

CHANGES IN GOVERNANCE:

Interviews with New York State Healthcare Leaders



September 2018



Healthcare Trustees
of New York State

CHANGES IN GOVERNANCE

INTRODUCTION

Since our first Changes in Governance report, published in 2017, we continue to see significant transformation in the healthcare environment, with a growing number of affiliations occurring and major care delivery reform. These changes are impacting the way governance is structured both at the system and local stand-alone hospital board levels.

This report highlights 11 interviews conducted with thought leaders from across the state about their experiences and views on the changing role of governance. These interviews were conducted by Sue Ellen Wagner, Executive Director, HTNYS, between fall 2017 and spring 2018.

HTNYS extends special thanks to these leaders for taking the time to share their valuable insight for this report.

GOVERNANCE TRENDS

Governance trends identified during the interviews include:

- Governance structures are changing at both the health system and stand-alone hospital board level. Health systems are continuing to get larger. Many local stand-alone hospital board roles and responsibilities are changing as these facilities become part of health systems.
- Diversifying boards and recruiting younger board members remains challenging.
- Many board members are working full-time jobs and have little time for education, even though they feel board education is extremely important.
- Many boards are allowing videoconferencing for those trustees who travel out of town for the winter months or who live in another state. It is important to maintain a personal “feel” to meetings.
- Some system boards have begun to examine the number of committee meetings and board meetings they have. Some are reducing these meetings or holding them on the same days as the board meetings for convenience of board members and to enhance participation. Other systems are exploring developing ad hoc committees to examine specific issues for a limited number of meetings and for a specific time period.
- Some boards are introducing new committees to address key issues such as wellness/ community health, cybersecurity, and advocacy.

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CHANGES IN GOVERNANCE:

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Interviews were conducted by
Sue Ellen Wagner, Executive Director,
Healthcare Trustees of New York State

*Interviews were conducted between fall 2017 and spring 2018;
they have been slightly edited for clarity.*



Healthcare Trustees
of New York State

AUBURN COMMUNITY HOSPITAL

Scott A. Berlucchi, FACHE, LNHA

PRESIDENT AND CHIEF EXECUTIVE OFFICER



SCOTT BERLUCCHI has been President and Chief Executive Officer (CEO) of Auburn Community Hospital since April 2007, and has been credited with its financial and operational turnaround. In addition, Mr. Berlucchi serves as President and CEO of Auburn Memorial Medical Services, P.C., and President and CEO of Finger Lakes Center for Living. He has more than 25 years of healthcare leadership experience.

Mr. Berlucchi has a master's degree in healthcare from George Washington University and a bachelor's degree in business from Stonehill College in Massachusetts. He is a licensed nursing home administrator and a Fellow of the American College of Healthcare Executives.

ABOUT AUBURN COMMUNITY HOSPITAL

Auburn Community Hospital is an acute care facility that provides acute and general hospital services to patients in Cayuga County and the surrounding areas. Its programs and services include behavioral health, cardiac and pulmonary rehabilitation, cardiovascular laboratory, diagnostic imaging, emergency, endoscopy, hospitalists, inpatient care, laboratory, neurology and stroke, obstetrics and gynecology, orthopedics, pastoral care, rehabilitation, sleep center, surgical, veterans clinic, wound treatment, urgent care clinics, Finger Lakes Bariatrics, and Finger Lakes Center for Living. The hospital was founded in 1878 and is based in Auburn, New York.

Has your governing structure changed over the past few years? And if it did change, why did you make these changes? If there was no change, do you see any changes in the future?

As a small, rural, independent hospital, governance has not changed all that dramatically. But we have made subtle changes to more of a committee structure. At board meetings, this structure allows the board more time to focus on strategic planning issues and discussion as opposed to the day-in, day-out obligations of governance, since a lot of the administrative work has already been completed.

What do I see coming in the future? I see a more complex governance, as we all seem to be working in collaboration with other healthcare providers.

What do you think will be your board's biggest governance challenge over the next two to three years?

Recruitment and retention of valued and qualified board members.

Do you have an idea of how you will actually look at recruiting more qualified board members, given that governance takes a lot of time and trustees aren't being paid for what they're doing? Do you have any secrets or tips you want to share with us?

We are evaluating payment or in-kind contributions for board members' time.

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Are there any processes that your board follows today that you see might be different in the future?

We don't have the virtual meeting yet, but we do a lot of conference calls because valued board members from Auburn leave the area during the winter months. One of the things that we added was Board Effect, a paperless, electronic board portal. We have provided all of our board members with an iPad, at our expense, and we load up all of the board meeting calendars and meeting materials on Board Effect. It's much easier for our administrative staff and we're updating Board Effect right up until the time of the meeting.

We do get our board packets out a week in advance, but sometimes there are informational items that come up in that week. We're able to just ask the board to refresh their Board Effect board portal. We seem to have more meetings, not less; more committees, not less; more ad hoc committees, not less.

The materials seem to be more in-depth if you're doing anything outside of the norm, which many hospitals are, as they are looking at levels of collaboration. We do allow our board members to call in, and with Board Effect and iPads, they can really be anywhere in the world and receive the board packets and information to call in. We have updated the level of sophistication to ensure proper governance.

We're seeing that many stand-alone hospital boards that are affiliated are moving more to an advisory capacity, with most of the decision-making being made at the system board level. Given this reality, what do you see the role of that stand-alone hospital board being over the next three to five years?

In my opinion, governance follows ownership. Specifically, if a local hospital is owned by a regional health system, then the local board is advisory. Conversely, if the local hospital is the owner, then governance is local.

How do you see Healthcare Trustees of New York State meeting some of the future board's needs? You attend our conferences, so I know you see those as value-added; but as board structures are changing, what do you see our role being?

I see Healthcare Association of New York State (HANYS)/HTNYS' role as board education through conferences and webinars. Also compliance with fiduciary responsibility, and engaging the board in state and federal advocacy specific to your system.

BERLUCCHI

LONG ISLAND COMMUNITY HOSPITAL
(formerly Brookhaven Memorial Hospital Medical Center)

Richard T. Margulis

PRESIDENT AND CHIEF EXECUTIVE OFFICER



Under the leadership of **RICHARD MARGULIS**, Long Island Community Hospital (formerly Brookhaven Memorial Hospital Medical Center) launched a \$60 million capital campaign to build the new Knapp Cardiac Care Center, providing advanced cardiac diagnosis, treatment, and recovery capabilities.

The recipient of a 2015 Outstanding CEO distinction from Long Island Business News, Mr. Margulis is a member of the boards of the Long Island Health Network and the Nassau-Suffolk Hospital Council, and a member of the American College of Healthcare Executives, Healthcare Association of New York State (HANYS), and American Hospital Association (AHA).

ABOUT LONG ISLAND COMMUNITY HOSPITAL (formerly Brookhaven Memorial Hospital Medical Center)

Island Community Hospital (formerly Brookhaven Memorial Hospital Medical Center) is a voluntary, not-for-profit community hospital in Patchogue, New York. The staff provide care at a 306-bed, acute-care hospital that is part of a multidisciplinary, multi-campus, state-of-the-art healthcare complex designed to meet the evolving needs of the 28 Suffolk County communities it serves.

Has your governance structure changed over the past few years?

It has changed. Certainly in our structure, we have moved to more committees. We have a very engaged board—chief volunteers, as we call them here. They are extremely interested in the community and in what we are doing to service the community. Our hospital, throughout its 61-year history, has always been very community-driven. It was originally named Brookhaven Memorial Hospital, in honor of veterans coming back from the Korean War back in the 1950s.

So, yes, we have seen committees that were not as active in the past become more active. Over the last 10 to 15 years, we have taken on a significant number of new board members who have energy and vitality, who want to be part of a community organization, and who represent its best interests.

Do you find that adding more of these committees is an effective way of seeking input and then having those committees move to the full board for discussion?

We work through a consensus agenda and do a lot of work in committees to try to streamline process, time, etc. It's a lot of work, absolutely. But what that up-front work generates is both engagement and the sense of pride in ownership. It allows us to really rely on and use the expertise of our board members as individuals in their areas of specialty.

What do you see will be your biggest governance challenge over the next two to three years?

Well, certainly the environment is changing daily. We need to provide education about payer models, quality, physician relationships, and regulations. Much of our medical staff have been here for many years, and they have grown their practices around Brookhaven. I don't think that these professionals really understand the economics of healthcare and all of the changes that are going on; this is an educational opportunity for the board as well.

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LONG ISLAND COMMUNITY HOSPITAL (FORMERLY BROOKHAVEN MEMORIAL HOSPITAL MEDICAL CENTER)

RICHARD T. MARGULIS PRESIDENT AND CHIEF EXECUTIVE OFFICER

I believe we have to be looking at different operational models. Brookhaven is certainly a community hospital, but the definition of a community hospital has changed. We had to close our obstetrics service about nine years ago. That was a major concern for our board: that we couldn't be everything to everybody in our community.

I see the financial pressures and the operational pressures. I believe our board experiences it as well and sometimes struggles with the fact that we are not going to be able to do everything all the time.

