Lori Knapp, Inc. Companies

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July 21, 2008
Legislative Council
Special Committee on Building Wisconsin's Workforce

I would like to recognize the Chairs, Legislators, the Legislative Council, and fellow citizen members. It is a privilege and honor personally to be part of this committee. More importantly, it is a tremendous statement of this Special Committee that the development of a stable workforce for health care workers is so significantly recognized.

I am currently the Development and Marketing Director of Lori Knapp Companies. I have been appointed and served for six years on the Council on Long Term Care Reform, appointed as a member of DHFS Homecare Advisory Committee, a current member of the Wisconsin Assisted Living Association Legislative Committee, elected as an executive board member of the Wisconsin Personal Services Association, and a former board member of the ARC-Wisconsin. I have worked with Northwest Concentrated Employment Program and La Crosse Workforce Connections writing and developing national grants to benefit training of healthcare workers. Currently, I am an advisor to Gateway Technical College on development of a Competency Training model, and working with Southwest Tech to further develop that competency training. I feel I have a familiarity with the needs of people with disabilities and the frail elderly and a knowledge of the workforce issues of those health care workers that serve them.

A historical perspective

My statements today will encompass both personal experiences in my own organization and statistics and examples from many different sources. These sources include the Wisconsin Long Term Care Workforce Alliance, U.S. Department of Labor Statistics, and the AARP Public Policy Institute. In my own organization, Lori Knapp Companies, there are over 350 employees throughout the state of Wisconsin, in four main areas of the state. Lori Knapp had its humble beginnings over 36 years ago when Don and Bette Knapp decided to take their daughter out of an institution, Central Colonies for the Mentally Retarded at that time, where she was placed as a young child, and bring her back to live in her own home community of Prairie du Chien. Those humble beginnings were the start of community based services in the State of Wisconsin - and the nation - for people with significant disabilities. Lori and seven other children were placed from the institution, and a community home for 8 children was begun. Many lessons learned, some very good, some not so good, e.g. eight children in the home was better than the institution, but probably not ideal for children to be raised in. The health care workers for that home were known as house parents, and as more homes were developed, more house parents were hired to provide care. The model was for a live-in couple to stay in the home rent free, generally the husband worked outside of the home, and the wife was paid to be responsible for the care of the consumers. Societal changes and attitudes, workforce laws, and insurance issues have made that model obsolete. This model changed to shift staff and "live-in" staff that remain in the home for at least five consecutive days, and by the way are not paid for sleeping.

Workforce shortages and quality of care

Previous to this session, I spoke with a number of Lori Knapp Companies' coordinators regarding the employment issues of our health care/homecare workers. There are always vacancies. Period. These vacancies often occur at those times that are extremely hard to fill, and remain unfilled for long periods of time. Times such as night care, overnight care, weekends, holidays. Even Wal-Mart closes for Christmas, but not people's needs. To a person who is frail elderly or has a physical disability or a developmental disability, not having a caregiver attend to their needs may mean the difference between life and death. Sometimes it means the indignities of not being able to get out of bed or go to the bathroom or take a drink because no one is there to help. Not having help might mean assistance with meals, basic help with bodily functions, or even something as simple as taking a medication, compromising the dignity, health, safety, and well-being of the person needing care. When a permanent position isn't filled, or a caregiver fails to show, our coordinators have always managed to meet the person's needs. But, at a cost that is not only monetary. The overtime required to maintain services is tremendous. Overtime pay is attractive for health care workers for a while. However, constantly being asked to fill a shift overnight or on a weekend leads to burn-out, especially if arrangements or accommodations have to be made for health care workers with families. Training or retraining someone is very time consuming. The costs of shortages extend to consumers as well. There are times when not all services can be given to a person, and we must chose just what is needed to sustain them.

