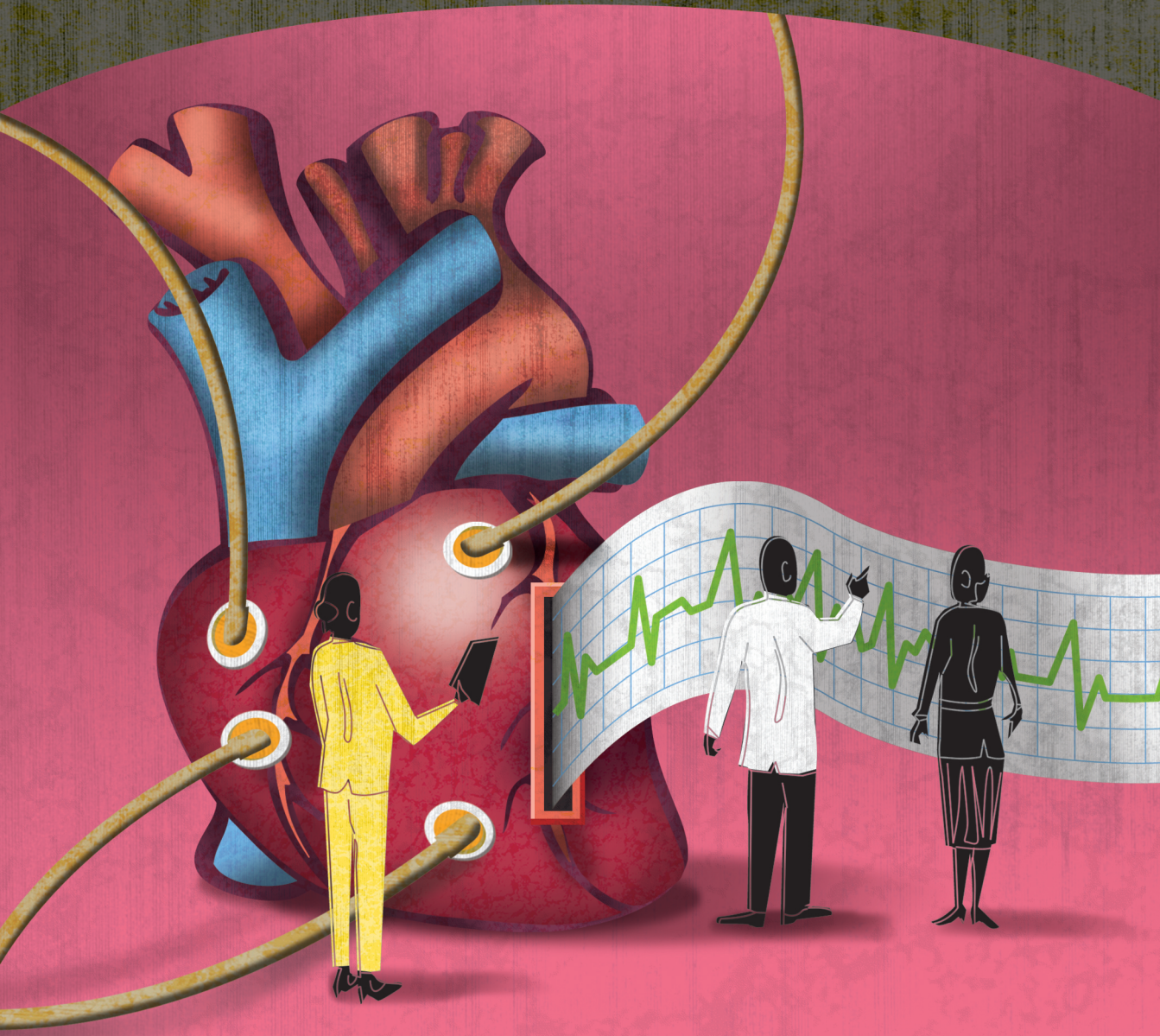
STRATEGIES FOR SUPERIOR CARDIOVASCULAR SERVICE LINE PERFORMANCE



ECG MANAGEMENT CONSULTANTS, INC.

