ISSUES FOR SYSTEM DEVELOPMENT

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Issues for System Development

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The history of charity in the United States is the saga of concerned citizens organizing grass roots efforts to meet community needs. The frontier self sufficiency that led so many community groups to form charities and solve community problems is as old as America itself. As the population and economy have grown over the years, so too has the not for profit sector.

In the for profit world, business sectors with many small and relatively inefficient operating units are prime territory for consolidation. Small, locally operated banks are all but gone. There are a handful of automobile manufacturers, and everything from cable television systems, to corner convenience stores are operated by an increasingly smaller number of companies which have demonstrated their efficiency in the marketplace and eliminated or acquired the less efficient competition. Most of us would readily admit that we both loose and gain something as business sectors consolidate. The individual character, personal relationships and uniqueness of the local business are lost. In exchange, we usually get predictable product quality, lower cost and better selection.

The local character and sense of “community ownership” of not for profit organizations, has made them much more resistant to consolidation than for profit enterprises have been. Perhaps because so much money is involved, hospital ownership has been the primary arena of incursion for both proprietary, and not for profit consolidation. Is this trend a harbinger or anomaly in the not for profit world? Only time will tell if the heretofore predominantly for-profit consolidation trend, spreads to higher education, libraries and museums, or begins and ends in the non-profit sector, with health care.

Most everyone intuitively understands the concept of economies of scale. It doesn’t matter if you’re setting out to build a business empire, or cook dinner – the idea is the same. We all know that it’s not twice as hard to make dinner for eight as it is for four. You have to follow the same steps, get out all the ingredients and dirty the pots and pans, either way.

Setting aside the niche companies in any market sector for a moment, there seems to be a clear competitive advantage to size in every area of business where volume purchasing, volume transactions, strategic management, brand equity and a predictable purchasing experience are important. Which is almost everywhere; including many aspects of healthcare. The interesting twist is that health care is also among the most personal and individual of professional services; delivered in the context of a relationship. I think everyone would agree that people are not interchangeable, and so, business or professional services, which are delivered through personal relationships, are not amenable to

centralization; and many professional services, delivered in the context of a relationship do not seem likely to be centralized.

Along those dimensions, there are some similarities between fund raising and medical care that I especially like to point out when there are physicians listening. The first is that both are highly personal. The choices we make about which organizations we will, or will not support, and to what extent we will support them, is usually very private, and highly discretionary. So too, until recently, were our healthcare choices. We are not very likely to criticize or second-guess someone's choice of a charity any more than we would his or her choice of a physician. And managed care subscribers are not taking kindly to the loss of their own discretion in selecting a physician or seeking specialty advice.

The second similarity is that the delivery of good medical care and the practice of good fund raising are both highly individualized. We don't try to raise real money with form- letter requests, any more than a physician would write one prescription for everyone in their waiting room. Perhaps because both fund raising and medical care are personal and individual, they share a third similarity in being delivered in the context of a relationship. To be most effective, a good fundraiser needs to know his or her donors individually and be known by them, just as good physicians can be most effective when they get to know and be known by their patients.

The point is that fundraising, like delivering medical care, is a hybrid business. There are certainly aspects of both that are ripe for consolidation, but also essential aspects that are so personal, individual and relationship based, that they could never be centralized. The perceived advantages of size and scale are fueling the merger trend in healthcare. But not all aspects of medical care are amenable to centralization. The relationship aspects certainly are not. And what about fund raising? Does size have any benefit there? And how can we get the advantages of size without losing the personal, individual relationships that are at the heart of both health care and fund raising?

After three years of monitoring the performance of over 25 foundations and development offices serving 40 hospitals, it has become apparent to me that larger fund raising offices are clearly, consistently, and almost unfailingly more economically efficient than smaller offices. Development offices consistently raising $3 million or more each year seem to routinely be able to do so at a cost of around .20 cents per dollar, year after year. Smaller offices can do that, but often don't. And the most inefficient offices routinely tend to be the smaller ones. Why might that be true? I can generate a number of hypotheses – typically, smaller shops are not able to pay to attract the same level of experienced leadership that larger shops can, and they tend to be in smaller hospitals, located in smaller, and less wealthy communities to begin with.

But there are probably some other reasons as well. Small shops have to do all the administrative and “back-office” functions that larger shops do – “they have to dirty all the pots and pans anyway.” But they have to do it with a smaller and less specialized staff, so a greater proportion of staff time must be spent in non-fundraising activities. Every small not-for profit organization operating in this country has a board and a prospect list. And almost every person on that list has at least one college or university that they attended – usually more - which would also like to have a donation. They also are on the list at their church, and three or four national charities. All of those charities have not two or three people on their development staff, but 50 to several hundred full time equivalent staff members. They have specialists in planned giving and direct mail. They have copywriters, grant writers, data base managers and prospect researchers. Our smaller not-for profits have 1 to 5 people trying to do all those things, at the same level of sophistication, while doing all the back office functions at the same time.