I also think one of our challenges is figuring out how we can continue to be effective as an independent community hospital and balance that with servicing the needs of our community to the best of our ability. A major component of governance is determining what the best interests of the community are and, more importantly, what our board members can bring to the table to ensure representation of the community's interests.

Are there any processes that your board follows today that you see might be different in the future?

Yes, I think so. First of all, with no disrespect to any member of our board, we are trying to attract some younger members (under the age of 40) onto our board. And you get into that different generational thinking. Maybe even—I wouldn't say all "millennial" thinking but some of it. And there is a piece of consumerism in that. If we are going to try to engage new members, we need to make it easier for them to participate.

People don't necessarily want to come to a hospital for a three-hour board meeting once a month. Or two subcommittee meetings that run an hour-and-a-half twice a month. We need to move more to the virtual environment. We have moved to a board portal where we post all of our information so that our board members can access it from their mobile devices, home computers, and work computers.

I think our obligation here is, again, to make the path easier for them to understand what is going on. We need to look at the technology piece here, understand the thinking of the people who we want to attract to our board and make it easier and to incentivize them to want to volunteer.

Do you see any challenges in recruiting board members in the future?

Yes. I think that we are already experiencing challenges, and have for a number of years. I think diversity is critical for our board. We are talking a lot about diversity training. As a matter of fact, we just had a presentation on board diversity. We were looking for assistance on how our board can be more representative of our community. We have had difficulties in matching the two. So I think it certainly is about diversity. It's also about finding people who have the time. Another challenge we face in finding younger individuals is that they often have young families, so it is harder to find the time.

It's also about volunteerism, and I don't believe that volunteerism is as strong as it has been in the past.

We're seeing that many stand-alone hospital boards that are affiliated are moving more to an advisory capacity, with most of the decision-making being made at the system board level. Given this reality, what do you see the role of that stand-alone hospital board being over the next three to five years?

Well, I think it's a question and an answer all in one. Because what is actually happening, as we talked about earlier, is that the number of independent stand-alone facilities is changing and this will continue to change going forward. We have a new federal administration. We're not really sure what direction our elected officials are going to take us in terms of healthcare reform. We don't have a good picture of how that will impact state financing, funding, or philosophy.

I think that hospitals are looking at their ability to maintain their independence, but with that comes an understanding of the reality that perhaps the hospital is going to have to transition, and the role of the board transitions in that as well.

Fortunately for us, we have board members who are true volunteers first and foremost, and they understand that their role may change. I think our job is to be able to help transition that, educate people, and make sure that they understand the significance of their role, whether it is as a trustee or a member of an advisory group in support to an institution.

Any last comments?

Every year hospitals say this was a tough year or this is going to be a difficult year. I think, though, that right now, 2017 and beyond, are truly exceptionally dynamic in the sense that not only are the mechanisms of delivering care changing dramatically, the relationships are also changing. The regulations are changing. The funding sources are not fully understood, maybe not fully integrated. This is a lot of information for a board member to process.

And what I see, and what I get concerned about, is the ability to provide that orientation. The complexities in healthcare are difficult for those who run an organization, much less for volunteers who try with all their abilities to understand a business that sometimes can't be explained.

The role of a trustee is critical to our success. I worry about how we support people to allow them to do that job, to volunteer, to understand this environment, and to be able to tap into the resources and insight that they bring from their external experiences.

How do you best see Healthcare Trustees of New York State meeting your governing board's needs in the future?

HTNYS is a well-respected organization, one that I know that our board has a great deal of respect for. Our former Chair is certainly involved and is very actively engaged with Healthcare Trustees. This involvement brings a lot of advocacy and a lot of information back to our hospital to be shared with our board.

I think the role of HTNYS is paramount right now because this is going to be a difficult transition, just in the comprehension and understanding of the rules of the road, so to speak, and anything that HTNYS can do to help us understand, on the political side, the advocacy side, and in the behind-the-scenes complexities of how healthcare legislation is put together is critical. How do we represent the patients in all of this? This is critical as well, and I think that the role there becomes a deeper, broader, more richer role for HTNYS because it is an organization that I would look to for support and assistance to be able to help me educate my board members, and help transition my board members, help make my board members stronger and even more valuable assets to our hospital.

Vincent Richard Back, MD

BOARD CHAIR



DR. VINCENT RICHARD “RICK” BACK is the Board Chair of Columbia Memorial Health (CMH) in Hudson, New York, where he has served in numerous capacities for nearly five decades, including as Chief of Surgery, President of the Medical Staff, and two terms as Chief Medical Officer. A graduate of the Yale School of Medicine and a board-certified surgeon, Dr. Back served his nation for several years on active duty with the U.S. Army’s 45th Field Hospital.

Dr. Back has also been a teacher and a mentor for countless colleagues from all disciplines, ranging from clinical to administrative and governance. He is perhaps best defined by his passionate advocacy for providing the very best healthcare possible to the community he has served faithfully since 1971.

ABOUT COLUMBIA MEMORIAL HEALTH

CMH has provided medical care for the Hudson Valley since 1893. Beginning with the Hudson City Hospital, CMH’s network has grown to serve more than 100,000 residents in Columbia, Greene, and Dutchess counties. In addition to its modern 192-bed hospital, CMH runs more than 35 care centers, including 15 primary care and more than 20 specialty care centers.

In 2016, CMH launched a formal affiliation with Albany Medical Center that enhances the strengths of both organizations and enables a coordinated planning process to improve patient care. The two organizations are continuously identifying opportunities to bring needed services closer to the patient, better align resources and services, and more efficiently use information technology to enhance community-based care.

Has your governance structure changed over the past few years, and why did you make these changes, if changes were made? Do you see changes coming in the future?

Yes. As you know, we affiliated with Albany Medical Center about two-plus years ago, and our governing structure had to change following the affiliation documents. Now, having said that, Albany Medical Center is our parent institution, so they have certain powers, but our board basically hasn’t changed its function or its governance structure.

As far as seeing changes in the future, not immediately. It will probably follow the maturation of our affiliation, so I think we’re a little bit unique in that we do not have a full asset merger but we do have a very tightly integrated affiliation.

What do you see as some of your biggest governance challenges coming up over the next two or three years?

One of our biggest challenges is finding new board members with the needed skills.

I think the board needs to be agile enough to deal with dramatic changes that we’re seeing in the delivery of medical care. It’s frightening to see that insurance companies and drug companies are merging. To me, the one missing part of that equation is care providers. I foresee that the care providers, whether it’s hospitals or large medical groups, will be integrated in a big healthcare conglomerate, and I think we’re going to see unprecedented change. I think we need to be agile as a board to follow along with that and make the right decisions.

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Do you see any recruitment challenges?

I have to admit to you that question made me come up with a plan. Some of my fellow board members and I have been talking about this. We have suggested to the board that we have to actively recruit board members with the right skills. I think we will have a board education discussion on the best way to identify some of our colleagues in the community who have the skills that we want and how to market to them the importance of a good medical care system, which they could be part of as a board member. This still needs to be formalized a little more, so I think that will be our plan.

Do you see the processes that your board follows today being different in the future?

The answer to that is not really. I mean, by statute our board is responsible for the care we provide, and we have our bylaws, which really determine our committees and their functions. I don't see us changing them immediately.

So, as far as virtual meetings, yes, I think we will use electronic means, with audio and visual more in the future to make it easier for board members to attend. But, as far as the structure and function of the board, I don't see that changing immediately.

Do some trustees from the Albany Medical Center board attend the Columbia Memorial Hospital Board meetings and vice versa?

Yes. Two of their board members are board members with a vote on our board, and we have one of our board members on their board. I am a member of the Albany Medical Center Hospital Affairs Committee and the Albany Medical College Affairs Committee.

So, yes, we do share governance positions with Albany Medical Center.

We're seeing that many stand-alone hospital boards that are affiliated are moving more to an advisory capacity, with most of the decision-making being made at the system board level. Given this reality, what do you see the role of that stand-alone hospital board being over the next three to five years?

I think the function of affiliated boards is fairly well established by the initial agreement and the reserve powers retained by the parent institution as well by philosophy discussed in setting up the affiliation. Our parent has expected us to make decisions that are clearly local and require local knowledge and local experience. Fortunately, we have an excellent relationship with the leadership of Albany Medical Center, having mutual trust and respect, so important decisions are shared. However, we do not act in primarily an advisory capacity. For us, this has been very successful. Mutual respect is the key.

Speaking from our experience, I do not see this changing in the next three to five years.

BACK

ELLIS MEDICINE

Paul A. Milton, FACHE

PRESIDENT AND CHIEF EXECUTIVE OFFICER



PAUL MILTON has more than 25 years of experience as a senior healthcare leader. He became President and Chief Executive Officer of Ellis Medicine in March 2016, having served in the acting role for a year and as Executive Vice President and Chief Operating Officer at Ellis since 2008.