Training inefficiencies

When a person is hired to work in a home, up to eighty hours of training are given before that staff is allowed to begin working alone with a consumer. There are initial mandated trainings, duplicative mandated trainings, personal care trainings, consumer driven choice trainings, and safety and rights trainings. These operate as silos of similar mandated trainings, each just different enough to require the careworker to complete each individually. The Division of Quality Assurance that regulates Adult Family Homes and Group Homes, Medical Assistance Personal Care Trainings, and DHS all require programmatic trainings whether individual staff are already trained and create the silos of duplicative and redundant and costly trainings. The proscribed 40 hour training to receive MA Personal Cares for those who have had experience providing care is one example. I have been working through the Wisconsin Personal Services Association for over six years with DHFS to get administrative rules changes to make these trainings competency based instead of hourly prescribed. (Actually when we started proposing the rules change, DHS, as it is now known, has gone thru two name changes.) I've personally enlisted the help of legislators of BOTH parties, spearheaded by Speaker Huebsch, to see if some movement could happen. A March 25th meeting with the Secretaries of DWD and DHFS and provider industry leaders was our most recent effort. Almost four months later, there are still excuses of why those administrative rules changes haven't come before the legislature.

Training recommendations

Solving these training issues can be done without a lot of funding. Previous to this meeting I asked Hector Colon, Executive Assistant to Secretary Gassman, to summarize what he thought were needed improvements:

- *portable industry recognized training to prevent redundancy*
- *more distance learning opportunities for training in various locations and settings*
- *recognition of levels of specialization competencies i.e., dementia, etc.*
- *safer conditions, i.e. - safe lifting equipment and training*
- *career pathway for PCWs, SHCWs to CNAs and levels within CNAs recognizing levels of experience and specialty*
- *support the Gov's youth and adult apprenticeship expansion in healthcare*

Lack of investment in direct care workforce

Other workforce issues were discussed and presented to the Secretaries at the March meeting. Some great future initiatives were laid out by Secretary Gassman through DWD. The Governor's budget in the next biennium will include funding for caregiver programs that I am sure will be presented by Secretary Gassman to

this committee. However, money for training, recruitment, and recognition is hampered by federal mandates that require funds be spent on those jobs that are "high growth, high pay." "High pay" is defined at around $13.20 an hour which is $4.00 per hour more than most health care-workers currently receive.

Additional issues were identified when then-Secretary Kevin Hayden visited the Lori Knapp Companies offices in October 2007. They include:

- *Recruitment of Foreign Workers*
- *Reformation of training and testing requirements*
- *Assurance of Family Care rates sufficient to support the health care workforce*
- *More dialogue between DWD and DHFS*
- *A Public Awareness campaign of health care workers recognition*

I have enclosed a copy of the "Significant Concerns Facing the Future of Long Term Care" and my synopsis letter to the Secretaries and legislators from the March 25th meeting. I'd like to highlight point #1 which deals with the administrative rules changes and have already discussed. Points #3, #4, and #5 deal with workforce, and would like to highlight them now.

Staff retention

In the programs that we provide housing for individuals, after completing all those hours of training, retention becomes a key issue. After around 80 hours of training, Lori Knapp's residential programs lose 39% of those health care workers in the first six months, and after a year, the turnover is 51% in the residential program and 45% in the in-home program. Our HR Department speculate that the reasons for this turnover involve dissatisfaction with hours, expectations on what the job entailed, and wages and benefits. When we are able to conduct exit interviews, wages and benefits are not cited as the number one reason for leaving, however. Additionally, turnover costs employers about $3,500 per employee. Since public funds pay for a considerable proportion of long term care, this means that taxpayers are spending substantial amounts for costs that increase neither the quantity nor the quality of care.