The inefficiency of that arrangement is even more apparent when you think about how money is really raised. Imagine that you owned a business in which the only source of your company’s revenue was orders generated by your sales force. In that situation, would you identify your top producing sales person and offer them a job as the office manager?

That’s exactly what we do in fund raising. We take the lead development person, presumably the most experienced, most skillful, best major gift fundraiser we have; and make them the office manager. In setting their daily priorities, they know that if they don’t get the board agenda or minutes done, the chairman will be embarrassed. If they don’t get the budget done, there won’t be any way to operate, and their CEO will be upset. If they don’t do the employee evaluations, human resources will call. The only thing they can put aside without a fairly immediate consequence is talking to donors.

In the years I have worked in development, I have never had a major gift prospect call me on the phone and say “Why hasn’t any one taken me out to lunch and asked me for a gift recently.” If you don’t call, they usually won’t volunteer.

The real potential advantage of size, the thing that could really improve fund raising results, is if we can take away the administrative responsibilities of our best fund raising staff members, and get them refocused on talking with donors. If our systems could “act like” a smaller number of larger offices, we would centralize the back office functions to free up our best fund raisers so that they can develop relationships with donors and through those relationships, raise money.

Advantages of Psychological Ownership

While many business functions are involved in running a development office, the essence of a development office is more than just a collection of business functions. I have already suggested that an important difference between raising money and many other business activities, is in the personal, individualized, discretionary and relationship based nature of it. There is a very good argument that a critical element in many economic transactions particularly those involving sales, is in relationships. People do business with people they like and trust, and the quality of personal relationships seem even more important in getting repeat business.

Donors give to organizations they know about and care about. The donor's relationship to the institution - which involves many personal relationships – is the key to success in fund raising. You can't centralize or substitute relationships. The realization of that fact came to me accidentally one day, several years ago, when I was new in my position as the lead fund raising person in the system office. I left the office for an appointment across town in San Francisco, at one of the hospitals in our system. Coming out of the office, I hailed a cab, got in and asked the driver to take me to St. Mary's Hospital.

"You mean the hospital over on Stanyon Street?" he asked.

"That's right", I said, happy that he didn't ask me how to get there.

"You know", the driver offered with just a hint of history in his voice, "I was born in that hospital".

It might have been the way he said it, I'm not really sure. But in that moment the thought occurred to me quite clearly, that no matter how long I work in the system office, no one – in a cab, at a cocktail party, or in casual conversation – is ever going to tell me that they were born at system headquarters. With that realization, I understood that whatever loyalties our patients and donors have, they have to the hospital where they had their surgery, or their children were born, or had their stitches, or a broken limb set in the emergency room. Perhaps a parent or relative died there, perhaps the life of a friend or family member was saved. But the essential point is that all of their experiences, good, bad or indifferent, make up their relationship to the individual hospital. They don't have, nor do they need to have or want to have, a relationship to the system.

My epiphany in the back of a cab on Broadway, is a story I have told many times. It is a standard part of the presentation I make to Foundation Boards at hospitals new to our system. The reaction is always the same. Board member's heads nodding enthusiastically all over the room. They know very clearly what they will, and will not do as donors. And what they know most certainly, is that they, and most of the people they know, have no intention of suddenly beginning to make donations to our system just because their local hospital is now a part of it.

The connection people feel to the institutions that serve them is the bedrock of philanthropic support. If we have done our job well, board members and major donors feel almost a sense of responsibility for the preservation and maintenance of those institutions. If we didn't have that sense of identification and psychological "ownership" of the organization among its closest constituents, we would be struggling to find ways to create it.

Hospital mergers that move too quickly to change names, reorganize staff, and dramatically change organization structures are inviting some period of reduced giving. Donors who feel their gift may be used somewhere other than the hospital it was intended for, will not give. Donors who feel that the system "their" hospital is a part of, is not sensitive to their local needs or concerns will at least wait and see how things turn out before making a major commitment. And every development officer knows that the thing we don't need any more of, are additional reasons for donors to wait before making a commitment.

So, if we accept the assertion that fund raising like health care, is a hybrid function; part business, part relationship based personal service, what does that mean for how we organize ourselves?

