The Future of Health Care

The Mount Sinai Medical Center on Manhattan's Upper East Side

An Interview with Kenneth L. Davis, M.D.,
President and Chief Executive Officer, The Mount Sinai Medical Center

EDITORS' NOTE *Dr. Kenneth Davis attended the Icahn School of Medicine at Mount Sinai and completed a residency and fellowship in psychiatry and pharmacology, respectively, at Stanford University Medical Center. Upon returning to Mount Sinai, he became Chief of Psychiatry at the Bronx Veterans Administration (VA) Medical Center and launched Mount Sinai's research program in the biology of schizophrenia and Alzheimer's disease therapeutics. Davis was appointed CEO of The Mount Sinai Medical Center in 2003. Prior to this, he spent 15 years as Chair of Mount Sinai's Department of Psychiatry and was the first director for many of the institution's research entities. Additionally, he received one of the first and largest program project grants for Alzheimer's disease research from the National Institutes of Health (NIH). In addition to his role as CEO, Davis served as Dean of the Icahn School of Medicine at Mount Sinai from 2003 to 2007. He also served as President of the American College of Neuropsychopharmacology in 2006. In 2002, he was elected to the Institute of Medicine of the National Academy of Sciences, and in 2009, Yale University presented him with the George H. W. Bush '48 Lifetime of Leadership Award.*

Kenneth L. Davis

INSTITUTION BRIEF *The Mount Sinai Medical Center (www.mountsinai.org) encompasses both The Mount Sinai Hospital and the Icahn School of Medicine at Mount Sinai. The School of Medicine was established in 1968 and has more than 3,400 faculty in 32 departments and 15 institutes. It is listed among the top 20 medical schools by* U.S. News & World Report *and it ranks fifth in the nation among medical schools for NIH and other funding sources per investigator. The school received the 2009 Spencer Foreman Award for Outstanding Community Service from the Association of American Medical Colleges.*

Founded in 1852, The Mount Sinai Hospital is a 1,171-bed, tertiary- and quaternary-care teaching facility and one of the nation's oldest, largest, and most respected voluntary hospitals. The Mount Sinai Hospital is consistently ranked among the nation's best hospitals based on reputation, patient safety, and other patient-care factors by U.S. News & World Report. *Nearly 60,000 people were treated at Mount Sinai as inpatients last year and approximately 530,000 outpatient visits took place.*

What makes The Mount Sinai Medical Center so effective at providing consistent service?

Having very clear values and expectations and a stable management.

Is the health care industry effectively equipped to deal with the challenges it's facing?

The industry is at one of its most precarious points. The reality is that neither federal nor state government can afford the health care that this population is demanding. So we're all seeking solutions from options that are not palatable.

The easiest solution for payers has been to cut money to providers and that has largely affected hospitals. As a consequence, we have a business model that, as we project out over the next 5 to 10 years, is clearly failing the business. Hospitals that are in the most marginal areas with the highest proportion of Medicaid and Medicare are the ones going bankrupt. The future is going to be exceptionally challenging.

How critical is scale going forward?

Scale is going to be very important for a number of reasons: as we move away from a fee-for-service system and increasingly accept risk, the systems that will be most successful at accepting risk will be those that have the least hazardous actuarial profile, which requires having the largest population so that you can distribute the risk over a large number.

Size also matters because many hospitals are non-for-profit and have important social missions because of the communities in which they're embedded. If you have a small scale and you still have to support those mission-driven services that lose money, it's tougher to do so. In a much larger system, those mission-driven services can be shared over a bigger group of hospitals or centralized in only a few hospitals within the system.

How much are these challenges going to affect actual care?

We will increasingly move toward asking people to perform the highest level of their license, which they may or may not be expert at. The responsibility for disease prevention and management, at the patient and population levels, will reside with the entry-point provider, such as a nurse practitioner or primary care provider who is capable of providing that service at the lowest possible cost. Fewer of these patients will be referred to expensive specialists for treatment and monitoring.

This may work for the average patient. The problem is that we're forgetting the patients at the extreme who are the most vulnerable and require the most complex care. These people may not get the expert care they previously received and there will be consequences.

Will we see more care being provided at home and other distribution areas?

As ambulatory surgery has grown, the recovery from some surgeries that are relatively complex no longer occurs in the hospital but instead, it happens at home and that is more demanding for people.

Also, as our government has learned that 5 percent of patients on Medicare in the last year of life take 30 percent of the resources, they realize that it's less expensive to have people die at home than in the hospital, so the hospital will be used less for end-of-life care.

In addition, as super-ambulatory platforms continue to roll out, patients will have one-stop shopping for all of their ambulatory needs in nice settings that are totally integrated far from hospitals. Patients will increasingly disassemble in their minds the previously held concept that all care is part of a hospital.

Does the U.S. need to move away from fee-for-service medicine?

There is no choice. Paying per procedure has ultimately incentivized medicine to deliver too much medicine, resulting in a system that payers can't afford – and the payers are largely the federal and state governments. So they're going to demand that we move to a different model and accept risk with them.

However, as much as the payers thought the incentives to do too much were destructive, once we move towards a risk-sharing model, the new incentives may be to do too little and our patients will appropriately complain about people dying or not being diagnosed early enough. So doctors have to make certain there are quality metrics that accompany risk-sharing.

Will you be able to provide the quality you're known for in the future with these challenges?

We will because it's in our DNA, even if it costs us extra money. The question becomes, how much is society willing to pay to save a single human life? That hasn't been a part of this dialogue: the value of a single human life. ●