Welcome to The Governance Institute’s E-Briefings!

This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance, as well as to update you on services and events at The Governance Institute.

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The Changing Nature of Medical Practice: As the Health System Evolves So Does Doctoring

By Todd Sagin, M.D., J.D., Sagin Healthcare Consulting, LLC

Many hospital board members grew up watching Marcus Welby, M.D., and he was the representative portrait of the wise and caring doctor. This iconic image of the 20th century physician was predicated on an understanding that the doctor was an accessible reservoir of essential medical knowledge, familiar with those he cared for and a ready source of continuity care. He was usually the sole custodian of the personal health information of his patients, and capable of treating most conditions without the assistance of a cohort of consultants and technicians or the use of complex medical institutions.

Of course, media portrayals of physicians can be fickle and today’s television purveyors of medical care range from the unprofessional, drug-addicted misconduct of Dr. House, to the endless romantic escapades on Grey’s Anatomy, and the scathing parody of medical professionals seen in Scrubs.

While these recent TV characterizations of physicians do not reflect the common practitioner, there is no question that doctoring in the 21st century is evolving rapidly and we have left Dr. Welby far behind. The drivers of this change are easy to spot and include:

- The continuing subspecialization of medicine, which causes individual practitioners to provide care for an ever more narrow range of medical issues
- The necessity of delivering complex medical care in teams comprised of medical specialists, technicians, non-physician practitioners, nurses, and other support personnel
- The progress in digital information management that has made medical knowledge and data instantly retrievable
- The advances in medical technology that have reduced the need for human touch in medical encounters
- The growing sophistication of computers and artificial intelligence that can inform clinical decision making in real time
- The decline of the hospital as a “medical home” for physicians since more and more of their time is spent in outpatient settings where the bulk of medical care can now be provided
- Accelerating demand for physicians to attend to population health needs and balance group interests against the needs of any individual patient under the doctor’s care
- The shift from a 20th century focus on acute care medical needs to a 21st century environment in which the dominant need is for doctors to manage the care of chronic medical conditions
- The rise of retail medicine, a scaled-down version of primary care delivered in shopping locations like Walmart and Walgreens, which highlights the access inadequacies of the traditional doctor’s office
- The advancement of telemedicine that allows for medical care to be accessed virtually through the Internet from a physician who may be hundreds or thousands of miles away

Doctoring in the 21st Century

As if the list above doesn’t represent enough change, in coming decades the nature of doctoring
will be additionally buffeted by the advancements in robotics (imagine a doctor who needs no sleep!), nanotechnology, and the manipulation of patient genetic material. Doctors will be sought out to not only address the ailments of individuals, but also to modify, customize, or enhance the physical capabilities of the human body to meet personal preferences or adapt individuals to achieve specialized goals. A host of new ethical concerns will accompany the ability of doctors to facilely transform the human body.

As the nature of doctoring changes, so too do the players who wish to provide the traditional services rendered by physicians. The growing numbers of nurse practitioners and physician assistants have been accompanied by an equally expanding scope of practice for these non-physician clinicians. This is a trend unlikely to diminish in the years ahead. In Missouri, a recent change in the laws governing medical licensing will allow medical school graduates to begin practice in rural areas even before completing traditional post-graduate medical training or taking (and passing) the clinical practice portion of the standard U.S. medical licensing exam. The rationale for this reduction in training requirements is to address a severe shortage of physicians in rural areas. There is a clear perception in many quarters that medicine can be practiced without the traditional and extensive preparation undertaken by physicians since the medical education reforms of the early 20th century. The traditional visit to the “doctor” will increasingly mean evaluation and treatment from someone other than a residency-trained physician. Expected shortages of physicians into the next decade will provide added impetus to this trend. As more routine care is provided by non-physicians, doctors will be more likely to specialize further or to serve solely as consultants to those providing care without “M.D.” behind their name.

It’s hard not to notice the advances in telemedicine that are transforming medical practice dramatically. Doctors can now care for even the sickest hospital patients remotely (e.g., through Electronic Intensive Care Units). Video consultations with specialists in underserved areas are becoming more common. Mayo Clinic now has a subscription-based smartphone app that provides real-time video chats with Mayo Clinic nurses. The app also offers a personal medical concierge who can provide health information and schedule patients’ doctor appointments. The market for smartphone-based concierge medicine is already quite crowded and

the use of doctors to provide telemedicine care is evolving quickly. Ongoing efforts by a large group of states to create a multi-state licensing mechanism for doctors will facilitate these telemedicine trends. Known as the Interstate Medical Licensure Compact, it would greatly reduce the barriers to gaining licensure in a multiplicity of states. In this second decade of the 21st century, when we hear the words “the doctor will see you now” it no longer implies an in-person face-to-face encounter. The smiling face of Dr. Welby who listens to our medical concerns may likely be an electronic avatar on a smartphone or an iPad.