The wage differentials between types of providers account for staff turnover. The wage of a personal care worker ranges from $8.50 to $10.50 an hour, the majority closer to the $8.50, with limited if any benefits. Nursing home wages are $2 to $4 per hour higher and staff may have access to benefits. My friends in the nursing home industry lament losing the health care workers to the hospitals and clinics that pay a decent wage with benefits. In effect, assisted living programs often provide the initial recruiting, training, and experience of health care workers who then take positions with more well-resourced organizations. Most of our assisted living programs and nursing homes are publicly funded. Unlike hospitals and other medical systems, we do not have the option of raising rates to cover costs. (I've submitted a chart of Retention Trends, both nationally and as pertains to Lori Knapp Companies. The national trends are from the College of Direct Support.) One promising development is a grant that is bringing the College of Direct Support's web-based training program geared to developmental disabilities to WI. This is a program that is now used in 39 states. Through research of health care workers, the College of Direct Support cites the lack of a good job description as the number one reason for leaving the health care field.

In-home care issues

Significantly less time is needed for training in-home care workers, but retention and recruitment problems still exist. A great majority of in-home care is provided to the elderly. Most of the workers are part time, caring only for one or two consumers and attracting part time workers is difficult. In addition, job stability is a problem as elders move out of their homes to receive more care or die. For full time health care workers,

travel and transportation is an issue, especially in a rural area. Because MAPC authorizes time and not mileage, driving for a distance to provide an hour or two of care is not economically feasible for individual staff.

Increasing expenses for agencies

In addition to turnover costs, employers have incurred other significant costs such as regular double-digit increases in utilities, health insurance premiums, liability insurance, mileage reimbursement, and workers compensation. These costs coupled with minimal to no increases in reimbursement rates have made it difficult for providers to provide comprehensive benefits and competitive wages.

Respect and recognition

A health care worker is generally not recognized as a vital member of society and this workforce seems largely invisible. I don't personally think health care workers think of their positions as careers, but rather as jobs. But most take great pride in what they do. Individual and public appreciation and perception of direct care workers' images needs to be improved. Local workforce alliances should be supported with staff and program dollars, and issues within the long term care should be addressed by our regional workforce development boards.

The Family Care Program

The need for health care workers will increase, not only because of the aging population and increased longevity, but because of Wisconsin's commitment to providing care for all of its citizens through Family Care. Eliminating waiting lists and providing expanded choices of living situations will require more workers. Without an adequate workforce, the "care" promised by the Family Care program will simply not be possible.

Demographic realities

The older population will continue to grow significantly in the future. This growth slowed somewhat during the 1990's because of the relatively small number of babies born during the Great Depression of the 1930's. But the older population will burgeon between the years 2010 and 2030 when the "baby boom" generation reaches age 65.

The population 65 and over will increase from 35 million in 2000 to 40 million in 2010 (a 15% increase) and then to 55 million in 2020 (a 36% increase for that decade). By 2030, there will be about 71.5 million older persons, almost twice their number in 2004. People 65+ represented 12.4% of the population in the year 2004 but are expected to grow to be 20% of the population by 2030. The 85+ population is projected to increase from 4.2 million in 2000 to 6.1 million in 2010 (40%) and then to 7.3 million in 2020 (44% for that decade).

Workforce demands

In May 2003, the U.S. Bureau of Labor Statistics reported that 68,000 direct care workers supported people with disabilities and aging adults in Wisconsin. These individuals hold positions as nurse aides, attendants, home health aides, personal care aides, or other direct care workers. However, it is believed that 68,000 significantly under represents the actual size of the workforce, since it does not take into account thousands of independent workers.

Direct care workers are a substantial segment of the state's health care economy and are a fast growing field. According to the Department of Workforce Development's Health Care Workforce Annual Report 2007, nursing aides/orderlies/assistants are the 2nd fastest growing occupation and home health aides are the 3rd fastest growing occupation. Combined, Wisconsin will need 13,750 new nursing and home health aides between 2004-2014. DWD also estimates that in that same time period, Wisconsin will also need 6,900

replacement workers, which are those who leave the field. These additional demands for workers will occur on top of an already stressed industry which experiences a shortage of direct care workers and significant turnover in all long term care settings. Even the highest paid workers, nursing aides, earn 22% below the median hourly wage for all occupations in the state. Direct care workers are twice as likely as other workers to receive government benefits and between 1/4 to 1/3 of workers do not have health insurance, 9-17% more than other workers.

