**Greater Ann Arbor Region Health Leaders Council Notes – 8.26.2014**

**Overview of Ann Arbor SPARK-**

MEDC Region-Many different regions across state. State elected to start Prosperity regions to consolidate all these different regions. Regionalization helps to make the area more recognizable to people outside of the state/country.

Regional prosperity region-governor wanted to put seed money into regional projects. 5 areas required to collaborate-higher ed, workforce, transportation, economic development, Region 9 submitted an application for an RPI grant. Identified the key areas of overall talent, shortage/inefficient talent. Mismatch between industry and talent. Developed a talent council format. Had a first talent council meeting in April. People on this council are higher education or orgs that have to do with talent. Industry meetings include IT, manufacturing, and health care.

**Attendees:**

Shannon Fisher-Evangelical Homes of Michigan

Kim Cybart-Glacier Hills Senior Living Community

Lori Hersig-United Methodist Retirement Communities

Brandon Buchanan-Trinity CHE Health System

Joyce Young-St. Joseph Mercy Health System

MaryBeth Morgan-Integrated Health Associates

Barb Brown-Integrated Health Associates

Jeremy Stephens-

Josh Fangmeier-Center for Health Transformation

Molly Kaser-Center for Family Health

Jeremiah Hodshire-Hillsdale County Health Center

Duke Anderson-Hillsdale County Health Center/ vice chair of Hillsdale economic development

Lisa Katz-Workforce Intelligence Network

Tricia Walding-Workforce Intelligence Network

Luke Bonner-Ann Arbor SPARK

Kathleen Griffiths-Washtenaw Community College

Michelle Mueller-Washtenaw Community College

**Workforce Intelligence Network**

Working with training and employer partners to fill the talent gaps. Provides quarterly workforce data reports for the WIN Region, Region 9 and all of the included counties. WIN region information is available by visiting [www.win-semich.org](http://www.win-semich.org). Information for Lenawee, Hillsdale and Jackson are available by contacting your economic developers. Please let WIN know if you would like us to connect you with the individual in Region 9 that receives these reports.

**Occupational cluster report and labor shed data**

-Refer to the PPT used during the meeting-

**Comments:**

Health services managers: could be elevated because of retirements – older workers are managers. Also, with consolidation, could be decline in managerial roles (fewer executives, more managers). Could nurse leaders be bundled in health services managers? Are companies investing in internal team members as leaders? Could be looking externally as leadership.

May average 7% nationally for turnover. Could take turnover with national data and see if we have natural spikes. Are we losing RNs because we see demand for BSNs vs. LPNs. ½ are hiring multiple nurses from one posting. Criminal background check could result in a posting staying up longer. For RNs we have an open posting that never comes down.

Health systems have not hired LPNs for years. @ least 10-15 years.

Possibly county-wide medical care facility may hire LPNs. Skilled care is LPNs vs. RNs.

Associates degree requirement for RNs will change from 44% (decrease). Many hospitals will not hire associates-level nurses—will require BAs. Looking at articulation programs from AA to BA. If associates, have 5 years to get BSN (St. Joseph Mercy). There is some tuition assistance. Target 80% BSN by 2020 (trinity health across the whole system). Look first for new hires with a BSN to jump numbers up within organization.

In rural areas, hire associates and BA. See need from BA but practical skills are limited. More and more time with orientation. For training, require both BA and AA nurses. Look at OB, surgery, etc. need to do a year on med surg because they are not ready.

Difficulty finding candidates in the following areas:

* Home health care RNS
* Mental health nurses
* Physical therapy
* Occupational therapy
* Surgery, ED, NICU, Psych – look for nurses coming in with experience in specialty areas.

Behavioral health units. Dementia care. Took 18 months to hire a director for inpatient behavioral health. That director is now leaving. They did two counter offers to attempt to get the person to stay but couldn’t compete with an employer in Wisconsin.

$2.50 premium just for behavioral health nurses– to attract. – schools don’t have programs, older populations, decline in services (funding/coverage decreases)🡺 at a tipping point because people are retiring and going out and most have identified it as a community health access need; need to grow services. Need skilled nurses, techs, NPs, psychologists.

Ambulatory care v.s. health system – telephonic care – redundant. Nurses go through clinical – don’t get ambulatory facility as part of training.