A Changing Medical Staff

As physician practice evolves, how will hospital medical staffs be affected? One impact will be an increasing diversity of practitioners joining the medical staff. In the years ahead, we will likely see more and more hospitals adding nurse anesthetists, midwives, nurse practitioners, and physician assistants to the ranks of the medical staff. Recent changes in Medicare’s Conditions of Participation for hospitals make clear that such expansion of medical staff membership is permissible. Medical staffs will not only become a more varied assortment of clinicians, but also expand to encompass outpatient practitioners across ever-larger geographic regions. Medical staff citizenship will cease to be defined largely by clinical activity provided within the walls of a hospital. Those doctors who spend lengthy periods in the hospital—the “ists” such as hospitalists, intensivists, laborists, surgicalists, and proceduralists—will be greatly outnumbered on medical staffs that are numerically dominated by ambulatory primary care and specialty practitioners. Across the country, medical staffs are already undergoing redesign in various ways, such as simplifying burdensome bureaucracy by downsizing committees and departments or merging staffs across hospitals in a health system.

Alternatively, medical staffs may disappear entirely. As hospitals and medical practice evolve, the historic medical staff model has become increasingly outdated. The employment of most doctors will mean that an organized medical staff is no longer needed to communicate the interests of private practitioners nor to serve as a means to protect their business interests. While physicians are important players in advancing quality in hospitals, medical staff organizations do not have a strong track record of improving safety and performance. Large companies manage quality and safety effectively without outsourcing these matters.

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to semi-independent organizations of workers. Similarly, integrated health systems will develop strong internal quality assurance and performance improvement capabilities and may come to rely less and less on the historically weak peer review activities of the organized medical staff.

Physician interest in medical staffs has been waning for decades since these organizations do little to meet the business needs of physicians. In the years ahead, we can expect doctors to identify increasingly with the accountable care organization (ACO) or clinically integrated network (CIN) to which they belong rather than the anachronistic medical staff organization. These new formulations of healthcare providers will be more closely in sync with the changing nature of medical practice.

The new world of healthcare is less hospital-centric, but we will still need these facilities to deliver complex care to seriously ill patients. Housed in buildings from the last century, many hospitals will need to alter their physical space as doctoring evolves. For example, space that can accommodate multi-disciplinary “team huddles” will need to be present in all patient service areas.

Many hospitals have recently upgraded doctor lounges and dining rooms to foster better communication and camaraderie between medical staff members who otherwise don’t see one another and spend most of their clinical time in off-campus sites. Many hospitals, noting the rapid changes in medical skills necessary to keep up with changing techniques and technologies, are building or expanding on-site simulation training facilities. The sophistication of clinical simulation technology and its use in medical education has become quite impressive. Having such training technology readily at hand allows a hospital to undertake prompt remediation of deficient medical staff members. It also provides a means to safely and quickly expand the clinical repertoires of existing medical staff practitioners without having to recruit doctors with these new skills.

Doctors and their activities have always been the beating heart of the hospital. Board members, who are fiduciaries for the hospital enterprise, will want to keep a close eye on the evolution of this profession and the impact on the future of our hospitals and healthcare institutions.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director, Sagin Healthcare Consulting, LLC, and Governance Institute Advisor, for contributing this article. He can be reached at TSagin@saginhealthcare.com.

Building a Hospital Joint Venture: A Blueprint for Success

By Barry Sagraves, Juniper Advisory, and Ken Marlow, Waller

This is the third and final article in a series examining the uses of health system joint ventures, the process of developing a joint venture, and expected trends related to these transactions.

In the first two articles, we looked back into the history of joint ventures (JVs), the factors leading to their emergence, and the potential benefits of a JV to a non-profit hospital or health system. We then looked at emerging trends in JVs and speculated as to the future directions that these models could follow to solve for rapidly evolving healthcare challenges.

In this article, we will explore the “nuts and bolts” of considering and creating a hospital JV, which will allow us to bring the hypothetical and theoretical into the practical. If you are a hospital or health system considering forming a JV, there are some important factors to think through before embarking on this complex process.

Hold It Right There—Before You Even Get Started...