Without serious intervention, the shortage of workers will worsen over coming decades. Due to medical advances that allow people with chronic illnesses and disabilities to live longer and the aging of the Baby Boom generation, an unprecedented increase in demand for long term care will occur over the next several decades. Between 2005 and 2030, the number of Wisconsin residents aged 85 and older, those most likely to need long term care, is projected to grow by nearly 46%, from 108,000 to 158,000. In the same time period, the 65 and older population will increase by 86%. At the same time, the population of those who traditionally provide that care, women between the ages of 25 and 54, is projected to decline by 8,000.

Recruiting and retaining employees is extremely important to the health of Wisconsin's long term care system. Unfortunately, though, staff turnover in long term care facilities and agencies is frequently high. Annual turnover rates range between 22% and 100% annually. This has considerable implications for the consumers, who experience care without continuity, inadequate and sometimes unsafe care, and reduced access to care.

Direct care worker shortages hurt everyone, but especially the people and families being served.

- *Inconsistency in care and direct care workers*
- *Long waits and unmet needs*
- *Physical and emotional health concerns*
- *Falls and accidents*
- *Loss of dignity*
- *Less time for personalized compassionate care*

Summary and conclusions

Our committee and the members of the legislature have an opportunity to avert the unfolding crisis in the health care field of long term care. We need a dedicated and state-wide effort to attract, retain, compensate and recognize dedicated direct care workers across care-provider settings. This will require investment in developing this workforce, locally and as a state. Other states have taken on these challenges; our local and state alliances and coalition can be are well aware of existing models; and our local program administrators and workers are ready to seek solutions. The innovation, compassion, and vision that have brought us Family Care and other person-center services must be applied to solve our significant workforce issues. Without this, Family Care will not live up to its potential and our existing long term care systems will continue to falter and struggle. Direct care workers and the people of Wisconsin, those who are receiving care now and in the future, deserve nothing less.

As I was preparing to finish this report on Friday, I received a call from Tom Moore of the Wisconsin Home Care Association. I stated early that many sources were used for my documentation, and I discussed this presentation with my colleagues in the home care and nursing home industries. Tom called to state that a report just came out on Thursday, July 17th that basically reinforces all I have reported. So this will be a conclusion to my conclusion. The report from the Association of Academic Health Centers is about 180 pages, and I have not had time to absorb it all. I've enclosed a News Release, a Key Findings Page, and an Executive Summary. Tom's synopsis, briefly, is the report is critical of both state and federal government to effect policy changes that will not only effect the health care of those requiring long term care but have a negative effect

economically. The horror stories that were being predicted about the Long Term Care Workforce crisis are now happening.

To finish I'd like to quote from the Executive Summary:

- *The dysfunction in public and private health workforce policy and infrastructure is an outgrowth of decentralized decision-making in health workforce education, planning, development and policy making*
- *Despite many challenges, the prospects for positive change are high.*

I look forward to being part of this committee and affecting positive changes.

Respectfully Submitted,

Steve Mercaitis, Development and Marketing Director
Knapp's Development, Incorporated
Lori Knapp, Incorporated
Lori Knapp Crawford, Incorporated
Lori Knapp Richland, Incorporated

State of Wisconsin

Department of Health and Family Services

Jim Doyle, Governor
Karen E. Timberlake, Secretary

May 19, 2008

Steve Mercaitis
Development Director
Lori Knapp Companies
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Dear Mr. Mercaitis:

Thank you for your letter regarding the recent meeting with Secretary Gassman, former Secretary Hayden, members of the Legislature and your colleagues in the long-term care provider industry. Secretary Hayden briefed me on that meeting and I intend to continue his commitment to working with all of our partners in long-term care to ensure that the necessary services are available and of high quality.

