiate with employers to meet some of their demands initially, lately this has changed. As employers begin to pay for training services based on the number of employees who participate in the Training Institute's courses, they are becoming more demanding. Employer's view their relationship with JPNDC and FCDC as more of a business—an employer-vendor relationship compared to when the Training Institute provided most of the financing via grants to keep the Training Institute sustainable. Therefore, employers do not feel as obligated to turn to the Training Institute for services if they can—1) Find a vendor that can do a better job; 2) Find a vendor that is less expensive, but who does not compromise quality; or 3) If they can provide the service internally through their own HR or training department's.

As the Training Institute continues to expand and grow, JPNDC and FCDC need to seriously consider if these two organizations can continue to effectively manage the intermediary. Staff turnover is high due to burnout from long hours and heavy demands that often is required to keep the Training Institute running efficiently. One possibility is that the Training Institute could be spun off into its own 501c (3) nonprofit organization. This would enable the organization to hire a staff who is solely responsible for running the organization. This would also likely result in less turnover, which would be a

positive change from the employers' perspective. In addition, the Training Institute as a separate nonprofit entity would theoretically be able to serve more residents because it would have the ability to expand beyond primarily the Fenway, Jamaica Plain, Roxbury neighborhoods in Boston. Regardless of what JPNDC and FCDC and their partners decide, the future sustainability of the Institute depends on establishing a steady funding stream, employer engagement and investment (time, in-kind contributions, and financial support), and a mechanism to link all partners together in a way that fosters trust, allows for open dialogue, and information sharing.

CHAPTER FOUR: A CASE STUDY OF PARTNERS IN CAREER WORKFORCE DEVELOPMENT

In this chapter I will provide an analysis of the Partners in Career Workforce Development (PCWD) workforce intermediary. I will discuss how PCWD first began and how it has evolved over the last 2 years. Despite being a Partners HealthCare driven workforce development intermediary, PCWD has struggled to establish itself as a legitimate and respected skills and education training program and has had difficulty overcoming negative perceptions, stereotypes, and cultural barriers that exist within Partners HealthCare. In addition, the increased competition for health care jobs in Boston has forced the leadership of PCWD to think creatively, make programmatic improvements, and to focus on establishing networks throughout Partners HealthCare Systems in order to improve the employment outcomes of program participants. So far, the outcomes for PCWD participants have been mixed.

Overview

The PCWD workforce development intermediary is an employer-driven partnership comprised of 13 partners—4 Partners HealthCare employers, 5 institutions of higher education, 3 pre-employment training and career case management agencies, and the Massachusetts Board of Higher Education. PCWD is managed and operated by Partners HealthCare's Community Benefits Department. PCWD has two main components to its employment and training program—a pre-employment component and incumbent worker component. The pre-employment job training component offers job

seekers a 5-week job training and internship program for Boston residents who are interested in entry-level health care careers and desire opportunities to gain further education, skills training, and career advancement.

The incumbent worker training component of PCWD is designed to help workers within the Partners HealthCare System advance along a career pathway. The component provides Partners' employees with access to pre-college preparatory courses that emphasize math, reading, writing, and study skills. It also places a strong emphasis on college education. PCWD is designed to encourage workers with limited skills and less formal education to consider seeking occupational certification and/or a degree by enrolling in college.

The overall goal of PCWD is two-fold—to help economically disadvantaged adults attain family-sustaining jobs in health care, while also meeting the employment needs of Partners HealthCare. According to Partners, PCWD is designed to serve the following individuals:

- 1) Under-skilled individuals seeking job training in order to enter the health care workforce;
- 2) Entry-level or frontline employees who want to gain additional skills so that they can progress along a career pathway to mid-level jobs;
- 3) Incumbent workers who are either ready for college or require a year or two of pre-college work; and
- 4) Employees who have professional health care experience and credentials from another country and need intensive instruction in English to meet the requirements for practice in the Commonwealth of Massachusetts.¹

¹ Partners HealthCare. 2004. "Partners in Career and Workforce Development Fact Sheet."

History

Prior to the creation of PCWD, Partners HealthCare's Community Benefits and Human Resources Departments had a history dating back over a decade of supporting workforce development programs aimed at increasing the skills of Boston residents. Formed in 1994 by Brigham and Women's Hospital (BWH) and Massachusetts General Hospital (MGH), the Partners HealthCare System is a not-for-profit health care delivery consortium that serves the greater Boston metropolitan area.² A key component of Partners HealthCare's community benefit mission is to support the health and well-being of the local community. In January 1995, Partners' Board of Trustees issued the following statement:

Partners is committed to working with community residents and organizations to make measurable, sustainable improvements in the health status of underserved populations.

Soon after adopting this mission statement, the opportunity arose for Partners to become involved in helping increase the economic opportunities of some of Boston's poorest and least educated residents.

As I mentioned previously in Chapter 2, during the mid- to late 1990's welfare reform legislation put greater pressure on major urban cities to help welfare recipients transition from welfare to work. In the City of Boston, Mayor Menino and other city leaders called upon the business community to do more to help welfare recipients

² Partners HealthCare includes the following: Brigham and Women's Hospital; Faulkner Hospital; Massachusetts General Hospital; North Shore Medical Center; Newton-Wellesley Hospital; McLean Hospital; Partners Continuing Care (Spaulding Rehabilitation Hospital Network, Partners Home Care, and the Rehabilitation Hospital of the Cape and Islands); MGH Institute of Health Professions; and the Associated physician groups and the community-based doctors and hospitals of Partners Community HealthCare.

improve their skills and increase their education so that they would be able to find long-term, stable work. To help jump start the process, the Boston Private Industry Council (PIC) in partnership with the Mayor's Office of Jobs and Community Services (JCS) and the Economic Development and Industrial Corporation (EDIC) applied for and received a four-year, \$11.3 million U.S. Department of Labor grant in 1998 to fund training and case management for the city's welfare-to-work sites. Partners HealthCare, like Jamaica Plain Neighborhood Development Corporation and their partners, responded by developing a welfare-to-work program called Project RISE (Reaching Individuals Striving for Excellence).

Project RISE was designed to be a comprehensive training program exclusively for Boston residents who received welfare benefits. The program was backed by the two founding hospitals of Partners HealthCare Systems—BWH and MGH (which combined, accounted for over 22,000 jobs in Boston) as well as a number of community partners including Jewish Vocational Service (provided pre-employment training), and WorkSource Staffing Partnership, Inc. (provided case management and career development services). This program had four main goals:

- 1) To satisfy the business need to fill entry-level openings with job-ready candidates.
- 2) To build on a longstanding commitment to improve the health of underserved Boston neighborhoods.
- 3) To provide employment opportunities for community residents scheduled to lose public assistance benefits due to welfare reform.
- 4) To improve job retention for entry-level employees.

In an effort to reach its goals, the original design of Project RISE provided welfare-to-work participants with an eight-week pre-employment training program that focused on basic skills and job-readiness, job shadowing and internships, job placement, case management, career development, and a job club for program graduates who had yet to secure permanent employment.³

Unfortunately, Project RISE had mixed results. Health care administrators familiar with the former program claim that Project RISE was never able to effectively meet the entry-level occupational needs of Partners' employers. During the first two years of Project RISE, early federal legislation requirements limited enrollment to individuals who lacked a high school diploma or GED, had low math or reading skills, and had a very limited work history.⁴ Given these factors, it proved to be too difficult to raise the skills and prepare "hard-to-employ" individuals for jobs within eight-week training program. As a result there was an education and skills mismatch between program participants and many entry-level health care jobs. Second, Project RISE was not able to reach the scale needed to meet the occupational demands of the Partners HealthCare System. This was especially critical because the failure occurred at a time when frontline and entry-level jobs were more plentiful throughout Partners' hospitals. Although federal welfare-to-work legislation was later changed to allow Project RISE to accept participants with a high school diploma or GED, the program was never able to gain momentum and reach sustainability. Finally, Project RISE was viewed by many throughout the Partners HealthCare System as a 'welfare-to-work benefits program' and was never taken seriously as a legitimate employment and

³ VHA Health Foundation, Inc. 2001. Welfare-to-Work Strategies for Health Care Work Force Development. Irving, TX.

⁴ Ibid 3.

training program. As one hospital official told me, “[Project RISE] wasn’t perceived by hospital administrators as a very good program. It didn’t have a good reputation.” This negative perception and the program’s inability to produce enough skilled workers to meet Partners HealthCare’s immediate employment needs directly influenced the amount of financial support and resources Partners’ top administrators were willing to put into the program. Many inside Partners were beginning to doubt if the program was worth the investment, while others felt that the program should be scrapped altogether.

By late 2000 and early 2001 Boston’s previously hot economy began to cool and by late 2001 it went into a recession. Suddenly, Boston was no longer experiencing a tight labor market and unemployment in the metropolitan area began to rise as thousands of higher skilled and educated workers were laid off, especially within the information technology sector. The layoffs had a ripple effect in Boston’s health care sector. Applications for entry-level health care positions skyrocketed and hospitals and medical clinics were easily able to fill positions that had been difficult to fill during the 1990s. A Partners HealthCare administrator stated, “around 2000 and 2001 entry-level jobs began to dry up. We ran recruitment days and highly educated adults began showing up. In one case, we even had a PhD graduate [show up]. Many had been looking for work.” Despite the fact that the economy had begun to weaken and it became easier to fill health care jobs from a pool of higher skilled, educated workers, Project RISE continued to exist. Even though many inside of Partners were less than enthusiastic about the employment and training program, they knew it would be politically damaging to completely eliminate the program because Mayor Menino

was pressuring Boston's health care industrial complex to do more for Boston's least educated and under-skilled residents. Most employers wanted to respond to Menino's demands because they were interested in gaining his approval of their proposed development projects.

Even with Project RISE's shortcomings, the program provided Partners with many lessons learned about the challenges faced by employers involved in education and workforce development. More importantly, Project RISE was a significant program for Partners HealthCare because it laid the foundation for PCWD's programs in several ways. Project RISE was the first major effort by the then newly created Partners HealthCare System, Inc. to manage and operate a community-focused workforce development program for under-skilled, economically disadvantaged adults. First, by developing a comprehensive workforce development program it required Partners to establish working relationships internal across multiple departments and institutions (i.e., human resource departments across hospitals) and develop external relationships with community and social service organizations. Second, the experience of managing Project RISE resulted in valuable lessons learned for Partners' administrators. The program helped them to better understand how to develop a comprehensive workforce development program. For these administrators this meant emphasizing post-secondary educational attainment and creating partnerships with community colleges. Finally, Partners administrators began to have a better understanding of the challenges that exist for under-skilled, chronically unemployed adults attempting to obtain long-term employment and what supports are necessary to help them succeed.

