

The Job Boost II Subsidized Employment Program

Gwendolyn H. Cohen

Over the last three years, Mecklenburg County created various subsidized employment programs to assist Work First participants with obtaining jobs. Work First is part of the Temporary Assistance to Needy Families (TANF) program. A subsidized employment program offers its participants an opportunity to discover or enhance occupational skill sets and to establish a viable work history. It also prepares them to secure unsubsidized employment with the goal of attaining sustainable self-sufficiency. Participating employers receive payroll assistance in return for developing and mentoring an underemployed workforce.

As a result of the success of Mecklenburg County's initial subsidized employment initiatives—the Opportunity Project (2009) and Job Boost I (2010)—the North Carolina Department of Health and Human Services expanded the program to Job Boost II. Like its predecessors, Job Boost II offered valuable employment experience in real work environments to Work First participants whose income was less than 200% of the federal poverty guidelines and who were considered work-ready. These subsidized employment programs operated in other counties as part of their TANF programs in addition to Mecklenburg county.

The objectives of the program were 2-fold. Job Boost II gave eligible individuals a chance to acquire or enhance viable skill sets and to establish a credible work history over a 20-week period. The program also assisted clients in moving toward self-sufficiency. The long-term goal was for citizens receiving state-supported financial assistance to become self-sufficient. The average wage of a Job Boost II participant was \$8.18 per hour. The Job Boost II Program was implemented from July 2011 through May 2012. The

program ended as funding was not allocated in the recent state budget.

Originally, the entire program budget was \$1.32 million, and the goal was to find placements for 200 individuals. However, 200 placements were made within the first 3 months, so Mecklenburg County was awarded an additional \$660,000 to fund another 100 placements. Ultimately 453 placements were made, and 93 participants were permanently hired when their placement ended. After covering administrative costs, Job Boost II used all of its resources to fund 75% percent of the wages of program participants; participating employers were responsible for paying the remaining 25% of each participant's salary. Administrative costs included the salaries of the Job Boost Team, which consisted of a program manager, a social worker, an administrative assistant, and a part-time research/data analyst.

Job Boost II was housed in the Community Resources Division of Mecklenburg County's Division of Social Services (DSS). The program's success relied heavily on the collaborative efforts between the Job Boost II staff, DSS Work First teams, community partners, and 2 staffing agencies (referred to as "job developers"). Program participants were given practical occupational experience and a chance to boost their overall quality of life. Community partners helped participants acquire the skills needed for job readiness and job preparedness. Job developers located employers willing to invest in the development of a less skilled workforce. The DSS Job Boost II and Work First teams assisted clients with support services and interventions.

Participating in Job Boost allowed clients to see

unavailability of wholesome food) and the absence of safe public recreation, which encourages a sedentary life style. In their study of neighborhood of residence and coronary heart disease, Diez Roux and colleagues list the following as characteristics of poor neighborhoods: danger, high crime rates, substandard housing, few or no decent medical services nearby, low-quality schools, little recreation, and almost no stores selling wholesome food [12]. Income, education, and environment do influence health disparities. The life expectancy of residents of Montgomery County, Maryland, a wealthy suburb of Washington, DC, is 9 years greater than that of residents of Washington, DC [13].

Children are more likely than other age groups to be members of families with incomes at or below the federal poverty guidelines [14]. The Adverse Childhood Experiences (ACE) study demonstrated a relationship between severe adverse experiences in childhood and the risk behaviors and diseases that are the leading causes of death in adult life, including ischemic heart disease, chronic lung disease, cancer, depression, alcoholism, and smoking [15]. Food insecurity is another factor that has an adverse effect on the health of young children [16].

Importantly, Marmot and Bell emphasize that although much of the discussion about health disparities in the United States centers on racial/ethnic differences, those health disparities are actually more the result of disparities in socioeconomic level and fairness in distribution of societal resources [13]. Both Marmot and Bell [13] and Wilkinson and Pickett [17] have postulated that the prevalence of poor health is related to inequality in wealth rather than to absolute levels of wealth. They contend that the problem is not caused by lack of income but where one's income stands in relation to that of others. Despite the high per capita income of the United States, it does not have fewer health problems than do many less well-off countries. Poorer people in developed countries have death rates 2 to 4 times greater than those of affluent people in the same country [18].

Median household income, median net worth, metrics of income inequality, and the poverty rate are all useful measures. The poverty rate is widely used. Poverty is a relative term, generally meaning an insufficiency of means for subsistence. The federal poverty guidelines for 2012 is \$11,170 per year for an individual and \$23,050 for a family of four [19].

themselves as having the ability to be self-sufficient and independent. After obtaining her goal of permanent employment, a client said that being in the subsidized employment program had enabled her to stop being dependent on government assistance and to take care of her children and pay her bills.

