HPN
HEALTH PROFESSIONS NETWORK

2022 Fall Conference Summary

November 9 – November 11, 2022

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Watershed Distillery

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Speakers' Biographies

Dr. Franklin Shaffer- EdD. RN, FAAN, FFNMRCSI

Dr. Franklin A. Shaffer is the President and Chief Executive Officer of [CGFNS International, Inc.](#), an internationally recognized authority on credentials evaluation and verification pertaining to the education, registration, and licensure of nurses and healthcare professionals worldwide. Dr. Shaffer earned his doctorate in nursing administration and education at Columbia University and has 50 years of progressive and varied nursing experience which includes administration, education, clinical practice, and research. He is a frequent speaker and consultant at meetings and conferences around the world and is an NGO representative at the United Nations (UN), World Health Organization (WHO), and International Council of Nurses (ICN).

Dr. Shaffer serves as the Secretariat of the [International Centre on Nurse Migration (ICNM)](#), a strategic partnership between ICN and CGFNS International. ICNM occupies a key role in establishing effective global and national migration policy and practice that facilitates safe, quality, and accessible patient care and positive practice environments for nurse migrants. He is the former Deputy Director of the National League for Nursing, the accreditation organization for nursing education. Dr. Shaffer made the business case for The Joint Commission (TJC) to develop a certification for the healthcare staffing industry, an initiative that has since grown to include over 400 healthcare staffing firms.

Ted Donnelly, BSN, MHA, CPHQ

Ted leads the NAHQ Navigator team in engagements with our client organizations in their efforts to transform their workforce into a Quality Force. Ted has worked in the healthcare industry for over 40 years starting as a nursing assistant, then completing his bachelor's degree in Nursing at Hahnemann University in Philadelphia; Ted worked as a staff RN in both the operating room and in cardiac care. After serving in leadership roles in both clinical settings, he has worked as a project manager and full-time instructor, while completing his master's degree in Healthcare Administration from Villanova University. Since then, Ted has worked in Clinical Value Analysis (CVA) and Lean project implementations with Johnson & Johnson Healthcare Systems and Premier Inc.

Prior to joining the NAHQ team, Ted was the corporate director of Quality and Patient Safety in the acute care division of Universal Health Services in King of Prussia PA integrating lean principles and the NAHQ Healthcare Competency Framework into the quality program across twenty-eight acute care facilities. In this role, Ted worked to incorporate activities of the NAHQ

Framework Healthcare Quality Competency Framework into quality initiatives to achieve improved outcomes in all facets of patient care.

Jamie Carmichael

Jamie Carmichael serves as the Chief Health Opportunity Advisor at the Ohio Department of Health. Jamie leads the new Office of Health Opportunity (OHO), which is focused on ensuring that all of Ohio's communities have a fair and just opportunity to thrive. OHO aims to eliminate population level health disparities through the aligning and focusing of strategic resources on communities with the highest levels of need. Since July of 2021, OHO has secured over $31M in federal funding to support health equity efforts across Ohio, developed hundreds of new community partnerships, and created several tools for operationalizing equity in state government.

Jamie serves on the Racism in Child Welfare report response workgroup, the Ohio Commission on Minority Health, and currently chairs the Governor's Task Force on Eliminating Racial Disparities in Infant Mortality. Jamie previously served as Deputy Director of Public Affairs for the Ohio Department of Mental Health and Addiction Services (OhioMHAS), leading the Offices of Communications, Legislative Affairs, and Behavioral Health Policy. Her experience also includes nearly a decade of service at the Ohio Department of Job and Family Services where she worked on poverty reduction and workforce development policy and programs, as well as on health equity initiatives. Jamie started her career working in the community as a case manager in county government and in non-profit community corrections. She holds a MA in Political Science and Public Administration from Ohio University, and BAs in Criminal Justice and Sociology from Kent State University.

Hope Arthur

Since 2016, Hope Arthur has been leading the Greater Cincinnati region's Healthcare Workforce Industry Sector Partnership. In this role, she convenes employer-led partnerships to increase the size, diversity, and preparedness of the region's healthcare talent pipeline. She creates and aligns training, education and apprenticeship programs with employer needs, develops robust and equitable health career pathways with multiple entry and exit points, and uses industry intelligence to build the region's talent supply. She works with partners to identify, address, and remove barriers limiting individuals' access, perseverance, and success in earning healthcare

credentials and degrees. Hope also assists the region's healthcare employers in identifying and implementing good job strategies.

Prior to this role, Hope was with Sinclair Community College in workforce development for almost ten years. There she also designed and implemented custom workforce solutions for key employers and served as the Employer Liaison for a Gates-funded Completion by Design initiative, aligning student education with employers' needs.

Hope is deeply committed to improving workforce development and has devoted countless hours volunteering with non-profit and professional organizations. She is one of five founding members of The Talent Collaborative of Greater Cincinnati, one of 34 National Fund for Workforce Solutions' sites in the US. She also serves on the Southwest Ohio Region Workforce Investment Board, Ohio Workforce Coalition's Leadership Committee, GROW Northern Kentucky's Employer Policies and Practices Committee, University of Cincinnati Colleges of Allied Health's DEI Committee, and several high school and career technical education business advisory committees.

Rachelle Martin

Rachelle possesses 40 years of public service experience in the healthcare field, including coordination of health care systems nationally and internationally. Currently she is the Executive Director of the National Alliance on Mental Illness of Franklin County. Rachelle was formally the Director of Training and Prevention Network Services Manager for the ADAMH Board of Franklin County and the co-founding partner of the Suicide Prevention Advisory Committee and the Suicide Prevention Foundation and where she chaired the Advisory Committee for over four years.

Rachelle has been Project Coordinator for the HIV Outreach Demonstration Support Project, sponsored by the Center for Substance Abuse Treatment (CSAT). She was the team leader for the Drug Abuse Prevention and Control Project, sponsored by the United States Agency for International Development (USAID).

Rachelle is a member of St. Dominic Catholic Church in Columbus and a Dominican Sister of Peace Associate. She was formally the Chair of the Martin de Porres Advisory Board and the former Executive Director of Black Catholic Ministries.

George Hicks III, OCPC, ICPS

George Hicks, is an Ohio certified prevention consultant with over 35 years of experience of working with "at promise youth" and communities. George is a high energy and seasoned professional with a tremendous breadth and depth in program development. He coordinates programs both in schools and communities settings. George works to identify the prevention needs of target populations and works with the community to address those needs. He also facilitates a variety of presentations and trainings in community settings. He is an Ohio Adult Ally for youth led programs and is currently partnered with the City of Columbus Recreation and Parks, Maryhaven Gambling Intervention Program, Columbus City Schools, NAMI Franklin County, Columbus Health Department, Asian American Community Services (AACS), Lead the Way Learning Academy, Capital University, CI Art Institute, and Be the Village OHIO.

Day 1- Sessions and Discussions

The Health Professions Network's 2022 Fall Meeting was organized around the theme ***Pushing Beyond Boundaries – Defining Creative Solutions within Limits***. Gathering in Columbus, Ohio, HPN meeting attendees discussed the various "boundaries" within which allied health professionals work and live.

Some of the boundaries discussed were more concrete concepts, like the physical boundaries of a municipality, or the state and federal legislation that directly impacts allied health professionals' ability to work. Other boundaries were a bit more abstract and malleable, like organizational cultures and hierarchies that provide structure while occasionally impeding flexible, agile decision-making. Or the *individual* boundaries of our internalized belief systems, biases, personal aspirations, past experiences, and competencies.

Our first speaker was Dr. Franklin Shaffer, who joined us virtually via Google Meet to discuss recent and ongoing changes to the global healthcare workforce. Throughout his presentation, Franklin emphasized that we are living in an "era of opportunity," but that most organizations lack the global perspective to truly take advantage of the many potential efficiencies that exist in the world of allied health. He noted that growing emphasis on the social determinants of health is forcing us to rethink the role(s) of allied health professionals, as we move from an episodic understanding of care, to a more comprehensive understanding of our complex and interconnected system.

Finally, Franklin concluded his presentation by highlighting the importance of embracing adaptability in today's allied health climate.

The following are free-form notes from the meeting and presentations, not a transcript.

Franklin Shaffer, EdD. RN, FAAN, FFNMRCSI
The Changing Global Healthcare Workforce: Perspectives and Possibilities

- Opportunities from workforce shortage
  - Migration has robustly increased since the turn of the millennium
    - 173m global migrants in 2000
    - 221m global migrants in 2010
    - 280m global migrants in 2021
  - Refugees and forcibly displaced persons- 2022 counts

- 100m forcibly displaced
- 30.4m refugees
  - Migration is expected to continue upwards post-covid despite slowing during onset
  - Countries like the Philippines and India train nurses and healthcare workers to be recruited internationally
- Supply and Demand
  - Cumulative impact of nurses leaving
  - 18 million healthcare workers are needed by 2030
  - Currently 1 in every 8 nurses worldwide are migrants
  - Increased demand is driving international recruitment from candidate pools of migrant workers
    - This quick fix brings up questions of other issues-are these recruits staying in the country? Is the recruiting country welcoming to migrants?
    - Foreign-educated healthcare workers are pivotal to worldwide workforces and are a major source of remittance for their home countries
- Ongoing dilemmas with Health Worker Migration
  - Countries will build a reliance on workers educated in other countries to fill shortages
  - Tension between individuals' rights to migrate vs. protecting countries from rapid Brain Drain
  - Ensuring ethical international Recruitment Practice
  - Ensuring a competent workforce when education is coming from different places with different standards
    - Re-credentialing raises a huge barrier to migration
    - The Great Attrition…Boomerang, Magnets of Recruitment
    - Employees are coming back, and bringing lessons
      - Use exit interview with new entrance interview
      - The reasons why people come back will be the future sustenance for the workforce
      - It's not always about money- people want meaningful work, but also fair pay and respect
- Graduates need to be prepared to join the global workforce
- Initiatives working together to promote ethical recruitment of healthcare workers
  - Passport to Liberty
    - 2022 Launch from CCGFNS
    - Expanded credentialing restoration for nurses impacted by war

- o [Passport to the Future]
    - Education and Training
    - Skill-Building- what is needed→ To what degree → when does it need to be replaced
    - Education should bring equality in access and technology
- o [UN Sustainable Development Goals]
    - SDG4: "Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all"
    - Education is essential to reach all UN 2030 Sustainable Development Goals
- o National Curriculum
    - Common program of study designed to ensure nationwide uniformity of content and standards of education
- o Quality Framework
    - Classification of individuals based on their credentials, degree, and experience
    - Categorization easily recognized beyond world borders
    - 50 countries currently moving towards this
    - Mutual Recognition: Bilateral agreements
- o Changes in Global Education
    - Students are increasingly older
    - Non-traditional students with different needs and expectations
    - Change in operational approach
        - Individualized service for each student
    - Reliance on technology
    - Mindset towards mutual recognition in education, accreditation, regulation, and credentialing
- Current Barriers and Challenges
    - o Global faculty shortage and aging demographics
    - o Higher education is slow to respond to global forces
    - o Inadequate clinical facilities
    - o Innovation, Creativity, and Entrepreneurship are rarely recognized- much less supported and rewarded
    - o Insufficient collaboration between leaders in education and practice
    - o Infrequent assessment of accreditation standards
    - o Factors affecting mobility
        - Bureaucracy
            - Decentralized federal systems

- Future of Global Education
  - Universities and Institutions are not immune to globalization
  - Career Pathing
  - Technology, Artificial Intelligence, Virtual Reality, and Virtual Learning will shift global education beyond traditional brick and mortar
  - Students will no longer need to migrate for an international education
  - A happier and more involved workforce
- Credential evaluation for public protection
  - Science is leaning more towards competency-based learning outcome methodology
  - Focus is on evidence beyond a quantitative documentation of credit hours to a qualitative evaluation of what is *learned*
  - Rituals impede progress
    - Analytics provide fuel for change, and technology is the vehicle
- Prepare for the healthcare worker migration tsunami
  - Unprecedented opportunity for *collaboration*
    - Act and advocate together
    - Inform with data and evidence
    - Embrace change
    - Build resiliency
    - The future belongs to those that can change
- 'What's Knocking at Your Door?'
  - Right-touch regulation
  - Nurse migration
  - Trade Agreements
- ***Interdisciplinary Collaboration is Key***

Ted Donnelly, BSN, MHA, CPHQ
The Imperative for Workforce Development for Quality and Safety to Push Boundaries

Ted Donnelly joined HPN from the National Association for Healthcare Quality, an organization that offers a strong and defined framework for quality and safety in healthcare. In 2022, NAHQ published the Healthcare Quality and Safety Report, which analyzes the answer to the question *"Is today's healthcare workforce doing the work that will advance critical priorities of quality, safety, equity, value, and system sustainability?"*

The NAHQ Quality framework was developed in recognition of the fact that while healthcare professionals work every day to advance "quality, safety, equity, value, and system sustainability," there is still work to be done if we are going to bake these principles into the fabric of our healthcare system.

Ted addressed HPN attendees virtually, leaving time for a Q&A after his recorded presentation.

The following are free-form notes from the meeting and presentations, not a transcript.

- There is yet to be a framework established for Quality and Safety
- Frameworks require *teams* for development
- National Association for Healthcare Quality (NAHQ) Wheel of Healthcare Quality Competency Framework (interactive tool)
    - Professional Engagement
    - Quality Leadership and Integration
    - Performance and Process Improvement
    - Health Data and Analytics
    - Population Health and Care Transitions
    - Regulatory and Accreditation Definition
    - Patient Safety
    - Quality Review and Accountability
- Certified Professional in Quality Healthcare (CPQH) Accreditation
    - Bigger Impact in Community
    - Continuous Improvement as a Quality Professional
    - Acquire Specialized Knowledge and Skills
    - Advance Professionally
    - Demonstrate Competencies
    - Investment in Self
- Published Insights in the NAHQ Workforce Report

- ○ Background on insights that led to the development of NAHQ Competency Framework
- ○ Aiming to reduce variability in delivery by reducing variability in skills
- Quality functions should not be isolated
- Develop a proactive and clear staffing plan
- Create your workforce development program- and *fund it*

Jamie Carmichael
Pushing Boundaries- Ohio Office of Health Opportunity

A retired couple goes to the opera one night to celebrate their 50th anniversary. They sit through the first act, thrilled and enraptured, when the lights lift for intermission. As they both rise, they admit that they are heading to the bathroom and hoping to grab a quick drink from the concession station before the show resumes. They agree that the first one to exit the facilities will run to the stand for the both of them and then they can go say hello to friends until curtain call. The theater they are in is designed with equality in mind, so they walk an equal distance away and wait to use equally equipped restrooms. In spite of this, the husband found himself waiting for so long for his wife to return that he had to throw away her untouched drink, and lost the entire break waiting for her. They met each other at their seats, and thoroughly enjoyed the rest of the show, but found a tense air for their ride home. After some prodding, the husband finally exclaims "I don't understand why it took you so long to come back! Or why is there always such a long line for you ladies! We had to go to the same place! I mean how much do you need!" The wife giggles, and tells him the story of the exchanging of bobby pins and lipsticks and setting powders while the stalls hide meticulously checking that all hemlines are properly placed and all purses properly equipped. The two of them collapse into a collective giggle when the wife emphasizes the luck that an extra stall wasn't taken for a *child*, and an understanding was met. Equality does not recognize the variation in human needs. Equity requires information and understanding in order to be realized.

Jamie Carmichael is a storyteller. Her presentation began with a story like the one above, to demonstrate one of the simple ways we all encounter equity every time we go to a public place. Jamie has implemented multiple boundary-pushing equity initiatives for the [Ohio Office of Health Opportunity](). Jamie understands that equity is about so much more than a simple DEI Committee. She understands that health can refer to so much more than whether someone is running a temperature, and she understands that health affects so much more in life than whether someone has to call out of work.

The following are free-form notes from the meeting and presentations, not a transcript.