An In-Depth Look at Partners in Career and Workforce Development

Program and Focus

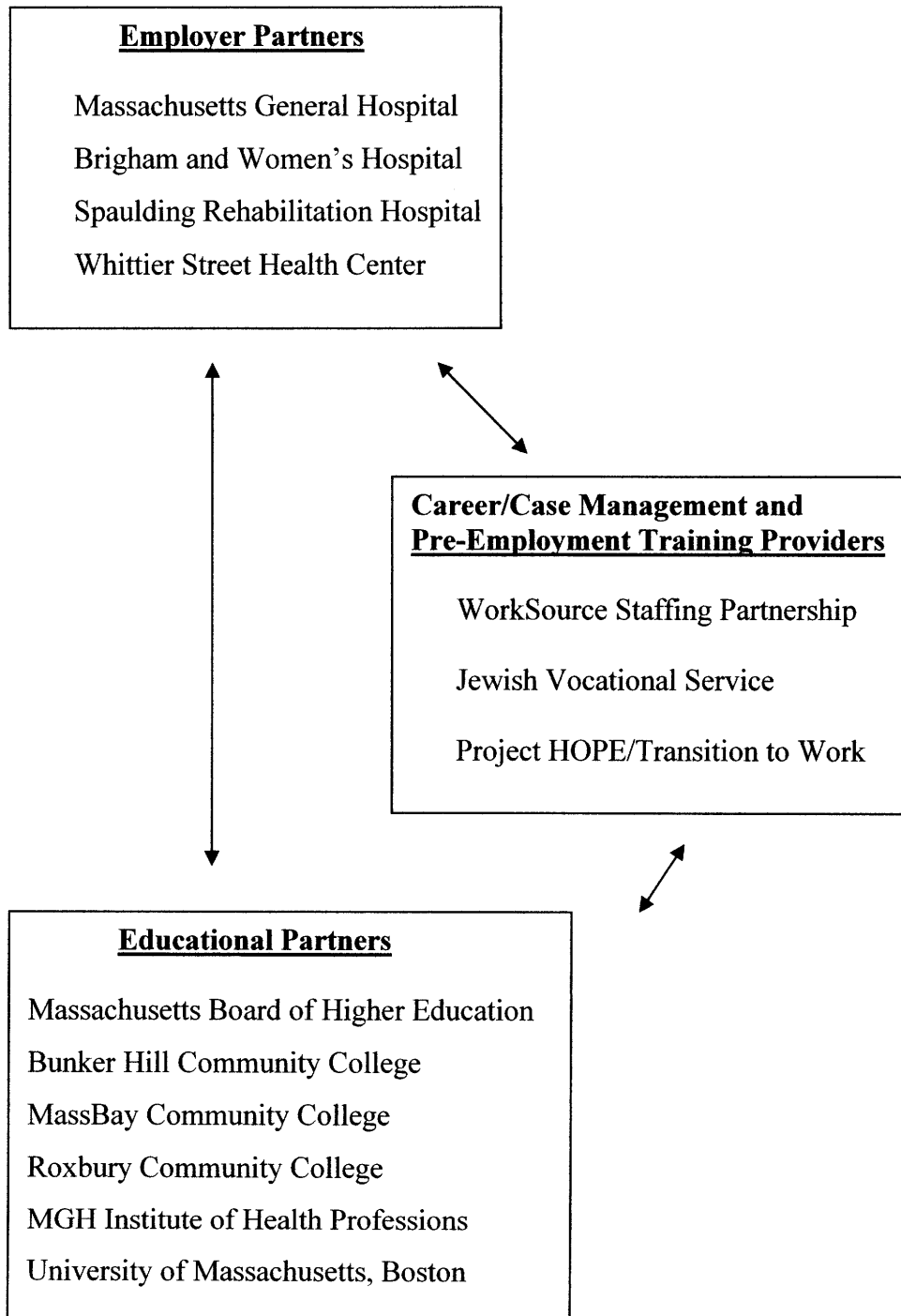
On November 17, 2003, SkillWorks (formerly called the Boston Workforce Development Initiative) awarded \$5 million in grants to support employment opportunities for economically disadvantaged Boston residents over a three- to five-year period.⁵ Partners Career in Workforce Development along with the Training Institute were the only two grant awardees with a focus on the health care industry. Partners HealthCare's Community Benefit Programs Department received a \$1 million, three-year implementation grant from SkillWorks and officially started PCWD in December 2003. This funding opportunity enabled Partners HealthCare to replace Project RISE with PCWD. Partners' administrators also knew that this was the perfect opportunity to learn from the past mistakes of Project RISE and to create a program that was both effective at developing the short- and long-term skills and education needs of its participants, while meeting the employment needs of the Partners HealthCare System.

The SkillsWorks grant helped Partners expand the size, scope, and mission of PCWD. The goal at the start of PCWD was to serve 500 adults over the three-year period of the SkillWorks grant. PCWD has a number of partners from the public and nonprofit sectors. Overall there are 13 organizations that are partners in PCWD—4

⁵ SkillWorks is the single largest public/private investment in workforce development in Boston's history, with an overall investment of \$14.3 million over five years. It is funded by: the Boston Foundation; the Annie E. Casey Foundation; the Paul and Phyllis Fireman Charitable Foundation; the Fleet Charitable Fund and the Frank W. and Carl S. Adams Memorial managed by Fleet's Charitable Assets Division; the Hyams Foundation; the Rockefeller Foundation; the State Street Foundation; the United Way of Massachusetts Bay; the Mayor's Office of Jobs and Community Services; and the Commonwealth of Massachusetts. (source: Partners HealthCare, 2004).

employers, 3 career/case management and pre-employment training providers, and 6 educational partners (see FIGURE #3.).

FIGURE #3. PCWD Organizational Partners



PCWD has tried to strike a balance between sustaining many of the same goals of Project RISE and expanding its scope, scale, and breadth. Project RISE was one-dimensional in that it was limited to being a pre-employment job readiness and training program, whereas PCWD is a workforce intermediary with various components, services, partners, and goals. Another key difference between PCWD and Project Rise is that, under the new design of PCWD, *all* pre-employment participants are required to have earned at least a high school diploma or GED *and* have at least one year of consecutive work experience. PCWD and its predecessor also differ because PCWD has incorporated an incumbent worker training component that is focused on helping Partners' employees advance along a career pathway. Finally, PCWD differs from Project RISE because it has a strong emphasis on post-secondary education and has established partnerships with local community colleges to develop health care certification programs for Partners' employees.

PCWD is also similar to Project RISE in several ways. PCWD, like Project RISE is focused on helping Boston's underprivileged residents obtain skills and find employment within Boston's health care sector. PCWD also kept the career coaching and case management focus that was developed under Project RISE, except this time Partners HealthCare teamed up with an experienced social service agency to assist with the recruitment and screening of pre-employment job seekers. This was an area in which that Partners HealthCare administrators admitted to having very little experience and expertise.

There are three primary categories into which PCWD program participants are placed into 3 primary categories :⁶

- 1) Health Career Starters—Job-seekers and incumbent workers in entry-level positions that need to develop basic literacy, math, and vocational skills.
- 2) College Bound Group—Incumbent workers with a high school diploma or GED that need 1-2 years of pre-college work in English, math, and/or science in order to pass the College Placement Exam and enter a health care focused higher education program.
- 3) College Ready Group—Incumbent workers with the education preparation necessary to pass the College Placement Exam and be admitted to a college program.

In the next section I will discuss how the various components of PCWD and how they operate.

How PCWD Operates

PCWD's employment and training programs are designed to be comprehensive and serve a diverse group of individuals—pre-employment job seekers, entry-level incumbent workers, health care professionals from other countries, and individuals who have limited English language skills. This has required PCWD to provide a number of disparate services, including college preparatory classes, educational initiatives, career planning, career coaching, and the engagement of managers, supervisors, and health career ambassadors.

⁶ Partners in Career and Workforce Development. 2006. www.partners.org/pcwd

Pre-Employment Program

PCWD's Pre-Employment Program is a five-week job readiness training program for Boston residents who are interested in entry-level employment within one of the Partners affiliated hospitals. PCWD's Pre-Employment Training Program has developed a labor force attachment approach to workforce development which encourages individuals to gain quick entry into the labor market (Poppe, Strawn, and Martinson, 2004), this is the opposite of the Training Institute which as I mentioned in the previous chapter has adopted a human capital approach to workforce development that emphasizes education and training before an individual enters the labor market. Although the labor force attachment approach to workforce development strategy can be effective in helping economically disadvantaged, under-skilled individuals obtain good quality jobs rather quickly in a tight labor market, this strategy does not appear to work as well during times when the economy has softened. I will discuss this in greater detail later on in this chapter.

During the first 2 ½ weeks of the Pre-Employment Training Program, students spend time in the classroom learning job readiness skills such as medical terminology, how to behave appropriately on the job, customer service skills, etc.. In the latter half of the program, students participate in an internship within a hospital. Participants' internships are generally in three areas—patient care, administration, and laboratory technology. PCWD personnel try to accommodate each student's occupational interests when placing them in an internship because many students are hired in the departments that they have conducted their internship, provided that they performed well. The department where the student is placed is also dependent upon the number

and types of internship opportunities that exist for the particular pre-employment cohort. Over the course of the five-week program students are expected to be on-site between the hours of 9 am to 5 pm.

There are a number of challenges for the Pre-Employment Program. One main challenge is that the program is only five-weeks long. This is hardly enough time to help participants increase their skill levels in comparison to when they first begin the program. There are primarily two reasons why the Pre-Employment Program is only five-weeks. First, PCWD wanted to increase the number and success rate of graduates they produced each year, so they decided to offer 4 pre-employment cycles annually. Each pre-employment cycle is limited to a maximum of 12 students. This ensures that PCWD's staff will be able to provide each participant with an internship opportunity and individualized support services, if needed, to help them successfully complete the Pre-Employment Training Program. The second reason why the Pre-Employment Program is only five-weeks is because many of the participants cannot afford to be in a non-paid internship for much longer than five-weeks. Some struggle to make ends meet and a five-week training and job readiness program is already a challenge. In addition, a number of individuals have small children at home and have difficulty finding affordable and reliable child care. Even though there appears to be a reason for the Pre-Employment Training Program to be only 5-weeks, it is not enough time to truly help individuals raise their core competencies or skill levels.

The short length of the Pre-Employment Program is a serious challenge because the skills demand for health care jobs is increasing. For instance, during the economic slowdown of the early 2000s, hospitals have tried to cut operating costs in

two ways. First, they reduced the number of nonessential positions and consolidated job responsibilities. Second, they have also incorporated the use of technology in the workplace in an effort to also save on additional administrative costs. As a consequence, the skills requirements and competition for jobs within the health care sector has increased. In most entry-level administrative positions (Administrative Assistant I) applicants are expected to have a solid understanding of computers and computer software such as Microsoft Office (Access, Excel, Word, etc.).

The lead instructor acknowledges this challenge and says that over the last two years, and especially post Project RISE, Partners has had to make some changes to the Pre-Employment Program. One of the main changes has been to raise the minimum requirements of enrollees into the program. Under PCWD, all participants must be at least 18 years of age and have a high school diploma or GED. Prior to the change there was no educational requirement for enrollees. PCWD pre-employment program participants must also take the Test of Adult Basic Education (TABE) in language and reading and score at the 8th grade level. In the past they were required to score at the 6th grade level or higher. PCWD has also added a computer skills test as an additional requirement of the program. Participants must also successfully clear a Criminal Offender Records Investigation (CORI) and have at least one year of consecutive work experience and a verifiable reference from a past employer. All enrollees must also be willing to work full-time, which can be a challenge for some applicants with children or other family responsibilities. A clear trend is beginning to emerge with PCWD and the Training Institute. Over time both intermediaries have slowly raised the skill requirements for participants who wish to enroll in the Pre-Employment

Training Program. One wonders when PCWD and Training Institute will eventually resemble other types of pre-employment training programs that target the more skilled individuals by practicing creaming.

In addition to increasing strict requirements for individuals enrolling in the program, PCWD administrators are trying to help participants get the most effective use of the short five-week training program by focusing on the development of soft skills (i.e., medical terminology, professional attitude, etc.) instead of hard skills (i.e. math, reading, etc.) . As a result, the lead instructor has focused on strategies to help participants stand out during their internship, in job interviews, and on the job. These skills include interviewing techniques, resume writing, and customer service skills. Students are also exposed to additional information ranging from financial management to accessing public benefits for themselves and their families. Despite all of these techniques, employers that I interviewed are still interested in employees with solid basic skills. A short five-week job readiness program is incapable of providing participants with the type of breadth and depth in skills that they will need on the job.

Another challenge for the Pre-Employment Training Program is overcoming negative stereotypes within the Partners HealthCare System. The mixed performance of Project RISE is still very much on the minds of many HR staff, hospital department managers, and department supervisors. In the beginning, many of those in charge of hiring were concerned that PCWD was simply a repackaged and remarketed Project Rise program. As I was told on at least six separate occasions during my interviews, many personnel within Partners HealthCare think of PCWD as a welfare benefits program or “The Welfare Program”. This negative perception of the program has

clearly affected outcomes for the first wave of pre-employment graduates. For example, when PCWD began, program staff held recruitment days such as “Operation Hire” and “Express Lane.” These were events in which human resource managers and/or other hospital administrators had the opportunity to meet PCWD graduates and interview them one-on-one. However, no hospital human resource personnel came to one of the recruitment days. On other occasions, human resource staff would not respond to e-mails from PCWD personnel requesting information about a particular job opening or respond to e-mails regarding a qualified PCWD candidate. This became frustrating for PCWD staff.