For me it means that if relationships are the key to the entire process, than preservation and protection of those relationships should be the key determinant of how we organize ourselves for raising money in a system. It just makes sense that the more a development office function requires personal contact, the more local it must be. And the reverse is also true. The less direct contact a function has with donors, the more invisible to the outside world, the more the function can be centralized. Why centralize at all if donor confidence and local relationships are so important? Because donors, and the charities they support, would like to see as much of each donated dollar going to support the work of the organization as possible, not to pay administrative or overhead costs. If we can do it better and cheaper without jeopardizing donor loyalty and the associated willingness to give, than we have an obligation to our donors to do so.

The goal of consolidation should be to improve functioning; that is to achieve both cost and management efficiency in order to maximize net gift income. We can accomplish that only by reducing costs in ways that don't significantly reduce revenue. A wonderfully efficient organizational plan that systematically offends and alienates donors will produce a foundation that is extremely efficient at raising no money. With that idea in mind, a group of Foundation Executives in our system developed the following guiding principles for consolidation. From these ideas, we went on to decide what we could and could not centralize.

1) Maintain personal and fiduciary responsibility to donors, past and present.
2) Increase net revenue available to support programs by developing or improving revenue generating capabilities and reducing the cost of existing programs.

3) Maintain/enhance the power of existing “product brand names” and identities, while educating publics to the added value of the system.
4) Existing boards should retain their current authority. Where a board doesn’t exist, a development council should be established to promote local ownership and involvement.
5) Balance respect for the special characteristics of each institution and its fund raising programs with the need to reduce cost and increase revenue. Don’t sacrifice success for the sake of uniformity. Don’t preserve less efficient methods for the sake of uniqueness.
6) Any consolidated function should result in a significant cost saving and/or increased revenue, and should be at least as effective as the unconsolidated function.

With those guiding principles in mind, our group generated a list of every function we could name involved in running a development office, and tried to decide, against the backdrop of our guiding principles, if each could be centralized, or needed to remain local.

Examples of Functions Best Performed at Each Institution

- ☐ Annual Giving
- ☐ Board Management
- ☐ Employee Campaigns
- ☐ Events (fund raising)
- ☐ Foundation Relations
- ☐ Gift Acknowledgments
- ☐ Major Gifts Cultivation and Solicitation
- ☐ Medical Staff Giving
- ☐ Planned Giving Cultivation & Prospect Identification
- ☐ Routine Planned Gifts

Examples of Functions Which Might Be Consolidated

☐ Accounting
☐ Audit
☐ Calendar Coordination
☐ Events - production
☐ Information Systems
-Check Data Input (timely)
-Report Generation
-Shared Data Base Software
☐ Institutional Comparative Performance Reporting
☐ Major Gifts Support
- Foundation and Corporate Research
- Prospect coordination and tracking
- Proposal Writing and Development
☐ Planned Giving - technical expertise
☐ Promotional materials (customized writing and production)

☐ Communication Among System Development Programs
☐ Development of a Management Information System Standard
☐ Pooled Income Fund & Gift Annuity Licensing & Reporting
☐ Purchasing:
-Direct Mail Services
-Donor/Prospect Research
-Promotional Materials
☐ Strategic Planning For:
-Board Development
-Patient Prospect Identification and Cultivation
-Physician Fund Raising
☐ System Fund Raising Policies
☐ Trust Administration

Some Real and Potential Examples

There are some very good examples of sophisticated cooperative programs done on a large scale. Done well, their complexity and size is transparent to the donor or prospect, who sees only the end product. An outstanding example is the direct mail program run by Jay Reardon at the Sisters of Providence Health System, headquartered in Seattle. The Sisters of Providence Health System has 19 hospitals in Alaska, Washington, Oregon and California. Jay began the mail program there in January of 1988. Today this growing program serves over 90 hospitals and foundations in 18 states. The Providence mail program has grown to become a direct mail cooperative of not-for-profit community hospitals and medical centers, much larger than the system that started it.

For a very reasonable fee, hospitals joining the program are able to participate in the purchasing, printing, data processing and post-mail analysis economies generated by a program that mails over five million pieces annually. Hospitals joining the program are asked to specify the zip codes comprising their primary service area. They choose a “theme” or beneficiaries, from a menu of options, well in advance of the mailing, and are assigned one of several professional copywriters around the country. The hospital’s development staff provides detailed background information to help the writer make the case for support. The hospital staff may also suggest key physicians, patients or administrative staff to be interviewed for the development of the letter. Drafts go back and forth between writer and Foundation, until the development staff is satisfied with the way their hospital and the appeal are presented.

Meanwhile, the hospital staff is assembling and sending “house lists” to Jay in Seattle. Those may be donor lists from previous annual appeals for renewal mailings. For acquisition mailings, discharged patients, auxiliary, medical staff,

Rotary or country club lists are assembled. Jay also rents commercially available lists of direct mail donors for acquisition mailings, through a list broker, for members of the cooperative. By renting in large quantities for ninety hospitals, required list rental minimums are easily achieved –an insurmountable obstacle for most single hospitals mailing alone.