- The official definition of "Health" is the complete physical, mental, and social well being of a person- not merely the absence of disease or infirmity
  - Even the members of society with the most resources have trouble meeting this standard
- Equity in Example

- Bathroom wait times at sporting events
- Different needs from men's bathrooms vs. women's bathrooms, so an equal number with equal resources does not result in an equal outcome
- Both parties end up missing out when there is no equity- in this case men and women miss the event for waiting
- The initial resource disparity is felt throughout the connected network of people
- Equity isn't just about race and ethnicity
- Health Outcomes
  - Ohio outcome gaps- geography and life expectancy correlate
  - Health behaviors and social/economic factors have outsize impacts on health outcomes
  - Impact of emotions, circumstances, etc. on health decisions
    - Example from every day: How often do you grab fast food at the end of a busy day? Or get caught in back to back meetings and snack on a chocolate bar rather than grabbing the packed lunch?
  - Drivers for tooth decay in third graders
    - Poor access to dental care
    - Low access fluoride water supply
    - Poor oral hygiene
    - Bacteria and plaque
    - High sugar and starch diets
  - But what is driving the drivers?
    - Unemployment
    - Stigma around mental health
    - Mass Incarceration
    - Bullying
    - Predatory Marketing
    - And on and on….
- Neighborhood Characteristic Comparison
  - Non-Health Outcome Gaps were identified in neighborhoods based off of a variety of metrics
    - Demographics
    - Poverty Rate
    - Inverted Job Growth Rates
- Improving Clinical Experiences for the Most Vulnerable Populations
    - Infant Mortality Focus Groups for black residents in Ohio
    - Of 200 men and 200 women, every conversation shared the common thread of rude treatment

- ○ Community Engagement
  - ■ Achieve change through engagement, share power with the groups you want to see change with
- ○ Collaboration
  - ■ State, local, public, and private systems communication and collaboration to improve social and community conditions for health
  - ■ Develop your champions for health and equity across systems
- How to use data
  - ○ Identify differences in outcomes
  - ○ Prioritize the highest-need communities
- Ohio Health Improvement Zones
  - ○ Ohio CDC uses vulnerability scores so that resources can be prioritized
    - ■ 16 elements develop the score
  - ○ Grant money distribution depends upon how resources are going to be distributed
  - ○ Public health is paternalistic, and paternalism is ineffective
  - ○ How do you effectively get into communities to hear what their biggest barriers are
  - ○ Mobile Health Units → Partnered with outside services and CDC to provide mobile health screenings
  - ○ Priority School Districts- defined by 40% or more students receiving free or reduced lunch
  - ○ Dashboard shows social determinants of health
    - ■ Data in five (5) domains
  - ○ Improving representation in public health surveys
    - ■ Oversampling rural and minority communities
    - ■ Incentives for high priority contributors
    - ■ Adding a racial *experiences* module
- Expand medicaid network participation
- Develop capacity for interprofessional health education, screening, referrals, and co-location of services
- Challenges
  - ○ Attitudes and beliefs about healthcare
  - ○ Fatalism
  - ○ Cultural views of health and healthcare
  - ○ Reliance on Self care
- ADDRESSING THOSE
  - ○ National Standards for Culturally and Linguistically Appropriate Services

- ○ Identify work areas → Governance/Resource Distribution; communication and language access; engagement; continuous improvement, accountability, and relationships.

Day Two – Presentations and Discussion

The closing day of the fall meeting was a day filled with open and collaborative discussion. Rather than spending the day in didactic presentations, the second day of the meeting was more focused on defining what HPN can do to shape the allied health professional landscape of the years to come. Attendees sat in a roundtable format for most of the educational sessions engaged in conversation about the "threads of work" that are woven across allied health.

What does it mean to promote an <u>*equitable*</u> *workforce pipeline?*
How can we best balance the urgency of meeting the workforce shortage in allied health, with our obligation to produce professionals who are highly competent in their roles?
Is there a future in allied health that moves away from licensure as an expectation of work?
These questions and more were discussed over the course of several collegial, comfortable conversations.

The first presentation of the day was by Hope Arthur. Hope was slated for a traditional lecture presentation, but she presented with an interesting and collaborative approach, taking a seat at the table with meeting attendees and using her presentation as a guide to a free-form discussion.

The following are free-form notes summarizing the conversations and presentations from 11/11, not an official transcript.

Hope Arthur
Practical Innovation to Expanding Healthcare Pathways

Hope Arthur addressed HPN attendees about the work currently being done by the Health Collaborative, an organization that seeks to connect students, educators, and employers to strengthen the healthcare workforce. One of the ways in which Hope and her team approach this work is by simplifying and aligning educational pathways, to reduce the time between education and employment.

Hope noted that turnover rates across the healthcare continuum are consistently high, representing a compounded problem with employee churn. By adopting a comprehensive perspective to the work of workforce development, the Health Collaborative challenges the prerequisites, accreditation requirements, motives, and beliefs of the current healthcare system. Hope illustrated this approach with three narratives of change focused on three professions respectively - respiratory therapy, medical assisting, and nursing.

Ultimately, by aligning mission and goals across the allied health space, Hope intends to facilitate more flexible and agile collaboration between the many entities that develop and interact with the allied health talent pipeline.

The following are free-form notes from the meeting and presentations, not a transcript.

- The mission of workforce innovation
  - To increase the size, diversity, and wellness of the region's healthcare pipeline
- Strategic Priorities
  - Living in the space where employers are failing to…
    - Increase available career exploration and work-based learning opportunities
    - Aligning and simplifying education pathways, including early college
    - Building connections to employment
    - Collecting and analyzing regional data
- Regional Workforce Education Platform in the works
- How can we center the importance of soft skills more in education programs
- No is easier, make a commitment to find a way to yes
- Turnover rates were higher in 2021 than at any time previous going back to 2007
- There is a *huge* number of vacancies across the healthcare industry
- Collecting data on turnover and vacancy rates is a critical first step to developing initiatives that meet the greatest, most immediate needs

- CASE STUDY: Respiratory Therapy
  - How to increase access to this profession?
    - Question prerequisites in an attempt to tie prerequisites to specific competencies
    - Dig into accreditation requirements to (again) ensure that the requirements have a bearing on the quality of care delivered by trained professionals
    - Look for opportunities to simplify the approach to incumbent workforce training
- CASE STUDY: Medical Assistant
  - What does collaborative pipeline development look like?
    - Partnering to create the apprenticeship
    - Working within the constraints of Registered Apprenticeship
    - Braided funding
    - Upskilling incumbent workforce
    - Hiring individuals who would have previously been denied
- CASE STUDY: Nursing
  - Convening career and technical college educators from across the state to identify and change barriers in the STNA & LPN program rules
  - Creating an accessible space to share best practices, ask questions, identify additional barriers that may impede pipeline development

Rachelle Martin and George Hicks
National Alliance on Mental Illness (NAMI)

Rachelle Martin and George Hicks' combined work lends itself automatically to pushing boundaries. Rachelle comes from the National Alliance on Mental Illness Franklin County, an organization that provides both afflicted peoples and their loved ones with education and support as they navigate their lives with mental illness. George comes from Arkbuilders, another local organization dedicated to ensuring healthy communities for the public good. These two came to speak to HPN together because they have worked closely together to push the boundaries of how people view and approach diversity, community improvement, and mental health.

The following are free-form notes from the meeting and presentations, not a transcript.

- Mission of NAMI Franklin
  - Improving the lives of people living with mental illness and their families
    - Advocacy
    - Support
    - Referral
    - Education
    - Outreach
- Family to Family Program
  - Support network
  - Lessons/education on types of mental illnesses, common drugs associated with illnesses, and how to communicate with affected loved ones
  - Education on fetal alcohol syndrome
- Crisis Intervention Team Training Program
  - Trains Franklin County PD on how to respond to mental health
- NAMI does not exist in a Silo
  - Collaborates with ArkBuilders to place sources of strength directly in the community
- ArkBuilders
  - Pilot Grant
    - BIPOC Alliance to address community mental health needs
    - Incubators for Success
      - Youth Led empowerment with 3 elements
        - Caring adults
        - High expectations (Not at-risk, at-promise instead)

- ○ Opportunity to develop skills
  - Youth identify an issue, and then they receive help to organize, and they are empowered to follow through and develop their voices
- Empowerment directly affects social determinants of health
- Steps to engage diverse communities
  - ○ Cultural humility
  - ○ License to operate
  - ○ Tribal trust
  - ○ Relationships, *Relationships,* **Relationships**
  - ○ Servant leadership
  - ○ NAMWM- Not about me without me
  - ○ What's in it for the community
- Barriers to cross cultural work
  - ○ Lack of humility
  - ○ Working *for* instead of *with* a community
  - ○ Becoming a life-long learner
  - ○ Honesty

Lynn Brooks
"Happily Ever After! And Other Fairy Tales from Healthcare"

The final presentation of the Fall Meeting was delivered by immediate past president of HPN, Lynn Brooks. Lynn offered a phenomenal "30,000 foot view" of the current situation in allied health, outlining the many obstacles, opportunities, and questions that characterize the current environment.

On top of the many *internal* questions impacting allied health, there are also concerns surrounding the new and growing pool of patients who have diverse needs, perspectives, and desires when it comes to the delivery of healthcare.

The following are free-form notes from the meeting and presentations, <u>not</u> a transcript.

- New realities
    - Money spent (salaries, reimbursements, etc) going up
    - No one controls healthcare, but we each have a place
    - Standardized practice is always hard to come by in an environment characterized by rapid change
- Covid has been the biggest healthcare disrupter in history
    - Compare to 1917 flu epidemic → lacking the political, global overtones
    - Unprecedented flexibility and cooperation is required
    - Hospitals and health systems are having to innovate as never before
    - 3-5 years of impact on payment models (Lynn's projection)
    - Hospitals and health systems must innovate to keep pace with newly forming organizations and partnerships, leadership becoming more strategic
- Covid will impact payment/reimbursement models for at least a few years, complicating healthcare spending that is already very high
- Changes initially made out of necessity will become routine in healthcare organizations (patient safety, virtual service delivery, etc.)
- Technology changing the training/education burden in a meaningful way…
- Training in a search and find sort of way (google it), is leading to more frequent burnout once folks get into professional settings
    - How could more traditional training be used, not only as a burnout reducer, but also as a way to integrate soft skill development which is prioritized by employers
- The "[Home Hospital](#)" model will make its way into more health systems

- [Non-traditional partnerships](#) will be seriously explored by healthcare systems that need to develop new, agile approaches to care
- With technology spurring on newer-yet technology in addition to the attendant protocols and regulations, critical thinking skills and bedside "soft" skills are taking a back seat to tech-competencies
- A driving question is **How many people can be served each day by a single team or professional leveraging technology to its full extent?**
- There are data questions around the use of EHRs, and the projected (eventual) ownership of the FDA

EXCURSIONS & Site Visits

While in Columbus, HPN's meeting attendees had the pleasure of visiting a number of the locations that make Columbus so special.

A **_HUGE_** thank you to everyone from Experience Columbus who helped make HPN meeting attendees feel welcome, and who took the time to share their phenomenal city with us.

Thank you also to the hotel partners who participated in HPN's annual meeting – the Hilton Columbus Downtown, The Sonesta Columbus Downtown, and the Hyatt Regency Downtown. All of the accommodations, meals, and staff we met and interacted with from November 9-11 were fantastic, and we can't wait to return with our organizations!

All educational sessions and meeting programming took place in the Greater Columbus Convention Center, a massive and extremely well-equipped building with multiple full ballroom and breakout spaces for groups of all sizes.

On our first night in Columbus, HPN attendees visited The Kitchen, a unique venue that specializes in participatory dining experiences, giving guests the chance to engage in meal creation from start to finish at their own comfort level with the support of staff. HPN attendees broke off into teams for a pizza making competition, wherein each team was given a set amount of money to purchase ingredients from the pantry. HPN Board member Connie Corrigan and her team won the competition despite being the second to last team allowed to visit th pantry for ingredients. Notably, theirs was also the only pizza that used _two_ different cheeses…

The first full meeting day concluded with a couple tours of The Ohio State University's Ohio Stadium and Wexner Medical Center, both of which were beautiful locations. From the helipad at Wexner the view of Columbus is unparalleled, and it was incredibly exciting to see the hospital functioning at full capacity (we had to hurry off the helipad so that a helicopter could bring patients into the hospital!).

The final tour (besides the many outstanding restaurants we visited while in Columbus) was at Watershed Distillery, a local distillery founded in 2010 on the strength of their flagship vodka.

Since 2010, the distillery has grown considerably, and HPN was thrilled to be able to experience some of that growth in liquid fashion before heading home.

Healthcare Workforce: Perspectives and Possibilities
The Entreprenurial Era

The Health Professions Network (HPN) 2022 Fall Conference

Franklin Shaffer, EdD, RN, FAAN, FFNMRCSI

President and Chief Executive Officer

45 Years of Service

- **<u>1977</u>:** Commission on Graduates of Foreign Nursing Schools (CGFNS) created between sponsorship of ANA and NLN

- Globally recognized, authority on nursing education, regulation, standards, and credentials evaluation

- U.S. Visa Screen authorization under section 343 of 1996 Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA)

- Immigration-neutral (does not recruit, sponsor, or hire FENs)

- Served over **4 million nurses** from over **200 countries and territories;** mission to protect the public

Global Network

CGFNS International has developed unique partnerships with a diverse group of national and global accreditation, educational, regulatory, and professional institutions.

CGFNS is at the nexus of the migration, workforce, and ethical recruitment through our programs, and partnerships

- **International Centre on Nurse Migration (ICNM)**:
  - partnership organization with the International Council of Nurses (ICN)
  - Center for research on global nurse migration
- **CGFNS Alliance for Ethical International Recruitment Practices**:
  - ensures that all foreign-educated health professionals are recruited in a fair, ethical, and transparent manner for employment in the U.S.

Migration

"Migration is one of the defining issues of the twenty-first century. It is now an essential, unstoppable, and potentially beneficial component of the economic and social life of every country and region."
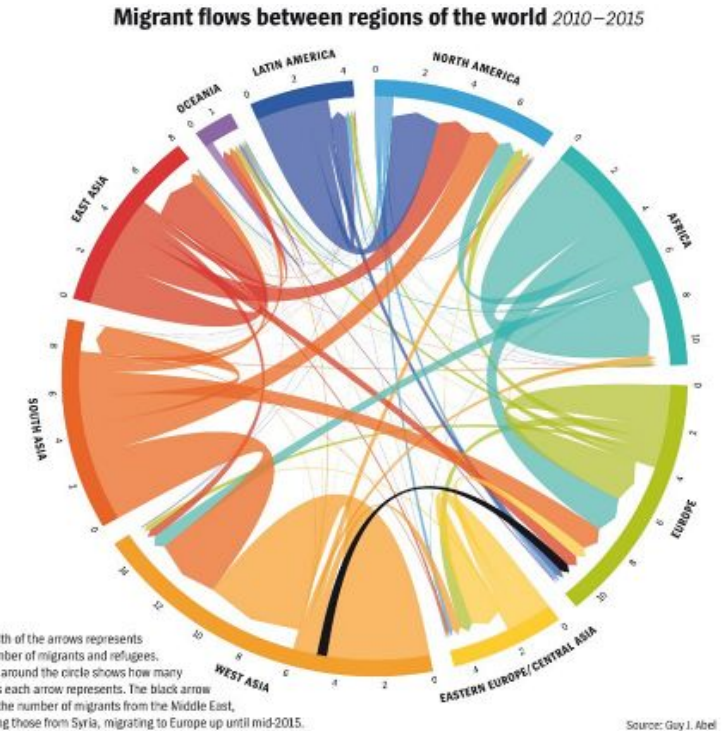
Brunson McKinley
Former Director General
International Organization for Migration

Global Migration has robustly increased since turn of millennium

- In 2021, more than **280 million migrants** worldwide
  - 221 million in 2010
  - 173 million in 2000

- In 2022, **100 Million** forcibly displaced persons
  - 30.4 million refugees

- While migration may have slowed due to pandemic, it is expected to continue upwards post-COVID

Migrant flows between regions of the world *2010–2015*

The width of the arrows represents the number of migrants and refugees. A scale around the circle shows how many millions each arrow represents. The black arrow shows the number of migrants from the Middle East, including those from Syria, migrating to Europe up until mid-2015.

Source: Guy J. Abel

Sources: (UN, 2021); (IOM 2021); (UNHCR, 2021).

45 CGFNS INTERNATIONAL. *years of service*

"I would like to work outside my home country in my career"

The Nurse Migration Tsunami Looms

- **18 million health workers** needed by 2030 (~9 million nurses)

- **1 in 8** nurses globally are migrants

- 70% of global nurse migrants are female

- In 2021, 550,000 foreign-educated nurses are working across 36 high-income OECD member countries (up from 460,000 in 2011)
  - 200,000 FENs in the United States
  - 100,000 FENs in the United Kingdom
  - 71,000 FENs in Germany
  - 53,000 FENS in Australia

Sources: (SOWN, 2020; Migration Data Portal, 2021)

Cumulative impact of nurses leaving the profession

Pre-pandemic nursing workforce: 27.9 million

Pre-existing nurse shortage: 5.9 million

For each 1% who leave the profession there is a loss of 280,000 nurses

4% would mean 1 million fewer nurses

Fig 1: Additional potential nurse leavers, millions, under different additional% leaving rates

Legend: ■ 2020 baseline ■ additional % of leavers
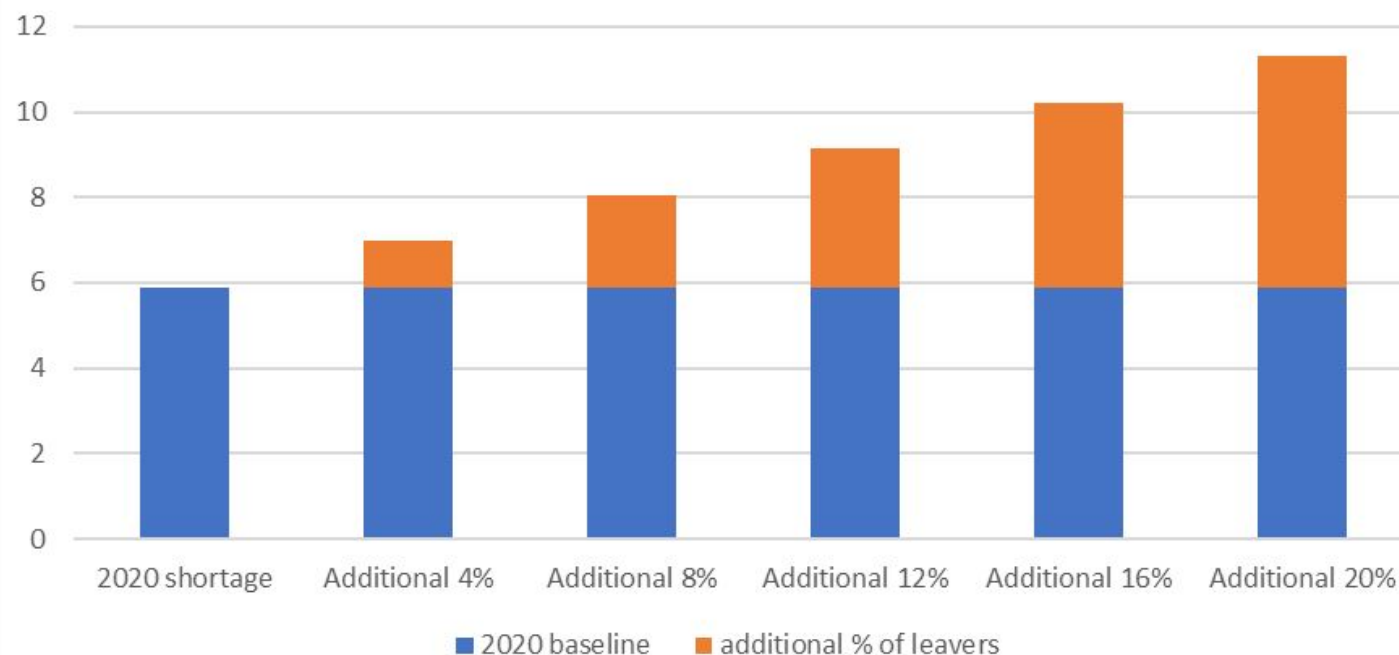
Pandemic and increased demand are driving international recruitment

- **England**: National Health Service had 39,813 vacancies in September 2021.
- **Germany**: In 2019 there were 27,400 vacancies. 150,000 new nurses will be needed by 2025.
- **Switzerland**: There will be a shortfall of 65,000 nurses by 2030.
- **United States**: 15% of nurses left their jobs in the first year of the pandemic. Nursing workforce expected to grow from 3 to 3.4 million by 2030. There will also be 194,000 nurse vacancies each year.