He brings to the Ellis executive team a proven track record of collaborative accomplishments under his leadership, including the development of Ellis' Medical Center of Clifton Park and the realignment of facilities and services at Bellevue Woman's Center, McClellan Street Health Center, and Ellis Hospital.

Mr. Milton earned his master's degree in health services administration from George Washington University and his bachelor's degree in business administration from Miami University. Mr. Milton's experience includes services as a community healthcare coordinator with the United States Peace Corps in Malawi, Africa.

ABOUT ELLIS MEDICINE

Located in Schenectady, New York, Ellis Medicine is a 438-bed community and teaching healthcare system serving New York's Capital Region. With four campuses—Ellis Hospital, Ellis Health Center, Bellevue Woman's Center, and Medical Center of Clifton Park—five additional service locations, more than 3,300 employees, and more than 700 medical staff members, Ellis is proud to provide a lifetime of care for patients. Ellis offers an extensive array of inpatient and outpatient services, including cardiac, cancer, emergency, neuroscience, and women's services.

Has your governance structure changed over the past few years?

The only thing that has come up in our governance discussions was whether physician employees could be on the board, and our board wrestled with that decision for part of last year and came to the conclusion that an employed physician who may become chief of staff could be on our board with a vote. They would only have to step out if there was a specific conflict. That's not a specific change, but one thing that we did deal with in the past year.

Since you haven't had any major changes, do you see anything coming in the next three to five years?

We possibly could see some changes in the future, the next three years or so. We are going through a strategic alignment project right now to see if

we will remain independent or whether we will partner with someone, so depending on how that ends up, we may see some changes with governance.

What do you think your biggest governance challenge will be over the next two to three years?

Probably the biggest challenge is what I just mentioned. I think if we go through a strategic partnership and identify a partner and work through that, this would be one of our biggest challenges because it does lead to a possible changing of the role, potentially, depending on what kind of a partnership.

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Do you have any challenges with diversity and recruiting younger members to the Ellis Board?

Those are two significant issues. We have our annual meeting every June and we have 23 members on our board. We do have three board members who will be terming out in June 2018 and we are looking at whether we add some new board members.

One of our challenges is diversity from an ethnicity standpoint, but the other issue that came up was age and having some younger thought leaders on the board. Those are two of our biggest challenges.

Diversity is so important, simply because it brings diversity of thought and perspective. So, we've made efforts as an organization to reach out and try and recruit potential board members of various backgrounds.

Do you have any ideas on how to help recruit for ethnicity and the younger members?

Yes, particularly in a community like the Schenectady area, there are leaders that you identify who are involved in other community organizations and so you reach out to them specifically because they have those differing backgrounds and perspectives. But you have to reach out and be proactive. You can't always expect it to happen right away. It's a process and maybe you get them interested and involved without getting them on the board immediately. Maybe you get them involved in some other committees so that they get engaged with the organization with the anticipation that through that development, they would become effective board members.

Do you see the processes that your board follows today different in the future?

I think so. It comes up at our governance committee meeting about the number of board meetings we have and I have said to the board at times that because of the number of board meetings that I'm preparing for, I spend probably more time preparing for board meetings than time that could be spent managing or leading the organization. That sometimes also leads to the need to better define what our governance issues are versus management issues or operational issues, so I think with things changing so much and the complexity of healthcare, the one thing we're going to be wrestling with is the time commitment.

Some board members spend quite a bit of time, and you can even see them getting somewhat burnt out by the amount of time that they're spending on board issues.

In terms of virtual meetings, we do have a couple of individuals who go down to Florida for the winter. We allow them to come in either through phone or video, but I know it's not ideal. There are other members of the board who think that attendance and physical attendance is important for an effective board meeting.

Do you foresee recruiting board members in the future? What about recruiting for skill sets?

I wouldn't say the skill set is as much of a challenge. We do have some business and corporate folks, legal, quality, and clinical expertise. We have five physicians on our board. Finding the skills is not as much of a challenge as is diversity.

Are there other recruiting issues that you might want to mention?

We are still on a monthly board meeting schedule and right now, I would say, attendance for some board members becomes problematic. In their own businesses or their own lives, they get busy, so having attendance by some of the types of folks you want on the board can be somewhat challenging.

Many board members today are working full-time jobs. They want to be involved with the hospital. They want to be involved in the community, but there are only so many hours in the day.

We're seeing that many stand-alone hospital boards that are affiliated are moving more to an advisory capacity, with most of the decision-making being made at the system board level. Given this reality, what do you see the role of that stand-alone hospital board being over the next three to five years?

There are fewer and fewer stand-alones out there, and I see the continuation of consolidation going on and I do see the changing role of governance. I'm discussing with our board now in anticipation that should something change here, what would be the role of advisory governance versus more of the oversight fiduciary role? That comes into play a little bit in the decision of a partnership and the types of governance models that exist. That's how we see that playing out right now—deciding what's a governance cultural fit for us as we look to potential partners.

Is there anything else that you want to add or that you feel you can add to the changing role of governance?

What is truly governance versus what is management and operations, I think, is going to be key. How much time and how much preparation are going to be reviewed. There's probably too much time spent going to meetings.

A peek into the future would likely reveal fewer meetings and when you get together, it will truly be about governance and less about getting into the management and the operations of the hospital. I see that happening over the next two to three years.

Given all these changes that are happening, what do you best see Healthcare Trustees of New York State doing to meet the needs of some of these system governance board roles?

Well, you know, I'm probably a little bit biased. We had 14 board members attend the 2017 Trustee Conference and they got a lot out of it. I think HTNYS does a good job of setting the stage for what's coming through those seminars.

If you keep sending trustees information and hold the annual Trustee Conference, this will continue to be effective ways to educate trustees.

ERIE COUNTY MEDICAL CENTER

Sharon L. Hanson

IMMEDIATE PAST CHAIR



SHARON HANSON is the Immediate Past Board Chair for Erie County Medical Center (ECMC), where she has served in a variety of board leadership roles over 20 years. Her leadership and advocacy on behalf of ECMC's thousands of caregivers and diverse community of patients has had a profound impact on the organization's day-to-day operations, its partnerships, and on the community it serves.

Ms. Hanson is also the Executive Director at Deaf Access Services of Western New York, where she is forging partnerships to ensure better understanding of the healthcare needs of deaf and hard-of-hearing individuals.

Ms. Hanson is a member of the governing board of the Healthcare Trustees of New York State. She received HTNYS' Trustee Leadership and Advocacy Award in 2016.

While on the Trocaire College Board of Trustees, Ms. Hanson helped establish a partnership with ECMC to provide an employment path for matriculating nurses. She helped create the Health Sciences Charter School by providing a curriculum for city students to prepare for future careers in healthcare. Ms. Hanson also served on the Seneca Nation of Indians' Healthcare Commission to design and improve healthcare policies and procedures focusing on diabetes, drug abuse, and obesity.

Ms. Hanson is a graduate of Canisius College with dual Bachelor of Science degrees in English and political science.

ABOUT ERIE COUNTY MEDICAL CENTER CORPORATION

Erie County Medical Center Corporation (ECMCC) was established as a New York State Public Benefit Corporation and since 2004 has included an advanced academic medical center with 583 inpatient beds, on- and off-campus health centers, more than 30 outpatient specialty care services, and Terrace View—a 390-bed long-term care facility.

ECMCC is Western New York's only Level 1 Adult Trauma Center, as well as a regional center for burn care, behavioral health services, transplantation, medical oncology, head and neck cancer care, rehabilitation, and a major teaching facility for the University at Buffalo.

Most ECMCC physicians, dentists, and pharmacists are dedicated faculty members of the university and/or members of a private practice plan. More Western New York residents are choosing ECMCC for exceptional patient care and patient experiences—the difference between healthcare and true care™.

How has your governance structure changed over the past few years? If it has changed, can you talk about some of these changes? If there weren't any changes, can you tell us about any changes that might be coming in the next three to five years?

Well, I can't say that there has been a change in our governance. As you know, we are a public

benefit corporation, which means that most of our governance is set by New York State law. Our board members are appointed by the county and state executive and legislative branches, so there has not been a lot of change.

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However, under my tenure as Chair of the Board, I did add a new committee, which is the Minority and Women Business Enterprise (MWBE) Committee. Governor Cuomo is a strong advocate for MWBEs, and we pay attention to making sure that we have MWBEs on our projects, involved in our organization, involved in our community, and our state.

This new committee was very helpful to have, as it reported to our board at least once a quarter to share what we are doing, how we are doing it, who we are getting involved with, and that we are meeting the requirements of state law.

The other initiative that we did, even as a public benefit corporation, was to ask for new legislation in our area. Right now, ECMC and Kaleida Health are collaborating more than they ever have.

What I see in the future, though we may have to go back to legislation to get it accomplished, is to be able to interlock boards. Kaleida, of course, has their board. ECMC has our board. And with ECMC being a public benefit corporation, it must always have a board. So, if there is a way for us to create a greater board such as we did with Great Lakes Health, I believe this would be very beneficial.

What do you think will be your biggest governance challenge over the next few years?