As you know from the recent Home Care Advisory Committee meeting, the revisions to HFS 105 and 107 are undergoing an internal editing process. I will explore options to expedite the rule-making process with managers in the Division of Health Care Access and Accountability. Staff will also explore ways that we can streamline current requirements related to training while the rule changes are pursued.

The Department is committed to ensuring that we have a qualified and committed direct care workforce. To this end, the Department participates in the Select Committee on Healthcare Workforce Development and the Quality Home Care Commission and has partnered with others in the public health community on the Wisconsin Public Health Workforce Call to Action.

The ability to attract and retain workers is a high priority as Family Care expands. This includes ensuring competitive pay and benefits. The Department believes that the mechanisms we use for setting capitation rates will allow the system to be more responsive than the fee-for-services system that relies on Legislative action to increase rates. The Family Care rate setting methodology must be "actuarially sound." That is, it must be based on the actual cost of services provided in prior years. Therefore, costs of providing services are reflected in the capitation payments made to Care Management Organizations (CMO). This allows CMO's to increase provider rates annually as appropriate.

The Department is open to exploring innovative options to ensure that sufficient resources are available to meet the needs of the long-term care population. In looking at these options the Department must consider the views of a number of stakeholders. I appreciate knowing the views

of you and your colleagues and look forward to working with you in the future to ensure that long-term care reform is successful. Thank you again.

Sincerely,

Karen E. Timberlake
Secretary

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Significant Concerns Facing the Future of Long Term Care
Lori Knapp Companies Perspective
Meeting with Kevin Hayden, October 2007

The two biggest issues facing Lori Knapp Companies are Workforce and Affordable Housing. In Managed Care Environment more people will be served in community settings. The simple solution to both problems would be unlimited resources to recruit employees and resources to subsidize affordable housing. Pragmatically that is not a reality; therefore some ideas regarding both issues are outlined below.

1. Workforce: Statistically, the health care workforce is shrinking and the population and anticipated population in the next several years is expanding unproprotionately. To meet the demands cooperation with all segments, public and private are a necessity.
   a. Recruitment of Foreign Workers. Many industries, both service and labor, rely on workers for filling those positions where there is an acute shortage or where our own workers are unwilling to fill the positions. Help with obtaining the 3-4 year visas for those that have an equivalent CNA training instead of mandating a nurse training. Shorter term visas can be obtained, but 9-10 months is not currently sufficient to train and provide quality.
   b. Reform training and testing requirements. Adopt as part of Administrative Rules Competency Based training and use as a Standard for Quality for Family Care. Make standards a cooperative industry driven and DHFS initiative.
   c. Assure Managed Care rates are sufficient to assure a decent wage for direct care staff. On the other side, require providers to adequately show that their increases include more in wages and benefits to go to direct care staff.
   d. Open more dialogue with DWD. DWD's premises are an unobtainable goal of approximately $13.50 per hour for that agency to implement programs to help with the workforce. Also one of the goals is career laddering. Establish a committee of representatives from provider groups, DHFS and DWD to find means and methods for DWD to implement innovative ideas for attracting and training a direct care workforce. Use career latticing rather than laddering for those wishing to remain as direct care workers without having the burden of working toward an unwanted higher degree of training such as a RN designation.
   e. Public Awareness campaign. Public appreciation and perception of direct care workers image needs to be implemented. Also, awareness with local workforce alliances and workforce development boards needs to be expanded and explained. Manufacturing and commerce is critical to the economy, but healthcare workers are also critical to the citizens of this state. Emphasis needs to be shifted or shared with this in mind.

