Finding the Best Ways to Help: Opportunities and Challenges of Intervention Research on Aging

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The Origins of Better Jobs Better Care

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Better Jobs Better Care was the nation’s largest single initiative created to reduce the high vacancy and turnover rates of direct care workers and improve workforce quality through both policy and practice changes. In this article, we describe the important role and key characteristics of direct care workers, what motivated the unique partnership between a provider association and a direct care worker advocacy organization to create this initiative, and how the initiative was designed to respond to the key challenges through applied research and demonstration projects. We conclude by discussing how BJBC has influenced providers, policy makers, and direct care workers to think about these frontline caregivers, who are the crux of the long-term care workforce.

Key Words: Direct care worker turnover, Direct care worker retention, Quality improvement, Quality workforce, Workforce improvement

Who Are the DCWs?

DCWs—nursing assistants, home health and home care aides, personal care workers, and personal service attendants—form the centerpiece of the formal long-term care system (Stone & Weiner, 2001). These so-called frontline caregivers provide hands-on care to millions of elderly and younger people with disabilities in settings ranging from the nursing home, to assisted living and other residential care options, to private homes. DCWs provide 8 out of every 10 hr of paid care received by a long-term care consumer and are often referred to as the “eyes and the ears” of the care system (PHI, 2001). In addition to helping with activities of daily living (e.g., bathing, dressing, using the toilet, and eating), these workers provide the “high touch” that is essential to quality of life, as well as quality of care, for elders and chronically disabled individuals.
were home health aides employed in home- and community-based settings (Center for California Health Workforce Studies, 2006). A study of the demographic characteristics of DCWs, using data from the 2000 Census, indicates that the median age of nursing home aides is 36 years. Home care aides are somewhat older, with a median age of 46 years (Montgomery, Holley, Deichert, & Kosloski, 2005). The vast majority of DCWs are female—91.3% of nursing home aides and 91.8% of home care aides. Three out of five nursing home aides and two thirds of home care aides are not married. A little more than one quarter of those employed in nursing homes and one third of those working in home care have not completed high school. Many of these women are likely to be single mothers who are supporting their families with one relatively low income while balancing their job (and sometimes more than one job) with child care and other family responsibilities. These conflicting pressures may contribute to absenteeism and affect the quality of the worker’s job performance and commitment to the work.

There is much ethnic and racial diversity among DCWs. Although a little more than half of nursing home and home care aides are White, 31% of those employed in nursing homes and 26% of those employed in home care settings are African American. Almost 8% of nursing home aides and 16% of home care aides are Hispanic. In addition, 14% of nursing home aides and almost one out of four home care aides are foreign born. The wide variation in ethnicity and cultures represented among staff in long-term care settings heightens the potential for tension, miscommunication, and conflict between caregivers and care recipients, between peers, and between supervisors and DCWs (McDonald, 2007; Parker, 2006). This increased diversity underscores the need for improving the English-language skills of many workers and building cultural competence knowledge and skills into formal and on-the-job training programs for DCWs and managers.

Motivation for Developing BJBC

Historically, concerns about DCWs in long-term care have ebbed and flowed, with the issue gaining greater attention during relatively prosperous economic times when employers compete for workers—and thus staff (who might otherwise be employed by the long-term care industry) find other, more attractive job options. During the late 1990s, such a period of low unemployment left many long-term care employers of DCWs not only with high rates of turnover (which is typical in the industry) but also with high vacancy rates. The latter in particular caused both providers and policy makers to pay increased attention to how direct care jobs were failing to compete within a suddenly competitive job market—admittedly more out of concern for how these vacancies were impacting consumers and the providers themselves, but nonetheless resulting in a renewed interest in how to find and keep DCWs.

Shortly thereafter, PHI and the Institute for the Future of Aging Services (IFAS; the research arm of the American Association of Homes and Services for the Aging) partnered to create a greater awareness among, and an evidence base for, policy makers and providers about the need for a more systemic approach to developing and sustaining DCWs. Both PHI and IFAS based their heightened efforts on the premise that, although the then-current spike in vacancy rates was indeed exacerbated by the full-employment economy, the underlying U.S. demographics of both the long-term care consumers (demand for services) and the health care workers (supply of labor) would combine in the future to make the resulting “care gap” not simply an episodic byproduct of occasional strong economies but a permanent crisis for the future of caregiving. (The U.S. Department of Health and Human Services, 2003, later reinforced this premise about future supply and demand projections in a report to Congress.)

