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**Community Clinics Initiative**

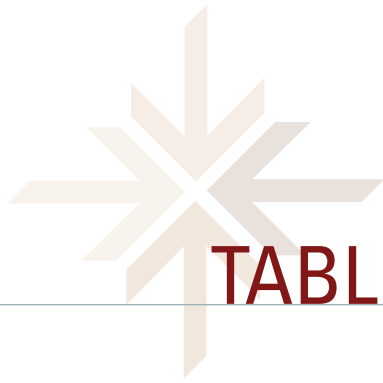
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**Maria Gitin & Associates**

The materials contributed to this toolkit represent the results of research/work with rural and urban health centers on capital campaigns, board development and strategic planning. Maria Gitin, Certified Fundraising Executive, Samuel Torres Jr., Esq. and Jeanne Hanks, MSW form the Maria Gitin & Associates team. They are available for consultation, coaching and training including by telephone and internet. Ms. Gitin has been the senior campaign consultant and major gifts trainer for the Tides Foundation Community Clinic Initiative for the past four years and is on the national training team of the Peter Drucker Foundation. Contact: 831.763.6983 or visit [www.mariagitin.com](http://www.mariagitin.com).

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# ABOUT THE PROJECT

Through grant funds provided by the United States Department of Agriculture (USDA) Rural Community Development Initiative, the California State Rural Health Association (CSRHA) and its partners John Snow, Inc. (JSI), and the Rural Health Design Network (RHDN) have developed a two-year capital campaign training program entitled Transforming the Future Health of Rural Communities through Economic Development. The program is designed to build the capital fundraising capacity of rural health organizations through leadership development and strategic planning.

Driven by a mutual vision to promote economically viable rural communities with strong healthcare infrastructures the project team is devoting their expertise to improving the leadership and fundraising skills of the following rural health organizations:

- Glenn Medical Center - Willows, CA
- Mendocino Coast Clinics, Inc. - Fort Bragg, CA
- Mountain Valleys Health Centers - Dorris and Tullake, CA
- Siskiyou Family Healthcare - Yreka, CA
- Southern Inyo Healthcare District - Lone Pine, CA
- Warner Community Resource Center - Warner Springs, CA

Through the course of this two-year program, the project team is laying a foundation for each participating organization to successfully plan for and initiate comprehensive capital fund development strategies while assisting each site to engage the local community in the planning and execution of fundraising campaigns.

*This capital campaign toolkit is a collection of resources and rural-focused advice compiled by the members of the project team to share knowledge and resources that will promote the financial viability and success of rural health-care organizations throughout California*

# WHY A CAPITAL CAMPAIGN

In California's rural communities, economic viability depends significantly on the local health care infrastructure. The health sector is typically the largest employer in rural California, and the chief source of health care to employees in the \$17 billion agricultural, forestry, fishing, and mining industries. A typical rural hospital may employ 15-20 percent of the local workforce and possess a multimillion dollar payroll. Furthermore, health sector employees, among the highest paid in rural areas, tend to spend their money locally, generating additional jobs and revenue. Sustaining the local health care infrastructure in rural communities is not only critical to the health of rural residents, but also to the economic stability of their communities.

Capital campaigns are effective strategies for building relationships between rural health organizations and their communities while developing strong healthcare infrastructures and rural economies. Capital campaigns help to engage Board, staff and community members in efforts to reach common goals for new or improved health facilities. This capital campaign toolkit has been assembled to assist all rural organizations interested in launching a capital campaign.

By improving the capacity of rural healthcare organizations to provide health services, the health of underinsured rural residents is improved, insured patients are able to boost the economic viability of their communities by seeking care locally, new opportunities for healthcare employment are generated, and ultimately rural economies that will attract new capital are created

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# I. PRE-CAMPAIGN PLANNING: STEPS TO READINESS

## → STEP 1

### **BUILD AN ORGANIZATIONAL FOUNDATION FOR A CAPITAL CAMPAIGN**

#### ROLE OF THE BOARD OF DIRECTORS

Having an actively engaged Board who is committed to fundraising is critical to ensuring the long-term financial viability of any organization.

