Optimizing Philanthropic Support For Clinical Excellence

Key Elements of an Effective 'Best Practice'
Fund Development Program in a Small Health System
or a Region of a Large Health System©

THE GREENWOOD COMPANY
Transformational Productivity in Fund Raising ™

"Except in exceedingly rare circumstances, no not-for-profit health system or freestanding community hospital can fund all of its future capital and programmatic needs through operating income and debt alone if it expects to maintain clinical excellence. As a result, community hospitals and health systems nationwide are depending increasingly on philanthropic support to help fund a portion of their capital and programmatic needs. It is widely agreed that, in the future, the only communities that will enjoy access to high-quality health care will be those that provide significant philanthropic support to their local not-for-profit hospitals.

Time is of the essence for every not-for-profit health care system and independent hospital to assess the effectiveness of their fundraising operations and immediately implement the 'best practice' methodologies necessary to maximize philanthropic support."

Robert H. Greenwood, CEO
The Greenwood Company

Table of Contents

Table of Contents Continued

Introduction

Hospitals and health systems are facing unprecedented challenges which are making it more and more difficult to sustain the clinical excellence that their communities expect and deserve. For decades, government and private insurers have underfunded the true cost of providing quality health care services. It is anticipated that this underfunding will continue – and become even more severe – as the dramatically increasing number of Americans entering retirement age require extensive medical care due to age-related conditions.

This chronic underfunding, along with the predicted effect of health care reform initiatives, is causing many systems and their affiliated hospitals to consider drastic cutbacks in services and staffing because they simply cannot generate sufficient operating revenue or borrow enough funds to maintain current levels of service. In addition, the pace and cost of clinical innovation continues to outpace available operating revenues, borrowing capacity and reimbursement.

In this challenging and complex environment, the need to maximize philanthropic support to help fund clinical excellence cannot be denied. However, many hospital foundations are not appropriately structured or prepared to raise the significant funds necessary to help maintain excellence and upgrade and expand services. In fact, the need for foundations to develop rigorous, disciplined, professional and effective 'best practice' fundraising programs is acute.

Optimizing Funding for Clinical Excellence: Key Elements of an Effective 'Best Practice' Fund Development Program in a Small Health System or a Region of a Large Health System© describes in detail the 'best practice' benchmarks and measures against which The Greenwood Company evaluates the effectiveness of ten key components of healthcare fund development programs. This document is based on more than three decades of experience in providing fund development counsel to several hundred hospitals and health systems throughout the United States.

It is evident that the continued provision of high quality health care services will only be possible if high performing hospital foundations raise philanthropic dollars by achieving excellence in the following ten components of their activities:

- Developing a vibrant culture of philanthropy throughout the institution they support;
- Setting compelling fundraising priorities;

- Maintaining an inspiring case for philanthropic support;
- Balancing centralization and decentralization of fundraising responsibilities between local hospitals and the health system;
- Ensuring effective and engaged foundation governance;
- Operating a full-range of 'best practice' fundraising programs;
- Efficiently staffing the development program;
- Determining appropriate fundraising goals;
- Ensuring an efficient cost of fundraising;
- Appropriately financing the foundation's operating budget.

Success in these key areas will ensure that foundations can generate significant and necessary support for their hospitals, thereby transforming the quality of health care in their communities. As important, Hospital Chief Executive Officers and Foundation Chief Development Officers who commit to developing a 'best practice' fundraising program will find that one result of a higher performing program is that community leaders, physicians and employees become more actively and enthusiastically engaged as champions and advocates for advancing the hospital's mission and vision.

The Importance of Philanthropic Support to the Future of the Nation's Not-for-Profit Health Systems

In any urban, rural, or suburban area in America, high quality healthcare services are among a community's most important resources – as important as clean water, fire and police protection, and high quality schools.

But as anyone who listens to the daily news is well aware, the healthcare system in the United States today is experiencing the most severe financial crisis in its history. Yet, as difficult as this environment already is, the future is expected to be even more challenging.

Three factors contribute to this crisis.

First, over the past two decades, Medicare, Medicaid, and private healthcare insurers have limited the inflation-adjusted amounts they pay hospitals and physicians for medical services. This trend has resulted in a serious underfunding of the actual costs of providing quality care, particularly in various parts of the country where Medicare and Medicaid reimbursement rates have historically been lower than in other regions of the country (e.g., West Coast, Upper Midwest).

Moreover, it is anticipated that health systems nationwide will continue to see reimbursements for services falling even further below the true cost of providing care as healthcare reform bills are implemented over the next several years.

Second, the prevalence of debilitating and often incurable diseases such as Alzheimer's, Parkinson's, cancer, heart disease and diabetes dramatically increases after the age of 65. As a result, the cost of providing medical care for someone 65 or older is nearly five times the cost of treating a younger person. In early 2011, the first of the nation's 76 million Baby Boomers turned 65 and became eligible for Medicare, dramatically increasing the number of Americans entering retirement years who will require medical care due to age-related health problems. This 'Silver Tsunami' is expected to place an extraordinary demand on the Federal budget and on not-for-profit healthcare providers.

Third, the number of families with little or no health insurance is growing steadily. There is a large increase in the number of unemployed due to the current recession. In addition, many employers have reduced or eliminated medical coverage for employees due to the skyrocketing cost of health insurance as an employment benefit. While it is anticipated that health care for these families will soon be covered by the implementation of healthcare

reform, payment for services will be funded at levels significantly less than the actual cost of care.

These and other factors are exerting unprecedented financial pressures on not-for-profit community-based health systems.

Across the country, many community hospitals have had no alternative but to close their doors, and numerous not-for-profit hospitals throughout the U.S. are expected to go bankrupt in the next decade. Other hospitals have been acquired by for-profit, investor owned hospital chains, often leaving their communities without access to not-for-profit, locally-governed health care.

Virtually ***all*** community hospitals, regardless of their ownership, have reduced their employee staffs and adopted aggressive cost-saving measures to cope with declining medical reimbursements.

One of the most serious consequences of these dynamics is the increasing shortage of capital funds to replace or modernize aging facilities and invest in the latest medical diagnostic and treatment technologies. Yet, except in the most unusual situations, there is simply no way that a not-for-profit community hospital can fund all of its high priority future capital needs through operating income and debt alone.

As a result, community hospitals and health systems nationwide are depending increasingly on philanthropic support to help fund a portion of their capital needs. It is widely agreed that, in the future, the only communities that will enjoy access to the best health care will be those that provide significant charitable support for their local hospitals.

Key Elements of a 'Best Practice' Fund Development Program in a Small Health System or a Region of a Large Health System

What follows is a description of how a mature and effective 'best practice' fund development program should be governed, staffed, organized, and operated in a hospital that is a member of either a small not-for-profit health system or in a regional division of a larger not-for-profit health system, in order to maximize its net income from philanthropy.

The following information is provided to illustrate the 'best practice' benchmarks and measures against which The Greenwood Company evaluates the effectiveness of healthcare fund development programs, and is based on more than three decades of experience in providing fund development counsel to several hundred hospitals and health systems throughout the United States.

Developing a Culture of Philanthropy

In order to set the stage for a 'best practices' program and truly transform a healthcare organization, a foundation must first create an institutional 'culture of philanthropy'. There are six primary components of a culture of philanthropy:

1. The institutional CEO understands and provides broad support for the fund development program by articulating the vision of the institution, articulating the need for philanthropy, helping the foundation obtain compelling funding objectives, helping to articulate the case to major gift prospects and by making a generous personal annual gift to the foundation.
2. Members of the senior management team understand and provide support for the fund development program that is specific to their individual areas of influence. Senior managers also make appropriate annual gifts each year, provide information for case statements, and support the implementation of concierge service programs for generous supporters.
3. The institution's governing board members understand and support the fund development program by making annual gifts to the foundation each year, attending the foundation's events, understanding and articulating the importance of philanthropy in funding excellence, and are willing to lead gift approaches when they are clearly the most appropriate person for a given donor prospect.
4. Members of the medical staff understand and support the fund development program by making annual gifts to the foundation each year, introducing the foundation to

grateful patients (in accordance with HIPAA), and helping to provide information to create case statements for needs that are to be funded in their areas.

5. Employees understand and support the fund development program by making modest annual gifts themselves, helping identify grateful patients (in accordance with HIPAA), and promoting the hospital and its need for philanthropy in the community.
6. The health system management team understands and supports the local fund development programs by articulating the vision of the system and its individual hospitals, articulating the need for philanthropy, and committing to fund projects that have funding "shortfalls" to be funded by philanthropy.

In summary, all six primary components of a healthcare culture of philanthropy can be developed through a concerted effort led and championed by the foundation's Chief Development Officer and institutional CEO. When all constituent groups realize that a successful philanthropy program will dramatically further each of their personal professional agendas, the foundation will gain very receptive allies for its fund development program.

The Priority Setting Process for Fundraising Objectives

In addition to establishing an institutional culture of philanthropy, it is imperative for the health system and its individual hospitals to have compelling strategic plans for the future.

With these visions and plans in place, a 'best practice' hospital foundation operating within a health system can set funding priorities that at all times correctly reflect the health system's capital and operating funding priorities for the hospital or other health-related entity supported by the foundation. This determination of priorities is tempered by the reality that donors are far more likely to be interested in certain types of compelling needs (e.g., surgical robots, cardiac catheterization labs, CT/PET scanners, new EDs, heart centers, cancer centers, pediatrics) than in other more mundane needs (e.g., facility renovations to meet seismic codes, routine equipment upgrades, medical office buildings, parking structures, etc.).

