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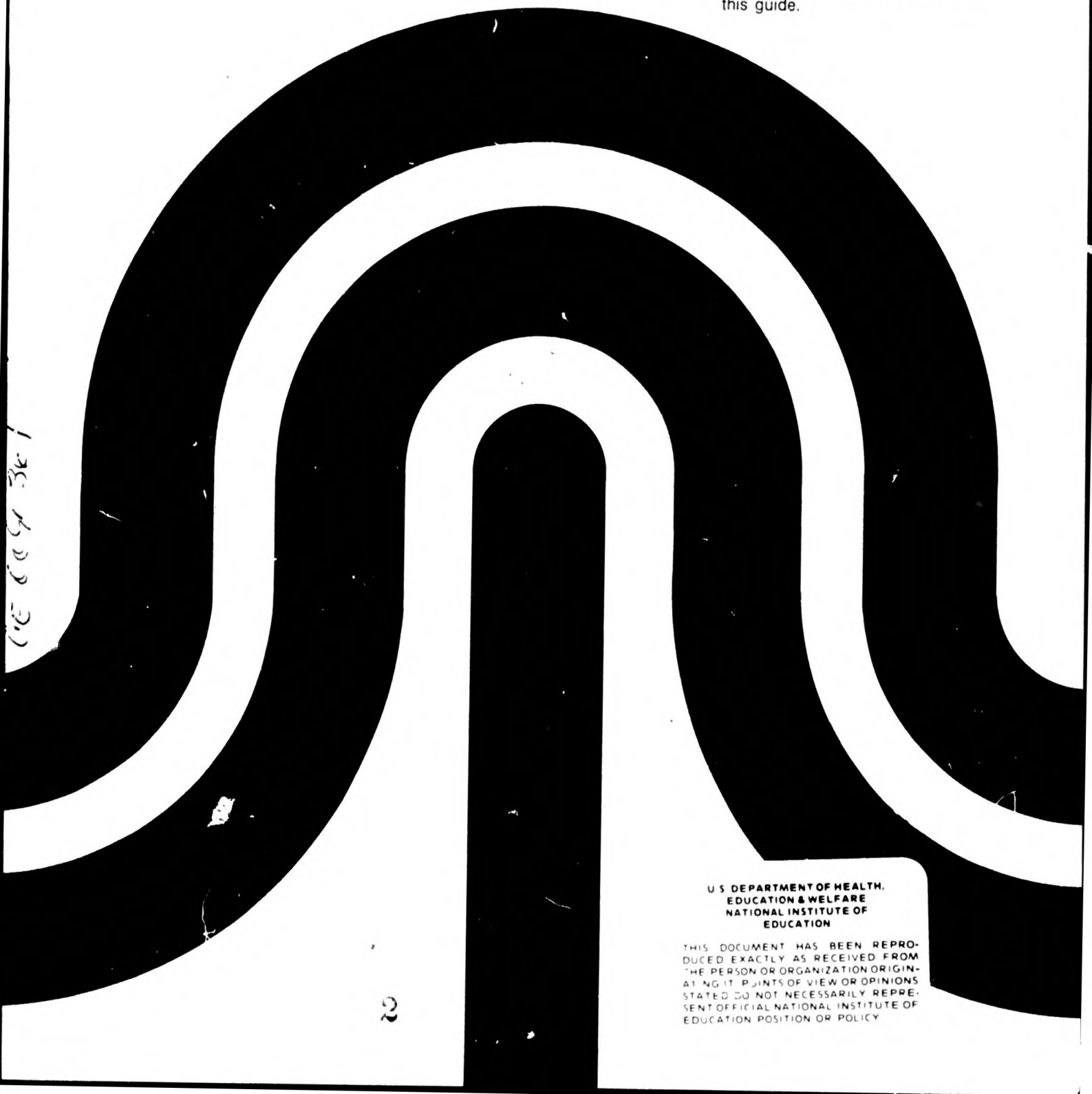
ABSTRACT

Written for State and local operators of Health Education and Welfare (HEW)-funded health service, health manpower, and health planning programs, this guide is intended to serve four major purposes: (1) Provide selected insights into the Comprehensive Employment and Training Act (CETA) and how it works; (2) point out potential areas for cooperation which, from study or field experience, hold the promise of benefit to the clients and administrators of both CETA and health programs; (3) present a brief analytical framework for identifying other arrangements not specifically outlined in this guide; and (4) review the HEW management techniques that have proven their value in negotiation and implementation of existing arrangements between CETA and health programs. One section of the guide focuses on description of CETA programs and the relationships between them and health programs. Nine specific examples of coordination opportunities are presented in another section, e.g., combining resources to develop a demonstration training program for disabled youth. Analysis, identification, and implementation of coordination arrangements are discussed in the final section, and an illustrative agreement is appended. (WL)

# Health and CETA
# A Coordination Guide for Health Administrators

This guide was developed for the Office of Manpower, HEW, by Urban Management Consultants of San Francisco, Inc., who, with their subcontractor, Lewin and Associates, are solely responsible for the accuracy of the document. Considerable advice and assistance was provided by individuals directly involved in subject areas. To them we owe sincere thanks. A list of those individuals and their affiliations is included at the end of this guide.



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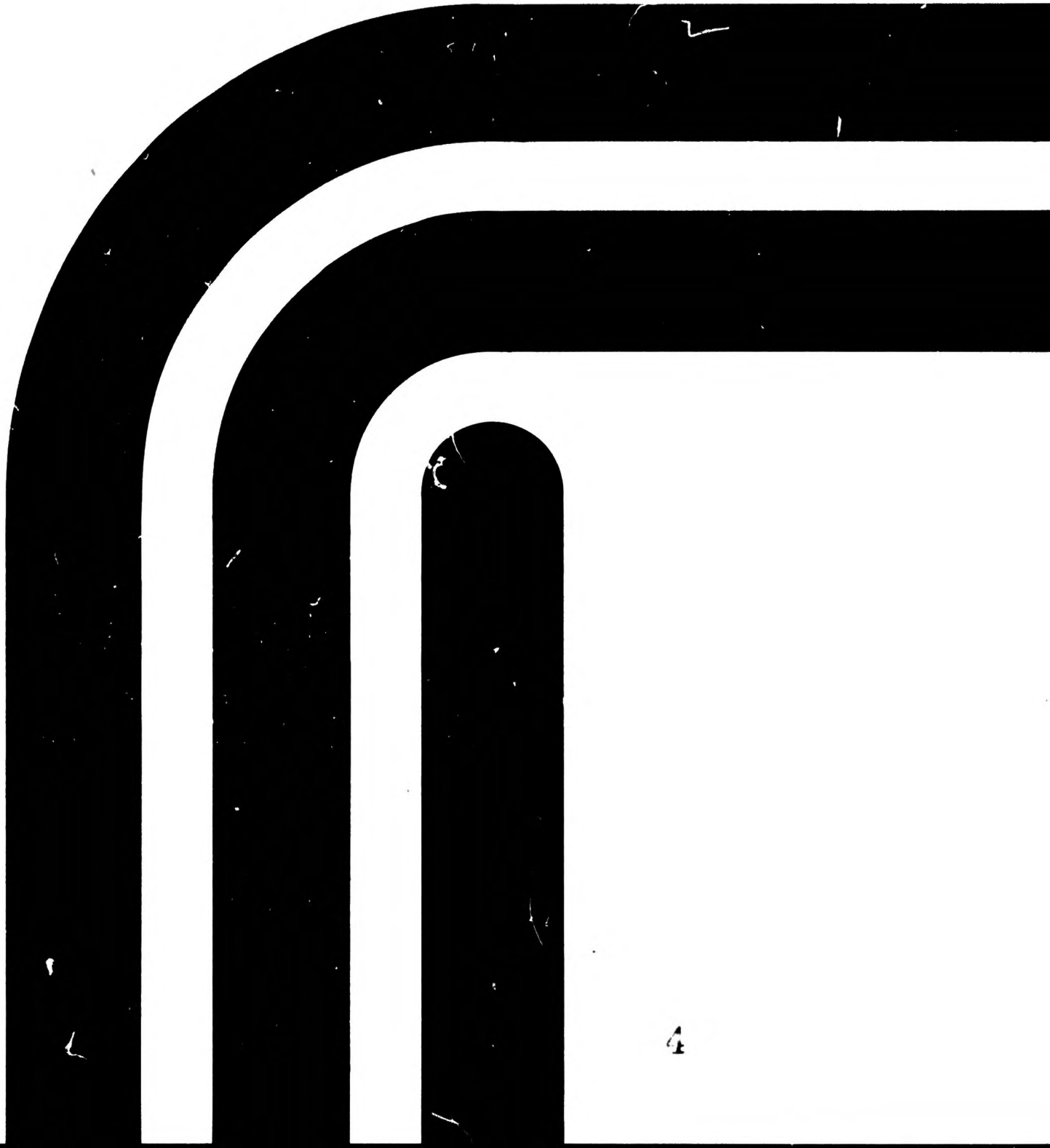


This guide has been written for state and local operators of HEW-funded health service, health manpower, and health planning programs. It is intended to serve four major purposes:

1. Provide selected insights into the Comprehensive Employment and Training Act (CETA) and how it works;

2. Point out potential areas for cooperation which, from study or field experience, hold the promise of benefit to the clients and administrators of both CETA and health programs;

3. Present a brief and practical analytical framework for identifying other arrangements not specifically outlined in this guide;

4. Review the key management techniques that have proven their value in negotiation and implementation of existing arrangements between CETA and health programs.

The usefulness of this guide is not limited to those health agencies receiving Federal or State funds. Many other agencies such as medical schools, community colleges, hospitals, and clinics, not currently recipients of Federal funds, may also find the types of cooperative arrangements described in this guide helpful to their service program.

**Defining Coordination**

Interprogram coordination is not defined specifically in this guide. Enough varying definitions already exist to fill a volume larger than this. You are simply encouraged by the Department of Health, Education, and Welfare and by the Department of Labor to work together with your counterpart CETA programs and appropriate other HEW-related programs. In seeking ways to work together you are likely to discover opportunities to better serve your clients, CETA clients, and the interests of both agencies. When you find ways to do so, you will have achieved the goals of coordination without great concern for whether you have met any particular definition.

Coordination for its own sake has no particular value. What matters are the results of coordination and cooperation, and how they serve the needs of all concerned. Arrangements which emanate from this effort should not be judged on the basis of their scope, scale, complexity, or formality. Simple efforts can yield significant results.

This document is not a mandate for cooperation with CETA Prime Sponsors. It is instead an invitation to explore interprogram activities as the means to achieving one or more of your own program objectives. Not all forms of coordination are desirable; the costs of some coordination options will be too high. Where the ideas and methods here described appear attractive to you, pursue them. Where they do not, continue to look for ones that do. This guide recognizes fully that the decision to coordinate is yours.

The Secretaries of HEW and Labor and the Assistant Secretary for Health will support any legitimate actions you may take in working together which benefit your clients and your agencies, and therefore the taxpayer.

**A Critical Assumption**

The approach taken in this guide regards as too simplistic the old axiom that "what is good for the client is good for the agency." While this is generally true, administrators may find themselves equally attracted by other benefits to their agency in cooperative arrangements designed to serve clients. Agency and agency leadership objectives exist, to some degree, separately from program objectives. To the extent that these objectives are mutually supportive, a productive relationship exists. Those who neglect this aspect will miss certain significant opportunities to strengthen client service, because those certain opportunities may come to light through pursuit of agency or leadership objectives, yet they may elude the analyst looking only for additional client benefits. Administrators are often faced with budget, staff, performance and other problems which coordination might resolve. If clients will also benefit, coordination should be pursued.

Accordingly, this guide recommends a separate review of agency and leadership objectives as an indirect route to identification of coordination arrangements that ultimately will strengthen client service.

**Finding Opportunities**
This guide offers insights into a process designed to help you find attractive opportunities to work together with CETA. The steps in that process are as follows:

—Assessing your program needs or unmet objectives

—Acquiring knowledge about CETA;

—Analyzing areas of commonality between CETA and your program needs;

—Weighing the costs and benefits of coordination; and, if applicable,

—Negotiating and implementing a joint project.

The chapters of this guide are organized accordingly.

**Why Coordinate With CETA?**
The philosophies underlying CETA and most HEW-funded health programs are similar and compatible: to assist individuals to better cope with their needs in order to effectively function within society. With a common concern for the well-being of people in need, the desire for better service encourages the development of opportunities to coordinate. Many HEW-funded health programs and CETA share common purposes and client groups, and provide similar services. Complementary strengths in manpower training and supportive services among these programs may in certain instances serve clients better together than alone.

**The Importance of Leadership**
Interprogram coordination can represent a significant challenge to the management skills of program leadership. First, coordination initiatives represent *change*, and organizations typically do not change comfortably without the artistic exercise of leadership. Second, coordination initiatives with substantial potential *gains* will always involve substantial *risk*, which some in the organization may perceive as intolerably high. If program leadership prepares properly, the risks associated with contemplated coordination arrangements can be identified early and openly discussed. Where the risks are acceptable there remains a third challenge: gaining consensus among the counterpart staffs, at the client service level if client service coordination is at issue, that the risk is acknowledged, that steps have been taken to reduce it, and that the residual risk is viewed as acceptable in relation to potential advantages.

Open and unequivocal commitment of the leadership of both agencies or programs is absolutely essential for the success of any coordination strategy.

The opportunities, problems and issues of inter-program coordination as they are identified and discussed in this guide are framed as leadership concerns. The approach proposed for searching out mutually appealing coordination arrangements assumes from the outset that the focus is on ways to preserve agency strengths, to improve agency performance, to enhance agency services, and to keep exposure to risk within tolerable limits. Of course, these are also primary concerns of CETA Prime Sponsor leadership.

In addition to this guide, the Department of Health, Education and Welfare has produced four others, in similar format, whose contents vary according to the intended readership:

Education and CETA—A Coordination Guide for Adult Education and Vocational Education Administrators

Title XX and CETA—A Coordination Guide for Title XX Administrators

Vocational Rehabilitation and CETA—A Coordination Guide for VR Administrators

CETA and HEW Programs—A Coordination Guide for Prime Sponsors.

This volume and the first three above provide an overview of CETA and discuss coordination opportunities from the HEW-funded program operator's perspective. The last volume describes HEW-funded programs and reviews coordination opportunities with those programs for the CETA Prime Sponsor.