JV partnerships have the ability to address many challenges faced by hospitals and health systems today. However, it is easy to “default” to a joint venture structure without thinking deeply about whether that is in fact the best way to organize collaborative activities. On the surface, a JV may appear to represent the “best of both worlds”—it can bring together the strengths of two or more organizations to create a new “super organization” (for example, the capital and community hospital operating expertise of an investor-owned company with the clinical prowess and brand appeal of a non-profit system or academic medical center). It is, however, important to not lose sight of what is
driving the exploration of a potential JV formation. What are you trying to achieve as an organization? What problems are you trying to solve, and what outcomes are you seeking for your community? Do these goals align with those of your potential partners? While it’s possible (and maybe even common) for partners to seek different objectives, it’s also important for the structure of the JV to flow from these objectives. Form should always follow function.

All too often, potential JV partners will get deep into collaborative talks only to discover that the organizations have fundamentally different goals for pursuing a partnership. One may want to become a preeminent hub for medical research, while the partner may be more focused on creating a regional system in order to create economies of scale. One organization may want to better fulfill its charitable mission by creating a large locally governed foundation, while another partner may want to leverage the branding of the partner in order to fuel new acquisitions outside of the market. It is important to be up front with all potential partners and to clearly outline:

1. What the JV will allow you to achieve that could not be achieved alone
2. What you are willing to commit as an organization in order to fulfill these goals
3. What you are expecting your potential partner to commit

Only then can a JV structure begin to emerge that can help all parties meet these goals within existing constraints. And, who knows, perhaps the delineation of goals, expectations, and commitments will make it apparent that another new, unanticipated party should also be involved, or that a different form of relationship may be preferable. The front-end exploration of goals and form are vital to laying the groundwork for a successful partnership that will thrive far into the future.

A JV Doesn’t Always Mean 50-50

A common misconception is that a JV involves two parties in a traditional 50-50 split. From the outside, this seems like the path to least resistance and the structure that will guarantee fairness and equality for both participants. However, sometimes goals will dictate unequal ownership and governance splits. It’s important to consider how the ownership split should be arranged. For starters, consider these questions:

- Is one party committing more capital, expertise, time, or effort?
- Is one party exposed to more risk than the other(s)?
- Is the JV more important to one party’s overall business success than it is to the other(s)?

It’s important that the structure of the JV follow the level of commitment from each participant. A less-committed party (financially or strategically) can lead to the weakening of a JV—or worse, can do real damage to the other involved parties. Everyone needs a proportionate amount of “skin in the game.”

Cultural Alignment: All That It’s Cracked Up to Be?

One of the biggest buzzwords in hospital and health system business combinations is “cultural alignment.” While it is crucial that the two organizations are culturally compatible, this is not the same as having cultures that are identical. For example, it is possible for each organization to highly value quality and employee fairness, but approach them in different ways.

A health system JV can be conceived of like an all-star team in sports. These “super teams” are made up of the best-of-the-best players from what are, usually, rival teams. While the players need to cooperate effectively on the team, they do not need to be the best of friends off the court. It is important that they have a common purpose and agree on the plan for achieving success, and be committed to the shared goal.

The Nuts and Bolts of a JV

Once a hospital/health system decides this is the path it wants to pursue, the following is an outline of how to start the process of forming a joint venture. This is written with the assumption that the organization has not yet identified a partner. If a partner has already been selected, many of these steps may not be necessary.

1. Prepare the Board and Management Team for the Process

Select an investment banker and counsel. Management and boards typically work with an investment banker to assess the needs of the market, outline strategic objectives, lead the request for proposals, set timelines, assist the parties with their negotiations, and more. A transaction advisor with experience working in this area will allow the board to take a step back, think more broadly, and may also assist in maximizing the competitive process to ensure the best partner is identified. In addition, counsel can be helpful in
advising the hospital on the negotiation of the definitive agreement, assessing the potential risks and benefits of a joint venture, and assisting with regulatory approvals and other review processes.

**Define objectives and review options.** The process, and ultimately the partner selected, will be guided by answering some fundamental questions early. At this point, it’s important to also compare a range of strategic alternatives, practical implications, and successful models. The board, management team, and investment banker should discuss the preparedness for the new healthcare environment and the expectations for overall size and positioning.

**2. Arrange the Joint Venture**

**Sign a confidentiality agreement.** By signing a confidentiality agreement, all parties involved ensure that all information exchanged will be kept quiet.