In an effort to help PCWD pre-employment graduates increase their opportunities to obtain employment, PCWD staff shifted tactics. Instead of focusing exclusively on HR personnel to hire PCWD graduates, they focused on developing a broad-based social network throughout the Partners HealthCare System. In a number of national evaluations conducted on workforce intermediaries, the ability to network across disparate departments, institutions, and individuals was a key element of successful workforce intermediaries. PCWD staff identified HR personnel, department managers, and supervisors who were supportive of PCWD. Social networking and worker advocacy are important factors in helping PCWD pre-employment graduates obtain employment. PCWD staff are constantly e-mailing, calling, and making presentations to various HR staff and hospital managers/supervisors to better inform them about the PCWD program, tout the accomplishments and skills of PCWD graduates, and to make it clear that they are a valuable resource. A PCWD administrator stated, “Internally I have built strong

relationships with MGH and other Partners managers and supervisors and I don't want to burn bridges by sending them a bad candidate." She went on to stress the fact that networking and relationships are important in helping participants obtain jobs.

Despite the fact that PCWD is supported by Partners HealthCare Systems, it must also develop a reputation just like any other outside training provider. In fact, because PCWD is managed by the Community Benefits Department, its graduates are often seen as being the beneficiaries of a special program for people with problems, which sometimes leads employers to be biased against them.

A third challenge for the PCWD pre-employment program is bridging the cultural gap that exists between the Community Benefits Department and the Human Resources Department of the Partners HealthCare System. The Community Benefits Department is focused on community outreach and improving the lives of neighborhood residents. As a result, PCWD has adopted more of a community-based culture. Many of the participants who enroll in PCWD's Pre-Employment Training Program have a number of social and personal problems. Some have struggled with issues such as substance abuse, domestic violence, homelessness, and chronic unemployment. When it comes time to accepting a prospective applicant to the Pre-Employment program or recommending a graduate for a job, the staff of PCWD will often meet with representatives from social service and community agencies who work with the particular individual. These meetings help PCWD assess an individual's ability to succeed in the program or in full-time employment with Partners. They will then disclose any important issues with HR staff or department

managers and supervisors to ensure that a particular individual is able to succeed on the job.

The Human Resources Department of Partners HealthCare has developed a different culture and approach to the hiring and applicant evaluation process, when compared to the Community Benefits Department. Located within the corporate offices of Partners HealthCare in the Prudential Center, the Human Resources Department has developed more of a business culture. HR personnel are primarily interested in an applicant's work history, education and skills, and attitude. They are especially concerned about a job applicant's ability to fulfill their work responsibilities and be a dependable employee who is not distracted by personal issues. As a Partners employee shared with me, "In HR it is much more black and white. You are either in or out, taking the job or not. You never ask personal questions, especially personal questions about an applicant's history of substance abuse, domestic violence, or anything like that. At PCWD, it is completely the opposite. Participants' personal histories are completely in the open and discussed." The cultural divide between Partners HR and Community Benefits Departments is real. PCWD program staff struggle on a daily basis to make sure that PCWD graduates, and the program in general, are on the radar screens of HR staff. More importantly, PCWD administrators do everything within their power to make sure hospital department managers and supervisors know that they have a place to turn if they have a problem or concern about an employee. They also make sure that PCWD graduates have the support and resources needed to succeed in the workplace. This is also the case with the Training Institute, except as a community development corporation, JPNDC is

often times able to directly provide or connect a prospective employee to the appropriate social service agency needed to help them succeed on the job. This is more difficult for PCWD because as an employer-led intermediary there are fewer resources available internally to provide prospective employees with social service support. As a result, the staff of PCWD has to contract out to social service agencies in order to provide employees with the adequate support that they need.

Incumbent Worker Program

PCWD's Incumbent Worker Program is open to employees that have been employed by Partners for at least six months, are in good standing, and have been referred to the program by a manager or supervisor. Once an employee is accepted into the program they have access to a number of resources including one-on-one career coaching, access to free pre-college classes, access to a career planning and career tools website, exposure to health careers via job shadowing and health fairs, and information regarding the ways to finance post-secondary education.

The PCWD Incumbent Worker program is very different from the Pre-Employment Program. The designers of the program decided early on that if workers are to succeed in increasing their career options and economic opportunities, they would need a post-secondary education. Therefore, they developed the following strategies to improve the career progression of incumbent workers:

- 1) Raise the awareness of health care-related careers and opportunities throughout the Partners HealthCare System.
- 2) Provide workers with an opportunity to develop a career plan and goals as well as a clear pathway for them to reach those goals.

- 3) Encourage Partners managers and supervisors to take a more active role, be more invested in helping develop the careers of PCWD employees.

PCWD and Partners administrators worked together to implement programmatic steps to support the above strategies. First, PCWD encouraged program participants to work with career coaches to develop their own career plans. Career coaches now meet with employees periodically to “check-in” with them, help them with their career plans, measure their progress towards meeting their long-term career goals, and provide overall mentorship. PCWD also developed a career planning/tools website for employees to access. The Career Planner website allows employees to conduct an online self-assessment test. The self-assessment test even includes a component that assesses an individual’s personality and gauges their interests. The Career Planner website also includes a Career Exploration section that provides employees with careers and career pathways including allied health careers, nursing/medical support positions, and health information management positions to name a few (see Example #1: PCWD Career Planner Website for Allied Health Career Pathway).

EXAMPLE #1. PCWD Career Planner Website for Allied Health Career Pathway

Allied Health Career Pathway

Below is a list of **positions that fall under Allied Health**

The positions in this section have been broken into three categories. This information can help you narrow down your search by answering questions like:

How much education and training do I need?

Will I need a license or certificate?

Do I need previous work experience in this field?

Entry Level: Little or No work-related skill, knowledge or experience is required. Positions may require a high school diploma or GED certificate. Some may require a formal training course to obtain a certificate or license. Employees in these positions need anywhere from a few days to a few months of training.

- [Radiology Aide](#)

Middle Level: Some previous work-related skill, knowledge or experience is required. Positions usually require a high school diploma and may require some vocational training or job-related course work. In some cases, an associates or bachelor's degree could be needed. Employees in these positions need anywhere from a few months to one-year working with experienced employees.

- [Medical Assistant](#)
- [Phlebotomist](#)

High Level: Previous work-related skill, knowledge or experience is required. Most positions in this step require vocational training, related on-the-job experience, or an associate's degree. Some may require a bachelor's degree. Employees in these positions usually need one or two years of training both on-the-job experience and informal training with experienced workers.

- [Diagnostic Medical Sonographer](#)
- [Respiratory Therapist](#)
- [Radiologic Technologist](#)

Continue to the [next Career Pathway](#) and complete **Assignment #6** in your [Career Plan Worksheet](#) to complete the section on career exploration.

The Career Planner website allows employees to set goals and develop an action plan. The Action Plan section of the website helps employees explore their educational and skills level, financial stability, work experience, and identify potential obstacles to employment such as childcare and personal life issues. Even though the Career Planner website is a good resource for incumbent workers and others interested in health care careers, the site has some drawbacks. One drawback is that there is no way to know how many employees actually make use of the site. It is safe to assume that the main individuals accessing and making use of the site are those who are self-motivated and self-directed, so it is unlikely that employees who are less knowledgeable about navigating their way through “the system” will benefit. Another drawback of the Career Planner tool is that the website is not user-friendly for those who do not have a strong command of the English language, such as recent immigrants. Immigrants and individuals who lack a formal education are precisely the type of individuals who could take advantage and benefit from such a resource to further their education and career in the health care profession.

The second programmatic step that PCWD implemented for incumbent workers was to focus on developing a broader social support network, similar to the Pre-Employment Program. PCWD program staff has worked hard to recruit Partners HealthCare personnel who are supportive of the program. So far they have been relatively successful in identifying managers and supervisors who are supportive in helping their employees increase their skills and education. PCWD’s staff refers to these individuals as “Workforce Development Champions.” Workforce Development Champions are rewarded for their support. They receive public recognition via Partners

newsletters and other forms of communication (i.e. bulletins, public announcements, etc.). They are also provided with support and training in career coaching and mentoring. PCWD's strategy serves two purposes. It is trying to build up support for the program and their participants. In addition to also trying to strengthen the program's networks across hospitals and departments within the Partners HealthCare System. As one of the key architects of the PCWD intermediary stated, "PCWD decided to encourage managers to help employees with career advancement by making 'successful' managers visible throughout Partners. We celebrate managers and participants involved in the program. We wanted to make it a club everyone wanted to join. This is why refer to them as Workforce Development Champions." PCWD did not stop there. They also began to identify health care professionals who are dedicated to sharing information about their profession with workers and who are willing to allow PCWD participants to shadow them on the job. PCWD refers to these individuals as "Health Care Ambassadors." Health Care Ambassadors represent a number of health care fields and often make presentations to PCWD participants about their career and career development.

The third and final programmatic step that PCWD implemented in an effort to assist incumbent workers in their career progression was their decision to place a strong emphasis on post-secondary education. PCWD participants have access to college preparatory classes. There are two main classes—a pre-college reading and writing for non-native English speakers course and a general pre-college course. The pre-college reading and writing course for non-native English speakers focuses on improving the English language skills of employees who have a high-level of education from their native country and who have previous experiencing working in

the health care profession. It is a 30-week, four hours per week course totaling 120 hours of classroom instruction.

The general pre-college course incorporates math, reading, writing, study skills, and an introduction to the college application writing process. The course is intended for employees with at least a high school diploma or its equivalent who need 1 to 2 years of pre-college course work in order to pass the College Placement Exam. It is a 20 week, three hours per week course totaling 60 hours of classroom instruction. An outside training vendor develops a list of online resources and the instructor provides assignments to students to complete outside of the allotted classroom time. Both of the pre-college courses are taught by licensed instructors from outside vendors such as Jewish Vocational Service or a local community college such as Bunker Hill Community College, Massachusetts Bay Community College, or Roxbury Community College. The two in-depth pre-college courses are different from the strategy of the Training Institute. The Institute offers several courses that are designed as short modules which allow participants to enroll in an array of courses while PCWD offers two pre-college courses that are designed to go in-depth in basic skills, which is aimed at helping participants prepare for college.

PCWD's Organizational Structure

The Partners in Career and Workforce Development intermediary has expanded well beyond its predecessor, Project RISE. PCWD is much more than just an employment and training program. It has built partnerships across Partners' affiliated hospitals and medical centers and has branched out to form partnerships with

community and social service organizations, post-secondary educational institutions, and training providers. Along the way, the executive staff of PCWD has been able to keep the organization operating with the help of their partners to ensure that the workforce intermediary is improving the quality, outcomes, and sustainability of the partnership. In this section I will describe how PCWD is structured and explain each partner's role within the intermediary. I will examine the following:

- PCWD Management Teams;
- Community and Social Service Organizations;
- Educational Institutions; and
- Employers

PCWD Management Teams

PCWD's management structure consists of three core teams—an Administrative Team, a Leadership Team, and a Pre-Employment Program Team. The Administrative Team is comprised of three individuals—the PCWD project director, a workforce development specialist, and an information and communication manager. This team is responsible for the day-to-day operations of the intermediary and for the strategic planning and long-term agenda of PCWD. The individuals who make up this team work tirelessly to ensure that PCWD is meeting its objectives and growing stronger as a program.

The Leadership Team (in conjunction with the Administrative Team) is responsible for program direction and employer engagement. The team is comprised of all three members of the Administrative Team as well as the program manager for

training and workforce development at MGH, the manager of workforce development for BWH, and a representative from the human resources department at Spaulding Rehabilitation Hospital. The Leadership Team is important because it is responsible for maintaining and building relationships with the primary employers—MGH, BWH, Spaulding Rehabilitation Hospital, and Whittier Street Health Center. The Leadership Team makes sure that all components of PCWD are running as smoothly as possible and that employers' needs are being met.

Finally, the Pre-Employment Team rounds out the key management staff of PCWD. It is comprised of the project director of PCWD, the PCWD Pre-Employment Program coordinator, a workforce career specialist from Project HOPE/Transition-to-Work, and the lead instructor at Jewish Vocational Service. The Pre-Employment Team has a fair amount of autonomy to make critical day-to-day decisions in how employment and training are delivered to pre-employment job seekers. The Pre-Employment Team develops the curriculum, helps set up internships, and is responsible for contacting employers on behalf of PCWD graduates.