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As an ECG consultant, Mr. Halverson has worked with AMCs on projects relating to strategy design, financial analysis, and business planning. He has expertise in evaluating and designing economic arrangements between medical schools and affiliated teaching hospitals. Prior to joining ECG in 2000, Mr. Halverson worked in the healthcare strategy practice of a nationally recognized management consulting firm. He holds master's degrees in healthcare administration and public health from the University of Minnesota Carlson School of Management, with concentrations in financial management and quantitative methods.

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A consultant since 1990, Mr. Kennedy has assisted dozens of hospitals, health systems, and medical groups with their strategic, financial, and operational challenges. He has expertise in operations improvement, hospital/physician relationships, and physician compensation planning. Recently, he's developed several hospital/physician cardiac joint ventures, facilitated cardiology practice acquisitions, redesigned compensation plans for hospital-employed cardiologists and CV surgeons, and conducted operations improvement studies in both inpatient and outpatient settings. He holds a Master of Business Administration from The University of Chicago and a Bachelor of Science in business administration from The University of Arizona.

Managed Care Services Affinity Group

ECG's Managed Care Services Affinity Group is responsible for the thought leadership and knowledge development of the firm's Managed Care Contracting practice, which focuses on all matters related to provider reimbursement. The group has extensive experience in the area of managed care and provider reimbursement, including strategy development, the development of reimbursement structures, health plan contract negotiations, and operations. Key contributions were made by the following members of the group:

- Ms. Terri L. Welter, principal, leads the firm's managed care contracting practice. She has more than 15 years of experience assisting hospitals and medical groups in the financial planning, assessment, and negotiation of their health plan contracts.
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Mr. Messinger has extensive experience in strategic and business planning, business development, mergers and acquisitions, and managed care. He has worked with a broad range of healthcare organizations and has assisted hospitals, health systems, and physician groups in CV strategy development and performance improvement. Mr. Messinger earned a Master of Health Services Administration from The George Washington University and a Bachelor of Science in clinical sciences from Cornell University.

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Ms. Reed has broad experience in strategic planning, financial analysis, service line development, and hospital/physician alignment. She has expertise in CV services and has worked with numerous clients on their CV service line and programmatic needs. In addition, she is a member of the firm's cardiovascular affinity group and helped spearhead ECG's recently published *Cardiovascular Service Line Management Survey – Key Findings and Implications*, publication date 2009 based on 2008 data, in partnership with Thomson Reuters.

Ms. Reed holds a master of business administration degree from the University of Washington Michael G. Foster School of Business and a bachelor of science degree in biology from The University of Texas at Austin.

About ECG

ECG MANAGEMENT CONSULTANTS

ECG offers a broad range of strategic, financial, operational, and technology-related consulting services to healthcare providers. As a leader in the industry, ECG provides specialized expertise to community hospitals, academic medical centers, health systems, and medical groups. For nearly 40 years, its approximately 80 consultants have played an instrumental role in developing and implementing innovative and customized solutions that effectively address issues confronting healthcare providers. ECG has offices in Seattle, Boston, Washington, D.C., San Diego, and St. Louis.

At the heart of its expertise in CV services is an understanding of the competencies needed to differentiate top-performing CV service lines. ECG has had the pleasure of working with premier CV programs, helping them build and develop service line strategies and structures. In addition, it has conducted industry-leading research to understand the mechanics of the best-in-class programs.

CHAPTER 1

Creating a Successful Cardiovascular Service Line

The market dynamics for cardiovascular (CV) services are changing rapidly, driven by new approaches to payment, more educated consumers, mandatory outcomes reporting, and purchasers searching for greater value. In the past, hospitals focused on creating a positive image or brand identity. Today, the solid reputation of a hospital in the community no longer ensures success. Rather, each of a hospital's clinical programs will succeed or fail based on its individual ability to respond to the needs of three separate constituencies—patients, payers, and physicians. This is especially true of CV programs. There is clear evidence that patients, payers, and physicians are beginning to shop not just for the best hospital, but also for specific programs that can demonstrate their value by combining clinical quality, economic efficiency, and patient satisfaction. Medicare demonstration projects showcasing bundled payments are a harbinger of future reimbursement schemes that will attempt to align incentives across various parts of the healthcare system, and the service line organizational structure seems ideally suited to this new environment. Because of the large dollar amounts involved and the prestige associated with a quality CV program, we believe these issues will affect CV programs sooner and more acutely than other service lines.