**Execute an information memorandum.** In the event the hospital decides to pursue the process and needs to identify the best joint venture partner, it will need to prepare an information memorandum. This document will set forth key information regarding the hospital and some basic guidelines as to the needs of the hospital and the potential strategic alternatives it is considering.

**Issue a request for proposals.** In order to solicit information from potential partners, the hospital (via the investment banker) will issue a request for proposals. This is an opportunity to find out the level of capital investment the prospective partner is willing to commit, its commitment to quality of care, and its historical financial performance or patient satisfaction information. In addition, assuming the hospital has identified its goals, the organization can ask specific questions to gauge the potential partner’s ability to meet or enhance its goals.

**Negotiate the term sheets and sign LOI.** Once the hospital has identified its joint venture partner, the parties will want to work on a letter of intent or term sheet. The purpose of the document is to provide the prospective partner a chance to focus on the goals of the joint venture and make sure the partners are on the same page. Some of the following themes should be considered:

- **Leadership and governance:** The parties will need to determine what each organization will contribute to the joint venture and the ownership percentages of each. They will also want to determine which entity will control the day-to-day operations of the joint venture. Will there be equal representation on the board or will one party have majority control? Put impactful people on the board and into the management of the JV.
- **Charitable purpose:** In the event the hospital is a tax-exempt 501(c)(3) organization, it will want to ensure that its charitable purposes are being fulfilled through the joint venture’s operation of the hospital. The hospital will want to confirm that the joint venture will conduct a community health needs assessment, adopt an implementation plan, and take other actions in order to comply with 501(r) requirements.
- **Financials:** An investor-owned hospital company likely will require that the financial statement of the joint venture be consolidated with the financial statements of the hospital. As a result, there may be tension between the goals of an investor-owned entity and those of a tax-exempt hospital.
- **Performance expectations:** The parties will want to identify key decisions that require approval of the parties or the governing body. If there were ever a deadlock, how would the partners resolve the dispute? For example, if the partners have made a good faith effort but cannot reach an agreement on capital or operating budgets or an additional capital contribution that may be required, do they want to have the ability for one partner to buy out the other?

**3. Tell Your Story**

Leadership must agree upon and communicate a well-planned, consistent, and truthful series of messages to all affected parties (employees, physicians, patients, elected officials, and payers) that accurately describes the hospital’s operating environment and conditions, the available alternatives being considered, and, ultimately, the actions to be taken to accomplish the organization’s goals. This step is crucial to execute prior to going to regulators, as you will want people behind you in this decision, not against you. Opposition can be your worst enemy as you head to regulatory bodies for approvals—particularly if you are considering a conversion from non-profit to for-profit in a state that has never done so.

**4. Negotiate and Execute a Definitive Agreement**

The partners will want to memorialize their understanding by entering into a definitive agreement, which will involve the following:

- **Contribution agreement:** This agreement provides for the contribution of capital to the
joint venture. It also sets forth the ongoing capital commitments, continuation of services and requirements to maintain certain levels of indigent care, and includes the conditions required to consummate the transaction (e.g., regulatory approvals and no material adverse effect), as well as allocation of liabilities and obligations of the parties.

- **Joint venture governing document**: This agreement sets forth the rights and responsibilities of the partners. This agreement also sets forth the governance structure of the joint venture, key decisions that require approval of the members, and unwind events should the partners find themselves in a deadlock.
- **Management agreement**: In the event that the joint venture appoints a manager to run the day-to-day operations of the hospital, it will enter into a management agreement with the manager, defining their responsibilities and those of the governing body of the joint venture.

### 5. Gain Necessary Third-Party Approvals

The change of ownership of the hospital to the joint venture could be subject to state and/or federal approval processes, including state attorneys general for joint ventures involving a conversion from non-profit to for-profit, the Federal Trade Commission for transactions exceeding the Hart-Scott-Rodino thresholds, and Certificates of Need by the applicable Department of Health.

### 6. Close the Transaction

Once the previous steps are complete, the organizations will work towards a closing, which will finalize their new partnership. At this point, this is when the real work begins.

### Conclusion

The successful execution of a JV begins in the planning stages. A JV’s form must always tie back to its function. Only then can the mechanics outlined above properly solve for the challenges of tomorrow’s healthcare landscape. Remember that while a JV can appear to be an easy solution on the exterior because it represents the “best of all worlds,” its ultimate success will reside on clear vision and commitment from all participants.