Overall the leadership of PCWD's executive team's has played an instrumental role in helping to improve the quality and broaden the scope of PCWD. They have learned to be advocates for their graduates, are creative in their management style, and are flexible enough in their decision making to address any internal and external forces that may negatively impact the intermediary. These actions have improved the quality, outcomes, and sustainability of PCWD. For example, PCWD administrators realized early on that the Pre-Employment Program suffered from negative stereotypes that prevented some HR staff and department managers and supervisors from fully

engaging with the program. The staff of PCWD responded by developing an informal integrated network of supporters of the program throughout the Partners HealthCare System. The establishment of this integrated network has helped to raise the recognition of PCWD within the Partners HealthCare System and has also helped PCWD graduates find employment opportunities via word. As a matter of fact, 52% of PCWD participants who are successful in gaining employment, do so based on internal “contacts” PCWD staff have with others within the Partners HealthCare System.

Community and Social Service Organizations

One of the key lessons learned by the administration at Partners HealthCare through their experience with Project RISE was the fact that they knew very little about how to recruit neighborhood residents and evaluate their ability to succeed through completing an employment and training program. During Project RISE, Partners HealthCare administrators realized early on that residents had a number of economic, social, and personal issues that each had to deal with on almost a daily basis (i.e., domestic abuse, lack of child care, history of drug and alcohol abuse, etc). Many external issues forced participants to drop out of the Pre-Employment Program altogether or prevented them from maintaining long-term employment. Partners’ staff realized that job readiness, skills training, and education were just part of a comprehensive strategy needed to help many economically disadvantaged, chronically unemployed adults succeed in the workplace. It became apparent to everyone involved with Project RISE that these individuals may also need additional services

such as career coaching, case management, and in some instances, access to family counseling, to name a few. For the Training Institute, this was a strength that the intermediary has possessed under the leadership of JPNDC and FCDC, while Partners HealthCare has struggled to develop a comprehensive community and social network of community-based organizations.

During the planning and development phase of PCWD, Partners' administrators were determined not to repeat the same mistakes of Project RISE. They decided to establish partnerships with local community and social service organizations and put them in charge of the recruitment, assessment, career coaching, and case management of any PCWD participants in need of these support services. As a Brigham and Women's human resources staff member stated, "We are experts in health care but not in education, career coaching, etc. This is why we [Partners] decided to create partnerships with other organizations that could provide a benefit to our organization." By reaching out to community and social service organizations who have proven track records in providing social support to economically disadvantaged adults, Partners hoped to create a support network that would help participants succeed in the Pre-Employment Program and in their jobs.

Project Hope's Transition to Work Collaborative (TTW) is the community partner in charge of recruiting and assessing prospective participants for PCWD's Pre-Employment Program. Located in the heart of Dorchester, TTW is a partnership of seven Boston family shelters, Boston Health Care for the Homeless, Greater Boston Legal Services, and the University of Massachusetts, Boston. It was founded in 1998 and assists homeless parents in finding employment. TTW was the ideal partner for

PCWD because of the organization's long-term commitment to serving the neighborhoods of Dorchester, Mattapan, and Roxbury. In addition, TTW commands a fair amount of respect and credibility among neighborhood residents. More importantly, TTW is easily accessible to a large number of economically disadvantaged and under-skilled residents and the organization is less intimidating than a hospital may be when these individuals are looking for employment. This sentiment was expressed by an administrator at TTW, "We have more flexibility than Partners at reaching out to low-income residents. If a hospital runs the program it can't go deeper than an outside organization." This is a clear advantage that TTW has over Partners HealthCare, especially when it comes to recruiting and evaluating a residents' personal situation, background, and ability to succeed in the Pre-Employment Program. TTW is able to recruit between 30-40 perspective residents for each of PCWD's four pre-employment training cycles per year.⁷ These residents all have high school diplomas or GED's. In addition to recruiting neighborhood residents, TTW completes all the initial screening of applicants which includes the following:

- Administering the Test of Adult Basic Education (TABE) and computer test,
- Conducting interviews,
- Initiating the mandatory criminal background check through the Criminal Offender Record Information (CORI) system, and
- Providing the orientation for new PCWD participants.

⁷ Generally, it takes about three to four times the number of applicants in order to fill each PCWD Pre-Employment Program cohort with 10-15 participants. Many people are excluded from the Pre-Employment Program because they do not score well on the TABE, do not pass the CORI check, etc.

If a prospective applicant is not admitted into the PCWD Pre-Employment Program, TTW works to assist them in obtaining additional training and education or helps them with their job search.

The relationship between Partners HealthCare and TTW has its challenges. One of the main challenges is trying to select residents who will succeed in the program and on the job. Neither Partners nor TTW want to see residents fail, but sometimes tension can arise over who is selected to participate in the program and who is not. TTW has an interest in placing as many residents in jobs as possible and Partners has an interest in seeing PCWD be successful in the number of residents it trains and employs. However, if residents do not succeed it reflects poorly on Partners and TTW. If a difference of opinion arises over a participant's background or ability to successfully complete the program, special meetings between TTW staff and the PCWD administrators to resolve the difference. This is a reflection of PCWD's flexibility. Each prospective candidate is evaluated on a case by case basis and their whole background—personality, test scores, motivation, personal situation, etc. are all taken into consideration when determining who will be accepted into the program.

Another key partner in supporting the development of PCWD participants is Worksource Staffing Partners Inc (WSP). WSP is an organization that specializes in entry-level employee career development and career and life counseling. WSP has had a long history of working with Partners HealthCare. They originally helped Partners' executives develop the early stages of the training program for Project RISE. As a PCWD partner, WSP provides the career counseling and career planning services to participants. This organization tries to help participants identify their career goals

by providing them with resources pertaining to health care careers, educational opportunities, and additional training programs.

Despite WSP's efforts to provide career counseling and support, the organization struggles to strike a balance between the needs of employers and the needs of entry-level employees. In working with employers, WSP sometimes has to determine which PCWD participants are motivated and willing to make the sacrifices necessary to succeed and which still have several social issues to deal with that might prevent them from making career advancements. This is a real challenge because, according to most of the members of PCWD, motivation and commitment are the key factors in determining the success of a particular participant. Motivation is hard to measure and, from a human resources perspective, it does not show up on a resume. HR is more interested in measurable criteria when trying to assess whether or not a particular individual is capable of employment, such as work experience and education.

Overall, the community and social service organizations are critical to the success of PCWD participants. These organizations provide the social support and resources that are often times needed for populations who are struggling to succeed. These organizations are constantly trying to find a middle ground between selecting participants who will succeed and those who may need additional help in succeeding. This has led to numerous discussions between employers and the organizations about "creaming," a situation where higher caliber individuals are selected to participate in the program at the expense of individuals who may need additional supports. As the skills requirements continue to increase and technology plays a larger role in the day-

to-day tasks of entry-level positions, the issue of selecting individuals who are likely to succeed versus those who require a higher degree of employment and training services will continue.

Educational and Training Organizations

The clear distinction between PCWD and other workforce development intermediaries, such as the Training Institute, is the intermediary's strong focus on college education. Partners' administrators have made a conscious decision to encourage all of their employees, especially those working in entry-level positions, to seek a college education. The administrators involved with PCWD believe that, in order for employees to succeed and progress along a career ladder, they need to be committed to lifelong learning. As a result, Partners HealthCare has established partnerships with local community colleges to provide education and certificate programs in health care-related fields for PCWD participants and other Partners employees. Currently, PCWD is working with MassBay Community College to encourage employees to enroll in the surgical technology certificate program. The certificate program requires 35 credits, but it is not clear as to whether the program allows employees to attend part-time. PCWD is also working with Bunker Hill Community College to develop a respiratory therapist program which is expected to be ready for the Fall 2006 semester. In order to make it easier for employees to afford these educational programs, Partners offers employees tuition reimbursement assistance. Depending on the number of hours an employee works a week, Partners provides them with tuition reimbursement for educational expenses. Partners'

relationship with community colleges is significant in many ways because it sends the message to employees that education and training is a priority of the organization. It also sends the message that additional education and training is necessary in order to advance within the organization.

Jewish Vocational Service (JVS) is another important educational partner of PCWD. JVS is an organization that provides workforce development services to the public and private sector. JVS' role within PCWD is to be the lead training provider. It provides the lead instructor for the Pre-Employment Program and is also responsible for leading the two pre-college courses for incumbent workers. JVS' instructors are all certified and most have master's degrees or higher. The involvement of JVS in PCWD grew from their previous relationship with Project RISE. During Project RISE, JVS was the original training provider and their relationship with Partners has grown over the years.

JVS' social mission and experience provides the right balance for helping PCWD participants succeed. The organization has years of experience in providing training and educational support to non-traditional groups. In one particular class, JVS brought in an outside speaker from their organization who specialized in the federal food stamp program. JVS was also responsible for the development of the Career Planning Tool website.

Employers

When PCWD was first formed, some HR staff and hospital administrators were skeptical of its employment and training component, while others simply wanted

nothing to do with it. There are several reasons for this. One has to do with the outcomes and failures of Project RISE as I have already mentioned. This has led to stereotypes and disparaging remarks about PCWD by Partners' employees. In addition to the negative stereotypes, some HR managers and hospital administrators view the participants of the PCWD Pre-Employment Program as "different." They do not identify with the background and lived experience of some of the pre-employment participants which has at times led to cultural and racial bias.

Another reason why employers have been slow to fully embrace PCWD is because the economy has changed. During the late 1990s when Project RISE began, more entry-level employment opportunities existed for neighborhood residents within the hospitals. Massachusetts was experiencing record low unemployment which led to a tight labor market. Since then, several structural factors have altered the local health care labor market. One factor is that Boston's economy has weakened and unemployment rates have risen, creating a higher surplus of labor than that of late 1990s and early 2000s. As a consequence, competition among qualified applicants for health care jobs increased and employers no longer needed to rely on workforce intermediaries to supply them with qualified applicants. Quite the opposite is true. It is typical for employers to screen out hundreds of applications for many health care positions, even at the entry-level.

A second structural factor directly affecting the health care labor market is technology. Technological innovation within hospitals has created a larger skills gap between under-skilled residents and the entry-level positions that exist. This skills mismatch appears to be growing so employers have very little patience or need for

employees who lack a basic understanding of computer skills. Moreover, technological innovation has also enabled employers to consolidate jobs by increasing the responsibilities of each occupation. This in turn further increases the skills mismatch between PCWD Pre-Employment Program participants and available jobs and also results in more people applying to fewer entry-level positions (i.e., administrative and laboratory technology-related positions).

Despite all of these challenges and structural factors, employers remain strong partners in PCWD. A key reason for this has to do with the fact that much of PCWD's services are funded through outside grant programs such as SkillWorks, which has greatly reduced the financial commitment that Partners HealthCare would have to contribute to sustain the program, but perhaps the biggest reason they remain involved is political pressure. As one of the largest private employers in Boston, Partners HealthCare executives understand that the health care sector must do more to support the well-being and economic opportunities of Boston residents. In the next section, I will discuss just how well they have been doing in helping economically disadvantaged, under-skilled individuals obtain employment within the health care sector and advance along a career ladder.

Participant Outcomes

Up until this point I have discussed the history, operations, and structure of PCWD. In this section I will provide an overview of the demographics of PCWD's Pre-Employment Program participants and their incumbent workers. I will then discuss the outcomes of the PCWD Pre-Employment Training Program over the last

two years. Unfortunately, I will be unable to provide the outcomes for the incumbent worker group because Partners HealthCare is in the process of collecting this data. Finally, I will discuss the barriers and opportunities that exist for pre-employment job seekers based on survey data collected from a small sample of participants.

During the two-year period (from January 1, 2004-December 31, 2005), 96 individuals enrolled in the PCWD Pre-Employment Training Program. The majority of the enrollees belong to ethnic minority groups. Almost two-thirds of participants were Black/African-American (60) and 21% were non-white Hispanics (20). Whites accounted for 12% (11) of all enrollees and there was only one person who identified themselves as Asian/Pacific Islander. Eighty-seven percent of participants were U.S. citizens and 10% had resident alien status. Similar to many training programs, especially those in the health care profession, 94% of the participants were female (89). This is because many men view health care occupations such as nursing and patient care as female specific jobs. Another reason why workforce intermediaries such as PCWD and the Training Institute are dominated by women is because many young, minority men living in economically disadvantaged communities are involved with the criminal justice system. By 2000, 12% of black men in their twenties were incarcerated and over 20% of all black men between the ages of 25-44 had been in prison at least once in the U.S. (Bonczar 2003; Oliver, Sandefur, Jakubowski, and Yocom, 2005). Overall the latest statistics suggest that among all African American men, roughly 1 in 3 are under the supervision of the U.S. criminal justice system.⁸ Criminal records prevent these men from taking advantage of employment and training programs and, on a larger scale, having a criminal record limits their job

⁸ The University of Wisconsin Racial Disparities Project. 2006.

opportunities and long-term earnings potential necessary to lift themselves and their family out of poverty.