#### DEVELOPING A MISSION STATEMENT

A mission statement should be a succinct description of the overall purpose of an organization.

#### DEVELOPING A VISION STATEMENT

A vision statement illustrates the ideal image of your organization in the future.

#### DEVELOPING A STRATEGIC PLAN

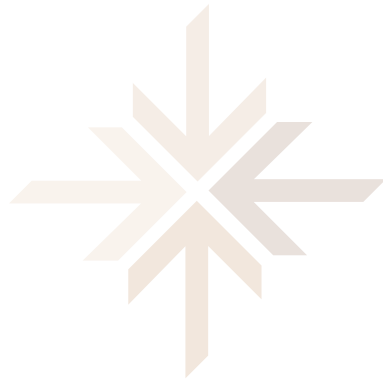
A strategic plan outlines strategies to achieve specific goals that are in line with your organization's mission and vision.

#### RESOURCES

- Building capacities self assessment tool (Appendix A)
- Case study: Siskiyou Family Healthcare Strategic Plan
- Website references



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## STEP 1: BUILD AN ORGANIZATIONAL FOUNDATION FOR A CAPITAL CAMPAIGN

Your organization's "capacity" to perform is influenced not only by the knowledge base and capabilities of your staff and Board of Directors, but also by available resources, and the relationships you build with your surrounding community.

*An organization that has developed a strong Board of Directors, a motivated staff and a responsive community will be most likely to achieve their vision for the future.*

When building organizational capacity, you will focus on improving elements of your organization's operations related to:

- Leadership (Board of Directors and internal management);
- Mission, vision, and strategic planning; and
- Resource Development, especially through collaboration with your community(1).

Understandably, building organizational capacity is a major undertaking, and will require the time and dedication of your staff, Board and community.



See Appendix item A (*Building Capacities Self-Assessment Tool*) to help identify your organization's strengths and weaknesses.

### → WHAT IS THE ROLE OF THE BOARD OF DIRECTORS?

A good Board of Directors not only provides guidance and direction to your organization's programs and services, it also makes fundraising a priority and is willing to participate in developing the organization's financial resources personally.

*Having an actively engaged Board who is committed to fundraising is critical to ensuring the long-term financial viability of any organization.*

#### **Other responsibilities of the Board of Directors include:**

- Formulating mission, vision and goals
- Setting policy/direction for organizational operations
- Dealing with legal/liability issues
- Hiring/evaluating the CEO and ensuring sufficient human resources
- Approving/monitoring programs and services
- Representing the organization in the community

**A Board member:**

- Attends and participates in all Board meetings
- Is knowledgeable about the organization
- Remains objective
- Maintains proper relationships with staff
- Is committed to the cause
- Acts in a professional manner
- Makes ethical decisions
- Is a flexible team player

*Most importantly, a good Board member must have a strong interest in fundraising, and a solid understanding that this is a substantial part of their role.*

**→ WHAT IS A MISSION STATEMENT?**

A mission statement is a succinct description of the overall purpose of an organization. In short, a mission statement outlines:

- The purpose of your organization
- The services you provide
- Your organization’s values
- The beneficiaries of the work that you do(2)

Your mission statement stems from a detailed, analytical discussion regarding your organization’s environment, values, services and public image. If you are considering revising your mission statement, examine the effects of adding a word to, or removing a word from, your statement. Does this alteration affect the meaning of your mission (3)?



*See Appendix item A (Building Capacities Self-Assessment Tool) to help identify your organization’s strengths and weaknesses.*

**→ WHAT IS A VISION STATEMENT?**

While a mission statement describes what your organization does, a vision statement illustrates an ideal image of your organization in the context of your community’s future. It articulates the values and beliefs that inform your organization’s work, and what it hopes to accomplish as a result. Commitment to a concise and well-understood mission will lead your organization toward its vision.

