Implementation of the Better Jobs Better Care Demonstration: Lessons for Long-Term Care Workforce Initiatives

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Purpose: Better Jobs Better Care (BJBC) was a long-term care workforce demonstration that sought to improve recruitment and retention of direct care workers by changing public policy and management practice. The purpose of this article is to document and assess BJBC’s implementation, analyze factors affecting implementation, and draw lessons from it for other long-term care workforce initiatives. Design and Methods: We analyzed qualitative data from project work plans and progress reports, and notes from telephone and in-person interviews with project staff, coalition stakeholders, and state policy experts. We abstracted the data, categorized it, and summarized it by state in matrices for analysis. Results: The five BJBC projects did implement their demonstration plans. Factors that affected project implementation included having demonstration resources; strong, stable leadership; strong coalitions that included key stakeholders; a neutral lead agency; clear goals; effective process; and a favorable state history and context. Implications: BJBC demonstrated that recruitment and retention is a long-term care industry problem, not just a nursing home problem. Future initiatives should: recognize that workforce policy and management practice change is difficult and takes time, obtain funding, develop strategies specific to the state history and context, engage key stakeholders, and develop relationships among stakeholders.

Key Words: Workforce, Aide, Nursing home, Home health, Assisted living, Long-term care

Nursing assistants, home health aides, and personal care assistants play a vital role in long-term care. Despite their importance, however, recruitment and retention of these direct care workers is a challenge for all long-term care providers (Stone & Weiner, 2001). Factors that lead to difficulty recruiting and retaining direct care workers include lack of training and upward mobility, hard emotional and physical work, workplace stress and burnout, poor supervision, lack of respect, and understaffing. Recently, a number of workforce initiatives have sought to improve recruitment and retention (Harris-Kojetin, Lipson, Fielding, Kiefer, & Stone, 2004).

The Better Jobs Better Care (BJBC) demonstration was a long-term care workforce initiative that sought to “create changes in policy and practice that will lead to the recruitment and retention of high-quality paraprofessional (‘direct care’) workers in both nursing homes and home and community-based settings” (BJBC, 2002, p. 3). The purpose of this article is to (a) document and assess BJBC’s implementation, (b) analyze factors affecting implementation, and (c) draw lessons from it for other long-term care workforce initiatives.

BJBC Design and Goals

Motivated by the current and anticipated future shortage of direct care workers and the belief that the quality of their jobs affects turnover and ultimately quality of care, The Robert Wood Johnson Foundation and The Atlantic Philanthropies (the Foundations) underwrote the BJBC demonstration. They funded projects enabling them to hire staff, issue subcontracts, and in some cases provide financial support to participating providers. The Foundations also funded the Institute for the Future of Aging Services to run the demonstration as the national program office and PHI (formerly the Paraprofessional Healthcare Institute) to
provide technical assistance to BJBC projects (Stone & Dawson, this issue).

The program office and technical assistance contractor designed the demonstration and developed a call for proposals. Awards were to be made to

... teams of stakeholders—providers, workers and consumers as well as long term care policymakers—that are already engaged in initiatives to improve workforce recruitment, retention and quality.... Each team should be headed by a nonprofit agency capable of providing the leadership and direction required to achieve the grantee team objectives. (BJBC, 2002, p. 5, italics in the original)

The program office, technical assistance contractor, and the Foundations, with input from an advisory committee, reviewed the submitted proposals and awarded demonstration project grants to a lead agency in each of five states: Iowa, North Carolina, Oregon, Pennsylvania, and Vermont. The lead agencies worked with a coalition of stakeholders to run each project. Each project received funds for a 3-month planning period, during which they were expected to work with “team members, the Program Office, and participating foundation staff to clarify goals and expectations and to devise a plan to achieve them” (BJBC, 2002, p. 6).