PHI, a policy and technical assistance organization for direct care issues, approached the issue primarily from a workforce development perspective: Based on a “quality care through quality jobs” analysis, PHI focused particularly on improving the financial, educational, and workplace dimensions of direct care employment so that DCWs would have the training, support, and stability to provide high-quality care. IFAS was interested in furthering this issue because of the DCWs’ integral place in the long-term care system. Furthermore, both organizations were committed to helping to advance the evidence base that would support changes in practice and policy. Several key issues motivated their partnership.

Workforce Improvement as a Long-Term Care Quality Issue

Over the past 20 years, there has been increasing interest in and concern about the quality of care being provided in nursing homes and other long-term care settings (Noelker & Harel, 2001; Wunderlich & Kohler, 2001). However, prior to 2000, much of the policy, practice, and research activity focused on how to improve quality outcomes for residents and home care clients through a range of regulatory and, more recently, quality improvement activities. With the exception of entry-level certification requirements for nursing home and home health aides, the performance of the DCW was usually an afterthought in those discussions of long-term care quality (Stone, Dawson, & Harahan, 2004). A 2001 Institute of Medicine report, however, identified workforce development as one of its nine guiding principles and acknowledged that quality of
care depends largely on the performance of the caregiving workforce (Wunderlich & Kohler, 2001). Until recently, most of the discussion of workforce issues had focused on achieving minimum staffing levels for nurses and DCWs: A major nursing home staffing study indicated that, to maximize quality of care, a nursing home would need to provide 2.78 hr of nurse aide care per resident day, substantially more than the current average of 2.02 hr of aide care per day (Abt Associates, 2003). The 2001 Institute of Medicine report, however, also emphasized that an adequate staffing level is a necessary, but not sufficient, condition for positively affecting the quality of life and quality of care of consumers. A more recent Institute of Medicine (2004) study focused specifically on transforming nurse practice emphasized that organizations must not only have adequate numbers of staff, but must also create work environments that help retain nurses and nursing assistants. The study highlighted the importance of both orientation programs for newly hired staff and continuing education for existing staff.

At the time planning for BJBC began, there existed only limited empirical evidence directly linking the performance of DCWs (and the factors that contribute to effective worker performance) with resident-client-level quality-of-care and quality-of-life outcomes. Nevertheless, government and media reports did suggest that high turnover among nursing home and home care aides could negatively affect the quality of the services delivered and the quality of life provided in nursing homes, assisted living settings, and home-based settings (Leon, Marainen, & Marotte, 2001; U.S. Government Accountability Office, 1999). Interviews conducted as part of a study of turnover and retention in not-for-profit California nursing homes indicated that, although all of the participating facilities had more than adequate staffing ratios, many of the administrators and supervisory staff felt that the largest obstacle to delivering high-quality care was the need to constantly accommodate DCW vacancies (Harahan et al., 2003).

Also, in an earlier study, Schnelle and colleagues (1993) developed and evaluated the effects of a quality improvement program in which nursing assistants were trained in how to reduce incontinence, how to collect and analyze data, and how to track their own performance relative to the residents for whom they were responsible. Seven of the eight participating nursing homes experienced significant increases in resident dryness and maintained this improvement over a 6-month follow-up. Eaton (2001) documented reductions in mortality and pharmaceutical use and increases in resident functioning after the introduction of innovative organizational programs that improved the work environment of nursing home aides. These models included the development of self-managed work teams, improved information sharing between nurses and direct care staff, and enhanced responsibilities for DCWs. In their evaluation of the Wellspring nursing home quality improvement program, Stone and colleagues (2002) found that the empowerment of the DCWs, including their significant participation in care planning and care plan implementation, was associated with reduced turnover, a reduction in health deficiency citations from state surveyors, and a decrease in incontinence rates. Researchers involved in a national nursing home staffing study found a strong relationship between aide retention in California nursing homes and select quality outcomes (Kramer, Eilertsen, Lin, & Hutt, 2000). For short-stay nursing home residents, the study found a strong negative association between retention rates and both electrolyte imbalances and urinary tract infection rates. Aide retention rates also affected the functional status and pressure ulcer rates of long-stay residents.