Use your vision statement as a motivational tool, but also make sure it is an attainable goal.

### **What exactly is the difference between a mission statement and a vision statement?**

According to the Long Island Center for Nonprofit Leadership (visit <http://www.adelphi.edu/linonprofit/tips.php>), the difference between a mission statement and a vision statement is:

- Mission controls, while the vision inspires
- A mission statement keeps an organization on track and guides it in the right direction
- A vision statement motivates and offers a framework for the mission to be dynamic

### **WHAT SHOULD OUR MISSION STATEMENT SAY?**

A Mission Statement should be a clear, concise statement that says who the agency is (the name, that it is a nonprofit, and what type of agency it is), what it does, for whom and where.

It should be a simple, easy to remember statement that your Board members, staff and volunteers can effectively use to lobby on behalf of your organization.

An example: "United Community Center is a 501(c)(3) human service agency providing emergency assistance, daycare, social services and recreational activities for low-income children and families at risk in inner city Atlanta, Georgia."

### **→ WHERE DOES STRATEGIC PLANNING FIT IN WITH CAPACITY BUILDING?**

Your strategic plan will outline strategies to achieve specific goals that the Board has put in place to achieve your organization's mission and vision.

When developing a strategic plan you will generally need to go through a three step process involving:

1. Analysis: Think about your organization's strengths and weaknesses in the context of taking advantage of current opportunities and addressing any threats to attaining your mission and vision.
2. Direction Setting: With opportunities and threats in mind, what are your goals and focus area priorities for the next 2 to 3 years?
3. Planning: Develop specific, measurable, action-oriented, realistic and timely strategies and activities to address your focus area priorities and reach your goals(3).

### **SAMPLE VISION/MISSION STATEMENTS FROM A RURAL AGENCY:**

Wayne County Rural Health Network  
Newark, New York

#### **Vision Statement:**

The Wayne County Rural Health Network will be the premier health and human service partnership working to achieve the highest level of health and wellness for the people of Wayne County.

#### **Mission Statement:**

In collaboration with partners, providers, and individuals, the Wayne County Rural Health Network plans, initiates, and implements innovative solutions for emerging and unmet health and human service needs that one provider alone could not undertake.

## **CASE STUDY FROM A RURAL AGENCY:**

### **SISKIYOU FAMILY HEALTHCARE RESULTS OF STRATEGIC PLANNING SESSION**

In January 2007, CSRSHA facilitated a strategic planning process for members of Siskiyou Family Healthcare's management team and Board of Directors. This document outlines the mutually established goals and strategies developed through collaborative efforts of the Siskiyou Family Healthcare leadership team.

#### **FOCUS AREAS (IN PRIORITY ORDER):**

1. Space
2. Providers
3. Protocols (clinical; office)
4. Behavioral health
5. Resource center for the needs of the medically indigent in the community

#### **GOALS:**

##### **I. SPACE**

1. In 2 to 5 years have a new health care facility that will be able to house consolidated operations (10,000 sq. ft.; 3 exam rooms per provider; behavioral health services; dentist; meeting space; media room)

## CASE STUDY CONTINUED

### STRATEGIES:

- Implement capital campaign; fund raising plan
- Create Foundation
- Present cohesive front to community (in order to do so, every employee needs clear understanding of clinic operations)
- Consider collaborations with other health and human service providers/organizations in Yreka
- Develop a business plan for the new facility (explore rent vs. build)

2. Use existing space more efficiently

### II. PROVIDERS

1. Increase the number of providers: 1 in 6 months, another 1 in 3 years (1 of which is MD)

### STRATEGIES:

- Recruitment and retention plan for providers
- Need to project positive image and have cohesive front for recruitment
- Ensure that potential providers understand the culture of rural practice and enjoy the independence
- Recruit residents from nearby medical school
- Develop standard set of protocols (this will enhance provider recruitment and retention)