Projects were to develop management practice goals within broad guidelines to “implement workplace improvements in one or more provider networks to enhance the quality of direct care workers’ jobs...” to improve recruitment and retention of the direct care workforce (BJBC, 2002, p. 3). Thus, projects had considerable latitude in developing management practice interventions, recruiting providers to test them, and supporting participating providers in implementing the interventions.

Projects had similarly broad guidelines concerning policy goals. Projects were to develop policy goals that “strengthen policies... that can help to attract and retain high-quality direct care workers” (BJBC, 2002, p. 3). Goals could include enhanced wages, improved health insurance coverage, subsidies of other benefits, funding for education and training, and “reimbursement changes aimed at rewarding job redesign efforts” (p. 5). Projects also were to develop a strategy and implementation plan for achieving their goals.

Methods

We based our implementation research on qualitative data from (a) documents, including initial project work plans and biannual progress reports that projects submitted to the national program office; and (b) notes from semistructured telephone and in-person interviews that we conducted. Respondents to these key informant interviews in each state were the project directors and staff at the five lead agencies that received the grants, stakeholders who were members of the five coalitions, and policy experts in the five states. Additional respondents had a “cross-state vantage point” that gave them perspective on all of the projects. These included the leadership of the national program office and staff of the technical assistance contractor, who provided technical assistance to all of the projects on policy and practice interventions.

We asked project directors to identify their projects’ organizational structures and the stakeholders in their coalitions. We obtained information about projects’ initial policy goals and practice interventions from work plans. We tracked modifications and progress toward these goals through biannual progress reports, which we supplemented with information from telephone and site visit interviews. We grouped similar policy goals and practice interventions into categories and abstracted specific information by state in text data tables for analysis. We abstracted basic information from them in the summary tables included here.

For our analysis of factors that affect implementation, we relied on responses to questions in the semistructured interviews “what factors are associated with successful implementation” and “what barriers hindered implementation.” We reviewed responses, identified themes, and developed detailed categories of facilitating factors and barriers, which we further grouped into six primary categories. We abstracted specific responses and recorded them in data tables by state and detailed category, identifying whether the respondent’s vantage point was within a state or across states.

We distributed a draft of this paper to the project directors and staff of the national program office and technical assistance contractor for feedback. We then reviewed the feedback, reexamined the information from the data sources we had, and made changes based on all of the information available.

Overview of the Projects

Stakeholder Coalitions and Project Structures

The coalitions included one or more representatives of the following groups: state agencies, trade associations, consumers, direct care workers or organizations that represent them, and educational institutions (see Table 1). No two projects engaged exactly the same stakeholders, but all were quite broad in their inclusion of stakeholders. In some cases, members left or joined the coalition during the demonstration. Notably missing from three of the five coalitions was the state Department of Labor. The extent of prior experience working together varied across projects.

The nonprofit lead agencies came from different stakeholder groups depending on the state (indicated by an L in Table 1). Some were advocacy groups completely independent of state agencies, whereas others were tied to such agencies through previous grant activities. Their respective missions ranged from promoting the quality of long-term care for consumers to improving direct care worker jobs.

Each lead agency hired or designated a project director. Projects in four states also hired a practice manager charged with implementing the practice change goals at providers participating in the demonstration. The practice managers were key resources in
promoting active involvement of the participating providers. Only one of the projects employed an equivalent policy development manager at any time during the demonstration; either the lead agency executive director or project director assumed this role in the other four projects. Two of the projects encountered hiring delays, and three experienced significant staff turnover. The project leadership housed in the five lead agencies was responsible for pursuing the projects’ policy and practice goals working with the stakeholder coalitions.

Management Practice Interventions

Although all five projects pursued the same overarching goal of improving jobs and reducing turnover, their specific management practice interventions differed (see Table 2). This article focuses on the activities of the lead agency in pursuing practice change; a separate analysis will address participating providers’ implementation of management practice changes within their organizations. Most of the interventions involved using existing training programs to bring about this “culture change.” Two projects offered training for senior level management, and three for frontline supervisors. Three projects provided standardized team building training to participating providers. Projects offered peer mentoring programs in all but one state. Two projects sought to enhance direct care workers’ clinical and caregiving skills. Finally, all projects created some opportunities for providers to develop provider-specific projects tailored to their specific needs.