The biggest governance challenge will be to get Kaleida and ECMC working together on a governance structure that will help us to provide and set policy for the entire system, not just for an individual hospital.

Right now there are a few rural hospitals that we are bringing under the Great Lakes model that will help to ensure that there is a quality of health, that there is healthcare, and that everyone in the community has access to healthcare.

At this point, we're not sure where we are going to end up. But at the end of the day, we all feel very strongly that everyone deserves to have access to healthcare. How that is going to come about is something that needs to be resolved over the next couple of years.

You mentioned the interlocking of boards and creating another board to look at things from the system level, so given that change that may take effect, do you see any of the processes that your current board follows today different in the future?

Hypothetically, there would be members from the ECMC board and members from the Kaleida board drawn together to create a greater board that would set policy for the entire system.

Do you foresee any challenges in recruiting board members in the future?

Yes, even though we don't perpetuate the board membership ourselves at ECMC, I still think that it is a problem because being a volunteer on a hospital board requires a lot of time. It's a busy board and a working board in that we have to create policy and ensure that the right leadership is in place. The ECMC board hires the chief executive officer, chief financial officer, and chief medical officer. And there are a few other positions that the board itself is required to hire. So there is a lot of responsibility for a volunteer board. As a volunteer, you have to be willing to dedicate your time and understanding as to exactly what it is all about before you agree to participate.

There are some hospital boards that I think pay their board members, and unfortunately ECMC is not one of them.

It is interesting that you mention board compensation because that is a trend we are starting to see happen across the country where some larger system board members are being compensated. So it will be interesting for us to watch that trend to see where that goes.

The rapid changes occurring in healthcare and breaking headlines and news have us all wondering what the right model is. The dedication of the board members is essential to the success of the model. We can't succeed without having those dedicated members who are willing to take the time to create the necessary policy to strengthen the hospital system.

We talked a little bit about this. Many stand-alone hospital boards are moving to function in an advisory capacity while most of the decision making is being made at the system board level. Is that the model you see happening?

I'm still studying that possibility. I think it is probably going to be something that we are going to have to take a look at. There are some members who will not be willing to serve in an advisory capacity.

They feel strongly that they want to continue to make policy and set the rules of the organization. In an advisory capacity, they would not be allowed to do that. The governance structure would have to change, and an advisory committee or board would have to send that up to the governing board.

Is there anything else that you want to add, to let the readers know about the future of governance the way you are seeing it, either from your own standpoint in your own area, or just governance in general?

I would like readers to understand and accept that the importance of serving on a hospital board is more than having your name on stationery. The members or the volunteers of the board need to realize the value that they are bringing to the board: their participation, leadership, and advocacy. We need to be able to pull those board members together and get them to agree that we need to make a greater awareness of what we are doing because it is not just local anymore. We are talking about a systems-sized change in model and the way that we are doing business.

How do you best see Healthcare Trustees of New York State meeting system governing boards' needs in the future?

I think the education of the board is going to be important. In other words, I think that if a person is being considered to sit on a particular board, they need to have an understanding of what is involved. Boards need to step up and create the policy that is going to effectuate the change to ensure the greatest number of people have access to quality healthcare wherever they are. HTNYS has that broad brush appeal and availability, and I think that will continue going forward.

Sharing information about what is happening at the state and federal level is important as well. But we have to make sure that our board members are involved in getting that information. In other words, HTNYS is going to have to provide education at the local level. We do some of it now, but we are going to have to increase those opportunities. HTNYS will be the teachers, and we, the hospitals, are going to be the students.

GUTHRIE CORNING HOSPITAL

Garrett W. Hoover, FACHE

PRESIDENT



GARRETT HOOVER has more than 25 years of senior healthcare leadership experience, including being the former President/CEO of Nason Hospital in Roaring Spring, Pennsylvania, and as Senior Vice President and Chief Operating Officer of Olean General Hospital, of the two-hospital Upper Allegheny Health System based in Olean, New York.

Mr. Hoover has extensive experience in leading strategies to improve patient satisfaction, increase employee engagement, and create a cultural transformation. He also implemented several successful patient revenue growth strategies, including a 7% average annual growth rate over a 12-year period while at Nason Hospital.

He is a Fellow of the American College of Healthcare Executives, and received a master's degree in health administration from Seton Hall University, a master's degree in human resources administration from Saint Francis College, and an undergraduate degree from Penn State University.

ABOUT GUTHRIE CORNING HOSPITAL

For more than 110 years, Guthrie Corning Hospital has grown and expanded to provide new and advanced services, the latest technology, and modern facilities to meet the needs of the communities it serves.

Guthrie Corning Hospital opened a new 65-bed hospital and regional cancer center in 2014. The new facility provides a wide range of inpatient and outpatient services (medical, surgical, and diagnostic) with an integrated team of skilled and compassionate physicians, healthcare professionals, and staff. The team is dedicated to Guthrie's mission of improving the health and well-being of the region and is supported by the latest in technology, state-of-the-art healthcare equipment, and electronic medical records.

How has your governance structure changed over the past few years, and can you talk about any changes that you've made?

We (Guthrie Corning Hospital) are a part of The Guthrie Clinic, a fully-integrated health system. The relationship started in 1999 with a five-year affiliation agreement and was completed in 2006 to become a full member of The Guthrie Clinic, so we've already been down the merger/acquisition path. Guthrie Corning Hospital's Board of Directors is a very engaged board that is focused on our Five Pillars: People, Quality, Growth, Service, and Finances. The local Board of Corning Hospital has adapted well to the typical changes associated with a member structure, such as relinquishing reserved powers around budget, strategic planning, and acquisition/disposition of assets.

Our board is highly focused on our quality improvement initiatives. We have a very strong quality improvement committee that meets each month before each board meeting. A typical agenda would include key performance metrics regarding readmission rates, mortality rates, patient satisfaction scores, hospital-acquired infection rates, central line-associated bloodstream infections, and catheter-associated urinary tract infections. It is a very active board committee.

I believe that more boards should replicate this process, because, ultimately, the local board is held accountable by regulatory agencies for the quality of the organization's care. The
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discussions of the quality committee get reported later that same day at the board meeting.

I'm proud to say that over the last two-and-a-half years, we have been recognized by the Centers for Medicare and Medicaid Services as a four-star hospital, one of 15 hospitals across New York State to have that designation. We believe that if we focus on all Five Pillars, strong financial performance will follow.

What do you think will be some of your biggest governance challenges over the next two to three years?

I think that our continued focus will be on becoming a “best-in-class organization” and what the upper-decile hospitals across the country are doing. We've done some great work, but to be best-in-class, we need to be in the upper decile (e.g., Solucient Top 100).

For example, *C. diff* rates. Our goal last year (2017) was 9.0% per 10,000 patient days. We ended up achieving 4.8%, so we set a very aggressive target of 4.3% per 10,000 patient days this year, which is really high performance. We have established various action plans around that goal (e.g., use of Xenex Robot Ultraviolet Cleaning System, and we have a hand hygiene program that uses badging technology called Proventix). We are trying to bridge the gap of leveraging technology, people, process, policy, and leadership in order to create a best-in-class organization. Our board will continue to focus on accountability on those quality metrics.

The second thing that I think will change structurally with the board is to focus on how we best utilize the time that our board members contribute to us. We have a finance committee meeting the third Tuesday of every month, followed by a board meeting the third Wednesday of every month, and sometimes there is some duplication. We will be changing the frequency of some meetings, so that board members feel their time is value-added. We will also look at what other top-performing organizations are doing from a governance standpoint that is different from what

we are doing. We do conduct an annual survey of board members to solicit their input and identify areas where we can improve.

I think our bylaws are already pretty clear on the roles and responsibilities of our local board and how that feeds up to the overall parent Board of The Guthrie Clinic.

Do you foresee any challenges in the future of recruiting new board members?

I think we've done a very good job of recruiting new board members, and we're blessed to have a super engaged board that is highly talented. This is an exceptionally strong board, probably the best board I've worked with in my 30 years of being in healthcare, and they are very metrics-driven, which adds to their level of engagement and understanding.

They also do a fabulous job of being the eyes and ears of the community. They are very civic-minded and true servant leaders in the community. Our bylaws allow for up to 21 board members. Each board member, their attendance, and their input is very valuable, from a participation and advisory standpoint.

One of the things I'd like to explore is the use of a technology platform. Many boards are now using iPads, so each board member would come with a secure iPad containing the documents to be reviewed at the meetings. I don't know how soon we can get there, but that's one of the things we're exploring.

This board holds the management team accountable and I really respect that. I've been on all kinds of boards and some have been rubberstamp in nature, but this board expects you to speak to your action plans. So, I'm really complementary of the people that I get to work with.

What do you see the role of the stand-alone hospital being over the next three to five years? Do you foresee that change continuing to happen to the local boards moving in that advisory role?