All the guides share a common organization, as follows:

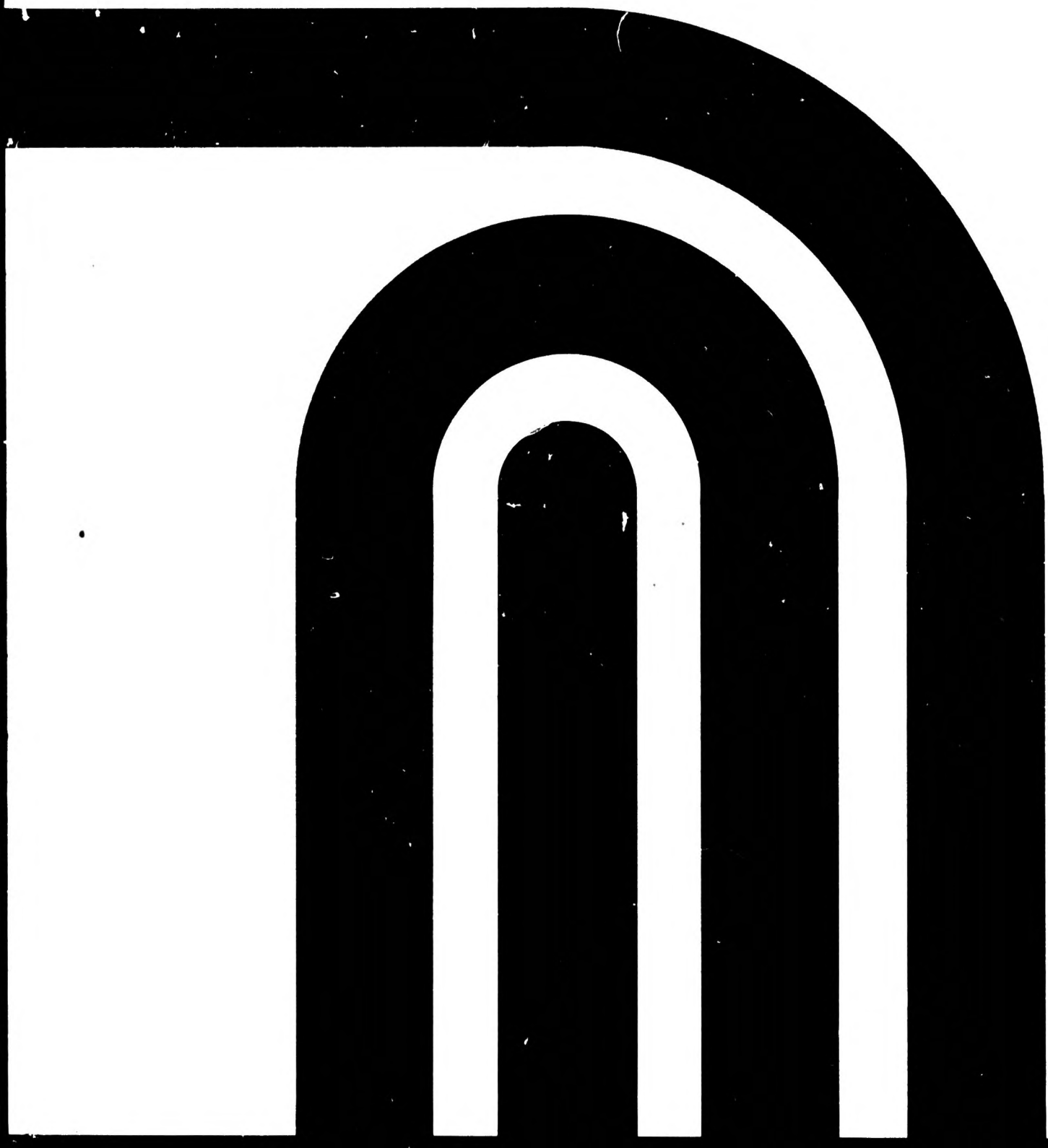
Chapter One—Introduction

Chapter Two—CETA Insights and Program Comparisons

Chapter Three—Some Specific Opportunities

Chapter Four– Analysis, Identification and Implementation.

# Chapter Two
# CETA Insights and Health Program Comparisons



Though the CETA program has been in operation for two years, many health program administrators may not have knowledge of CETA in its entirety. The following summary of CETA legislation, regulations, programming and issues is provided to enable administraiors and their staffs to be conversant with CETA as a first step to pursuing mutually beneficial cooperative agreements between their programs.

To facilitate comparisons with CETA, each health program included in this guide was analyzed in relationship to the major features of CETA. Potential commonalities between CETA and HEW-funded health programs are charted for major sections of this chapter. These exhibits are intended only to highlight similarities and differences among these programs as a starting point to identify *potential* opportunities for cooperative arrangements. Every adminis rator must examine the actual commonalities between the two programs in detail and within the context of the local situation. The exhibits are explained and summarized (in italics) at the end of each section.

For the purposes of this chapter, twenty-eight of the forty or more HEW-funded health service, manpower and planning programs were selected for comparisons with CETA. These programs are the ones most likely to have joint arrangements with CETA, based upon an analysis of the existence of current and potential agreements between manpower and health programs. However, the exclusion of some programs does not indicate that mutual cooperation is not possible, depending upon the situation at program operation levels. Indeed, many of the grantees of excluded programs may have interests and capabilities for coordination with CETA similar to the grantees described in this guide.

The table on the next page lists the HEW-funded health-related programs, including those selected for the guide.

Throughout the guide all programs are referred to by their assigned number in the 1975 Catalog of Federal Domestic Assistance.

**Background**

The Comprehensive Employment and Training Act (CETA) (Public Law 93-203) was passed and signed in December, 1973, decentralizing manpower programs throughout the nation to the state, county and city levels. An outgrowth of the "New Federalism" concepts of the early 1970's, CETA represents the belief that solutions to local manpower are best developed at the local level. The latest Federal regulations governing CETA were published in the *Federal Register* Vol. 40, Number 101, issued May 23, 1975. A subsequent publication (August 12, 1975) contains regulations for Title III programs. The applicable Title VI regulations were published on January 10, 1975.

**Need for CETA Legislation**

Prior to the passage of CETA, manpower programs were categorical in nature, designed in Washington and administered locally to serve specified segments of the population in a prescribed manner. These programs, Concentrated Employment Program (CEP), Neighborhood Youth Corps (NYC), Manpower Development and Training Act (MDTA), Operation Mainstream and New Careers, worked well in some locations, and not so well in others. Complicating matters, categorical programs were operated by various agencies and organizations within the same states and communities and were funded by several different Federal agencies, creating severe coordination problems. The Chief Elected Officials (CEOs) of jurisdictions seldom had program design or operating responsibility for these programs.

In order to make manpower resources more responsive to diverse local needs and to integrate more effectively all manpower resources emanating from the Department of Labor, CETA consolidated most prior manpower programs under the control of the Chief Elected Official. Control brought with it the responsibility for program planning, implementation, operations and evalution. CETA, in fact, was the first full-scale special revenue sharing experiment.

**TABLE 1: HEW-administered Health-related Assistance Programs**

(Source: 1975 Catalog of Federal Domestic Assistance)

**Health Manpower**

13.104 Food Research Training Grants

13.106 Radiological Health Training Grants

13.225 Health Services Research and Development—Fellowships and Training

13.227 Health Statistics Training and Technical Assistance

13.233* Maternal and Child Health Training

13.238* Mental Health—Hospital Staff Development Grants

13.241 Mental Health Fellowships

13.244* Mental Health Training Grants

13.260* Family Planning Services—Training Grants

13.263 Occupational Safety and Health Training Grants

13.270 Alcohol Fellowships

13.274* Alcohol Training Programs

13.276 Drug Abuse Fellowships

13.280* Drug Abuse Training Programs

13.287* Grants for Training in Emergency Medical Services

13.288 National Health Service Corps Scholarship Program

13.305* Allied Health Professions—Special Projects

13.319 Training in Expanded Auxiliary Management

13.320 Continuing Dental Education Grant Program

13.339 Health Professions—Capitation Grants

13.342* Health Professions—Student Loans

13.359* Nurse Training Improvement—Special Projects

13.364* Nursing Student Loans

13.370 Schools of Public Health—Grants

13.375 Minority Biomedical Support

13.379 Family Medicine—Training Grants

13.380* Health Manpower Education Initiative Awards

13.383* Health Professions—Special Projects

13.384 Health Professions—Startup Assistance

13.398 Cancer Research Manpower

**Health Services**

13.210* Comprehensive Public Health Services—Formula Grants

13.211 Crippled Children's Services

13.217* Family Planning Projects

13.224* Health Services Development—Project Grants

13.228* Indian Health Service

13.232 Maternal and Child Health Services

13.235* Drug Abuse Community Service Programs

13.237 Mental Health—Hospital Improvement Grants

13.240* Mental Health—Community Mental Health Centers

13.246* Migrant Health Grants

13.251* Alcohol Community Service Programs

13.252* Alcohol Demonstration Programs

13.254* Drug Abuse Demonstration Programs

13.256 Health Maintenance Organizations

13.257* Alcohol Formula Grants

13.258 National Health Service Corps

13.259 Mental Health—Children's Services

13.261* Family Health Centers

13.269* Drug Abuse Prevention Formula Grants

13.284 Emergency Medical Services

13.630 Developmental Disabilities—Basic Support

13.631 Developmental Disabilities—Special Projects

13.632 Developmental Disabilities—Demonstration Facilities and Training

13.714* Medical Assistance Program

13.800 Medicare—Hospital Insurance

13.801 Medicare—Supplementary Medical Insurance

**Health Planning**

PL 93-641* National Health Planning and Resource Development Act (Health Systems Agencies)

*Programs included in this guide.

**Purposes of CETA**
As stated in the legislation, the purpose of CETA is to:

"provide job training and employment opportunities for economically disadvantaged, unemployed and underemployed persons and to assure that training and other services lead to maximum employment opportunities and enhance self-sufficiency by establishing a flexible and decentralized system of Federal, state and local programs."

The Congress had in mind three major changes for the national manpower network: (1) decision-making was decentralized , (2) programming was decategorized so as to permit maximum local flexibility, and (3) consolidation was promoted as a coordination and/or integration theme for locally administered programs.

To achieve these broad purposes the CETA legislation was organized into seven titles, each with a different emphasis:

**Title I—Comprehensive Manpower Service**
The primary manpower development title under CETA. The emphasis in Title I is the provision of training, manpower and/or supportive services leading to subsidized employment. Title I replaces prior categorical programs. (FY 1976 appropriation—$1,580 million).

**Title II—Public Employment Programs**
Created public employment programs in areas of high unemployment. Here the emphasis is placed on transitional subsidized positions in the public sector which will lead to permanent unsubsidized employment for the participants (FY 1976 appropriation—$400 million).

**Title III—Special Federal Programs and Responsibilities**
Administered directly by the Department of Labor, unlike programs under the other Titles which are administered under grants to Chief Elected Officials. Title III gives the Secretary of Labor authority and funds to deal with special target groups, manpower problems and geographic areas. Indian tribal governments receive CETA funds under this title (FY 1976 appropriation—$191 million)

**Title IV—Job Corps**
Retains the Job Corps as a Federally-sponsored manpower program for the disadvantaged. (FY 1976 appropriation—$225 million).

**Title V—National Manpower Advisory Council**
Established to review and make recommendations on national manpower policy. (No special appropriation.)

**Title VI—Emergency Jobs Program**
Passed in 1974 as an amendment to CETA. Like Title II, Title VI establishes public employment programs for unemployed individuals. Unlike Title II, Title VI was passed as an emergency measure to ease the impact of high national unemployment. Jobs subsidized under Title VI need not lead to unsubsidized employment. However, they may be funded for no more than one year. (No FY 1976 appropriations. FY 1975 appropriations for two years—$2,500 million).

**Title VII—General Provisions**
(Formerly Title VI) sets forth the administrative requirements under the Act.

The intended result for all CETA-funded program participants is self-sufficient, unsubsidized employment.

**Table 2: Purposes**
The chart on the next page illustrates which of the purposes of CETA are similar to those of HEW health programs. The circles denote similarities between programs that might form the basis for cooperative arrangements. It should be noted that the CETA purposes in the chart encompass all the purposes of HEW-funded health programs.

***Both CETA and health manpower programs provide training for jobs. However, HEW-funded manpower programs are oriented specifically to the development of manpower resources through education to meet the demand for health care, and CETA is primarily concerned with the employability of the individual. Few of the health manpower programs provide employment opportunities for their students.***

***HEW health service programs and CETA share a similar purpose of enhancing the capability of the individual to function effectively in the community through the provision of important, if different, services. These service programs, however, are oriented to strengthening the capabilities of the health service system in terms of accessibility and quality of care as opposed to the CETA emphasis on the individual.***

***Though not specifically designed to serve the disadvantaged, enabling legislation and HEW regulations provide incentives for many HEW health programs to overcome financial, educational and social barriers to access for the disadvantaged to health training and health service delivery. Thus Prime Sponsors and HEW health program grantees may share a special concern for the disadvantaged.***

**Table 2: Purposes**

| HEW Program | Purposes of CETA: Provide Job Training and/or Employment Opportunities | Provide Service to the Disadvantaged | Provide Services to Enhance Self-sufficiency | Establish Flexible & Decentralized Programs |
|---|---|---|---|---|
| **Health Planning Programs** | | | | |
| PL 93-641: Health Systems Agencies | | | | ● |
| **Health Manpower Programs** | | | | |
| 13.233 Maternal & Child Health Training | ● | | | |
| 13.238 Mental Health—Staff Development Grants | ● | | | |
| 13.244 Mental Health Training Grants | ● | ● | | |
| 13.260 Family Planning Services—Training Grants | ● | | | |
| 13.274 Alcohol Training Programs | ● | | | |
| 13.280 Drug Abuse Training Programs | ● | | | |
| 13.287 Grants for Training in Emergency Medical Services | ● | | | |
| 13.342 Health Professions—Student Loans | ● | ● | | |
| 13.364 Nursing Student Loans | ● | ● | | |
| 13.305 Allied Health Professions—Special Project Grants | ● | ● | | |
| 13.359 Nurse Training Improvement—Special Project Grants | ● | ● | | |
| 13.380 Health Manpower Education Initiative Awards | ● | ● | | |
| 13.383 Health Professions—Special Projects | ● | ● | | |
| **Health Service Programs** | | | | |
| 13.210 Comprehensive Public Health Services—Formula Grants | ● | ● | ● | ● |
| 13.217 Family Planning Projects | | ● | | |
| 13.224 Health Services Development Project Grants | ● | ● | ● | |
| 13.228 Indian Health Service | ● | ● | ● | |
| 13.235 Drug Abuse Community Service Programs | | ● | ● | |
| 13.254 Drug Abuse Demonstration Programs | | ● | ● | |
| 13.269 Drug Abuse Prevention Formula Grants | | | | ● |
| 13.240 Community Mental Health Centers | | ● | ● | ● |
| 13.246 Migrant Health Grants | ● | ● | ● | |
| 13.251 Alcohol Community Service Programs | | ● | ● | |
| 13.252 Alcohol Demonstration Programs | | ● | ● | |
| 13.257 Alcohol Formula Grants | | ● | ● | ● |
| 13.261 Family Health Centers | | ● | ● | |
| 13.714 Medicaid | | ● | ● | ● |

● Indicates similarities between programs that might form the basis for cooperative agreements.

**Grantee Eligibility**

Cities and counties with populations over 100,000 are eligible to apply for CETA Title I funds. Grant amounts are determined in advance by formula. In some instances an eligible city or county may combine with other eligible jurisdictions or with jurisdictions not themselves eligible in applying for funding as a consortium. This is encouraged by the Act, which recognizes that many labor market areas consist of more than one political subdivision. States also apply for CETA Title I funds to serve all areas of the state not covered by city or county programs. The state program is generally referred to as the "Balance-of-State" program.

In the case of Title II programs, the same grantee eligibility requirements apply. In addition, however, the jurisdicton must contain an area or areas of "substantial unemployment" in order to qualify. Areas of substantial unemployment must have unemployment rates of at least 6.5 per cent for three consecutive months or more.

If an eligible applicant (Prime Sponsor) under Title II has separate units of government within its areas which have populations of 50,000 or more and qualify as areas of "substantial unemployment", then the Prime Sponsor must designate those governments as *program agents* and allow them to operate their Title II programs. This occurs most frequently among state Prime Sponsors dealing with counties or cities within the Balance-of-State. Large counties may also have city program agents within their boundaries.

All Title I Prime Sponsors are eligible to receive Title VI funds, and those with areas of substantial unemployment receive additional Title VI allocations.

Title III funds may be applied for by established Prime Sponsors, other state agencies, or by public or private organizations. Frequently Title III fund recipients are community-based organizations serving special target groups or delivering special services. Indian tribal governments are eligible if Federally-recognized and with a population of 1,000 or more residents. Regulations also permit consortia of tribal governments and private, nonprofit agencies meeting certain requirements.

The formula for allocating Titles I, II and VI funds take into account such factors as proportionate number of unemployed underemployed and low income persons compared with total number of each in all eligible jurisdictions. The formula varies slightly depending on the Title.

**Role of the CETA Lead Agency**

The Chief Elected Official, as recipient of CETA grant funds, must designate a lead agency or organization within the jurisdiction to operate the CETA program. Lead agency responsibilities include preparation of the grant application and comprehensive manpower plan, development and operation of administrative systems, delivery of activities and services and development and administration of subcontracts for services.

The State agency designated by the Governor is usually a:

—Governor's Office of Manpower,

—State Employment Security Agency,

—State Office of Planning and Programming,

—State Office of Community Affairs,

—Office of the Labor Commissioner,

—A comprehensive Human Resources Agency.

The County level lead agency would most likely be a:

—Supervisors' Office of Manpower,

—County Human Resources Agency,

—County Personnel Department.

The Mayor is most likely to designate a:

—Manpower Office,

—Department of Human Resources,

—Department of Personnel (smaller Prime Sponsors).

**Table 3: Grantees and Program Operators**

The table which follows indicates which entities eligible to receive CETA funds are also eligible for HEW-funded health program grants or contracts. However, in order to portray a realistic picture of the types of agencies receiving health program funds, the table also describes the "usual" grantee for these programs. The circles denote common eligibility for similar usual group operators.