Accordingly, the 'best practice' hospital or health-related foundation is integrally involved in its hospital's strategic planning and capital budget planning process at a very early stage. This provides senior foundation staff and foundation board members the opportunity to choose the most compelling capital needs for foundation funding. Such needs are ordinarily identified as much as two years – or

even three or four years – in advance of their actual funding by the foundation and rarely less than 18 months in advance of funding. Such lead time is essential so that the foundation can plan and execute appropriate fundraising programs on behalf of these needs. Hospital managers and physicians assist the foundation in developing persuasive arguments for these capital funding needs.

The Case for Philanthropic Support

At all times, an effective hospital or health-related supporting foundation maintains a well-written, clear, and compelling general case statement about its hospital's history, its impact on the community's medical needs, its centers of excellence or special services, its distinguishing features compared with other local or regional 'competitors,' and its need for philanthropy. A **comprehensive case statement** ties to the hospital's strategic plan and vision and is comprised of the following elements:

1. A compelling description of the primary purposes of the hospital – including in-depth information about its major services and programs.
2. A compelling description of the hospital's *accomplishments* as it carries out its mission in the community. This section of the case should include a description of the problems addressed by the hospital and provide both quantitative and qualitative examples of the organization's accomplishments. It is critical that this section provide compelling proof of the organization's value to the community by demonstrating an impressive set of accomplishments;
3. A statement of the hospital's annual budget and how this budget is funded.
4. A statement of how much philanthropic support the foundation must therefore raise each year to help the hospital carry out its mission and a breakdown of the required funding by program, capital needs, and/or other funding components;
5. A description of each funding need for which the foundation must raise philanthropic support over the next 12 to 36 months and how much must be raised for each need. Thus, this component of the case not only describes each funding need in compelling terms but also places a dollar figure on each of these needs.
6. The case also describes the various forms of donor recognition available for gifts of different denominations.

The 'best practice' case statement usually exists in at least two – and sometimes three – formats:

- ***Word processed format*** so that elements of the case may be excerpted at any time for one of many purposes, including foundation proposals, government grant

proposals, corporate proposals, annual giving support request letters and major gift approach talking papers.

- ***Brochure format*** that is usually created annually or every other year. The brochure is used as a 'leave behind' for major gift asks and as a general educational tool which is almost always left behind with donor prospects (or mailed to them) or audiences after they have witnessed presentations about the organization, its accomplishments and its needs.
- ***Video format*** which serves as the focal point of educational briefings provided to prospective donors, prospective board members and others who are of particular importance to the organization.

In addition, the foundation ***has specific case statements for individual needs for which it is currently raising funds.*** These documents are essential to the ability of the organization to present a compelling rationale for charitable support.

Balancing Centralization and Decentralization of Fundraising Responsibilities Between Local Hospitals and the Health System

The task of developing the most productive and cost-effective fund development programs within a small health system, or a region within a large health system, shares striking similarities to the challenge of developing a health system that provides superior clinical outcomes, excellent physical accessibility to outpatients, and streamlined administrative support. Just as it may make sound strategic sense to develop a network of primary care clinics close to where patients live and work, it also may make sense to centralize expensive, technology intensive acute care services to assure high volumes and consistent medical outcomes, and to consolidate various administrative functions (HR, legal, finance, etc.) to eliminate costly duplication and redundancy.

Similarly, the central challenge in organizing an effective 'best practice' fund development enterprise for a small health system or a region within a large health system is to ensure that fundraising staff and programs that are essential to establishing and maintaining personal relationships with donors, patients, doctors, nurses, other caregivers, and foundation board members (e.g. major gifts, capital campaigns, and special events) remain 'decentralized' among the health system's member organizations. At the same time, it is viable to centralize or consolidate the 'back office' administrative or specialized technical services (e.g., gift processing, database management, prospect management/research, donor acquisition and retention, and planned giving) that are less visible to donors

and other key participants in the fund development process.

Achieving the proper balance between decentralization and centralization is absolutely critical to creating the most appropriate, effective, and efficient fund development programs for the health system or the health system region.

Philanthropic support of the nation's leading community hospitals remains a very local phenomenon. Donors who provide philanthropic support for hospitals and other healthcare providers – other than major academic medical centers – typically give to those local institutions that serve their families' medical needs or the needs of those in the communities in which they live or work.

Donors seldom make major gifts to health systems or to hospitals or medical providers located in distant communities unless they or their loved ones have received life-changing or life-saving care at such institutions. For this reason, developing and maintaining strong hospital or clinic-supporting foundations governed by volunteer boards comprised of local volunteer leaders ***is essential to maximizing philanthropic support*** for each health system member hospital or health related entity.

Similarly, system 'branding' of its member hospital foundations represents a complex issue for local hospital fund raising due to the fact that a system's brand and perceived values and reputation can either add or detract from the attractiveness of the local hospital as a recipient of philanthropic support. A few health systems – e.g., Mayo, Scripps, Cleveland Clinic, M.D. Anderson – confer instantaneous status and prestige on their member hospital foundations because they are old, established institution 'brands' associated with medical excellence and a not-for-profit charitable mission. Even though these high-profile systems are widely known to be financially successful, they still attract very substantial philanthropic support because they constantly and effectively demonstrate how philanthropy contributes to their superior medical outcomes.

In contrast, many health systems were created in the past 15 to 30 years and possess system names bearing little or no historical significance, are not widely known for medical excellence, and are not even clearly perceived to be ***not-for-profit*** charitable organizations. Affiliation with these systems does not tend to help fund raising; indeed, ***it almost always hinders fund raising***. Still other health systems are well regarded by their patients but are widely perceived as having 'deep pockets' and thus as not needing philanthropic support from local communities served by their member hospital foundations.

Accordingly, the 'smart' health systems are those that thoroughly research their brand equity in the 'microclimate' environments in which their member hospital foundations operate, and then carefully position their system brand and logo in relation to the name and identity of the affiliate so as to enhance – rather than detract from – the brand equity in the name and reputation of their local affiliates.

Because health systems and their reputations and brand equity evolve over time – for better or worse – the 'smart' health systems that aspire to establish high performance fund development programs are careful not to impose their system name and brand on their member hospital foundations prematurely. It is critical to evaluate if doing so risks undermining or diminishing the reputation of the affiliated organization and/or alienating potential major donors who may feel that their local hospital has been acquired by a corporate enterprise that does not need philanthropic support. Moreover, potential major donors may perceive that the system does not add value to the local hospital or that the system does not pay close attention to the needs of the local community. In addition, 'systemized' hospital foundations often create the impression that some of the donor's gift may pass through to the health system to support administrative overhead rather than local patient care.

In summary, health systems that seek to maximize philanthropic revenues must recognize that centralizing some fund development functions is essential to cost effectiveness. However, most member fundraising programs must be locally governed, largely locally staffed, and look and feel 'local' to local philanthropic establishments. Furthermore, heavy-handed system branding in local communities can sometimes seriously impede fund raising.

Governance

Governing Structure

An effective 'best practice' fund development effort for health system or health system regional affiliates is organized around individual hospital or healthcare organization-specific, subsidiary 501(c)(3), not-for-profit corporations that are also 509(a)(3) supporting foundations under the Internal Revenue Code. Each foundation is governed by its own volunteer board of trustees, and the health system or its local hospital ordinarily serves as the foundation's 'sole corporate member,' having ultimate control over – and ultimate ownership of – each foundation's assets and programs. As a practical matter, however, each local foundation board governs the foundation's fundraising program.

In order to foster a 'culture of philanthropy' throughout the health system, and to set an example for all hospital

foundation board members, system employees, affiliated and employed physicians, and prospective community donors, ***all*** members of the health system's regional governing board are expected to provide generous personal philanthropic support for the system (or for the region) each year ***or*** for one or more of its member foundations. When major fundraising campaigns are conducted for one or more of their member hospital foundations, regional governing board members are expected to provide 'stretch' pledges to campaigns conducted by affiliates located in their home communities.

Health system (or system regional) board members are also expected to be vigorous volunteer advocates of the fundraising needs of the system's (or region's) member hospitals and other member hospital foundations, and to demonstrate to the community that those who are closest to the system and are in the best position to understand the affiliates' funding needs are strongly supportive of the individual hospital fund development efforts.

In addition to overseeing multiple hospital foundations, the governing boards of many 'best practice' health systems contain either formal **Development Committees** or more informal **Development Councils**, which typically consist of the chairpersons of each of the system's foundation boards, together with a few members of the system governing board. This 'hybrid' committee structure ensures that good communication is maintained between the system's governing board and the system's various foundation boards. It also sends foundation board members a clear message that their involvement is valued and that they are vital partners in creating healthcare excellence for their individual hospitals.

To convey to the community that its charitable donations are being used appropriately to benefit the donor's ***local hospital*** and not for other system needs, each hospital foundation within a health system raises funds solely for its associated hospital and not for the health system or a hospital located elsewhere. Moreover, the hospital foundation should not make grants to other community nonprofit organizations except in certain cases where such grants may be used to support local health-related causes whose missions are a logical extension of the hospital's mission (e.g., disease-prevention activities such as smoking cessation, childhood obesity prevention, hospice care, etc.).

Some health systems have attempted to establish a single fundraising foundation at the system level or system's regional level (in lieu of foundations at member hospitals) to benefit multiple member hospitals operating in a particular region. ***However, these efforts have almost universally failed***

because donors and volunteers do not derive a sense of 'local ownership' and accountability from such a fundraising structure, and also because such a system-wide or regional foundation's message is too diffuse and its attractiveness as a vehicle for meaningful donor and volunteer participation is too diluted.

Foundation Board Composition

Each 'best practice' hospital (or health-related organization) foundation board should be comprised of ***at least 20*** (often as many as 30) lay volunteers who have substantial stature and credibility in the philanthropic establishment of the communities served by the hospital. A foundation board should also have as members three or four prominent and respected physicians from the hospital's active medical staff.