In response to these pressures, most hospitals have taken at least preliminary steps to develop CV service line structures that improve performance, encourage physician involvement, and seek to gain competitive advantage. The level of this activity varies widely, from those just initiating the service line to those that have a decade or more of experience and may be on their third or fourth permutation. Even though there are remarkable success stories, most hospitals' CV service line activity is still a work in progress, and in many facilities, the CV service line is stagnant or foundering.

Understanding service line principles and options is essential to ensuring that a hospital's CV program can reach its potential. The first key point to understand is that the decision to organize CV programs as a service line is not monolithic. It should be thought of as at least eight different decisions, each of which can be considered separately. Although these issues are related, CV program design can and should be tailored to your hospital's specific needs and environment.

Introduction to Service Line Principles

A service line is organized around patient diagnosis to provide coordination of care and accessibility of information over time, regardless of where the care is provided or who provides it. Service lines are typically recognizable to patients and caregivers as rational collections of inpatient and ambulatory services that a patient may require during treatment for an episode or condition.

What features characterize a service line?

For years, hospitals have advanced a range of programs under the heading "service line," but a center of excellence, product line marketing, logo, or an occasional team meeting does not constitute a mature service line unless the following features are also present:

- Is recognized by physicians, management, and patients as a collection of services needed for specified conditions
- Provides a single point of patient access throughout the treatment process
- Offers coordinated provider teams for patient-based services and care
- Incorporates standardized processes, protocols, and outcome measurements
- Reports financial, operational, and quality-of-care data at the service line level
- Demands full alignment of physicians, staff, and management across all sites of care
- Offers participation in strategic, operational, and financial decision-making for key providers
- Has a unified management control structure that governs critical operations and the strategy regarding service line delivery assets

What services should be structured as a service line?

Consideration for a service line should focus first on those areas where the hospital has established experience. Progress will be more rapid and greater

value will be created by organizing existing expertise rather than starting from scratch. Second, the service must have a significant ambulatory component because coordinating services and clinical information across varying sites is what adds value for stakeholders. Third, the service must have the potential for profitability. If increasing market share only leads to greater financial losses, investing time and money is difficult to justify. Finally, service lines typically have an element of multidisciplinary care that benefits from the coordination and superior information flow that service lines provide.

CV programs are arguably the most common service lines to be developed by a hospital, followed by oncology, women and children, neuroscience, and orthopedics. These services meet the criteria introduced earlier and are often a priority for payers in terms of demonstrating quality and efficiency in the delivery of care. Smaller and/or more narrowly focused programs can also meet the criteria for service line development and should be given consideration—especially if physician leadership is available.

Key Elements for Service Line Success

When considering a new service line or enhancing an existing service line, the following eight key elements must be addressed.

1. Service line composition

The first and most basic question might be, "What services are included?" This question may seem simple at first glance, but determining which activities

should be managed by the service line structure gets significantly more complex when you consider that many of these services could be claimed by multiple hospital departments. CV surgery, for example, could be part of the operating room (OR) or part of a CV service line. Similarly, many CV imaging services could "belong" to the diagnostic imaging department. (Figure 1.1 shows a typical list of CV services that most would agree are appropriate for a fully developed service line.) The decision of which services should be controlled by CV service line governance and management features is therefore critical and often fraught with internal "turf battles."

FIGURE 1.1

TYPICAL SERVICES INCLUDED IN A COMPREHENSIVE CV SERVICE LINE

Screening and Early Detection	Treatment, Diagnosis, and Follow-Up	Support Services	Education and Outreach
• Blood pressure. • Carotid Doppler. • Cholesterol testing. • Diabetes screening. • Dietary consultation. • ECG. • Echocardiogram. • Electrophysiology consultation. • Exercise stress test. • Noninvasive imaging. • Screening for peripheral artery disease.	• Angiography. • Calcium scoring. • Cardiac surgery. • Catheterization. • Heart failure management. • Interventional cardiology. • Pacemaker/ICD implant. • Medical therapies. • MRI/PET. • Radiofrequency ablation.	• Cardiac rehabilitation. • Diet and exercise consultation. • Mental health counseling. • Palliative and supportive care. • Smoking cessation.	• Community seminars, CME for physicians. • Dietary consultations. • Pamphlets. • Participation in turnkey programs. • Self-assessment risk questionnaires.