All projects recruited provider organizations to participate in the demonstration. The recruitment process varied across states, ranging from a formal process of responding to a request for proposals to lead agency outreach to participating providers. A total of 148 providers signed memoranda of understanding to

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Note: L = The state’s lead agency falls into this stakeholder category.
participate in the demonstration (see Table 3). Depending on the project’s design, the total number of providers in each state varied from 11 in Oregon to 66 in North Carolina. Recruited providers included nursing facilities, assisted living facilities, home care agencies, and adult day service providers.

**Policy Goals and Implementation**

The five projects established a variety of policy goals, which we grouped into five categories (see Table 4), and all projects implemented initiatives to pursue their goals. Although the call for proposals identified several possible options related to compensation, none of the projects called for increases in wages, and only one worked to increase benefits. Two projects sought to create incentives for providers to implement management practices that improve direct care jobs. Three sought to create or strengthen direct care worker professional associations. All five projects had one or more goals that sought to develop direct care worker training curricula, expand formal credentialing of direct care workers, or make information on credentials available to employers through registries. All five projects promoted public awareness of direct care workforce issues and advocated for policies that addressed these issues. Beyond these broad similarities in the types of goals, specific goals varied greatly within categories. Although few goals were fully achieved, as detailed below, all were at least partially achieved by the end of the demonstration.

**The Five Projects and Their Implementation**

Despite some similarities, the five demonstration projects differed in their organization, experience,
The project also sought to streamline educational and training standards and expand an existing registry of direct care workers. It surveyed direct care workers and providers regarding education and was instrumental in the passage of two laws with appropriations. One modified the state’s existing nurse aide registry to include all classifications of direct care workers and their education and training. The other established a governor-appointed Direct Care Worker Education Taskforce to which three direct care workers were appointed, one serving as co-chair.

North Carolina: State-Related Agency With a Clear Vision

The North Carolina Foundation for Advanced Health Programs, a private organization that provides staffing and a vehicle for receiving grant funds for programs of interest to state policy makers, was the lead agency in North Carolina. It purchased the services of the half-time program director from the state Department of Health and Human Services. Assisted by a professional facilitator, she provided staff support and leadership to a broad coalition of stakeholders from policy, practice, and advocacy organizations. These stakeholders had a prior history of grant-funded projects focused on long-term care workforce development. The project accomplished much of the provider-level intervention work through subcontracts with five provider associations that also were members of the coalition.

The practice and policy initiatives of the North Carolina project differed somewhat from those of the other projects in that they were fully integrated under a single vision. The project’s long-term goal was to establish reimbursement differentials for providers whose management practices create high-quality jobs for direct care workers. The project’s plan was, first, to establish a special designation on state licenses for providers that met practice criteria that its coalition was to develop and, later, to pursue differential reimbursement.

Through a well-structured, consensus decision-making process, the coalition developed specific operational requirements that providers would have to meet to receive the designation and tested them at providers that participated as pilot sites. The special designation standards were in four domains: supportive workplace, training, balanced workloads, and career development. Providers were allowed to develop their own approaches to meeting these standards. The only exception was a required standardized training program for supervisors, the PHI’s Coaching Supervision training. It is designed to build “relationships with supervisees, constructively presenting and addressing problems, and helping workers develop problem-solving skills” (PHI, 2007, p. I.2).

The North Carolina legislature passed legislation establishing this special designation, laying the foundation for establishing in future legislation higher reimbursement rates for providers receiving the designation. Once providers felt they fulfilled the requirements outlined in the special designation criteria, they were able to submit applications and undergo both a desk and onsite review. To date four providers have received the special designation. (See Brannon, Barry, & Kemper, 2007, for additional information on the North Carolina project.)