***CETA Prime Sponsors are eligible for grants and contracts under HEW health programs, with the exceptions of the HEW formula grant programs, for which only state agencies are eligible, and the student loan program and certain training programs which can only be awarded to eligible educational institutions. In reality, HEW health manpower grantees are usually post-secondary educational institutions or affiliated training institutions such as hospitals, and HEW health service grantees are usually local public or private non-profit agencies. It is not uncommon for a public agency to be a joint CETA/HEW grantee, though the lead agencies (Public Health Department, Office of Manpower) may be different. Private non-profit groups are eligible Title III grantees and may also be HEW health program grantees such as in the migrant health program.***

**Table 3: Grantees and Program Operators**

| HEW Program | Eligibility for CETA Funds | | | Usual CETA Program Operators | | |
|---|---|---|---|---|---|---|
| | City or County Governments | State Governments | Public or Private Non-Profit Organizations (Title III only) | State and Local Public Agencies | Public or Private Education and Training Institutes | Private Organizations |
| **Health Planning Programs** | | | | | | |
| PL 93-641: Health Systems Agencies | ● | ● | ● | | | ● |
| **Health Manpower Programs** | | | | | | |
| 13.233 Maternal & Child Health Training | | ● | ● | | ● | |
| 13.238 Mental Health—Staff Development Grants | | ● | | ● | | |
| 13.244 Mental Health Training Grants | | | ● | | ● | |
| 13.260 Family Planning Services—Training Grants | ● | ● | ● | | ● | ● |
| 13.274 Alcohol Training Programs | | | ● | | ● | |
| 13.280 Drug Abuse Training Programs | | | ● | | ● | |
| 13.287 Grants for Training in Emergency Medical Services | ● | ● | ● | | ● | |
| 13.342 Health Professions—Student Loans | | | ● | | ● | |
| 13.364 Nursing Student Loans | | | ● | | ● | |
| 13.305 Allied Health Professions—Special Project Grants | ● | ● | ● | | ● | ● |
| 13.359 Nurse Training Improvement—Special Project Grants | ● | ● | ● | | ● | ● |
| 13.380 Health Manpower Education Initiative Awards | ● | ● | ● | ● | ● | ● |
| 13.383 Health Professions—Special Projects | | | ● | | ● | |
| **Health Service Programs** | | | | | | |
| 13.210 Comprehensive Public Health Services—Formula Grants | | ● | | ● | | ● |
| 13.217 Family Planning Projects | ● | ● | ● | | | ● |
| 13.224 Health Services Development—Project Grants | ● | ● | ● | ● | | ● |
| 13.228 Indian Health Service | | | | | | |
| 13.235 Drug Abuse Community Service Programs | ● | | ● | ● | | ● |
| 13.254 Drug Abuse Demonstration Programs | ● | ● | ● | ● | | ● |
| 13.269 Drug Abuse Prevention Formula Grants | | ● | ● | ● | | |
| 13.240 Community Mental Health Centers | ● | | ● | ● | | ● |
| 13.246 Migrant Health Grants | ● | ● | ● | ● | | ● |
| 13.251 Alcohol Community Service Programs | ● | | ● | ● | | ● |
| 13.252 Alcohol Demonstration Programs | ● | ● | ● | ● | | ● |
| 13.257 Alcohol Formula Grants | | ● | | ● | | |
| 13.261 Family Health Centers | ● | ● | ● | ● | | ● |
| 13.714 Medicaid | | ● | | ● | | |

● Indicates similarities between programs that might form the basis for cooperative agreements.

**Activities and Services Under CETA**

CETA authorizes broad and diverse activities and services in keeping with CETA's mandate to provide whatever an individual may require in order to obtain self-sufficient employment. These activities include manpower planning and resource development, provision of training and other manpower-related services (including financial assistance to clients and employers) and provisions of supportive services. The authorizing legislation gives much latitude to Prime Sponsors in their activities and services to fulfill the purposes of CETA.

**Manpower Planning and Resource Development Activities**

CETA grants Prime Sponsors responsibilities for manpower planning in their respective geographic areas in order that manpower training programs be conducted for permanent positions available in the labor market. State Prime Sponsors are given special planning and coordination responsibilities for all manpower programs operating in the state, including the development and distribution of information pertaining to economic and other factors affecting the labor market. In addition, all Prime Sponsors have the flexibility to fund innovative programs that meet the employment needs of the local community. The state Prime Sponsor has specific authority to fund special model training and employment programs.

Manpower Services

Common activities under Title I include classroom training, on-the-job training, public service employment and work experience, though the Act does not limit the ranges of possible services that can be provided by the Prime Sponsor.

*Classroom training* is provided in an institutional setting, on an individual or group referral basis, and may provide specific occupational skills or upgrade basic skills. Individuals receiving classroom training under CETA may receive a basic training allowance (minimum wage) and may receive dependent allowances where appropriate.

*On-the-job training (OJT)* takes place in an actual work situation with a private or public employer. OJT is designed to provide specific occupational skills or to refine skills acquired in a formal training setting. Individuals receiving OJT are considered employees of the organization providing the training, and receive wages comparable to other employees carrying out the same kind of work. CETA may reimburse the employer for training expenses in excess of those normally incurred while training a new employee. CETA may *not* reimburse a profit-making employer for wages.

*Public service employment* is designed to provide an individual with:

—a consistent work history in a particular occupation, and/or

—on-the-job training, and/or

—access to a public sector unsubsidized position.

Public service employment jobs are located in public or private non-profit organizations. CETA participants in public service employment receive wages and benefits (unemployment compensation, health insurance) identical to others doing similar work in the organization. CETA normally reimburses the organization for (or in some cases provides directly) wages and benefits paid to CETA participants. Organizations may only receive public service employment funds for new positions not previously budgeted, and are encouraged to move at least 50%* of the CETA subsidized individuals into regularly budgeted positions.

*Work experience* is designed to provide short-term work assignments in public or private non-profit organizations, in order to introduce participants to actual job environments or to build creditable work histories. Participants receive wages equaling at least the minimum wage (state or Federal, whichever is higher).

The emphasis or mix of activities in any Prime Sponsor program will be dependent on the policies and priorities set locally. There are no Federal requirements regarding the mix of activities or whether a particular activity is included at all. It should be noted, though, that Titles II and VI focus primarily on public service employment.

*Note: Prime Sponsors are free (and many take advantage of the opportunity) to formulate policies more restrictive or performance standards more exacting than those in the Act and regulations. Prime Sponsors, for example, may increase this percentage as high as 100%.

In addition to the above activities, Prime Sponsors may provide other *manpower-related services* to the extent necessary for an individual to achieve his or her career objectives. These services include, but are not limited to:

*outreach*

—Emphasized during times of low employment and low demand for training. Also utilized for contacting special target groups.

*intake*

—Eligibility determination certified after interview

*assessment*

—To determine what CETA services are needed; usually limited to 2-3 weeks

*individual service plan*

—Detailed employability development plan (Prime Sponsor option)

*counseling*

—Emphasis on realistic choice given training availability and labor market conditions; vocational counseling often primary focus

*job development*

—Emphasis on solicitation of both mass and individual job development.

**Supportive Services**

Supportive services may include those listed below; CETA does not limit the Prime Sponsor in this area.

—physical examinations

—preventive health care

—medical diagnosis and treatment services

—psychiatric counselling

—alcoholism and drug abuse services

—dependent care

—family planning on voluntary basis

—residential support

—transportation

—assistance in securing employment bonds

—legal services.

In addition, post-placement services, including any of the above may be provided to CETA participants for 30 days following placement on a job.

Under Titles II and VI CETA must provide or assure that health benefits equivalent to health benefits provided other workers in the employing organization, are provided to participants funded by these titles.

While there is generally no ceiling on costs allowable in the provision of services to an individual, Prime Sponsors are urged to keep total expenditures per client and costs per placement within "reasonable" limits. Moreover, the legislation limits allowance and other payments to a duration of 104 weeks.

**Delivery of Services**
Prime Sponsors may elect to provide manpower and supportive services directly to participants or through subcontracts with other agencies or organizations in the community. This decision depends upon the relative costs to develop internal capacity to deliver services versus utilizing existing capabilities in the community. In addition, Prime Sponsors must consider the quality of existing services versus the quality of services they might develop themselves.

Services frequently subcontracted include:

—classroom training

—health care and medical services

—child care

—some job development and placement

—outreach.

Services typically provided by CETA staff include:

—intake and assessment

—orientation

—counseling

—administration of OJT

—portions of job development.

The actual degree of in-house delivery versus subcontracting may vary dramatically from Prime Sponsor to Prime Sponsor.

**Table 4: Activities and Services**
The table which follows illustrates the range of similar activities and services between CETA and HEW health programs. The circles denote similarities between programs that might provide a basis for cooperative arrangements. The table headings refer to the CETA activities and services detailed in the above text.

***As the chart indicates, all HEW health manpower programs and some health service programs involve a component of planning for health manpower needs, or the development of resources for manpower training through funding research, curriculum development and innovative training programs. Individual grantees must assess needs and resources on a local level as does CETA.***

***Classroom and on-the-job training (internships) are offered by HEW health manpower programs, usually in an educational institution. Certain HEW health service programs also authorize training to meet their manpower needs. Financial assistance to trainees or students is an aspect of some health manpower and health service sponsored training programs. Special projects for outreach, pre-training educational services and eventual placement may also be funded under certain programs. Supportive services may also be provided to students or trainees though none of the HEW programs have the service flexibility characteristics of CETA.***



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| **Table 4: Activities and Services** **HEW Program** / **CETA Authorized Activities and Services** | Manpower Planning and Resource Development | Manpower Services | Financial Assistance to Participants | Manpower-Related Services | Supportive Services |
|---|---|---|---|---|---|
| **Health Planning Programs** | | | | | |
| PL 93-641. Health Systems Agencies | ● | | | | |
| **Health Manpower Programs** | | | | | |
| 13 233 Maternal & Child Health Training | ● | ● | ● | ● | |
| 13 238 Mental Health—Staff Development Grants | ● | ● | | | |
| 13 244 Mental Health Training Grants | ● | ● | ● | ● | ● |
| 13 260 Family Planning Services—Training Grants | ● | ● | ● | ● | |
| 13.274 Alcohol Training Programs | ● | ● | ● | ● | ● |
| 13.280 Drug Abuse Training Programs | ● | ● | ● | ● | ● |
| 13.287 Grants for Training in Emergency Medical Services | ● | ● | | ● | |
| 13.342 Health Professions—Student Loans | ● | ● | ● | ● | |
| 13.364 Nursing Student Loans | ● | ● | ● | ● | |
| 13.305 Allied Health Professions—Special Project Grants | ● | ● | | ● | ● |
| 13.359 Nurse Training Improvement—Special Project Grants | ● | ● | | ● | ● |
| 13.380 Health Manpower Education Initiative Awards | ● | ● | ● | ● | ● |
| 13.383 Health Professions—Special Projects | ● | ● | | ● | ● |
| **Health Service Programs** | | | | | |
| 13.210 Comprehensive Public Health Services—Formula Grants | ● | ● | | ● | ● |
| 13.217 Family Planning Projects | | | | | ● |
| 13.224 Health Services Development—Project Grants | ● | ● | | ● | ● |
| 13.228 Indian Health Service | ● | ● | ● | ● | ● |
| 13.235 Drug Abuse Community Service Programs | | | | ● | ● |
| 13.254 Drug Abuse Demonstration Programs | | | | ● | ● |
| 13.269 Drug Abuse Prevention Formula Grants | ● | | | ● | ● |
| 13.240 Community Mental Health Centers | | | | ● | ● |
| 13 246 Migrant Health Grants | ● | ● | | ● | ● |
| 13 251 Alcohol Community Service Programs | | | | ● | ● |
| 13 252 Alcohol Demonstration Programs | | | | ● | ● |
| 13 257 Alcohol Formula Grants | ● | | | ● | ● |
| 13 261 Family Health Centers | | | | ● | ● |
| 13 714 Medicaid | | | | | ● |

● Indicates similar activities and services that might form the basis for cooperative agreements.

**Eligibility to Receive CETA Services**

Eligibility for participation in CETA-funded programs is quite broad. The legislation stipulates only that an individual must be:

—a resident of the Prime Sponsor's geographical program area and be

—economically disadvantaged, unemployed, or underemployed.

An "economically disadvantaged" individual is a member of a family receiving cash welfare payments or a member of a family which has a combined income of less than the poverty standard relative to family size as established by the Office of Management and Budget.

An "unemployed" individual has been out of work for one week or more and is actively seeking employment.

An "underemployed" individual is working part-time and seeking full time work or working full time and receiving less than the poverty wage as established by OMB.

The definition of "unemployed" varies slightly for Title II and Title VI purposes where the length of time since last employment is generally required to be at least thirty days. There are exceptions to this, however, so applicable regulations should be reviewed as they pertain to programs in any given area.

In addition to requirements established by law, Prime Sponsors have developed additional more restrictive requirements for programs within their jurisdiction. For example, some Prime Sponsors have limited enrollment to the economically disadvantaged. Local policies governing CETA operations should be reviewed in each jurisdiction.

**Target Groups And Significant Segments**

Prime Sponsors must ensure that, within the broad eligibility requirements prescribed by law, "significant segments" of the population are served and that those "most in need of service" are given priority. Significant segments identified in the Act include veterans, economically disadvantaged, public assistance recipients and youth. Additional significant segment groups might include:

—ethnic minorities

—women

—migrants

—persons of limited English speaking ability

—elderly

—the physically handicapped

—individuals with mental, emotional or other health handicaps

—ex-offenders

—educationally disadvantaged

—former manpower program enrollees.

Prime Sponsors are encouraged to serve significant segments in proportions consistent with their incidence in the labor force. However, no numerical requirements are established.

**Table 5: Participant Eligibility and Target Groups**

Participant eligibility requirements and target groups of HEW programs that are similar to those of CETA are outlined in the following table. The table headings refer to the CETA requirements described in the above text. The circles denote similarities between programs that might provide a basis for cooperative agreements.

***With few exceptions, there are no financial or residency requirements for eligibility imposed by HEW health programs comparable to those of CETA. Under CETA criteria most CETA participants would also be eligible for HEW health programs. However, additional criteria such as educational level, physical or mental impairment may exclude CETA participants from health programs.***

***Many HEW health programs have legislatively designated target groups in addition to administratively imposed service priorities. Since CETA target groups are specified at the discretion of the Prime Sponsor, possibilities for common target groups for both HEW grantee and Prime Sponsor will be dependent upon the local situation.***

**Table 5: Participant Eligibility and Target Groups**

| HEW Program | CETA Participant Eligibility Requirements | | Special Eligible CETA Target Groups | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Economically Disadvantaged, Unemployed or Underemployed | Residency | Limited English Speaking or Migrants | Individuals with Health-Related Handicaps | Veterans | Educationally Disadvantaged | Minority Groups | Economically Disadvantaged |
| **Health Planning Programs** | | | | | | | | |
| PL 93-641: Health Systems Agencies | | | | | | | | |
| **Health Manpower Programs** | | | | | | | | |
| 13.233 Maternal & Child Health Training | | | | | | | | |
| 13.238 Mental Health—Staff Development Grants | | | | ● | | | | |
| 13.244 Mental Health Training Grants | | | | ● | | | ● | |
| 13.260 Family Planning Services—Training Grants | | | | | | | | |
| 13.274 Alcohol Training Programs | | | | ● | | | | |
| 13.280 Drug Abuse Training Programs | | | | | | | | |
| 13.287 Grants for Training in Emergency Medical Services | | | | | | | | |
| 13.342 Health Professions—Student Loans | ● | | | | | | ● | ● |
| 13.364 Nursing Student Loans | ● | | | | | | ● | ● |
| 13.305 Allied Health Professions—Special Project Grants | | | | | ● | ● | ● | ● |
| 13.359 Nurse Training Improvement—Special Project Grants | | | ● | | | ● | ● | ● |
| 13.380 Health Manpower Education Initiative Awards | | | ● | | ● | ● | ● | ● |
| 13.383 Health Professions—Special Projects | | | | | | ● | ● | ● |
| **Health Service Programs** | | | | | | | | |
| 13.210 Comprehensive Public Health Services—Formula Grants | | | | ● | | | | ● |
| 13.217 Family Planning Projects | | | | | | | | ● |
| 13.224 Health Services Development—Project Grants | | | | | | | | ● |
| 13.228 Indian Health Service | | ● | | | | | ● | |
| 13.235 Drug Abuse Community Service Programs | | | | ● | | | | |
| 13.254 Drug Abuse Demonstration Programs | | | | ● | | | | |
| 13.269 Drug Abuse Prevention Formula Grants | | | | ● | | | | |
| 13.240 Community Mental Health Centers | | ● | | ● | | | | ● |
| 13.246 Migrant Health Grants | | | ● | | | | | ● |
| 13.251 Alcohol Community Service Programs | | | | ● | | | | |
| 13.252 Alcohol Demonstration Programs | | | | ● | | | | ● |
| 13.257 Alcohol Formula Grants | | | | ● | | | | |
| 13.261 Family Health Centers | ● | | | | | | | ● |
| 13.714 Medicaid | ● | ● | | | | | | |

● Indicates similarities between programs that might form the basis for cooperative agreements.