One unique component of the Mecklenburg County Job Boost II Program was built-in case management for its participants: The program employed a full-time Job Boost social worker whose primary objective was to help clients. In collaboration with Work First and employment social workers, the Job Boost social worker helped clients overcome such barriers to success as problems with transportation or child care or a domestic situation; supported clients and employers through site visits and on-site interviews regarding client performance, attendance, and attitude; and provided positive reinforcement throughout the client's Job Boost II work experience. For many clients, the case management component was crucial to their success.

A client who is now taking classes that will count toward an Associate Degree in Human Services stated that being placed in subsidized employment through Job Boost had helped her realize what she wanted to pursue as a career, adding,

I am now more comfortable in talking with others and sharing information about my life experiences. I am also in a position to take care of my own financial responsibilities.

Community partners, job developers, and the Job Boost II team had access to Sepweb, a database designed specifically to store and process the demographic, personnel, eligibility, and program history of individuals who quali-

fied for subsidized employment. Sepweb matched potential clients with employment openings, which according to one job developer made the job placement process "more targeted and effective." Data from Sepweb was used to produce weekly reports for the respective DSS teams and monthly reports for the North Carolina Division of Social Services.

Job Boost II received 2 awards from the National Association of Counties—an Achievement Award and Best of Achievement Category for 2011-2012. **NCMJ**

Gwendolyn H. Cohen, MDiv, MBA formerly Job Boost II Program business manager, Community Resources Division, Mecklenburg County Department of Social Services, Charlotte, North Carolina.

Acknowledgments

Financial disclosure. The Job Boost II Program receives financial support from the North Carolina Department of Health and Human Services.

Potential conflicts of interest. G.H.C. has no relevant conflicts of interest.

Editor's Note: When we first invited Ms. Cohen to submit this sidebar, the Job Boost II program was in operation. As noted, funding no longer exists for the program and it has since ceased. However, we decided to publish this sidebar as an example of a subsidized employment program because of the potential such programs have to help low-income people gain employment.

Electronically published October 12, 2012.

Address correspondence to Ms. Gwendolyn H. Cohen, Mecklenburg County Department of Social Services, Community Resources Division, 301 Billingsley Rd, Charlotte, NC 28211 (gwendolyn.cohen@mecklenburgcountync.gov).

N C Med J. 2012;73(5):367-368. ©2012 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2012/73510

In 2010, 17.5% of the population of North Carolina had an income below the federal poverty guidelines [20], compared with 15.3% of the US population [21]. The poverty rates for both the state and nation had increased over the preceding decade, up from 13.2% and 11.3%, respectively, in 2000 [22]. There is great disparity across the state. Current comparable estimates of poverty rates by county in North Carolina range from 8.5% to 30.2% [23]. Wealth, a corollary to poverty, is not accurately or regularly measured at the state or county level. However, at the national level, median net worth dropped by more than 39% between 2007 and 2010, from \$126,400 to \$77,300 [24].

Median household income is known to be an important health risk factor, irrespective of race or ethnicity [25]. The median household income in North Carolina was \$43,326 in 2010 [26]; that figure is 13% lower than national median household income of \$50,046 and is 6.9% lower than the \$46,549 that it was in North Carolina in 2008, a peak before the recession [27]. The relationship of household income to health has been found to be substantial using both subjective and objective health outcome measures. Data from the 2010 Behavioral Risk Factor Surveillance System (BRFSS) show that 46.3% of North Carolinians in households earning

less than \$15,000 a year reported themselves to be in fair to poor health, compared with 10% of those earning \$50,000-\$74,999 per year and 5% of those earning \$75,000 or more per year. The gradient is linear (see Figure 1).

Median household income and the poverty rate are the 2 most useful measures to weigh against health outcomes such as mortality rates. The premature mortality rate—the number of years of life lost before age 75 per 10,000 population—is a particularly good summary measure. North Carolina ranks 36th among the states in premature mortality [28].

The associations between various types of mortality and economic risk factors observed across the 100 North Carolina counties are presented in Table 1. Using Pearson product moment correlation, all of the types of mortality shown in the table were found to correlate with the poverty rate and with median household income. The strongest correlations were between premature mortality rate (using 2009 data) and poverty rate (a positive correlation, $r = .599$, significant at the 0.01 level, 2-tailed) and between premature mortality and median household income (a negative correlation, $r = -.646$, significant at the 0.01 level, 2-tailed).

As Figure 2 shows, as the poverty rate (the percentage of the population with a household income below the federal