2. Management/organizational models

Service lines are emerging as the organizational backbone of many hospitals, with well-defined business units replacing the traditional "siloed" organizational structure. There is a continuum of organizational ideas on how to best run a service line (see Figure 1.2).

Organizations seeking benefits of the service line concept without radical adjustments to their organizational structure often begin with creating a "coordinator" position. This role typically represents the service line in organizational decisions but has no actual operating authority. The coordinator role is often a thankless one, since this individual has accountability for CV program development and progress but has no formal authority to make the changes required to

FIGURE 1.2

RANGE OF MANAGEMENT STRUCTURES UTILIZED

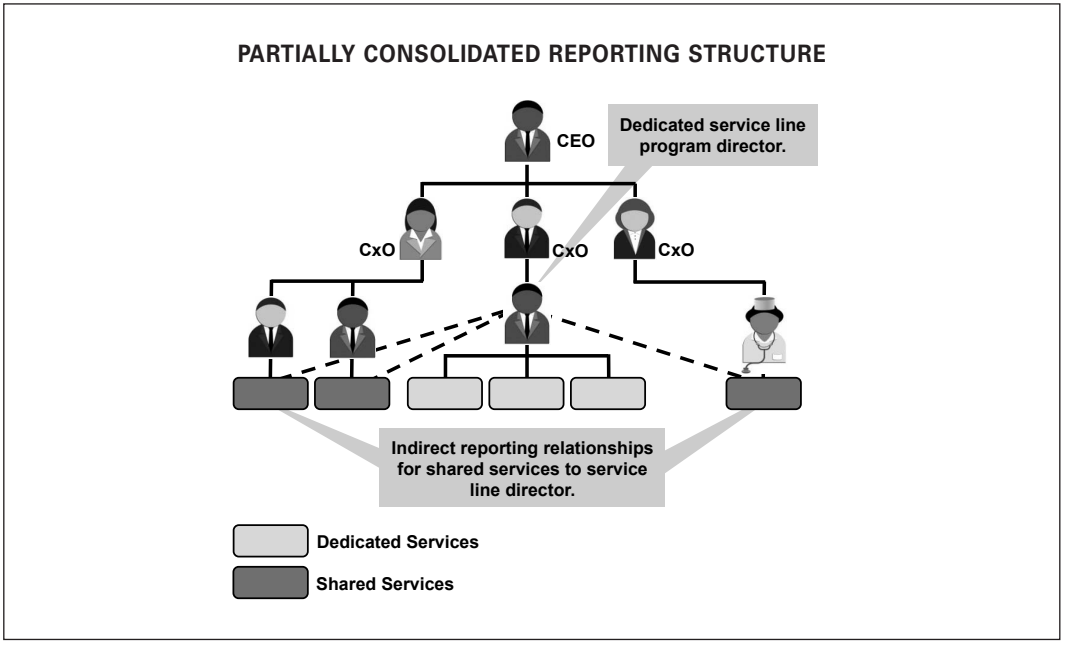
Model	Description	Relative Effort Required to Implement	Relative Effectiveness
Matrixed	Key and shared service line areas have an indirect reporting relationship to service line coordinator.	Medium	Low to Medium (Depending on Physician Alignment and Senior Leadership Commitment)
Partially Consolidated	Key service line areas are under the direct control of service line administrator. Shared services have an indirect reporting relationship.	Medium to High	Medium to High (Depending on Physician Alignment and Senior Leadership Commitment)
Fully Integrated	All areas within the service line report directly to service line administrator, who is fully dedicated to service line management.	High	Medium to High (Depending on Ability to Integrate with Nursing)

achieve these goals. Instead, this position will succeed or fail based on the ability to influence individuals through persuasion, data, and appeals to the greater good of the institution. Strong executive support is required for this position to be successful—and a well-functioning governance structure is also helpful.

Some of the key decision-making authorities that generally vary with the service line model chosen are budgetary control and hiring and termination of staff and physicians within the service line. Organizations that invest the service line leader with real authority by giving him or her these management responsibilities can dramatically increase the effectiveness of the service line lead, almost irrespective of structure. However, if an organization is seeking the most integrated model and does not provide the leadership with these responsibilities, it will substantially suboptimize the ability of management to achieve the desired results of the more highly integrated model.