We have already lived some of that, given that we're part of a larger system. And so organizations that are still stand-alone and independent will struggle with this issue. They will feel that they are going to lose all of their identity, autonomy, and ability to make decisions, and then it becomes an emotional decision. I've been down this path in the past. I actually sold a hospital in Pennsylvania to a for-profit company. It was the right thing to do, and I would do it all over again. The perception is that the local board has no presence, no purpose, and that simply is not accurate.

I'll use my experience in Pennsylvania. When we were exploring an RFP and a potential partner, we developed a list of haves, have nots, and deal-breakers. And so we were willing to give up certain things in order to be more viable at the end of the day.

Would an organization lose some ability to determine strategy, as well as handle the disposition of assets, and other budgetary matters? Well, of course; however, if at the end of the day, it makes you a stronger organization, then my advice to the stand-alone organizations is to get past the emotional issues and make the right decision for your community. One of the ways we deal with this at Guthrie Corning Hospital is that for key decisions (budget, strategic plan, and capital acquisitions) the local board makes formal recommendations for approval to the parent board for final consideration.

The Guthrie Corning Board truly understands their role and how they can drive quality and become a best-in-class organization. Thinking strategically around quality and patient experience can be the differentiator.

Our board members are also ambassadors in the community—they are the eyes, the ears, the soul of the community, and, yet, they make sure they also carry out their fiduciary duties to the organization.

I would say again, to those organizations who are looking for partners, to keep in mind that your board members are highly valued and they represent the voice of the community and businesses.

If you lead the organization with key values in place, such as being fair, honest, consistent, transparent, approachable, accountable, and patient-centered, you will make the right decisions.

These days, everything's transparent on Facebook, Yelp, and hospitalcompare.com, or whatever the website is, and so I always try to end meetings by focusing on a positive story that we call "Carrying Compassion Forward." I often have the privilege of either seeing a Facebook posting or I receive a handwritten letter that talks about the great care that has been given or that we saved someone's life, and I share those positives so that each board meeting, the board members know that they are making a difference in the community.

The last question really pertains to Healthcare Trustees of New York State as an organization. How do you see us continuing to meet the governing needs of your board in the future?

I think that HTNYS and HANYS do fabulous work. Your annual conferences are always very well done.

MONTEFIORE HEALTH SYSTEM

Joel F. Emrich

DIRECTOR, BOARD RELATIONS



As Montefiore Health System's Director, Board Relations, **JOEL EMRICH** manages the day-to-day operations of its Board of Trustees. He is lead staff to the governance and nominating committee, and works with the board's audit, community services, compensation, development, executive, finance, and strategic planning committees.

Mr. Emrich has more than 15 years of experience in the C-suite driving best practices in board engagement.

He began his post-college career in healthcare, working for two years as a patient care counselor at Henry Ford Health System, before starting a career in board relations at YMCA's national headquarters in Chicago.

Mr. Emrich is a graduate of the University of Michigan and has lived in New York for the past 13 years.

ABOUT MONTEFIORE HEALTH SYSTEM

Montefiore Health System consists of 11 hospitals; a primary and specialty care network of more than 180 locations across Westchester County, the lower Hudson Valley, and the Bronx; an extended care facility; the Montefiore School of Nursing; and the Albert Einstein College of Medicine.

Has your governance structure changed over the past few years, and if it did, why did you make changes? If not, do you see any changes coming in the future?

The simple answer is, yes. We established our Montefiore Medicine Board, which is an umbrella for our Montefiore Health System Board and our Albert Einstein College of Medicine Board, in late 2015/early 2016 in response to our partnership with Einstein.

At the committee level, our committee structure and reporting relationships have been revisited and revised to help shape board agendas and focus.

What do you think will be your biggest governance challenges over the next two to three years?

Like many expanding health systems, establishing the roles and key functions of our boards, including those of our member organizations, will continue to be a focus.

Do you see any of the board processes changing?

We are always looking to be strategic with our board and committee meetings. We do this by reviewing meeting agendas, frequency, and timing so we make the best use of our trustees' time. We will also continue to make use of ad hoc committees to meet specific goals when possible, allowing us to be even more efficient.

When it comes to technology, the trustee experience here is both online and offline. We're exploring platforms that enable virtual participation not only in traditional meetings, but also in one-to-one or in small-group settings. This should increase opportunities for trustee engagement and connectivity, which is especially important to us, as many of our trustees are longstanding members with longtime relationships.

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Our governance and nominating committee recently approved new processes related to prospect vetting and the onboarding of new trustees and committee members. While it's important to be disciplined about following these processes, we'll need to be open to adapting them to meet the needs of each of our boards as the health system evolves.

Do you foresee challenges in recruiting board members in the future, and if you do, do you have any plans in place to overcome those challenges?

We are in a big city, and with a big city comes big competition for resources, including new board members. One way to approach this is to focus on recruitment as a give/get experience, which means being open to how we approach a prospect. At Montefiore, we have one of the nation's premier centers for research and medical education in the Albert Einstein College of Medicine. Under the Montefiore Health System umbrella, we have centers of excellence in cancer, cardiology and vascular care, pediatrics, and transplants; as well as hundreds of touch points in communities across the Bronx, Westchester, and the Hudson Valley, including a widely respected school-based program. This provides us with a unique opportunity to tailor the recruitment experience to meet or exceed a prospect's interests.

As many stand-alone hospital boards are moving to function in more of an advisory role, because they have aligned with larger systems, most of the decision-making is being made at the system board level. Given this reality, what do you see as the role of the stand-alone hospital board in the next three to five years?

My focus at Montefiore has been board work at the system level, so stand-alone hospital boards are newer to me. My perspective is that these boards will continue to be representatives of, and connectors to, their communities. They should also benefit from their affiliation with Montefiore and Einstein as both recipients and providers of shared services and financial, clinical, and philanthropic resources.

Muhammed T. Javed, MD

BOARD VICE CHAIR



MUHAMMED JAVED, MD, is currently Vice Chair of the Board of Directors of Upper Allegheny Health System (UAHS), the parent company of Olean General Hospital in Olean, New York, and Bradford Regional Medical Center, in Bradford Pennsylvania. He has been a board member since the inception of UAHS in 2009. Before that he was a member of the Olean General Hospital Board of Directors.

Dr. Javed has held various leadership positions at both Olean General Hospital and Bradford Regional Medical Center. He serves as Assistant Medical Director and Physician Advisor at Olean General Hospital. He has been President of the Olean General Hospital Medical Staff, Chairman of the Department of Medicine, and has served on numerous other hospital committees. To enhance his leadership capabilities, he completed the process for national certification as a certified medical staff leader. He has served as President of McKean County Medical Society. He is a Clinical Assistant Professor at State University of New York (SUNY) at Buffalo School of Medicine, teaching resident physicians at Olean General Hospital's family medicine residency program, and is three-time winner of the program's "best teacher award."

He is a current board member of Healthcare Trustees of New York State and The Physician Leadership Board of Optimum Physician Alliance, an independent practice association comprised of more than 500 Western New York primary care physicians and specialists and serves as the chair of its quality committee. Dr. Javed has long been active in the local community. He is currently a board member of the Olean/Bradford YMCA.

Dr. Javed completed his residency in internal medicine and his fellowship in nephrology at SUNY Downstate Medical Center.

ABOUT OLEAN GENERAL HOSPITAL

Olean General Hospital is a member of Kaleida Health, based in Buffalo, New York, and part of UAHS. The Olean General Hospital campus includes 186 patient rooms, together with comprehensive patient, administrative, and physician services and accommodations to meet the diagnostic, treatment, administrative, and educational needs of its patients and medical staff. UAHS provides care to a service area with more than 160,000 individuals in southwestern New York State and northwestern Pennsylvania.

Has your facility's governance structure changed over the past few years, and if you made changes, can you tell me why they were made?

As we know, healthcare is changing rapidly in how we deliver care to our communities. Olean General had their own board and decided to affiliate with a local hospital, Bradford Regional Medical Center, which is across the state border in Pennsylvania. Once the affiliation process started, we had

to make some changes to accommodate both hospitals' needs. We created a mirror board. This way both communities were represented. That was the biggest change. Having a mirror board helped to increase the standardization of clinical processes and also allowed us to create a strategy on how to deliver more effective care to our communities. During that transition we continued to meet monthly.

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But, we created joint quality committee meetings and joint finance committees. These changes brought more standardization and minimized the duplication of effort in both hospitals. At the time of this interview, we are in the process of formally merging, so that both hospitals become one under the parent company, Upper Allegheny Health System.

The next step was to affiliate ourselves with another larger health system. This required our board to do a lot of strategic planning. After multiple interviews and talking with different healthcare systems, we ultimately decided to have an affiliation with Kaleida Health. So, now we are going through board changes again because the system board and the local hospital board rules are slightly different. But ultimately, our goal is to provide care locally and at the same time have an affiliation with a larger system so we can access their resources.

In the past, the focus was only to deliver acute care; but now we are in the continuum of care where we need to provide care to the whole population and manage their care from screenings and preventive care to treatment. So, the board is going through another transition—determining how to identify the role as a local board and also have an affiliation with the Kaleida system and how to govern within the system.

What do you think will be your biggest governance challenge over the next two to three years?