Oregon: Process Orientation With a Focus on Management Practice

The Oregon Technical Assistance Corporation, which provides training and technical assistance including support of state human service programs, was the lead agency in Oregon. Although its executive director assumed the role of project director officially, a four-person leadership team ran the project: a project manager and a part-time practice manager housed at the lead agency, a local evaluator, and a staff member from Oregon’s Aging Services Department. The project coalition members had a prior history of working together on long-term care initiatives. They approached the project in what respondents referred to as the “Oregon way,” emphasizing a process-oriented, consultative approach that takes time. The project manager, along with the other three leadership team members, provided direction to a set of committees and councils, which were composed of coalition members.

The project’s plan was to develop its policy goals over the course of the demonstration based on the policy barriers to management practice change providers encountered. Under this plan, the Oregon project focused first on its practice goals.

The underlying philosophy of providing person-centered care pervaded the practice interventions. The project used the Learn, Empower, Achieve, Produce (LEAP) program training module for nurses to improve supervisory skills. The training focused on building relationships with residents, families, and direct care workers; giving feedback to direct care workers; and empowering residents and direct care staff with an emphasis on person-centered care (Hollinger-Smith, Ortigara, & Lindeman, 2001; Mather LifeWays, 2006). The project also used LEAP training to improve communication skills among practice teams at each provider and to improve relationships between direct care workers and their supervisors; in addition, it used the module for direct care workers to teach peer mentoring skills. To promote diversity, the project encouraged providers to use a diversity training video with all levels of staff to stimulate discussion of diversity issues specific to their organizations.

The project developed few specific policy goals and made little tangible progress on policy, in part because the practice implementation experience did not generate a policy agenda as planned. In addition to raising awareness of public policy issues related to the long-term care workforce, the Oregon project sought to expand the use of Oregon’s new nurse delegation law. The project also worked with the Oregon Consortium for Nursing Education to develop scenarios on working with direct care workers for a new statewide nursing curriculum.
Pennsylvania: Leadership Turnover in a Large, Complex State

The lead agency in Pennsylvania was the Center for Advocacy for the Rights and Interests of the Elderly, which provides outreach, training, referral, and advocacy for older adults, their caregivers, and service providers in the Philadelphia region. After early turnover, the lead agency was able to hire a project director and practice manager to lead the project. The original coalition was a 10-member steering committee that served during the project’s planning phase. Subsequently, the lead agency created a new, nonprofit subsidiary to oversee project implementation, and governance shifted from the steering committee to the subsidiary’s board. Decision-making authority for the project, however, remained with the lead agency. Late in the project, the role of the subsidiary and its board was terminated. The coalition dealt with significant opposition from certain regions of the state and struggled with obtaining consensus from a diverse group of stakeholders.

Because of Pennsylvania’s large size, the lead agency established subcontracts with organizations in five geographic regions to work with stakeholder groups locally to pursue practice and policy change. Each subcontractor was responsible for implementing practice interventions at participating providers in its region.

The practice interventions included senior management training, team building, supervisor training, and provider-specific projects. A 2-day leadership training seminar conducted by the Professional Care Management Institute prepared managers to support the organizational change that was expected to result from team-building training. Direct care workers received team-building training using the Professional Care Management Institute’s (2007) Key Solutions Team Building training, which aimed to improve direct care workers’ perception of organizational culture and employee satisfaction. Providers also were offered the PHI’s Coaching Supervision training in problem-solving skills (PHI, 2007). Finally, joint teams of managers and direct care workers developed provider-specific interventions focusing, for example, on orientation, mentoring, or improving communication about care.