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The Governance Institute thanks Barry Sagraves, Managing Director at Juniper Advisory, and Ken Marlow, Partner at Waller, for contributing this article. They can be reached at bsagraves@juniperadvisory.com and ken.marlow@wallerlaw.com. Juniper Advisory is an independent investment banking firm dedicated to providing its hospital industry clients with M&A and other strategic financial advice. Waller is a law firm specializing in healthcare transactions and regulations.

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### What It Takes to Really Grow Healthcare Philanthropy

*By William C. McGinly, Ph.D., CAE, PA, Association for Healthcare Philanthropy*

Healthcare and its philanthropy are changing quickly in the U.S. as healthcare organizations face an unprecedented array of challenges. The Affordable Care Act is reducing payment by the federal government to hospitals and health systems by more than $200 billion over 10 years, as the fee-for-service model is shifting to an outcome-based reimbursement structure. Additionally, we see costs going up as reimbursement rates decline. There is increased competition for high-end, expensive services and increased competition from non-traditional providers. Many healthcare executives are facing the potential of 15–20 percent reduction in government and commercial reimbursements over the next five years—some have experienced this already.

Hospitals and health systems everywhere are looking for ways to cut costs, and a significant number of layoffs have happened throughout the industry in the last few years. Healthcare executives have been developing their own initiatives to deal with change, such as instituting Lean management programs to raise productivity and increase morale among staff. Hospital mergers and consolidations are also on the rise, and new levels of expectation are being placed on foundation executives to bring in more philanthropy for hospital programs.

### Strategies for Growing Philanthropy

As hospital and health system leaders seek to use philanthropy to help the bottom line, this
environment can lead to a more robust integration of philanthropy into hospital operations. This reality requires a more integrated position for philanthropy and a growing specialty for development executives in healthcare, along with the need to demonstrate greater executive-level philanthropy skills. In building an effective, results-oriented fundraising program while taking advantage of the drive for more philanthropic dollars, there is an increasing need to invest in the structures necessary to dramatically increase philanthropy.

Exhibit 1: Important Factors in Philanthropy Growth

There are many proven key strategies for significant growth in healthcare philanthropy. Results from the Association for Healthcare Philanthropy's (AHP) benchmarking program have shown consistently that having the right programs and the right people in the right places and positions is essential. High performers in the program raised nearly 11 times more in net philanthropic production revenue compared to their counterparts.¹ Their direct fundraising staff outnumbered all others by three to one. These healthcare organizations also compensated their staff at higher levels indicative of more experienced professionals working for the foundation. On average, professionals employed by high performers earned nearly $160,000 compared to $100,000 by all other peers. The salary gap contributes to major differences in the average amount raised per professional. For high performers, the average individual return was $11.46 for each direct compensation dollar spent, while the return for all others was $6.45.

Data from this program has shown that a significant investment in philanthropy can really pay off. AHP reported that those organizations spending the most on total fundraising expenses ($2 million–$4.8 million) had median net fundraising of $9 million—substantially higher than the median fundraising revenue of those that spent the least on total fundraising expenses. The AHP data showed a break point of approximately $600,000 in expenses among the high performers where philanthropy began to take a large growth jump. Important factors in philanthropy growth are illustrated in Exhibit 1.

The emphasis on major gifts requires shifting resources to major gift/planned giving programs to address increased philanthropic needs thus changing how campaigns are managed and evaluated. This shift also is creating longer fundraising cycles with the CEO’s involvement to reach major donors. These factors are essential as the focus on major gifts is increased in all program operation.

¹ Every year AHP analyzes data submitted by those participating in the benchmarking program and defines high performers as those organizations that are in the 75th percentile for net production.
Exhibit 2: High Performers: Direct Staff Comparison

<table>
<thead>
<tr>
<th></th>
<th>Annual Giving</th>
<th>Major Giving / Corp Fdn</th>
<th>Planned Giving</th>
<th>Public Support</th>
<th>Special Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Performers</td>
<td>1 (1–2)</td>
<td>5 (1–12)</td>
<td>1 (1–2)</td>
<td>2 (1–4)</td>
<td>2 (1–5)</td>
</tr>
<tr>
<td>All Others</td>
<td>1 (0.5–3)</td>
<td>1 (0–6)</td>
<td>0 (0–1)</td>
<td>0</td>
<td>1 (0.5–2)</td>
</tr>
</tbody>
</table>

Note: The top number in each row represents the median number of full-time employees allocated to each fundraising activity; the bottom numbers (in parentheses) represent the range of full-time employees in each category, as reported to the AHP Performance Benchmarking Service in FY 2014.