Workforce Improvement as an Economic Development Issue

The second major issue driving this interest in the recruitment and retention of a quality, stable direct care workforce is the potential for these occupations to contribute to the economic development of communities across the country—assuming, of course, that the overall quality of these jobs (including wages, benefits, and career opportunities) is improved. Given the aging of the U.S. population over the next 40 years and increased longevity among younger people with disabilities, the long-term care sector will undoubtedly be a growth industry. In 2000, approximately 13 million Americans needed long-term care. By 2050, the number is expected to increase to 27 million; the population aged 85 and older—who are most at risk for needing long-term care—is expected to increase fivefold (U.S. Department of Health and Human Services, 2003).

Although it is difficult to predict the level of family caregiving that will be available and relied on in the future, projections of wealth patterns among elderly Americans in 2015 and 2030 indicate that real income and liquid (nonhousing) assets will increase greatly between 2000 and 2030 (Knickman, Hunt, Snell, Alexich, & Kennell, 2003). These estimates suggest that many individuals needing long-term care will prefer and be able to pay for services (Center for California Health Workforce Studies, 2006). Furthermore, to the extent that more baby boomers are motivated to purchase long-term care insurance, this is almost certain to stimulate increased demand for paid services—especially at home and in residential alternatives to nursing homes.

The U.S. Bureau of Labor Statistics (2006) estimated that employment of DCWs in long-term care settings in the next 10 years will grow faster than health care employment in general and 3 times as fast.
as all industries. During the coming decade, there will be an increase of 35% in jobs for nursing assistants, home health and home care aides, and personal care workers. Including both new jobs and replacement jobs for retiring workers and those who leave the occupation, the Bureau of Labor Statistics projects that almost 1 million new DCWs will be needed between 2004 and 2014 (Hecker, 2004). The demand for DCWs in home- and community-based settings is projected to grow even higher than for nursing homes: The Bureau of Labor Statistics projects a 41% increase in the demand for home care and personal care aides and a 56% increase in the demand for home health aides over the 10-year period (Hecker, 2004; U.S. Bureau of Labor Statistics, 2006).

Although the projections farther out into the future are more equivocal, the demographic trends suggest that the demands on the long-term care sector will create many job opportunities, particularly in communities that are becoming disproportionately elderly because younger people have moved out (e.g., in many rural areas), substantial numbers of elders have aged in place (e.g., in many inner cities), or elderly individuals have migrated to retirement destinations. Workforce improvement efforts that help to create more valuable, attractive jobs for young people as well as older people looking for second careers can positively affect the economic health of many communities and regions across the country.

**Workforce Improvement as a Moral Imperative**

Despite the critical role that DCWs play in the long-term care system, they are among the lowest wage earners in the United States. In 2000, the year that we began to develop the BJBC initiative, the median hourly wage for DCWs was $8.21 (PHI, 2003). Five years later, in 2005, the median hourly wage for DCWs had risen to $9.56 (PHI, 2006b). The median annual income of a nursing home aide in 2000 was $13,265; the comparable figure for a home care aide was $12,265. These incomes were below the federal poverty level for a family of four, which was $16,700 in 2000.

These low wages may encourage DCWs to leave the long-term care or health care fields. One study in North Carolina found that nursing aides who had left jobs in the health sector were better off financially than those who remained in the field (Konrad, 2003). The study compared North Carolina workers trained as nursing aides who remained certified as aides with those who did not remain certified. Among those who had not been certified as aides since 1990, the median 1998 wage was $14,425 compared to $11,358 for actively certified nursing aides. The median wage of those no longer certified rose to $17,359 in 2001, whereas the comparable wage increase for currently certified aides was $12,877. Although wages increased slightly in North Carolina over the 4-year period, median wages remained substantially lower for those still certified compared with those who had left the field.

This financially disadvantaged status is exacerbated by the lack of health coverage experienced by a large portion of these caregivers: 1 in every 4 nursing assistants and more than 2 out of 5 home care workers lack health insurance coverage (Lipson & Regan, 2004). DCWs are uninsured at a rate that is 50% higher than the general population younger than age 65, and nursing home workers are twice as likely to be uninsured than hospital workers (Case, Himmelstein, & Woolhandler, 2002). Furthermore, coinsurance premiums for workers in long-term care can be as much as 50% of the total premium (Michigan Assisted Living Association, 2001). For low-wage workers, this makes offering health coverage meaningless because it is unaffordable.