The Pennsylvania project’s policy goals included expanding direct care worker training resources and credentialing, developing a professional association for direct care workers, and promoting awareness of long-term care workforce policy issues. The project developed a Universal Core Curriculum designed for direct care workers in all settings. By demonstration’s end, two Area Agencies on Aging had adopted it for personal care worker training. The project also worked on developing training and a competency exam based on the curriculum with the expectation that it will be used in Pennsylvania’s new personal care attendant training regulations. The project established a direct care worker advisory committee to represent the needs of the state’s direct care workers, put on a statewide worker conference, and published a newsletter with an editorial board composed of direct care workers. These accomplishments led direct care workers to establish a statewide direct care worker association. Finally, some members of the project staff and coalition served on legislative workgroups in an effort to integrate BJBC into other long-term care workforce policy initiatives.

Vermont: Leadership Turnover in a Small, Collaborative State

The lead agency in Vermont, the Community of Vermont Elders, promotes improved quality of life for seniors through education, policy development, and advocacy. The lead agency’s executive director played an active leadership role, overseeing a project director and additional staff hired to manage the practice initiative. Initially, the project was governed by a 24-member steering committee and a 7-member executive committee whose members had a history of working together on long-term care workforce policy issues. The executive committee made decisions with input from the steering committee. Significant turnover occurred among project staff members and, coincident with the transition to a new executive director and project director, the structure developed into a network with workgroups. These workgroups included project staff, executive committee members, or both who did the bulk of the work and decision making, with the executive committee serving in an advisory and steering capacity.

Vermont’s practice goals focused on peer mentoring and caregiving skill development. The project provided training in peer mentoring and direct care worker leadership development to help foster culture change at the providers. As part of its policy work, the Vermont project developed advanced direct care worker training programs (see below) that it offered to participating providers.

The project’s policy goals included creating incentives for job redesign, developing curriculum and credentialing, creating a direct care worker professional association, and promoting awareness of long-term care workforce policy issues. The Vermont project added criteria to an existing annual state quality award for nursing facilities that required the use of best practices for recruitment and retention of direct care workers. It also established a similar industry award for home care providers, although without financial incentives.

The project developed three training curricula for direct care workers. These curricula offered training for personal care aides and two advanced training modules, one on palliative care and the other on the care of persons with dementia for existing workers. The project then received a grant from the state Department of Education to develop a methodology for assessing personal care aides’ proficiency based on the curriculum it had developed.

Although technically not a BJBC initiative, the Vermont lead agency had a concurrent, complementary grant to establish a direct care worker association that was integrated with the BJBC project. The result was the creation of a direct care worker association. The BJBC project offered continued support of the association through events and education, access to training,
and reimbursement for direct care workers’ travel to national conferences.

Finally, project staff and coalition members participated in other state long-term care workforce development workgroups. They also met and maintained close contact with state legislators, playing an important role in the passage of workforce study legislation with an appropriation.

Factors Affecting Implementation

Respondents to telephone and in-person interviews identified factors that helped and barriers that hindered implementation of the BJBC projects. Table 5 reports the number of states in which the factors were mentioned by one or more within-state respondents; an asterisk indicates whether one or more respondents with a cross-state vantage point mentioned the factor. We grouped them into six categories that in our judgment are important overarching factors for successful implementation.

Demonstration Resources. — Not surprisingly, demonstration funding and in-kind technical assistance provided by the national program office and technical assistance contractor were essential to the demonstration projects. Respondents identified resources as a facilitating factor and their decline after the demonstration as a barrier to continuation. External support, however, was able to do little to overcome one significant financial barrier to provider participation and commitment to the project: the limited financial resources and staffing in the competitive long-term care industry, much of which relies heavily on low Medicaid reimbursements. Indeed, instability among providers’ senior management, which is likely related to competition and low pay, was an important barrier to engaging and sustaining provider participation in the project.