2. Recruit a dentist

3. Provide flexibility for providers through hours and rotation through clinic

### III. PROTOCOLS

1. Achieve standardized measurable clinical outcomes.
2. Develop internal policies and procedures.

### STRATEGIES:

- Review existing protocols, revise and develop new set of protocols and have ready for EMR implementation
- Appoint committee, allocate staff time to work on protocols
- Provide in service regarding protocols once completed
- Enhance internal communications

## → RESOURCES

### DEVELOPING ORGANIZATIONAL CAPACITY:

#### WORLD WIDE WEB:

##### **Components of Organizational Capacity**

<http://www.oac.state.oh.us/grantsprogs/BuildingCommunitiesEnglish/ComponentsOrganizationalCapacity.doc>

##### **Organizational Capacity Checklist**

[http://www.advocacy.org/pdf/capacity\\_checklist.pdf](http://www.advocacy.org/pdf/capacity_checklist.pdf)

##### **Nonprofit Good Practice Guide**

<http://www.npgoodpractice.org>

##### **Building Capacity in Nonprofit Organizations**

[http://www.urban.org/uploadedPDF/building\\_capacity.PDF](http://www.urban.org/uploadedPDF/building_capacity.PDF)

### LEADERSHIP DEVELOPMENT:

#### WORLD WIDE WEB:

##### **Journal for Nonprofit Management V. 10 No 1, Leadership and Change**

<http://www.supportcenteronline.org/images/journal2006Vol10Num1.pdf>

##### **Nonprofit Management Resources**

<http://www.idealists.org/tools/management-resources.html>

### DEVELOPING MISSION AND VISION STATEMENTS:

#### BOOKS:

##### **Wilder Nonprofit Field Guide to Crafting Effective Mission and Vision Statements, by Emil Angelica.**

#### WORLD WIDE WEB:

**Don't Make Your Organization's Statement of Purpose a Mission Impossible, Fund-Raising Forum Library**(<http://www.raise-funds.com/1101forum.html>)

##### **Basics of Developing Mission, Vision and Value Statements,**

The Free Management Library ([http://www.managementhelp.org/plan\\_dec/str\\_plan/str\\_plan.htmP](http://www.managementhelp.org/plan_dec/str_plan/str_plan.htmP))

### STRATEGIC PLANNING:

#### WORLD WIDE WEB:

**Various Overviews of Strategic Planning (basics, models, skills to have),** The Free Management Library ([http://www.managementhelp.org/plan\\_dec/str\\_plan/str\\_plan.htm#anchor320170](http://www.managementhelp.org/plan_dec/str_plan/str_plan.htm#anchor320170))

##### **Strategic Planning (in non-profit or for-profit organizations),** Carter McNamera MBA, PhD

[http://www.managementhelp.org/plan\\_dec/str\\_plan/str\\_plan.htm](http://www.managementhelp.org/plan_dec/str_plan/str_plan.htm)



## → STEP 2

### **CONDUCT A FEASIBILITY STUDY TO ASSESS POTENTIAL FOR A SUCCESSFUL CAPITAL CAMPAIGN**

#### PURPOSE OF A FEASIBILITY STUDY

A feasibility study identifies potential leaders, donors, as well as the strengths and weaknesses of a campaign.

#### DETERMINING THE NEED FOR A CAMPAIGN CONSULTANT

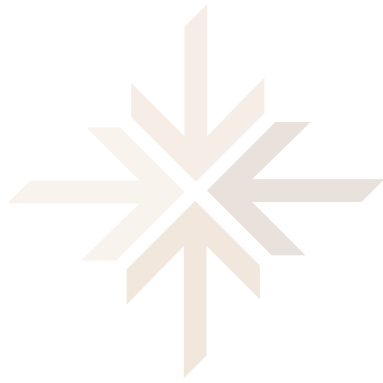
A campaign consultant can help determine an organization's readiness for a capital campaign through an internal capacity assessment and an external feasibility study.