Board Staffing

The 'best practice' hospital foundation board is supported by a salaried foundation President who serves as a senior-level member of the hospital's administrative team and as the hospital's primary fundraising spokesperson.

Board Committee Structure

A 'best practice' hospital foundation maintains certain key standing committees that reflect the foundation's mission of resource development: executive, nominating/trusteeship, development, and finance/investment. Because the most important functions of a hospital foundation are to procure new gifts in support of the hospital and to steward past gifts, the foundation's development committee often may consist of several more specialized sub-committees focused on major gifts, planned giving, special events, stewardship, allocations and other *ad hoc* fundraising activities. The existence of the development committee and its various sub-committees provides the proper accountability for the productivity of each of the foundation's fundraising programs, and encourages foundation board members to become immersed in the gift solicitation process. This committee also prevents the foundation from becoming predominantly 'staff-driven' or event driven.

The 'best practice' hospital foundation board meets at least five (5) times per year (including one annual planning meeting or retreat), to encourage continuity and participation. Board committees meet at least once between board meetings and provide reports on their respective activities at full board meetings.

Board Terms

Board members of a 'best practice' hospital foundation typically serve for up to three (3) three-year consecutive terms, followed by a mandatory year off the board between terms before becoming eligible for reelection.

Board Giving and Fundraising Responsibilities

During periods in which the foundation is not engaged in a major campaign, each foundation board member is expected to make an annual personal gift to the foundation which reflects his/her individual giving capacity. During a capital campaign, each board member is expected to make a 'stretch' three- to five-year capital pledge commensurate with his/her financial circumstances. Further, each board member participates in at least two or three face-to-face gift solicitations for significant gifts each year and attends the foundation's 'signature' special event.

Fund Development Programs and Support Functions

Effective supporting foundations in a health system or health system region typically operate six basic fundraising programs and maximize revenue from each. These include:

1. **Major Gifts Program**
2. **Private Grants Program**
3. **Planned Giving Program**
4. **Fundraising Campaigns**
5. **Annual Gifts Program**
6. **Special Fundraising Events**

Effective supporting foundations also operate – or obtain access from the health system's central offices – various support functions to provide the necessary resources to support the fundraising programs. These include:

1. **Prospect Identification, Research, and Management**
2. **Gift Recording and Acknowledgment, and Database Management**
3. **Donor Stewardship and Communications**
4. **Donor Concierge Services**
5. **Finance and Accounting**

What follows is a brief explanation of each of these programs and functions in a mature and effective hospital foundation:

Major Gifts Program

Regardless of whether a hospital foundation is conducting a major capital campaign, the major gifts program is the foundation's fundraising centerpiece and should – with only rare exception – receive the most emphasis in terms of senior staff and board time, attention, and effort.

The major gifts program nearly always raises the most funds in new gifts and pledges each year (except in cases when a large deferred gift matures), and it is responsible for keeping the cost ratio of expenses-to-funds-raised in line with 'best practice' benchmarks. The major gifts program typically enjoys the lowest cost ratio of any fund development program — usually no more than 10% (i.e., it spends no more than 10¢ to raise $1.00) and sometimes less than 5%.

When a hospital foundation is not conducting a major capital campaign, an effectively run major gifts program makes no fewer than 30 approaches to individuals, corporations, and foundations each year for gifts of $50,000 or more (some for $1 million or more). Each gift approach is carefully choreographed for maximum effect, and each usually involves at least two trained members of the foundation board and a senior hospital or foundation manager. Many approaches also include a physician and a written proposal that is left behind after the verbal presentation and gift request.

The most compelling major gift requests seek support for compelling, high-profile capital (new equipment or facilities), programmatic, or endowment needs that will provide important healthcare services to the community, such as for an intensive care unit, neonatal service, pediatric service, emergency department, cardiac or cancer center.

When a hospital foundation conducts a major capital campaign, the number of major gift approaches increases dramatically, usually up to 100 gift approaches per year in the community phase of the campaign. The most effective major gifts programs are conducted with dedicated major gifts staff located at the hospital to ensure regular physical interaction with patients, physicians, and caregivers.

Private Grants Program

A 'best practice' hospital foundation maintains an active program of identifying, and then submitting grant applications to local, regional, and even national foundations, disease-specific grant-making associations, businesses, and corporate foundations whose grants programs support the types of programs and services that the hospital operates.

The extent to which a foundation can generate grant support is determined in large part by whether the hospital or other health-related organization offers innovative clinical care, addresses unmet community health needs, or participates in clinical research. Generally speaking, the more 'academic' and innovative the programs, the more likely they are to receive foundation grant support, thus explaining why leading academic medical centers often receive tens of millions of dollars a year in foundation grant support for their health programs, while most community hospitals receive a relatively modest amount from foundations and other institutional funding sources.

Regardless of whether a community hospital is more or less 'academically' inclined in its programs and services, a 'best practice' supporting foundation is remiss if it does not carefully research all private and corporate foundations based in its primary service area to

determine whether any of the hospital's programs would potentially qualify for grant support.

The most effective grant procurement programs are conducted using dedicated, experienced grant writers who are familiar with the full spectrum of national, regional, and local private grant-making organizations (foundations, health-oriented grant-making associations, and corporations). Such staff need not be located at a particular hospital and often are part of a centralized fundraising support team in a healthcare system or system region. However, because such staff members are expected to be well acquainted with the programs for which grant support is requested, grant procurement staff have regular on-site interaction with principals involved in programs for which grant support is sought. Generally, these grant procurement programs do not seek government grants.

Planned Giving Program

A planned giving program based in a health system, a system region, or in an individual supporting foundation focuses on obtaining gifts that are made through estate planning instruments and feature various favorable tax-saving consequences for the donor. In contrast to a major gifts program that focuses on current (lifetime) gifts of assets that are generally easily liquidated (e.g., cash, stock, real property), a planned giving program focuses on procuring testamentary bequests (through one's will or trust), deferred irrevocable gifts (e.g., a life estate involving one's residence, a charitable gift annuity, or a charitable remainder trust), and other various complex transfers of personal assets (e.g., a charitable lead trust or a supporting organization).

A planned giving program is the most complex of the health system's or the foundation's fund development programs to create and administer, but it can sometimes double the level of philanthropic commitments received by the foundation during a given year. An effective planned giving program requires competent staffing and stewardship by a skilled professional who is conversant with current federal and state tax laws as well as the latest estate planning instruments and approaches. A planned giving program ordinarily accounts for some of the largest gifts a hospital foundation is likely to receive over an extended period of time.

Planned gifts are often made to a foundation's permanent endowment, and are usually the primary way for a foundation to create a substantial endowment, inasmuch as most cash 'lifetime' gifts are restricted for specific current expendable purposes.

A 'best practice' planned giving program generally conducts the

following activities designed to attract and cultivate prospective donors of planned gifts:

First, a planned giving program in a small health system or a system region is usually managed by a skilled **Director of Planned Giving** at the system or regional level, and is often assisted by additional senior-level planned gift officers in the case of a major health system or a large health system region. The Director possesses an excellent working knowledge of estate planning concepts and techniques and, in particular, has extensive experience in understanding the technical aspects of all the leading outright and deferred gift instruments, and is adept at applying these instruments in all interactions with prospective donors.

The Director also works closely with all health system or health system region major gifts officers to make certain that they are conversant with the basics of these gift instruments and can selectively incorporate planned gift instruments in major gift approaches when such instruments have the potential to leverage additional gift support.

Second, the program organizes special **donor recognition groups** (or 'societies') at the individual hospital foundation level that are designed to pay special attention to those who indicate their intention to provide for some type of deferred gift for the hospital foundation. Members of these groups are invited annually to exclusive cultivation and recognition events; receive publications about the hospital and patient testimonials, as well as charitable estate giving topics explained via simple case studies; and are solicited for annual gifts.

Priority constituencies to approach for membership in the planned giving groups include: former and current governing and foundation board members; senior managers, physicians, volunteers, and older employees; and current and past donors known to be 60 or more years old.

Third, the 'best practice' planned giving program conducts an ongoing direct mail program to 'acquire' new members of its donor recognition groups with two high quality, personalized mailings per year to all of the foundations' past and current donors who are known to be 60 or more years old. At least one of the two mailings should be an invitation to attend a reception of the planned giving donor recognition group featuring a major speaker on a current health topic of keen interest. These events provide prospective donor recognition group members an opportunity to participate in a recognition group activity before committing to formal membership.

Fourth, the planned giving program is assisted by dedicated **professional advisory groups** organized at the level

of the individual foundations and consisting of 10 to 15 volunteer 'agents of wealth' who represent insurance, trusts and estates, commercial and residential real estate, retirement investment, and other professional advisory sectors relevant to issues involving seniors and their financial needs.

Fifth, the planned giving program should market **charitable gift annuities** aggressively in the current economic environment. For those ***70 years old or older,*** gift annuities remain ***an excellent vehicle to substantially increase one's investment income compared with what can be earned through conventional stock and bond investments.*** Moreover, as federal and state income tax rates increase, the portion of gift annuity income that is not subject to marginal income tax rates grows in financial impact.

Sixth, the planned giving program has a unique opportunity to position itself as a charitable **'market leader'** in its respective region by offering the combined **Life Estate - Gift Annuity (LEGA)** vehicle to those 75 or older in the local community. Some planned giving programs are generating millions of dollars per year in new gifts through the LEGA vehicle by using foundation or hospital/system assets to fund gift annuity payments to donors in exchange for receiving charitable life estate gifts of donors' residences, ranches or farms. It is important to emphasize that these donors should be at least 75 years old. As more and more senior citizens find it difficult to maintain their lifestyles on fixed or reduced incomes, the LEGA vehicle offers an opportunity for a health system or a supporting foundation to provide a source of additional lifetime income for older residents – by itself a very significant 'service' to the community. At the same time, the LEGA enables the health system or hospital foundation to enlarge its endowment by ensuring a steady flow of gifts of residences.