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April 17, 2008

Secretary Roberta Gassman
Wisconsin Department of Workforce Development
201 East Washington Ave.
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Secretary Karen Timberlake
Wisconsin Department of Health and Family Services
1 West Wilson
Madison, WI 53707

Dear Secretaries Gassman and Timberlake:

Thank you for the participation of you Departments on March 25 and for your attention to the issues that we raised. While basic funding for home care, nursing home and assisted living care, and other community programs continues to be a concern of ours and this funding has a substantial impact on our ability to recruit and retain direct care staff, the main focus of our meeting was on the DHFS rules that relate to home care, costs for housing and residential and nursing home programs; and working with DWD and local workforce development boards on recruitment, retention, training, certification, and quality of our direct care staff. The following points summarize the key issues and are the items that we would like to have some follow-up discussions with your agencies:

1. HFS 105 and 107 have been in discussion for over 5 years. We are seeking a draft of the most recent versions that have been developed by DHFS. In the meantime, there are some items that DHFS has agreed to implement, but the method to accomplish these is on a case-by-case basis with each agency each time asking for a waiver to implement approaches DHFS and providers have agreed to. We would like to work with staff from DHFS on input into the current version of HFS 105 and 107 as well as come up with some systemic waivers that would allow all agencies to implement some of the approaches that we have all agreed are appropriate and without as much unnecessary administrative paperwork and bureaucracy. Part of this also involves approaches to training our workforce as described below.

2. With the implementation of Family Care throughout the state, many more people will be able to receive community long-term care. Some of these folks will need 24-hour community care. Especially for people with disabilities, the residential care is frequently provided in a 4 to 8-bed residential program. The cost of accessible housing that can provide 24-hour care is continuing to rise as is the cost of meeting all of the regulatory requirements. One way to make the cost of this type of program more accessible is to expand the less onerous Adult Family Home program to 6 or 8 beds. We realize these

definitions are based in statutes, but we would like to explore with you and your staff a modifications in these statutory definitions and their concomitant administrative rules.

3. As you are aware several agencies have been pilot testing a direct-care workforce training and competency tool that now needs to be expanded to more agencies, needs more funding to expand its implementation, needs to be included in regulatory requirements for home-care programs. In addition to this initiative, there are a number of other training, experience, and staffing requirements that exist in the existing home-care rules that are being waived on a case-by-case basis. It would appear more efficient to develop some mechanisms to implement some of these changes system-wide until the revised rules are promulgated. We would like to insure DHFS/HCF/DDES approval oversight of those organizations that will be responsible for the Direct Care Competency Training of Provider Organizations.

4. Funds for enhancing training for direct care workers is most critical. The care rates in nursing homes, waiver programs, Family Care, and other community programs are such that higher wages for direct-care staff are not possible. Yet these folks form the core of what we do. Having funding only to enhance career ladder opportunities for lower paid workers would actually create serious problems for care providers since we not only need the staff we have now, in the future we will need more direct-care staff. Enhancing the ability of agencies to recruit, train, retain, and assure quality is critical to our mutual success in providing care for people who depend on such care for their quality of life and at times for their very existence.

5. We appreciate the legislative attendance at the meeting. Our intent was to make key legislators aware of the enormity of serving many more people and the workforce issues involved in the Family Care expansion. We would hope to work with you on keeping our legislators informed of these issues, and would like to press for public hearings well in advance of the biennium budget process.

We would like the opportunity to have further dialogue with your staffs about these issues. We will contact you in the very near future to set-up such meetings. Thanks again for meeting with us and for your willingness to help us resolve these challenging issues.