These workers also face strenuous physical demands and high job-related injury rates compared to other health- and non-health-related industries: 13.9 employees per 100 employees in nursing homes and personal care facilities had a workplace injury in 2000 compared to 5.3 employees per 100 in eating and drinking places or 9.1 per 100 in hospitals (Service Employees International Union, 1999). The nursing home aide occupation ranks second only to truck driver in the federal government’s list of dangerous professions (Service Employees International Union, 1999). Car accidents pose the greatest danger for home care workers.

In addition to this disadvantaged status, these workers—who provide up to three quarters of all long-term care—have few opportunities for job advancement and upgrading of their skills. There is, furthermore, often a stigma associated with being a DCW, particularly a home care aide or personal care attendant, such that one is frequently referred to as a “girl” or viewed as simply a domestic worker—“the maid” (PHI, 2003).

Given the very low quality of and value attributed to these jobs, Friedland (2004) noted that it could reasonably be argued that our long-term care system—paid primarily by public tax dollars—has an obligation to create jobs that provide a livable wage; that our publicly funded health system has a responsibility, at the very least, to provide its own workers with health insurance. (p. 7)

Friedland went on to lament that moral persuasion alone has failed to offer significant improvements in the quality of direct care jobs. We agree with this sentiment and believe that there is a moral imperative to improve the recruitment and retention of DCWs in long-term care by supporting public policies and educational and provider practices that help to elevate these jobs to recognized, valued professions.
The Current Problem

Across the country, long-term care providers report DCW vacancies and high turnover rates. Nursing homes, assisted living and other residential care providers, home health agencies, community-based home care and adult day programs, and individuals and their families all indicate that they experience difficulties in recruiting and, more importantly, retaining frontline caregivers (PHI, 2001; Stone & Weiner, 2001). This workforce problem was the pivotal issue that motivated BJBC’s two funders—the Robert Wood Johnson Foundation and the Atlantic Philanthropies—to invest in the national demonstration and applied research program.

Nationally, data on turnover rates show wide variation ranging from 40% to 100% annually (American Health Care Association, 2003; PHI, 2001). Most states—major stakeholders in financing (via Medicaid) and regulating the long-term care sector—identified DCW recruitment and retention as a major policy concern in 1999 when the United States was experiencing very low rates of unemployment and there was great competition for workers at the local level (NCDHHS, 1999). Even with increases in unemployment rates, however, states continue to view these long-term care workforce issues as priorities (PHI and North Carolina Department of Health and Human Services Office of Long-Term Care, 2004).

High staff turnover and vacancies have negative effects on the major stakeholders within the long-term care system: workers, consumers (including their families), long-term care providers, and third-party payers—primarily the Medicaid and Medicare programs (PHI, 2001; Stone & Weiner, 2001). Turnover is expensive, although a dearth of studies has attempted to quantify the per-worker costs of frontline turnover in different long-term care settings. Seavey (2004) conducted a meta-analysis of the literature and concluded that a minimum direct cost of turnover per worker is at least $2,500. Most of the studies she reviewed (Straker & Atchley, 1999; Waldman, 2004) estimated the costs of separation and vacancy, hiring, training, and increased worker injuries. Seavey noted, however, that the indirect costs of turnover (lost productivity until the replacement is trained, reduced service quality, lost revenues, lost clients to other agencies, deterioration in organizational culture and employee morale) may be substantial and tend to be overlooked because they are less visible and harder to measure.

In addition, turnover and vacancies are costly not only to providers but also to consumers (through reduction in quality of care and life and care hours not received) and to workers (through increased worker injuries, increased physical and emotional stress, deterioration in working conditions, and increased likelihood of quitting). Compromised care quality can result in deterioration of the resident/long-term care client’s health or functional condition, which in turn leads to increased transfers to more expensive, higher acuity settings, unnecessary emergency visits and hospital stays, and even higher mortality (Kosel & Olivo, 2002; Seavey, 2004). Such adverse outcomes have a ripple effect and inevitably raise costs to third-party payers (primarily Medicaid and Medicare). These downstream medical costs ultimately are borne by citizens whose tax dollars support the public programs that finance long-term care (PHI, 2001; Seavey, 2004; Stone & Weiner, 2001).