The next step is to assign operational accountability to the service line manager. Typically, the direct-reporting areas are those that do not significantly interact with other hospital departments. For CV services, the only easy decision is the cath labs, and even that is challenged by vascular surgeons and interventional radiologists, who see these labs as critical to their own success and may resent the influence provided to cardiologists under a service line. As with any matrix structure, it is critical to specifically define what is signified by the dotted line (see Figure 1.3).

FIGURE 1.3



Under a fully integrated model, the health system views the service line as the primary organizational unit. Ideally, support services departments (nursing, information technology, finance, etc.) will view the CV service line director as an important client, and he or she will report directly to the chief operating officer or CEO. Like the other structures, this model has trade-offs, specifically that decisions can sometimes be made in a vacuum without fully considering the impact on non-CV departments. However, physicians and managers tend to enjoy this structure the most since it simplifies the decision-making process. This structure typically requires significant scale to be effective.

3. Governance structures

The allocation of resources and close coordination of services across sites of care, physician specialties, ancillary services, and support departments are central to effective CV service line development. Policies, procedures, and protocols need to be developed that are distinct from those of the traditional hospital, and these should be based on collaboration between providers and managers. The governance structure determines, to a large extent, who makes key operating decisions affecting CV services and how those decisions are made.

The complexities of service line management and the difficulties of breaking down barriers between multiple care disciplines demand a high level of physician involvement. A service line governance structure that engages physicians will not only result in massive improvements in decision-making and resource allocation, but also will secure physician commitment to service line success.

When developing a service line governance structure, it is necessary to consider how representation will be determined, specifically the number of seats and how they might be apportioned across groups, specialties, or campuses. (See Figure 1.4 for a full range of CV service line governance structures). This is critical for CV services because of the potential for conflict across specialties.

FIGURE 1.4

RANGE OF CV SERVICE LINE GOVERNANCE STRUCTURES COMMONLY UTILIZED

	Limited Governance	Ad Hoc Committee	Standing Committee	Leadership Board
Overview	■ No established mechanism for governance. Individuals informally consulted.	■ Formed to discuss specific issues (e.g., new products, workforce planning) as they arise	■ Established governance body responsible for wide range of oversight functions	■ Board maintains complete accountability for service line performance reporting directly to hospital CEO
Strategic Planning	■ No role	■ Informed	■ Advisory	■ Advice, direction, and approval
Management Selection	■ No role	■ Input into hiring	■ Input into hiring, performance review	■ Accountability for hiring and firing
Budgeting	■ No role	■ Occasional advisory	■ Advisory	■ Advice and approval
Physician Composition	■ Individual physicians may be consulted	■ Limited physician involvement	■ Significant physician composition	■ Majority physician composition

4. Management composition

The question of day-to-day management and accountability for performance of the service line is often given too little thought. A service line administrator can be given responsibility for operations. Although management by an administrator is familiar and easy to implement, the interdisciplinary nature of service lines and the increasing importance of clinical standardization suggest that a physician medical director should be part of the team. Shared management responsibility can be difficult to implement, but it is central to creating both quality and efficiency in a CV service line. Alternative approaches to management are shown in Figure 1.5.

FIGURE 1.5

ALTERNATIVE APPROACHES TO SERVICE LINE LEADERSHIP

Administrative Director	Physician Leader	Dyad Leadership
Philosophy: A highly trained, experienced manager who understands the organizational, operational, and financial implications of running a successful service line is best equipped to lead these complex enterprises.	Philosophy: Physician leaders may be best prepared to ensure quality and safety, achieve patient outcome goals, pursue service development opportunities, and foster relationships with key physicians.	Philosophy: The benefits of having both the clinical expertise of a physician and the business experience of an administrator may outweigh the added complexity that accompanies a dyad leadership structure.
Benefits and Concerns	**Benefits and Concerns**	**Benefits and Concerns**
■ An experienced administrator may have a better understanding of the business aspects related to service line organization and development. ■ It may be easier to facilitate effective communication between administrative staff and physicians. ■ The medical staff may relate better to a physician leader.	■ Physicians have a unique understanding of the healthcare environment, which may result in improved patient outcomes and clinical coordination. ■ It may be easier to recruit top physician talent under this model. ■ It is difficult to find a physician leader who has business experience and can balance the clinical and management demands of the position.	■ Each leader brings a specialized skill set to the organization, integrating a patient care and clinical focus with a hospital business focus. ■ A more effective line of communication is created between administrative and medical staff. ■ A dual reporting relationship introduces additional complexities into the system. ■ Lines of authority may blur, leading to confusion or inefficiencies.