High income countries using the quick fix of international recruitment

- **United States** has 194,000 international nurses, the **UK** 100,000, **Germany** 71,000 , **Australia** 53,000.

- It is on the increase in **France**, **Switzerland** and **Canada**.

- Countries targeted for recruitment include **Nigeria**, **Lebanon**, **Brazil**, **Algeria**, **Libya**, **Mauritania**, **Morocco** and **Tunisia**.

High income countries using the quick fix of international recruitment (continued)

- **India** and the **Philippines** have schemes to train nurses specifically 'for export'.
- Outward migration of nurses from **Botswana**, **Eswatini**, **Kenya**, **Lesotho**, **Malawi**, **Mauritius**, **Mozambique** ,**Namibia**, **Rwanda**, **Seychelles**, **South Africa**, **South Sudan**, **Tanzania**, **Uganda**, **Zambia**, and **Zimbabwe** is reducing the supply of nurses in these countries.

Foreign-educated healthcare workers are pivotal to workforces worldwide and a major source of remittances for sending countries

Percentage of Foreign-Trained Nurses in National Workforce (2021)

Remittances Received in 2021 (USD)
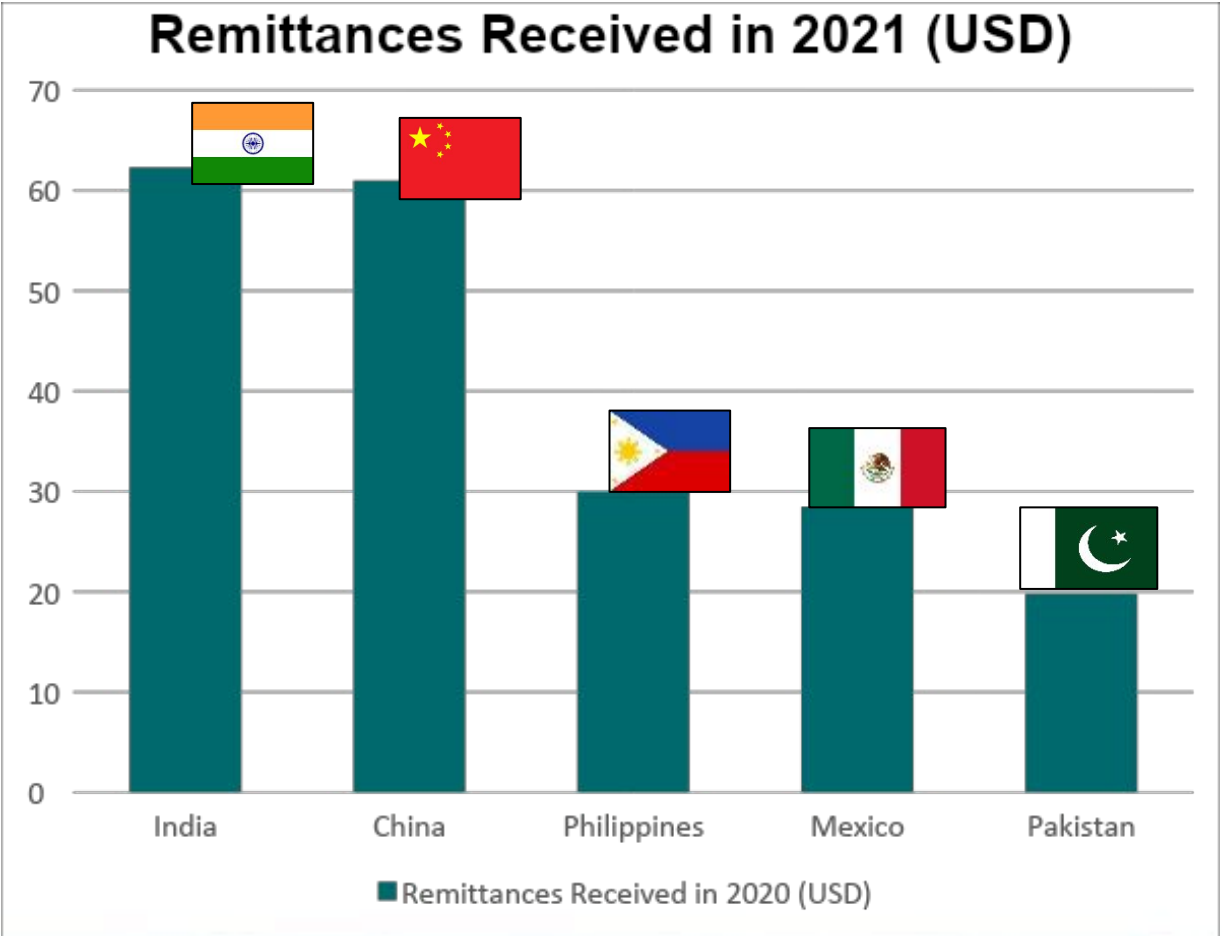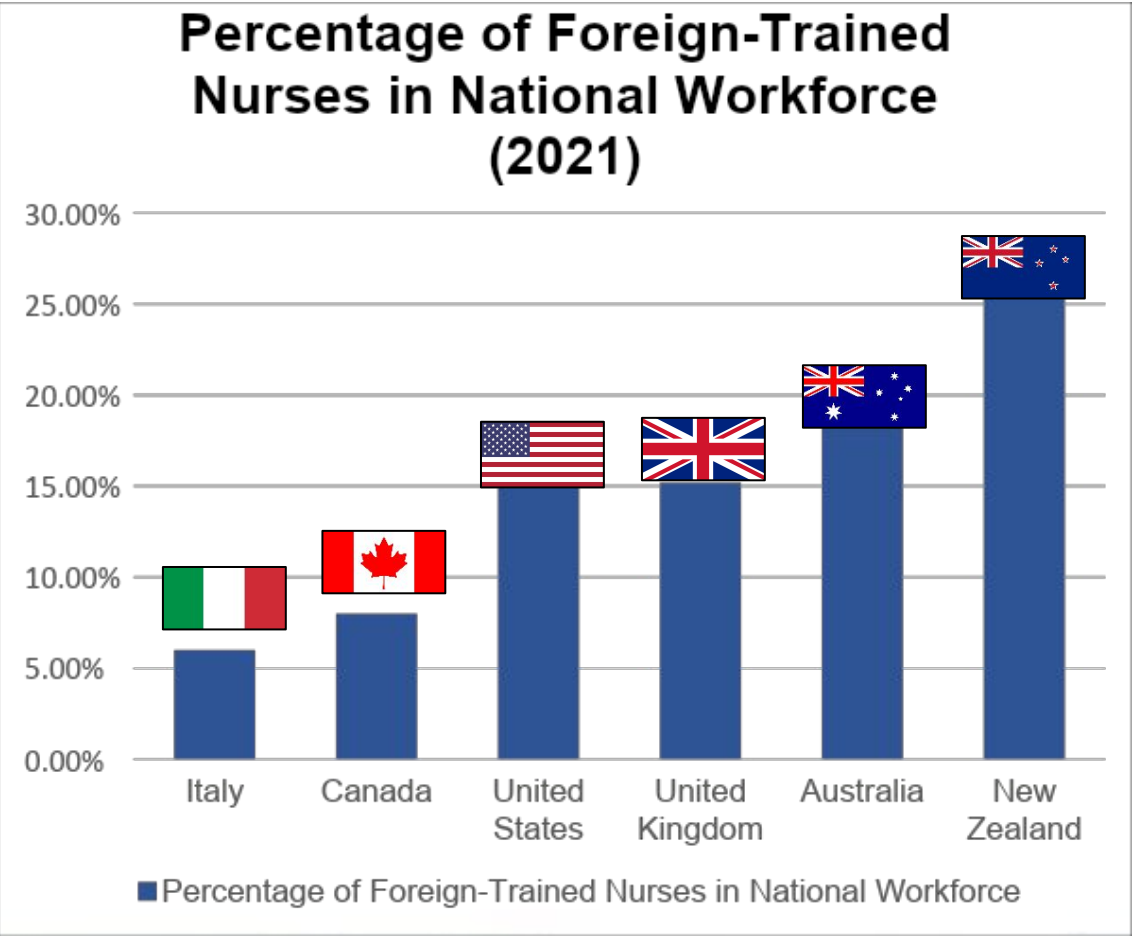
16 U.S. states with critical staffing shortages in *at least* 25% of their hospitals

Percentage of Hospitals experiencing critical staffing shortages
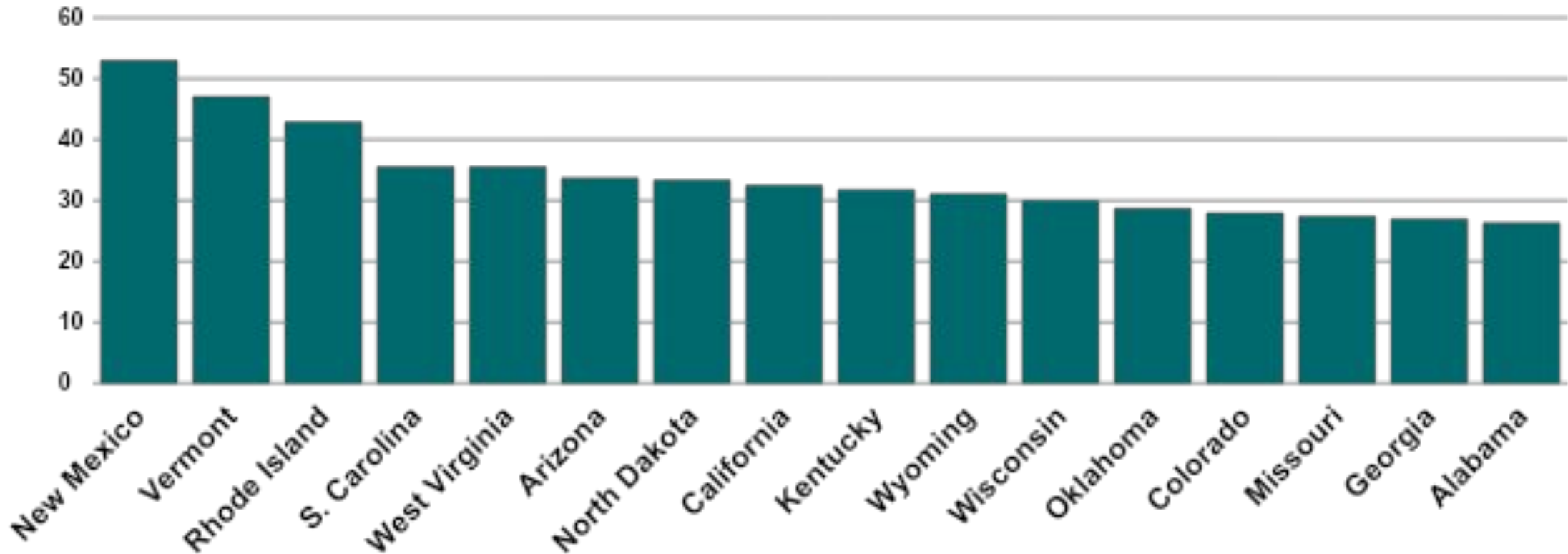
CGFNS launches 'Passport to Liberty'

- CGFNS is expanding its credentials restoration services for Ukrainian nurses impacted by the war

- More than 5 million Ukrainian refugees crossed international borders; UNHCR predicts more than 6.5 million may be internally-displaced

  - Out of the 100,000 Ukrainians authorized to enter the United States, ~1,000 are likely to be nurses

- Email passport2liberty@cgfns.org to learn more about and support these efforts

Ongoing Dilemmas with Health Worker Migration

- Today, more than ever, countries are going to rely on internationally-educated health workers to fill their shortages

- The individual right to migrate versus protecting the health systems of typical "sending" countries (brain drain vs. brain gain)

- Ensuring ethical international recruitment practices

- Ensuring a competence workforce: competency-based credentials evaluation for patient safety (care beyond borders)

- Great Attrition …Boomerang ….Magnets of Recruitment

Allied Health Migration:
Global Challenges, Local Implications

- Human Resources for Health (HRH)
  - Planning for sustainability and sufficiency must factor in health workforce mobility
  - Health professionals will continue to seek opportunities to meet their career goals in a borderless world, regardless of localities and jurisdictional control
- CGFNS Alliance' Code for Ethical International Recruitment Practices – safeguards the interest of all stakeholders
- Educators must prepare graduates to join the global workforce within their teaching, coaching, and mentoring

Global and national initiatives work together to promote <u>ethical</u> health professional recruitment

- Provides overarching framework (for migration, recruitment fees, etc.)
- Principles support efforts of other multinational and local initiatives

- **"Top down"** code that provides guidance for **member states**
- Applies to member states around the world
- Used the Alliance Code as a model
- Voluntary, with reporting obligations for member states

- **"Bottom up"** code that provides guidance for active stakeholders including recruiters and employers
- Focused on recruitment to the U.S.
- Voluntary, with reporting obligations for certified ethical firms (CER)

Passport to the Future

Education and training (skill building) that can be *qualified* and *quantified* is the *currency* for mobility of healthcare professionals and the standards upon which healthcare institutions employ and sustain their workforce.

"Education today should combine knowledge, life skills and critical thinking. It should include information on sustainability and climate change. And it should advance gender equality, human rights and a culture of peace."