One of our biggest challenges will be to define our role in two ways: how we integrate ourselves with the larger healthcare system, and how to execute the larger system’s strategy. The larger system’s job will be to create a broader picture and provide a vision and broad strategy where we can improve the health of the population we serve through prevention, screening, and treatment.

It is important for the local board to have a significant role in the execution of that strategy and growth, credentialing of the medical staff, and also providing quality and value while caring for the community. Another very important role is philanthropy, where people can contribute to the local foundation. We need to be able to engage the community to seek their input to improve the structure or provide equipment. We need to ensure we do not lose the local flavor as well, and do not become irrelevant in a larger system.

Do you see any of the processes your board follows today changing in the future?

We’re trying to create a board meeting schedule to mimic the Kaleida system’s schedule. So we have reduced the number of board meetings from 11 to six meetings a year. This ensures better communication between the local and system board. We can utilize board members’ time better for their input if we meet every other month. However, the finance and the quality committee meetings will continue as usual, monthly and quarterly. Also, we want to continue to keep the local board engaged with a clear updated strategy so they can continue to be a part of the decision-making process of the system. Though they will be in a more advisory capacity, they still need to provide input on local opportunities, community needs, and assessments.

Do you see any recruiting challenges for board members in the future?

Yes, that has been a problem even before we affiliated with the Pennsylvania hospital and now we are affiliating with the larger system. The reason, basically, is that in the past, the bigger donors usually always got a seat on the board, but as healthcare continues to change, we want a knowledge-based or expert-based membership on the board. This is always a challenge because not every community has all the experts and knowledgeable professionals living within it.

We did open the recruitment of members within the community and outside the community. And so far, we have been able to recruit local board members with specific interests, such as finance, technology, and medical. In the new larger system structure, our chairman of the board will be on the Kaleida system board as a full voting board member. This gives us a link so we can bring the information back and forth between the system and local board. I think we see there is a challenge to recruiting the right people for the right reasons, but so far we've been fortunate to recruit a full slate of diverse board members.

Also, in the Kaleida system's finance committee, there will be a representative from the local system with voting rights.

As you know, many stand-alone hospital boards are moving to function in that advisory capacity. Most of the decision-making is being made at the system level. Given this reality, and this is not just talking about your system, what do you see the role of that stand-alone hospital board being in the next three to five years?

You know that is going to be a challenge since you see this appearing in the literature—how to keep the local boards engaged even though they are in the advisory capacity. But I see that the local board still can function and provide a significant strategic value to the larger health system because ultimately, healthcare is local. People on the individual hospital boards can still contribute to the quality and the community need. In our system for example, we kept the credentialing of the medical staff with the local board, obviously the system has to bless it every time. But we still have a say on the credentialing of the medical staff. We also developed a very strong quality committee so we can continue to provide quality care. We do plan to connect to the larger system's quality apparatus so we can function within that system, but continue to provide quality care locally.

We also see the employment model changing with the physicians. Most of the physicians would like to be an employee of the health system, so that's where the local board can help the larger system

board to engage physicians locally and make them an integral part of the local community as well as the larger system we are working within. I think the larger system is good to have, but we have to remember they will focus on strategic development. When it comes to the execution, you still need local supervision. I think the local board will have to define themselves and insert themselves into that role going forward, not sit back and let the larger system send us the orders. Transformation will occur at the local and system board levels.

Before we get to the last question, are there any other comments that you want to add?

Yes, basically as I was saying earlier, we need to remind the local board that just because they signed an affiliation agreement, that should not take them off the hook in terms of contributing to the strategy and execution of initiatives. They still need to continue to reevaluate their competency and recruit people who have some expertise relevant to the mission. If we keep them engaged at that level, they are the potential future members of the larger system board. The local board can continue to assert themselves in quality and credentialing. I think utmost is that we need to keep the hospital mission upfront and remind ourselves the reason they became members of the local board: to provide the care to the local community in the best way they can.

What role can Healthcare Trustees of New York State play for future boards?

HTNYS can play a role to continue to remind the smaller and local hospital boards that just because they are a part of a larger system, they still provide value to the community. Local boards can still be responsible for recruiting, managing, employing, or satisfying physicians and improving patient satisfaction. The board must continually strive to achieve the Quadruple Aim. If you remind yourself of your responsibilities, you always are going to find your role can be more than an advisory role.

ST. JOHN'S EPISCOPAL HOSPITAL

Gerard M. Walsh

CHIEF EXECUTIVE OFFICER



GERARD (JERRY) WALSH is a proven healthcare executive with more than 25 years of healthcare leadership experience. Mr. Walsh has a depth of expertise in organizational change, physician development, and implementation of quality and patient safety programs, mergers and acquisitions, and a strong knowledge of community hospitals. He has proven success in developing strong medical staff relationships through recruitment of talented physicians and creating new programs and services that drive margin growth.

A native New Yorker, Mr. Walsh was born and raised in Queens and attended high school in East Elmhurst. He has a bachelor's degree in health care administration from St. John's University and a master's degree in health systems management from Iona College.

ABOUT ST. JOHN'S EPISCOPAL HOSPITAL

St. John's Episcopal Hospital is a 240-bed community hospital affiliated with Episcopal Health Services and welcomes people of all faiths. The care team includes more than 400 physicians, 1,500 employees, and many committed volunteers.

St. John's Episcopal Hospital is fully accredited by The Joint Commission and is a teaching affiliate of SUNY Downstate Medical Center and Lake Erie College of Osteopathic Medicine. The hospital is also a New York State Designated Stroke Center and is a certified emergency heart care station.

Has your governance structure changed over the past few years?

The formal board structure has not really changed that much, although in my tenure over the past two years with the organization, we have done a lot of structural changes to our Board Quality Committee and our Board Finance Committee, mostly on the quality side, including new membership, more frequent meetings, more of an in-depth look at quality metrics, and educating the quality board on how to interpret those metrics.

And the other big change at St. John's was a restructuring of leadership. We have pretty much an entirely new administrative C-suite here since I arrived in 2015.

Do you see more changes coming, either in some of your committee structures or in your board structure, over the next three to five years?

Absolutely. We are in the process, through our board retreats—we have had two formal board retreats (one in 2016 and one in 2017). We are getting a lot of energy from our current board members around redoing how we evaluate and assess board performance. We are doing a lot around education and development. I've had national speakers at the board retreats talk about the importance of the role of the board as well as the coordination between medical staff leadership and administration. We are currently in the process of redoing our board membership job descriptions as well.

There is going to be a tremendous amount of work done over the next 12 months to put some of these changes in place.

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What do you think will be your biggest governance challenge over the next two to three years?

Probably the biggest challenge is to recruit new board members with specific skills and expertise that they can bring to the table, as well as diversifying our board. Diversity is a big issue. And the Rockaways, in particular, is an extremely diverse community—very wealthy to very poor. There is a lot of religious and ethnic diversity. We really need to take into account the demographic makeup of the communities that we serve. I think this will drive cultural change.

Do you see any of the processes that your board follows today being different in the future, such as maybe less or more meeting time, less or more committees, virtual participation, things like that?

Yes. As a matter of fact, on the finance committee side, we've had some changes in retirements and added some new trustees. We are still having 12 meetings a year, but we have gone to a virtual model of meetings for the finance committee. That just started within the last couple of months. So far it is working well, but we are going to monitor it and see how it goes.

We also are looking at how frequently we meet as a full board, and how many members on our subcommittees we can use as succession planning for the future of our board. But as we interview new prospective members, one of the first questions they always ask is "what is the time commitment?"

We want people to engage and give freely of their time, but we want to be sensitive to the fact that this is a voluntary board and we need to use their time as best we can.

It is going to be a big challenge as we move forward, engaging a younger population that is in the workforce. The advantage for having these young members is that they are much more technologically savvy and they are more willing to do virtual meetings.

We spoke a lot about challenges in recruiting board members for the future, and about diversity. Is there anything you want to add to some of those challenges?

A big challenge will be board member recruitment. As we recruit for these positions, we really have to think strategically about what we need and where those members need to come from. I would love to get someone from manufacturing or the airline industry to sit on our board, especially considering the quality perspectives that they bring to the table. But it is a challenge, and we are being very strategic and intentional in who we interview to become members of our board.

As you know, there is a trend to have a few members on your board from outside of your service area because they bring those key skills that you need. So, you can look beyond the boundaries of your service area and your community to get some of those key positions that you are looking for.

Yes, we have—at our retreat last year, we had a board member who was a member of a health system in Baltimore, but he lived in Philadelphia.

But he brought a specific skill set to that organization. And it was a hospital that is demographically very similar to St. John's. We talked a lot about skill sets and diversity around that. I thought it was valuable for our board to hear from someone who understood the complexities we deal with.

What do you see the role of the stand-alone hospital board being in the next three to five years? This doesn't necessarily pertain to your board, but stand-alone hospital boards in general.