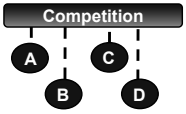
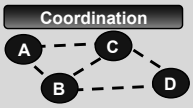
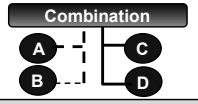
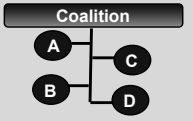
5. Physician alignment

The critical objectives of most CV programs—growth, patient care protocols, outcome measures, enhanced patient experiences, and meaningful efficiency improvements—are not likely to emerge from traditional relationships between hospitals and independent physicians. The basic alternatives to unaffiliated practices are to offer medical directorships (essentially buying clinical input); develop contractual relationships (lease arrangements, joint ventures, gain sharing, etc.); or to employ physicians. There are benefits and drawbacks to each of the options. However, our experience suggests that a combination of approaches may be most useful and practical, depending on the unique characteristics of each situation.

In addition to the relationship between physicians and the hospital, consideration should be given to the relationships among different CV specialties that will be part of the service line. The interdisciplinary nature of CV services places a premium on cooperation between physicians, and so ensuring the desired level of collaboration, especially among physicians who may be competing for patients or resources, is a major management challenge (see Figure 1.6 for some of the structural variety in these relationships and the implications of each).

FIGURE 1.6

PHYSICIAN ALIGNMENT CONSTRUCTS

State of Alignment	Description	Strategic Priorities
	Each subspecialist is independently affiliated with the hospital. Clinical integration is lacking, and groups compete for patients and available resources.	▪ Forming a strong, physician-led governance body. ▪ Building trust and coordination between groups through modest joint initiatives (e.g., service line dashboards, joint outreach clinics, coordinated physician referrals).
	Subspecialists remain independent but take a coordinated approach to referral relationships and physician recruitment.	▪ Clearly aligning economic incentives. ▪ Developing more complex joint service line initiatives, such as program development and service line marketing.
	Some specialists remain independent, while others are formally employed by the hospital.	▪ Building trust between employed and independent physicians. ▪ Aligning the financial incentives of all physicians regardless of employment status.
	All subspecialists are employed, resulting in a unified and coordinated physician workforce. Program planning, resource allocation, and physician recruitment are aligned.	▪ Developing a compensation plan that aligns physician and service line incentives and accounts for the unique needs of each individual subspecialty. ▪ Ensuring physician engagement in service line planning and governance.

6. Financial management

Hospital financial management systems—characterized by granular "cost centers" and more general revenue reports—are not well suited to the

cross-divisional and multidisciplinary management needs of most service lines. To accurately measure financial performance, each service line should be accounted for as if it were a separate business unit, with all revenue and all costs for each patient allocated back to the service line. For example, if a CV service line patient is seen in the clinic and then has a CV surgical procedure and a three-day hospital stay, the revenue from all three services should be credited to the service line. Likewise, the cost associated with each service should be charged to the service line through a system of transfer pricing within the hospital. (See Figure 1.7 for the range in financial reporting structures.) This may be difficult to achieve, but basing accounting on service lines can provide significantly improved data for the management of the organization, enabling better decisions on resource allocation.