The prospect on the rented list receives the appeal letter from the hospital in whose primary service area they live. . When all the lists are compiled and coded, the information is sent to a computer services company in Phoenix. There, a complicated merging of letters, logos, names and addresses occurs. High-speed computer driven laser printers insert the name and address of the prospect or donor on the letter specific to their local hospital. The appropriate laser printed signature of the local physician, administrator or board member selected as the signer is added, as is the local hospital or foundation logo. Business reply envelopes and key-coded response cards are laser printed at the same time, bearing the return mail address of the local foundation or hospital which will receive the gift.

The mailings are assembled and then bulk mailed from Phoenix to the main post office in the community where each participating hospital is located, then delivered to the recipient by the local post office. The donor or prospect opening the mail sees a stamped envelope containing an appeal letter, bearing the logo of the local hospital, with specific details about it's need for support. It is signed by a local board chair or other official from the hospital, and includes a return envelope addressed back to the local foundation. There is nothing about the package that would give the recipient any clue that this letter is the product of a team of direct mail experts located across the western United States. Gifts generated by the mailing are received and processed at the local hospital or foundation, then forwarded to Jay in Seattle for post-mail analysis of response rates, average gift size, yield and cost. Each list, zip code and appeal theme is similarly examined for its effectiveness for future use. Other reports are produced that allow all members of the co-op to compare results –acquisition and renewal—with their own.

The value, or relationship between the cost and quality of the program is exceptional. The cost is far lower, and the sophistication of the product and analysis of results far higher than the average small development office could ever duplicate. And most important, the purchasing economies, sophistication and production are all done successfully in the background. The part that touches the donor or potential donor is indistinguishable from a mailing originating in his or her own community.

The Sisters of Providence mail program is a good example of how unrelated small development offices can, by working cooperatively, develop services that compete in quality, cost and sophistication with much larger organizations. It is also an example of how they can do so without shaking donor confidence, or

creating any concern that the gift will be used anywhere other than at the hospital where it was given.

Some other areas where there is high added value for development offices working together are:

Pooled Investments – The cost to independently manage relatively small endowments and other long-term investments is high. Investment managers typically charge the highest rate on the first million invested. The rate goes down as the amount invested goes up, typically, additional reductions are offered for amounts over $5 million, or $10 million and higher. Each company sets the rates differently, but few small foundations have enough to invest, to qualify for the lowest rate. A group of organizations pooling resources to invest $50 million or more, would realize a significant cost saving. And there are other advantages.

Foundation boards exercising their fiduciary responsibility sometimes spend significant time and energy scrutinizing every holding in their portfolio and discussing every proposed investment change. They and their staffs often don't realize that their detailed attention to the management of their assets is actually a distraction from increasing the size of their assets in a much more efficient way, through fund raising. Pooling the assets of several foundations would probably produce lower management fees, better quality management and more attention to fund raising.

Research – Foundation and individual prospect research requires special knowledge and materials. Part of the important information about both individual, and foundation prospects is local knowledge, part is publicly available information. The local knowledge will always have to be uncovered through personal conversations and careful local inquiry. But the library of electronic and printed sources necessary to learn about real estate holdings, stock ownership, or IRA funding for individuals; or to research funding priorities for foundations, is expensive and the process is time consuming. Many organizations could be served from the same cooperative library and the same time spent investigating foundation sources.

There are also a number of companies that provide electronic screening or computerized comparisons of donor lists or inpatient census lists with databases of known wealthy individuals. Such services can almost always be purchased less expensively when bought in large quantities by a cooperative of organizations.

Gift Processing/Data Base Management – The essential, detailed and specialized tasks involved in gift processing and data base management are among the most challenging for any development office to consistently do well. It sometimes seems that nothing is more difficult than effecting consistent data entry, developing and maintaining a rational coding system, or producing useful

and meaningful reports. This is especially true in a small office where the person in charge of gift entry or data base management is also likely to be the office secretary, or to be less than a full time employee. As most of us who use any kind of software know, we usually don't use anything close to it's full potential, and if you only use a program for a few hours each week, you are even less likely to use it efficiently or know its capabilities well.