Strong, Stable Project Leadership. — Also not surprisingly, the skills and abilities of project leadership were important for effective implementation, as was prior experience with public policy and practice interventions. Several projects did not have a designated person with policy experience to lead work on policy, making it difficult to pursue policy goals. Projects sometimes used consultants effectively to add needed expertise that the leadership did not have. Hiring and retaining appropriately qualified leadership turned out to be quite challenging, and delays in hiring and turnover of leadership were oft-cited barriers to implementation.

Strong Coalition With Key Stakeholders. — Having representation of key stakeholders, particularly provider and direct care workers, as well as state agencies, was essential for project implementation. A history of collaboration greatly increased the ability of the stakeholders to function as a coalition and compromise on issues when they had competing interests. This was the experience in Oregon, North Carolina, and Vermont, where coalition of stakeholders previously had worked together on related issues. The particular individuals representing stakeholders, of course, matter: They should be key decision makers, have policy or practice experience, be committed to the project, and be able to participate regularly.

A Neutral Lead Agency. — Having a lead agency that other stakeholders, particularly providers and direct care worker organizations, did not perceive to be neutral was a barrier to implementation in some states. For example, as indicated, in Iowa some providers perceived the lead agency, as a caregiver association, to be pro-unionization, making it difficult to engage providers in the project and leading one provider association to actively oppose the project. In contrast, stakeholders in North Carolina perceived the lead agency, which was linked with state government and had prior experience with coalition stakeholders, as sufficiently neutral to lead the coalition with the confidence of the stakeholders.

Clear Goals. — The pursuit of a clear goal that stakeholders agreed on contributed to effective implementation. In North Carolina having a single, clear goal encompassing both policy and practice from the beginning of the demonstration was important to project implementation. In contrast, in some states, the absence of clear goals from the beginning made it difficult to focus project implementation efforts and resources. Respondents also viewed achievability of goals as important, mentioning as barriers the demonstration’s unrealistic expectations, its short duration, and the difficulty of pursuing both policy and practice goals. Strategies for pursuing goals appeared to be less important than the goals themselves or the process for pursuing them. However, respondents identified several specific strategies for achieving policy goals: (a) monitoring policy activity and flexibly exploiting current policy interest; (b) having a public education and communication strategy from the project beginning; and (c) collecting information to document the workforce problem and, later, the project’s successes.

Effective Process. — The emphasis on process and how it was used was an important factor that could be either a barrier or a facilitator of successful implementation. Overemphasis on process can delay implementation, whereas excessive task orientation can limit the breadth and sustainability of a project’s impact. At the same time, skillful use of process can be effective in reaching compromise and building relationships among stakeholders, as it did in North Carolina (Brannon et al., 2007). For developing practice interventions, respondents with cross-state vantage points viewed involving providers and direct care workers as facilitating development, and several respondents underscored the importance of good communication between the lead agency and participating providers. Structural factors appeared to be less important than process, although the structure should support the goals and process, as well as the unique characteristics of the state.
Favorable State History and Context.—A state’s history and context had major effects on implementation, both favorable and unfavorable. As indicated, a history of stakeholders working together on workforce issues greatly facilitated project implementation. Current interest of state policy makers in changes in policies affecting direct care workers also was essential for achieving policy goals. However, projects identified tight state budgets and unwillingness of policy makers to increase spending as barriers to policy change. Fear of unionization, greater in some states than others, was sometimes a barrier to both provider participation and policy change. A state’s size (population and geographic) also affected implementation. For example, competing regional stakeholders and having to travel long distances to meetings posed barriers to implementation in large, diverse Pennsylvania.

Discussion

Conclusions

BJBC’s implementation experience clearly demonstrates that engaging providers in practice change and
bringing about policy change to improve direct care jobs is extremely difficult. Efforts to engage providers in management practice change often confront understaffed organizations in an underfunded industry; management that may have limited training; and high turnover of management, supervisors, and direct care workers. Policy change requires stakeholders, who often have competing interests, to agree about goals; it confronts resistance when it would increase state spending; and it relies on the interest and support of legislators, which takes skill, persistence, and time to develop. The BJBC experience, moreover, almost certainly underestimates the challenges. Because the projects chose to apply for the grant and were selected based on a highly competitive process, they almost certainly had greater than average ability to implement their projects. Similar efforts elsewhere might well encounter greater barriers and have less success in implementation than the demonstration projects.