I think for us and stand-alone boards, if big systems are making the high-level decisions, the stand-alone boards need to increase their community involvement. They need to be more present in the community. They need to concentrate on the things that affect their hospital with a higher level of accountability, say, for quality. And, they need to be advocates for the hospital in either their system or in the community as far as government relations and other community activities that are taking place that affect that individual facility.

How do you best see Healthcare Trustees of New York State meeting your board's needs in the future?

I think that the educational conferences and webinars are extremely valuable. I am going to try this year to coordinate getting more of our board members involved in attending some of the conferences and webinars.

The last point I will make is how important it is to engage our board with state and federal advocacy. This is a priority for us, and it should be for all stand-alone facilities like St. John's.

ST. LUKE'S CORNWALL HOSPITAL

Joan Cusack-McGuirk

PRESIDENT AND CEO



Joan Cusack-McGuirk, a longtime resident of the community, has more than 40 years of experience in healthcare, serving more than 30 years at St. Luke's Cornwall Hospital (SLCH). She was instrumental in finalizing the partnership between SLCH and the Montefiore Health System, which was announced in early 2016. Since that time, Ms. Cusack-McGuirk has worked to integrate SLCH into the Montefiore Health System (MHS), a national leader in transforming healthcare to improve access, quality, and experience of care, and a leading academic health system.

Ms. Cusack-McGuirk graduated as a registered nurse from St. Vincent's Hospital and Medical Center in New York City, received her Bachelor of Science in nursing degree from SUNY New Paltz, earned a Master's degree at New York University, and is a graduate of the Wharton's School Fellow Program.

Ms. Cusack-McGuirk is a member of the Executive Board of the Orange County Partnership, and is also an active member of HANYS, Northern Metropolitan Hospital Association, and Patterns for Progress.

ABOUT ST. LUKE'S CORNWALL HOSPITAL

SLCH is a not-for-profit hospital dedicated to serving the healthcare needs of those in the Hudson Valley. In January 2002, St. Luke's Hospital and The Cornwall Hospital merged to create an integrated healthcare delivery system, providing quality comprehensive healthcare services. In January 2016, SLCH partnered with the MHS, making SLCH part of the leading organization in the country for population health management. With dedicated staff, modern facilities, and state-of-the-art treatment, SLCH is committed to meeting the needs of the community and continuing to aspire to excellence.

SLCH is accredited by The Joint Commission and has more than 300 physicians on staff, representing dozens of medical specialties. Additionally, more than 1,500 clinical and support personnel work at the hospital, making it one of the largest employers in Orange County.

How has your governance structure changed over the past few years? If you did not make any changes, can you tell us why not?

It has. It really started well over a decade ago, when we merged two competing hospitals into one to form the St. Luke's Cornwall Hospital Board of Trustees. We went from two separate boards to one, comprised of collective community members and leaders.

More recently, when we partnered with MHS, three members of the MHS leadership team joined the St. Luke's Cornwall Hospital Board, filling vacancies that existed at the time. They were

welcome additions as we were further integrating within the system. The "voice from the mother ship" isn't only valuable, but also essential, as we jointly develop strategic direction.

Do you have any of your hospital board members that sit on the Montefiore Health System board?

Not at this time.

(continued)

Are you the gatekeeper between the voice of your hospital and the board, or are those three board members from the Montefiore board the gatekeepers to transfer the information back and forth?

Actually both. Dr. Safyer, President and CEO of MHS, conducts CEO roundtable meetings that I actively participate in. I also have access to Dr. Safyer at any time. Dr. Ozuah, Executive Vice President and the Chief Operating Officer of MHS, also meets with the CEOs from all of the entities within the system on a routine basis. Again, I have open access at any time. Many times I apprise both of them directly—it's that type of relationship and it is encouraged. In addition to that, there is a member of the MHS board who is one of our board members. He and I have frequent meetings and direct contact. I have many avenues of contact within the entire system; it's a big system with a "small town" feel.

Do you foresee any additional changes to your hospital board within the next three to five years?

Yes, I do. As we become more integrated with the system, I foresee that our board will take on more of an advisory role, with the final decisions relative to the strategic direction and financials being made at the system level. With that said, I believe that our local board will have a strong voice at the table. It aligns with Dr. Safyer's vision of keeping the care local; decision making will be made in a collaborative effort with our local board, a board that has the interest of the hospital and the community in the forefront, and a board that also knows and understands we are a part of something bigger. There will be a synergistic effect. We are no longer looking at SLCH in a silo but rather as being part of one of the leading systems in the nation! Together, we are growing SLCH's footprint across the region, which has been a significant, positive change.

What do you think your biggest governance challenge will be over the next few years?

Dealing with and responding to the unpredictability of healthcare. Healthcare is in a very vulnerable time. The analogy of having one foot in each canoe or standing on the platform as the train is pulling away is real and we need to prepare for both and move very quickly when the tide changes.

Our board is very well versed in the tenets of population health and value-based payments. They are business leaders in our community and understand the role of "fee for service" as well as the need to operate in this dichotomous payment structure. It's the unpredictability that will be the biggest challenge.

Do you see any of the processes that your board follows today different in the future? For example, board meeting times, the committees, virtual meeting participation, etc.

Yes, I do. The integration of our board at the system level may change the frequency of meetings and types of meetings at the local level. As healthcare delivery continues to change, the role of the governance board continues to evolve. All of our board members are volunteers and dedicate a tremendous amount of time. The advocacy efforts required are greater than ever before. I see that continuing in the future. The technology capabilities of our meetings have advanced and we are able to provide board members with the opportunity for virtual participation, which is beneficial.

Do you foresee any recruiting challenges for board members in the future? If so, do you have any ideas for overcoming some of those recruitment challenges?

It's always been the challenge to have a diverse board and to have it mirror the population which we serve. Recruiting the right board member is critical. They are the advocates for our community and they have to understand the fiduciary responsibilities of being a board member in today's environment. With the added demands, I do think this may become a challenge in the future. The time commitment required and the level of commitment needed and understanding of the complexity of the business are a large part of the role of today's board leadership. It's not just going to a meeting for an hour and coming in and out. It's a multifaceted business. We have been successful in meeting these demands thus far, but that could be a challenge going forward.

We're seeing that many stand-alone hospital boards are moving to functioning in an advisory capacity, while most of the ultimate decision making is being made at the system level. I know you alluded to the possibility that your board could end up in that advisory role. Do you see that a lot of the stand-alone hospital boards will be participating in governance more at that advisory role in the next three to five years?

I do, but I believe the local board is going to remain relevant.

They are the business leaders that represent the community every single day. They live and they work here. As it's been said, all politics is local. No one knows the local politics better than the community members that serve as a hospital's board of trustees. It also depends on the philosophy of the system. Dr. Safyer has been very clear: whenever possible, keep the care local. This transcends to the voice of the local board leadership. I believe it will remain relevant, needed, and welcomed at the system level.

This philosophy prepares the organization well for working with other healthcare organizations and priorities: our home health agencies, skilled nursing facilities, multi-specialty practices, family health centers, the integration of behavioral health services into primary care, and investing in social determinants of health. The list is endless. As we know, there is uniqueness to each community. This, in combination with the shift in the delivery of healthcare, will have its effect on the consumer at the local level; therefore, the voice of the local board of trustees is going to remain important.

How do you see Healthcare Trustees of New York State meeting your governing board's needs in the future? You've been very supportive of coming to our conferences, so what do you see our role as the role of the board is changing? Where does HTNYS fit and how can we help?

HTNYS offers quite a bit of education through the Annual Conference, webinars, and face-to-face discussions. That's incredibly helpful. The policy and the compliance issues will remain pertinent to the local board and the system boards, as well as the fiduciary roles and responsibilities. I have a seasoned board; they are the business leaders in this community. They are, on many levels, our advocates for our community. We need HANYS to continue to "fight the fight" on regulatory changes and payment reform as the delivery of care changes to pull cost from the overall healthcare system by having the patient in the right setting. We need the payers and regulations to catch up. Hospitals need to be rewarded for providing care in the most appropriate setting . . . even if it means a loss of revenue; hospitals should be compensated, not penalized. HTNYS has done a nice job with advancing "the cause" and needs to continue.

In closing, it is an absolute pleasure working alongside HANYS and HTNYS.

Daniel E. Clark

TRUSTEE



DANIEL E. CLARK has been a member of the Board of Directors of Alice Hyde Medical Center since 1980, serving as Chair from 2001 to 2005 and again from 2012 to 2016. He served as Chair of the Board's Executive Committee from 2001 to 2005, and remains an active member of several board committees.

Mr. Clark is also the owner of King-Clark, Co., Inc., and co-owner of North Country Realty and Adirondack Quarry, Inc./Rainbow Quarries, Inc. Mr. Clark is a former member of both the Malone Economic Development Corporation and the North Country Workforce Investment Board, and a member of the Housing Council. Mr. Clark served on the board of HTNYS from 2007 to 2015.

He is a graduate of State University of New York at Canton, where he earned his associate degree in banking, insurance, and real estate.