António Guterres
UN Secretary-General

UN Sustainable Development Goals (SDGs)

- UN SDG Goal 4: aims to **"ensure inclusive and equitable quality education and promote lifelong learning opportunities for all."**
- Education is essential to achieve all goals of the UN 2030 Agenda for Sustainable Development

Foreign-educated allied health professionals who entered the U.S. at age 21 or older

- 🟡 Physical Therapist
- 🔴 Lab Technicians
- 🔵 Pharmacists
- 🟠 Occupational Therapists
- 🟣 Speech Language Pathologists
- ⚫ Other
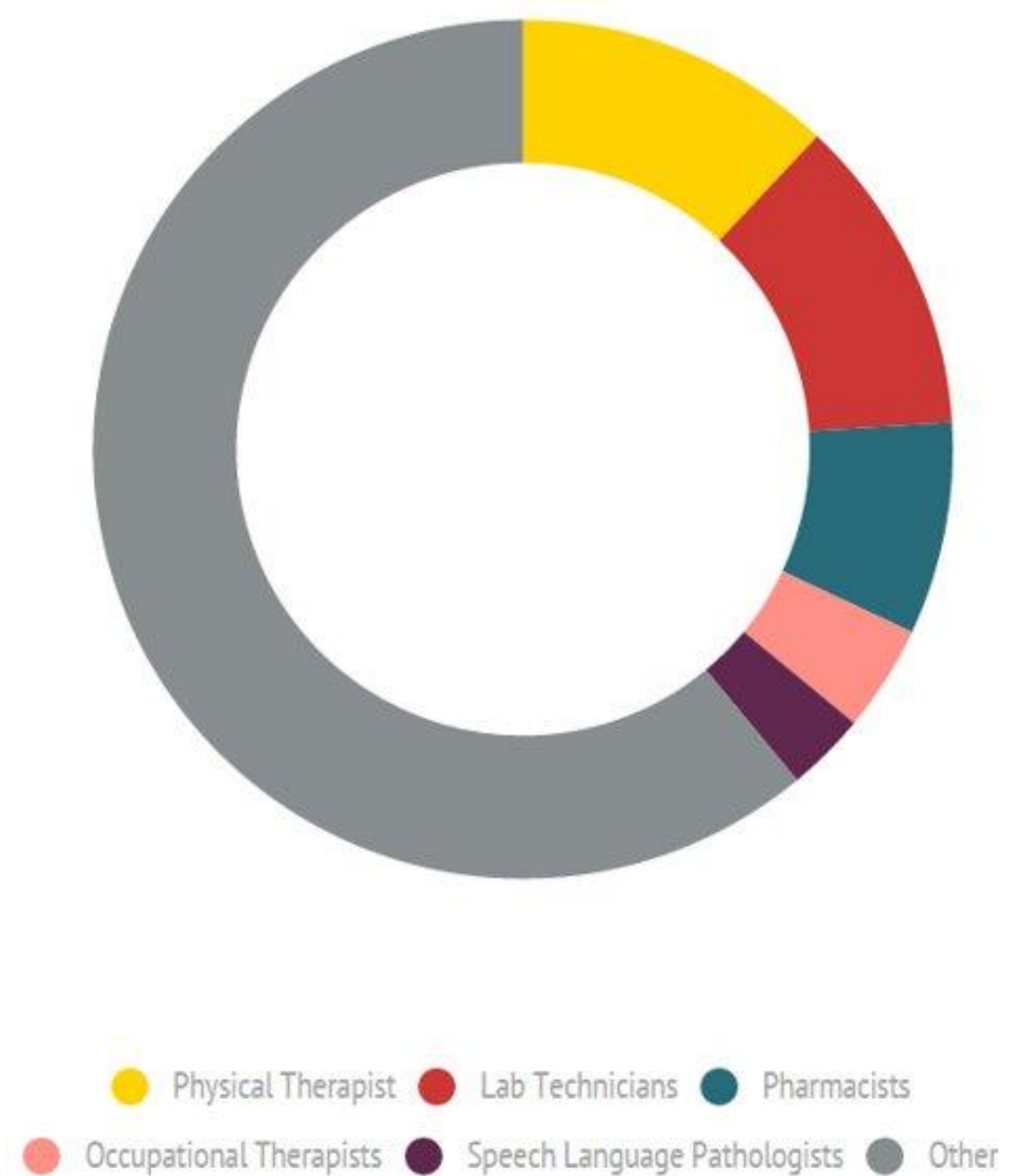
Changes in Global Education

- Change in student demographic (i.e., increasingly older)
- Emergence of non-traditional students with different needs, schedules, and expectations
  - Students desire education for employment, transferability, portability
- Change in operational approach
  - Educational institutions are providing individualized service to each student
- Reliance on educational technology
  - Includes online learning, artificial intelligence, virtual reality, simulation, etc.
- Education, Accreditation, Regulation and Credentialing: with a mindset towards mutual recognition

Current Barriers

- Higher education is often slow to respond to global forces

- Global faculty shortage, and the aging demographics across all types of programs

- Inadequate facilities that provide clinical experience

- Global citizenship certificates/degrees, while valuable, can be problematic

- Innovation and Creativity and Entrepreneurialism is not always recognized, supported or rewarded

- The insufficient collaboration between education and practice leadership

- Infrequent assessment of the accreditation standards to the changing society and education

Future of Global Education

- Universities are not immune to effects of globalization
- Technology, AI, VR, and virtual learning will shift global education beyond traditional brick and mortar
- International students no longer need to cross borders to gain a global education
- Faculty will shift to an agile mode of thinking, acting, and leading
- Adaptability and curiosity are key to seeking a world beyond what one knows today
- Strive for creativity and innovation –Talent Plus

National Curriculum & Quality Framework

- **National Curriculum:** common program of study in schools designed to ensure nationwide uniformity of content and standards in education

- **Quality Framework:** the classification of individuals based on their credentials, degree, experience into a categorization that is easily understood across borders
    - Currently, 50 countries moving towards this or a similar model
    - Bilateral agreements –mutual recognition. Ireland, Singapore, UK and NZ

Credentials Evaluation for Public Protection

- The science of credentials evaluation is evolving to a competency-based learning outcome methodology based on comparability science

- It focuses on evidence beyond a quantitative documentation of credit hours to qualitative evaluation of what is learned—a crucial first step to ensuring patient safety (comparability science)

- Technology is and will increase taking the place of a labor intensive process…Analytics provides the fuel for change …technology the vehicle …Research linked between the two ..rituals impede progress..

- Learn to let go and quickly…hanging on clutters practice

CGFNS: Setting the Standards

- Educational standards are typically based on program accreditation standards in the U.S:. And developed using CGFNS Education Comparability Tool (ECT)

- Focus on content comparability, not degree equivalency

- CGFNS Educational Database serves as a state-of-the-art resource

- Standards for English language proficiency are set by HRSA (US Health Resources and Services Administration), using standardized English language tests (e.g., TOEFL, OET)

Factors Affecting Mobility:
Health Professionals to the U.S.

- Complex, bureaucratic immigration system / policies (i.e., visa retrogression)
- Decentralized federal system; multiple structures governing professional regulatory requirements
- Long and costly evaluative processes to enter the health professions
- Difficult for FEHPs to demonstrate how their academic qualifications meet U.S. standards
- Work experience outside of the U.S. is less valued; health professionals often have to return to entry-to-practice status
- Regulatory practices that need to be fit for practice and right touch

Healthcare leaders need to be prepared for a health worker migration tsunami

- Leaders in health professions should increase workforce data on their domestic workforces (analytics)
- Ethical considerations and recruitment should be center stage during the impending migration tsunami
- Workforce (recruitment and retention) must become a more strategic imperative than it has in the past
- Migration is an economic imperative. The UN High-Level Commission on Health Employment and Economic Growth recognized nursing as an economic asset, not a cost. The health of a nation depends on the health of its workforce
- We must recognize the shifting trends in migratory patterns, implications for healthcare settings, health workforce, and the public

What's Knocking at Your Door?

1. Right touch regulation — meaning, implications

2. Nurse migration

3. Trade agreements

4. Transformational Imperative

5. Opportunities

Right-Touch: Well-Balanced Approach
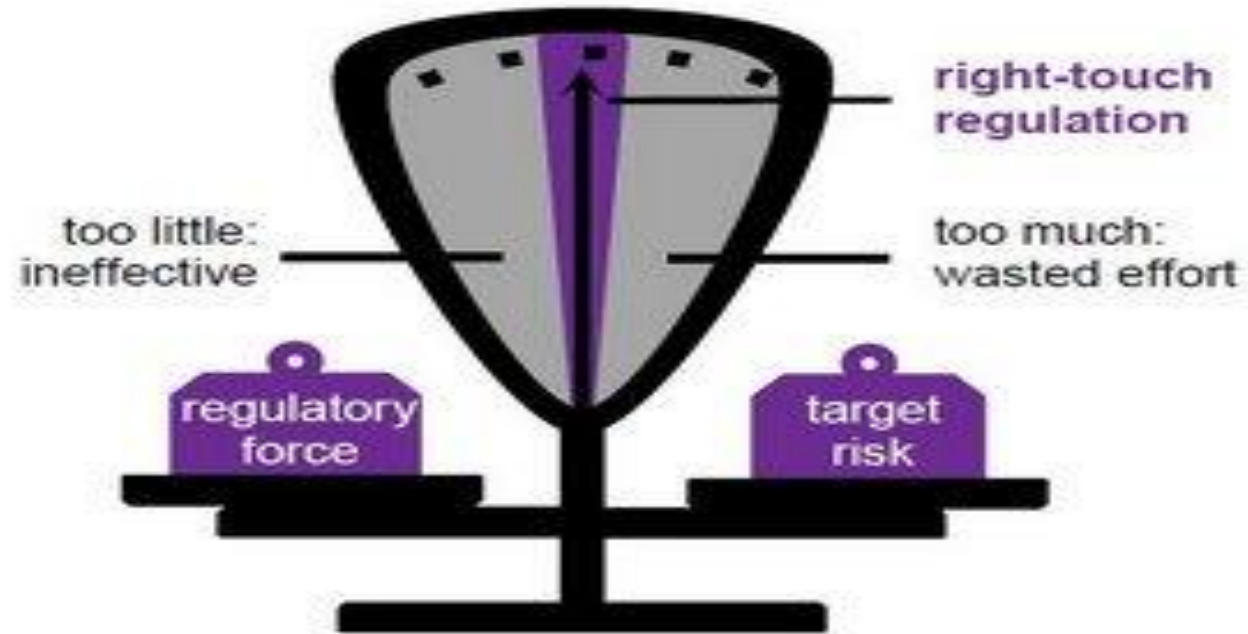
The Continuum of Regulatory Practice
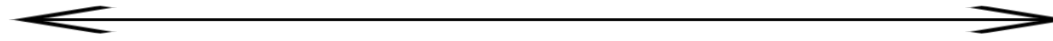
	Laissez-Faire	Right-Touch Regulation	Zero Tolerance
Dominant Thinking	"Buyer knows best" and "caveat emptor"	Quantify and qualify the risks Focus on the outcome	"Small benefits that are certain are better than large benefits that are uncertain or carry risks"
Attributes	Tolerance	Adaptability	Discipline/punitive action
Methods of Promoting	De-regulation		Rules and regulations
Needed to Work	Market-like structures	Regulation only when necessary	Extensive system of codified rules, monitoring and intervention
Engenders in Parties	Self-interest		Punishment and defensiveness

Right-Touch Usage for Regulators & Credentialing Organizations

RIGHT-TOUCH REGULATION	Regulators	Credentialing Organizations
Targeted	Regulation should be focused on the problem, and minimize side effects	Assist in identifying opportunity
Transparent	Regulations simple and user friendly	Offer insights from dealing with applicants, institutions and countries
Agility	Adapt to anticipate change	Offer feedback on impact of regulation
Accountable	Justify decisions, and be subject to public scrutiny	Ensure requirements set by regulators are met
Consistent	Rules and standards implemented fairly	Quality processes
Proportionate	Intervention adequate to the risk posed	Offer opinion and expertise during interventions

Transformational Imperative

- Technological revolution
- Consumer-centric shift
- Changing demographics
- Social Media influence

Opportunities

- Act and advocate together
- Inform with data and evidence
- Embrace change
- Build resiliency

Concluding thoughts

- The future belongs to those that can change. Innovation, flexibility, and creativity are the keys to our success

- Leaders in the new Entrepreneurial Era must shift mindsets to lead the workforce of tomorrow and beyond

- Healthcare is a team effort: not one profession can, nor should, solely provide one nation's health. Interdisciplinary collaboration is key

"It is not the strongest species that survives, nor the most intelligent, but the most responsive to change."

Charles Darwin
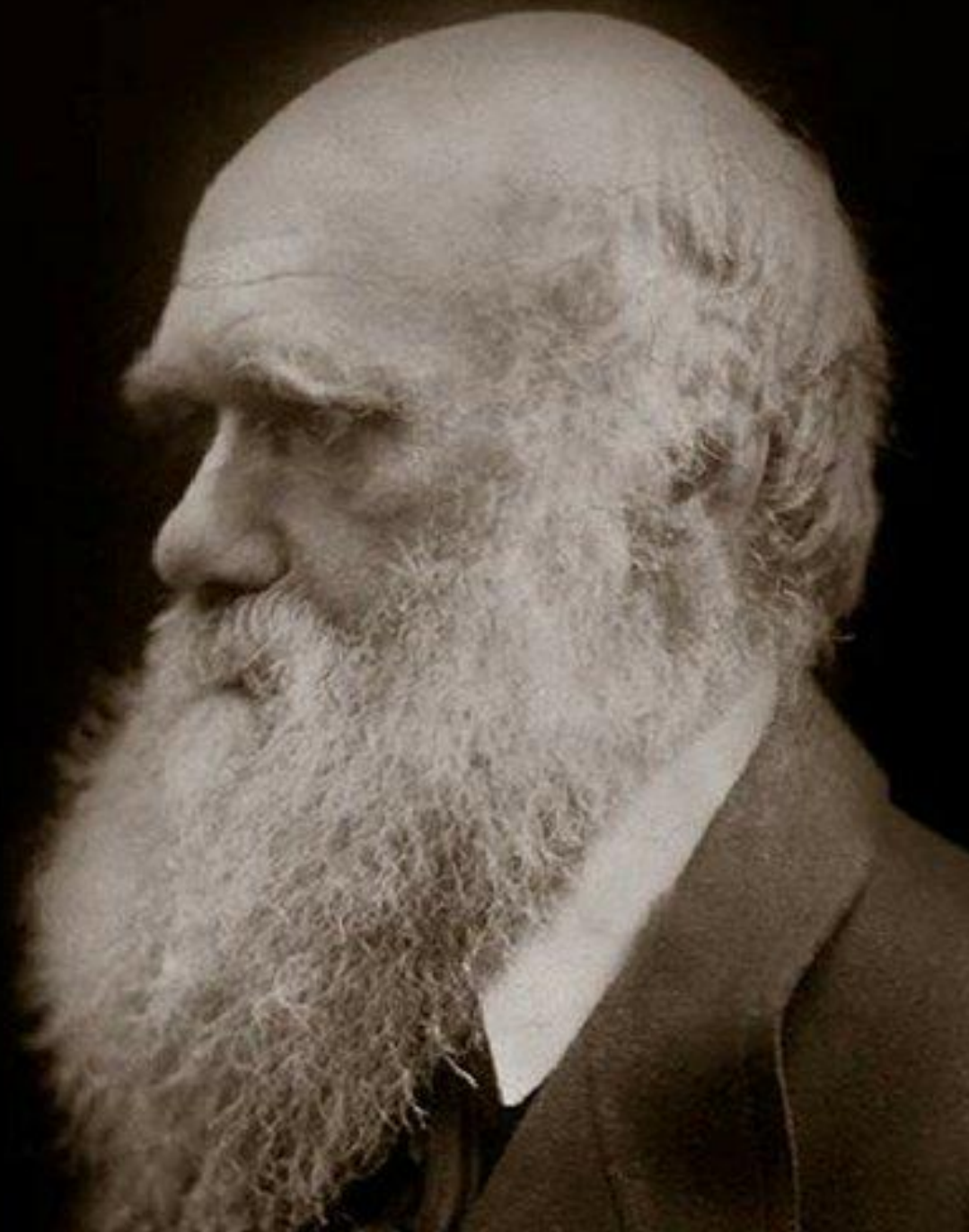
Thank you

Franklin A. Shaffer

EdD, RN, FAAN, FFNMRCSI

President and Chief Executive Officer

CGFNS International, Inc.

- How many of us our doing what we thought we would be doing when we were age 8?
- What about at age 12?

Office of Health Opportunity Mission

ENSURING ALL OHIO COMMUNITIES HAVE A FAIR AND JUST OPPORTUNITY TO THRIVE.

Ohio | Department of Health

Definition of Health

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. – *World Health Organization*
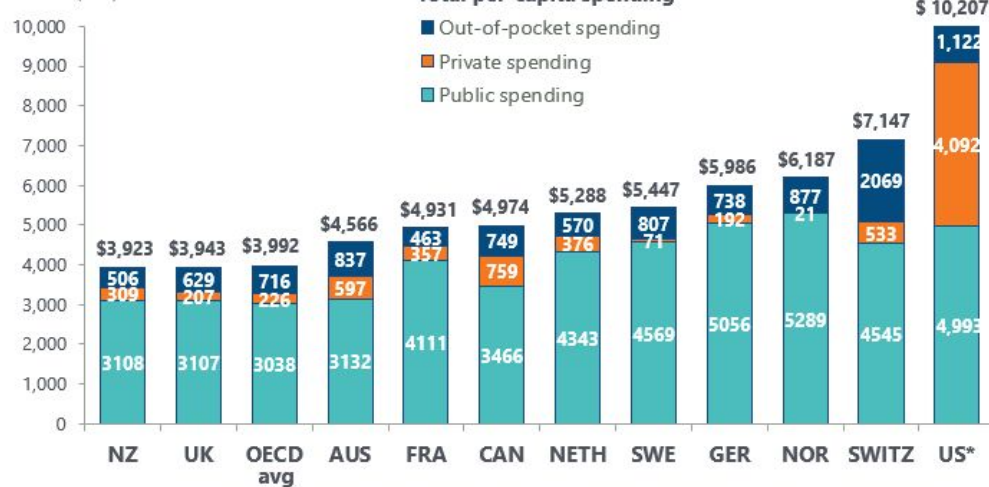
What is Equity?