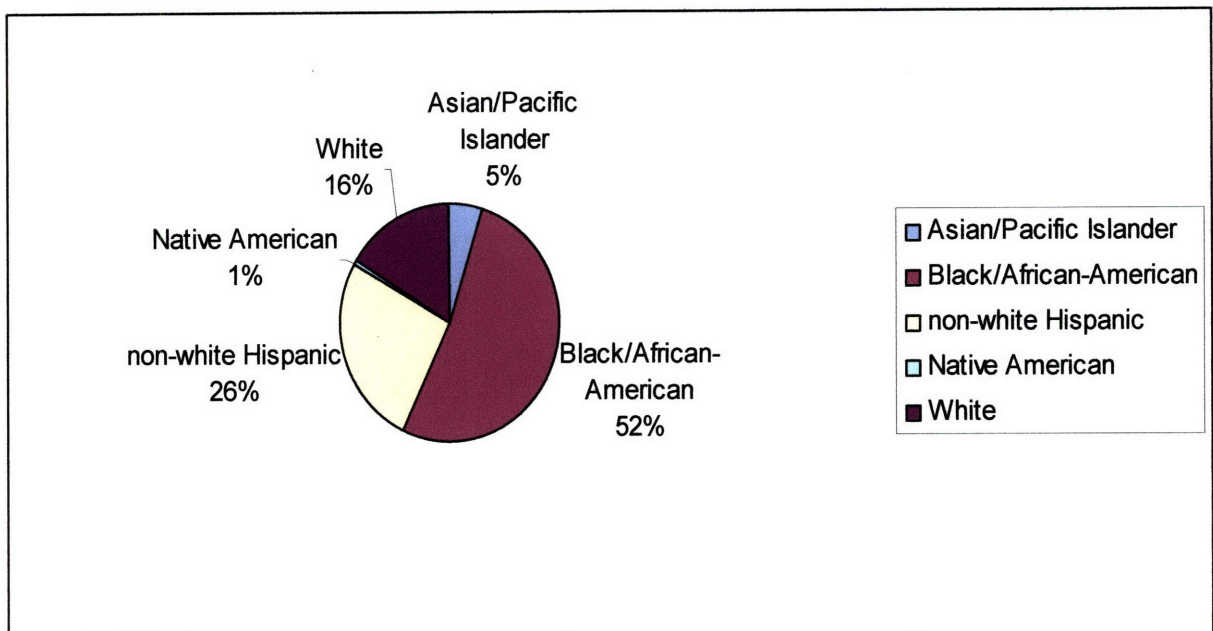
Among the pre-employment participants who reported their annual household income, just over 75% had annual household incomes of less than \$10,000. This data suggests that PCWD is serving severely low-income individuals. The second largest group had annual household incomes of between \$10,000 and \$24,999 (20%). Combined, an astonishing 96% of PCWD Pre-Employment Training Program enrollees had annual household incomes below \$25,000.

Among those who reported their marital status and family structure, 70% of participants (66 individuals) were single and, among this group, 91% had at least one child (60 individuals). Eleven of the 96 enrollees were married (12%), 7 were separated from their spouse (7%), 5 living with their partners (5), 4 had been divorced (4%), and 2 were widows (2%). Finally, 14 of the enrollees were both married and had at least one child (15%).

There is a demographic difference between the pre-employment job seeker group and the PCWD incumbent workforce group. During the same period between January 1, 2004-December 31, 2005, PCWD enrolled almost 400 incumbent workers in their two pre-college courses. Among this group, just over half were Black/African-Americans (52%) and 26% were non-white Hispanics. Together these two groups accounted for nearly 8 out of every 10 pre-college enrollees. Sixteen percent of PCWD incumbent worker participants were white and 5% of participants identified themselves as Asian/Pacific Islander (see below for CHART #1: Race/Ethnicity of PCWD Incumbent Workforce). Two-thirds of the incumbent

workers were U.S. citizens and 31% had resident alien status, in contrast to the pre-employment participants, where 87% were citizens and only 1 in 10 had alien resident status. This suggests that more immigrants who were already working took advantage of PCWD’s training services compared to those who are not yet employed.

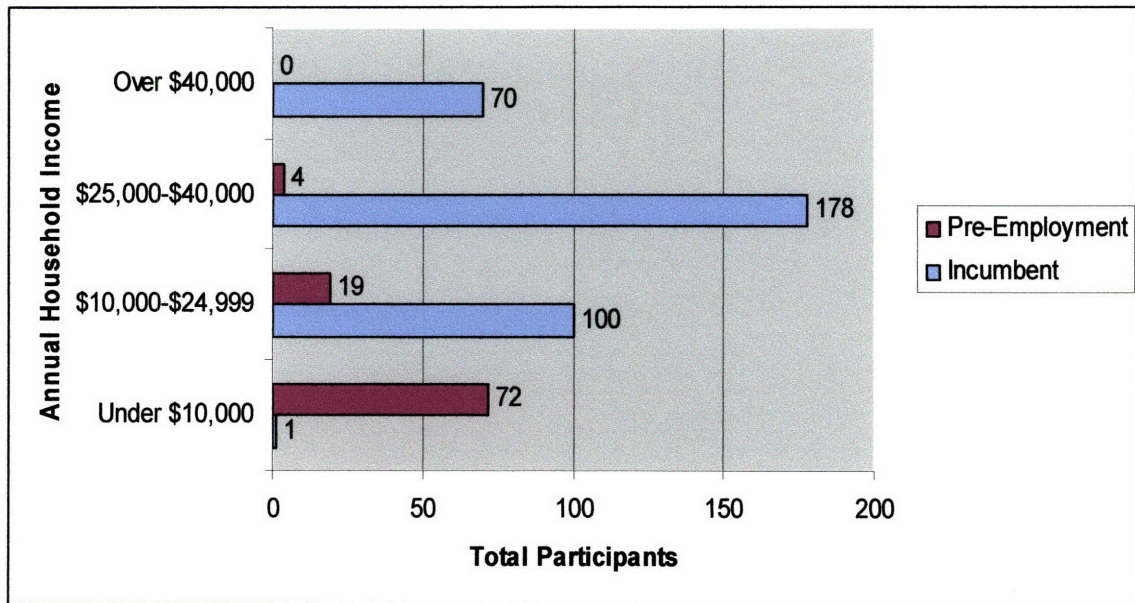
CHART #1: Race/Ethnicity of PCWD Incumbent Workforce



As would be expected, the incumbent worker group had higher annual household incomes when compared to the pre-employment group. Just over half of all incumbent workers who reported their annual household income made between \$25,000 and \$40,000 (51%). Twenty percent reported an annual household income over \$40,000 (70 individuals) and, on the other end of the scale, 29% (100 individuals) reported that they earned between \$10,000 and \$24,999). Only 1 individual reported having an annual household income of less than \$10,000 (see below for TABLE #11:

Comparison of Annual Household Income between PCWD Incumbent and Pre-Employment Individuals).

TABLE #11: Comparison of Annual Household Income between PCWD Incumbent and Pre-Employment Individuals



The marital and family status of the incumbent worker group was balanced. Among those who reported their marital status, 48% were single (184 individuals) and 36% were married (140 individuals). Among those who were single, 65% had at least one child, of those who were married, 89% had at least one child. Twenty-five percent of incumbent workers (89 individuals) reported their family status as other and 4% reported being a couple, but not married (15 individuals).

Next, I focus on the outcomes of the PCWD Pre-Employment Training Program. As I have already mentioned, a total of 96 individuals enrolled in the PCWD Pre-Employment Program between January 1, 2004-December 31, 2005. During that time, PCWD has run 8 pre-employment cycles. Among the 96 enrollees,

89 completed the five-week Pre-Employment Training Program for an overall retention rate of 93%. Out of the 89 individuals who completed the PCWD Pre-Employment Training Program, just over three-fourths (76% or 68 individuals) got jobs working for Partners HealthCare or Bullfinch Temporary Service (BFT), a temporary staffing service that is part of the Partners HealthCare network. BFT provides temporary staffing to all Partners HealthCare affiliates, including MGH, BWH, Faulkner Hospital, Newton Wellesley Hospital, North Shore Medical Center, Spaulding Rehabilitation Hospital, and McLean Hospital in addition to many primary care medical practices affiliated with Partners.⁹ This is noteworthy because once you calculate the number of PCWD pre-employment graduates who were hired, BFT accounts for 35% (24 individuals) of the total. Overall, the median starting hourly salary for all PCWD pre-employment graduates is \$11.50 (\$11.86 on average) or almost \$24,000 annually for a person working full-time. After separating out BFT employees, the median starting salary is the same for individuals hired by Partners HealthCare, but the average starting wage is slightly lower at \$11.83. For BFT hires, the median starting hourly wage is a bit higher at \$11.75 and the average starting hourly wage is almost \$12.00 (\$11.98). However, unlike Partners HealthCare, BFT does not offer employee benefits, which is a critical need for low-income working adults with dependent children. Among those hired by Partners, 98% qualified for the employee benefits package which includes, but is not limited to, a medical/dental/vision plan, short- and long-term disability, paid time off, a 401(K) retirement plan, and life insurance. So even though the average starting hourly wage is marginally lower for the Partners HealthCare hires when compared to those hired by

⁹ Massachusetts General Hospital. 2006. www.mgh.harvard.edu/jobs/bulfinch.htm

BFT, once you include Partners' benefits package and the opportunity for relatively long-term job stability, there is no comparison in terms of which outcome provides the most opportunity for entry-level workers.

Given that all the PCWD graduates went through the exact same training and job readiness preparation, it is important to examine what other factors might differentiate between those hired by BFT and those hired by Partners HealthCare System. On the surface there appears to be no obvious difference, but after analyzing each groups Test for Adult Basic Education (TABE) scores I found a difference in average scores between the two groups. All of the participants were given the TABE, which tests for reading and writing aptitude. Each person was given a score ranging from 6-12 representing secondary grade levels. If a person received a 9 in reading and 8 in writing, this suggests that their reading at the 9th grade level and that their writing at the 8th grade level. If you combine the maximum score for both the reading and writing it would equal 24. For each participant I combined their TABE scores and then compared the average TABE scores of the BFT and Partners hires. There was a notable difference between the BFT group, which had an average combined TABE score of 15.4, and the Partners group which had an average combined TABE score of 18.4, a difference of 3 grade levels. Unfortunately, the number of participants between the two groups was too small to determine if the difference in TABE scores between the BFT hires and Partners hires was just random or was the difference statistically significant. However, it still was worth noting.

Partners divided PCWD graduates' jobs into three categories—administration, allied health, and general clerical. The difference between the administration category

and the general clerical category is that general clerical jobs' responsibilities tend to not be clearly defined. A person hired as a general clerical worker may end up doing many different clerical tasks within the hospital such as charting, filing, etc., while someone hired in an administrative position usually has a job with a clear set of tasks that do not change from day-to-day. An analysis of the employment data shows that between January 1, 2004 and December 31, 2005, 60% of all jobs were in administration, 20% were in general clerical, and 19% were in allied health occupations. Just over half of the pre-employment group were hired full-time (55%), 10% were hired part-time, and as I already stated, 35% were hired temporarily. Unfortunately, not all of the graduates succeeded in the workplace. A total of 19 individuals were terminated (6 were voluntary terminations), which results in a retention rate of 72% for PCWD pre-employment hires. I was unable to obtain overall retention rates from any of the hospitals making it impossible to state whether or not these stats are in line with other Partners employees.¹⁰

Conclusion

PCWD has only been in existence for just over two years. During this time the intermediary has worked hard to develop a positive name for itself within Partners HealthCare. This has not been easy because many HR staff, managers, and supervisors still associate PCWD with its predecessor Project RISE, although this is slowly changing. As a result, PCWD and its participants have had to overcome negative stereotypes and cultural biases. The leadership of PCWD has responded by

¹⁰ Each hospital views retention and turnover rates as confidential and was not willing to share that data with me.

establishing a wide network of health care professionals and administrators within the Partners HealthCare System who are supportive of PCWD and its employment and training programs.