Have had to grow our own specialty nurses – start scouting and developing internally. OR, ED, critical care, SICU, NICU, Med Surg ==look at med surg – clinically/acute care and pull them in.

Health care poaching – nurses plan the rotation between health systems to maximize benefits. It depends on who is giving the best perk. It is a small group you are recruiting from. Does not allow us to pull from outside markets. Scary. Need to work together to attract nurses and other care occupations from other areas.

People are mobile and looking for opportunities within and across states; looking at the issue of **compact-state licensure.** Look at old legislation to reissue compact licensure for MI. Could help recruiting. Need to recruit from OH, IL, IN. Need to look at cultural fit.

ACE system – a program that works with hospitals for clinical placements – need available space for clinical requirements in the program. Not everyone knew about the program. Look at this for possible areas in ambulatory and other. Make sure pre-reqs are taken care of.

MECIA – partner with employers and build pipelines.

Clinical learning opportunities – a ton of students with public health administration majors. What to do with this? Great title—no meat. No specialty- no backbone. Need a minor or something to fill. Not a job for them – one working at ford, or HR in a non-health care field. They can’t just enter health care administrative positions without any health care experience.

Internships and opportunities – we are open – but it may not be the right people or there might not be the right occupation. Also, while open, also look for best of the best.

Growth in programs – it is hard to find enough sites – medical assisting. Lots of churning.

Partner with K-12, come out of HS with a CENA, then relationship with Hillsdale students – get them degrees, and put them through the process. Try to increase the labor force for the future. Also, the ISD, CC, and Hillsdale put in resources for coordinators. We put in $ for training and experience.

DATA? Do work at categories of nurses, projected retirements, etc. Do have planning across demographics of age, type of provider, nurse, physicians, ed data (Trinity).

Health care has no idea what’s happening. Need more efforts like working with the K-12 system and colleges. Pipelines are not developed, and there will be a mass rush to get there. Compare to other industries – not even close. Development of the pipelines are not there. Those systems are long-term. 3-5 years before you get them in the school and get them where you want. Starting to get tougher—it is going to flip. Need legislation, need relationships with schools.

What about other major changes – Affordable Care Act?

Lots of focus on reimbursement pressure for at least a decade. It is going to get really tough. By end of decade, hospital industry could lose 1:4 (health systems cease to exist). We anticipate hospitals shrinking – less acute and more in the community, in the home, in long-term care. Outsourcing of care – lots of growth in the continuum of care. In ambulatory care, see drastic changes of volume. Their vision of the patient is that health is managed by everybody—seen by everybody. How do you look at the patient? When think about staff member who is extremely flexible, specialty training and general medical training. Came out of a hospital and moved to ambulatory—acute but different. Ambulatory volume is heavy. EMR: have to be quick. When thinking about skillsets, think about complicated IT. Need to understand EMR and their responsibility. Have to do this because work as a partner with the physician all day long. Complexity about access is a push. Beyond 8-5 – have to have that access. Interesting evolution. Started succession planning 3-5 years out for physicians. Have not done this for staff. Pull flexibility we need from contingent workers – so that when ebb and flow, have to be able to adjust to visits. Have to adjust to the payers and the patients.

Immunizations: changes in schedules, growing demand, do this on a daily basis, and can only bill at certain times for reimbursement. H1N1? Also, put on hook for immunizations for pneumonia, shingles, etc.

Physical therapy is a PhD. A new program, so no graduates yet at UM. No other programs known within the region.

Would like to see of those with degrees, how many staying, and how many attracting from other states. Sense losing a large number of people.

Have talked about recruiting from each other and other states – what about retaining people? Cultural fit. May not steal from Hillsdale to Ann Arbor. Knowing who you are and what you offer is important. Is there a referral opportunity?

Good best practices from health systems from a talent perspective?

Hillsdale: Utilize SC MWA through talent recruitment; jobfit assessments, onboarding in preliminary stages.

Trinity: Compact licensure; also, mobile career for life – For Henry Ford Health System, can find a career anywhere in MI where HF exists.

Development programs where students rotate health systems – apply to larger systems.

**Next steps:**

SPARK/WIN will reconvene this group in late September. Avoid Mondays.

WIN will send the PowerPoint, notes, information about the STTF grant opportunity, and the ACE clinical placement system.