Seventh, some foundation or hospital finance departments provide financial 'credit' to fundraising campaigns for capital building and equipment projects based on the actuarially discounted net present value of *deferred irrevocable gifts* made by donors aged 65 years or older to the campaign. Providing such credit can often yield a substantial irrevocable gift commitment from donors who are not comfortable making a large outright gift of assets during their lifetime. In cases where credit is given for a current funding need, the entire value of the planned gift is made available to the internal entity that originally provided the gift credit.

Eighth, for reasons of institutional liability, the fundraising program ***should avoid serving as the official***

trustee of any charitable trusts (e.g., charitable remainder trusts), even those that designate the foundation as a charitable beneficiary. Instead, the program should encourage planned gift prospects to have their charitable trusts managed by trust companies and other financial services companies that specialize in trust management.

Finally, it is imperative that all fund development staff who are involved in major gifts be well versed in the basics of all major deferred and other planned gift vehicles: bequests, charitable remainder trusts (all types), charitable life estates involving residences, charitable gift annuities, charitable lead trusts, gifts of securities and real property, and other complex giving instruments. A useful working knowledge of these gift vehicles is a prerequisite for major gift officers to maximize the giving potential of all prospective major donors.

Fundraising Campaigns

A hospital foundation may periodically elect to conduct a fundraising campaign over a defined time period. Such an effort is designed to address a substantial and compelling funding need (e.g., a new building) or set of needs (e.g., new facilities, equipment, physician/faculty recruitment, endowment, program start-up and ongoing support, etc.) by generating a substantially higher level of gift income than is available through year-to-year fundraising activities.

A successful campaign is carefully planned and is always preceded by an intensive campaign planning and feasibility study that evaluates the level of volunteer and donor support for the need(s) to be supported by the campaign, identifies the primary obstacles to success, and produces a campaign plan of action if a campaign is deemed feasible.

If the study recommends that a campaign should be undertaken, a 'working' financial goal is set for purposes of soliciting lead gifts in a 'quiet phase' over 18 to 24 months, involving members of the hospital's governing and foundation boards, senior management, medical staff, employees, and a small number of lead gift prospects. Once these commitments are formalized, a formal goal is set and the 'community phase' of the campaign is announced and conducted over an additional 18 to 24 months. This community, or external, phase approaches those capable of making campaign commitments of $10,000 or more (but with a particular focus on those capable of giving $100,000 or more).

A campaign is focused primarily on large gifts that are paid within a three- to five-year pledge period. Such gifts ultimately comprise 70% to 90% of the campaign goal. If the campaign seeks a significant amount for endowment, deferred gifts that are irrevocable are often counted toward the campaign at

full or discounted value, depending on the donor's age. (Note: Bequest expectancies that are not accompanied by a binding pledge agreement are generally not counted toward the campaign goal.)

The key obligations of any credible campaign planning exercise are to develop a campaign plan that addresses both the hospital's most pressing financial needs and donor giving potential, and to recommend a campaign financial goal that is challenging yet ultimately achievable.

The first of these two campaign planning responsibilities is to identify the type of campaign that will be the most successful in supporting the hospital's highest priority funding needs and in elevating the foundation's overall fund development program to a higher level of productivity after the campaign is successfully concluded.

Hospital campaigns typically fall into two distinct categories:

1. A **Special Focus Campaign**, in which the campaign highlights one or two very specific funding priorities (usually a major facility such as a cancer or heart center or the endowment) and thus focuses donor attention intensively on the importance of supporting these particular needs as distinct from other organizational needs; and
2. A **Comprehensive Campaign**, in which the campaign raises funds for a variety of organizational needs, counting all annual gifts, capital gifts, and endowment gifts into the campaign total for a defined period of time.

The **Special Focus Campaign** approach is employed frequently when a nonprofit organization must mobilize its donor and volunteer constituency to deal with a very pressing and expensive capital funding priority. For example, many hospitals have recently undertaken major special focus campaigns to raise funds to help underwrite replacement hospitals or to build expensive new cancer centers, heart centers, or emergency departments.

An advantage of the Special Focus Campaign is that it redirects potential donors to a specific funding priority, virtually assuring that the funding priority will receive significant support. However, focusing on a single purpose does not necessarily appeal to all potential donors, some of whose interests may lie elsewhere.

The most common alternative to a Special Focus Campaign is the **Comprehensive Campaign**, which contains multiple featured objectives and generally treats all gifts for all purposes from all private sources with equal importance. In a comprehensive campaign, all annual gifts, all capital gifts, all endowment gifts, and all deferred (planned) gifts are counted toward a stated dollar goal over a pre-deter-

mined defined period of time to fund multiple objectives.

A comprehensive campaign is an effective vehicle to showcase a hospital's diverse strengths and to provide a variety of opportunities for philanthropic support. The comprehensive campaign provides a useful platform to draw community attention to a hospital's wide array of services and programs. Hospital foundations often employ the comprehensive campaign approach to significantly 'raise the bar' in their overall fundraising productivity, so that their post-campaign annual philanthropic revenues will increase substantially over the levels before the campaign.

Moreover, a comprehensive campaign approach enables the hospital foundation to set a campaign fundraising goal that is larger and more psychologically impressive than the goal of a more limited special focus campaign. In fact, there is significant evidence that suggests that many lead gift donor prospects 'scale' their campaign pledges in relation to the magnitude of a campaign's financial goal.

Accordingly, a larger comprehensive campaign goal often prompts lead gift donors to increase the size of their campaign pledges compared with what they might have committed to a campaign with a smaller goal. The comprehensive campaign approach is not intended to create an artificially inflated goal or to 'out-do' other competing organizations in terms of the size of the potential campaign goal. Instead, it is an approach that helps a hospital elevate its importance and status in the community, conveys a message that it is serious about philanthropic support, and treats annual gifts, capital gifts, and endowment gifts as equally important.

The most serious downside to a comprehensive campaign is that certain individual funding objectives often do not receive adequate financial support because too many funding priorities are featured, and because the primary focus is on total dollars raised rather than on whether individual funding objectives and goals are met.

Depending on the size of the prospective donor constituency to be approached, a comprehensive campaign is usually conducted over a minimum of three years to a maximum of five or more years when the constituency is very large (similar to a major university). Comprehensive campaigns may often take several years longer to complete than special focus campaigns because a larger number of people are solicited and more money is raised.

While it may be tempting for hospital foundations to prefer the comprehensive campaign approach because it addresses multiple hospital funding priorities simultaneously and appeals

to a broader donor constituency, a comprehensive campaign is far more complex and difficult to conduct successfully than is a special focus campaign. Moreover, a comprehensive campaign requires: skilled and productive foundation staff in major gifts, planned giving, annual giving, special events, and development support areas; superior development support systems in prospect research, database management, communications and stewardship, etc.; and a much larger number of highly dedicated volunteers who are willing to participate for a much longer period of time than in a typical special focus campaign. ***Generally, a hospital foundation that does not have the appropriate staff, high performing fundraising programs, fundraising support systems, and volunteers in place should avoid a comprehensive campaign approach.***

The second key element in campaign planning involves the determination of a challenging yet attainable campaign financial goal. The importance of ultimately attaining an announced campaign goal cannot be overstated; failure to reach a campaign goal must not be considered an option because it will harm an organization's image and fundraising programs for years to come. Major donors do not appreciate giving to what appears to be a 'failure.'

Hospital foundation 'best practices' follow these key steps in setting a challenging yet attainable campaign goal:

- ***first,*** an ambitious preliminary campaign goal – often considerably higher than the amount that a campaign might normally be expected to yield – is 'tested' in a campaign planning and feasibility study to determine the campaign's appropriate size and focus;
- ***second,*** based on the conclusions of the study, a 'working goal' for the campaign which might represent a 'stretch' for the hospital's donor constituency is established for purposes of soliciting campaign gifts from the internal hospital family of board members, employees, physicians, and the Auxiliary, and from a few key external lead gifts; and
- ***third,*** based on the actual dollar results at the end of the internal phase of the campaign, after all internal donor prospects have been approached for campaign pledges (as well as a few key external lead gifts), a formal campaign goal is established prior to launching the campaign's external community phase.

To ensure the success of a major campaign – whether special focus or comprehensive – a hospital foundation should always retain the services of a highly qualified campaign management firm with extensive experience in healthcare fund raising

to assist the foundation in studying feasibility, planning and managing the campaign. Expert counsel is essential to ensure that the campaign utilizes effective campaign methodologies, that it adheres to the campaign plan and that it 'pushes the envelope' to maximize gift revenues.

Annual Gifts Program

With rare exception, a donor acquisition, donor renewal, and sustaining 'annual gifts' program is most effectively conducted in the name of the health system's individual hospital foundations and other major affiliated entities rather than in the name of the health system itself. A 'best practice' hospital annual gifts program typically generates a steady stream of gift income from small- to medium-sized donations ($10,000 or less, with most from the direct mail program), with proportionately less effort (but a greater cost-per-dollar raised) per donor than is necessary in the major gifts or planned giving programs.

An annual gifts program is important for two primary reasons:

- ***first,*** to generate a significant amount of unrestricted or loosely restricted gift income to support hospital or health-related programs and projects, as well as foundation operations, on a predictable year-to-year basis; and
- ***second,*** to develop a constituency of future major gift and planned gift donors by 'acquiring' new donors and nurturing their involvement in the life of the hospital or health-related organization over time.

