

# RETAINING AUTHENTICITY IN THE RUSH TO MERGE

BY SR. MARY HADDAD, RSM, M.S.W.

In 1849, San Francisco newspapers reported that gold had been discovered along the American River near present-day Sacramento. For most readers of these local papers, it was just another good story. But when a storekeeper in San Francisco displayed a bottle filled with gold dust and shouted, “Gold! Gold from the American River!” the locals had proof. Word spread quickly, and the California Gold Rush began. People came from far and wide, abandoning jobs and families for the gold fields of California. “*California or bust*” became the cry of these fortune-seekers. Life would never be the same.

Fast-forward to 2013, and a new type of gold rush appears to be in full swing as newspapers across the country report story after story of new business arrangements being formed within the health care industry. Mergers, affiliations, strategic alliances and clinical integration have become common parlance, with hospitals, health systems, medical group practices and health plans now equal players in these lead stories. No one wants to be left behind.

Catholic health systems are not exempt from this modern gold-rush mentality. Over the past few years, we have seen partnerships develop between Catholic systems and other faith-based, secular and investor-owned entities. Caught up in the momentum, the pursuit of new business arrangements has become the strategic priority for the majority of the Catholic health ministry. But the rush to form partnerships for the sake of expansion is cursory at best. The intensity and rapidity of these developments prompt deeper questioning. Is our mission at risk of being compromised in these new business arrangements?

Haven't we been here before? Remember the integrated delivery networks (IDN) of the 1980s and 1990s. Someone cried “Capitation!” and before the gold dust settled, the mantra quickly became “Integration or bust!”

The rush was on to employ new strategies. Vertical integration included acquisition of primary care physicians; strategic alliances with physicians in physician-hospital organizations and management services organizations; and development of health maintenance



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organizations and preferred provider organizations. Simultaneously, horizontal integration brought about the formation of multihospital systems and local integrated networks.

With the help of group purchasing organizations, we believed that these new alignments would position IDN members to better negotiate competitive payer contracts, physician relationships and to enhance supplier relationships. The concept of capitation, however, was never fully realized. Perhaps the strong emphasis on increasing in-network utilization obscured the real purpose of integration: to improve patient care. After all, the World Health Organization defines integrated care as “a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency.” This understanding of integration is at the heart of health care reform.

Moving from a health care model driven by utilization to one based on quality and efficiency requires multifaceted changes: changes in the payment model, changes in the delivery model, new technologies and new relationships. The effects of financial pressures brought about by a federal budget deficit, volatility in the credit markets and high unemployment supplied ample proof that the current health care system is unsustainable. The Affordable Care Act (ACA) provided the necessary nudge needed to drive the changes. The ACA's primary aim is to increase access to care by increasing coverage and reducing costs. Additional reforms aim to improve health care outcomes and streamline the delivery of health care.

Today, the transformation of health care is in full swing as new organizational models are being created to manage the health of populations through

improved coordinated care while increasing accountability for quality, cost and service. One such model, the Accountable Care Organization (ACO), seeks to provide a defined population access to coordinated care and chronic disease management with payment based on quality goals and outcomes that result in cost savings. This model requires mergers, affiliations, strategic alliances and various other

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new business arrangements that create the necessary working relationships among health care providers in order to deliver a full range of services.

Catholic health care is experiencing the impact of this transformation in many ways, but the formation of ACOs seems to be the focus of our attention. These new business arrangements are raising theological and ethical questions for the Catholic health ministry. “What does Catholic identity mean in a new health care environment?” has become the essential question. Throughout the past year, the Catholic Health Association has convened members to consider how we remain authentic to our core purpose while enhancing collaboration and partnering with others.

At the risk of seeming simplistic, it is important for us to recognize that a partnership is much more than a legal arrangement. Partnership is created and nurtured through relationship. An inherent mutuality exists. Social sci-

ence and the study of human behavior have revealed that interpersonal relationships influence identity development and formation. This theory holds true for organizations as well. Relationships, and in this case partnerships, contribute to the formation of organizational identity. Given this, perhaps an additional question needs to be considered when forming new partnerships on Catholic health care: Does the partnership enhance and nurture who we are, or does it diminish our Catholic identity?

In 1970, singer/songwriter, Neil Young released the album “After the Gold Rush.” The title song's allegory-filled lyrics seem to speak of an uncertain future as Young questions what will endure. It appears that similar uncertainty exists today as we ponder both the impact of a transformed health care industry and what we believe will be the enduring characteristics of the Catholic health ministry.

During the Gold Rush, “forty-niners” frequently left behind jobs, homes and dependent families for the promise of a payoff in the California gold fields. For many, their hopes and sacrifices yielded nothing. Although “gold rush” may not be a perfect analogy, that chapter in our national history might serve as a reminder for those of us in Catholic health care. We need to pause and consider what may be at risk, what critical components of our heritage may be lost, as we move into a new health care environment.

The primary task before us is to articulate the essential elements of our identity that must endure for the sake of Jesus' healing mission as we lead the Catholic health ministry into an uncertain future.

Of this, we can be certain.

**Sr. MARY HADDAD, RSM**, is senior director, sponsor services, the Catholic Health Association, St. Louis. Contact her at [mhaddad@chausa.org](mailto:mhaddad@chausa.org).

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