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**CETA Comprehensive Manpower Plan**

With their annual application for funding Prime Sponsors must submit a comprehensive manpower plan that states, for each Title of the Act, how they intend to use their CETA funds and how they intend to coordinate CETA activities with other manpower programs and services operating in the area. The plan generally consists of a narrative description of the program, a program planning summary (number of people, significant segments, services and activities planned), a budget information summary, and a labor market summary.

Generally, the comprehensive manpower plan sets forth:

(1) the Prime Sponsor's policy with respect to purposes of the program,

(2) a description of the economic conditions and the labor force characteristics in the area,

(3) identification of shortage occupations,

(4) a definition of the area manpower needs,

(5) the groups to be served, and

(6) the goals (quantitative results expected) of the program.

In addition, the plan states how the planned activities serve identified manpower needs and the reasons for selecting the various activities, and describes how activities and services will lead CETA participants to economic self-sufficiency. Plans must include a description of how the program will be organized, how each service included in the plan will be operated, how significant segments and veterans will be adequately served, how financial and administrative systems will be designed, and the ways in which CETA will be coordinated with other manpower services in the area.

The comprehensive manpower plan is submitted to the Department of Labor annually, usually in April or May, but prior to the start of the new fiscal year. Prime Sponsor planning staffs generally initiate accelerated planning activities early in the calendar year in order to meet the spring deadline. This timing will change with the new Federal fiscal year.

**Advisory Groups And Plan Review**

The CETA legislation requires that, as part of the planning process, each Prime Sponsor establish a Manpower Planning Council to review and make recommendations for the Prime Sponsor plan.

The Prime Sponsor Manpower Planning Council is composed of members representing:

—the participant community

—community-based organizations

—the State Employment Service

—education and training agencies and institutions

—business and organized labor

—agriculture where appropriate.

Specifically, the Planning Council advises the Prime Sponsor on establishment of basic goals, policies and procedures. In addition, the Planning Council monitors all activities funded under the Act and provides objective evaluations of other manpower and related programs operating in the Prime Sponsor's area in order to improve the utilization and coordination of such services.

The state, as a Prime Sponsor, must establish a Manpower Planning Council for its responsibilities in the Balance-of-State. The Balance-of-State consists of those areas not included in the comprehensive manpower plan of another Prime Sponsor and therefore under jurisdiction of the state.

In addition to its Prime Sponsor Manpower Planning Council, the state must establish the State Manpower Services Council (SMSC) which serves all Prime Sponsors in the state, reviews the plans of all Prime Sponsors in the state (including the Balance-of-State plan prepared by the Planning Council) and makes recommendations concerning the provision and coordination of manpower services among Prime Sponsors and manpower-related state agencies.

The SMSC consists of:

—at least one-third representatives of Prime Sponsors (required)

—one representative each from:

the State Vocational Education Board (required)

the State Employment Service (required)

any other state agency the Governor believes has an interest in manpower or manpower-related services

(Participation by the State Health Planning Council is one approach to health representation and coordination with CETA)

—representatives are also suggested from:

organized labor

business

the general public

community based organizations

client populations.

In its advisory capacity the SMSC reviews all Prime Sponsor plans within the state and all state agency plans for providing services to Prime Sponsors within the state. Reviews are conducted for the purpose of recommending ways to improve coordination between Prime Sponsors and state agencies in the delivery of services. In addition to plan review the SMSC is charged with monitoring the availability, responsiveness and adequacy of state services provided by all manpower-related agencies to assure that effective coordination is taking place.

**Key Performance Measures**

The primary measure of Prime Sponsor success is effectiveness in "placement", moving participants into unsubsidized employment at wage levels providing self-sufficiency. Placement success is measured by placement *duration:*

—short term (0–3 days)

—medium term (3–150 days)

—long term (greater than 150 days).

Prime Sponsors receive credit for placements that result from services and activities provided. Placement credit is also received for other agency services and activities that are a direct result of referral from CETA.

Secondary performance categories include:

—effectiveness in committing CETA resources within the Prime Sponsor's program area (speed of implementation and full expenditure within the grant period),

—cost per participant,

—cost per placement,

—service to the "most in need" (focusing on disadvantaged),

—service to identified "significant segments" and veterans.

During the initial year of CETA activity Prime Sponsors were rewarded their ability to commit CETA funds rapidly. As program operations continue, however, and as more programs begin operating near capacity, the issues of placement and service to "significant segments" will probably dominate performance reviews.



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**Reporting Requirements**
Each CETA Prime Sponsor is required by the Department of Labor to submit certain statistical data. This includes:

Enrollment of and distribution of clients within CETA activities (classroom, OJT, public service employment, work experience);

Characteristics of CETA clients, including:

—sex

—age

—education

—health status

—income

—ethnic background

—veteran status;

Successful placements by CETA clients in permanent jobs without subsidy (short-term, medium-term, long-term);

Status of other CETA clients (dropouts, etc.).

**Table 6: Plan Review and Advisory Councils**
Table 6 compares the governmental level of review processes and advisory councils of CETA and health programs. The circles denote similarities between programs that might provide a basis for cooperative agreements. It should not be implied, however, that the *nature* of the review processes between CETA and health programs is the same.

***Like CETA, HEW health program grantees must submit a plan or proposal to receive funds. Proposals from health manpower grantees are generally approved at the national level, usually in conjunction with a national advisory council, after HEW Regional Office review. There is an exclusively national orientation of the mandated advisory groups to these programs.***

***Most HEW health service program proposals and plans undergo extensive local, state and regional review. However, with few exceptions advisory groups are also nationally oriented.***

***Many manpower and service projects funded by HEW will be reviewed and approved by the Health Systems Agencies once the National Health Planning and Resource Development Act (PL 93-641) is implemented in 1976. Approximately 200 Health Systems Agencies will be established throughout the U.S. replacing existing comprehensive health planning bodies, Regional Medical Programs, and Hill-Burton agencies.***

**Table 6: Plan Review and Advisory Councils**

| HEW Program | CETA Plan and Levels of Review | | | | | CETA Advisory Groups | | |
|---|---|---|---|---|---|---|---|---|
| | Required Plan or Proposal | Local Review | State Review | Regional Review | National Review | Local | State | National |
| **Health Planning Programs** | | | | | | | | |
| PL 93-641 Health Systems Agencies | ● | | ● | ● | ● | ● | ● | ● |
| **Health Manpower Programs** | | | | | | | | |
| 13.233 Maternal & Child Health Training | ● | | | | ● | | | |
| 13.238 Mental Health—Staff Development Grants | ● | | | ● | | | | |
| 13.244 Mental Health Training Grants | ● | | | | ● | | | ● |
| 13.260 Family Planning Services—Training Grants | ● | | ● | | ● | | | |
| 13.274 Alcohol Training Programs | ● | | | | ● | | | ● |
| 13.280 Drug Abuse Training Programs | ● | | | | ● | | | ● |
| 13.287 Grants for Training in Emergency Medical Services | ● | | | ● | ● | | | |
| 13.342 Health Professions—Student Loans | | | | | | | | |
| 13.364 Nursing Student Loans | | | | | | | | ● |
| 13.305 Allied Health Professions—Special Project Grants | ● | | | | ● | | | ● |
| 13.359 Nurse Training Improvement—Special Project Grants | ● | | | | ● | | | ● |
| 13.380 Health Manpower Education Initiative Awards | ● | | | | ● | | | ● |
| 13.383 Health Professions—Special Projects | ● | | | | ● | | | ● |
| **Health Service Programs** | | | | | | | | |
| 13.210 Comprehensive Public Health Services—Formula Grants | ● | | | | ● | | | |
| 13.217 Family Planning Projects | ● | ● | ● | ● | ● | | | |
| 13.224 Health Services Development—Project Grants | ● | ● | ● | ● | | | | |
| 13.228 Indian Health Service | | | | | | | | |
| 13.235 Drug Abuse Community Service Programs | ● | ● | ● | | ● | | | ● |
| 13.254 Drug Abuse Demonstration Programs | ● | | ● | | ● | | | ● |
| 13.269 Drug Abuse Prevention Formula Grants | ● | | ● | | ● | | | ● |
| 13.240 Community Mental Health Centers | ● | ● | ● | ● | | ● | ● | |
| 13.246 Migrant Health Grants | ● | ● | | ● | | ● | | |
| 13.251 Alcohol Community Service Programs | ● | ● | ● | | ● | | | ● |
| 13.252 Alcohol Demonstration Programs | ● | | ● | | ● | | | ● |
| 13.257 Alcohol Formula Grants | ● | | ● | | ● | | ● | ● |
| 13.261 Family Health Centers | ● | ● | ● | ● | | ● | | |
| 13.714 Medicaid | ● | | ● | ● | | | | |

● Denotes similarities between programs that might form the basis for cooperative agreements.



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**Special Responsibilities Of State Prime Sponsors**

The state as Prime Sponsor, in addition to operating the Balance-of-State program, has certain additional responsibilities for statewide manpower activities. Each state receives a special grant for the provision of statewide manpower services and staffing the SMSC.

Special manpower services may include:

—services under the Act throughout the state by state agencies responsible for employment, training, and related services;

—financial assistance for special programs and services designed to meet the needs of rural areas outside major labor market areas;

—developing and publishing information regarding economic, industrial, and labor market conditions;

—technical assistance, without reimbursement and upon request, to any Prime Sponsor serving an area within the state;

—special model training and employment programs and related services, including programs for offenders and similar programs.

**Special Vocational Education Funds**

The Governor of each state receives a special grant to provide vocational education services to Prime Sponsors within the state. These special grant monies must be channeled through the State Board for Vocational Education and may only be used for the provision of vocational eduction services to each Prime Sponsor.

Each Prime Sponsor negotiates a non-financial agreement with the State Board for Vocational Education which specifies the kind of services to be provided and the manner in which services will be provided. Services under the special grant/non-financial agreement are in addition to any educational services which the individual Prime Sponsors may purchase with regular Title I funds.

**Mandate for Coordination**

Congress, in deliberating the CETA legislation, expressed a strong desire that CETA activities be coordinated effectively with other manpower and manpower-related activities in each Prime Sponsor jurisdiction. Section 106(b) (2), (3) & (7) requires that each Prime Sponsor, to the extent feasible, must establish cooperative relationships or linkages with other manpower and manpower-related agencies in the area. In addition, any Prime Sponsor intending to provide service to recipients of Aid to Families with Dependent Children (AFDC) must coordinate with the local sponsor of the Work Incentive Program (WIN).

Beyond these direct charges to establish program coordination the states, through the SMSC and special grant funds, are responsible for encouraging and facilitating coordination among CETA Prime Sponsors and other state agencies providing manpower and manpower-related services.

# Chapter Three
# Some Specific Opportunities

Several specific examples of co-operative arrangements are described in this chapter. These arrangements are illustrative of ideas which may be identified through application of the analytic framework set forth in Chapter Four. No attempt is made here to present an exhaustive list of coordination ideas, nor should the list be construed as fully representative of the range of possibilities between HEW health program grantees and CETA Prime Sponsors. These nine opportunities represent illustrations of actual experience in various parts of the country.

The purpose of this chapter is to initiate or nurture, in as many jurisdictions as possible, the analytic process by which health program administrators and staff can identify potential relationships with their counterparts in CETA Prime Sponsors, which in turn will benefit HEW grantees, CETA and their common clients.

Each of the opportunities is organized into eight parts, as follows:

A. Issues Facing Health and CETA Programs

B. How Coordination Can Help

C. How It Might Work

D. How Health Programs Can Benefit

E. How CETA Can Benefit

F. Risks to Health Programs

G. Risks to CETA

H. How to Reduce the Risks

**Opportunity 1: Allied Health Manpower Project**

**Issues Facing Health and CETA Programs**

Placement of enrollees in permanent, unsubsidized employment is the primary goal of CETA Prime Sponsors.

The health care industry offers increasing numbers of employment opportunities, particularly in the allied health occupations, in many geographic areas. However, many Prime Sponsors have neither the technical capability to pinpoint future demands for health manpower, nor the expertise to provide training for those occupations.

HEW health manpower grantees face a prospective future decline in Federal institutional support for curriculum development and student financial support, but shifts in health care industry technology have created demand for new training methods for new occupations.

**How Coordination Can Help**

CETA Title I training funds can be utilized to support curriculum development and innovative training techniques for new occupation areas such as those in the allied health field. HEW health manpower grantees may have the capability to identify demand for new allied health occupations, develop appropriate training programs, and provide student financial support.

**How It Might Work**

In St. Louis, the city Prime Sponsor has entered into an agreement with the Forest Park Community College, an HEW health manpower grantee, to establish a training program for allied health occupational clusters flexible enough to meet the changing needs of the health care industry. To insure the responsiveness of this training program, the Prime Sponsor has established an employer committee consisting of representatives of some hospitals and other health care institutions in the St. Louis area, who were recommended by the Community College. Committee members are responsible for supplying job demand information at their institutions and for review and approval of the training program developed under the project. Membership on the employer committee is limited to those institutions anticipating hiring in allied health occupations in the immediate future and willing to guarantee that completion of a training program would certify the graduate as meeting standards for employability at their institutions.

After approval of the training packages by the employer committee, CETA clients enter the training program. Upon completion, placement of the CETA clients is the primary responsibility of the Prime Sponsor, with the assistance of the Forest Park Community College and the employer committee.

**How Health Programs Can Benefit**

—CETA funds support the development and implementation of training programs responsive to demands in the health industry. In St. Louis, these programs were developed in an integrated manner allowing for vertical and horizontal career mobility for the CETA clients.

—CETA funds provide financial assistance and supportive services to CETA eligible students.

—CETA referrals expand enrollment.

—Placement of students may be higher due to services of CETA staff and the employer committee.

—CETA information on labor market demand allows adjustment in enrollment so that students do not continue to be trained in low-demand occupational areas.

**How CETA Can Benefit**

—CETA clients are trained for occupations of high demand in the allied health field.

—Required approval of training programs by the employer committee assures standards for immediate employment.

—Relationships are developed with employers in the growing health care industry that might be utilized for the development of OJT and work experience projects.

—Availability of job information on the dynamic and changing needs of the health delivery system provides input on future manpower requirements for the Prime Sponsor's planning process.

**Risks to Health Programs**

—There may be an overcommitment of resources to transitional CETA requirements without regard for long-term needs and availability of support.

**Risks to CETA**

—Heavy reliance on employer-based forecasts of health manpower demand may not reflect true area-wide demand because of the narrow base of the committee.

—Jobs projected might not occur at times trainees are ready.

**How to Reduce the Risks**

—Expand the employer committee to include other health care employers such as physicians, medical laboratories and representatives from health planning agencies and Federal health manpower programs.

—Develop contingency plans with employers (i.e., Title II or VI employment) if graduates are not immediately employable due to economic conditions in the health care industry.

—Coordinate the project with the local health planning agency to insure that training programs developed reflect long-term areawide needs.

**Other Applicable HEW Programs**

Grantees of the following HEW programs may have the capability to develop the type of cooperative arrangement with CETA Prime Sponsors described in this example:

13.104 Food Research Training Grants

13.106 Radiological Health Training Grants

13.233 Maternal and Child Health Training

13.244 Mental Health Training Grants

13.274 Alcohol Training Programs

13.280 Drug Abuse Training Programs

13.287 Grants for Training in Emergency Medical Services

13.305 Allied Health Professions—Special Project Grants

13.359 Nurse Training Improvement—Special Projects

13.380 Health Manpower Initiative Awards

13.383 Health Professions—Special Projects

**Opportunity 2: Health Occupation Planning Project**

### Issues Facing Health and CETA Programs

The provision of health services, including direct care and related supportive services, is among the nation's largest industries. It provides employment at all occupational levels, including entry level positions, in a wide variety of occupations. These may be jobs directly related to patient care as well as supportive services in technical, clerical, and other areas. CETA needs to identify the jobs that would be appropriate to its clients, and organize a comprehensive approach to recruitment, training, and placement in this area.