An annual gifts program seeks to acquire new donors by seeking first time donations, then renewing these gifts a year later at the highest possible rate of renewal (75% is an appropriate 'best practice' goal), and subsequently encouraging increased gifts from those who have become regular annual donors. An effective annual gifts program includes compelling direct mail requests as well as in-person gift invitations directed at selected prospects at least once each year. Direct mail requests that seek specific gift amounts are generally much more effective than those requests that do not suggest a specific gift amount.

Because an annual gifts program relies heavily on direct mail, it always has a much higher fundraising cost ratio than do major gifts or planned giving programs.

A comprehensive and multi-faceted donor acquisition and annual gifts program contains several key components: an annual board campaign, an annual employee campaign, an annual physician campaign, and an annual community campaign, as follows:

~ Board Giving ~

An effective annual giving campaign begins with strong support from governing and foundation board

members who make gifts in response to personalized approaches by teams that include the foundation President and at least one board member. Except in unusual cases, foundation staff other than the foundation President should not participate in gift approaches to board members. Soliciting board members' annual commitment once at the start of each member's term as a pledge made over the duration of the board term of three years is the most efficient method to secure board support.

~ Employee Giving ~

An effective annual employee giving campaign is very important not only for the dollars that are contributed but also to inspire other donors to give generously and to convey to community donors – individuals, foundations, and businesses – that the hospital's major internal stakeholders (i.e., the employees) are themselves committed financially to the hospital's mission.

'Best practice' employee giving campaigns adhere to a philosophy of voluntary giving, peer-to-peer solicitation, and thorough employee education about the organization's priority needs and the employee campaign. Managers should have no role in soliciting rank-and-file employees.

A successful employee annual giving campaign seeks ongoing, payroll-deducted commitments and provides special public recognition for those who contribute a particular minimum percentage of their total income through payroll deduction (e.g., the equivalent of one hour of pay per 80-hour pay period, amounting to 1.25% of one's gross earnings).

The most effective employee campaign begins with hospital senior managers (solicited by the Foundation President) participating at the 100% level with a significant commitment, often a minimum of one-hour-per-pay-period pledges (but preferably two-hours-per-pay-period), followed by hospital managers soliciting pledges from management colleagues and rank-and-file non-management employees soliciting pledges from their peers. Peer gift solicitations are conducted after all employees have been educated about the importance of employee support to the hospital's financial well-being as well as to the hospital's public image as a worthy recipient of philanthropic support from community donors.

The employee campaign is led by a group of volunteers recruited from across the organization. The leaders of the campaign (Co-Chairs) are recruited by the foundation staff and assist with recruiting the broader committee. Employee campaign volunteers are trained by the foundation staff to effectively ask their peers for voluntary gifts.

Employees are encouraged to make an ongoing payroll-deducted pledge rather than asked to 'do what you can.' Employee pledges may be amended or canceled at any time. 'Best practice' employee giving programs promote employee giving via the hospital intranet and facilitate pledges and gifts online.

All employee pledges are confidential; pledge cards are held by the foundation in strictest confidence, and hospital management has no access to pledge cards. Payroll deductions are then entered into the donor database and hospital payroll system by assigned staff who do not discuss gift information with others.

The employee campaign is conducted annually to renew employee donors who may have made one-time gifts the previous year and to solicit new on-going pledges from those employees not already participating.

~ Physician Giving ~

An annual physician campaign seeks and publicly recognizes annual gifts of $1,000 or more from each doctor – an amount that includes their financial participation in special events. Gifts should be sought in the form of three- to five-year signed pledges, whenever possible, to avoid the need to re-solicit physicians each year.

The physician campaign utilizes a committee of physicians, foundation board leaders, and staff – the Physician Gifts Committee – which requests pledge support from the hospital's active medical staff. The committee is co-chaired by at least two physicians who are very influential with their peers. Other committee members are also influential and respected physicians who have particular entrée to, and stature with, at least one important group of doctors on staff.

The physician Co-Chairs are recruited by select members of the hospital foundation board. Once recruited, the Co-Chairs strategize with foundation staff to determine which doctors would make the most effective members of the Physician Gifts Committee. The Physician Campaign Co-Chairs then recruit the committee membership, who will solicit employed physicians, physicians who practice in the community-at-large, and retired physicians.

Members of the Physician Gifts Committee are asked to: attend a presentation about the hospital's funding plans and needs; read the case for philanthropic support; and evaluate the active medical staff list to determine which doctors should be approached for significant contributions. Each committee member chooses three to five physician prospects to approach for gift support. Committee members attend a Physician Gifts Campaign kickoff meeting at which they will receive training on how to approach their colleagues for gift support. Members strategize with

each other and with foundation staff about how much to ask each physician to consider pledging. Members then make the necessary visits and follow-up visits in order to obtain signed pledges. The foundation staff and board members also help to approach physicians for gift support.

~ Community Giving ~

An effective annual giving program directed at grateful patients and community donors includes compelling direct mail and online requests, and in-person gift invitations directed at selected prospects at least once each year. The annual giving program should attach the highest level of importance to its grateful patient program and to retaining and 'upgrading' past donors, rather than emphasizing the acquisition of first-time donors who do not have an affiliation with the hospital. With the exception of mailings to grateful patients, requests that seek a specific gift amount are generally more effective than requests that propose a variety of gift amounts (e.g., "please give $10, $25, or whatever you can afford") or that do not suggest a specific gift amount.

In a small health system or in a region of a large health system, an effective 'best practice' program of grateful patient and community donor acquisition, donor renewal and upgrading is best managed in a centralized capacity to ensure rigorous adherence to complex mailing schedules, to obtain financially advantageous relationships with direct mail vendors, and to apply the latest direct mail solicitation techniques to gift requests. In such an arrangement, all mailings are highly personalized with respect to individual hospital foundations served by the centralized team.

◆ **Donor Renewal and Gift Upgrade Program**

Because the annual giving program relies heavily on more costly direct mail, it always produces a much higher fundraising cost ratio than do the major gifts or planned giving programs. Acquiring a donor's first gift dollar typically entails a fundraising cost ratio of approximately 125% to 150% (i.e., spend $1.25 to $1.50 to yield $1.00 in gift revenue), while renewing a donor's gift the following year and in subsequently years typically costs no more than 10% (spend 10¢ to yield $1.00 in gift revenue).

Thus, an annual giving program that is particularly effective in renewing the gifts of past donors and utilizes online giving appropriately yields an overall fundraising cost ratio that is considerably less than a program that achieves a lower gift renewal rate and relies heavily on expensive donor acquisition measures to meet its gift revenue goals.

A well-organized and executed gift renewal and gift upgrade program uses a series of up to four personalized letters and phone calls from foundation staff or board members to seek recurring gifts at the same or higher levels, depending on the frequency of one's past giving.

◆ Grateful Patient Donor Acquisition Program

The cornerstone of a 'best practice' donor acquisition program is a grateful patient program which encourages hospital patients to consider gifts to recognize caregivers who have made a positive impression on them. This program involves two to three attractive mailed gift invitations over the 24-month period following discharge – the first letter is sent within three months of discharge – and seeks first-time gifts from patients.

This type of program gives grateful patients and their loved ones the opportunity to support the hospital with the option of paying tribute to caregivers who made a difference during the patient's visit or stay. Each honored caregiver receives a card from the foundation informing him or her of the gift made by grateful patients, as well as a custom-crafted lapel pin that is presented to the caregiver at a foundation board meeting.

The grateful patient program also provides a viable pool of major gift prospects for future gift approaches.

◆ Community Donor Acquisition Program

A 'best practice' community donor acquisition program quantitatively tests the effectiveness of different formats and messages in its direct mail pieces, email 'blasts', and phone calls. To conduct the proper testing to determine the most effective approach to community donor acquisition, gift renewals, and gift upgrading, a hospital foundation should retain the services of an experienced direct mail and phone calling consulting firm to help the annual giving staff.

A primary service area-wide donor acquisition program purchases lists of prospective donors from list vendors, other direct mail vendors, its own internal direct mail production capabilities, or a combination of these methods, for production and distribution of direct mail solicitation packages.

◆ Stewardship and Recognition of Annual Donors

Within 10 months after making their previous gift, and before being solicited for another gift, all donors who gave $1,000 or more the previous year receive a personalized stewardship report that describes how their previous year's gift was used to benefit patient care.

On-campus receptions and medical presentations are held twice a year for all donors of $500 or more. Hospitals

with a primary service area that covers a large geographic area often conduct regional donor receptions and presentations.

Special Fundraising Events

The primary purposes of a special fundraising event are to elevate the profile of a hospital or other health-related organization, its foundation, and its need for philanthropic support with important donors, to honor existing donors, and to engage new prospective donor prospects in ways that other cultivation activities are not able to accomplish.

Fund raising is a special event's ***secondary*** purpose because of the high cost and the immense amount of staff and volunteer time entailed in staging an effective special event, when compared with the much higher revenue potential and lower cost (in staff and volunteer time and money) of major gifts and planned giving programs. A special event is generally considered successful financially if it consistently nets ***at least 50%*** of the amount of gross event revenue after calculating both direct costs ***and*** the prorated cost of salaries and benefits of ***all*** fundraising staff that help conduct the event.

Moreover, a fundraising event should not simply be viewed as an end unto itself but rather should always be followed up with cultivation efforts to involve event participants in the hospital's programs, services, and related activities.

Every not-for-profit community hospital or health-related organization foundation should seek to conduct one – but rarely more than two – special fundraising event each year. The foundation should avoid assuming responsibility for more than one event to avoid distraction from the foundation's signature event(s) and to minimize the amount of staff time that would be diverted from their non-event responsibilities.