The Long-Term Outlook

As noted earlier, the unprecedented increase in the size and proportion of the elderly population and the growth in the nonelderly disabled population will increase the demand for DCWs across all long-term care settings. There is, however, serious concern about the availability of these caregivers in the future. In the coming decades, as baby boomers enter old age and begin to require assistance, the pool of workers available to provide basic long-term care services will fail to keep up with demand (Feldman, 1997; PHI, 2001; Stone & Weiner, 2001). That is, the number of potential entry-level workers who traditionally fill direct care jobs—women aged 25 to 54 in the civilian workforce—is projected to increase by only 3.2% during the next 7 years (U.S. Bureau of Labor Statistics, 2006). This tightening of the traditional labor pool is caused by the baby boom generation having passed through this age range, and the slowed rate of increased participation of women in the workplace.

The educational level among minority women—those most likely to enter the direct care workforce—is also improving dramatically. Although the educational status of both White and Black women improved substantially over the past several decades, the increase was most striking for the latter group. Between 1990 and 2007, for example, the proportion of Black women aged 25 or older with at least a high school education increased from 66.5% to 82.6%; the proportion with 4 years or more of college increased from 10.8% to 19% (U.S. Census Bureau, 2008). These more educated women will be less willing to work in the same low-wage, low-benefit jobs than those who preceded them.

The Response: Design of the BJBC Initiative

In response to the caregiving, economic development, and moral challenges presented by the emerging care gap, IFAS and PHI engaged with the two national philanthropic organizations during 2002 to design BJBC. This program, funded at $15.5 million over 4 years, would soon become the largest frontline health care staffing initiative in the
The proposed solutions were applied across a range of long-term care provider types and settings—including nursing homes, assisted living facilities, adult day care centers, home care agencies, and independent home care provider programs. Although each of these provider types exists within unique funding “silos” and is subject to differing regulatory and finance environments, direct care positions are somewhat similar across these settings and draw from much of the same labor pool. Interventions, therefore, were likely to be effective in multiple settings.

At the same time, the designers also assumed that differing silos create warring political factions among providers, consumers, and worker/labor organizations, which in turn impede change. Therefore, the designers posited that if the walls of misperception between these factions could be
lowered and “win–wins” could be created for all stakeholders by working together within the BJBC program, greater success and potential for sustainability across all of the silos might result.

Based on these design assumptions and features, the designers distributed widely two requests for proposals—one soliciting proposals for applied research projects that examined various aspects of workforce improvement in long-term care, and the other soliciting proposals to develop state-based demonstrations. A National Advisory Committee appointed by the two foundations reviewed more than 200 research proposals and recommended funding for eight applied research projects. The Committee also recommended funding for 5 out of the 220 demonstration proposals they reviewed. The overwhelming response to both of the requests for proposals underscored the interest in and concern about this workforce issue among state stakeholders and researchers across the country.

The Applied Research Projects

Six of the eight applied research grantees were university-based, one was located within a provider-based research center, and another was based within a workforce development program. Two projects focused on the role of various aspects of leadership, work design, and relationships between and across staff and residents in improving workplace outcomes in nursing homes. One grantee developed and evaluated the effectiveness of a cultural competency assessment and training tool in helping to create a healthier work environment for DCWs. Two other grantees assessed the role of tailored and ongoing training programs in improving job satisfaction and reducing turnover in the long-term care sector. Another grantee examined the effects of improved wages and benefits on the likelihood of home care workers entering and staying in the job. The final two grantees explored issues related to expanding the labor pool of DCWs, including the potential for older adults and family caregivers to enter this labor market. Summaries of the applied research projects supported by the national program are on the BJBC website (www.bjbc.org). In addition, specific articles related to these research projects are published elsewhere in this special issue of The Gerontologist.

The State Demonstration Policy and Practice Solutions

The National Advisory Committee awarded grants averaging $1.4 million each to the following five lead nonprofit agencies: the Iowa CareGivers Association, the CCommunity of Vermont Elders, the North Carolina Foundation for Advanced Health Programs, the Oregon Works! Coalition, and the Pennsylvania-based Center for Advocacy for the Rights and Interests of the Elderly.

Each of the demonstration states eventually crafted a unique cocktail of policy and practice responses. Although none of the demonstration programs had the resources to consider a fully comprehensive solution to recruitment and retention, taken together the BJBC programs addressed what we consider to be nine essential elements of a quality job program for DCWs (PHI, 2006a). These nine elements fall within the three broad categories of compensation, opportunity for advancement, and organizational support (see Table 1).