Organizations with health manpower planning responsibilities, such as the new Health Systems Agencies, may reach only some of the resources being devoted to training for health manpower. These agencies need to develop relationships with the wide array of organizations providing health manpower training, regardless of funding source, to more directly influence training for areas of need.

### How Coordination Can Help

A combined effort with health manpower planning organizations can assist CETA to identify job possibilities in the health field, appropriate educational and training programs, and future employers of health personnel. The participation of CETA in health manpower planning helps assure a wider scope for health planning, enabling access to state and local programs which control the response of other manpower resources to the planned need.

### How It Might Work

The Comprehensive Manpower Program of Greater Hartford has contracted with the Connecticut Institute for Health Manpower Resources, a grantee of the Regional Medical Program, to identify entry level jobs for possible training and placement of CETA clients. The Institute conducted an inventory of health employers and current job possibilities for CETA clients, and analyzed potential future opportunities, and projected levels of employment in the health field for the "disadvantaged." This information was transmitted to CETA for use as a guide in planning training and placement of CETA clients.

### How Health Programs Can Benefit

—Manpower planning information identifies needs that impact on health occupation training programs at the local level.

### How CETA Can Benefit

—Health labor-market information can identify shortage occupations for inclusion in the comprehensive manpower plan.

—Health student enrollment projections can assist CETA in identifying future strengths and gaps in health manpower supply.

—The health manpower planning function is accomplished at lower cost than creation of in-house capability would require.

### Risks to Health Programs

—None apparent.

### Risks to CETA

—CETA may be funding an activity that would be carried out regardless of CETA participation

### How to Reduce the Risks

—Prior to negotiations both parties should conduct a review of the extent of existing health manpower planning information and set standards, specified in the agreement, for level of detail and quality of information.

### Other Applicable HEW Programs

Under P.L. 93-641, the Regional Medical and Comprehensive Health Planning programs were consolidated into new Health Systems Agencies. Health manpower planning in HEW is conducted by the Bureau of Health Manpower and Bureau of Health Planning and Resource Development in the Public Health Service. Many other agencies are involved with health manpower planning, including State Higher Education Commissions, State Vocational Education Agencies, and State Health Agencies.

In order to maximize support for cooperative efforts towards training and utilization of health manpower, CETA Prime Sponsors and manpower planning councils at state and local levels should plan for and develop continuing cooperative arrangements with Health Systems Agencies and State Health Planning Agencies to be established under P.L. 93-641. A wide range of subjects for collaborative action is likely to develop through such arrangements. Of particular importance will be joint efforts to identify health occupation supply and demand, institutions to train for occupation shortage areas, and future employers of health manpower personnel.

**Opportunity 3: Prepaid Health Services for CETA Clients**

Issues Facing Health and CETA Programs

CETA is required either to provide or to assure that health benefits are provided to CETA public service (Title II) and emergency employment (Title VI) participants, equivalent to those provided other workers in the employing organization. In addition, CETA may purchase medical services for participants in other training and work experience programs. Seeking the most efficient and cost effective method of providing comprehensive health care is therefore important to CETA.

Many HEW programs are designed to strengthen comprehensive health services for certain target groups with unusual needs and to demonstrate new health service delivery mechanisms. Most of these programs are under Federal pressure to reduce their reliance on HEW funds and to increase self-sufficiency through third-party reimbursements.

How Coordination Can Help

Some HEW-funded health service programs can provide comprehensive medical services to CETA participants. Those programs operating under the prepaid health maintenance concept can also offer comprehensive health benefit packages. Services may be available to CETA participants at lower cost than services purchased through the traditional health service delivery system.

How It Might Work

In Santa Clara County, California, the county Prime Sponsor contracted with the Health Alliance of Northern California, a health maintenance organization partially funded by HEW, to provide health benefits to selected CETA participants in work experience, public service, and emergency employment status. Payment for service was on a prepaid, capitation basis for each CETA participant. Difficulties arising from the comparability of Health Alliance benefits to benefits provided by the Title II employer were resolved by giving the enrollee the option to join the Health Alliance only when the Alliance was one of the health benefit plans offered by the employer.

How Health Programs Can Benefit

—The CETA group is a needed source of third-party income supporting the service program.

—CETA coverage may open up other group opportunities with Title II employers.

—An economically needy target group —CETA clients—is assured of quality health services.

How CETA Can Benefit

—Required health benefits are provided to Title II and Title VI enrollees at lower cost, through a single simple agreement.

—Health benefits are also provided to certain Title I enrollees, encouraging preventive care through the health maintenance concept and assuring their continuance in the training program if illness strikes.

Risks to Health Programs

—Service costs may be higher than CETA prepayments because of the transitional nature of CETA clients, thus limiting the utility and cost-effectiveness of the health maintenance approach.

—Variability in CETA group size may affect plan revenues significantly due to the changing nature of the CETA client group, particularly given the uncertainty of Title II and Title VI funding levels.

Risks to CETA

—Administrative difficulties may occur as enrollees transfer from work experience or emergency employment to public service positions with employers not offering the specific agreement health maintenance plan as one of their health benefit plans.

—CETA may incur costs for enrollees already eligible for the health plan or for Medicaid.

—Local unions and health insurance companies may object to utilization of non-traditional health service plans for Title II and Title VI enrollees.

—Costs for a prepaid plan for Title I enrollees may prove to be more expensive than paying for medical services on an as-needed basis if the anticipated demand does not materialize.

How to Reduce the Risks

—Negotiate a periodic review of the costs and services provided under the agreement, with options for discontinuance by either party if the agreement becomes disadvantageous.

—Agree on how to handle payment for persons already eligible for the health plan; exclude enrollees on Medicaid unless the enrollee exercises an option to receive Medicaid services through the CETA-designated health plan.

—Negotiate a minimum group size for coverage of CETA clients.

Other Applicable HEW Programs

HEW health service programs that fund projects capable of providing comprehensive health services or benefits to CETA enrollees are listed below. The Indian Health Service has its basis in American Indian treaty rights as well as Public Health Service laws. As such, it is a Federally-managed system of direct patient care that serves as an equivalent of state/local health service delivery systems in the unique tribal jurisdictions. The other programs listed below (except Medicaid financing) are operated at the state and local level by selected non-Federal entities who are funded for varying lengths of time because they demonstrate a capability to serve the community in a highly effective or innovative way which contributes to the overall improvement of the health service delivery system. All of these programs have a substantial impact on community health services but not all service-deliverers are participants, a fact that requires CETA to give attention to these programs in the context of what the total community of resources has to offer.

13.228 Indian Health Service

13.224 Health Services Development—Project Grants

13.246 Migrant Health Centers

13.256 Health Maintenance Organization

13.261 Family Health Centers

13.714 Medicaid (financing only)

**Opportunity 4: Demonstration Training Program for Disabled Youth**

**Issues Facing Health and CETA Programs**

Some CETA Prime Sponsors may have employment priorities for "most-in-need" target groups such as the developmentally disabled or physically handicapped, yet the Prime Sponsor may lack the assessment, counseling and training capability to serve these populations.

HEW projects (such as those funded through community mental health centers or Federal programs for the developmentally disabled) may have the skills to serve these target groups but may lack the resources to expand service beyond a small population. In many cases, those individuals with mild disabilities or potential employability often receive lowest priority and are excluded from service.

**How Coordination Can Help**

CETA funds can be used by the Prime Sponsor to fund development and operation of innovative training programs by qualified agencies to assist these client groups to reach unsubsidized employment. HEW funded projects for these target groups must utilize such funding to develop demonstration manpower and training projects as part of a more balanced service program. A successful demonstration program might possibly expand the capability of both the health agency and Prime Sponsor to serve more of the population in need.

**How It Might Work**

In St. Louis, the Prime Sponsor contracted with the Child Development Center, a HEW-UAF facility of St. Louis University, to develop a demonstration job experience and skill training program for developmentally disabled youth for employment in the food service industry. The duration of the program was a minimum of 120 hours of training in 6 weeks, with 2 classes of 10 individuals each.

In addition to training in food service, the Child Development Center performed such activities as diagnostic and evaluation assessments to determine individual strengths and weaknesses related to future employability and provided counseling and needed medical service to the enrollees. Job development and placement was also the responsibility of the Center. The CETA program made referrals, certified eligibility of the enrollees, and assisted in the placement process.

Graduates of the program were tracked after job placement as part of the overall evaluation conducted by the Center. The Center provided the city with a complete evaluation of the training project, including recommendations for future programs.

**How Health Programs Can Benefit**

—Staff capacity is enriched through knowledge and skills gained during the project period, useful even if the program is not successful or not continued.

—Service is expanded to a broader client group normally receiving limited service due to their degree of disability.

—Access to job placement resources of CETA may be opened to other clients not enrolled in the program.

—Seed funds provided by CETA might attract additional support for the standard service program of the agency.

**How CETA Can Benefit**

—Information is generated on the training needs of a special group in the CETA population and the probable success/costs to serve that target group.

—Program capability is developed to serve segments of the population in need designated by the Prime Sponsor.

—Program capability through contract services may be more cost-effective than direct service delivery.

—The CETA evaluation capability developed for the demonstration project can be utilized to assess similar projects proposed by other agencies.

—A relationship is developed with a resource having capability to deal with the special needs of certain CETA clients.

—Coordinated programming can provide a potentially more stable group of employees in unskilled jobs often marked by low turnover.

**Risks to Health Programs**

—CETA may recruit health program staff to become part of a new CETA unit providing services to developmentally disabled youth.

—The program, even if successful, may not be implemented by CETA though the demand for such services may continue.

**Risks to CETA**

—The demonstration project may not be successful in developing an effective training project nor generate sufficient information for conclusions about feasibility of alternative methods.

—The demonstration project may be skewed to guarantee success of initial enrollees in order to insure continued funding.

—Costs of serving developmentally disabled clients may be higher than the cost of service to the traditional CETA client.

**How to Reduce the Risks**

—Negotiate the "level of developmental disability" which will allow a client to be accepted into a CETA program and which will enable appropriate work-up by CETA staff. Allow adequate time for recruitment and referral to that level.

—Negotiate, in advance, responsibilities for referrals to service delivery if the program is not continued by either CETA or the health program.

—Explore funding possibilities for the health program if the project is successful.

—Agree that the health program will explore already tested training methods for the target group prior to development of new methods, and will report such information to the Prime Sponsor.

—Agree that enrollees in the program will be a representative sample of the target group and that evaluation of the project will be conducted by an independent organization, or insure close CETA review of evaluation results.

**Other Applicable HEW Programs**

The described capabilities of the Center for Child Development may exist in other HEW-funded grantees under the following programs:

13.211 Crippled Children Services

13.240 Community Mental Health Services

13.259 Mental Health—Children's Services

13.630 } Programs for the
13.631 } Developmentally Disabled

**Opportunity 5: Training for Health Program Manpower Needs**

### Issues Facing Health and CETA Programs

HEW health service programs must respond to rapid increases in knowledge and changes in delivery techniques through service restructuring and improving staff capabilities. Many service programs do not have the resources to implement major staff development programs or training courses for new positions. In certain specialized positions the overall demand may be too small to generate independent training opportunities.

### How Coordination Can Help

CETA can fund classroom and on-the-job training for eligible participants. Health service programs can indicate manpower demand needs and assure placement of training program graduates for new positions. Employment of the participants in the health service program meets individual needs and fulfills CETA placement goals.

### How It Might Work

In Colorado, an agreement between the Area Council of Governments—Manpower Administration, the University of Southern Colorado (USC), and the Colorado State Hospital was developed to train and place 30 psychiatric technicians. CETA undertook eligibility determination and intake for all referrals to the University. Under contract to CETA, USC staff assisted in education counseling and designed individual service plans. CETA provided funds for student tuition, books, and teaching costs. The University provided an instructor and access to all University services. The Colorado State Hospital, a current recipient of HEW drug abuse formula grant funds, identified the need for the psychiatric technicians within the institution. The hospital was the site for field work, paid the student stipends (basic training allowance) and agreed to hire the enrollees after training.

### How Health Programs Can Benefit

—An unmet need for allied health personnel within health service institutions is filled through cooperation with CETA.

### How CETA Can Benefit

—Placement is reasonably certain for CETA enrollees in allied health occupations, without utilization of public service slots.

—Financial participation of the health service program reduces average cost per client.

### Risks to Health Programs

—None apparent.

### Risks to CETA

—Training program graduates may not be placed because of the uncertainty of future funding of Federal and state financed health care institutions.

### How to Reduce the Risks

—Negotiate evidence of commitment from health care institutions for hiring of graduates (i.e., budgetary requests).

### Other Applicable HEW Programs

All HEW health service programs might have the interest and capability to participate in the arrangement described in this example.

**Opportunity 6: Joint Manpower Services to Veterans**

### Issues Facing Health and CETA Programs

CETA has a special mandate to serve veterans under Title II, as well as the likelihood that they will be part of the "significant segments" to be served under Title I. Many returning veterans have military-based job-related skills; however, some Prime Sponsors do not have the capability to identify and develop these skills in shortage occupation areas for employment.

Veterans are also a priority target group for HEW-funded health manpower programs, and special projects have been funded to identify, counsel, and refer those veterans with military medical-care experience to health-care jobs. These projects are called Operation MEDIHC—(Military Experience Directed Into Health Careers). However, Operation MEDIHC projects are limited in their ability to provide training, subsidized employment and other manpower-related services.

### How Coordination Can Help

CETA Title I funds can be used for training and manpower-related activities; Title II supports public service employment. Operation MEDIHC can identify veterans with related military experience in medical care, determine skill shortage areas, and identify job opportunities in the health care industry. A joint program maximizes the resources of each program in serving a target group of both.

### How It Might Work

The State of Illinois (Balance-of-State Prime Sponsor) and the Operation MEDIHC grantee, the Illinois Hospital Association, have agreed to sponsor jointly a job development and training program in allied health professions for veterans in a five-county rural area. Also involved in the project, either by contract or by agreement, are the local county CETA program agents, the Veterans Administration district office, the Illinois State Employment Service district office, local hospitals, and community colleges.

The Illinois Hospital Association, under contract to CETA, conducts an outreach program to reach unemployed veterans, provides employment counseling, and coordinates classroom and/or on-the-job training for allied health positions such as Emergency Medical Technician. CETA funds the training directly and provides other manpower-related services. Stipends are available to enrollees through the Veterans Administration. The Illinois Hospital Association also makes health manpower projections in the five-county area for CETA and develops public service positions and permanent jobs in the health care industry for placement of the enrolled veteran.

### How Health Programs Can Benefit

—Training, work experience, and public service employment activities are made available to Operation MEDIHC clients.

—Operation MEDIHC services are expanded to a larger client population, with a higher placement rate due to the availability of CETA services.

—Eventual placement is possible in a greater variety of health care occupations due to the provision of specialized training services.

### How CETA Can Benefit

—Title I and II enrollees are placed by the Prime Sponsor in skill areas and industries not normally accessible.

—CETA services are provided to a larger percentage of a designated target group, with a higher placement rate due to the services available through Operation MEDIHC.

—Arrangements can be made for training credit for military experience that might allow advanced standing in some health career training programs.

—Costs per CETA client are reduced due to joint program operations and the financial participation of the Veterans Administration.

—Forecasts of health manpower needs are useful in overall planning by the Prime Sponsor for employment opportunities.

### Risks to Health Programs

—CETA funding, particularly Title II and Title VI, can be unstable, threatening continuance of the project and therefore the good relationships developed with the employers in the health industry.

—Reliance on CETA manpower services may divert attention from veteran clients not requiring such training services for placement.

### Risks to CETA

—Veterans may be diverted from placements in other fields to enter this program; however, placements are not guaranteed, but rely on goodwill between local hospitals and the Operation MEDIHC grantee.

—CETA may unnecessarily fund training services that are otherwise available through the Veterans Administration.