Another problem in many offices is that there is usually no back up for the one person who knows how to use the data base software. If that person leaves, there is no one to train the next person, nor any documentation about the coding system. During periods when the position is vacant, someone tries to "fill in" temporarily, or nothing happens at all for some time. Then, a new hire, often with no relevant experience, must try to learn the system and fix problems created in the breach without much procedural documentation or background about the coding system's design. After a few years, most offices have had 3 or 4 people performing this role, all trying without help to understand the "system" used by the last person, and making changes guided only by their own sense of how it might work better. Multiple idiosyncratic embellishments to the coding system over a period of years render the database almost useless for generating meaningful reports about past giving patterns.

By working together as part of a system or cooperative, development offices can realize significant volume discounts for group purchasing of hardware, software, training and annual maintenance costs. For large groups, the provision of in house technical support may be more economical than the cost of separate site maintenance agreements with the Software Company. If everyone in the group is using the same software, interfaces with other applications such as general ledger packages and patient admissions might be done much more economically.

Leading donor-management software producers have already begun introducing enhancements to their software, which will allow users at a remote site to "read", donor files on a database resident elsewhere. In the not too distant future, remote users will be able to add gifts and biographic information via the World Wide Web. In short, we are not far from the day when a central data processing office will be able to do the data base management functions for multiple development offices in a cooperative, or system from a single location. Development officers working in any of the connected organizations would be able to access donor records from their desk tops, just as they do now through local area networks.

Using partitioned coding systems and built in security measures, development officers at multiple locations could read and edit demographic information only for their own donors. Data entry for gifts could be done either at each site, or, using post office boxes for gift returns, at a central processing center. Gift acknowledgement letters could be generated centrally and then electronically

returned to the local hospital for editing, printing on the local stationery, signature and mailing. If we can provide adequate safeguards and assurances for the inevitable local concerns about preventing others from snooping in their donor records, we would have the possibility for a much more efficient system.

With a larger, more centralized data processing center, better trained, higher skilled staff would process many more gifts according to a standard set of procedures. Adjusting to staff turnover or illness would be much easier because the back up is already there, and temporary or replacement staff would be instructed in standard procedure, and get competent supervision. All of this could be achieved with no delay in the development staff's access to donor information, or any significant delay or inflexibility in the generation or customization of acknowledgement letters.

With all the forgoing as possibilities, now, or soon to be available, why haven't we done more to take advantage of these potential economies? Even though "systems" are relatively new, at least in healthcare, we haven't even begun to really explore the possibilities for streamlining the back office functions in development offices. In fact, it sometimes seems like development offices have been among the most resistant areas to consolidation. Part of the reason is that technology has truly not yet caught up to the promise we see on the horizon. Perhaps, with each new electronic tool or capability spawning a dozen new possibilities, it never will. It seems like a curse of the electronic age to have current practice always be a step or two behind the latest technology. But the most important inhibition to progress in developing shared services is political not technological.

Over the past eight years in California, I have been employed as the foundation head at two hospitals that merged into larger systems. Since January of 1996, I have worked in the corporate office at Catholic Healthcare West, a 40 hospital system with facilities in California, Arizona and Nevada during the incorporation of approximately 15 hospitals into our system. Seeing anything happen that often makes patterns and similarities apparent. One of the most apparent similarities in almost every hospital merger I have witnessed, are the concerns fears and anxieties of the foundation board members and staff. What are merging development staff, board members and donors afraid of?

Loss of Control

They are afraid they're going to lose control. Control of big things, small things, and even some things that they don't really control now. Here are some things board members, staff and donors say, as expressions of their fear of losing control.

"We're Different" – This is a reason often given to explain why what works wherever you come from, won't work in the hospital new to your system.

Inevitably the differences between urban and rural, small urban and large urban, religious and non-religious, one state and another, are seized upon as reasons why no cooperative activities are possible. Every hospital has a unique history in both health care delivery and development. Board members, staff and donors worry that the “uniqueness ” of the community may be lost if development efforts are directed from headquarters. Board members want to preserve their authority to review and approve the plans and beneficiaries for new fund raising initiatives. The system’s goal should be to negotiate appropriate performance and reporting requirements for both controlled and independent foundations prior to the merger. Those requirements should be aimed at protecting the system’s interests without negatively effecting the merger agreement, or significantly reducing charitable gift income by diminishing the sense of local ownership

“Local Investment” - Board members and donors are frequently concerned that local relationships will be lost if group purchasing and investment management are done elsewhere. The monetary value of those local relationships sometimes is more a wish than a reality when the giving histories of the local bank or broker are reviewed. And in these days of sweep accounts and huge cash management funds, it’s not likely that the local bank is really managing the money anyway. The expressed desire to support the local economy may really be a desire to protect the foundation’s resources. Protect them from being raided by the system for use elsewhere, or, from being spent locally after the merger, for general operating expenses rather than service enhancements.