Ohio | Department of Health

Healthcare Costs and Life Expectancy

SPENDING

Health Care Spending per Capita by Source of Funding, 2018

Adjusted for Differences in Cost of Living

Dollars ($US)

Total per-capita spending
- Out-of-pocket spending
- Private spending
- Public spending

$ 10,207

	NZ	UK	OECD avg	AUS	FRA	CAN	NETH	SWE	GER	NOR	SWITZ	US*
Total	$3,923	$3,943	$3,992	$4,566	$4,931	$4,974	$5,288	$5,447	$5,986	$6,187	$7,147	$10,207
Out-of-pocket	506	629	716	837	463	749	570	807	738	877	2069	1,122
Private	309	207	226	597	357	759	376	71	192	21	533	4,092
Public	3108	3107	3038	3132	4111	3466	4343	4569	5056	5289	4545	4,993

Data reflect current expenditures on health per capita, adjusted using US$ purchasing power parities (PPPs), for 2018 or the most recent year: 2017 for FRA, SWIZ, UK, US; 2016 for AUS. Data for 2018 reflect estimated/provisional values. Numbers may not sum to total due to excluding capital formation of health care providers, and some uncategorized health care spending. Public spending reflects government and compulsory spending (HF1); private reflects voluntary schemes (HF2); out-of-pocket (HF3).ª For the US, 'Compulsory private insurance schemes' (HF122) spending was reclassified into the 'Voluntary health insurance schemes' (HF21) category, given that the individual mandate to have health insurance ended in Jan 2019. OECD average reflects the average of 36 OECD member countries, including ones not shown here. Source: OECD Health Data 2019.
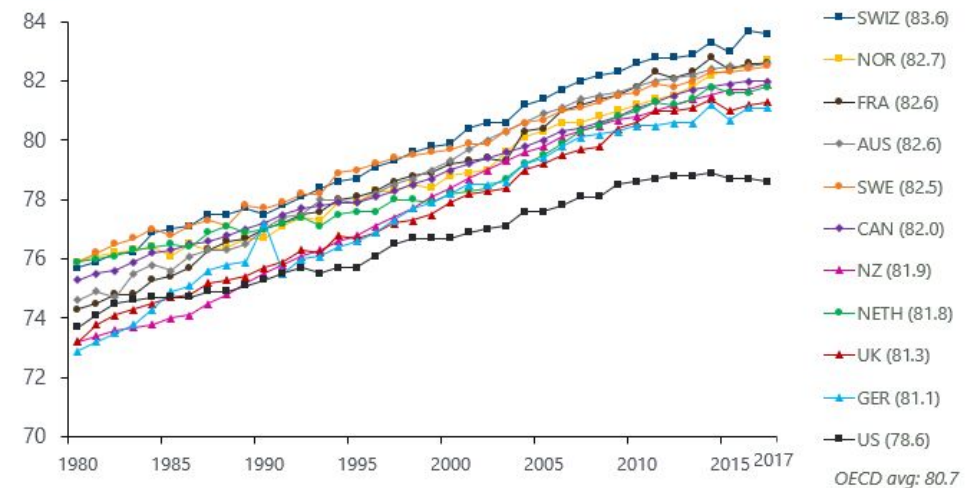
The Commonwealth Fund

3

HEALTH OUTCOMES

Life Expectancy at Birth, 1980-2017

Years

2017 data:
- SWIZ (83.6)
- NOR (82.7)
- FRA (82.6)
- AUS (82.6)
- SWE (82.5)
- CAN (82.0)
- NZ (81.9)
- NETH (81.8)
- UK (81.3)
- GER (81.1)
- US (78.6)

OECD avg: 80.7

OECD average reflects the average of 36 OECD member countries, including ones not shown here.
Source: OECD Health Data 2019.
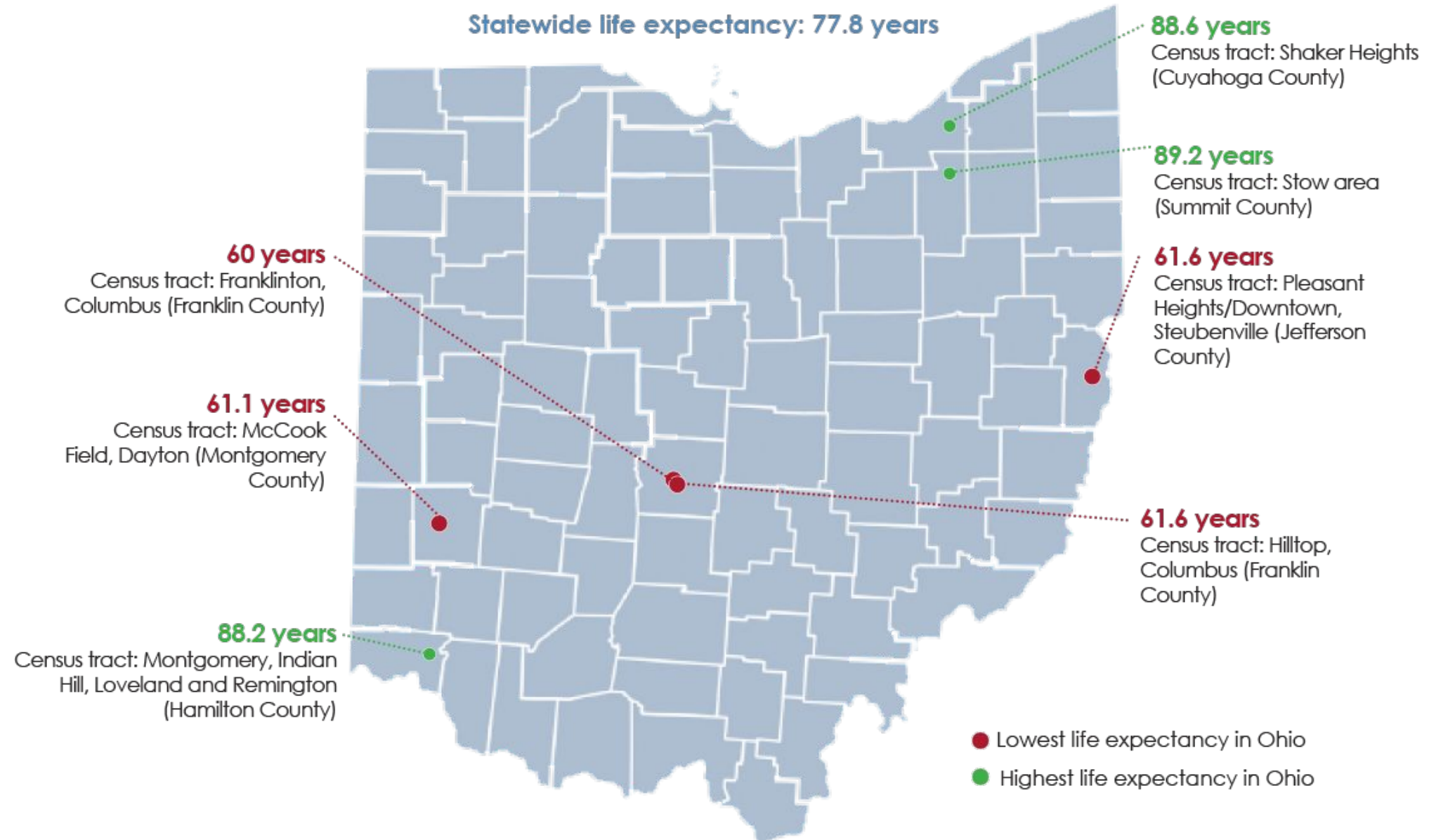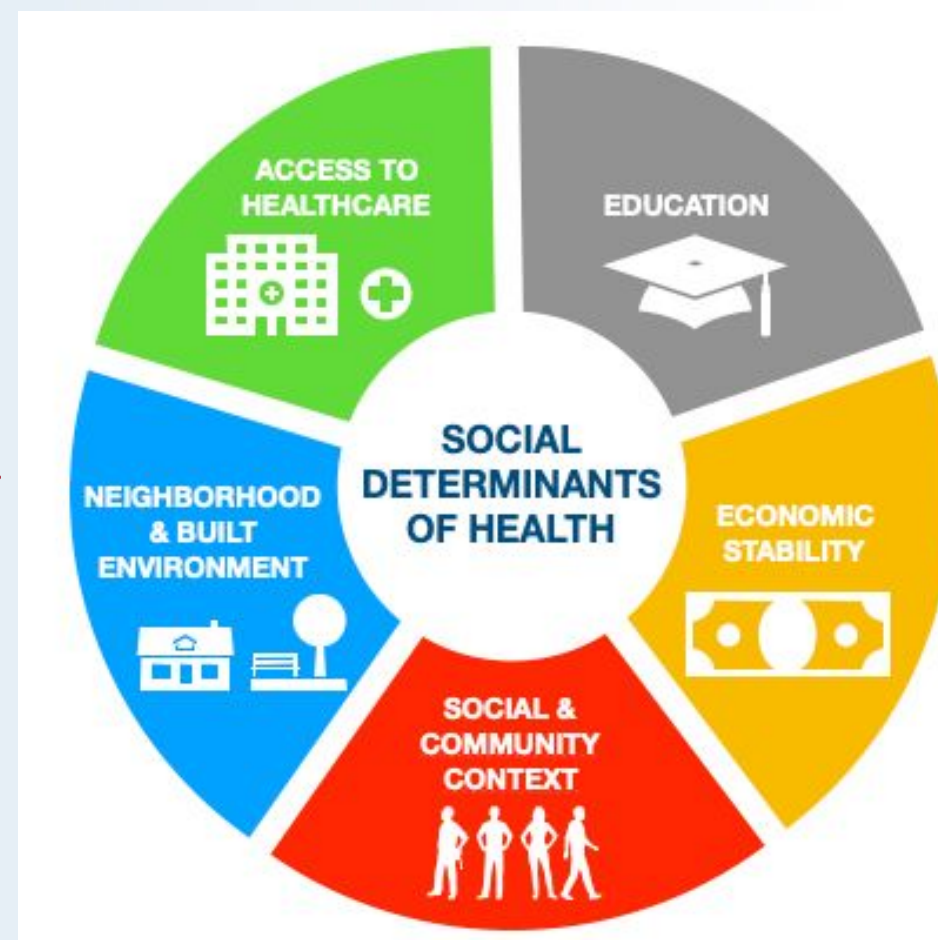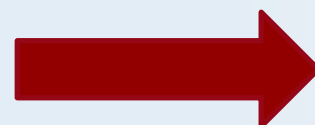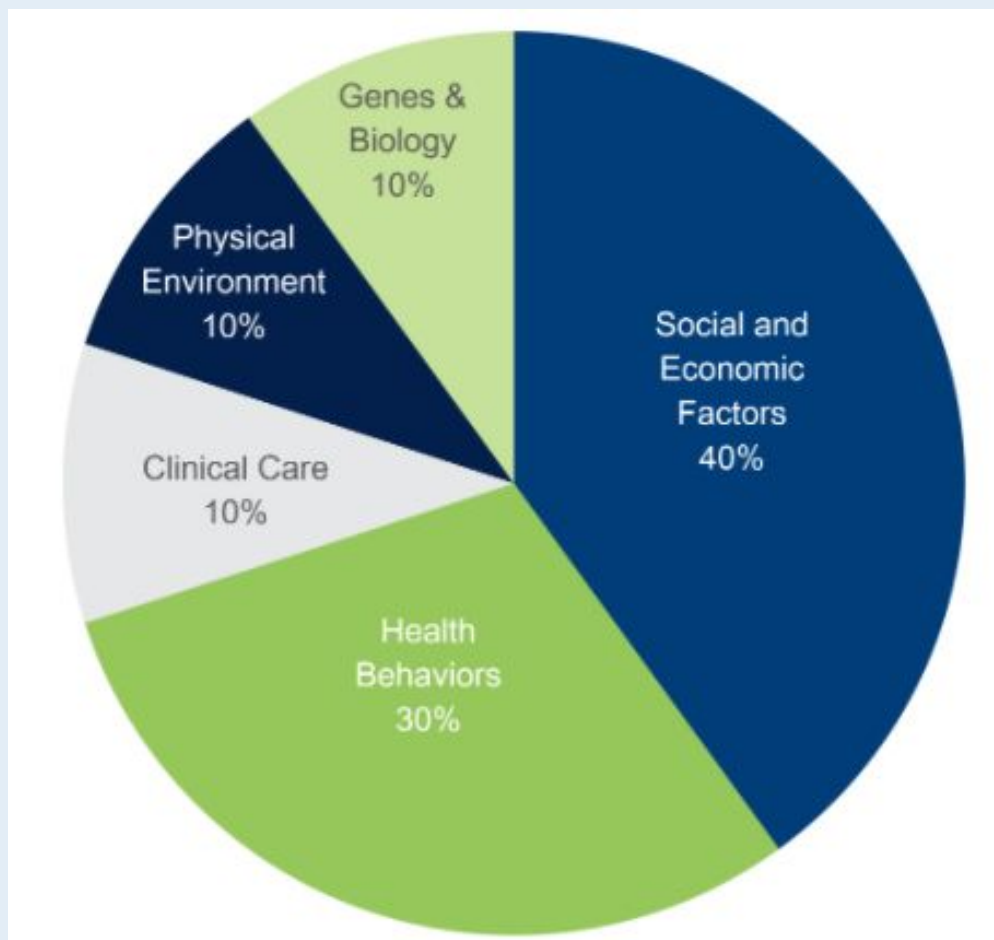
The Commonwealth Fund

4

Equity isn't just about race & ethnicity

- Inequities exist between and within racial and ethnic groups.

- Health disparities exist between geographic locations, disability status, socioeconomic status and community type, as well as race.

- Data is limited by how federal, state and local programs collect demographic and place-based data.

Ohio | Department of Health

Ohio's gaps in outcomes

Statewide life expectancy: 77.8 years

88.6 years
Census tract: Shaker Heights
(Cuyahoga County)

89.2 years
Census tract: Stow area
(Summit County)

60 years
Census tract: Franklinton,
Columbus (Franklin County)

61.6 years
Census tract: Pleasant
Heights/Downtown,
Steubenville (Jefferson
County)

61.1 years
Census tract: McCook
Field, Dayton (Montgomery
County)

61.6 years
Census tract: Hilltop,
Columbus (Franklin
County)

88.2 years
Census tract: Montgomery, Indian
Hill, Loveland and Remington
(Hamilton County)

● Lowest life expectancy in Ohio

● Highest life expectancy in Ohio

Why are some people healthy and others not?

Tooth Decay in 3rd Graders

- Children from families with lower incomes and those who live in Appalachia have higher rates of tooth decay.
- Children covered by Medicaid had the highest prevalence of tooth decay.

Tooth Decay

Slide adapted from Health Policy Institute of Ohio

Diet high in sugars and starches

Bacteria & Plaque

Low fluoride water supply

Poor oral hygiene

Poor access to regular dental care

Low oral health literacy

Tooth Decay

Slide adapted from Health Policy Institute of Ohio

Low fluoride water supply

Diets high in sugars and starches

Bacteria & Plaque

Low oral health literacy

Poor oral hygiene

Poor access to oral care

Poverty

Lack of access to healthy food
Lack of physical activity

Lack of access to health care and dental services

Income inequality

Substance use disorders

Mental health stigma

Domestic violence

Homelessness and housing instability

Residential segregation

Air and water pollution

Unemployment/low wages

Mass incarceration

Predatory marketing

Community violence

Racism

Adverse Childhood Experiences

Toxic stress

Bullying

Exposure to suicide

Intimate partner violence

Sexual experiences and identity

Non-health Outcome Gaps – Children Raised in Bexley (Bullitt Park)

The Opportunity Atlas

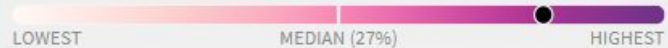search for address or place...

Tract 39049009000, Bullitt Park, Columbus, OH

CHILDREN'S OUTCOMES IN ADULTHOOD ⓘ   show fewer

HOUSEHOLD INCOME AT AGE 35	$73k ⓘ

LOWEST   MEDIAN ($44k)   HIGHEST

INCARCERATION RATE	<1% ⓘ
TEENAGE BIRTH RATE (WOMEN ONLY)	N/A ⓘ
INDIVIDUAL INCOME (EXCLUDING SPOUSE) AT AGE 35	$46k ⓘ
FRACTION MARRIED AT AGE 35	57% ⓘ
SPOUSE'S INCOME AT AGE 35	$52k ⓘ
EMPLOYMENT RATE AT AGE 35	84% ⓘ
HIGH SCHOOL GRADUATION RATE	N/A ⓘ
COLLEGE GRADUATION RATE	N/A ⓘ

show fewer outcomes

NEIGHBORHOOD CHARACTERISTICS ⓘ

show more characteristics

EXPLORE STORIES   DOWNLOAD AS IMAGE   DOWNLOAD THE DATA   OVERLAY YOUR DATA

GUIDE   METHODS   FAQ

HOUSEHOLD INCOME AT AGE 35   for   ALL INCOME   ALL RACES   ALL GENDERS

$73k
Tract 39049009000, Bullitt Park, Columbus, OH

Bexley

<$10k 29k 34k 38k 41k 44k 47k 50k 55k 61k >$80k

color scheme: EVERYONE   SELECTED GROUP   ON SCREEN

Developed by Darkhorse Analytics | © Mapbox © OpenStreetMap Improve this map

Ohio | Department of Health

Non-health Outcome Gaps, Children Raised in Franklin Park

The Opportunity Atlas

search for address or place...