—Funding of health manpower programs may be discontinued, forcing CETA to bear the entire cost of Operation MEDIHC in order to retain the capabilities developed by the project.

### How to Reduce the Risks

—Jointly discuss multi-year funding expectations and develop contingency plans outlining responsibilities of both programs if funding of either is discontinued.

—Agree on eligibility standards for joint program enrollees, with consideration of placement costs and possibilities in other than health occupations.

—Agree on service responsibilities of both programs, particularly in relationship to services and benefits provided by other veterans' programs.

### Other Applicable HEW Programs

This example may also be applied to other CETA target groups, such as offenders, ethnic minorities and youth, in situations where HEW health manpower grantees have specific responsibilities for those target groups. Such HEW project grants may be funded under the following programs:

13.305 Allied Health Manpower—Special Projects

13.259 Nursing Training—Special Projects

13.375 Minority Biomedical Support

13.380 Health Manpower Initiative Awards (Operation MEDIHC; Special Health Career Opportunity Grants)

13.383 Health Professions—Special Projects

13.263 Emergency Medical Services Training

**Opportunity 7: Recruiting Disadvantaged for Nurse Training**

**Issues Facing Health and CETA Programs**
HEW health manpower programs actively recruit ethnic minorities and economically disadvantaged students. However, these students often need remedial education prior to admission to health training programs. Federal financial assistance in health programs is not available for remedial education; as a result many of these students do not enroll in the program or drop out because of lack of preparation.

**How Coordination Can Help**
CETA Title I funds can be used for remedial education and training allowances for eligible clients who might be interested in pursuing health careers. Financial assistance (HEW grants or loans) is available to students upon enrollment in the health career program.

**How It Might Work**
In the State of Washington a program is promoting relationships between CETA Prime Sponsors and collegiate schools of nursing which receive HEW nursing training funds. Schools of nursing will refer prospective students for CETA eligibility determination and recommend a program of remedial education in certain areas. CETA will purchase the necessary remedial education and provide stipends if necessary. The school will guarantee acceptance into the nurse training program after completion of the remedial education course; all costs attendant to the training are borne by Federal funds. In some cases a certain number of the nurse training positions will be reserved for CETA-initiated referrals. After one year of training, the student will become eligible for certification as an LPN; after 2 years, RN certification is possible.

**How Health Programs Can Benefit**
—Economically disadvantaged and ethnic minority students can be successfully recruited and accepted into health career programs.

—Dropout rates in training programs are reduced.

—Eligibility of students for CETA allows access to special CETA services.

**How CETA Can Benefit**
—Economically disadvantaged students are provided skill training and placement in significant employment at limited cost to CETA.

**Risks to Health Programs**
—There is no guarantee that students, after receiving CETA remedial education, will decide to enter the school and pursue a health career.

—CETA participants referred to health career programs may not be qualified for enrollment.

**Risks to CETA**
—Once in the training program, CETA has no control over training or placement decisions for a student.

—Credit for placements is received one to two years after the CETA expenditure.

**How to Reduce the Risks**
—Negotiate student commitment and tie financial assistance to entry and completion of the proposed training program.

—Negotiate standards for remedial education courses and student qualifications for entry into training.

**Other Applicable HEW Programs**
Other HEW health manpower programs that might benefit from the arrangement described above include:

13.233 Maternal and Child Health Training

13.263 Occupational Safety and Health Training Grants

13.287 Grants for Training in Emergency Medical Services

13.288 National Health Service Corps Scholarship Program

13.342 Health Professions—Student Loans

13.364 Nursing Student Loans

13.380 Health Manpower Education Initiative Awards (Operation MEDIHC; Special Health Career Opportunity Grants)



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**Opportunity 8: Training of CETA Enrollees in Drug Abuse Counseling**

**Issues Facing Health and CETA**
HEW Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) grantees, including community-based alcohol, drug abuse and mental health centers and training projects, have needs in certain skilled occupations such as vocational and outreach counselors and public education specialists to strengthen their service impact and effectiveness. However, funds available through these programs to train in these fields may be insufficient to meet all needs.

**How Coordination Can Help**
Prime Sponsors can use CETA Title II and VI funds for public service employment positions in non-profit alcohol, drug abuse and mental health treatment centers. The treatment centers can provide training to CETA participants while on the job, leading to unsubsidized staff positions. Treatment programs can utilize their professional staff to train CETA participants to develop skills to meet program needs.

**How It Might Work**
In Worcester, Massachusetts, the Prime Sponsor allocated CETA public service employment positions to the Chandler Street Center, a community-based outpatient drug treatment program. CETA positions are utilized as career ladder slots for subprofessionals in training for full staff positions in the treatment program. The Chandler Street Center provides training in outreach, counseling, and street work. Staff vacancies that occur within the regularly funded positions in the Chandler Street Center are first offered to CETA participants, creating unsubsidized employment and allowing for recruitment of new CETA participants into the training program.

The Prime Sponsor is responsible for referrals to the public service employment positions in the Chandler Street Center. These individuals often include those program graduates (ex-addicts who have gone through treatment) that the Center refers to the Prime Sponsor, though there is no such requirement in the agreement.

**How Health Programs Can Benefit**
—Limited training dollars are maximized through CETA participation.

—CETA-funded public service employment positions allow expanded service to health program clients.

—Opportunities to train and employ treatment program graduates (i.e., recovered alcoholics, ex-addicts) are created.

**How CETA Can Benefit**
—Professional health staff personnel are utilized to provide in-service training opportunities to CETA participants.

—CETA meets its goal of unsubsidized employment.

**Risks to Health Programs**
—Uncertainty in CETA Title II funding could jeopardize public service slots.

—Permanent employment positions in the program may not exist at the time training ends.

**Risks to CETA**
—ADAMHA grantees' desire to expand service may cause an overestimation of the number of public service positions with real future employment opportunities.

—Quality of on-the-job training may not be sufficient to permit CETA enrollees to transfer skills to other available unsubsidized jobs.

**How to Reduce the Risks**
—Review the need for and availability of public service employment positions in terms of future budgets and plans of both the ADAMHA grantee and the Prime Sponsor, and negotiate a specific commitment for employment of the CETA public service participants.

—Agree on the content of the training provided CETA enrollees and establish a level of competency for program graduates.

**Other Applicable HEW Programs**
Grantees from ADAMHA and other HEW health service programs likely to benefit from such an arrangement include:

13.217 Family Planning Projects

13.235 Drug Abuse Community Service Programs

13.246 Community Mental Health Projects

13.251 Alcohol Community Service Programs

13.384 Emergency Medical Services

## Opportunity 9: Health Examinations for CETA Clients

### Issues Facing Health and CETA Programs

Many Prime Sponsors believe that a necessary early element of CETA services is the determination of a client's medical status (which is often essential to counseling and employability development). Most Prime Sponsors do not have the capability to conduct mass physical examinations at low cost.

HEW health service program grantees are under pressure to increase self-sufficiency through third-party reimbursement because of declining Federal support. These grantees have been heavily subsidized to enable those in need to obtain health services at minimum cost.

### How Coordination Can Help

Local public health departments and other HEW health service grantees can sometimes provide health examinations for CETA clients at less cost than the private sector. CETA may purchase medical examinations for its applicants during the intake process.

### How It Might Work

In Texas, the City of Houston Health Department provides basic physical examinations to CETA applicants under a contract with the city Prime Sponsor. The Prime Sponsor purchases examinations by receiving blocks of time for CETA enrollees at the Health Department Clinic. A fee is charged per block of time reserved. The Health Department completes a physical examination report on each client for use by the Prime Sponsor.

### How Health Programs Can Benefit

—Payment for CETA health examinations is a source of third-party reimbursements.

—Health screening services are extended to an important segment of the population: the potentially employable disadvantaged.

—CETA clients who become eligible for health benefits through an employer may select the health program as a provider of medical care (if the program provides such services).

### How CETA Can Benefit

—CETA clients with no health problems have an advantage with potential employers.

—CETA clients with minor health problems can have them corrected as part of their employment development plan, increasing potential employability.

—Clients with major health problems can be screened out prior to training and placement, thus reducing negative terminations.

### Risks to Health Programs

—Examinations may increase demand for health services that CETA will not reimburse.

—CETA clients may fail to keep appointments.

### Risks to CETA

—CETA may have to provide extensive medical supportive services for clients with health problems.

—CETA may be paying for examinations available free of charge to clients already eligible for Medicaid or other HEW health service programs.

### How to Reduce the Risks

—Agree on a regular, but reasonably flexible, time schedule for services to CETA referrals.

—Agree on mutual responsibilities for payment of medical services required as a result of the examination.

### Other Applicable HEW Programs

In addition to city and county public health departments, the grantees of the following HEW health service programs may have the capacity to provide or finance health examinations:

13.210 Comprehensive Public Health Services—Formula Grants

13.224 Health Services Development —Project Grants (Neighborhood Health Centers)

13.228 Indian Health Service

13.246 Migrant Health Grants

13.261 Family Health Centers

13.714 Medicaid



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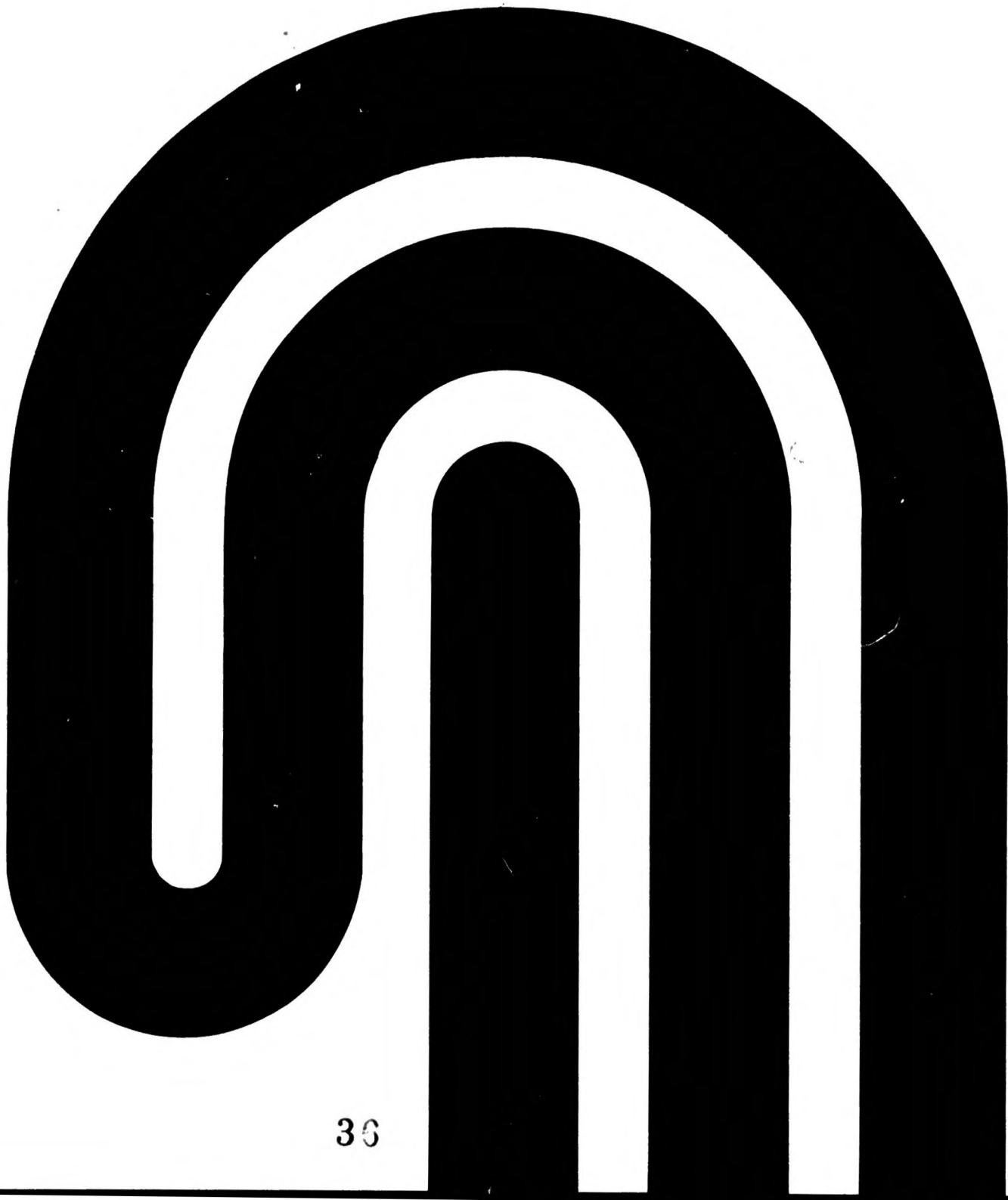
# Chapter Four
# Analysis, Identification and Implementation



This is a chapter on "process": the process of identifying a coordination arrangement that makes sense in a particular setting, and the process of putting the identified arrangement into effective operation. Obvious coordination opportunities with CETA, particularly those with easily recognized high payoffs for both programs, are likely to present themselves to both staffs without detailed analysis. But the process described in this chapter may be useful to identify those less obvious opportunities which may be as worthwhile. The specific coordination arrangements described in Chapter 3 were identified using this same process.

Though this chapter ends with a description of a model contractual agreement that would implement a coordination arrangement with a Prime Sponsor, not all cooperation with CETA needs to be formalized. Information exchange, representation on advisory/planning councils and plan review are informal means of cooperation that can be effective in achieving progress towards mutual goals of both programs.

Essential steps in identification and implementation of worthwhile arrangements are presented in overview form on the next page. Each is discussed in some detail within this chapter.

**Comparative Program Analysis**

The first two major steps in comparative program analysis have been taken in the preparation of this guide. HEW grantees are familiar with what issues and program concerns will be primary to their operations in coming months, and a fairly detailed summary of CETA legislation, guidelines, programming and administration has been included in Chapter 2. By reviewing CETA's capabilities against the needs of HEW program operations, grantees will begin to sense the most logical areas for joint action.

Clearly, in a document published and distributed nationally, the written description lacks local specificity. Additions to the description, with regard to how options are exercised in each jurisdiction, must be left to the program staffs at the state and local levels. This is particularly true since the CETA Prime Sponsor has great latitude in determining local program priorities.

The comparative analyses done above from a national perspective reveal a wide range of common features between CETA and HEW-funded health programs. Each HEW program administrator must assess the relevancy of the particular mix of commonalities between his/her program in the context of the local situation in order to determine the appropriate relationship, if any, with CETA.

**The Common Client**

Perhaps the most important stimulus to cooperative agreements between CETA and HEW-funded health programs is the mutual eligibility of the individual for both CETA and HEW-funded health programs. Even in those HEW programs with no legal eligibility restrictions, regulations and guidelines tend to stress service to a population at need similar to that of CETA. Joint program relationships tend to enhance the variety and quality of services available to the client, with the positive benefits of greater success outcomes and lower client cost potentially available to program administrators.

**Combining Elements**

Reviewing the common elements identified in Chapter 2 in the context of local situations enables development of strategies for coordinating program services to take advantage of those commonalities. As is illustrated by the series of coordination examples in Chapter 3, opportunities may include:

1. *Combined Planning/Placement Effort.* The Prime Sponsor and local health agency assist each other in the identification of need and eventual placement of clients of either program into health-related occupations. Manpower or supportive services *may* be provided to common clients.

2. *Concurrent Services.* Services provided by HEW-funded health programs are provided to CETA clients, or vice-versa according to a purchase of service or similar agreement, but no common responsibility for the client exists after provision of the service.

3. *Sequential Services.* CETA services are provided to former clients of HEW-funded health programs, after having received health services in order to be capable of undertaking job training, or former CETA clients enter HEW-funded health manpower programs to receive further training for future placement in a health occupation.

To this point, the process is analytical. The underlying purpose so far is to identify all signficant possibilities with respect to clients, client services and joint service potentials for which cooperative agreements might be possible. The next step begins the process of selecting the best option, making it as appealing as possible to both programs and working out the details of an agreement.