It is not unusual for various civic and other affinity groups in the hospital's local community to organize and conduct special fundraising events to benefit the hospital. Such events are appropriate as long as: they do not rely on foundation staff to conduct the event; they use the hospital's name only with formal approval and in a professional manner; they seek to net at least 50% from event revenues; they do not request the foundation's donor list or hospital's vendor list for purposes of generating event participants; and they coordinate such events with foundation staff to avoid schedule conflicts or other problems.

To obtain corporate underwriting for special events, some health systems employ a full-time fundraising staff member who is responsible for seeking health system-wide corporate sponsorships that enable companies to be

showcased as event sponsors across a range of special events hosted by system affiliates. Many large companies find this synergistic approach highly attractive, ultimately contributing far more to the health system as a result of the system-wide sponsorship approach than they would otherwise give to individual hospitals approaching them to sponsor a single event.

There is no correct way in which special events should be staffed. Some hospital foundations have dedicated staff to organize and conduct events while others contract for these services. And some small health systems or regions of larger health systems establish centralized staff positions responsible for conducting special events on behalf of multiple system member hospital foundations. The usual result of such centralization, if accompanied by a centralized corporate sponsorship procurement capability, is a series of special events that are more professional, cost-effective, and satisfying than if managed on a foundation-by-foundation basis.

Prospect Identification, Research, and Management

A 'best practice' hospital foundation places considerable emphasis on systematically identifying and developing extensive financial and biographical information on potential major donors, and then using this information to hold foundation staff accountable by monitoring their progress in cultivating, soliciting, and stewarding gifts from these prospective supporters. Names of prospective donors are assembled from a variety of sources: patient lists, local news publications, physician and board member referrals, local club rosters, lists of previous annual donors, lists of memorial or testimonial gifts, and other sources.

A 'best practice' hospital foundation retains specialized vendors to conduct frequent or periodic 'wealth screenings' of its patient and donor databases to identify those with the potential to make major gifts. This information is used by foundation staff for purposes of making personal calls on new prospects when they are in the hospital or outpatient clinics. These prospects are also targeted for gift approaches through direct mail (e.g., highly personalized invitations to join $1,000 per year giving societies), or for special campaigns, or for invitation lists for donor cultivation events.

Working in conformity with HIPAA guidelines, the more innovative 'best practice' hospital foundations conduct daily electronic screenings of the hospital's patient census (outpatient as well as inpatient if available) to identify the names of those with significant philanthropic potential. Such information enables foundation staff to visit selected patients in the hospital or outpatient clinics to identify their

special needs and concerns and to learn more about their potential interest in supporting the hospital at some future date.

At any given time, a 'best practice' hospital foundation prepares in-depth background profiles on those prospects it determines have the capacity to give the hospital or health-related organization $50,000 or more. It is not unusual for a foundation to maintain several hundred such prospective donor profiles as it enters a major campaign, compiled either by in-house staff skilled in advanced prospect research techniques or outsourced to skilled freelance prospect research specialists.

As background information on prospective major donors is prepared, these prospects are then 'assigned' to members of the foundation staff who have responsibility for major gifts. Making such assignments is particularly important in foundations, health systems, or system regions where multiple staff members are involved in major gifts to ensure the proper coordination of 'who is doing what with whom' at any given moment.

All prospect assignments are recorded in an interactive electronic database, and narrative and other information on all mailings, personal contacts, meetings, and other encounters with prospects are entered by foundation staff on the database's prospect management system. Such a practice ensures that essential information on the foundation's relationship with its donor prospects is always up-to-date and accessible to all foundation staff as needed.

The proper management and timely inputting of this critical information are fundamental to the success of any effective major gifts program in which multiple foundation staff and many board members and others are involved in the prospect identification, cultivation, and solicitation process.

Gift Recording, Acknowledgment and Recognition, and Database Management

At all times, the 'best practice' hospital foundation maintains a comprehensive and up-to-date set of Gift Policies and Procedures, which describes how the foundation manages the processes of gift solicitation, gift acceptance, gift valuation, gift processing, gift acknowledgement, and gift recognition. A comprehensive set of Gift Policies and Procedures typically covers such subjects as:

- procedures for donor prospect clearance and coordination;
- acceptance or declination of gifts;
- types of acceptable or unacceptable gift transaction fees;
- procedures for gift recordation, acknowledgment, and stewardship for gifts of various sizes;
- policies on gift valuation;

- determination of the date of a gift;
- types of acceptable (or unacceptable) outright gifts (e.g., pledges, cash, gifts via credit card, publicly traded securities; closely held securities, restricted securities, mutual fund shares, real property, tangible personal property);
- types of acceptable (or unacceptable) deferred gifts (e.g., bequests, charitable gift annuities, charitable remainder trusts, charitable lead trusts, life insurance);
- categories of gift funds (unrestricted, temporarily restricted, and permanently restricted);
- policies on gift counting and campaign gift counting;
- policies on establishing and stewarding endowment funds (e.g., types of endowment; endowment restrictions; establishing new endowment funds; minimum amounts to establish a separate endowment fund; endowment donor reporting); and
- summary of approved donor recognition opportunities.

A 'best practice' health system and its member hospitals and health-related organizations maintain a common electronic donor constituency database that contains comprehensive information on all donors, donor prospects, and other individuals of interest to fund development. Such a database is constructed on a sophisticated software platform developed by one of the nation's leading companies specializing in fundraising databases. The database is maintained by the foundation and information is made available as needed (but on a highly restricted access basis) to other administrative departments in the health system or hospital. As these databases grow in sophistication, 'best practice' foundations are encouraged to utilize the growing capabilities of such systems in their day-to-day fund raising.

One of the major functions of the foundation's database is to maintain detailed gift records on all gifts made to the foundation. An important function of those responsible for maintaining an accurate and current donor database is to review and retain all written and other information that accompanies gifts, and then promptly and accurately acknowledge all gifts, regardless of size. All gifts are formally accepted, recorded on the database, and acknowledged within two business days with a minimum of an official gift receipt which is necessary for the donor to claim an income tax charitable deduction.

In the case of all memorial and testimonial gifts, the individual being honored, or the family of the individual being memorialized, is sent a letter or note mentioning the name of the donor who has made the memorial or testimonial gift, with no mention of the gift amount.

In the case of all non-tribute type gifts

of some predetermined gift amount – usually $100 or more – an individualized letter of thanks is sent in addition to, or in lieu of, a perfunctory gift receipt.

Gifts of **$1,000 or more** are usually acknowledged with a **personalized letter** from the foundation president or foundation board chair, as well as a letter from the administrative or medical director of the program which the gift supports, if the gift is restricted to a particular program.

Gifts of **$5,000 or more** are usually also acknowledged with a **personalized letter** from the chief executive of the hospital as well as the foundation board president or chair. Major gifts of **$25,000** usually justify **four letters of thanks**: from the foundation president, the hospital or health-related organization chief executive, the foundation board chair, and the program director. In addition, a phone call to the donor from these individuals which ***precedes*** their thank-you letters is also advised.

The underlying philosophy of gift acknowledgment is that it is impossible to thank donors too much for their gifts.

Donor Stewardship and Communications

A 'best practice' health system and its member hospital foundations understand the importance of regular, high-quality, substantive communications with their donor constituencies. At a minimum, a foundation produces a regular newsletter or magazine providing updates on health-related programs and services of distinction, personal profiles of notable caregivers and donors or volunteers, articles on medical topics of interest to the donor family, a calendar of hospital/ clinical and foundation events, pictorial features on recent events, announcement of significant gifts, and other pertinent information. At least one issue per year includes a listing of all donors to the foundation and/or announcement of the annual donor list online.

A hospital foundation also holds periodic donor stewardship events, hosted by the foundation, which are intended to sustain and enhance the strength of the relationship between donors and the hospital/clinic and its various centers of excellence or special programs of keen donor interest.

A 'best practice' hospital foundation is attentive to the importance of highly visible donor recognition by maintaining an attractive and up-to-date donor recognition area, located in a place of prominence and heavy patient traffic (usually in the hospital's or clinic's main lobby) and updated twice each year. The categories of donor recognition are:

- An alphabetical list of ***all current annual donors*** to the hospital foundation of a certain minimum gift level (usually $1,000);

- A donor wall including a list of the names of all donors who have made ***cumulative gifts (including realized planned gifts) to the hospital foundation totaling $10,000 or more***, divided into groups based on cumulative gifts;
- A separate alphabetical list of the names of ***all donors who have arranged for a planned gift*** (e.g., bequest) to the foundation.

Moreover, the foundation manages a hospital-wide program of permanent donor recognition plaques that recognize gifts of specific amounts to 'name' various areas of the hospital or clinics. The plaques are attractive, clearly visible, and unified in design throughout the hospital facilities.

Finally, the foundation maintains a visually stimulating, informative, and easy-to-access website that contains information including:

- the foundation's mission and objectives;
- how to make a gift on-line or by mail;
- brief description of current foundation fundraising priorities;
- lists of the names, professional affiliations, and home towns of foundation board members (including photographs);
- list of foundation staff and their titles and contact information (including photographs);
- list of all donor recognition opportunities, societies and membership benefits;
- list of the names of all foundation donors of $25 or more, organized by gift level;
- calendar of upcoming foundation events;
- profiles of grateful patients and their families;
- links to streaming videos that pertain to the hospital; and
- news of significant developments at the hospital, etc.

