2-16-2018

How to Merge Libraries in an Era of Hospital Mergers

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NEJM LibraryHub

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Librarian shares insights from repeated centralizing in an ever-growing system

February 16, 2018 SHARE

Providence St. Joseph Health

Combining and centralizing hospital libraries has become a specialty for Heather Martin.

As a health sciences librarian who has been with Providence Health and Services (PH&S) since 2013, Martin helped bring together her library in Oregon with two other hospital libraries to serve all eight PH&S hospitals in the state. This reorganization marked a shift from hospital-based to region-based services and provided every hospital access to library services.

With Oregon as a model, next came the 2014 creation of one central library department for all 34 Providence hospitals in Alaska, California, Montana, Oregon, and Washington — including those of a new affiliate, Swedish Health Services. In this new central department with shared services, consolidated contracts increased efficiency and more people could access library resources and professional services.

Now, as director of System Library Services at Providence Health & Services, Martin is addressing a bigger challenge and a bigger merger: centralizing library services for the 50 hospitals of Providence St. Joseph Health. This reflects the 2016 merger of PH&S with St. Joseph Health, adding 16 St. Joseph acute care hospitals in California and Texas.

The value was evident, according to Amy Compton-Phillips, MD, chief clinical officer, Providence St. Joseph Health: “Centralizing the library service into a single, geographically distributed team made so much sense for our organization, allowing for a more equitable and cost-effective model of delivering library references and resources across the entire enterprise. The support for research and innovation is essential, and benefits of the model have been broader access, growing usership and improved satisfaction levels.”

Approaching the January launch of the new, merged library system, Martin spoke with NEJM LibraryHub about the logistics, decisions, and goal of creating equity in a large, geographically dispersed system.

Q. At what point in the merger with St. Joseph did you begin talking about centralizing library services? Did everyone agree on it?

A. The idea was initiated by Library Services at Providence, ultimately with executive support. Soon after the merger became official, we began pitching the library merger initiative.

We had learned that some St. Joseph hospitals didn’t have a library. Some hospital libraries had only part-time staff, but some had a robust library service and were worried about change. There also was some thinking that if a hospital didn’t have a library system all this time, it probably didn’t need one. But many other people

throughout the system were excited. We spent more than a year reaching out to stakeholders at St. Joseph Health and getting buy-in, while also figuring out needs and lining up resources.

In the end, we got wide support, recognizing the need for high-quality, evidence-based resources and professional services throughout the system. It also was acknowledged that integrated library services could reduce subscription duplication across sites and bring economies of scale in purchasing online resources and in administrative efficiency.

Until now, much of the merger between Providence and St. Joseph has been locally focused, with some services shared, but not truly merged. We're proud that the library is one of the first services to come together to serve everyone as one.

As of January 2018, we have a single collection so that everyone has access to a single library, with the same resources. And every hospital will have access to a librarian, with 12 librarians sharing the work to support the 50-hospital system.

Q. What happens to physical libraries and their staffs when hospitals merge and a centralized system results?

A. In every consolidation, we have kept libraries and their staff where they were, rather than create one centralized physical library. This allows us to keep a personalized touch and a local feeling. People on the ground know their communities, and they know local strategy, structure, and priorities. We've seen (non-library) departments consolidate across states and struggle with maintaining the same human touch.

We eliminated all print journals and most print books. This removed any duplicate costs if we already had electronic access, but also met our mandate to serve the whole of the health system. Many employees don't have access to a physical library, so an electronic collection is essential to ensuring equal access no matter their location.

We now have a single web portal that gives all employees and medical staff of Providence St. Joseph Health System access to our single resource collection. We

provide in-person trainings at hospitals that have physical libraries/librarians and webinars for others.

Most needs (training, article requests, literature reviews) are addressed by the librarian on site or the librarian who is closest geographically. However, our entire team is available for backup in times of heavy workload or librarian time off. We also capitalize on individual talents and interests, meaning a librarian in Oregon might work on a project with a California-based team if it aligns with their expertise.

Q. How do you address everyone's needs, with so many different types of hospitals?

A. We are now a very large system that embraces training hospitals, community hospitals, a specialty hospital with a strong research component (the John Wayne Cancer Institute), even rural critical access hospitals. As librarians, we've had to become more agile as our users changed. We call upon broader skills and develop different strengths.

One of the biggest changes that has accompanied our diverse needs is how we relate to publishers. Because we purchase a single collection, publishers want to price according to our total size. But while we have 100,000 FTEs and 11,000 beds, we may have just 50 researchers in the whole system who use a particular journal. Pricing based on our total size makes it difficult for us to purchase those journals. We need a good-faith solution based on usage. I wish more publishers would be more creative in their pricing.

Q. Do hospital librarians change their purchasing habits if they know that their physicians are likely to have access to e-resources through a medical school or other hospital affiliations?

A. Hospital libraries have such limited resources it doesn't make sense to double pay if users have access to resources elsewhere. It may, though, affect purchasing for some libraries.

However, our user group is very diverse: physicians in one of our regions may have alternatives, but those in another may not. One of our biggest mandates is to provide information and access to services to all our users, no matter their location. We don't want information haves and have nots. While we consider local markets or location-specific specialties when purchasing, we make some difficult decisions to meet the needs of the system as a whole. At this point we have a single collection that is available to everyone. If we can't afford to license something for the entire system, we don't purchase it.

Q. Has anything changed to make consolidation easier or harder in recent years?

A. It hasn't been that many years. But publishers have shifted — despite the complaints already mentioned! While health system purchasing is still new for publishers, they are getting more used to large multisite purchases. For the most part, though, pricing across multiple sites is still a custom endeavor, so it often takes a while for someone to get back to you with a quote. On the positive side, there's also more room for negotiation. It's more time-intensive, but there's also more opportunity.

Another change is the increased user expectation to get mobile access to everything, which can be challenging with the need for remote access authentication.

Q. You've been a champion of medical libraries marketing themselves. Do the same tactics hold in a merged system?

A. There are a lot of challenges in marketing libraries, period. I stand by my prior recommendations of a multifaceted approach that includes getting out of the library and taking initiative — such as attending rounds, then following up with relevant searches on points of uncertainty and articles about current issues.

But getting out of the library looks different when you are so geographically dispersed. And it is harder to market your services if your users and other colleagues are halfway across the state. If you know your own hospital's marketing manager, you can get an email list of all nursing managers. In a large system, finding the person who has the ability and authority to send an email to 100,000 people is hard.

You still reach out to individual users, and word of mouth is still effective. You follow up after a positive interaction and build champions who will spread the word. If we do great work for someone in a department, they tell their colleagues. Word spreads. We still seek out those extra touch points. But it looks different in an organization of this scale.

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Heather J. Martin, MISt, AHIP, serves as the director of system library services for Providence Health & Services (PH&S)

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