FIGURE 1.7

RANGE OF FINANCIAL REPORTING STRUCTURES

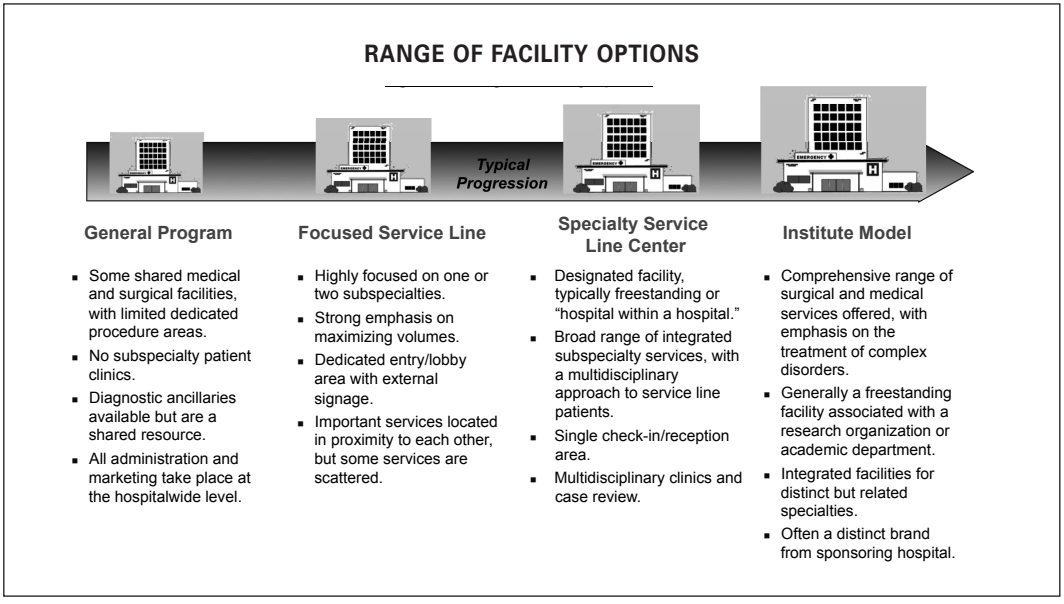
Model	Description	Considerations	Relative Effort and Effectiveness
Traditional Reporting	Traditional structure; each cost department is accountable for creating and maintaining its own budget (e.g., cath lab, OR, and cardiology clinic all have separate budgets and financial statements).	▪ Requires no additional implementation. ▪ Necessitates a manual collection process. ▪ Provides ambiguous reports on overall service line performance because of different reporting systems.	Low
Structured Service Line Reporting	Partially integrated financial structure; some financial reporting methods are consolidated to provide more comprehensive service line performance reports.	▪ Requires the development of a standardized reporting process to ensure the development of comparable financial reports. ▪ Provides some indication of overall performance, but results are often still ambiguous. ▪ Is a somewhat labor-intensive process.	Medium (Depending on Extent of Decision Support Services)
Integrated Service Line Reporting	Fully integrated financial structure; the cardiac service line has one budget for all cardiac-related facility and management services and reports integrated financial statements.	▪ Offers the most accurate method for assessing service line performance. ▪ Requires a more comprehensive financial reporting system. ▪ May be a labor- and cost-intensive implementation process.	High (Depending on Extent of Decision Support Services)

7. Facilities

From a patient's perspective, nothing says "organized care" more clearly than being able to see all major components of the continuum of care immediately upon entering the lobby. Proximity of related services is inherently comforting to patients. From a practical standpoint, locating related services near each other provides opportunities for information sharing, reduced travel time for staff, and more immediate identification of work flow and bottleneck issues.

Dedicated "heart hospitals" are the ultimate ambition of nearly all CV service line managers, and are among the most difficult to achieve due to constraints on capital, real estate, and the necessity of shared services that support other hospital departments. Nevertheless, a facility strategy needs to be part of any service line plan. This is inherently more difficult for CV services that tend to blend inpatient and outpatient services. At a minimum, a hospital should group service line components as close together as is practical. Other details, such as a dedicated entry and common signage, will provide comfort to patients, impart a sense of coordination, and help establish a brand identity. Since most CV patients will visit a physician before needing a hospital stay, integrating CV clinics with hospital-based services should be a priority. (See Figure 1.8 for the continuum of facility options.)

FIGURE 1.8



8. Information management

For a CV service line to be successful, it should be able to demonstrate that its outcomes are better, its costs of care are lower, and its patient satisfaction is high—in short, that it is providing greater value than its competitors. The driving principle of service lines is that coordination of services creates improved quality and efficiency. Gathering and reporting data that measures performance is crucial and is a major shortcoming in many of the service line initiatives that we have reviewed. Database requirements for a fully developed service line include:

- Patient encounters by site
- Diagnosis

- Treatments
- Outcomes of care
- Cost of care by diagnosis and treatment
- Financial performance of the service line
- Patient satisfaction

Furthermore, each of the metrics needs both internal and external benchmarks to measure improvement and to demonstrate performance relative to competitors. CV surgery is among the most measured and benchmarked services provided anywhere in the hospital, and most top programs invested long ago in the necessary staffing and information resources to measure performance and outcomes. Committed CV programs devote the financial and staffing resources to utilize these databases and track institutional progress against these measures.