Board members want to be guaranteed that endowment funds raised prior to the merger will not be taken away by the system or used for purposes other than those for which they were intended. This is usually expressed as a desire for the board to independently manage it’s own investments or to keep them invested with local institutions. Donors and Board members also want assurances that their contributions and those they help raise, will not be spent elsewhere. In these times of affiliations between religious and non religious organizations, non-sectarian hospitals joining religious systems are also concerned that their money may be used to further a religious agenda which they do not embrace. Systems should give them those assurances prior to the merger.

While these concerns are usually present to some degree in every merger, the depth of emotion associated with them can be very different from place to place. The prior relationship between merging hospitals in a market can be a source of deep distrust. The previous fund raising success of the foundation and financial condition of the parent hospital both seem to have a direct bearing on how protective the hospital joining a system is. In general, and as you might expect, the larger the endowment, better the hospital balance sheet, and more successful the development office, the more protective the board and staff. Hospitals in remote or rural areas seem also to have a self-reliant and self determined attitude that is not particularly trusting of outsiders.

In addition to the circumstances of the hospital being acquired, the system's style, or approach to the merger, assuming the system exists prior to the merger and is not being created by it, can have a significant effect, positive or negative, on the relationship. Among the most sensitive items in all mergers are the issues of the institution's name and logo. The name and identity of most hospitals is filled with history and tradition. It is the most difficult loss for a community of supporters to sustain. Health systems that insist on immediate and dramatic changes to the name and logo of the hospitals joining their systems may give up one or several names, with significant brand equity and loyalty in the community, in order to impose a new name with none. Only hospitals seeking to erase a really negative reputation for low quality service are likely to benefit immediately from taking on the name of the system, and only if the system name has the kind of quality reputation in the acquired hospital's primary market that is truly differentiating. Few hospitals or systems really do have that kind of reputation.

Whatever will happen as a result of the merger, to logos, names, legal and organizational structures, will be of great interest to the board, staff and donors. Administrative teams negotiating the agreement may be reluctant to share too much about post merger plans, even when they exist, for fear of stimulating opposition and concern. The development staff must be proactive in these situations because donors, who read and hear about merger plans, will have their own concerns. They must be actively reassured with well-reasoned explanations concerning the economic rationale for considering the merger in the first place, and to have absolute reassurance that their past and future donations will be used as they intend. Such assurances cannot reasonably be given if the development staff are not involved, and in communication with each other, and those negotiating the agreement. The importance of accurate and timely pre-merger communication between development staff members, foundation boards and with donors cannot be overstated. Bad management of this process can seriously harm the joining organization's ability to raise money for years to come. For a further treatment of communication issues, please see chapter xx.

The importance of pre-merger communication about the development function can not be overstated. A few years ago, when gift income was icing on the sizeable healthcare cake, arrangements for the foundation were often an afterthought in pre-merger negotiations. As hospital operating margins continue to shrink, the income from development represents an increasingly significant portion of the consolidated organization's margin. It is in the best interest of both the system and the hospital joining it, to have the details worked out in advance, and to do everything possible to minimize donors' concerns. When no arrangements are made in advance, the hospital foundation joining the system either assumes or hopes that they are totally autonomous or that their part of the organization will not be effected in any way by the merger. That assumption could make any cooperative activities more difficult to implement later, especially if they are interpreted as changes to the explicit or implied terms of the initial agreement.

Also, if arrangements for fund raising are not specifically negotiated as part of the agreement, the foundation staff and board of the joining hospital might very well begin making changes to bylaws and legal structure specifically designed to codify their independence, and to assure legal separateness. Our standard merger agreement now includes some provisions dealing with fund raising that didn't exist several years ago. The basic provisions were developed to address recurrent concerns on both sides of the proposed relationship. These assurances and requirements are extended regardless of legal structure to controlled and independent foundations alike.

1) Endowments- The use of donor designated endowment funds is guaranteed for the purposes intended by the donor(s). The endowments and their purposes should be clearly defined as part of the final agreement.
2) Use of Funds - Use of donor designated funds are absolutely guaranteed as intended by the donor, and assurances are given that all funds, including undesignated funds, will be spent at the local institution. The fact that this is standard ethical practice is not known or understood by most boards and donors. They appreciate the assurance in writing, because they don't know that we are ethically bound to adhere to donor restrictions.
3) Fund Raising Initiatives - The ability to make final decisions about all fund raising initiatives and methods are retained by the local board but made in conformance with system policies and made in consultation with institutional and or system leadership. The idea here is that before we would attempt to mount a system or multi institutional campaign for some shared service delivery project, each board would have to agree to participate. There is no successful campaign that happens without board involvement and participation anyway.
4) Stewardship - The control of assets is probably the most emotionally charged issue. The right of each board to control its own assets is assured, provided that the board carefully exercises its fiduciary responsibility to manage the assets in a prudent manner and at the lowest possible cost. We also specify that after the merger, both proceeds from endowments and current gifts be granted to the hospital according to an agreed upon schedule. For example, 5% of the value of endowment accounts and at least 50% of current funds to be granted each year with transfer within 90 days of the close of the fiscal year.
5) Accounting & Reporting - To provide the system and the local foundation board with reliable benchmarking information regarding financial performance, the foundation should be asked to:
    - Conform to the system fiscal year.
    - Use a standard fund raising chart of accounts for budgeting and reporting to allow comparison with other system development offices.
    - Provide an annual opportunity for system representatives to review the foundation's relative financial performance, and the system's fund raising performance with the local foundation board.