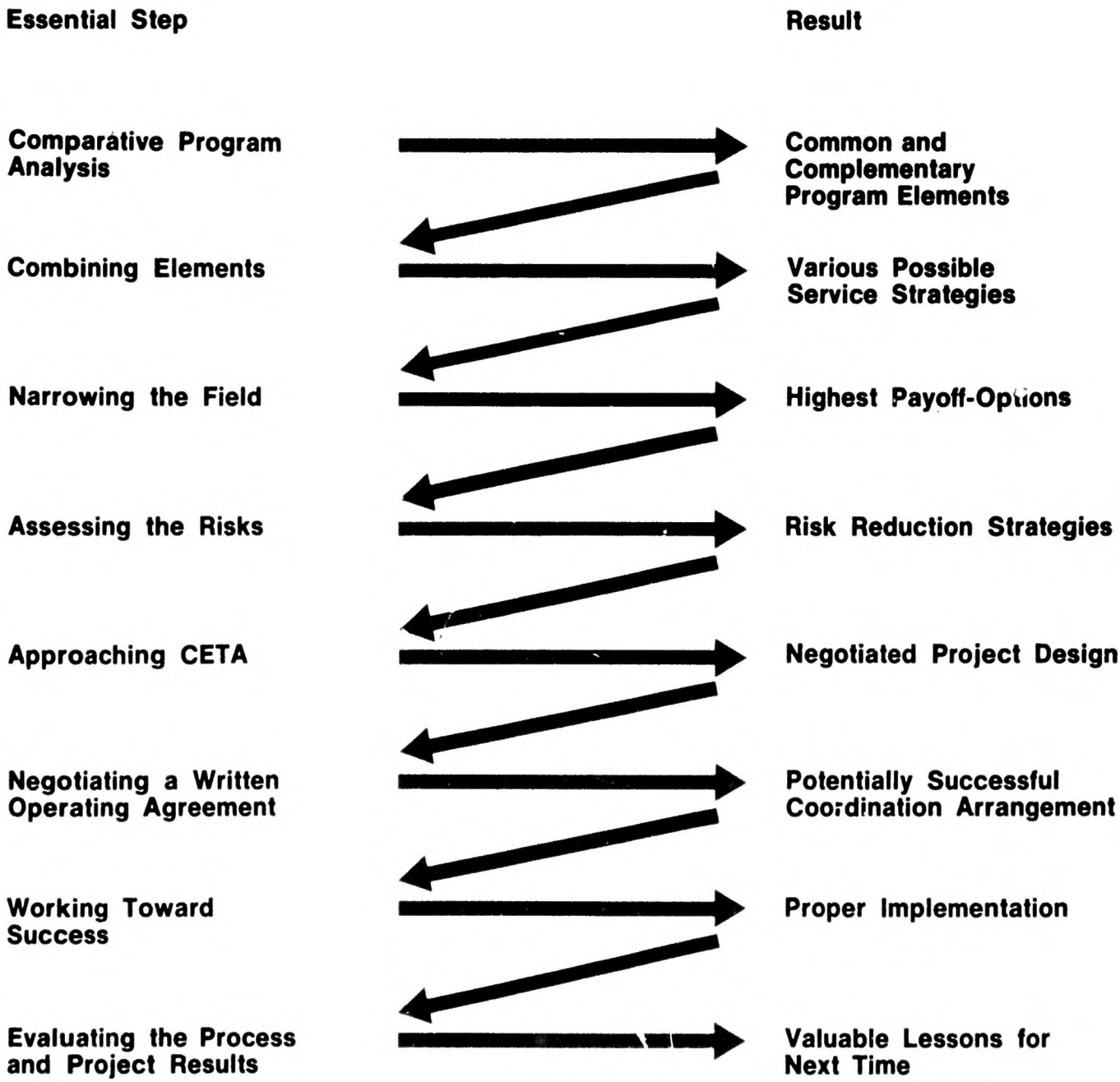
**Narrowing the Field**

Two major considerations, over and above the obvious (welfare of the common client), will help in narrowing the field of opportunities to those with the highest payoff for both programs and, therefore, those with the highest probability of success. First, the alternatives selected should contribute to resolution of the most significant issues facing both CETA and the HEW grantee. Second, the arrangements to be considered need to be consistent with the objectives of any agency administrator.

"Scientific method" calls for systematically weighing each option or alternative against the priorities, issues and objectives and selecting the arrangement which meets "most of the highest ranked" objectives, etc. In fact, coordination activities seldom lend themselves in total to such rigorous analysis. In practice, the most appealing option in a particular context generally stands out far above the others.

It is also true that a basic project or option, once singled out as potentially attractive, can often be strengthened considerably by reviewing priorities, issues and objectives from a design rather than evaluation perspective. The basic idea can sometimes be modified or supplemented *in response to* particular objectives, like those listed below, that are known to be strong concerns of agencies or administrators. Coordination arrangements which meet multiple objectives will normally generate proportionally more support than those which meet only one.

# Identification/ Implementation Process



### *Significant CETA Issues*

Individual issues can always be identified as major strategic concerns of any public-funded social program. Though these may change over time, certain issues are clearly on the minds of HEW and CETA program administrators as FY '77 approaches. If each can understand the other's current priorities, and if coordination arrangements developed act simultaneously on both CETA and health priorities, then those arrangements can expect the full support of both parties to the agreement.

Just as HEW program administrators devise strategies for shifting priorities such as third-party reimbursement, affirmative action and paraprofessional resource development, the CETA administrator is feeling pressure on some of the following issues:

1. *Performance emphasis.* Employment and Training Administration goals and objectives for FY '76 included the natural shift in emphasis from *implementation* of the first year program to increased *performance* in serving clients. Mentioned first among performance criteria are *program mix* and *client groups* served.

2. *Building capability.* Many CETA Prime Sponsors have never before directly operated comprehensive manpower programs. Consequently they are in various stages of organizational development and stabilization. Newly-formed and as yet unstable organizations may not be attracted to arrangements which place extraordinary administrative burdens on them.

3. *Finding jobs.* Few Prime Sponsors can find enough jobs to meet the needs of their clients. The private sector is still in a period of recovery and many Prime Sponsors report that the public sector is approaching saturation with transitional public service jobs. Yet certain target groups, like the handicapped, benefit from both advertising and efforts towards "corporate responsibility" which could make finding jobs for this group relatively easier than for the traditional clients of CETA Prime Sponsors.

4. *Spending the grant.* Prime Sponsors are under constant pressure to spend their grants within the grant period. Interestingly, many Prime Sponsors report difficulty in developing productive uses for a portion of their grant funds and the strategy of entering external arrangements for special one-time projects (i.e., research and demonstration grants) to absorb remaining funds is not uncommon.

5. *Serving the "most-in-need".* CETA legislation requires that Prime Sponsors give priority to those in their population who are most in need of CETA services. However, two factors inhibit efforts to do so. One, pressures on performance and placements, is discussed above. Additionally, Prime Sponsors have developed only very limited technical capabilities to serve some population groups in need.

6. *Cost per placement.* The Employment and Training Administration (that arm of DOL which oversees CETA) places great weight on this measure of Prime Sponsor performance. There are Prime Sponsors who would welcome any reasonable suggestions about how to lower average cost per placement. Conversely, there are Prime Sponsors with the opposite problem: they are accused of "creaming" because their cost per placement is low.

7. *Valid data on "significant segments".* Prime Sponsors would, in most cases, welcome valid data on target groups who ought to be included as "significant segments" in their annual grant proposals. The required analysis should be straightforward and objective but often lacks reliable data, which health program grantees may be able to provide.

8. *Manpower Planning Councils and State Manpower Services Councils.* These councils, required by the Act, are operating in a wide range of roles and relationships to the various states and substate jurisdictions. A current priority of the Employment and Training Administration is to strengthen the councils in the roles envisioned for them by Congress and the Labor Department.

### *The Administrator's Objectives*

In addition to positive impact on the above CETA priorities and issues, high payoff coordination arrangements should meet some objectives of the agency/program administrator for improved activity. The three categories might be grouped thus:

1. Improved Service Delivery

a. through expanded service

b. through addition of services

2. Improved Resource Utilization

a. through access to untapped resources

b. through better-focused resources

3. Improved Program Operations

a. through a strengthened information base

b. reflected in higher performance

c. through a supply of qualified, entry-level staff.

#### Improved Service Delivery

(a) *Through expanded service.* Joint service to common clients permits each agency either to serve more clients with the same resources or (looking at it the other way) to provide substantially expanded services to existing clients at no extra cost to either agency.

(b) *Through addition of services.* HEW and CETA programs, because of costs and responsibilities of serving common clients, can also share the costs of services which might be infeasible for either without some form of cost-sharing. These additional services, of course, can be purchased jointly, depending on the availability and reliability of a third party to provide them.

#### Improved Resource Utilization

(a) *Through access to untapped resources.* Coordination can make possible access to funds not otherwise available to either party. Research and demonstration funds earmarked for coordination experiments are an obvious example. Many HEW-funded health service programs include legislatively authorized *training programs* for which CETA expertise may be invaluable.

(b) *Through better-focused resources.* Several illustrations of shared funding for common clients have been mentioned above. Any resulting relief of the financial burden for current clients of HEW programs would permit shifting of freed funds to other priorities

### Improved Program Operations

(a) *Through a strengthened information base.* With the labor market information CETA planners gather for their own purposes, HEW health program counselors could make better-informed decisions as to how to guide clients toward their employment goals. With accurate data on the extent and magnitude of heath resources in their jurisdiction, CETA can better plan for the potential market demand for the health occupations.

(b) *Reflected in higher performance.* Where programs share responsibility for a common client, the end result may be higher reported performance for both programs. While in **one sense** this is double-counting, from the client's perspective it is coordinated service with a positive outcome that neither program could provide alone and at the same level of expenditure. In that client's case a simple reporting incentive may have played a role in achieving *better results* than otherwise might have been possible.

(c) *Through a supply of qualified, entry-level staff.* The examples above illustrate several cases where CETA has trained clients of HEW-funded health programs for placement in those (or other) HEW programs. However, one of the most broadly overlooked coordination opportunity classifications is that through which Federally-supported programs can combine to serve each other directly. In fact, broader coordination opportunities are available in this area; for example, CETA training alcoholism clients to work for Title XX vendors with Title XX financial participation in the training.

### Assessing the Risks

Steps in the analytic process up to this point will have assisted in **identifying** and assessing the benefits to organizational objectives and clients of possible coordination arrangements. They will also have enabled a relative judgment as to which among several potential opportunities might have the greatest likely benefit.

Prior to proceeding it is wise to assess the internal environment in which a coordination arrangement must operate. Here, agency leadership will be crucial. Often non-standard projects such as coordination fail to achieve their potential because those pursuing coordination fail at the outset to anticipate fully the nature or magnitude of potential obstacles or, when confronted with those obstacles, are unable to invest the efforts required to steer the initiative around them. Before moving forward it is essential to assess agency commitment to achieving the results of coordination and the time and effort such commitment will demand.

Organizational disruption and resistance to change are bound to accompany new operating and administrative arrangements with an agency. The resistance, moreover, is often unconscious. People continue in the old ways out of habit, simply forgetting to adapt to the required change. The experienced administrator, however, will assume that these obstacles are part of the price to be paid for coordination. And keeping an eye on the potential benefits, he or she will take appropriate action to head-off or remove the inevitable obstacles.

Among the factors that should further be assessed are:

—organizational and administrative factors

—political implications

—personality considerations

—the Federal agency position

This can be carried out informally and unofficially. It is usually counter-productive to involve more than a small group at this stage in the process, until agency leadership has decided that the overall situation is favorable to the initiative being proposed. If your analysis of the opportunities and your current agency situation reveals strong potential for success, then conversations with others can begin.

### Organizational/Administrative Factors

Organizational and administrative considerations may have the most immediate impact on success or failure. It is unlikely that coordination objectives will be realized in the absence of cohesive internal support in either program. On the other hand, internal issues represent the area over which you have greatest influence, and early recognition of potential internal problems can lead to their successful resolution. We have listed a number of organizational considerations that might be reviewed

#### Organization/Administration

☐ What components of your organization will be most affected by the proposed coordination? Are there components that will be affected indirectly (budget, payroll) rather than through direct involvement?

☐ What do you already know about your own program components' probable willingness to cooperate?

☐ Which individuals within your organization will be most supportive of your proposal? Which do you think will offer the most resistance?

☐ Are there performance goals that will be affected positively or negatively by the coordination effort?

☐ Are there any internal organization "political" issues that might affect coordination efforts?

☐ What do you currently know about the organization with which you will be dealing regarding the above questions?

☐ With which individuals in the counterpart organization do you currently have strong relationships?

☐ Who in the counterpart organization is in a position to make the kinds of decisions you think will be needed to accomplish the proposed coordination?

☐ Is there any prior history of coordination attempts between the two programs that might enhance or interfere with your current undertaking?

☐ Are there other organizational relationships (e.g., advisory groups) that have to be taken into account while pursuing coordination?

☐ Are there existing procedural requirements of which you are aware that will be obstacles to achieving coordination?

☐ Is there any prior history of attempts at modifying procedural requirements in the manner envisioned?

☐ Who in your own organization is in a position to accomplish procedural modification? How long will it require?

**Political Implications**
In recommending that decision-makers consider the political environment when assessing coordination opportunities, it would seem that, rather than politicizing the issues, proper identification of existing political concerns that may affect coordination is necessary in order to take advantage of supportive policies of the Chief Elected Official (CEO), to reduce the chances that political issues may overrun the project and to avoid embarassment to that official and to the agency. Where the objectives of the project and the aims of the CEO coincide, prospects of success are significantly bolstered. (See the checklist which follows.)

**Political Environment**

☐ What attractions or risks might your proposal for coordination hold for the Chief Elected Official (CEO)?

☐ Has the CEO or any of his representatives expressed a public position on the type of initiative you are proposing?

☐ Are there minor modifications to your proposal that would not affect the desired outcomes but which would make it more acceptable to the CEO?

☐ Will the planned undertaking involve groups within the community or external organizations which might indirectly involve the CEO (e.g., appointed advisory groups, etc.)?

☐ Will the proposed undertaking require the formal approval of the CEO; tacit approval? Is any direct action by the CEO required?

☐ How is access to the CEO best achieved (directly; through others)? If intermediaries are involved, do they represent additional obstacles? What is needed to convince them?

☐ If CEO involvement is advisable, when is the best time, for him and for you, to introduce your proposals to him?

☐ Does your program or the program with which you will be dealing have a prior history of political controversy that is likely to affect your efforts?

☐ Are there legislative committees whose approval will be necessary to carry out the project? What is the best way to deal with them and who is best to do it?

**Personalities**
A realistic appraisal of the situation must consider the personalities of all those who will be involved. The tendencies, approaches, styles and idiosyncracies of the various individuals must be counted. A review of individuals should also include an assessment, if possible, of the characteristics of key CETA management, so an HEW administrators' program will be best prepared to present the project in the most appealing fashion.

**The Federal Position**
Both HEW health programs and CETA are dominated by the presence of Federal dollars. Even though agency autonomy in program activity is high, coordination initiatives are not likely to succeed without Federal support. In certain cases Federal officials can be of value in removing obstacles to success, such as the granting of formal waivers or informal approval of a use of funds. Assessing early the potential benefits and/or problems that the Federal sector can bring to the effort will enable deliberate actions to take advantage of the benefits and minimize the problems.

The HEW Regional Director's manpower coordination unit, headed by the Regional Manpower Coordinator, exists for just the purpose of assisting state and local program operators and CETA Prime Sponsors to work together more effectively. This staff has in recent months conducted detailed analyses of the operation of HEW programs in each state and is accordingly well-versed in the basic issues. Assisting the Regional Manpower Coordinator in his or her duties is a representative from the Public Health Service who serves on an HEW regional CETA work group established by the Regional Director.

The Regional Manpower Coordinator will not attempt to deal with individual program issues, which are properly the responsibility of state and national agencies, Prime Sponsors, or the Department of Labor, but will be available to assist *where requested* with the analysis, design, or implementation of coordination opportunities.

Lists of Regional Manpower Coordinators and Public Health Service CETA representatives are included as an appendix to this guide.

**Reducing the Risks**
Each potential coordination arrangement will include certain risks as a part of its design. These risks are real and cannot be ignored in developing a successful agreement to implement the arrangement. The illustrative coordination arrangements in Chapter 3 specify major risks likely to be perceived by staffs of both programs and the actions that could be taken to reduce each risk. Similar analysis for other coordination options will generate similar indications of likely risk areas.