PCWD has also attempted to drastically improve the quality and outcomes of their employment and training programs. PCWD has a greater focus on not just basic skills and education, but on post-secondary education. The intermediary has established and is continuing to establish relationships with local community colleges to develop health care-related certificate programs geared towards Partners HealthCare employees. Realizing that more skills and education are needed in order to succeed within the health care industry, PCWD, like the Training Institute, has raised their entry-level requirements for individuals enrolling in the Pre-Employment Training Program. Despite less than stellar results in the first year of the Pre-Employment Program, PCWD has improved dramatically in the second year by increasing graduation rates, retention rates, and helping workers secure higher average starting wages.

There is still much room for improvement as PCWD continues to evolve. One of the key developments of the program is to increase the social support and resources available to pre-employment participants. PCWD's evolving relationships with community and social support organizations is playing a larger role in helping marginalized populations succeed during the 5-week training program and on the job. These wrap around services help individuals who, under normal circumstances, would have had a difficult time succeeding.

If economically disadvantaged, under-skilled adults are going to succeed in finding meaningful employment, workforce intermediaries such as PCWD and the Training Institute will need to continually improve their outcomes and increase the scale of their programs to have greater impact. In order to accomplish these goals, it is important to understand which elements of these intermediaries work and which elements do not. In the case of PCWD, the intermediary has been successful in addressing some of the key elements necessary to be successful at helping low-skilled adults obtain employment within the health care sector and advance along a career ladder. For example, PCWD has been entrepreneurial in shedding the old negative stereotypes of Project Rise by gaining the support of Workforce Development Champions and others within and outside of Partners HealthCare that are supportive of the intermediary. PCWD has also learned to develop an advocacy agenda that is focused on helping participants of the Pre-Employment Training Program obtain jobs within the health care sector. PCWD has a long ways to go, but it is slowly developing a strategy that may began to develop many of the key elements outlined by Giloth, Kazis, and others about what programmatic functions help lead to successful workforce intermediaries.

PCWD's outcomes over the last two years have been relatively modest and have had only a slight impact in meeting Partners' employment needs. During the last two years, PCWD has enrolled 96 individuals in their Pre-Employment Training Program and has provided training to roughly 150 incumbent workers. In all PCWD has provided training services to 246 individuals at a cost per person of about \$1,350. This is less expensive than the Training Institute's cost of \$2,000 per person. In the

next chapter I will compare and contrast the key elements of PCWD and the Training Institute in order to determine which has been the most successful at helping economically disadvantaged, under-skilled Boston residents obtain employment within the health care sector and advance along a career ladder. I will base my analysis on two factors. I will conduct a present value analysis of human capital for the pre-employment participants of both intermediaries to determine over a 10-year period which intermediary is likely to be most effective at helping participants increase their economic opportunity. I will also use the theoretical framework developed by Robert Giloth to determine based on his five characteristics of successful intermediaries, how these intermediaries actually performed.

CHAPTER FIVE: CONCLUSION

In this concluding chapter I conduct a comparative analysis of the Training Institute and PCWD. I discuss which intermediary over the last two years has been most effective at helping under-skilled, economically disadvantaged adults obtain employment within Boston's health care sector and advance along a career pathway. I discuss the factors that most likely contributed to the difference in outcomes between the two intermediaries. Finally, I end by discussing the future of workforce intermediaries and what role they play and will continue to play in our current public workforce development system.

Comparative Analysis of the Training Institute and PCWD

My research findings of the participant outcomes for both the Training Institute and PCWD are mixed. The Training Institute is more effective than PCWD in helping under-skilled adults obtain employment within the health care sector, although the difference between the two intermediaries' outcomes was modest. I measured six factors to determine each intermediary's effectiveness. The factors that I used to determine effectiveness are as follows:

- Number of individuals completing the Pre-Employment Training Program and/or taking advantage of pre-employment services (i.e. resume writing workshops, job interviewing skills, ESOL classes, etc.);
- Number of individuals obtaining jobs within the health care sector;
- Starting hourly wage of Pre-Employment Training Program graduates;

- Number of promotions and wage increases;
- Retention Rates;
- Types of occupations pre-employment participants obtained within the health care industry; and
- Average cost to train each person.

Between January 1, 2004 and December 31, 2005 the Training Institute provided pre-employment training and services to 164 individuals, while PCWD provided pre-employment training and services to 89 individuals. Although the Training Institute provided pre-employment training and services to more individuals than PCWD, only 57 individuals obtained employment with a partner-affiliated employer within the health care sector. In the case of PCWD, 68 out of 89 individuals who completed the Pre-Employment Training Program obtained jobs within the health care sector (see below Table #12 Training Institute and PCWD Pre-Employment Training Program Participant Outcomes). Even though this was more than the Training Institute, a large percentage of PCWD pre-employment graduates were hired by Bulfinch Temporary Service, a temporary staffing agency that is affiliated with Massachusetts General Hospital. Just over a third of PCWD graduates (24 individuals) were hired as temporary workers, thus only 44 of PCWD's graduates obtained permanent health care positions. PCWD's total of 44 participants obtaining permanent health care jobs fell short of the 57 placed in permanent positions by the Training Institute.

TABLE #12: Training Institute and PCWD Pre-Employment Training Program Participant Outcomes

	Training Institute	Partners Career in Workforce Development
Length of Pre-Employment Training Program	12-weeks	5-weeks
Total No. of Participants Receiving Pre-Employment Training and Services	164	89
Total No. of Participants Employed by Health Care Employers	57	68*
Average Starting Hourly Wage	\$12.28 (\$22.28 w/benefits)	\$11.86 (\$18.40 w/benefits weighted for temp employees)
Median Starting Hourly Wage	\$12.00	\$11.50
Two-Year Retention Rate	89%	72%
Total No. of Promotions	10	10
Occupational Mix	30% Administrative; 30% Laboratory Technology-related; 26% Patient Care; 14% Other health-related	60% Administrative; 20% General Clerical; 20% Allied Health
Estimated Cost Per Participant**	\$2,000	\$1,353

*24 were hired by Bullfinch Temporary Service, an affiliate of Partners HealthCare System

**Cost per person is based on total number of participants for pre-employment and incumbent workers

In addition to the difference in the number of individuals placed within health care occupations, the Training Institute and PCWD also differ in a number of other important areas. One major difference is the starting hourly wage of pre-employment graduates. Training Institute pre-employment participants had an average starting hourly

wage of \$12.28 and a median starting hourly wage of \$12.00 compared to PCWD's \$11.86 and \$11.50 respectively. Another major difference between the two intermediaries is the two-year retention rate for pre-employment participants. The Training Institute's participants had an 89% retention rate for the two-year period compared to PCWD graduates' low retention rate of 72%.

Another difference between the outcomes of the Training Institute and PCWD has to do with the cost of training each participant. The Training Institute costs about \$2,000 per participant while PCWD costs roughly \$1,353 per participant. Even though the cost per participant is lower, the Training Institute has a higher retention rate which can save employers money down the road on recruitment and on-the-job training costs. According to estimates made by the Saratoga Institute, the Institute for Healthcare Improvement, and the Voluntary Hospital Association, the cost of employee turnover is estimated to be between .5 and 2.5 times an employee's annual salary. I believe .5 is a more realistic estimate of the cost of employee turnover in the health care profession for entry-level positions. To get a better sense of which program is the best investment for hospital employers I conducted a cost benefit analysis. Assuming that the average entry-level employee annual salary is about \$24,000, it would cost health care employers approximately \$12,000 to recruit and train a new employee. Since hospitals were unwilling to share their retention data with me, I worked under the assumption that the hospitals in Boston have a retention rate of 85%, the national average for U.S. hospitals. Therefore, for both the Training Institute and PCWD, the expected retention rate for graduates of their training programs would be 85%. In order to determine how much each program saved or cost hospitals in turnover costs I used the following formula:

$(1 - \text{national retention rate}) * (\text{cost of employee turnover})$ minus the difference
 $(1 - \text{actual retention rate for each training program}) * (\text{cost of employee turnover}) / (1 - \text{annual discounted value}) - (\text{cost of training per participant})$.

In the case of the Training Institute it would be the following:

$$(1 - .85) * (\$12,000) - (1 - .89) * (\$12,000) / (1 + .04) - \$2,000 = -\$1,538$$

The Training Institute costs hospital employers \$1,538 a year per employee on turnover costs.

In the case of PCWD, the savings or costs to hospital employers on turnover would be the following:

$$(1 - .85) * (\$12,000) - (1 - .72) * (\$12,000) / (1 + .04) - \$1,353 = -\$2,853$$

PCWD costs hospital employers \$2,853 a year per employee on turnover costs. The Training Institute and PCWD both costs hospitals more money they it would cost them to recruit a person off the street. From a purely cost benefit analysis it is not cost effective for employers to invest in the either workforce intermediary. However, a cost benefit analysis from the employers perspective is just one way to calculate the benefits of the Training Institute and PCWD. One would also have to take into consideration the benefit to the employee.

Which intermediary is most effective in raising a graduate's wages over the long-term, say over a 10-year period? I conducted a net present value analysis which allowed me to assume the difference in wages if the average PCWD and Training Institute participants completed the Pre-Employment Training Program or if they decided to continue working without seeking additional training. The average annual salary for

PCWD pre-employment participants was about \$15,000 (\$7.21 per hour). Assuming that an individual was able to continue working over a 10-year period, their earnings assuming a 3% annual raise at the end of the period would be \$19,572. However, if that same individual decided to seek additional training by enrolling in PCWD's 5-week Pre-Employment Training Program, they would make more money over the 10-year period. The initial decision to enroll in the Pre-Employment Training Program costs an individual 5 weeks of salary (\$7.21 per hour) which would equal \$1,442. However, after receiving training the average PCWD participant earns \$11.86 an hour. Since all permanent employees working full-time receive full benefits, the average starting wages including benefits for PCWD participants would be \$18.40 (weighted for number of individuals hired by Bullfinch Temporary Service agency). Over a 10-year period, assuming a 3% annual increase in salary, the individual would earn \$49,936 a difference of \$21,334 between their annual salaries taking into account an annual discounted value of 4% if they decided to forgo additional skills training (see below).¹

I also conducted the same analysis for the Training Institute. The average annual pre-training salary for the pre-employment participants was about \$20,500 (\$9.90 per hour). Assuming that an individual was able to continue working over a 10-year period, their earnings assuming a 3% annual raise at the end of the period would be \$26,748. However, if that same individual decided to seek additional training by enrolling in the Training Institute's 12-week Pre-Employment Training Program, they would make more money over the 10-year period. The initial decision to enroll in the Pre-Employment Training Program costs an individual 12 weeks of salary (\$9.90 per hour) which would

¹ This assumes that PCWD participants' pre-training jobs did not include benefits, which based on the pre-employment data suggests is an accurate assumption.

equal approximately \$4,750. However, after receiving training the average Training Institute participant would earn \$12.28 an hour not including benefits. Once you factor in benefits, the average hourly salary for Training Institute participants would be \$22.28. Over a 10-year period, assuming a 3% annual increase in salary, the individual would earn \$60,466 a difference of \$23,690 between their annual salaries (taking into account the annual discounted value of 4%) if they had decided to forgo additional skills training.² Based on the total net present value of enrolling in training, it appears as though the Training Institute in the long-run would help raise low-income Boston resident's annual salary the most a total net present value for the 10-year period of \$242,770 versus a total net present value for the 10-year period of \$221,462 for PCWD. This is simply because the jobs that Training Institute participants obtain are better quality jobs. The balance of jobs that Training Institute participants obtain are not just in administrative positions, but are also in laboratory technology-related positions, and patient care. For example, Training Institute participants were more evenly distributed across administrative (30%), laboratory technology (30%), patient care (26%), and other health-related occupations (14%), while PCWD's participants primarily obtained administrative and clerical jobs (80%) and more than a third were hired for temporary positions.. Although some administrative and clerical jobs pay a livable wage and provide benefits, the upward mobility of these types of jobs is more limited than in nursing or direct patient care health occupations

² This assumes that Training Institute participants' pre-employment jobs did not include benefits, which based on the pre-employment data is an accurate assumption.