Additionally, high performers had at least one full-time equivalent (FTE) in each category of fundraising programs: annual giving, major giving, planned giving, public support, and special events (see Exhibit 2). Healthcare organizations that were not considered high performers (seen in Exhibit 2 as “All Others”) were at varying stages of staffing for these programs where they existed. The organizations not yet at this capacity generally start expanding growth by focusing on the programs that are most successful in terms of return on investment (ROI)—usually with an emphasis on major gifts/planned giving. Fluctuations in the economy and localized factors (such as whether or not a capital campaign is underway) can influence the impact of annual giving or revenue raised from corporate grants and special events. However, and most importantly, the AHP benchmarking data consistently indicate the overarching effectiveness of major gifts and planned giving.

The patient perspective in the philanthropic program is essential as is patients’ knowledge that philanthropy has a unique ability to unlock the power of gratitude to help patients heal.Clearly, when a patient or their family member is grateful for the care received, they are more motivated to give. Creating this culture of gratitude is key to growth in philanthropy and stresses major gifts development. Launching and maintaining meaningful patient philanthropy programs are a way for patients to express their appreciation through philanthropy. Everyone in the hospital whose work touches the patient has the potential to create gratitude for them and family members. Expressing this gratitude through their physicians, nurses, and other caregivers is important for healing among patients and to increase the focus and results from major gifts and patient/family and community support in philanthropy.

Increasing these gifts requires recognition, acceptance, and welcoming the gratitude being expressed. When a patient shows interest in giving back, knowing how to refer that patient to the philanthropy office is often the beginning of a long and meaningful relationship. A partnership for the future requires identifying your grateful patients, introducing patients to the philanthropy team, and involving physicians, nurses, and other caregivers in the philanthropy process in a way that is comfortable to them and meaningful.

Through the years, AHP’s research has proven that the following principles lead to the greatest success:

1. Begin with a renewed focus on major gift fundraising.
2. Work toward integrating philanthropy as a core strategy at your healthcare organization at all levels.
3. Execute a plan to embrace physician/nurse/caregiver patient referrals.
4. Adopt philanthropy reporting standards (benchmarking) to identify the factors that influence fundraising performance and maximize overall returns.²
5. Focus on ROI to measure fundraising effectiveness and look for areas of opportunity. Development professionals agree that ROI is the most important metric in measuring

fundraising performance, more so than the cost to raise a dollar (CTRD), which is a measure of efficiency only.

6. Lead with your organization’s mission.

The hospital board and foundation board need to be engaged in advancing philanthropy. Each board opens critical networks, provides leadership, and impresses upon the public, executives, and clinicians the crucial roles they play for philanthropic growth. Hospital boards play a specifically critical role by communicating the organizational importance of philanthropy, ensuring significant investment in development to enable planned and consistent growth, and by insisting on a major giving focus to ensure high-performance results.

For true success, philanthropy must be viewed as a governance role—one squarely in the realm of the hospital board. While much attention is directed to the foundation board and the role it assumes in fund development, healthcare organizations must engage the hospital board with, among other things, inclusion of philanthropy on the board agenda and in its current and future planning. Several key elements of hospital board roles are essential in philanthropy, such as requiring CEO participation in measurable ways; securing the organization’s commitment for growing philanthropy; accepting and demanding that philanthropy is acknowledged as a strategic revenue source for the hospital; devoting budget resources to building capacity and continued philanthropic growth; developing connections to donors, grateful patients, and families; and being donors at levels commensurate with the capacity to give. Board members should be leaders in these efforts and help ensure that philanthropy goals always align with the organization’s mission and vision.

The Governance Institute thanks William C. McGinly, Ph.D., CAE, PA, President Emeritus, Association for Healthcare Philanthropy, for contributing this article. He can be reached at billmcginly@gmail.com.

New Publications and Resources

Hospital Accounting and Finance, Fourth Edition (Elements of Governance, April 2015)

PopCity Episode 5: The Value of Non-Equity Partnerships in Population Health (PopCity DVD Series, April 2015)

BoardRoom Press, Volume 26, No. 2 (BoardRoom Press, April 2015)


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The new Governance Institute Web site will be your source for healthcare governance publications, resources, conferences, and advisory services tailored specifically to those focused on premier board performance.

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**Governance Support Conference**
Gaylord Palms Resort & Convention Center
Orlando, Florida
August 9–11, 2015

**Leadership Conference**
The Broadmoor
Colorado Springs, Colorado
August 30–September 2, 2015

**Leadership Conference**
The Ritz-Carlton, St. Louis
St. Louis, Missouri
October 18–21, 2015

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