Because large gifts are so important to the success of a hospital foundation, special attention is paid to regular communications with such contributors. Accordingly, major gifts officers are expected to regularly prepare or orchestrate personalized communications to their key donors. Such communiqués may take the form of:

- copies of press releases or news articles that discuss programs or services supported by their past gifts;
- hand-written notes from doctors, other caregivers, senior executives, or patients expressing gratitude for past donations; and
- donor visits to the hospital to be reminded of the impact of their past support.

In the case of donors who have previously established restricted endowment funds, foundation major gifts or planned giving staff are expected to work closely with the foundation's or hospital's finance department to prepare annual reports

on each endowment fund approximately two months after the hospital's fiscal year has ended. Each endowment stewardship report should contain two components:

- ***first,*** a summary of the financial performance of the donor's individual endowment fund (original corpus, market value at the beginning of the fiscal year, market value at the end of the fiscal year, annual payout rate, and actual dollar amount from income and/or appreciation used to fund current programs or services supported by the endowment; dividends or appreciation used to support hospital program, etc.); and
- ***second,*** a narrative statement describing the specific use and impact of the endowment on a particular hospital program or service.

The stewardship report containing the two types of information is sent or hand-delivered by foundation staff to all donors (or their heirs or other family members) each year, as most endowment donors are especially interested in the ongoing impact of their endowment funds and often elect to add to their endowment funds through additional lifetime or deferred gifts.

Donor Concierge Services

In recent years, numerous leading community and teaching hospitals that cater to a population consisting of a significant number of affluent patients have established comprehensive concierge services programs that span outpatient as well as inpatient services. Concierge services offered vary from one hospital to another, but a fairly typical array of services includes:

- around-the-clock telephone access to foundation staff who help facilitate access to hospital services, expedite the admission and registration process, make appointments, and meet the donor at the hospital to provide assistance as needed;
- upgraded and more lavishly appointed inpatient rooms;
- special meals catered by local restaurants;
- courtesy parking;
- special assistance in resolving billing issues;
- specialty physicians who provide around-the-clock telephone access or medical advice by phone for donors who are travelling away from home;
- executive health exams; and
- travel clinics.

In many cases, the hospital foundation is integrally involved in managing selected aspects – or is fully responsible for - of these concierge services programs.

In all such hospitals with donor concierge service programs, the impact of these concierge service programs on philanthropic support has been profoundly favorable.

Finance and Accounting

The extent to which a 'best practice' hospital foundation handles finance and accounting functions is based on its level of independence from, or dependence on, the hospital that it supports.

A hospital foundation that operates independently from its parent hospital corporation typically has:

- a foundation ***board finance/investment committee*** that oversees the management of all unrestricted, temporarily restricted, and permanently restricted gifts – current and past – including the selection, oversight, and performance evaluation of investment counselors and fund managers; and
- an **audit committee** that oversees the selection of an external auditor (usually the same firm retained to conduct the hospital audit).

A member of the foundation staff typically serves as Finance and Accounting Manager, to assure that all restricted contributions are properly designated for specific funds, to prepare regular internal financial reports for foundation staff and board members, to prepare financial reports for donors of large gifts and endowments, and to work closely with external auditors.

The primary ***advantage*** of this independent foundation 'model' is that it gives volunteer board members a sense of profound involvement in the management and eventual allocation of funds that they have helped raise. The principal ***disadvantage*** of this model is that it encourages board members to focus excessive time and attention on functions not related to fund raising and to allocate insufficient energy to procuring new gifts.

In contrast to hospital foundations that operate relatively independently from the hospitals they support, those hospital foundations whose finance, investment, accounting, and auditing functions are merged or blended with those of the hospital itself generally place minimal emphasis on finance and accounting functions and instead focus their efforts on fund raising. In such cases, the foundation board receives regular reports from the hospital chief financial officer concerning investment performance of funds received via gifts and bequests, fund balances in restricted gift accounts, and the hospital's overall financial performance.

The primary ***advantage*** of this model is that the foundation focuses virtually all of its attention on procuring gifts for the hospital. However, the ***disadvantage*** of this model is that many excellent candidates for foundation board membership are not interested in a role that is confined largely to 'giving and getting.' Thus, a foundation that is effectively an extension of the hospital and is really no more than a 'paper' foundation often is challenged to recruit potentially strong board members who seek a deeper involve-

ment in the process of overseeing funds once they are donated.

Fund Development Staff

The System Chief Development Officer

A mature and effective 'best practice' fund development program in a small health system, or in a health system region consisting of community hospitals in close geographic proximity, is usually managed by an experienced fundraising professional who carries the title of 'Senior Vice President for Philanthropy' and 'Chief Development Officer' and who reports directly to the CEO of the health system (or the CEO of the health system region) – not to a member of the system's or system region's senior management *other than* the CEO.

In certain instances, where the health system's (or system region's) affiliates operate in a highly decentralized manner, the President of the hospital foundation that supports the 'flagship' hospital in the system or the system's region is often appointed to serve as the system (or system region's) Chief Development Officer on a part-time basis. In such cases, the 'Chief Development Officer' portion of the position reports to the CEO of the health system or the health system region, and the portion of the position that serves as President of the flagship hospital foundation reports to both the hospital's CEO and the foundation governing board.

While this 'joint appointment' arrangement reduces administrative expenses to the health system, it is sometimes not as productive because it requires that the Chief Development Officer split his/her time and attention between fundraising responsibilities for managing the flagship hospital foundation and supervising the presidents of the other foundations, as well as overseeing the centralized support services that provide administrative support for all of the system's hospital foundations. Moreover, such a 'split' arrangement may sometimes cause a negative reaction among donors and volunteers associated with the smaller hospital foundations who may resent the dominant hospital foundation for 'controlling' them.

The health system's Chief Development Officer is responsible for:

- guiding the system's (or region's) overall fundraising strategy and organization;
- helping the system's (or region's) senior management identify the most appropriate capital funding priorities for philanthropic support at each hospital or other health-related entity;
- supervising and mentoring the presidents of the individual hospital foundations in partnership with the individual hospital's CEO and foundation board;
- monitoring the relative effectiveness and productivity of each hospital foundation;

- supervising those fundraising support resources that are centralized at the level of the health system or health system region;
- serving as a senior-level spokesperson for the health system or the health system region, along with the system (or region's) CEO and other members of the system (or region's) senior management team; and
- soliciting system board member gifts, the gifts of peer senior managers, and the gifts of key major donors.

The Chief Development Officer (CDO) or 'Senior Vice President for Philanthropy' (as the position is sometimes titled) serves as a key member of the system CEO's (or regional CEO's) senior management team, together with equivalent senior administrators who manage the system's finance, medical affairs, legal affairs, clinical operations, marketing and communications, human resources, information services, strategic planning, and other key administrative responsibilities. The CDO also works closely with the system's (or health system region's) governing board and any formal committees or informal councils organized to oversee the system's fund development effort.

The CDO and the CEOs of each of the system's hospitals jointly supervise the presidents of the supporting foundations, together with the respective foundation governing boards.

In order to be effective, the Chief Development Officer has previously compiled an outstanding record of fund development program management at a major hospital foundation with a large fundraising staff, and is a skilled administrator who functions effectively in complex organizational structures. The CDO is also experienced in cultivating and soliciting large gifts. Because such gifts are critical to the success of any healthcare fund development program, the Chief Development Officer must be highly skilled in choreographing the identification, cultivation, and solicitation of such gifts, and must set both a symbolic and substantive example for governing board members, system senior managers, and foundation staff and boards to follow in their own major gift approach efforts.

Because compensation levels associated with the nation's leading healthcare fund development managers have risen considerably in recent years, the Chief Development Officer earns a salary that is equivalent to other senior members of the system's (or system region's) senior management team.

Presidents of the Hospital Foundations

The chief executives of the various hospital foundations hold the title of 'President', or 'President and CEO' – not 'Executive Director,' a title that conveys a lower-level and less important function in the hospital's

hierarchy. The President of each hospital foundation serves as a key member of the hospital's senior management team, spends as close to 100% of his/her time and attention as possible directing activities that raise funds, and personally carries a large portfolio of major gift prospects for cultivation, solicitation, and stewardship.

A nearly total focus on fund raising by the foundation's top executive is absolutely essential, given a hospital's urgent need for substantial philanthropic support. Reporting jointly to the system's (or region's) Chief Development Officer, to the foundation board, and to the hospital's CEO, the hospital foundation President works directly with the Chair and other officers and trustees of the foundation board to guide board members in their fundraising responsibilities.

Other Fund Development Staff

In keeping with healthcare fundraising 'best practices', hospital foundations should organize their fund development staff and programs to achieve the following objectives:

- strengthen staff and program support and accountability for those fundraising and fundraising support functions that will enable the member hospital foundations to maximize their potential gift/grant revenues;
- reduce staff and program support for those fundraising-related functions that require less attention, either because they do not generate an appropriate return on investment or because they are less essential to the future fund development effort;
- achieve economies of scale, more consistent day-to-day workloads, and/or improved results and more favorable outcomes by consolidating selected 'back-office' positions and functions that are redundant, duplicative, or non-existent; and
- identify opportunities to more effectively utilize the experience, skills, and talents of staff from the current fund development teams.

Depending on the gift potential of a particular hospital foundation, the foundation President supervises certain staff positions that are more effectively located at the foundation than at a centralized system-wide or system region-wide fund development office.

For example, a hospital foundation that is capable of consistently generating more than $2 million per year in gift revenues can usually justify having on its staff one or more dedicated major gifts positions, a stewardship officer to coordinate the donor concierge services program, and an annual giving officer dedicated to higher gift levels ($1,000 to $9,999), in addition to the foundation President and an administrative assistant.

Moreover, a hospital foundation that conducts several major events (both fund raising and cultivation) often can justify having a special event coordinator on the foundation staff.