Tract 39049003700, Franklin Park, Columbus, OH

CHILDREN'S OUTCOMES IN ADULTHOOD   show fewer

HOUSEHOLD INCOME AT AGE 35	$22k

LOWEST   MEDIAN ($44k)   HIGHEST

INCARCERATION RATE	5.2%
TEENAGE BIRTH RATE (WOMEN ONLY)	N/A
INDIVIDUAL INCOME (EXCLUDING SPOUSE) AT AGE 35	$19k
FRACTION MARRIED AT AGE 35	16%
SPOUSE'S INCOME AT AGE 35	$34k
EMPLOYMENT RATE AT AGE 35	71%
HIGH SCHOOL GRADUATION RATE	N/A
COLLEGE GRADUATION RATE	N/A

show fewer outcomes

NEIGHBORHOOD CHARACTERISTICS

show more characteristics

EXPLORE STORIES   DOWNLOAD AS IMAGE   DOWNLOAD THE DATA   OVERLAY YOUR DATA

GUIDE   METHODS   FAQ

HOUSEHOLD INCOME AT AGE 35   for   ALL INCOME   ALL RACES   ALL GENDERS

$73k
Tract 39049009000, Bullitt Park, Columbus, OH

<$10k 29k 34k 38k 41k 44k 47k 50k 55k 61k >$80k
color scheme: EVERYONE   SELECTED GROUP   ON SCREEN

Developed by Darkhorse Analytics | © Mapbox © OpenStreetMap Improve this map

Ohio | Department of Health

Neighborhood Characteristics Comparison

Tract 39049003700, Franklin Park, Columbus, OH

CHILDREN'S OUTCOMES IN ADULTHOOD ⓘ   show fewer

NEIGHBORHOOD CHARACTERISTICS ⓘ

show more outcomes

JOB GROWTH RATE FROM 2004 TO 2013	-2.5% ⓘ
MEDIAN HHOLD. INCOME OF RESIDENTS IN 2012-16	$33k ⓘ
MEDIAN HHOLD. INCOME OF RESIDENTS IN 1990	$24k ⓘ
POVERTY RATE IN 2012-16	38% ⓘ
FRACTION COLLEGE GRADUATES IN 2012-16	N/A ⓘ

FRACTION NON-WHITE IN 2010   72% ⓘ

LOWEST   MEDIAN (27%)   HIGHEST

FOREIGN-BORN SHARE IN 2012-16	3.5% ⓘ
FRACTION SINGLE PARENTS IN 2012-16	52% ⓘ

show fewer characteristics

Tract 39049009000, Bullitt Park, Columbus, OH

CHILDREN'S OUTCOMES IN ADULTHOOD ⓘ   show fewer

NEIGHBORHOOD CHARACTERISTICS ⓘ

show more outcomes

JOB GROWTH RATE FROM 2004 TO 2013	2.7% ⓘ
MEDIAN HHOLD. INCOME OF RESIDENTS IN 2012-16	$130k ⓘ
MEDIAN HHOLD. INCOME OF RESIDENTS IN 1990	$120k ⓘ
POVERTY RATE IN 2012-16	8.8% ⓘ
FRACTION COLLEGE GRADUATES IN 2012-16	N/A ⓘ

FRACTION NON-WHITE IN 2010   8.7% ⓘ

LOWEST   MEDIAN (27%)   HIGHEST

FOREIGN-BORN SHARE IN 2012-16	6.3% ⓘ
FRACTION SINGLE PARENTS IN 2012-16	20% ⓘ

show fewer characteristics

Ohio | Department of Health

W.E.B. DuBois

- (1868 – 1963)
- The Philadelphia Negro – A Sociological Study
- Published in 1899
- Connected health outcomes to the conditions in which black residents were living, including level of access to quality educational opportunities.
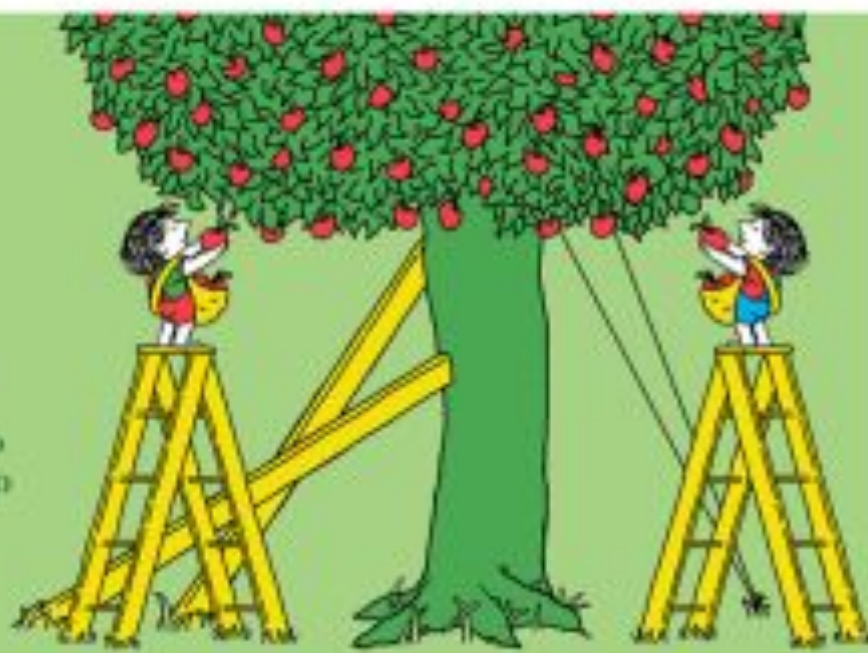
Office of Health Opportunity Key Objectives

- Establish equity as a pillar of Ohio's public health system.
- Improve clinical experiences and outcomes for the most vulnerable.
- Elevate and address the social determinants of health by impacting upstream social and community conditions of health.
- Ensure an equitable response to COVID-19.

Ohio | Department of Health

Approach

Data
- **Identify -** differences in outcomes
- **Prioritize** the highest-need communities.

Community Engagement
- **Share power** with residents to achieve change through meaningful community engagement.

Collaboration
- **Collaborate** across state and local, public and private systems to improve social and community conditions for health.
- **Develop champions** for health and equity across systems

Ohio | Department of Health

Centers for Disease Control and Prevention
COVID-19 Disparities Grant

Ohio Health Improvement Zones

- CDC Social Vulnerability Scores of .75 and higher

- Prioritizing limited resources

- Identifying communities for engagement

- Providing the correct interventions

- Aligning place-based efforts across systems

Overall Vulnerability

Socioeconomic Status
- Below Poverty
- Unemployed
- Income
- No High School Diploma

Household Composition & Disability
- Aged 65 or Older
- Aged 17 or Younger
- Civilian with a Disability
- Single-Parent Households

Minority Status & Language
- Minority
- Speak English "Less than Well"

Housing & Transportation
- Multi-Unit Structures
- Mobile Homes
- Crowding
- No Vehicle
- Group Quarters

Ohio | Department of Health

What if we asked people what they need to be healthy, and then listened?

Ohio | Department of Health

Mobile Health Units

- 6 fully staffed mobile units.
- COVID-19 vaccination.
- Core 4 Services.
- Focused on partnerships and opportunities in Ohio Health Improvement Zones, especially those with the lowest vaccination rates.

Priority School Districts

- Located in Ohio Health Improvement Zones.
- At least 40% of students receive free or reduced lunch.
- Low broadband access*.
- $17 million investment.

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Ohio | Department of Health

Community Wellbeing: Social Determinants of Health Dashboard

Social Determinants of Health

- Education Access and Quality
- Health Care Access and Quality
- Economic Stability
- Neighborhood and Built Environment
- Social and Community Context

- Built on publicly available data, including:
  - Census Bureau
  - Centers for Disease Control and Prevention
  - American Community Survey
  - *What data could be added to benefit your agency?*

- 5 Domains and more than 100 Metrics
- Data at the Census Tract level
- Now available publicly on data.ohio.gov

Innovate Ohio Platform

Ohio Department of Health

Poverty Rates By Census Tract

17.4%

Avg. Poverty Rate

23.0%

% Children < 5 Below Poverty

18.8%

% Children 5-17 Below Poverty

19.9%

% Children < 18 Below Poverty

2,948

Census Tract Count

Select Metrics:

Poverty Rates

*Big Number KPI Poverty Rate above might be inaccurate dues to the source data only have percent value with unknown sample size.

Low   25th Pct   100th Pct   High

Select A County:

County	
Adams	
Allen	
Ashland	
Ashtabula	
Athens	
Auglaize	
Belmont	
Brown	
Butler	
Carroll	
Champaign	
Clark	
Clermont	
Clinton	
Columbiana	
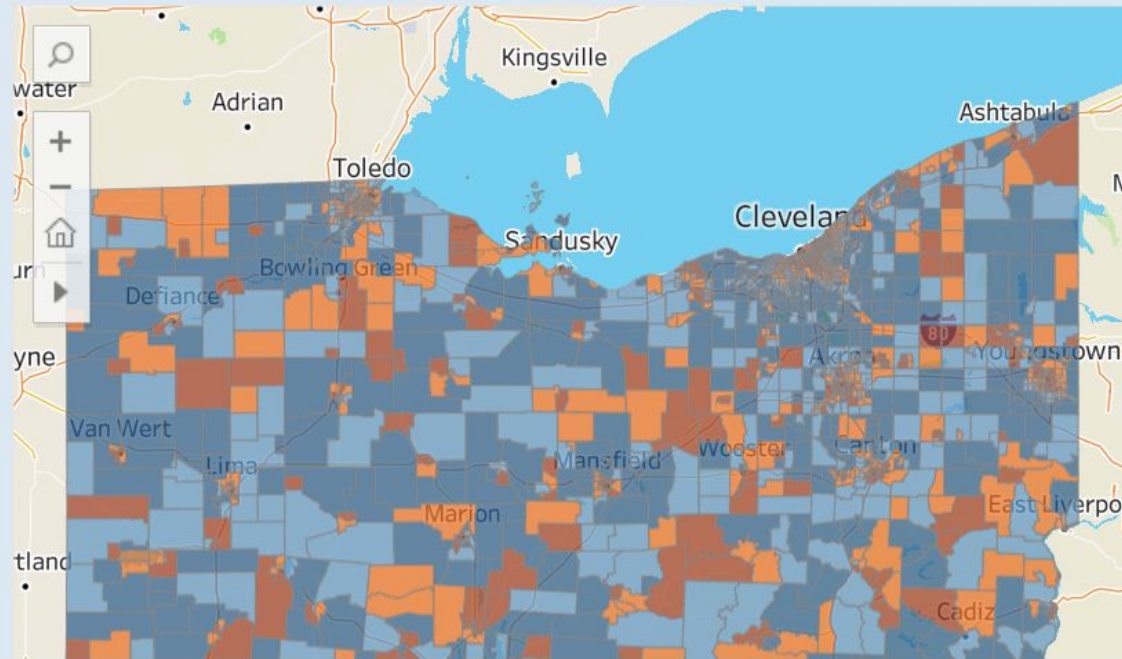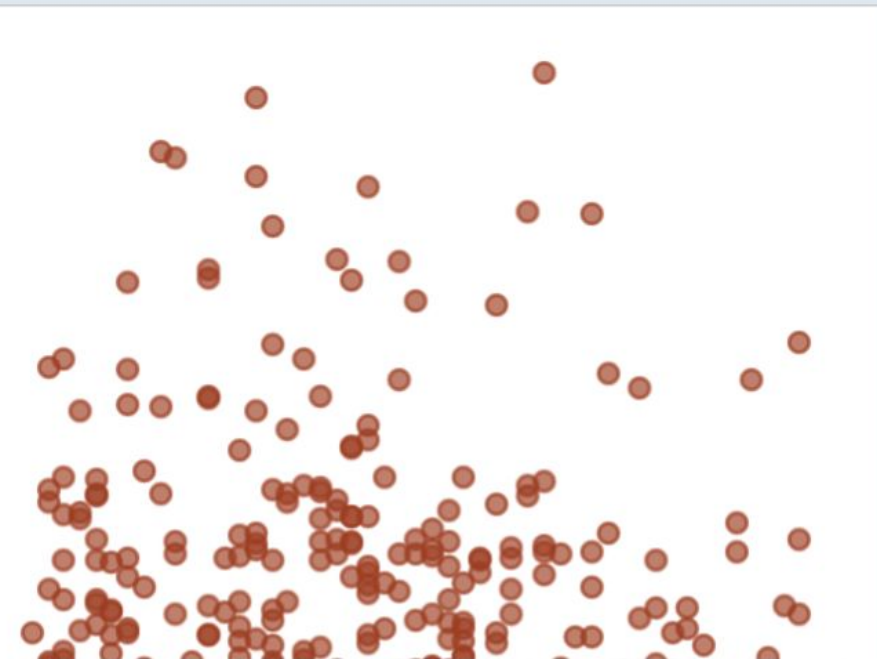
Elevating the Voice of the Community

- **Improving representation in public health surveys through**:
    - Oversampling of rural and minority communities.
    - Focused intentional outreach and incentives to high priority schools youth risk assessment surveys.
- **Adding a Racial Experiences module to BRFFS.**

Ohio | Department of Health

Challenge: Healthcare deserts

- More than 80% of counties across the U.S. lack adequate healthcare infrastructure .

- Over 20% of counties are hospital deserts.

- Healthcare deserts are more likely to affect those who face additional barriers to access.

Population Living in a Hospital Desert

Percent of county's population living over 30 minutes from the closest hospital.

0% ↑ 100%

Majority desert counties

Ohio | Department of Health
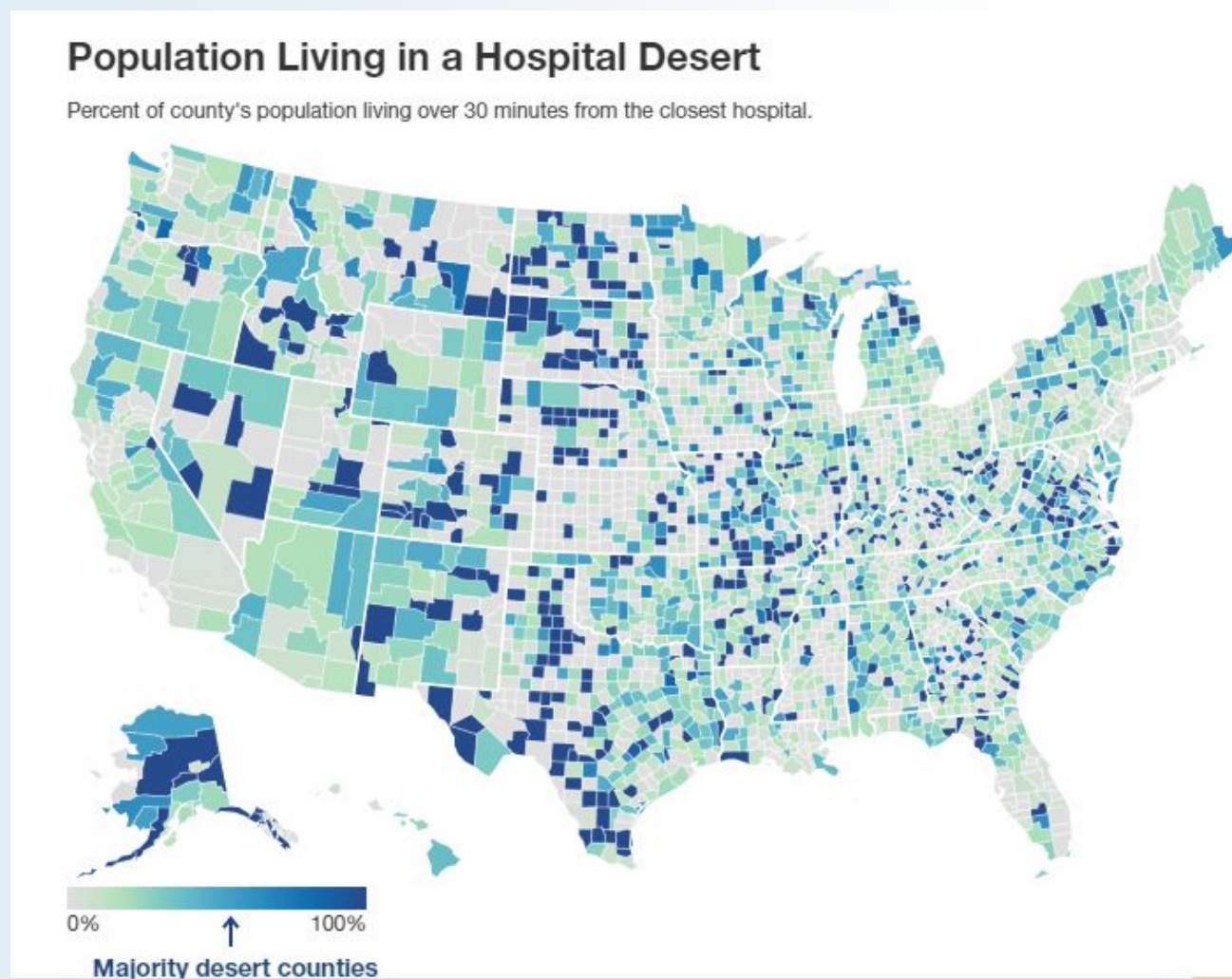
Strategies to Address Healthcare Deserts

- Seek designation as a HPSA.
- Expand Medicaid network participation.
- Develop capacity for interprofessional health.
  - Education.
  - Screening and referral.
  - Co-location of services.

Challenge: Attitudes and Beliefs about Health

- Fatalism - "Everyone loses their teeth eventually."
- Lack of health knowledge / "health literacy"
- Cultural views of health
- Reliance on self-care

Strategies to Address Attitudes and Beliefs:

- **National Standards for Culturally and Linguistically Appropriate Services (CLAS) -** Provide effective and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- Work areas
  - Governance, Leadership and Workforce
  - Communication and Language Access
  - **Engagement, Continuous Improvement and Accountability**
  - **Relationships**

Challenge: Patient engagement and treatment adherence or follow up

- Nonadherence can account for up to 50% of treatment failures, around 125,000 deaths, and up to 25% of hospitalizations each year in the United States.