ABOUT ALICE HYDE MEDICAL CENTER

The University of Vermont Health Network-Alice Hyde Medical Center, located in Malone, New York, is comprised of a 76-bed acute care facility, a 135-bed long-term care facility, 30-bed assisted living facility, four family health centers, a walk-in clinic, a cancer center, an orthopedic and rehabilitation center, cardiac rehabilitation unit, hemodialysis unit, and dental center.

The Medical Center is an affiliate of The University of Vermont Health Network, a six-hospital system that includes The University of Vermont Medical Center, UVM Health Network-Central Vermont Medical Center, UVM Health Network-Champlain Valley Physicians Hospital, UVM Health Network-Elizabethtown Community Hospital, and UVM Health Network-Porter Medical Center.

Has your governance structure changed over the past few years, and if so, can you tell us some of the changes you made? If there were no changes, can you tell us if you see any changes coming in the future?

Alice Hyde joined the University of Vermont Health Network in May 2017. The answer is did it change before? No. Has it changed since? Substantially.

Can you describe some of those changes since May 2017?

I've been a hospital trustee for about 37 years now, and have been through a lot of changes. I think, to be totally honest with you, a lot of the smaller hospital boards have actually had their fingers well into management and not into governance. I think there's been such a

misunderstanding of what a board should be doing compared to what management should be doing. That's been our biggest change. It's also been our biggest challenge.

Is there anything else you want to add to the specific changes?

Well, I mean I can dive into a lot of different topics on that, but as you join the system, you give up, or it forces you, into actually doing what a board should be doing as opposed to the day-to-day management. There is more focus on partnerships, more focus on making decisions on services that are going to be provided in your area that you really couldn't make before because of the structures of the local boards.

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What do you think will be some of your biggest governance challenges over the next two to three years?

Working within the system, I think the biggest challenge is being able to give up those pillars of power and to be able to pass on the day-to-day management. Working within the system and trying to keep involved, but yet don't try to make those actual decisions.

I think an example is you can start taking advantage of restructuring your management so that every single hospital (within a six- or ten-hospital organization) will not have a CEO at all of their locations. You're going to be able to take advantage of much more seasoned management and the structure is going to change so you're going to have a COO and a CIO and they are going to be able to look over three or four different hospitals and drive the changes actually needed within all of our organizations.

Could you talk about some of the process changes for the Alice Hyde board that you've seen and that you will continue to see?

The need to be able to have monthly board meetings that last for hours and do nothing but review what the management has done in the past are going away very quickly. The way things are moving is you're going to be taking a look more on health and quality, which will be one of your major functions.

The function of finance even is changing substantially because now boards are working within an organization, not just with one hospital. So, a lot of the change is being driven by the system CFOs, and there's another change: that a hospital might not have a CFO. They may have very strong controllers or they may have very strong vice presidents of planning, but your CFO is going to be from the system and this is from Burlington in our example, who thoroughly understands reimbursement and has a lot of the things already working within the organization that you take advantage of.

What about committee meetings of the board? Do you see any changes in committees?

Yes, I think quality is going to be one of the committees that will meet monthly. I think we'll definitely have a finance committee that will meet monthly. Those are probably your two basic ones that'll work together. The monthly meetings are going to be done on the level of a whole system, which a couple of your board members will be part of, but you're not going to go back every single month and have a monthly meeting with the board. We're looking at doing probably quarterly meetings, taking advantage of email, etc. to be able to educate our board members with what's going on at a system level and within our own hospital, and not spend so much time at meetings that really aren't needed any longer.

Do you know if virtual meeting is allowed?

Yes, that's something that's getting to be utilized more and more. And of course, the key to that is having a person who knows how to run a personal meeting.

We are lucky in that with the UVM Network, they've been doing this already, so they've got seasoned people involved who know how to engage participation from people who are joining in virtually. That's critical. That's a skill that definitely is needed. That's going to be done and we're going to be able to join any meeting or any committee meeting of the network that way.

Do you see any challenges in recruiting board members in the future? If so, what are they?

I think the board member that we've looked at in the past, who is coming from the community, people who answer a specific need on your board, is going to change very quickly. A representational board is something that systems push. When you're changing things around totally, the idea of sitting on a hospital board for the prestige is going away. So you're going to be looking at grabbing expertise in different areas.

Now that's the system board. On your regional board, I see that changing completely. You're going to be looking for more people who will know how to run meetings and get participation out of the local board members. You're almost going back to the days of where you had foundation boards. That's where you drew your members from. Those would be used for fundraising. Those would be used for specific items, and there is your feel on what the community is.

How do you see community being represented?

That is the biggest challenge. It's also the biggest reason a lot of small hospital boards have gotten in trouble financially, trying to be everything for everybody. There's a huge balance in trying to figure out how you're going to handle that. For example, dialysis. If you needed inpatient dialysis for six people in your community, that is a huge money loser. How do you take what the community needs and provide that within the system?

Many stand-alone hospital boards are moving to function more as an advisory role with most of the decision-making being made at the system level. Given this reality, what do you see the role of that stand-alone hospital board being in the next three to five years? Do you think it will still exist or not?

I think that they're going to exist, but with diminished power and authority. The key is going to be how many of those board members are willing to put the time and effort into travel to be part of the system board. That's always been a challenge. Who can afford to take two days a month off from their day time work? Because that's the way that these board meetings run, where your committee meetings are done one day, and the board meeting is done the next day. I do like this approach because I'd rather give up two days in the month than travel back and forth to all of the different committee meetings. But who is going to take that on? It goes with the day of the business person who works for themselves. It's going to be a challenge to have the time to devote away from their business.

What we're trying to work through though are ideas—how can we all better ourselves? It's very challenging.

How do you see the stand-alone hospital boards functioning in the future? What do you see as a key role they will continue to play?

The biggest challenge for the system board is how do they know that the community needs are addressed by the local hospitals? UVM is a teaching facility, so their reimbursements are completely different. Decisions that they may be making as a group for us require that they understand what the challenges are: the largest employer of the area, percentages of people who need different services, how you deliver the services—that's critical. They are starting to realize that the old days of building bricks and mortar and having the patients go to you is changing.

Do you see the stand-alone hospitals still having a critical role in making that connection with the community and then somehow having that information filtered up to the system level?

Yes. And it's got to be done by the strongest people who sit on those local boards who are also willing to sit on the network boards. That's the key. If you don't have anybody from the local board on the network board, then you're talking to a CEO. And then you have problems about who does a CEO work for? Does a CEO work for a local board? Does a CEO work for a region system? Or does a CEO work for other systems? Everyone is challenged with those questions.

(continued)

Any other comments or thoughts to share?

Well I think the only other comment I would make would be: What's going to be the function of the trustees of your board? How are you going to change so that trustees can be educated to what happens within the organization when you either work within the system or partner with another one, or whatever the case might be? The local board members don't really get that education. They don't really get to see exactly what's going to happen until it happens.

A huge need for board members is to be able to work together with other board members to share stories. I may not be able to do that with my neighbor who is 45 miles away, but I can certainly do it with somebody who is 90 miles away. The integration of working the trustees together within HTNYS is an interesting concept.

And do you think that's something that HTNYS can provide a platform for doing?

100%.

How do you see Healthcare Trustees of New York State meeting governing board needs as they're changing in the next three to five years?

Education is going to be key to effective boards in the future. And, the education needs will be different for different systems. The education has got to be so much broader. You can't have the days of doing our conference where we have one speaker come in, assume that it's going to relate to all the hospitals. That's not happening anymore.

The decision to align or partner with another healthcare organization is one of the most important undertakings of a board. Selecting the right partner, strategy, and structure are all critical decisions boards will continue to be challenged with when determining the future of their organizations.

There is not a “one-size-fits-all” approach on the best governance structure. We will continue to see different models of governance evolve as systems modify their board structure to meet their needs. Sharing these models, their effectiveness, and structure will help other boards determine the right model for them.

While the role of the local stand-alone hospital board remains uncertain, it is important that the local community perspective be represented, regardless of whether there is both a system board and a local stand-alone hospital board level, or just a stand-alone hospital board.

As governance structures continue to change, board education will remain critically important. Engaged boards that are prepared with information are best positioned to achieve success. The healthcare environment is changing on a daily basis, and board members are confronted with critical issues that will impact the way care is delivered in the future. It is imperative to ensure that a governing board, whether at the system or stand-alone hospital level, is well educated on these changing issues and how they will impact the hospital, health system, and community.

ABOUT HEALTHCARE TRUSTEES OF NEW YORK STATE

HTNYS provides leadership and continuous learning and growth for trustees of all experience levels. We offer the education, support, resources, and timely information trustees need to better understand and navigate the shifting healthcare landscape, advocate for their organizations, and fulfill their governance responsibilities:

- **Expertise**—thought-provoking state and national experts share strategic insight on compelling topics and issues.
- **Education on Demand**—30-minute recorded programs on must-know governance topics.
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HTNYS' MISSION: To assist voluntary healthcare trustees through education, communications, and advocacy to promote the delivery of quality healthcare to all communities in a cost-effective manner.

QUESTIONS

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