Mount Sinai

Transforming Healthcare

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

Kenneth L. Davis, M.D.

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 Mount Sinai-affiliated Bronx Veterans Administration 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 after spending 15 years as Chair of Mount Sinai's Department of Psychiatry. He was the first director for many of the institution's research entities and received one of the first and largest program project grants for Alzheimer's disease research from the National Institutes of Health. 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 *The Mount Sinai Health System (mountsinaihealth.org) 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, 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. In 2014, Mount Sinai Health System hospitals treated more than 3.5 million individuals as inpatients, outpatients, and through emergency department visits.*

The Icahn School of Medicine at Mount Sinai opened in 1968 and has more than 5,600 faculty members in 34 academic departments and 23 clinical and research institutes. A renowned medical school, it is ranked number four in the nation among medical schools for National Institutes of Health (NIH) funding per principal investigator. The Mount Sinai Hospital is ranked number 16 in the nation by U.S. News & World Report *and earned "top rankings" in six medical specialties in the 2014-15 "Best Hospitals" guidebook. The New York Eye and Ear Infirmary of Mount Sinai was also ranked nationally, (number 10 in Ophthalmology). Mount Sinai Beth Israel, Mount Sinai St. Luke's, and Mount Sinai Roosevelt were ranked regionally.*

What is the key to the success of Mount Sinai and what has made the system work so well?

We have a management team that gets along well and shares many core values that are so ingrained that they are pretty much unspoken, though occasionally we have to reiterate them. We trust each other and we are transparent with our problems.

We aren't protective and we aren't a group of rivals – we're a team of friends. As rivals, everybody wants to prove to the boss that they're smarter than everyone else. They're not going to share their information, and they all want to triumph. It's hard for a group of rivals to think that the team shares a victory. But with a team of friends, everybody shares the victory.

We have problem-solvers who are a team of friends.

There is a strong culture within Mount Sinai. How do you make sure you don't lose that culture as the health system continues to expand?

It's difficult. Our culture is embodied within the core management group. As we get larger, I have to continue to reiterate the values I think are critical.

Before I hire new people, I always consider how they will fit into our culture. We make sure that we get recommendations about those people and that we can be convinced they have the right kind of personalities – ones that are not afraid to be open and transparent, that aren't protective, and that can work well in a group.

Is the correct dialogue needed to address the future challenges of the healthcare industry?

I'm deeply concerned about that. Right now, the industry is overwhelmed with the question of how we move from fee-for-service to value. It's about examining what value means and what it will look like, and how long it will take to transition to that new look. It's trying to derive a business model that will succeed and determining which metrics will be used to evaluate it, and whether we can all get on the same page.

Clearly, this is terribly important but, within that dialogue, we're forgetting to talk about many other things that are also very important. For instance, if 25 percent of our Medicare healthcare costs are spent during the last year of life, and we're still not having a meaningful dialogue about advanced directives or living wills, then we're still going to be in a situation where we're going to spend a ton of money on futile care and that is going to continue to cause the cost of healthcare in the U.S. to be as high as it is now.

The major point I'm making is that we're forgetting to discuss some of the driving forces behind healthcare costs, such as obesity. We know that a huge percentage of our healthcare costs are being driven by the consequences of obesity and Type 2 diabetes, and the downstream implications. Yet, we still don't have enough of a dialogue that elevates the awareness of the downstream cost of obesity to the level we did with tobacco.

Lung cancer is so awful, acute, and transformative to one's life that it hit everybody in the face. The consequences of obesity are more subtle, but the costs are awful – it's the tobacco of our time.

In debate after debate, we get no traction. This has not become as national an issue as it should be. Instead, we continue to subsidize high-fructose corn syrup.

Another issue we're not talking about is the ecosystem of innovation. We sit at an enormously opportune time in science when the genomic revolution has given us new targets that have the potential to transform therapeutics. However, the laws and the regulations that we're forced to work under from the time we develop a therapeutic target and intellectual property to the time that we get it to the market include so many contradictions and inconsistencies that we've made it very hard to develop the kind of drugs we need to treat the chronic conditions that cost the country the most money.

Many of the breakthrough medications have been for orphan drug indications for diseases that are not that chronic, and we're still waiting for the major breakthroughs in Type 2 diabetes and Alzheimer's disease.

These two illnesses by themselves will bankrupt the country. But where is the dialogue that asks what we have to do to the innovation ecosystem so we can encourage drug development in those areas and fast-track them? There are all kinds of problems – from getting venture capital to the length of time of clinical trials to how to price the drug to market exclusivity, that are not being addressed. We're immersed in this problem of how to get off of fee-for-service medicine, so we're forgetting what drives the real costs in healthcare and what we're going to do about them.

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Does the dialogue need to be driven by the health systems?

It needs to be driven by important people in the Senate and the executive branch of the Administration, in addition to leaders in academic medicine and in public health institutions.

Most importantly, we're missing the imperative on the federal level to really address these problems.

What will the hospital of the future look like and will it only be for your sickest patients?

The hospital of the future will increasingly host more ICU beds. It will have a higher level of telemedicine and patients will have hospital beds at home and will be monitored by telemedicine and apps. A caretaker will be dispatched from the care team to visit patients in the home. I see a broader, larger, and more effective ambulatory platform with much more connectivity and much more care coordination. There will be fewer inpatient beds, which will be only for those with more acute and more intense needs, and there will be a lot more going on at home.