TABLE #13: Net Present Value of extra income from training

	Years	0	1	2	3	4	5	6	7	8	9
Training Institute											
Cost to employee	-\$4,750										
Income with training		\$41,592	\$47,732	\$49,164	\$50,639	\$52,158	\$53,723	\$55,335	\$56,995	\$58,705	\$60,466
Income without training		\$20,500	\$21,115	\$21,748	\$22,401	\$23,073	\$23,765	\$24,478	\$25,212	\$25,969	\$26,748
Extra income from training		\$21,092	\$26,617	\$27,416	\$28,238	\$29,085	\$29,958	\$30,857	\$31,782	\$32,736	\$33,718
	102.89%	126.06%	126.06%	126.06%	126.06%	126.06%	126.06%	126.06%	126.06%	126.06%	126.06%
NPV of extra income		\$21,092	\$25,594	\$25,347	\$25,104	\$24,862	\$24,623	\$24,386	\$24,152	\$23,920	\$23,690
Total NPV of extra income (inflation-discounted)		\$242,770									

Assumptions Training Institute:

base salary with training \$46,342
 base salary without training \$20,500
 rate of salary increase 3%
 inflation rate 4%
 12-week training program

	Years	0	1	2	3	4	5	6	7	8	9
PCWD											
Cost to employee	-\$1,442										
Income with training		\$36,830	\$39,420	\$40,603	\$41,821	\$43,075	\$44,368	\$45,699	\$47,070	\$48,482	\$49,936
Income without training		\$15,000	\$15,450	\$15,914	\$16,391	\$16,883	\$17,389	\$17,911	\$18,448	\$19,002	\$19,572
Extra income from training		\$21,830	\$23,970	\$24,689	\$25,430	\$26,193	\$26,979	\$27,788	\$28,622	\$29,480	\$30,365
	145.53%	155.15%	155.15%	155.15%	155.15%	155.15%	155.15%	155.15%	155.15%	155.15%	155.15%
NPV of extra income		\$21,830	\$23,048	\$22,827	\$22,607	\$22,390	\$22,174	\$21,961	\$21,750	\$21,541	\$21,334
Total NPV of extra income (inflation-discounted)		\$221,462									

Assumptions PCWD:

base salary with training \$38,272
 base salary without training \$15,000
 rate of salary increase 3%
 inflation rate 4%
 5-week training program

Explaining the Differences in Pre-Employment Participant Outcomes between the Training Institute and PCWD

There is clear evidence that the Training Institute and PCWD differ in regards to the outcomes of their pre-employment participants. The real question that needs to be answered is what might account for these differences between the two intermediaries. My research suggests that the differences in the Pre-Employment Training Program effectiveness between the Training Institute and PCWD may be a result of the following factors:

- 1) Length of Pre-Employment Training Program
- 2) Approach to Workforce Development
- 3) Workforce Development Experience
- 4) Political Support and Activism

Based on these four factors, the Training Institute overall has been able to outperform the PCWD in meeting workers' and employers' workforce needs.

Length of Pre-Employment Training Program

Perhaps one of the most important factors that has contributed to the Training Institute performing better than PCWD in helping more participants obtain employment in the health care industry has to do with strategy and the length of their Pre-Employment Training Program. The Training Institute, as I mentioned in Chapter 3, is focused on providing participants with a core set of skills before they enter into the labor market.

This strategy is concerned with increasing the basic competencies of individuals so that they will have better outcomes (retention rates, promotion rates, merit wage increases) over the long-term. The length of the Training Institute's Pre-Employment Training Program is also an important factor. During the 12 week training program the Institute is focused on providing participants with job readiness training (soft skills), basic skills training (hard skills), and contextualized on-the-job training. The first six weeks of the training program is focused on developing the participants' hard skills in areas such as computers, basic math and science as well as reading, writing, language, and communication skills. Participants in the Pre-Employment Training Program are given access to laptops in order to better familiarize themselves with the latest computer software and hardware. This has proved to be an important factor in helping entry-level workers transition into hospital settings where computers have become a part of day-to-day operations. Participants in the Training Institute's Pre-Employment Training Program also complete an 8-week internship with a health care employer which requires them to work three days a week while also attending classes. This enables participants to gain on-the-job training and provides them with an opportunity for hospital personnel (i.e. department managers/supervisors) to evaluate their skills, attitude, and approach to work.

PCWD's Pre-Employment Training Program is only 5 weeks long and focuses exclusively on job readiness skills rather than teaching basic skills that can help participants increase their math, science, language, computer, and communication skills, all of which employers say are important skills to have when working in a hospital setting. In any short training program, it is unrealistic to assume that the skills of

participants will rise much higher than when they first enrolled in the program, but 2.5 weeks of job readiness instruction just does not seem to do much of anything for participants, except provide them with a brief overview of jobs in the health care sector and familiarizes them with the Partners HealthCare System. Moreover, PCWD's Pre-Employment Training Program offers only a 2.5 week internship, significantly less than the internship provided by the Training Institute. In just 2.5 weeks it is difficult for managers and supervisors to truly evaluate a participant's skills because they spend the first week in a half learning how to perform the basic duties of their job.

Finally, PCWD's Pre-Employment Training Program is focused on getting participants into employment quickly. This type of strategy requires participants to take practically any job that they are offered because they do not have the time to be selective with the type of job they get. This is probably one of the main reasons that 35% (24) PCWD graduates have ended up working for a temporary services agency. Moreover, the short training program provides participants with few extra skills, so they do not end up in a broad segment of occupations in nursing and allied health. Instead, nearly 80% of PCWD hires have been limited to administrative and clerical positions, positions that over time do not provide many opportunities to advance along a career ladder.

Approach to Workforce Development

Another factor that most likely accounts for differences between the pre-employment outcomes of the Training Institute and PCWD has to do with the differences in their approach to workforce development. For instance, since the Training Institute is managed by JPNDC in partnership with FCDC and the Mission Hill Network, they have

adopted a workforce development strategy that is job-centered. This strategy goes beyond just placing residents in jobs. Their strategy is focused on identifying the better paying entry-level jobs with long-term opportunity for upward job mobility. This is tied to the Training Institute's core mission which is to improve the job retention, wage progression, and overall career mobility of under-skilled, low income Boston residents. As a result, the intermediary has created social support mechanisms for economically disadvantaged job seekers/workers by connecting them to the necessary educational and social service agencies (i.e. childcare support, transportation, family/individual counseling, etc.). In addition, the Training Institute staff has tried to change the demand-side of the labor market by working with employers to improve the workplace environment by allowing their employees to have flexible time on the job to attend Training Institute courses. They have also encouraged employers to have hospital managers and supervisors enroll in Training Institute courses that are designed specifically to help them become more effective managers and supervisors. Training Institute staff have also worked with employers to develop a comprehensive career pathway for employees in entry-level nursing and allied health positions and has pushed employers to provide more mentoring and career counseling to their entry-level employees. All of these efforts have helped modestly improved the workplace conditions for workers, especially for entry-level workers who stand to benefit the most from additional support on the job.

PCWD, like the Training Institute, is also committed to helping workers advance along a career ladder. However, PCWD is an employer-driven workforce intermediary that is limited in how much they can meet the long-term needs of the pre-employment

workforce because they are first accountable to employers who are concerned about their bottom line. In other words, Partners HealthCare affiliated-employers are conscientious of the types of employees they hire and how much money they spend on pre-employment training services. This is evident based on several factors. First, Partners HealthCare System has placed PCWD under the management of the Community Benefits Department. Internally this is significant because this suggests that PCWD is not part of Partners' core human resource strategy, instead it has traditionally been viewed by most within Partners HealthCare as a community benefits initiative. As I mentioned in Chapter 4 there are huge cultural barriers and different operating styles that exist between Partners' Human Resources and Community Benefits Departments. Since PCWD is managed by the Community Benefits Department it is viewed by many managers and supervisors as a "benefits" program that is geared towards helping "welfare mothers" rather than being viewed as a serious workforce development intermediary focused on meeting the occupational needs of their employer-members. This has ultimately resulted in fewer managers and supervisors being invested in the program and hiring individuals who have completed the Pre-Employment Training Program. If Partners HealthCare were more serious about the long-term sustainability of PCWD, then they would invest more time and resources in making sure that the intermediary's Pre-Employment Training Program is designed in a manner that helps them meet their long-term employment needs.

Another factor that demonstrates how Partners is more committed to their bottom line rather than supporting PCWD's efforts is seen in the administration's limited commitment towards the intermediary. Partners HealthCare System administrators have

been slow to support PCWD's efforts. Few administrators have encouraged managers and supervisors to get involved in supporting the program by offering pre-employment participants internships or employment opportunities. As a consequence the staff of PCWD has had to create incentives and build-up support for PCWD throughout the Partners HealthCare System by identifying supporters of the intermediary who they refer to as Health Care Ambassadors or Workforce Development Champions. These individuals' contributions are recognized publicly via announcements or newsletters. Although support for PCWD is beginning to grow, it has taken about two-years for the intermediary to begin to be known, respected, and supported by Partners HealthCare staff.

Finally, PCWD's approach to workforce development thus far has been on placing as many participants in jobs as possible. There is tremendous pressure from funders and Partners HealthCare administrators for the intermediary to place graduates of the Pre-Employment Training Program into jobs. As a result, PCWD has not been as successful as they would have wished in placing graduates in permanent health care occupations. Moreover, unlike the Training Institute, PCWD has been unable to change the demand-side of the labor market in a manner that is favorable to employees such as providing a longer pre-employment training program that is focused on hard skills rather than job readiness; encourage hospital managers/supervisors to provide more internships across a disparate number of departments and occupations; work with employers to provide better mentoring and career counseling to entry-level employees; and develop clear career pathways within the workplace.

PCWD has not received a significant amount of funding from employers in comparison to the Training Institute over the last couple of years. Instead, PCWD is almost exclusively funded by the 3-year \$1 million SkillWorks Grant that they received in December 2003. A significant reason for this is that as an employer-led intermediary, PCWD does not have the political ability to challenge employers to the extent that the Training Institute is able to (I address this in a later section). Therefore, PCWD's approach to workforce development is controlled more from the employers perspective and meets the employers needs rather than the needs of workers. In this case, PCWD is driven by the numbers of participants they place in jobs because Partners HealthCare knows that local politicians, state representatives, and Boston's Mayor Menino have tied local economic development within the LMA and other parts of Boston to workforce development.

Workforce Development Experience

Although the Training Institute and PCWD are both used as examples of leading models for health care workforce development intermediaries in the country, the Training Institute has been around longer and has considerably more experience working with under-skilled individuals, all of which has helped the intermediary develop deeper partnerships with employers, community organizations, government agencies, etc. than PCWD. The Training Institute has been in operation for nearly five years and during that time, has been able to build political support, gain the trust of employers, and learn from their previous mistakes about how to provide workforce development training targeted at Boston's poorest and least educated residents. PCWD has only been in operation for two-years and has not been able to build the political support, gain the trust of employers,

and been able to “fine tune” their workforce development efforts the way the Training Institute has been able to. PCWD also does not have as much experience as the Training Institute in working with under-skilled, economically disadvantaged adults. This is one of the main reasons that PCWD formed a partnership with the community-based consortium Project Hope/Transition-to-Work collaborative. PCWD staff and Partners HealthCare’s administrators admitted to me that they have little experience working with community organizations, educational institutions, or economically disadvantaged residents. This is something that they are striving to improve upon and have made real strides in establishing agreements with Massachusetts Bay and Bunker Hill Community Colleges to design courses exclusively targeted for their incumbent workforce.

