Lessons Learned

Below we outline key lessons learned for successful replication of best practices based on success factors and major barriers/challenges we encountered during the grant period:

- Iterate: Formalizing the HCPI model and cultivating best practices required constant reflection by staff and adjustment of models, workflows and processes. The HCPI model is only relevant and responsive to participants if it is used as a flexible guide that is constantly critiqued and refined. Given DHTI's team-based structure (see next point), staff was able to meet several times to reflect on and iterate the HCPI model as well as integrate new design elements into program implementation.

- Align staffing and organizational structure with program model: Another learning is to ensure that staffing and organizational structure support implementation of the HCPI model. During the grant period, DHTI was able to expand the team and move to a team-based structure. A team-based structure allowed DHTI to move from a centralized to a shared decision-making model which also facilitated better communication, promoted shared ownership of outcomes and leadership development of staff. DHTI is structured into the following project teams: 1) Outreach & recruitment; 2) Participant enrollment & supports; 3) Program development, implementation, & evaluation; and 4) Work-based exposure and learning, with a support team to aid the work of each project team. Each project team is coordinated by a team facilitator with all staff as members participating in each team. While staff expansion and organizational re-structuring was at once a success factor for program implementation, it was also a challenge due to necessary training and on-boarding processes that take time away from program implementation.

- Innovate outreach strategies: DHTI has had challenges with recruiting diverse participants that fulfill the needs of employers and the community. Through meetings, FQHCs have told us that their highest needs languages are languages that our participants are lacking, such as Cantonese and Mandarin. Additionally, while we currently have high numbers of participants from Nepal, we are still behind in recruiting participants from Latin American countries and the Middle East. During the grant period, we built our social media presence and began building momentum through word of mouth due to successful programs, job/volunteer placements and referral partnerships with organizations such as Berkeley Adult School. DHTI intends to expand the word of mouth strategy by developing an Ambassadors Program in which former participants can gain paid work-based learning as a Community Outreach Worker with DHTI. DHTI is also conducting focus groups with partner agencies to identify and learn strategies for engaging diverse participants.

- Set up systems for participant tracking: Excel is not ideal for participant tracking and, with refinements to the HCPI model, has demonstrated the need for a more visual system for participant tracking. During the grant period, DHTI transitioned to using Salesforce as the central point of tracking of all participants. While it is a challenge as it requires adjustment and training, we have built a solid foundation in Salesforce for our tracking system, which will help us track participant processes from start to finish, including outreach, recruitment, selection, and retention of participants.

- Collaborate and build partnerships: HCPI's success relies on buy-in from partners that operate in the larger health/healthcare workforce system. DHTI believes in a systems approach to workforce development and strives to foster collaboration and partnership at every opportunity. As evidence by the curricula, the implementation if HCPI requires immense partnership in order to deliver services and work-based exposure and learning essential to participant success.

- Outcomes comparison between 18 to 30 group, and older than 30 group

  Because many other programs service specific age groups, it is often assumed that there is a difference between working with young adults and youth, and older adults. Although there is evidence to base these assumptions, this funding has helped DHTI understand significant differences and similarities in working with older adult and younger adults. Although there is some evidence that demographics (such as country of origin, income, previous community work) play an important role, the most important data collected that points to successes of individuals points to their activity in programs, continuous connections with coaches, number of coaching sessions attended, and openness with coaches.

  Due to the relatively small number of participants in the program, there were very few demographics that demonstrated any significance in whether a participant would be successful. Generally, participants from El Salvador, Mexico, and Nepal showed higher numbers that had successful outcomes. Spanish speakers and Nepali speakers proved to be more likely to be successful. Another indicator was whether a person had previously worked in the local community. Although a higher number of participants with these demographics demonstrated successful outcomes, an overall few of the program shows that these are not indicators of success since the numbers of people from these countries, languages, and previous community work, show much higher numbers than other groups.

  Certain demographics seem to be significant from the outside but prove to not line up with successful outcomes. One specific demographic that does not line up with successful outcomes is whether a person has a healthcare degree from another country. Many of our participants who have been successful did not have a healthcare degree from another country, and were looking for other avenues to do community work. However, if a participant did community health work in their previous country and in the United States, they were highly likely to show successful outcomes. This demographic shows that experience in community work is more likely to demonstrate success in healthcare than any other demographic indicator.

  Once demographics have been removed, certain patterns emerge that show distinctions between the two groups. The 18 to 30-year-old group desires experiences and knowledge about health care careers, while the people over 30 generally know the area they would like to pursue but are dealing more with helping their family survive and to get help accessing services. Trauma also plays a significant role in whether participants will have successful outcomes. Although youth experience continuous trauma, there are services that youth can access at schools, and many create friendships at schools. Adults can be more isolated, and have to not only contend with continuous trauma from their country of origin, but have to wrestle with trauma from being unable to create sustainable living situations for their family, contribute to their family in their country of origin, and/or living in unsafe areas. Trauma also affects the ability of older participants to maintain connections with coaches.

The most significant similarity between the two groups to create successful outcomes is the knowledge of a well-defined career path. Both groups differ slightly in their development of career plans. Often, youth find that they are interested in several paths, and even though they might find one of interest, there is a high likelihood they will alter that path given new information. However, most older participants either will pursue the path that has been drawn out for them, or will only change their path once or twice.

Barriers to Positive Outcome

Although DHTI participants work hard and continue to do amazing work in the community and throughout their activities, we continue to see barriers that negatively affect outcomes and directly affect the lives of participants. One of these barriers is housing, and the connection between housing and transportation. Many participants do not state that their barrier is housing, but that transportation is the problem. After speaking with them, we find that the barrier is housing in Oakland and areas closer to Oakland. Participants are being pushed out of the area and continue to take long trips to our office and to participate in our programs. Since 2014, we have seen more participants who have to take longer bus and BART rides to come to our classes. For the future, we will need more funding to bring the services to them, which is a community-centered model practiced in healthcare, and a direction which we know DHTI should go. However, this is an expensive project for us to take on and will be looking for ways to take this work to the community even if they are living in areas far outside of Oakland such as Contra Costa County.

Another barrier for participants is the confluence of a lack of well-paying survival jobs while participants are completing our programs and taking on job shadowing and volunteering opportunities. During the last year, several participants who wanted to participate in DHTI's programs were unable to because they had to work another job instead of pursuing their dream job. Even if participants obtain jobs that pay $14 or $15 an hour like many caregiver jobs, the salary is not sustainable. Because of the confluence of these factors, additional stipends to allow participants to participate in our programs while being able to take care of their family's needs would be of great benefit.