How important is scale for today's health systems? Is it required to survive?

It's critical. A mission-driven hospital in a community with a high number of Medicaid and Medicare patients, can only provide the necessary services by having size and scale. This can decrease corporate expenses and supply-chain costs. Small populations with an adverse selection could become disproportionate and can't be divided over a much larger population if they're small. Scale helps manage this risk.

This means size and scale is critical for the missions we have to provide in economically diverse communities if we're going to be full-spectrum hospitals that are able to take on risk.

Is it valuable to incorporate a hospitality component within hospitals and how do you convey to your people that this is essentially a service business?

When I began working in medicine, we had doctors who viewed themselves as iconic figures. If a patient called for an appointment, they would often face multiple-week waits. It wasn't that they were concerned about providing service but that they were doing patients a favor by allowing them to be seen.

That's a destructive value system. We have changed to become an industry that is closer in some respects to the hotel industry. Access has to be terrific, appointments have to be easy to make, food has to be great, service has to be wonderful, and the place has to be spotless.

We have many more resources than we could have conceived of 20 years ago that are engaged in the hospitality component of our industry.

How important is community outreach and involvement for your employees?

It's more important than ever. One of the biggest problems we have is the patient whose disease is identified too late or the patient who hasn't gone for an annual physical. Much of wellness is prevention and disease can't be prevented if contact isn't made.

To ensure the fiscal health of the institution as we take risk and the health of our communities, we have to get people engaged. This isn't something we do out of benevolence but out of mutual interest. Clearly, it's very important for our institution to show we're good citizens of the community as well.

Is the necessary talent still being attracted to healthcare? What do you tell young people about a career in medicine?

This year, we've seen the best pool of applicants we've ever had. They have great MCATs and great GPAs, and have come in greater numbers than we've ever seen before. Despite the indebtedness that medical school creates, we have the best talent coming into medicine that we've ever had.

Whether that talent winds up taking a path within medicine that is driven by their financial needs rather than by what they would really like to do in medicine, or what the community needs, is another story.

The big problem concerns the next generation of scientists, because we sit at the cusp of the greatest revolution in biology with the most extraordinary opportunities. However, the funding of grants is now at a horribly low level. We haven't had any change in real dollar value for the past 16 years. This means that what the dollar buys today in healthcare research is about what it could buy 20 years ago, but we have many more people who need grants. Statistics reveal that 93 out of 100 grants are turned down, and the average first grant is given at the age of 42. This means that young people see no future and they're leaving science. This is catastrophic considering what the country and medicine need to be doing to prepare for the future. ●

Research That Changes Medicine

An Interview with Dennis S. Charney, M.D., President for Academic Affairs, Mount Sinai Health System

Dennis S. Charney, M.D.

EDITORS' NOTE *Dr. Dennis Charney is also the Anne and Joel Ehrenkranz Dean of the Icahn School of Medicine at Mount Sinai, and a world expert in the neurobiology and treatment of mood and anxiety disorders. His career began in 1981 at Yale, where, within nine years, he rose from Assistant Professor to Professor of Psychiatry, a position he held from 1990 to 2000. While there, he chaired the NIMH Board of Scientific Counselors. In 2000, NIMH recruited Charney to lead the Mood and Anxiety Disorder Research Program and the Experimental Therapeutics and Pathophysiology Branch. That year he was also elected to the Institute of Medicine of the National Academy of Sciences. His scientific research has been honored by every major award in his field. In 2004, Icahn School of Medicine at Mount Sinai recruited Charney as Dean of Research. In 2007, he became the Dean of the School and Executive Vice President for Academic Affairs of the Medical Center. In 2013, he was named to his current post. Charney has written more than 700 publications, including groundbreaking scientific papers, chapters, and books.*

What makes the Icahn School of Medicine at Mount Sinai so special?

It has to do with not being a part of a major university. We consist of a medical school that trains medical students. We also train scientists – Ph.D. students – and doctors and their specialty house staff, and post-doctoral students who are becoming researchers.

We have a seamless relationship with our hospital, so we have one board of trustees, and the mission of the hospital and the school are in sync.

When we raise money, we're doing it to change medicine and to recruit scientists whose mission is to discover new ways of treating human disease, as well as to build clinical programs in which we treat those diseases.

We're not competing with the priorities of a major university. We're focused like a laser beam on research that changes medicine and on delivering exceptional care to those who need it most.

Also, the CEO, Dr. Kenneth L. Davis, and I have been best friends for 30 years, which is unique in medicine. We have a very generous board of trustees, so philanthropy makes a difference. The CEO and I have built an environment in which creative ideas are valued, innovation is the coin of the realm, and challenging tradition is the norm. This allows us to achieve things that were not thought possible, be it delivering care to the underserved or coming up with research findings that have the possibility of fundamentally improving treatments for the most serious diseases.

The most important part of my job is identifying great talent and providing the environment that allows the main limitation to be their imagination and not resources.

Are physician-scientists harder to find?

The key to great science is coming up with an idea that nobody else has had. That's creativity, which is a different kind of intelligence.

Most physician-scientists now are mainly scientists, because in order to achieve true scientific breakthroughs, they can't be spending more of their time in the clinic. The value of the physician-scientists is that they learn medicine, and that context helps their science.

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