Sincerely,

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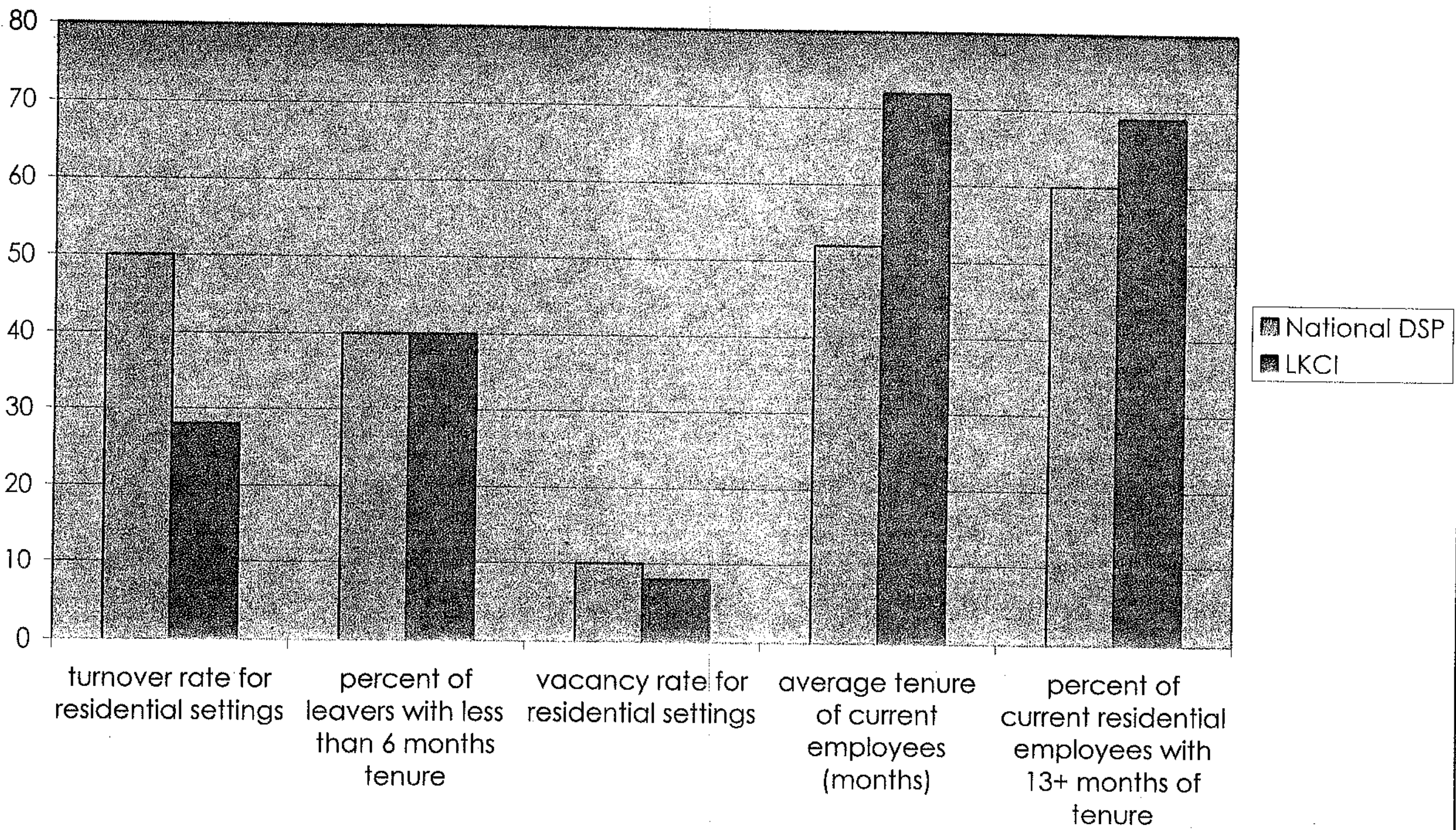
cc. Rea L. Holmes, DHFS Executive Assistant to the Secretary
Hector Colon, DWD Executive Assistant to the Secretary
Legislators
Meeting participants


Retention Trends
80
70
60
50
40
30
20
10
0
turnover rate for residential settings
percent of leavers with less than 6 months tenure
vacancy rate for residential settings
average tenure of current employees (months)
percent of current residential employees with 13+ months of tenure
National DSP
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Association of Academic Health Centers
Leading institutions that serve society

For Immediate Release
July 17, 2008

News Release

Contact: Elaine Rubin (202) 265-9600

New Report Warns Current Policies Will Not Avert Health Workforce Crisis

Coordinated national planning needed to adapt to changing workforce demands and threats

WASHINGTON, July 17 - Without immediate action to develop an integrated, comprehensive, national health workforce policy, the U.S. is at risk of losing its status as the global health care leader, states a new report released by the Association of Academic Health Centers (AAHC, www.aahcdc.org). The report was funded in part by the Josiah Macy, Jr. Foundation.