Implementation Issues

The theoretical considerations of the service line design elements discussed in this chapter can present challenges, but in practice these may seem trivial compared to the implementation barriers. We have found two major potential roadblocks to service line implementation: institutional culture and physician leadership.

Institutional culture

Service lines demand the integration of traditionally siloed hospital functions. While this is a positive development, it represents potentially significant

change within the established hospital hierarchy. Management in nursing, finance, ancillary services, and employed physician clinics will be challenged to respond to service lines' needs in these environments. For instance, nursing within a service line may entail staffing for physician offices, diagnostic and procedure centers, patient education programs, and inpatient care. CV service line leadership will seek nurses with specific expertise who are dedicated to that service line and accountable to service line management. This may mean different pay levels for nurses, resistance to "floating" service line nurses to another unit, and a claim of ownership of the nursing staff by the service line. Nursing administration may have legitimate concerns related to education and enforcement of nursing standards and may resist accommodating such changes.

Other hospital departments and members of the medical staff will face similar pressures, and intramural disputes can be expected. For hospital executives, the technical challenge of how best to organize a CV service line may end up seeming easy compared with the management challenge of getting employees to embrace it.

Physician leadership

CV service line development demands tight alignment of physician and hospital interests, and getting there is often the most challenging aspect of service line management. Regardless of the structures used to align with physicians, hospitals with successful service lines acknowledge the requirement of physician champions and the importance of ceding true clinical and operational power to physician leaders.

Physicians, for their part, often do not realize that the input they have long sought can be achieved through service line management. Few hospitals have ongoing programs to identify and develop physician leaders, and many of our clients find it frustrating to cultivate signature programs because physician leadership cannot be found. From a different perspective, many of our academic health system clients have built distinguished clinical service lines due in large part to the power and vision of clinical department chairs.

Unfortunately, it is rare for a community hospital to have a physician with both the interest and the ability to lead a service line. So it is tempting to appoint the physician with the strongest technical skills to this position, the assumption being that the physician's strong clinical reputation corresponds with his or her ability to lead. However, the skills required for this type of role more often resemble those of a compromise-crafting politician. Often, the hospital has to identify a doctor with potential and then work to create the interest and skills necessary to be an effective leader. Hiring from the outside should be carefully thought out, since there is a danger of antagonizing existing providers. The challenge for CEOs is to first acknowledge the importance of physician leadership and then invest in the structure needed to make it happen.

The Future for CV Service Lines

It is appropriate to ask if service lines are simply the most recent manifestation of a 30-year organizational fad or if they will have a long-term impact on hospitals. Existing trends point toward the likely future direction of service lines. In the near term, hospitals will probably be focusing on the one, two, or three

service lines that can best attract patients, providers, and payer contracts. For many hospitals, if not most, this will include the CV program. In this short-term scenario, service lines are essentially an "add-on" to the organization's business. Over time, however, service lines have the potential to *be* the organization's central business. Today's generalist hospital with limited coordination between hospital and ambulatory services will be replaced by coordinated groupings of inpatient and outpatient facilities interconnected by a shared organizational culture, value-driven leadership, and IT infrastructure. In most of today's tertiary centers and advanced community hospitals, an advanced CV service line will be a critical component of that structure.

The underlying (perhaps unsettling) implication is that many hospitals and health systems are not likely to remain as full-service providers. Providing the full range of services to all patients is simply not going to work in an era of focused competition, limited resources, and empowered patients. With the increased availability of effectiveness data to both payers and patients, services must be highly rated for both cost and quality or they will fail in a competitive marketplace. Thus, it is likely that markets will be split up by service line, with a relatively small number of providers in each niche and "turf battles" in emerging or contested services. We are starting to see the beginning of this evolution, with payer requests for proposals for services that are costly yet data-rich—especially CV services.

Fundamentally, service line development must be viewed as a major organizational commitment, and service lines should be carefully nurtured over time. It is likely that the future of an organization's service lines will determine the

future of the organization as a whole. Since many organizations have begun this transformational process with their CV programs, it may well be this critical service that sets the tone for the future of the organization and plays a critical role in its ability to compete in a very different healthcare landscape.

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