Early identification of potential risks can assist in making a final decision whether to proceed. It can also identify immediate actions that can be taken to reduce the risk. Once the project is underway, however, the most significant risks will develop: those operating problems which may cause failure through lack of communication or absence of mutual agreement. A thorough written operating agreement (about which more later) will do much to prevent these occurrences. Identified risks can be addressed in the agreement and specific actions to prevent their occurrence laid out.

**Approaching CETA**

Heretofore, the program analysis and review of benefits and risks have likely been conducted only verbally. It is wise at this point to develop, for limited internal use only, a written description of the present conceptualization of the project. Doing so provides a second look at some of the assumptions underlying the project, helps identify potential problem areas and often provides the first opportunity to specify the actual negotiation and implementation steps that will need to take place.

This project description need not (should not) be a formal document. Rather, it provides a rigorous review of the pros and cons of the project before discussing it with CETA and provides a "script" for explaining the project to others. It should include:

—What results (benefits) are expected;

—Why they are best achieved through coordination;

—With what specific programs and agencies it is appropriate to coordinate;

—What benefits will be attractive to that program/agency;

—Disadvantages which are readily apparent and which must be overcome;

—Obstacles and risks and strategies for their reduction;

—Specific steps each participating agency must take in order to get the project under way and in order to carry it out.

Activities to this point in analyzing the benefits and risks (internal and external) of a coordination project should provide good preparation for the discussions with others that will follow. Consider several basics, though, before proceeding.

—The benefits of coordination must be as clearly perceived by CETA. If both organizations don't feel they will gain, the project will fail.

—The more individuals actively involved in negotiating a coordination agreement, the higher is the probability that progress will break down before agreement is reached.

—Early support of individuals in key decision-making capacities can make the process easier but it is essential that the merits of the proposal be argued convincingly while risks are presented in proper perspective.

—Resistance to change will occur within both organizations but realistic strategies can be developed to overcome it. Habit, tradition and fear for one's role in a new system are powerful deterrents to cooperation. If you anticipate them, you can deal with them on an individual-by-individual basis. If you ignore them, the resistance can gather momentum and severely compromise the goals of the project.

—When planning to implement a coordination proposal, be as realistic as possible about what can be controlled, possible influences and what is beyond current agency capability or capacity.

At this point discussions with a counterpart in the other organization can begin with realistic chance of success; however, initial discussions seldom result in immediate agreement. The individual with whom you are dealing will need time for internal assessment of the benefits and risks from his/her perspective. Therefore, it is important in first discussions to:

—Introduce the proposal logically and as simply as possible, stressing the benefits to both agencies and to both agencies' clients.

—Stay away from premature discussions of organizational implications, budgets, authority, or other issues that involve "turf."

—Try to view the initial reactions of the counterpart from that program's perspective. Remember a person is not convinced merely because his objections have been silenced.

If the initial discussions are successful, there should be basic agreement as to the value of proceeding further. The first step therein should be the development of specific, mutually agreeable, realistic results for the project. In determining what is realistic both programs should:

—Review all original expectations for the project and modify them as necessary to be satisfactory to each organization.

—Agree on the specific results that are expected from the coordination proposed. When this is achieved, put them in writing.

—Exchange frank views on what constraints and obstacles to the proposal exist from the point of view of each agency, based on both internal and external analyses.

Once there is agreement on the results that both parties expect and the issues each thinks will arise as those results are pursued, it is necessary to design the operating details of the project and to record them in a written agreement. Developing the project plan is critical in one very special way: it is the initial test as to whether or not both programs can work together toward a common purpose.

Key officials of the agencies involved should agree on:

—Specific actions/decisions that must take place prior to the signing of an agreement. This should include items such as procedural waivers, legal opinions, authority to enter into financial arrangements, broad organizational requirements, etc.

—Specific individuals or other agencies that will need to be involved. These should be those individuals in a position to approve the specific actions or decisions listed above.

—Strategy and timing for involving key individuals, particularly the Chief Elected Official, if required, or other highly placed individuals. Plans should include identification of issues that should be resolved prior to soliciting support and identification of arguments that will be most persuasive in gaining their support.

—A schedule for completing the agreement. This should detail the schedule on which each action item or decision should take place and should specify individuals responsible for accomplishing each item.

**Negotiating a Written Operating Agreement**

Two steps remain in putting the project into operation:

—Finalizing a written agreement that will specify the way coordination will take place.

—Working together to carry out elements of the plan.

Both steps will probably move forward concurrently. In many cases the agreement will not (and need not) be a formal *contract* between agencies. Rather, the written agreement serves as a document which ensures that all staff participants in the project, particularly those who were not a part of its development, understand the results to be achieved and the various assignments that will ensure their accomplishment.

**Note: An unwritten agreement is not an agreement at all; it is an understanding and understandings are easily misinterpreted as time goes by. If programs have something worth doing together, then it is worth taking the time to record the details properly. Everyone will have invested far too much time and energy by the time actual coordination activities are scheduled to start to base success on memories, impressions, or prior perceptions of what was agreed.**

A written operating agreement is very different from a legal enabling agreement between the agencies. Because, in the eyes of many, detailed "agreements" are synonymous with contracts, they are frequently avoided as unnecessary or restrictive. In other cases, agencies sign agreements establishing the legal basis for coordinating but omit the necessary detailed description of how that coordination will take place. In either case, the result is usually confusion and misunderstanding at the operating level, requiring considerable time to discuss what was supposed to happen and in what way. In fact, absence of a written operating agreement can cause the project to begin wrong or too late, dooming it from the start. It only takes limited experiences of this nature before both parties are ready to concede that it is easier to work alone.

Although they may vary widely in format and language, all good agreements state, at a minimum:

1. Precisely what is to be accomplished between the two parties (purpose, reason for coordinating).

2. The situation in which the agreement will apply.

3. A summary of the agency activities that are affected by coordination and the way in which these activities will be expected to serve the coordination project.

4. Who, in each organization, is responsible for the specific activitities listed.

5. What will constitute service standards, response time, etc. (e.g., provision of counseling interviews within 5 days of request);

6. Administrative procedures (reporting procedures, supervision, etc.)

7. How and how often service standards will be reviewed.

8. Modification procedures.

9. Financial arrangements.

An agreement that covers the above items leaves little room for debate on what was intended, what was supposed to occur, when it was supposed to occur, or who was responsible. Although it is more difficult to agree on this kind of detail than it is to wait and "work things out" once the project begins, your work in putting together a good agreement will be more than offset by the strengthened, predictable nature of the coordination which results.

An example of a complete operating agreement is included as Appendix I to this guide.

**Working Toward Success**

Once the project is underway, the challenge to all participants is keeping the initiative moving forward despite whatever obstacles may arise. If major obstacles have been anticipated, the task will be easier but under no circumstances will a new and different experience such as this be easy. Offered below are some tips on keeping the initiative on track.

1. Expect problems and budget enough time (both calendar time and person-hours) to deal with them; even the most thorough planning cannot account for all contingencies.

2. When lack of progress in any one specific area threatens the undertaking, review the original agreement on benefits, particularly those accruing to clients, and the agreement to date, emphasizing where the ability to resolve issues has already been demonstrated.

3. Keep in mind that individuals in both organizations have the same kinds of concerns (political, personalities, regulations) and that both must decide how and with what speed to deal with internal issues.

4. If unable to resolve an issue that is critical to the success of the project, don't move ahead until it is resolved (see item 1 above). There is almost never reason to expect that resolution will become easier in the future.

5. Don't let individuals involved in implementing a coordination strategy get so involved in the *process* of accomplishing it that they forget why they wanted it in the first place.

6. Plan the work with a view toward conflicting or competing time requirements. If, for instance, the major activity in preparing for coordination must occur simultaneously with final preparation of the yearly program plan or an agency reorganization, chances are coordination will come in second, and last.

7. Once it has been decided that coordination will in fact take place, internal staff of both programs should be thoroughly oriented on what this means for them and what will be expected of them. If staff is involved at the proper time, they are likely to have more of an interest in and commitment to the success of the effort.

**Evaluating the Process and Project Results**

If agencies agree to proceed on a coordinated approach to service delivery, they should make certain that both agencies profit from the experience and, if successful or not, learn why.

To gain this knowledge, which will be very valuable in designing future activities, some form of evaluation of the results of the project *and the processes that took place* will be needed. While that evaluation is not the subject of this guide, it is clear that whatever form the evaluation takes (simple or complex, formal or informal, quantitative or qualitative) the written operating agreement will provide the basic record of what the project set out to do. From this, any intentional or unintentional deviations can be measured and analyzed.

**Appendix I**

**Illustrative Agreement**

The following agreement is an adaptation of an actual agreement which illustrates the principles set forth in this chapter. The actual agreement pertained to the cooperative situation described in Opportunity 4: Demonstration Training Program for Disabled Youth.

This contract, entered into this _____ day of _____, 19____, by and between the Manpower Office of the City of _____, hereinafter called the Contractor, and the _____ Hospital, hereinafter called the Contractee. As used in this contract, the following terms have the meaning set forth below:

(a) "Contractee" means the organization or agency named in this contract as the recipient of the contract award.

(b) "Contractor" means the person or persons executing this grant on behalf of the Manpower Office of the City of _____. The term includes, except as otherwise provided in the contract, the authorized representatives of the contractor acting within the limits of his authority.

The City of _____ has entered into a contract with the United States of America for a grant for the execution of a Comprehensive Manpower Program for certain services pursuant to Title I of the Comprehensive Employment and Training Act, (Public Law 93-203, 87 Stat. 839), (P.L. 93–567, 88 Stat. 1845); and

The cooperation of the Office of Manpower and the Contractee are essential for the successful execution of the Comprehensive Manpower program; and

***Financial Arrangements***

One of the projects and activities approved under the said grant agreement to be funded from grant funds is a demonstration job experience and job training project for developmentally disabled youth in skill areas for employment in the food service industry in the amount of up to $_____ and designating the _____ Hospital as the Operating Agency.

**I. Expected Results**

***Purposes***

This program proposes a demonstration job experience and job training project consisting of two consecutive sessions. A maximum of ten participants will be accepted for each session.

The program will attempt to train developmentally disabled youths in the skill areas of food service. The specific skills related to employment may include the following:

a. general kitchen cleaning (following scheduled serving periods within the routine of the cooperating agencies);

b. dishwashing services (including operation of automatic dishwashers and cleaning of large kitchen utensils);

c. pre-preparation of foods (such as the preparation of salads);

d. clearing tables and overall bussing duties;

e. cafeteria service;

f. advanced food service delivery work (as determined by the opportunities presented by the cooperating agencies and the abilities of the individual youth participants).

The goal of the program shall be employment in an unsubsidized position in the skill areas described above.

**II. Scope of Service**

***Agency Activities***

The parties hereto do mutually agree that this Agreement is made upon the following terms, all and every one of which the parties hereto agree to observe and perform:

1) The Operating Agency shall, in a satisfactory and proper manner as determined by the Office of Manpower, perform the following. As used in this section, the following terms are strictly defined.

A. Referral and Intake

The Contractee will receive and refer developmentally disabled and economically disadvantaged youths to initial screening and evaluation procedures by the Office of Manpower for selection as participants in a summer training program designed

to develop employment skills in the area of institutional food service. Following this initial evaluation by the Office of Manpower, further diagnostic assessment will be conducted by the Center for 20 youths tentatively designated for participation in the program. This assessment will be administered for the purpose of determining individual strengths and weaknesses related to future employability and for program evaluation purposes. This assessment battery will consist of those standardized or specially constructed instruments which the Contractee deems advisable for these purposes and will, most likely, include:

a. a measurement of general intelligence

b. a self-concept measure

c. a behavior rating scale

d. an evaluation by the training supervisor

e. employer evaluations following placement.

The Contractee may modify this proposed battery in accordance with the above evaluation purposes. These data, which will be helpful to determine variables with high predictive validity for successful employment, will be made available to the Office of Manpower.

The purposes of the proposed assessment program are twofold:

1. To attempt to determine those factors within the individual client that will most help him/her to be successful within the program.

2. To attempt to determine those factors within the group as a whole that contribute to success in the program.

Thus, for the individual client, it is expected that the client would gain personal knowledge and insight into himself/herself as to areas of strengths and weaknesses that contribute to general vocational success; whereas for the group as a whole it should be possible to determine what general characteristics are most productive of future success in such programs. The assessment battery, then, should be looked on as a tool for helping the individual client to maximize his/her potential; and, as a tool by which the program can analyze what vocational/personal factors are most likely to maximize success in similar programs.

The Contractee will also provide medical examinations for the youth participants accepted into this program. This medical examination will include the following:

a. general physical examination

b. blood serology

c. urinalysis

d. chest X ray

as required by the participating agency and accepted health standards for work in the food service industry.

Following successful completion of these diagnostic, assessment and evaluative procedures, twenty youths will be finally accepted for participation in the training program.

Upon entrance into the program, the Contractee will provide these participants with an adequate supply of sanitary uniforms.

***Service Standards***

B. Eligibility Criteria

The developmentally disabled youths accepted for participation in this training program will possess the following criteria for eligibility:

a. the youth participant will be from 16 to 21 years of age;

b. all of the youth participants will be residents of the City;

c. all of the youth participants will meet economically disadvantaged guidelines issued by the Department of Labor.

At least 50% of the youth participants will be accepted from applicants initially referred by the Office of Manpower.

C. Training Time and Wages

Each youth participant will train in selected skill areas for a maximum of forty hours per week. Each trainee will receive a minimum of 120 hours of training within a maximum of six weeks. He/she will receive wages at a maximum rate of $2 25/hour. The supervisor of training and the requirements of the cooperating agencies shall determine the level of food service performed for purposes of reimbursement.

D. Social Services

During the conduct of this project manpower-related and social services will be provided by the Center for each of the participants. These services will concentrate upon employment counseling, development of job placement opportunities, and follow-up counseling following the termination of each training session.

***Administrative Procedures***

E. Termination Procedures

At the termination of the training session a reevaluation of each participant will be conducted under the auspices of the Child Development Center in order to determine any attitudinal/interest changes toward the area of food service. This information will be valuable for evaluation and analysis of the predictive aspects of individuals seeking future employment in the food service industry. It must be emphasized that significant increases in performance on standardized instruments have not been recorded in the literature dealing with such short-term measurements. The ultimate criterion for success in this proposed project will be continued employment. Decision processes regarding the replication model will be advised to give this considerable priority.

F. Information Dissemination

All information relating to job placement and program evaluation collected during the conduct of this project will be available to interested parties. In particular, labor market data regarding the food service industry will be made available to the Office of Manpower upon request. In order to facilitate the availability of this information, the Contractee will follow the employment experiences of the youth participants voluntarily by telephone contact until the end of the calendar year.

**III. Staff Responsibilities**

A. Center

The scope of the project requires the services of a number of qualified personnel. These positions will be:

a. *Project Director.* In order to implement and coordinate the services proposed for this project, the Director of the Child Development Center will be designated as Project Director for this grant. Approximately 10% FTE (full-time equivalent) will be required to compensate for the services this staff member will devote to the administrative responsibilities associated with the successful implementation of this project. The Project Director will report directly to the City Project Officer.

b. *Food Service Consultant.* The Chief of Nutrition Services of the Child Development Center will provide consultation services in the area of effective teaching techniques for the training of the developmentally disabled youths in food service. 25% FTE will be devoted to this program.

c. *Supervisory Instructor.* The project will necessitate the full time services of an individual knowledgeable in the employment requirements of the food service industry. This individual must be prepared to train developmentally disabled youths who qualify under the eligibility requirements established for this program which aims to prepare the trainees for employment in unsubsidized positions. A candidate will be employed for a 12-week period under the provisions of this proposal.

d. *Social Service Counselor.* The collection and coordination of all diagnostic and assessment data as well as the finalization of evaluation information relevant to the project will require the services of an individual competent to fulfill these responsibilites. In addition, this individual must provide employment counseling following the termination of the project. These responsibilties are extensive and will require the services of a highly competent person in the varied fields of social service, employment counseling for the handicapped and program evaluation.

B. City Office of Manpower

The Project Officer designated for the Office of Manpower will be _____. He will be responsible for insuring that the Office of Manpower will refer individuals to the Center, and performing eligibility determination for all potential applicants selected by the Center, as stated above.

**IV. Modification Procedures**

At the end of the first training session the initial program results will be reviewed. At that time both parties to the agreement may terminate this agreement. The Contractor may also terminate this agreement at any other time with thirty days notice to the Contractee, and will be responsible for any project costs incurred to the date of termination.

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