That said, BJBC demonstrated that despite competing interests, key provider and direct care worker stakeholders can work together to pursue common workforce issues and that long-term care providers of all types can engage in efforts to improve direct care jobs. All five lead agencies and stakeholder coalitions were able to implement their projects. All established policy goals and had some success in achieving them. All projects also developed management practice interventions, recruited providers to undertake the interventions, and supported providers with implementation.

The BJBC demonstration stimulated some important steps forward. By developing expertise, establishing networks within and across states, and fostering working relationships and trust among stakeholders, the demonstration laid a foundation for continued change in the five demonstration states, and it focused attention more broadly on the challenge and importance of improving jobs in long-term care.

Finally, BJBC demonstrated that direct care workforce issues cut across settings. Recruiting and retaining direct care workers is not just a nursing home problem or a home care problem—it is a long-term care problem in which nursing facilities, assisted living facilities, home care providers, and adult day service providers and their residents and clients all have a common interest. Indeed, shifting the research, policy, and provider community’s focus from the silos and competing interests of each provider type to the common workforce issues that cut across settings will be an important legacy of BJBC.

Future Research

More questions about the BJBC demonstration remain to be addressed. We have not yet analyzed factors affecting implementation of management practice changes at providers that participated in the demonstration. Nor have we analyzed the effects of practice interventions on retention and turnover, supervision, job satisfaction, respect, or other indicators of direct care job quality. These analyses all will be part of the broader evaluation of BJBC. A number of important questions, however, cannot be addressed through BJBC and should be addressed in future research: What are the effects of increasing compensation on job quality and turnover? How do recruitment practices affect turnover? What are the effects of management practice changes and compensation on the quality of the lives and care of clients and residents?

Implications

This article has focused on the implementation of five particular BJBC projects in five particular states at a particular time in their history. Some of the factors affecting implementation that demonstration respondents identified are unique to the particulars of the demonstration or ignore the history and context that, from projects’ perspectives, are outside their control. Nonetheless, their experience has implications for those pursuing similar efforts in other states.

Obtain Money and Staff.—Addressing the considerable challenges of changing practice and policy to improve direct care jobs requires resources. Money and staff were instrumental in effecting both practice and policy change in BJBC. Foundation funding enabled the projects to hire staff to convene and support the coalition, receive direction and technical assistance, pursue legislative change, and assist providers in implementing practice interventions. When undertaking similar initiatives, obtaining financial support to hire staff should be an early step.

Engage Key Stakeholders.—Provider and worker organizations are key stakeholders that must be engaged in and committed to the initiative. Other stakeholders, particularly state government, are important, but without providers and direct care workers—with their sometimes competing interests—compromise and progress are unlikely. Indeed, efforts led by either providers or worker organizations are unlikely to have a large impact because neither is seen as neutral by the other.

Pursue a Clear Vision.—The initiative should have an important vision that key stakeholders agree on. BJBC projects without clear vision faced difficulty implementing their projects.

Develop Stakeholders’ Working Relationships.—Although task orientation can lead to task accomplishment, process orientation can build relationships and trust. And strong relationships and trust among stakeholders are more likely to lead to sustained workforce efforts than accomplishment of discrete tasks (Brannon et al., 2007).

Seek to Change the Context.—Although some state factors such as size and culture cannot be changed, many factors that are immutable in the short run may be mutable in the long run. In addition to developing experience working together and trust, stakeholders...
can seek to stimulate policy interest and additional workforce efforts, one step leading to the next. If one thing has been learned from the BJBC experience it is that improving jobs in long-term care is a challenging, long-term process requiring vision, commitment, and persistence.

References