6) Collaboration-Local foundations should be required to participate in collaborative efforts to improve fund raising capability and reduce cost throughout the system. Such participation would include:
    - Regular attendance and participation in appropriate meetings of the fund raising staff.
    - Full participation in planning and developing shared resources.

As I mentioned earlier, in contemplation of joining a system, and often in the absence of any specific information or guidance about life after the merger, the board and staff of the joining foundation often attempt to protect their assets and autonomy. Usually they do that through changes in their bylaws perhaps to reduce or weaken the reserve powers of the sole member (usually their hospital) or to change their legal structure entirely so that there is no sole member making them an independent rather than subsidiary corporation. The battle to dissolve foundations, merge staff, and streamline governance may make sense from a pure management efficiency standpoint, but probably causes more lasting harm by missing the emotional point. Systems that move in to consolidate and control, and foundations that try to build legal walls around themselves in contemplation of a merger, misunderstand the symbiotic relationship between foundations and the hospitals they support. For a further treatment of governance issues, perhaps with a different point of view, see the chapter by George Maynard.

At the center of the concern, anxiety and defensiveness, which seems to dominate the pre-merger atmosphere is the foundation executive of the joining hospital. How he or she manages their own board and their own questions and concerns about the future, is a key determinant of how the entire relationship will unfold. I am convinced that foundation executives, who are concerned, afraid for their own jobs and suspicious about what will happen, create boards that are concerned, anxious and suspicious. Unfortunately, they are often given little to go on about the merger arrangements, and so are left to imagine the worst, without any accurate information about the future, or voice in helping to design it. It would be nice if CEO's, attorneys and others involved in negotiating the agreements understood the powerful opportunity their foundation executives have to influence community opinion makers about the desirability of the merger. Many of those opinion makers probably sit on the foundation board. It is an opportunity often not taken and even more often turned to a disadvantage when the foundation executive shares worries, concerns and fears with members of the board. How can a foundation executive serve the organization in those uncertain circumstances? There are some attitudes and prescriptions that I think can work.

1) Be Proactive- Ask questions, seek information and talk to as many people as possible in your own organization and in the other hospital(s) or system you are about to join. Sometimes its easier to do this unofficially rather than through official channels, since the general rule for negotiations seems to be

not to say or explain anything, until it is not only signed, sealed and delivered, but already widely known in the community.

2) Work out requirements and freedoms in advance- If there is a person responsible for fund raising in the system already, go see them and ask how they're organized. Find out what plans, if any, they have for you and your board. If there is an organizational structure already in place in the system, will you be expected to conform to it or not? Find out what's flexible and what isn't.

3) Make an Early Decision – If there is already a person in charge of development for the system, do you like him or her? Do you believe that you could work for them? If there is not, will one be named? Will you have a chance at the position? Will your CEO or another CEO be heading the merged organization? That could make a big difference in your chances. It is important to come to a decision as quickly as possible about your own future. Do you think there could be an opportunity for you as a part of the new organization? Would you want it, if it were there? If it looks something is possible and attractive, than you need to get all the way on board, trying to make the transition happen smoothly and being positive about the new arrangement. If your not sure, or are absolutely sure that you will not be happy or welcome as part of the new organization, than you need to reach that conclusion as quickly as possible so that you can begin to look elsewhere.

4) Serve the Institution, Not Yourself or the Current Board – When the whole world changes, it's hard not to think about how you're effected. It's also hard to imagine how anything is going to work out better if there is no board, or the hospital's name changes. Resistance to change is a well-documented and fairly normal reaction. Often in this situation, board members and staff members feel the need to mourn the passing of their freestanding organization, as they knew it. I think it is a mistake for development leaders to get too wrapped up in lamenting the changes, or working to resist or insulate themselves from them. No one can raise much money in an atmosphere of worry, doubt and pessimism. Don't be a part of fostering that atmosphere.

