Redesigning the Healthcare System

The Icahn School of Medicine at Mount Sinai

An Interview with Kenneth L. Davis, MD,
Chief Executive Officer and President, Mount Sinai Health System

Kenneth L. Davis

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). Davis also served as Dean of the Icahn School of Medicine at Mount Sinai from 2003 to 2007 and 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, his undergraduate alma mater, Yale University, presented him with the George H. W. Bush '48 Lifetime of Leadership Award.*

INSTITUTION BRIEF *In 2013, the Mount Sinai Medical Center combined with Continuum Health Partners to form the Mount Sinai Health System (mountsinai.org), which encompasses the Icahn School of Medicine at Mount Sinai, and seven hospitals, as well as a large and expanding ambulatory care network. The seven hospitals – Mount Sinai Beth Israel, Mount Sinai Beth Israel Brooklyn, Mount Sinai Queens, Mount Sinai Roosevelt, Mount Sinai St. Luke's, New York Eye and Ear Infirmary of Mount Sinai, and The Mount Sinai Hospital – have a vast geographic footprint throughout New York City. Last year, the Mount Sinai Health System treated more than 3.2 million individuals in its inpatient, outpatient, and emergency departments.*

The Icahn School of Medicine at Mount Sinai was established in 1968 and has more than 5,000 faculty in 33 departments and 23 institutes. It is listed among the top 20 medical schools by U.S. News & World Report *and it ranks fourth in the nation among medical schools for NIH and other funding sources per investigator. The School of Medicine received the 2009 Spencer Foreman Award for Outstanding Community Service from the Association of American Medical Colleges.*

The Mount Sinai Hospital is ranked 16th in the nation by U.S. News & World Report *and earned "top rankings" in six medical specialties in the 2014 – 15 "Best Hospitals" guidebook. Also ranked nationally was the New York Eye and Ear Infirmary of Mount Sinai (No. 10 in Ophthalmology); Mount Sinai Beth Israel, Mount Sinai St. Luke's, and Mount Sinai Roosevelt were ranked regionally.*

How has the creation of the Mount Sinai Health System positioned you for the future?

The hospitals gave back an awful lot of money in the Affordable Care Act (ACA) in exchange for what they thought would be increased access. But that increased access has been minimal, particularly in places like New York, which had a very generous Medicaid program to begin with. The cuts have not only been real from the ACA but they have to be added to a number of things that the Centers for Medicare & Medicaid Services (CMS) has cut in order for them to try to bend the cost curve.

So the group of providers that are under the most pressure as healthcare changes are the hospitals, and those with the biggest problems are those with the social missions: the hospitals that support the communities that have the largest Medicare and Medicaid populations.

Before we formed the relationship with Continuum, about 62 percent of our patient base was Medicare/Medicaid, and it has pretty much remained exactly on that trajectory with Continuum..

Communities that need full spectrum hospitals with robust emergency rooms have real problems with the margins they can generate from those businesses that are required in order to meet the social responsibility of a mission-driven hospital.

So how do we meet our mission and sustain our values in an environment of shrinking revenues?

One of the ways is to move away from fee-for-service medicine toward population management. The corollary of much of our Medicaid and Medicare populations is that they're very high users of services in an unmanaged care system. The opportunity to manage their healthcare better and spend less money while providing better care is quite real in those populations.

As we looked over our spectrum of hospitals and the patients they serve, we realized the opportunity to provide robust care management and population management was quite real and perhaps a much more effective business model.

But to do that, we needed to integrate clinical services, to end duplication of services, to enhance primary care, to give alternatives to emergency room care, to have alternatives to specialty care, and to really redesign what a healthcare system should look like.

One of the great things about the Continuum system was that it had a robust primary care network that we could build upon. We could consolidate services, decrease expenses, manage care, and generate a different business model.

Additionally, we knew that the traditional corporate services could also provide some opportunity for savings. We can consolidate information technology functions, human resource functions, and development and marketing, as well as provide more robust contracting from our suppliers, manage the supply chain more effectively, and consolidate finance, billing and collections.

It's a big job, but we're starting to see real traction.

Are we looking at a future with a handful of very large healthcare systems?

Some will say the United States will ultimately move toward a two-tiered system of healthcare where you will have core insurance that will have high deductibles and limited preventive care covered through relatively inexpensive policies. The more affluent will supplement their insurance with more robust insurance, which will allow them to access any doctor, and they won't have to worry about narrow networks and won't have the kind of co-pays that discourage the utilization of services.

If we move to that two-tier system, there will always be smaller niche hospitals that provide great care that can service that community.

In this business, geography is destiny and if their hospitals are in the right geography, they may be able to do that. But we are talking about what will be a change in healthcare because the states and Feds will still be the biggest payers, and they're going to necessitate that we spend a lot more time on prevention and wellness, end unnecessary testing, and be far more efficient at providing value.

In those kinds of systems, it is hard to do that if you're small. ●