THE TAOS NEWS
Best U.S. Weekly Paper- NNA 2007,2008, 2010
Inland Press Nation's Best Weekly Newspaper 2009

Network might be difference for hospitals on the brink

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The Taos News, 6/30/2016

Guadalupe County Hospital in Santa Rosa is home to the only emergency room between Albuquerque and Tucumcari — a 173-mile stretch of Interstate 40 that spans the lonely eastern half of New Mexico. The small city is home to less than 3,000 people, making it the largest town in a county with less than 5,000. More than a quarter of the population lives below the poverty line.

For Guadalupe County's isolated and scattered populace, the hospital plays a critical role.

"If this hospital closes, my kids have nowhere to go. My neighbors have nowhere to go. My employees have nowhere to go," says Christina Campos, the hospital's CEO.

In New Mexico, this scenario — a remote hospital struggling to serve a poor community — is all too common. According to federal data, one-third of the state's population lived in "Health Professional Shortage Areas" in 2010. Thirty-one of New Mexico's 33 counties faced shortages.

Like most rural hospitals in the state, Guadalupe County has to fight to get by. Many of its patients rely on government health insurance, which often doesn't cover the hospital's costs, let alone provide a profit. That situation is only expected to get worse as the state faces a $417 million Medicaid shortfall.

At the same time, the needs are overwhelming. New Mexico often finds itself near the bottom of nationwide lists related to health and well-being. America's Health Rankings, for instance, placed the state 37th in 2015, partly due to high rates of diabetes, drug deaths and children living in poverty.

Finding collaboration

To better counter those challenges using its limited resources, Guadalupe County Hospital is teaming up with other small hospitals to share information, hire experts and offer advice on how to navigate an increasingly uncertain industry.

"We're all facing the same thing," Campos says.

In 2014, the Santa Rosa hospital and five others officially founded the New Mexico Rural Hospital Network, an initiative intended to improve cooperation — and with it, fiscal health — among small hospitals scattered across the state. The network now contains 10 members altogether, including Holy Cross Hospital in Taos.

"All of our hospitals are the only hospital in their town, sometimes even in their whole county or beyond," says Stephen Stoddard, the network's executive director.

The group's creation was aided by the U.S. Department of Health and Human Services, which regularly funds rural hospital networks to improve efficiency, expand access and

improve quality of care. In its most recent round of funding two years ago, the agency awarded a total of $11.6 million to 39 networks nationwide from Alaska to Maine.The New Mexico network received a $300,000 grant.

“Generally, the purpose of these hospital networks is to focus on helping them thrive,” Stoddard says. “But in the case of New Mexico, it’s to survive.”

Rural network

In some cases, that means creating economies of scale. For example, the network gives its members more leverage when buying supplies. One network in North Carolina helped save its members more than $20 million from 2002 to 2007. In New Mexico, some member hospitals have entered into group purchasing agreements, lowering prices on bulk purchases for necessities like bandages and bedpans. Guadalupe County Hospital has already cut its annual supply costs by nearly one-third, from $100,000 to $70,000.

But Stoddard says the real strength of the network is in building relationships and exchanging ideas. To that end, he has organized quarterly “peer committee” meetings in which employees doing the same job in disparate hospitals get together to talk shop.

“In an urban environment, there are lots of opportunities to collaborate and share ideas,” Stoddard says. “But in a rural setting, you’re often very isolated.”

Before the network’s creation, says Campos: “If you were a medical records office manager, you were the only one you knew. Now you have nine others that you can call on.”

That might sound simple. And obvious. But Stoddard explains that staff members in small hospitals suffer professional isolation that can hurt their performance and stifle innovation. And without a formal network, conversations that inspire learning and creativity — and, in turn, lead to cost savings — usually don’t happen.

That was true for Leslie Sanchez, who oversees medical records at Guadalupe County Hospital and has been part of the network’s committee meetings for about a year. “It was just nice to be able to hear their experiences and their problems and realize, ‘Wow, I’m not the only one going crazy,’” Sanchez says.

Finding a fix

Sanchez says one of her greatest challenges is getting doctors to finish paperwork so she can code procedures and submit them for payment. If that paperwork doesn’t get done, the hospital doesn’t get paid.

According to Sanchez, another records clerk in Lovington has experienced the same problem. So he developed a series of emails to prompt doctors to complete paperwork. It was a basic approach, but it was more structured, Sanchez says. And it works much better than her strategy of gentle nagging.

The network has also hired its own specialist to analyze contracts with insurance companies to ensure that terms are fair and comparable to other hospitals. That kind of expertise would be hard for any one of these hospitals to afford alone.

Similarly, the network funded a salary survey, providing small hospitals useful hard data on New Mexico-specific labor costs.

Furthermore, the network is working with the University of New Mexico to draw more medical students to do rotations in rural hospitals. Studies have found that attracting a medical

student to a small hospital makes it easier to later hire them when they finish school. Although many of the 10 hospitals have previously tried to combat retention problems on their own, the existence of the network gives these small facilities more to offer medical students, Stoddard says.

For all the group's accomplishments, its success remains tenuous. It's not clear whether cooperation and bulk purchasing will be enough to keep small hospitals viable. But network members say it can't hurt.

In the short term, the big concern is whether this nascent network can survive after its federal grant funding runs out next year.

"That's the question," says Bill Patten, CEO of Holy Cross Hospital in Taos. "How do we achieve sustainability? We don't want to develop a network if it's just going to end after three years."

According to Patten, the decision to join the network a few months ago was "low risk." Holy Cross gets all sorts of benefits for basically no cost. Each hospital now pitches in a few thousand dollars. But it will take much more to keep the network running.

The good news is that a 2012 study found that 83 percent of rural health networks were still in operation two to four years after losing their federal funding, thanks in some cases to small state grants that picked up the slack.

If the network can prove its worth to its members, they might be willing to shell out more money or find funding elsewhere — and face these challenges as a group rather than going it alone.

Steve Rozenboom, CFO at Holy Cross Hospital, has been in 'peer committee' meetings with others doing the same job and small hospitals across NM.

Katharine Egli