   A hospital decides to join a system as a strategic action which reflects a certain conclusion that has been reached about its future and it's viability as a stand-alone facility. The organizations we work for are struggling for survival in a turbulent time. As their agents and employees, our charge is to try to do the things that are in the long term best interests of our organizations, not of ourselves. If everything about the present were working well, there wouldn't be a need to so dramatically change our circumstances. It is in the best interest of your institution, after the decision to merge is made, for you to find ways to help make a smooth transition and craft a good working relationship, even if you won't be a part of it.

The strategy I don't think can work very well is for a foundation to try to protect itself by separating from the system. I suggested earlier that to do so is a failure to understand the inseparable relationship between the foundation and hospital. To be successful, hospital foundations must have the strong support and confidence of the hospitals they serve. In some cases the support is economic, and can be direct or indirect economic support, (such as free or reduced rate office space, inclusion in hospital benefits programs, and use of hospital facilities and services). But even if foundations are economically self-supporting, they still require other forms of support to be effective. Examples are access to the hospital's strategic plans, use of the hospital's name, advance knowledge of publicity initiatives, and access to physician, patient and employee groups. Even when hospital foundations are legally independent, they are not functionally independent from their beneficiary hospitals. They function as the exclusive fund raising agents of their hospitals to the extent that it is advantageous for the hospitals to have them do so. The donations they receive are almost always philanthropic expressions of support for the work of the hospital, not the foundation, and hospitals do not require separately incorporated foundations to receive or manage charitable support.

The functionally dependent relationship of foundations to their hospitals, and the exclusive franchises they enjoy, make it obvious that hospitals should seek, and foundations should grant, reasonable requests for information, involvement, communication and direction of the foundation's activities. A system retaining independent foundations supporting its hospitals grants them the exclusive right to ask for and receive charitable expressions of gratitude for the work performed by one of it's hospital's. They may also continue to independently administer and control significant assets that are "in trust" for, and intended for the furtherance of the mission of the hospital. These exclusive franchises cannot be given without any requirement as to the cost or quality of service provided; any term for the provision of that service, any standard for performance, or remedy in the event of substandard performance. A system clearly would not easily agree to similar arrangements for purchasing, housekeeping or the administration of any other support service required by a hospital entering the system.

Joining a hospital system is a strategic decision made by hospital board members struggling to ensure the very survival of their independent hospitals. The decision to merge is a decision to fundamentally change the nature of the institution. It must be fully embraced if it is going to work to assure the survival of the facility as a part of the larger system. Accommodating the individual history and unique characteristics of each institution must be balanced with an equal desire to accommodate its future as an increasingly integrated component of a system. Finding a functional balance between such competing forces is the essence of good management. The responsibility to find that balance must be an expectation of all managers working in a system, including foundation managers.

Their performance should be evaluated against the achievement of both individual hospital, and system development goals.

I have taken some time exploring the importance of relationships in healthcare and fund raising. I have suggested that the work we are engaged in is in some ways like any other business and in other important ways, very personal and individual. The bedrock of our work is in the relationships formed between people: between physicians and patients, board and staff, donors and development officers. In many ways, charitable gift support is the product of a relationship between donors and institutions, the institutions being embodied by the people who work in them.

If we can accept the idea that individuals have relationships with institutions, then perhaps its not too difficult to think about relationships between institutions as well. Any cooperative venture between organizations, from a full merger of assets to the slightest cooperation on some political issue, is an expression of a relationship between those organizations. Some institutional relationships remain cool or distant, while others grow closer with time. Relationships between organizations depend heavily on the relationships between the people who work in them. It takes time and an understanding of mutual interest for them to develop fully. Fully productive relationships must have a strong element of trust between the parties involved. There is no substitute for personal contact in allowing trust to develop.

Building strong cooperative relationships, like the formation of a regional health care system, and the consolidation of resources, is a dynamic and evolving task. A single plan, particularly one imposed or developed before the relationship begins, cannot permanently resolve all issues. And plans made before mutual trust has been fostered will almost certainly be perceived as too controlling or isolationist. The maturation of relationships allows things to become possible and even welcome later that were not possible earlier in the relationship. There must be a continuing process in place to explore opportunities and ensure progress in the months and years after the ceremony is over and our unions begin to mature. Changes in technology, public perception, mutual trust and our own organizational identity will make new initiatives possible that are not possible now. We must keep the relationship in mind as a process that requires attention and does not end, but really just begins, when the merger agreement is signed.

In that frame of mind, we may resist the temptation to develop the ultimate organizational structure before we start. And by providing assurances, guarantees and a clear and short set of expectations at the outset, we may actually avoid doing serious damage to donor and institutional relationships in the process.