Within the demonstration sites, these essential elements were reflected in practice-based initiatives, such as a peer mentor program in Iowa, supervisory training in Oregon, and leadership training and team-building activities in Pennsylvania. They were also reflected in policy-based initiatives, such as the New Organizational Vision Award licensure program in North Carolina, state-funded long-range needs analysis for DCWs across settings in Vermont, and the infusion of person-centered care into the state nurse aide and nurse training requirements in Oregon. The efficacy of these initiatives, although still being assessed, is reported on by researchers from The Pennsylvania State University’s Department of Health Policy and Administration, the evaluators of the BJBC program (see Kemper, Brannon, Barry, Stoot, & Heier, this issue).

Conclusion

Since the inception of BJBC, issues related to the availability of and quality of the direct care workforce have received increasing attention by policy makers at the federal and state levels, providers, consumer and worker organizations, and researchers. We believe that this national program, with the foundations’ generous support and imprimatur, helped to catalyze this increased attention. During the past 4 years, the current status and future of the direct care workforce was the subject of two national provider-sponsored long-term care commissions (Biles et al., 2003; Harahan & Stone, 2007), and it is a major focus of the current National Campaign for Quality Nursing Homes. The Centers for Medicare & Medicaid Services required workforce improvement activities and outcome measures to be developed and implemented in the eighth scope of work of the Quality Improvement Organizations, the groups with which it contracts in each state to work with nursing homes and home health agencies on quality improvement initiatives. Many state-based culture change coalitions have recognized the crucial role of direct care workforce improvement in ensuring that change actually occurs and is sustained within nursing homes and other long-term care settings. The U.S. Department of Labor and its state
Table 1. Nine Essential Elements of a Quality Job Program for Direct Care Workers (DCWs)

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<tr>
<td><strong>Compensation</strong></td>
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<td>• Family-sustaining wages (Wider Opportunities for Women, 2001).</td>
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<td>• Affordable health insurance and other family-supportive benefits (e.g., paid sick leave, subsidized child care, transportation, and housing).</td>
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<td>• Full-time hours if desired, stable work schedules, and balanced workloads.</td>
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<td><strong>Opportunity for Advancement</strong></td>
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<td>• Training that helps the worker develop and hone all skills—both technical/clinical and relational—necessary to support long-term care consumers.</td>
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<td>• Participation in decision making, acknowledging the expertise that DCWs contribute not only to workplace organization and care planning but also to public policy discussions that impact their work.</td>
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<td>• Career advancement opportunities.</td>
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<td><strong>Organizational Support</strong></td>
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<td>• Linkages to both organizational and community services, as well as to public benefits, in order to resolve barriers to work.</td>
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<td>• Supervisors who set clear expectations and require accountability, and at the same time encourage, support, and guide each DCW.</td>
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<td>• Employers (including owners and managers) willing to lead a participative, ongoing quality improvement management system—strengthening the core caregiving relationship between the long-term care consumer and the DCW.</td>
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and local counterparts have invested significant new dollars in the development of training and apprenticeship programs for the direct care workforce employed in long-term care settings. As the BJBC national program comes to a close, we and the participants in this initiative face several challenges. As is discussed in more detail in this special issue, the research projects and demonstration sites have produced many findings, lessons learned, and concrete products and tools (e.g., peer mentoring programs, supervisory and cultural competence training programs, model DCW and supervisor curricula, model occupational profiles, workforce improvement assessment tools, legislative and administrative changes at the state level) that need to be disseminated and replicated across the country at the practice and policy levels.

One major challenge for the demonstration coalitions, participating providers, worker and consumer associations, and policy makers will be to sustain their successes and to help diffuse their efforts beyond their own organizations and states. The national program partners also have a commitment to and responsibility for designing and implementing dissemination strategies to share the successes and failures of BJBC with a diverse audience and to promote replication of the most promising practices and policy changes.

Over the 4-year grant period, BJBC helped to raise the visibility of DCWs, gave them a voice, and made some important inroads toward developing better jobs and producing better care for this country’s aging population. The practice, policy, and research communities now must build on that momentum to help create and sustain a quality long-term care workforce today and in the future.

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