Mark Taylor

EDITORS' NOTE *Mark Taylor is President and Chief Executive Officer of Columbia St. Mary's, a member of Ascension Health, which is the largest Catholic health care system in the country. Previously, Taylor served as President and CEO of Genesys Health System in Grand Blanc, Michigan. Genesys Health System is also a member of Ascension Health. Prior to his time at Genesys, he served as President and CEO of St. John Hospital & Medical Center, a 632-bed hospital in Detroit and its 96-bed community hospital. He was also the executive leader of all cardiovascular programs for the entire St. John Providence Health System, which is also a member of Ascension Health. Previous to his tenure with St. John, Taylor served as President and CEO of St. Mary's Health Center in Jefferson City, Missouri. Taylor earned his master's degree in Health Services Administration from the University of Michigan and his bachelor's degree in Economics and Business Administration from Hillsdale College in Michigan. He is a Fellow in the esteemed American College of Healthcare Executives.*

INSTITUTION BRIEF *Columbia St. Mary's (www.columbia-stmarys.org), sponsored by Ascension Health and Columbia Health System, is an organization comprising four hospitals, more than 60 clinics and ambulatory care facilities and several Urgent/Express Care Centers, and the Columbia College of Nursing and a partnership with Madison Medical Affiliates, and is a member of Quality Health Solutions, a joint venture ACO. Columbia St. Mary's cares for individuals and families throughout Milwaukee, Ozaukee, Washington, and Sheboygan counties, with more than 164 years of service to individuals and families within these communities with a special concern for those who are vulnerable.*

What is different about the current health care environment and how is change accelerating?

Change is constant, but this is about a much faster change of pace. It's about driving health care from the perspective of the delivery of care at a population versus patient level and how we organize ourselves to cater to what those customers want and not just what we're accustomed to doing.

It is also about accelerating the cycles of improvement that we have to go through because the world around health care has shifted and we have to catch up.

One of the biggest shifts is in orientation away from hospitals – it's not hospital-centric anymore.

It requires a change of thinking about becoming a health system executive as opposed to a hospital executive and taking on responsibility for populations. How fast will that become a significant portion of the business?

It's going to come first with the commercial part of the business because that is an easier population to manage initially.

I have been the CEO of large medical groups and of a managed care organization, so I've been in areas where we didn't have a hospital to operate as part of the system. So you think of this not just as a physician organization but as a "big P (physician), little H (hospital)" organization. It's about how you integrate the physician.

That said, this model we have been scrambling to get to has been around for a long time and is tried and true. The difference was that, in the past, even if you were able to deliver higher quality care for a third less cost, no one wanted to make a change and buy into that. It didn't shift market share.

What we're seeing now is that the market is being driven to change. The commercial insurers and the private, self-insured companies need to find a way to get that cost break and improve quality, and they're going to move the volume to a system that can offer that.

Do you envision doing something similar to what was done at Genesys, in terms of having risk pools or do you envision going to full capitation?

An idea is not driven by the payer mechanism but by the right delivery system. This is tightly integrated with strong physician leadership in that "big P, little H" organization, and connecting that network to any one of a variety of payment mechanisms.

If you have a high performance network, it doesn't matter which mechanisms you're connecting with. So if you want to do a full global shared premium contact, you can manage that level of risk because you know with great predictability how your network will perform.

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How do you take any group of physicians and help them to get to the point of taking 25 or 30 percent of the cost out?

You have to park your ego at the door. It's a collaborative way of bringing the physician leadership into the operations of the health network and being totally transparent about the data, and about where you're going and how you need to get there.

What do you think about scale?

I characterize it by saying, in this environment we're going into – which is one that we've been in for 20 years but didn't know it – we need to get big but we also need to get small at the same time.

By big, I mean you need to have a large enough population that you're interacting with to support the activities associated with population care.

If you don't have enough population, you don't get the statistical opportunities to manage care in a clinically and economically safe way – the risk becomes too big.

Also, given that you will have a hospital as part of your network, the hospital needs to get thinner, smaller and more efficient, and have less infrastructure that weighs it down.

For instance, in a network that covers a geographic area, you might say: "We don't need to have an open heart program in every one of our eight hospitals; we're going to have two regional ones." This is when you get cost savings.

The large, physician-led organizations that have become managed care organizations have had the most success in bending the cost curve. They would take 85 percent of premium and be responsible for the population – they were getting 30 percent of the costs out. How have you been able to do it on the commercial side and the senior side?

We talk about the commercial population and we should; we talk about the senior population and we should; and we have taken this same model and moved it into the uninsured population. This model doesn't just apply to commercial or seniors but to anyone, even the uninsured, you can manage costs more effectively by using this model.

Is there more money to be made if you use this model of care delivery for the senior population? The answer is yes.

The seniors, because they use so much more health care, because of the complexity of their diagnoses and comorbidities are so much greater, the risk is so much greater. So there is more cost savings proportionally, simply because the cost of their care historically has been higher.

A lot of people are talking about the post-acute capacity. In your strategies, have you deployed thinking about building capacity in post-acute and palliative or hospice or skilled nursing or home care?

We have actually put the hospice program in the hospital itself as opposed to outside of the hospital.

We have found by doing that, referrals to hospice happen much earlier. The care is greatly enhanced for those patients. The opportunities for appropriate interventions occur more rapidly and the transitions of care are much smoother.

Some of that is because the doctors and nurses who see the patients that are in need of palliative care are interacting with their colleagues who work in the palliative and hospice setting, so it's on their minds.

Is it tough to remain optimistic when you look at all the industry challenges?

I'm the buoyant optimist. It will be a mess when we go through it simply because so much is changing. We're revolutionizing a care delivery system that needed to be revolutionized and we talk about the cost being 30 percent lower. My experience has been that we can consistently drive up the quality of care by 30 or 40 percent. In good conscience, how can someone believe that there is a predictable tried-and-true model that can give you 30 percent cost savings and drive up quality 30 percent, and then not move there? ●