In the larger health systems or system regions (usually eight or more hospitals), it is not unusual for the highest performing foundations (i.e., that raise $10 million or more per year) to have on their own staffs development officers who are technically proficient in handling planned gifts.

In most small health systems or regions within large health systems, centralizing various 'back-office' functions (e.g., donor acquisition and renewals, gift processing and acknowledgement, prospect research and wealth screening, corporate event sponsorships, website development, printed and electronic publications, and grant proposal writing) and certain 'front office' functions (e.g., gift planning) is almost always the best method of ensuring consistent, high quality service at the lowest possible cost by creating economies of scale and concentrations of professional talent.

While the process of establishing centralized fund development staff support functions among multiple hospital foundations in a health system or health system region can often generate political sensitivities associated with centralizing administrative functions, the extent to which these staff positions are organized centrally or not should be based primarily on what staff configuration is likely to generate the most gift revenue in the most cost-effective manner.

Determining Fundraising Potential

Preparing annual fundraising and capital campaign projections for mature, high-performance fundraising programs can be reliably based on quantitative data because these nationally renowned organizations possess extensive records of past giving trends resulting from years of vigorous annual giving, major gifts, planned giving, and major campaigns.

In contrast, the method of projecting fundraising potential for a hospital foundation that is performing at a level considerably lower than its potential remains more of an art than a science, and thus is based on qualitative factors as much as on quantitative considerations.

Nonetheless, both underperforming and high-performing foundations are subject to various qualitative variables (e.g., state of the local and national economies, attractiveness of capital giving opportunities, and the gift decisions of a small number of seven-, eight- and nine-figure donor prospects) that are virtually impossible to convert to quantitative analysis.

Thus, for underperforming programs, a projected **range for its annual gift**

revenues is more appropriate than a specific dollar figure, as a range reflects both constant and variable factors that reflect a hospital's unique circumstances and that influence its fundraising potential:

- its historic record of fundraising results measured against what it might have raised had it operated a 'best practice' fund development program – particularly in major gifts and planned giving;
- the extent of wealth in its primary service area;
- the relative interest in the hospital which is shared by the region's philanthropic establishment;
- the relative sophistication and reputation of the hospital's specialized services;
- whether the hospital maintains cutting-edge research and/or teaching programs;
- the extent of philanthropic competition the hospital faces with other major nonprofit organizations in its regional market, including other community hospitals and academic medical centers;
- the 'caché' of the hospital and thus the 'social status' conferred on those who associate with, and give to, the institution;
- the extent to which the hospital's physicians are involved as strong advocates for the foundation's goals and objectives;
- the community profile of the foundation directors (wealth, connections to wealth, business leaders, etc.) and the degree to which these volunteers are actively involved in fund raising; and
- other intangible factors that can influence fund raising, such as the impact of organizational changes that may have occurred in the hospital's recent past, such as changes in its identity, composition, structure, and donor affinities in recent years.

The Cost of Fund Raising as a Percentage of Funds Raised

A mature and effective hospital foundation that is not engaged in a major capital campaign typically maintains a cost of fund raising that is somewhere between **15%** (meaning that it costs about 15¢ to raise $1.00) and **30%** (costs about 30¢ to raise $1.00). Whether the hospital foundation is at the lower or higher end of this range depends upon the local community's giving capacity and the efficiency and effectiveness of the program. Some hospital foundations that operate in very small or poor communities cannot raise more than about $1 million per year. Since it is virtually impossible to run any freestanding hospital fund development program for less than about $400,000 per year, due to fixed costs of staff and programs, there are circumstances for which an ongoing higher cost of fund raising is acceptable.

Note: *The foundation's cost-per-dollar-raised should* ***always*** *be calculated in the context of a three-year rolling average, in order to compensate for year-to-year fluctuations in gift revenue which invariably result from unusually large pledges and bequests which FASB accounting regulations require be counted in their entirety in the fiscal year in which the pledge is signed or the bequest made.*

Most large hospital foundations have sufficient fundraising capacity to be at or below a cost of **30%** (example: spend $2 million to raise $6.67 million), and hospital foundations with relatively wealthy constituencies should strive for a fundraising cost ratio of **20%**. Only a few hospital foundations do better than a 20% cost of fund raising, and almost all of these institutions are raising $20 million or more per year.

When a 'best practice' hospital foundation conducts a major community-wide fundraising campaign, it ordinarily generates substantially more in new gifts and pledges annually during the pledge payment period of the campaign (usually three to four years) than during years in which no campaign is conducted. It is not uncommon for a hospital foundation that raises $5 million to $10 million per year in a non-campaign mode to generate $10 million to $20 million in new gifts and pledges during each year of the three- to four-year period in which a campaign is conducted. In such instances, the foundation's fundraising cost ratio drops significantly during the campaign period: for example, from **30%** during a non-campaign period to perhaps **15%** during the campaign period.

Small health systems or regions within a large health system have the financial advantage of being able to centralize certain fundraising support functions (e.g., planned giving, prospect research, database management, and finance/accounting functions) that are usually less costly to maintain for multiple foundations than for individual foundations. Moreover, such centralized functions usually perform at a higher level of quality and consistency when centralized than if these functions are dispersed among different hospitals and handled by staff who are simultaneously responsible for other diverse support functions. When these support functions are effectively centralized, the health system or health system region can reduce the cost of fund raising and reinvest these dollars in staff and programs designed to generate additional gift revenue (e.g., major gifts, planned gifts).

While it may be tempting for a hospital foundation to attain a 'best practice' fundraising cost ratio by reducing fundraising expenses, it is essential to keep in mind that an effective fundraising program that spends 25¢ to generate $1.00 in gift income is producing net income of 75¢ (a return on investment of 3:1). By comparison, a hospital that

generates net income from operations of 5% has an ROI of only 1.05:1. ***Put another way, an effective fundraising program is 60 times more effective in generating revenue on a pro-rata basis than are most hospital operations.***

Accordingly, a hospital foundation that can consistently generate an ROI of 3:1 or better should consistently look for productive ways to invest in new staff and programs that will increase its gift revenue until its ROI risks dropping below 3:1.

In other words, when a hospital 'service line' such as the foundation can consistently produce net income of $3.00 for every $1.00 spent – versus other hospital services than generate only 5¢ in net income for every $1.00 spent – why would the hospital not be motivated to make additional investments in fund raising?

Financing the Hospital Foundation Budget

There is no universal 'best practice' approach to funding the staff and programs of hospital foundations. Some hospital foundations are funded entirely by the hospitals they support, while other foundations are supported entirely by income from unrestricted gifts and endowment earnings. Still other foundations are supported by a combination of funds from the hospital and from unrestricted gifts and income from the foundation's endowment and short-term investments. And some foundations impose a 'gift tax' on all restricted gifts to supplement funds from unrestricted gifts and income from investments.

The **advantage** of funding the foundation budget ***entirely*** from hospital funds is that the foundation can focus all of its efforts on raising funds for specific projects of highest priority for the hospital, which is far more compelling to donors than seeking gifts to support the foundation's operations. In this case, foundations can state unequivocally that 100% of every gift is used for its intended purpose – not to support foundation operations. This is a very significant advantage and a compelling argument for the hospital funding the entire foundation budget.

The **disadvantage** of this approach is that the foundation is subject to the financial status of the hospital in a given year; in the event of hospital operating losses or other serious financial issues, the foundation may be forced to cut staff and programs as part of the hospital's overall expense reduction effort, which can dramatically erode foundation financial performance and can harm progress made in key fundraising programs and staff/donor relationships.

The **advantage** of the foundation funding its own operations is that it removes the foundation from the

financial 'ups-and-downs' of the hospital, thereby enabling the foundation to plan for the long term and develop staff and fundraising programs that are financially immunized from the status of the hospital's financial position.

The **disadvantage** of this approach is that most donors object to having their gifts used to support fundraising activities, and most donors seriously object to having their restricted gifts subject to a 'gift tax' of any amount.

The Greenwood Company

The Greenwood Company is a selective, mid-sized, fundraising firm that specializes in the design and management of comprehensive development programs, including campaign planning and feasibility studies, campaign management, and fund development planning studies in support of the capital, endowment, and operating needs of nonprofit organizations.

Most of the firm's work has been conducted on behalf of hospitals, health systems, medical research organizations, and health policy centers. However, an increasing number of clients are in the educational, cultural, social service, and international aid sectors as a result of referrals from satisfied health-related clients who understand that Greenwood Company fundraising methodologies developed for the health sector can be especially effective when applied to other nonprofit industries.

The Greenwood Company was founded in 1979 and has served nonprofit organizations in 28 states, including every geographic region of the country. The company's primary services include:

- Fund development planning studies;
- Campaign planning and feasibility studies;
- Capital and endowment campaign management;
- Comprehensive long-range development plans;
- Gift solicitation training programs;
- Interim development program management;
- Major gift and planned giving programs;
- Strategizing for major gifts, training gift approach teams, and negotiating complex outright and deferred ('planned') gifts of all types and sizes;
- Employee giving programs;
- Physician giving programs
- Board development;
- Constituent education programs;
- Financing the Hospital Foundation Budget;
- Board retreats; and
- Executive recruitment.

The Greenwood Company has conducted campaign planning and feasibility studies and fund development planning studies and has managed successful capital and endowment campaigns for hospitals, medical centers, and research institutions, independent schools, social and animal welfare organizations, cultural organizations, and international NGOs that are among the most respected nonprofit organizations in the United States.

NOTES:

THE GREENWOOD COMPANY

Transformational Productivity in Fund Raising ™

201 California Street, Suite 630
San Francisco, CA 94111
(415) 837-5858 (415) 837-5850 fax

www.thegreenwoodcompany.com