Political Support and Activism

A final factor that has contributed to the differences in pre-employment outcomes between the Training Institute and PCWD has to do with political support and activism. The Training Institute has had a clear advantage over PCWD in gaining the political support of elected officials and being politically active in support of their constituents—primarily minority economically disadvantaged neighborhood residents. The staff of JPNDC, FCDC, and MissionWorks have been politically astute at gaining the support of local politicians. They have invited local politicians to community meetings to discuss development projects being proposed by local hospitals and medical facilities. The staff of all three organizations have also invited Boston’s Mayor Menino and other elected officials to attend Training Institute graduation ceremonies. This has helped raise the visibility of the Training Institute not only among health care employers but among

politicians and philanthropic organizations as well. One of the key drivers of the Training Institute's political agenda has been the director of the Training Institute who has been able to establish personal relationships with employers, advocate on behalf of community residents, and build a politically active base of community leaders and residents that place pressure on employers to hire more residents from Boston. The staff of JPNDC and their partners knew that by getting the political support of the mayor and other elected officials they would be able to demand more from employers. They were able to get employers to invest money into the Training Institute. They were also able to get health care employers to commit time and donate resources to the Training Institute such as classroom space, provide internships to pre-employment training program participants, encourage managers and supervisors to serve as mentors to workers, and encouraged employers to begin the process of developing career pathways for entry-level workers. Most recently, the Training Institute has been able to get employers to open a new training center within the LMA which will provide much needed classroom space, computers, books, and other resources needed for instruction.

Unfortunately, PCWD has not had the same political support as the Training Institute. The intermediary was created in late 2003, several years after the Training Institute was able to establish itself as the primary health care workforce intermediary in Boston. More importantly, PCWD is unable to take any political stances that are critical of health care employers because it is employer-led. Taking a strong stance against Partners HealthCare affiliated-employers could result in the end of the intermediary. Partners employers—BWH, MGH, Spaulding Rehabilitation Hospital, and Whittier Community Health Center as well as others have a direct influence on PCWD. They can

directly influence the long-term sustainability of the intermediary by reducing the number of individuals they hire, limiting the amount of investment of time and money into the intermediary, or by simply requesting of Partners HealthCare administrators that the program be phased out.

PCWD is not able to be as critical of employers as the Training Institute because it does not have the same political base or activism. PCWD is largely disconnected from community organizations that understand the power of mobilizing and organizing around a particular issue. Without a strong political base and ability to actively apply pressure on employers to change workplace culture, offer higher wages, increase education and employment opportunities, etc., then PCWD will be mostly one-dimensional—only able to address the needs of employers and only moderately improve the economic and employment opportunities for under-skilled, economically disadvantaged Boston residents.

All of the four factors that I have discussed above contributed to the differences in outcomes for the pre-employment participants between the Training Institute and PCWD. JPNDC's longer pre-employment training program, its long-time presence working with economically disadvantaged residents, its approach to workforce development along with the fact that it has gained political support from elected officials, has given the Training Institute an advantage over PCWD in training job seekers and helping them obtain employment within the health care sector. In the following section I will describe some policies that might help strengthen Massachusetts' workforce development system.

As I mentioned in Chapter 1 of my dissertation, the emergence of new workforce intermediaries has raised questions about how well these intermediaries perform and

what factors might help explain why some perform better than others. Robert Giloth and Richard Kazis (2004) have argued that the most successful workforce intermediaries are those that are able to carry out three important tasks:

- 1) They have an *entrepreneurial focus* on outcomes like long-term job retention, wage progression, and career mobility;
- 2) They *are able to network and partner* across supply, demand, educational, financial/funding, and spatial dimensions of regional labor markets; and
- 3) They have the *ability to learn and adapt* as market conditions and opportunities change.

My research findings suggest that these three factors are indeed important in determining the success of workforce intermediaries such as the Training Institute and PCWD.

However, I would add two more tasks to the three tasks advanced by Giloth and Kazis.

A fourth important task that helps determine the success of a workforce development intermediary is its ability to *be an advocate* for its participants. In the case of the Training Institute and PCWD, both worked hard to advocate on behalf of their pre-employment participants. This involved contacting human resource personnel and hospital managers and supervisors on behalf of an individual. Since the volume of job applications for hospital jobs has increased dramatically in recent years, it makes it that much more important for Training Institute and PCWD pre-employment training program graduates to have additional help in obtaining employment.

The fifth, and perhaps one of the most important tasks for a successful intermediary to accomplish, is its ability to *build a political base of support*. This means that workforce development intermediaries need to establish relationships with elected officials, local political leaders, community activists, and neighborhood residents to keep

them informed of the intermediaries' mission, goals, and outcomes. In addition, intermediaries with a strong political base and support are better able to negotiate with employers when it comes to improving the workplace environment, quality of jobs, and compensation. Most employers such as those who deal directly with the public are conscientious of the way they are perceived by the public. Moreover, many of these employers want to be good neighbors and give back to the local community, but without strong political activism and the ability to develop partnerships, very few positive outcomes will emerge that ultimately can benefit both employers and workers.

Conclusion

As the number of workforce intermediaries continue to grow around the country, it is important to assess their real impact on improving the supply- and demand-side of the labor markets. My case study analysis of PCWD and the Training Institute suggests that overall the Training Institute was the best investment for employers and resulted in the best outcomes for low-income, Boston residents. Although both workforce intermediaries have limited capacity to dramatically increase the supply of skilled workers. The Training Institute and PCWD have produced only a modest number of graduates over the last two-years, hardly enough to meet the workforce demands of health care employers. Moreover, both intermediaries had minimal ability to change the demand-side of the labor market. Employers still have the power to decide who to hire, how much to pay, and control workplace conditions. In reality, workforce intermediaries are only a small segment of the entire 7 billion dollar workforce development system (Fitzgerald, 2006).

However, workforce intermediaries do serve an important function. In today's economy the haves and have nots are being further divided by education and skills. Those who have the skills and education are able to earn significantly more money over their lifetime compared to those who are under-skilled and less educated. Workforce intermediaries are important because they fill a structural gap that exists in today's publicly funded workforce development system. Workforce intermediaries serve the less educated and under-skilled populations by helping them obtain the additional skills and education training needed to help them obtain a job or enroll in post-secondary education (i.e. community college). Workforce intermediaries help immigrants, displaced workers, and the chronically unemployed get their "foot in the door" to long-term employment. This is an important role that both PCWD and the Training Institute play. During my interviews and focus groups with students in both programs, over 50% of respondents said they had applied to health care jobs before enrolling in a pre-employment training program. In every single case, not one participant received a job offer or even a call for an interview. After successfully completing the pre-employment training, not only did the participants get an interview, but everyone got at least one job offer. As one student who migrated to Boston from Ethiopia six years ago told me, "The Institute helped me get my foot in the door. That's all I needed. I just needed an opportunity to get hired and I can do the rest on my own." This sentiment was shared by 80% (18) of the students I surveyed and interviewed. The majority of students feel like PCWD and the Training Institute is the back door into health care employment. Since competition for health care jobs (even entry-level jobs) is so strong, job applicants with limited education and basic

skills (math, writing, reading, etc.) need all the additional help they can get. This is perhaps the most important role that workforce intermediaries play.

As the Training Institute and PCWD continue to evolve, one has to wonder about their future sustainability. Giloth (2004) has argued that the most successful and sustainable intermediaries are able to do the following:

- 1) Serve a dual-customer model by addressing the needs of employers and less-skilled workers and jobseekers;
- 2) Go beyond job matching, but instead work with employers to improve human resource systems, career ladders, job quality, and overall competitiveness;
- 3) Serve as integrators of funding streams, public and private sector services and programs, and information sources to better serve the needs of jobseekers, workers, and employers;
- 4) Are generators of ideas and innovations about what workers, firms, and communities need in order to prosper; and
- 5) Are not single purpose or function organizations, but instead serve multiple purposes.

Both PCWD and the Training Institute have struggled to perform many of these tasks. PCWD and the Training Institute have not been able to serve a dual-customer, at best the Training Institute has been able to better serve the needs of workers/job seekers compared to PCWD, but both have not been able to help participants advance along a career pathway. In addition, both have not been able to serve the workforce needs of employers. The number of graduates of both Pre-Employment Training Programs has been relatively small and the outcomes have been mixed.

In considering Giloth's second task, PCWD and the Training Institute both have gone beyond just job matching. Both have worked hard to connect participants to jobs and provide them with career coaching, educational and skills training, etc. The Training

Institute has been the most successful so far in working with employers to improve job quality and improve workplace conditions. One promising effort has been working with employers to develop clear career pathways within a hospital setting. This has the potential to help more entry-level employees develop a career plan that will enable them to better understand the skills, education, and work experience required in order to advance towards a higher paying position.

Giloth's third point is that successful workforce intermediaries will be able to serve as integrators of funding streams, public and private sector services and programs, and information sources to better serve the needs of jobseekers, workers, and employers. This has largely been the case with the Training Institute and PCWD. Both intermediaries have been able to get money from the public and private sectors and have developed partnerships with a number of organizations across sectors. The real challenge for each intermediary is how to operate efficiently. In the case of the Training Institute, there are numerous partners and sometimes it takes weeks for decisions to get made. In addition, with so many community-based organizations involved in the partnership, turnover is constantly an issue as employees come and go from different organizations. This becomes a challenge for the Institute because it makes it hard to keep continuity and for employers, they have to constantly get used to working with a new community member. In the case of PCWD, they too have been able to combine funding streams from both the private and public sectors. The intermediary's main challenge has been developing sustainable relationships with social service and community organizations. They have been able to develop a strong relationship with Project HOPE/Transition-to-

Work, but will need to continue developing a strong community base if the program is going to remain sustainable.

Giloth's fourth point is that workforce intermediaries that are successful are also able to be generators of ideas and innovations about what workers, firms, and communities need in order to prosper. This is an important task that intermediaries must be able to carry out. The Training Institute has been innovative to a point. The intermediary realized early on that hospital managers and supervisors are important in helping workers advance along a career pathway. As a result, the Institute began offering managers and supervisors training in how to be better managers. The Institute also realized early on that in order to be successful, employees would need social support such as career counseling and planning and access to social services. The Institute has been able to team up with other community-based organizations to provide a social support network to employees, but has also been able to use that network to place political pressure on hospital employers. PCWD on the other hand has largely been limited in this area. The intermediary has been unable to develop much support from politicians and institutions outside of Partners HealthCare, although PCWD has been innovative in building support for the intermediary internally within Partners HealthCare by identifying supporters as Health Care Ambassadors or Workforce Development Champions. This has been successful in raising the visibility of the intermediary and getting more people involved who can support the intermediary's mission and long-term goals.

Finally, Giloth argues that the most successful and sustainable workforce intermediaries are not single purpose, but instead serve multiple purposes. Both PCWD and the Training Institute perform multiple functions. The intermediaries focus on

providing social services to participants, education and training as well as career and educational advice. The intermediaries also network and advocate on behalf of their participants in order to get them jobs or help them advance within the workplace.

Although the points that Giloth raises are all important in determining which intermediaries are successful and sustainable and which are not, perhaps the most important factor of all in determining the success of a workforce intermediary is their ability to politically mobilize and build a strong base of support. It is clear, based on my dissertation research in Boston, that the main reason why PCWD and the Training Institute are still around is because of politics. Employers invest in these programs because it is important to Boston's Mayor Menino. The employers within the Longwood Medical Area would like to continue to grow upward and outward and they understand that their ability to get building permits approved by the Boston Redevelopment Authority is tied to the workforce outcomes of neighborhood residents, especially residents living in communities contiguous to the LMA. Government policies encouraging the business community to serve disadvantaged populations is not new. In 1977, Congress passed the Community Reinvestment Act. The Community Reinvestment Act required depository institutions to help meet the credit needs of the communities in which they operate, including low- and moderate-income neighborhoods, consistent with safe and sound banking operations.³ Since CRA was enacted, tens of billions of dollars have been invested in low- to moderate-income communities. This has helped small minority and women owned business get started, created opportunities for homeowners in low-income communities to renovate their homes as well as provided

³ Federal Financial Institutions Examination Council. 2006. <http://www.ffiec.gov/cra/history.htm>

loans to small developers who have revitalized poorer, urban communities. So, in many ways, what is happening in Boston is very similar. The mayor and local politicians are trying to encourage Boston's largest private employers to invest in the education and skills of the local community. The hope is that over time, these residents will have access to better jobs and economic opportunities which can help them move out of poverty and have enough income to become home owners and productive tax paying citizens. In addition, the hope is that over time, Boston's health care workforce will also better resemble its growing immigrant and minority population, resulting in increased cultural competency and language proficiency, ultimately leading to better health outcomes for all of its residents. Only time will tell if this type of political strategy produces the positive outcomes that politicians and local community residents desire.

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