Out of Order, Out of Time: The State of the Nation's Health Workforce warns that the nation is running out of time to ensure an adequate health workforce to meet the needs of our aging population, such as the increased demand for health services and other critical socioeconomic challenges for health care.

"It is essential that the nation take a critical look at its policymaking framework that has created a system for the health workforce that may no longer be adaptable to changing national health needs," said AAHC President and CEO Dr. Steven A. Wartman. "We also need action because the workforce plays such a pivotal role in biomedical research and science as well as in the U.S. economy and jobs creation," he added.

Key recommendations in the report include:

- Making health workforce a priority domestic policy issue;
- Developing an integrated, comprehensive national health workforce policy that recognizes and compensates for the inherent weaknesses and vulnerabilities of current decentralized multi-stakeholder decision-making; and
- Establishing a national planning body to create a national workforce agenda and promote a national health workforce policy that ensures the nation's health and economic well-being. Diverse federal and state agencies, along with multiple public and private stakeholders, should participate.

If coordinated action at the national level is not taken, the workforce will "continue to be plagued by the problems that arise from fragmented and inconsistent policymaking," according to the report. Wartman said academic health center leaders have a unique vantage point on the workforce, given the leadership role their institutions play in education, research, and patient care. "Academic health center leaders recognize the urgent need for action and are committed to changing the nation's approach to the health workforce as laid out in this report," concluded Wartman.

To download an electronic copy of the report, visit www.aahcdc.org. The AAHC is a national non-profit association dedicated to advancing the nation's health and well-being through leadership in health professions education, patient care, and research.

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Strengthen. Advocate. Lead.

CHAPTER ONE

THE HISTORY OF WORKFORCE POLICY

Seeds of Disarray Sown Early On

KEY FINDINGS

1. A multitude of decision making entities control health workforce policy making.
2. An era of state and professional regulation of medical and other health professions schools has produced a decentralized and distributed approach to health workforce regulation and oversight.
3. Public workforce planning commissions have tended to have a limited focus, often concentrating on one profession or a limited series of issues, rather than a broad strategic vision.
4. Federal funding has tended to be driven by responses to crises rather than long-term commitment to investment in health workforce infrastructure.
5. Recent trends toward government retrenchment and reliance on the private sector have exposed additional vulnerabilities.
6. Reimbursement policy and health workforce policy are inextricably linked, but not harmonized.
7. Focusing on model educational programs and curricula may be unrealistically narrow given current socioeconomic realities.
8. Health workforce policy has not been a primary focus in the contemporary health reform debate.

Executive Summary

O*ut of Order, Out of Time: The State of the Nation's Health Workforce* is a report undertaken by the Association of Academic Health Centers (AAHC) to focus attention on the critical need for a new, collaborative, coordinated, national health workforce planning initiative. The report is based on the following premises:

- The dysfunction in public and private health workforce policy and infrastructure is an outgrowth of decentralized decision-making in health workforce education, planning, development and policy-making (*out of order*);
- The costs and consequences of our collective failure to act effectively are accelerating due to looming socioeconomic forces that leave no time for further delay (*out of time*);
- Cross-cutting challenges that transcend geographical and professional boundaries require an integrated and comprehensive national policy to implement effective solutions;
- The issues and problems outlined in the report have not been effectively addressed to date because of the inability of policymakers at all levels to break free from the historic incremental, piecemeal approaches; and
- Despite many challenges, the prospects for positive change are high.

The report presents findings, conclusions and recommendations. The detailed findings are discussed in seven chapters:

- Chapter One reviews the historic evolution of health workforce policy and considers how the decentralization of health workforce