- In 2018, only 46% children, adolescents, and adults living in the United States used the oral healthcare system.

- More than 1 in 3 low-income children did not have a preventive dental visit in 2019 - 2020.

Strategies to Improve Patient Engagement and Follow Up

- Be thoughtful about how to leverage technology.
- Consider developing messages for specific populations.
- Engage early and often. The waiting room is too late!
- Practice shared decision making.
- Screen for and address the social determinants of health.
- Partner with trusted community organizations.

Call to Action –
What you can do right away!

- Explore tools for screening and addressing the social determinants of health.

- Develop your professional network.

- Consider applying for HPSA status.

- Learn more about the National CLAS standards.

- Review your use of technology.

- Practice shared decision making with patients.

- Learn more about who you are serving and explore their perspective to identify more areas for action.

Questions and Comments

Ohio | Department of Health

Contact us to learn more!

Visit our webpage:
https://odh.ohio.gov/know-our-programs/health-equity

Subscribe to our newsletter:
HEALTHOPPORTUNITY@ODH.OHIO.GOV

Send us an email:
HEALTHOPPORTUNITY@ODH.OHIO.GOV

Ohio | Department of Health

Workforce Innovation – mission

To increase the size, diversity, and preparedness of the region's healthcare talent pipeline

THE HEALTH COLLABORATIVE | WORKFORCE INNOVATION

Workforce Innovation – strategic priorities

To live in the spaces where our employers are not…

- Increasing available career exploration and work-based learning opportunities

- Aligning/simplifying education pathways, including Early College

- Building connections to employment

- Collecting and analyzing regional data

https://workforce.healthcollab.org

THE HEALTH COLLABORATIVE | WORKFORCE INNOVATION

Practical Innovation

To expanding healthcare pathways…

- Finding and working with "partners-of-the-willing"

- Aligning with individuals
  - Determined to "find a way to yes"
  - Living the adage "a rising tide lifts all ships"

THE HEALTH COLLABORATIVE | WORKFORCE INNOVATION

Historical Turnover Rates

- Turnover rates were higher in 2021 than at any point going back to 2007

Greater Cincinnati Health System Turnover Rates

Historical Turnover Rates

- First year turnover rates were higher in 2021 than at any point going back to 2017
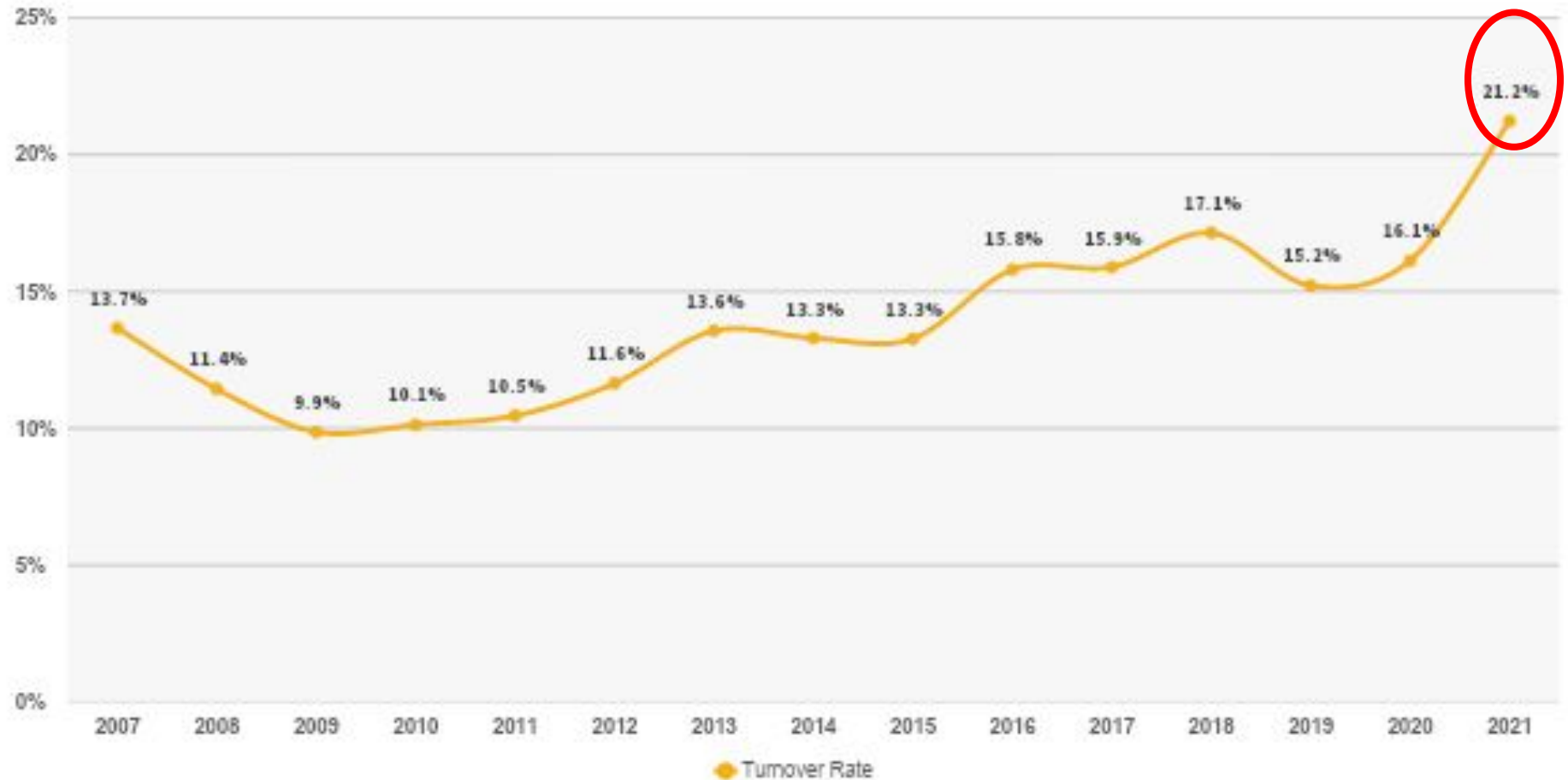
Greater Cincinnati Health System First Year Turnover Rates
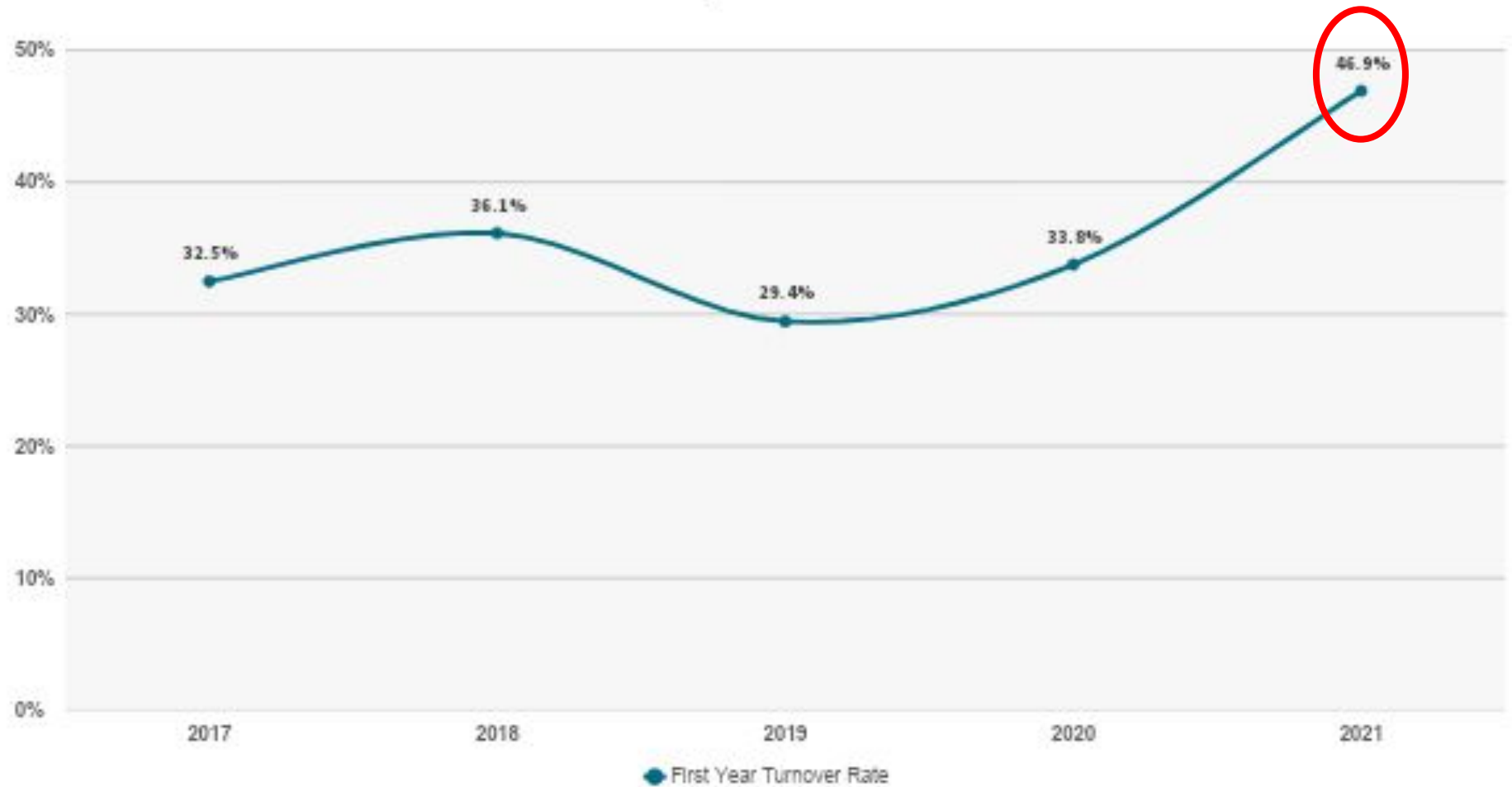
First Year Turnover Rate

THE HEALTH COLLABORATIVE | WORKFORCE INNOVATION

Historical Vacancy Rates

- Vacancy rates spiked significantly in 2021 up to 10.5 percent, which is by far the highest vacancy rate going back to least 2007.

- This represents more than 5,800 open positions among surveyed health systems.

Greater Cincinnati Health System Vacancy Rates

For Today:

I'm here to share and answer questions about several success stories of practical innovation in 3 healthcare pathways:

- Respiratory Therapy

- Medical Assistant

- Nursing

THE HEALTH COLLABORATIVE | WORKFORCE INNOVATION

28 Job Titles w/ Vacancy Rates >8%

21 Job Titles >10%

Job Title	All Openings by		Total Number of Employees as of 12/31/21		VACANCY RATE Data Effective 12/31/21	
	Head Count	FTE	Head Count	FTE	Head Count	FTE
Paramedic	36	26	85	67	29.8%	27.9%
LPN	76	67	236	212	24.4%	24.0%
Echocardiograph Technician (Registered)	26	24	106	97	19.7%	19.7%
Monitor Tech	55	39	236	158	18.9%	19.6%
Medical Lab Tech (MLT)	37	30	173	153	17.6%	16.5%
Surgical Technician (Certified)	52	49	244	223	17.6%	18.0%
Medical Assistant (Certified & Non-Cert Combined)	138	127	651	594	17.5%	17.6%
PCA/Nurse Assistant - Total Employees	386	288	1,939	1,308	16.6%	18.0%
Radiology Tech (Registered)	66	58	336	294	16.4%	16.4%
Respiratory Therapist (Registered)	116	91	592	490	16.4%	15.7%
Central Supply Tech/Sterilization Tech	45	40	243	235	15.6%	14.5%
Registered Nurse - All RN Employees	1,701	1,355	10,555	8,530	13.9%	13.7%
Medical Technologist I	50	44	339	298	12.9%	12.8%
Patient Transporter	29	22	198	160	12.8%	11.9%
Food Service Worker (Entry)	42	36	291	247	12.6%	12.6%
Phlebotomist	42	35	325	287	11.4%	11.0%
Laboratory Services Representative	18	15	140	114	11.4%	11.6%
Registered Nurse - (PP)	38	35	301	271	11.2%	11.5%
Environmental Services Worker (Entry)	67	64	543	524	11.0%	10.9%
Social Worker (MSW)	31	21	253	217	10.9%	8.8%
Pharmacy Technician	53	50	437	395	10.8%	11.1%
Patient Representative	66	58	691	618	8.7%	8.6%
MRI Technician (Registered)	14	12	150	134	8.5%	8.3%
Ultrasonographer (Registered)	18	15	193	160	8.5%	8.7%
Nurse Practitioner	48	45	524	471	8.4%	8.8%
Mammography Tech (Registered)	7	6	77	64	8.3%	7.9%
Admitting Clerk	48	40	530	451	8.3%	8.2%
Patient Financial Services Representative	26	26	297	290	8.0%	8.1%

Respiratory Therapy

Key Points:

Increasing access through:

- Questioning pre-requisites

- Digging into accreditor requirements

- Simplifying approach to incumbent workforce training

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Discussion

Medical Assistant

Key Points:

- Partnering to create the apprenticeship

- Working within the constraints of Registered Apprenticeship

- Braided funding

- Upskilling incumbent workforce

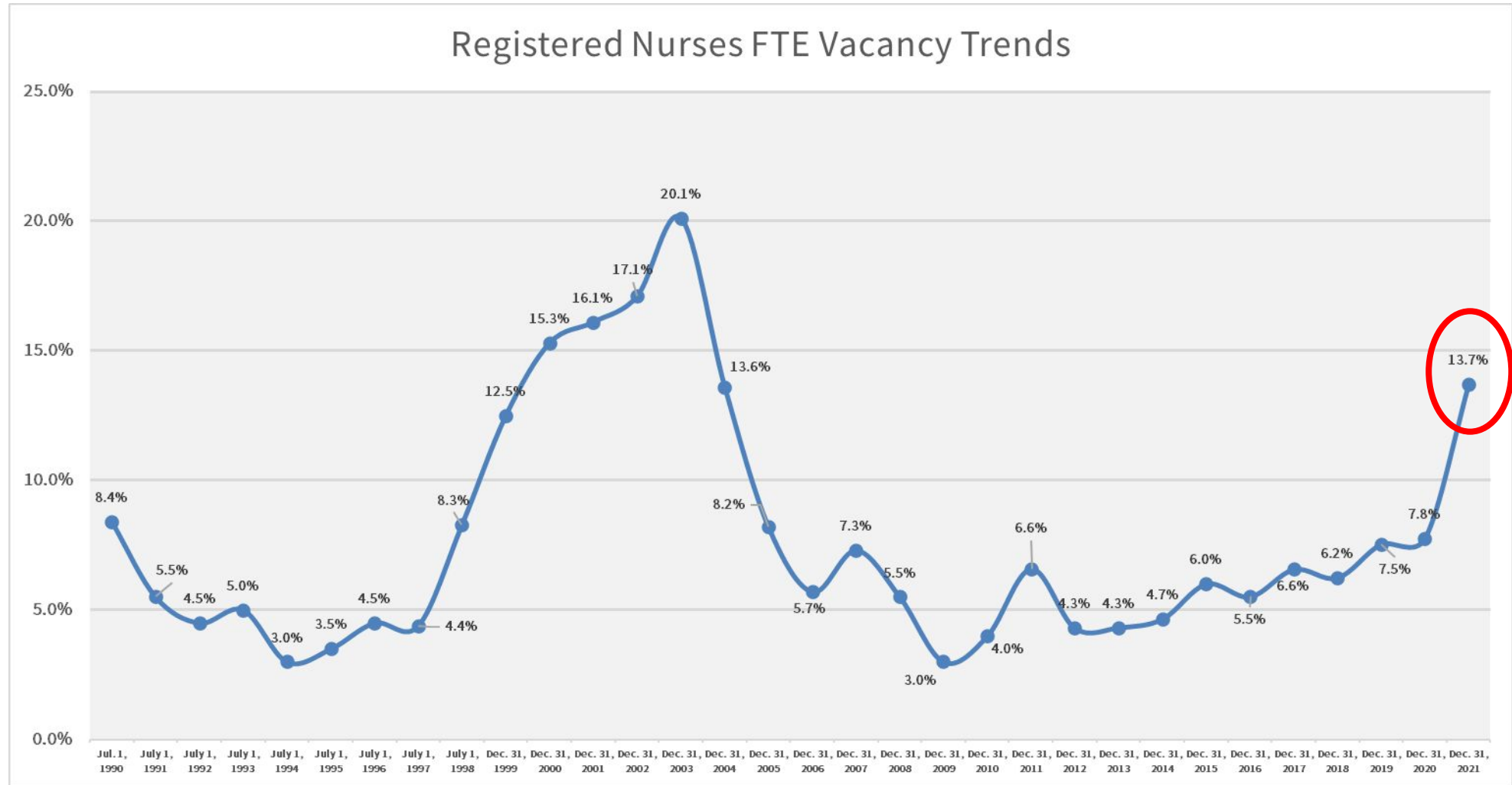- Hiring individuals who would have previously been denied

Discussion

Nursing Pipeline

Historical RN Vacancy Rates

Registered Nurses FTE Vacancy Trends

SW Ohio Healthcare Education & Workforce Coalition

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Working together to increase the health education pipeline through…
∴ **Advocacy** for smart regulations   ∴ **Collaboration** with regional and state partners
∴ **Sharing** innovative practices   ∴ **Pursuing** resources

Building Statewide Collaboration

Regional partners hosted 2 statewide meetings in mid-September

- Attended by >160 education leaders from career tech and community colleges across Ohio
- Shared how we identified and advocated to change barriers in the STNA & LPN program rules
- Presented some of the opportunities we see to grow this vital talent pipeline together

>30 partners interested in joining us in a statewide healthcare workforce collaboration to:

- Share best practices
- Advocate to remove barriers
- Seek funding to support new Secondary & Adult LPN, LPN-to-RN Bridge, and RN Programs

https://workforce.healthcollab.org

THE HEALTH COLLABORATIVE | WORKFORCE INNOVATION

Creating a Robust Nursing Talent Pipeline:
Summary of Recent Rule Changes in Ohio

LPN Changes

6/24/22: Governor DeWine signed **House Bill 583** which included **changes to instructor requirements for LPN programs.**

Sec. 4723.072 (A)(2) of the bill allows that:

▷ LPN faculty can include any individual who is **scheduled to receive a baccalaureate degree in nursing within twelve calendar months** after the date the program first uses the individual as a member of its faculty.

This change is effective through 1/31/28.

STNA Changes

7/29/22: Gov. DeWine's **Executive Order 2022-13D** implemented ODH's proposed STNA rule changes while they complete their formal rule review process.

Notable changes include:

▷ **Right-sizing instructor requirements**, including with regards to the "Train the Trainer" program.
▷ Allowing **virtual delivery** of didactic content
▷ Allowing **simulated clinicals** with ODH's prior approval of proposed methodology
▷ Adopting the federal **passing score of 70%**

This order is effective for 120 days from its effective date. Permanent changes are expected to be included in the ODH rule changes.

Key Points:

- Our "secret sauce" has been the power of this partnership

- Advocacy can work

- There are many, many barriers

- Best practice sharing is a best practice itself

Discussion

Introductions

Giving honor to my ancestors whose faith endured the middle passage, enslavement, the Jim Crow south, and the great migration to the north to give to their family the hope of a brighter future. I am second generation refugee.

Working in Diverse Communities

City on a hill
(Marvel Studios)

Objectives

1. How to engage diverse communities – steps of engagement
2. How to overcome barriers to cross cultural work - NAMWM
3. Before SPF, After SPF
4. Program examples

Cultural Humility: The Key to Serving Diverse Communities

- You don't know me, unless I let you

- No one is an expert of someone else's culture

- Language experts Steve Kaufmann, say it take 5 -7 years to learn another language – "You start a language, but you never finish"
  - Enjoying the process is the reward – of learning other cultures
  - Engaging new communities is a continuum and hopefully we can enjoy it

https://www.bing.com/videos/search?q=how+long+does+it+take+to+master+a+language&docid=607988767356050973&mid=AB996326D7C0B6F98F01AB996326D7C0B6F98F01&view=detail&FORM=VIRE

https://youtu.be/Nl_KLRa_8rM\

Engaging Diverse Communities – Steps of Engagement

- License to Operate

- Tribal Trust

- Relationships, Relationships, Relationships

- Servant Leadership

- NAMWM (Not About Me Without Me)

- What's in it for them

Barriers to Cross Cultural Work – NAMWM

- Lack of Humility
- Work with the community, not for the community
- Becoming a lifelong learner
- Honesty- Let's Get Real

The need for Radical Candor

- We all are in this field because we care deeply

- So we challenge directly

The need for Radical Candor

- We all are in this field because we care deeply

- So we challenge directly

Resilience model

- "We believe that every child is innately "at promise" rather than "at risk" – filled with capacity, realized and unrealized, for healthy transformation and change"

- Our prevention efforts must focus on environmental change, creating healthy, inviting climates verse "fixing" youth.

What would Good look like?

Presented by:
Rachelle A. Martin
Executive Director

National Alliance on Mental Illness of Franklin County (NAMI FC)

Mission

NAMI Franklin County is dedicated to improving the lives of persons with mental health conditions and their family members and friends through education, outreach, support, referral, and advocacy in Central Ohio.

NAMI FC

Objectives

- **Provide quality education** on mental health to persons with mental health conditions (lived experience), their family members, friends, and mental health professionals.

- **Raise awareness** and enlighten community members through outreach efforts about what NAMI Franklin County is and what services we provide.

- **Offer support and/or referral of services** to those with lived experience, their families, and friends.

- **Advocate on behalf of individuals with mental health conditions and their family members** to improve the mental health system of care, remove stigma, ensure system accountability, and strengthen our grassroots network.

- **Provide** a forum where parents, spouses, siblings, adult children, and friends of individuals with mental health conditions may share experiences and give emotional support to one another.

There are more than 600 **NAMI** State Organizations and Affiliates across the **country**.

NAMI Ohio has 34 Affiliates in the State of Ohio
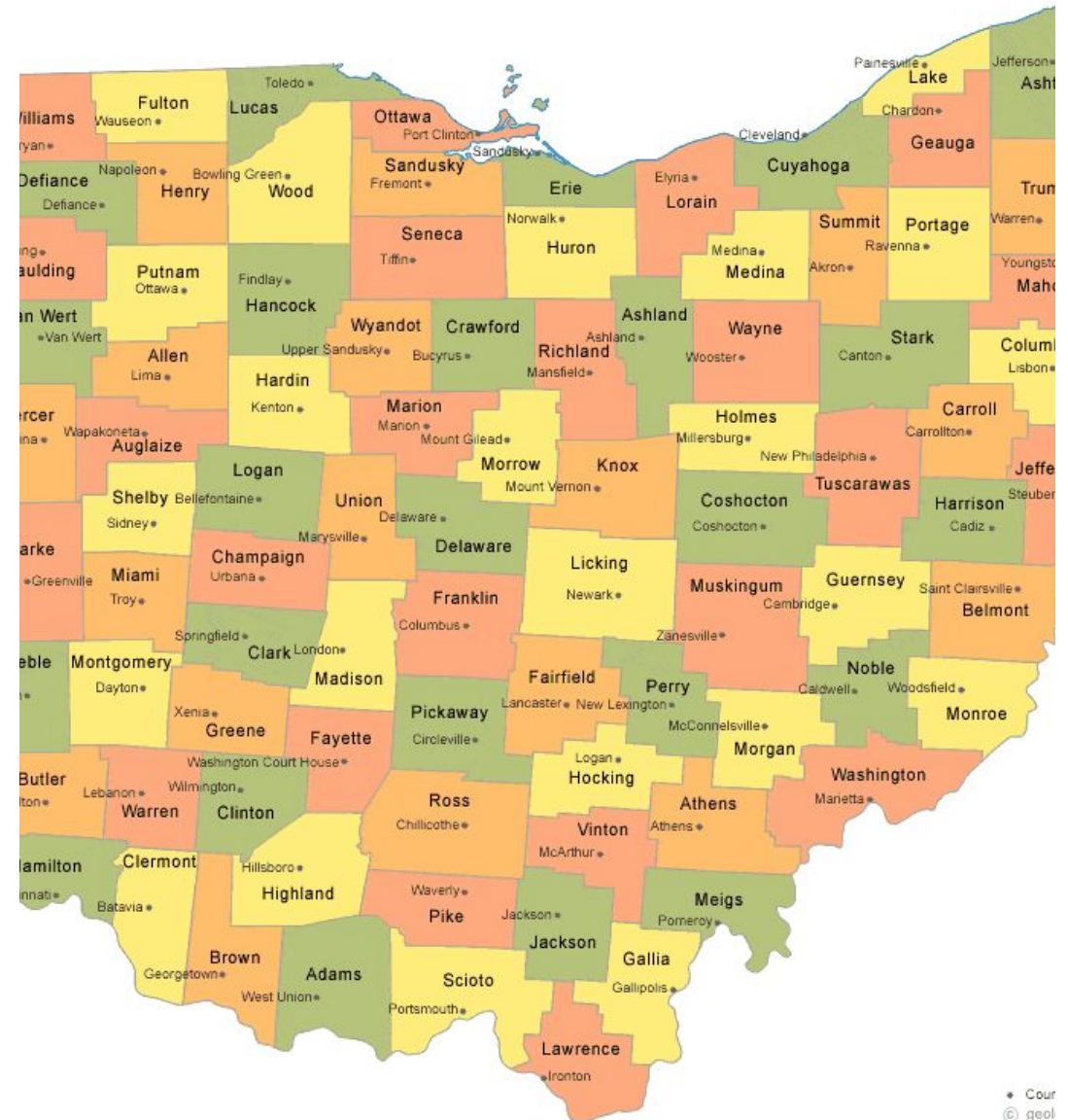
NAMI Signature Programs

Classes
• Family-to-Family
• Peer-to-Peer
• Basics
• Homefront

Support Groups
• Family Support
• NAMI Connection

Other Programs

- The following free programs are hosted by NAMI Franklin County or in conjunction with our partners.
Click below for details on how to participate.
- <u>Concord Counseling Respite Program</u>
- <u>Crisis Intervention Team (C.I.T.) Training Program</u>
- <u>NAMI Ending the Silence</u>
- <u>NAMI In Our Own Voice</u>
- <u>NAMI Mentor Program</u>

www.namifranklincounty.org
mail@namifc.org
614.501.6264

On Behalf of
NAMI FC
Thank you

"…Happily Ever After !"

(…and other fairytales from healthcare)

Lynn Brooks
Health Professions Network
November 11, 2022

The New Realities

- *"You'll never get as much in reimbursement as you get right now."*
- Salaries can only go up, they will never go down
- Public expectations of healthcare are approaching entitlement status:
  Everything; NOW; free, cheap, or heavily subsidized !!
- As always, all of the coming changes will happen at different locations or within systems at different speeds at different times and under different situations or factors for either proactive or reactive reasons
- Little if anything will be coordinated, standardization is always under threat.

The New Realities:

- No one owns or controls healthcare, but we all feel we have a place in it

- You can't control the change, but you can create your place ??

*"We're going to create the change **without** you,*
*But we're not going to do it **for** you*
*We'd like to do it **with** you,*
*But if not, we'll do it **to** you !!"*
(Reality of the Current and Future State of the Industry)

What's Going On……..

- General Trends
- Economics
- Provider and Delivery Systems
- Demographics and Staffing
- Technology
- EHR and Artificial Intelligence
- New Players
- Education

General Trends:

- COVID has become the biggest total disrupter in history
- Overall outlook is very positive, but will require unprecedented FLEXIBILITY and COOPERATION!
- Some trends won't change, but others already have and are accelerating
- Resurgence has driven hospitals back to initial protocols/environment; elective surgeries, more definitive use of facilities and locations, etc.
- Infrastructure developments dropped, delayed, or re-directed
- Inconsistent and unstable health care policy will dominate
  Fee for service vs. ACA vs. reform/repeal vs. influence of emerging players vs. COVID
- Hospitals and health systems must innovate to keep pace with newly forming organizations and partnerships, leadership becoming more strategic.

Economics:

- "COVID Corruption" will be here for 3-5 years (impact on payment models)
- Health care spending will continue to soar for immediate future
- Affordable Care Act (Obamacare) continuous quiet alterations: outcome to restructure payment models
- The battle of government control vs. market competition; price transparency will continue to heat up
- Development and economic impact of new players will increase dramatically.

Provider and Delivery Systems:

- COVID workplace innovations/protocols will be integrated long-term; employee protection measures, foot traffic in facilities, visitation, etc

- Remote work for non-patient employees will remain the norm; in-house "busyness" will be replaced by off-site productivity and incentive pay systems.

- Enhanced cross-training of employees to maximize efficiencies; skill-sets and competencies across disciplines vs. traditional job titles

- New technologies will encourage patients to become more involved in their care

- Digital health will create revenue diversification opportunities and speed value-added health care technology to consumers *(telemedicine and other new revenue streams).*

Provider and Delivery Systems:

- Technology in Ambulatory and Home Health will take health care everywhere, the "electronic house call" will become the new normal
- "Home Hospital" concept emerging into networks
- Providers will explore non-traditional partnerships for greater stability of services
- Cybersecurity will continue as a major system challenge.

Demographics and Staffing:

- Baby boomers are gone. High turnover and shorter career time of new grads
- Bedside needs exist now, but future growth of caregivers will continue to be non-traditional and outside of the traditional hospital setting *(chronic disease mgmt, geriatrics, outpatient, specialty operations, home network systems, assisted living/memory care, etc.)*
- Technology will take on larger role in patient care allowing for skills enhancement and shifting
- Critical thinking skills are being edged out by patient case management with AI analytics and data.

Demographics and Staffing:

- Care coordination and collaboration with other disciplines will increase as silos diminish

- Scopes of practice shifting across disciplines and within the food chains of traditional silos *(multi-skilling and upskilling c/w labor expense reduction)*

- Every major discipline in healthcare has altered their respective delivery model – EXCEPT NURSING !!

  Health care is becoming a "lattice work" to provide "the right skills at the right place at the right time to deliver the right care at the right price."

Technology

- Latest technologies going off the charts in all major disciplines, greatly accelerated by COVID. Providers jump started pre-COVID, enhanced

- Technology accelerating new studies/programs/research which creates new treatments and protocols; new technology is driving new technology

- Technology of/within genomics opening new research and opportunities, also enhancing development of AI platforms

- Telemedicine evolution from phone calls, to transmission of data, to interactive live feeds with data dumps; all at higher levels of technical quality and competence

However……………

Technology

- Technology innovations are leveling off due to limitations of current infrastructures
- A new generation and complexity of platforms are needed, but cost prohibitive
- Concept of Home Hospital emerging:
  - allows significant and substantial remote patient monitoring data,
  - streamlines future population/community health management reimbursement with application of RAF (Risk Adjustment Factor)
- Shortage of human factor resources (IT/R&D staff) to develop and implement in addition to cost of equipment, training, analytics, etc
- **Driving Question: *How many patients can a physician see daily with existing or evolving technology?***

EHR and Artificial Intelligence:

- EHR:
  - Often cited as one of top three reasons for physician/heavy user burnout
  - Epic has emerged as major EHR contractors, with Cerner and Meditech falling behind; Meditech focusing on hospitals less than 200 beds
  - Enhanced platforms allowing for multiple inputs and influence, natural language programming to reduce number of "clicks"
  - Technology, Training, and Workflow: continually changing as enhancements arise and programs develop *(sets up a continuous loop of training/retraining)*
  - **EHR will probably be controlled by FDA in 10-15 years. If government is footing the major percentage of the bill, they want total access/ownership of data**

EHR and Artificial Intelligence:

- Artificial Intelligence:
  - Able to emulate human intelligence and potentially exceed it; control is critical
  - No longer just hype for health care usage, becoming quite comfortable to use, potential legal protections
  - Legacy medical systems frustrating, smart collective devices being developed
  - New cybersecurity – lattice cryptography – unable to be hacked – cloud based
  - Reduction/elimination of "biased" AI systems and algorithms (GIGO).

New Players:

- Walmart, CVS, Walgreens, Costco, etc., not only forming internal health systems but also setting up for and marketing for consumers. COVID providing major opening:

- Intermountain, HCA, Providence, etc., constantly expanding business model networks

- Alphabet, Microsoft, and Apple – AI programs and mobile monitoring explosion

- Amazon, others – drugs and medical devices. *(Emergence of Mark Cuban venture??)*

- Amazon, Berkshire Hathaway, JPMorgan Chase partnership is dead, but concepts, programs, partnerships, and systems are developing independently.

Health care delivery is now entering a multi-level matrix which will drive the shift from root-bound traditional programs to innovative options from the market systems.

Summary Points:

Health care is becoming a "lattice work" to provide "the right skills at the right place at the right time to deliver the right care at the right price."

(Disruption of the Professions)

Health care delivery is now entering a multi-level matrix which will drive the shift from root-bound traditional programs to innovative options from the market systems.

(Disruption of the Workplace)

*"There is no way the industry can have all these changes in the **workplace** without corresponding changes in the **workforce**."*

(Disruption of the Education Process)

Education:

- COVID impact negative to student motivation and commitment, teacher retention *(thinking/learning giving way to "cut and paste;" longevity threat)*
- Education forced to embrace technology and virtual training methods.
- Emergence of simulation facilities/methods gave access to other clinical sites
- Entry level (HOSA) and professional level (ASAHP) still intact; everything in between somewhat in chaos
- Non-traditional education/disruptive programs emerging *(apprenticeship, etc)*
- Shortages allowing gloves to come off from/against traditional programs/standards.

Where does HPN fit in ??

Do we need to make any changes or just ride it out?

Can we only be reactive or do we want to be proactive?

What do you see as opportunities?

What needs to change in our role with the new changes in the industry?

How do we do it?

How can we plan for it in the future ??

THE KITCHEN

KITCHEN
Welcome
HEALTH PROFESSIONS
NETWORK

HPN
HEALTH PROFESSIONS NETWORK

EXPERIENCE COLUMBUS & WEXNER CANCER CENTER

These Panels Are Made Possible By
A Generous Gift From The Motorists Insurance Group

OHIO STATE
HAZELWOOD FAMILY TUNNEL

100
OHIO STADIUM
1922   O   2022
™

HPN
HEALTH PROFESSIONS NETWORK

OHIO STATE
BUCKEYES

THE OHIO STATE
UNIVERSITY