#### RESOURCES

- Case studies from rural agencies
- Website references



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## STEP 2: CONDUCT A FEASIBILITY STUDY TO ASSESS POTENTIAL FOR A SUCCESSFUL CAPITAL CAMPAIGN

An assessment of external support and internal resources, also known as a feasibility study, will help you decide if your organization is truly ready for a capital campaign. You may decide to hire a consultant to conduct your feasibility study and to help you implement your campaign.

### → WHAT IS A FEASIBILITY STUDY? DO WE NEED ONE? AND HOW DO WE CONDUCT ONE?

The feasibility study determines if the campaign has a good chance of success. A feasibility study involves interviews with organization leaders and influential community members. The interviews help to assess the organization's reputation in the community, and predict how receptive community members will be to donor cultivation.

*A feasibility study identifies potential leaders, donors, strengths and weaknesses of a campaign.*

On the whole, a feasibility study will help you:

- Learn about your organization's image
- Build connections with community members
- Discover prospective donors
- Identify volunteer leadership
- Develop campaign strategies and plans for soliciting gifts

It *is* possible to conduct a capital campaign without conducting a feasibility study. However, organizations that choose not to implement a feasibility study often find themselves surprised by campaign outcomes that could have been anticipated if a study had been conducted.

Your first step to implementing a feasibility study may be to hire a campaign consultant. A campaign consultant will schedule interviews with leaders in your organization and influential community members, and use the gathered information to produce a report analysis.

A feasibility study often takes 3 to 6 months to complete and can cost anywhere from \$15,000 to \$50,000, depending on how many interviews are conducted. Another cost variable is the geographical spread of the interviewees. Travel costs for interviews must be taken into account (4).



*If your organization does not have the funds to hire a consultant and pay for a feasibility study, there are a number of options available to you. See the resource list at the end of this section.*

➔ **DETERMINING YOUR NEED FOR A CAMPAIGN CONSULTANT:**

A campaign consultant is hired to help determine an organization's readiness for a capital campaign through an internal capacity assessment and an external feasibility study. The consultant may also help in the areas of volunteer training/education, fundraising efforts, and board development.

**You may need a consultant if:**

- Your organization lacks human resources to conduct the feasibility study or the actual capital campaign.
- Your organization's staff lacks substantial fundraising experience.
- Your organization is located in a small, low-income community without resources to support a capital campaign.
- There is competition for community funds.

## CASE STUDIES FROM RURAL AGENCIES:

### **SHASTA COMMUNITY HEALTH CENTER**

Dean Germano, CEO of Shasta Community Health Center, says rural organizations "shouldn't be scared away by the price tag" of a consultant. A good consultant will give you a good answer as to whether your capital campaign is feasible. "They don't want to take your money and fail," says Germano. Before hiring a consultant, negotiate with him/her on a feasibility study price, and then do a reference check.

### **GOLDEN VALLEY HEALTH CENTERS**

When Golden Valley Health Centers (GVHC) in Newman, CA wanted to begin their first capital campaign, they interviewed fundraising consultants to learn about a consultant's role in a campaign. Michael Sullivan, CEO of GVHC, found that hiring a consultant with fundraising expertise was critical to their campaign. Sullivan stresses sticking to a plan once you hire a consultant. Make sure your organization and the consultant are on the same page and working toward the same goal.

## RESOURCES

### GRANT RESOURCES FOR CAPITAL PROJECTS:

**USDA Community Facilities Grant Program**

[http://www.rurdev.usda.gov/rhs/cf/brief\\_cp\\_grant.htm](http://www.rurdev.usda.gov/rhs/cf/brief_cp_grant.htm)

**USDA Distance Learning & Telecommunications Program**

<http://www.usda.gov/rus/telecom/dlt/dlt.htm>

**HUD State Community Development Block Grant Program**

<http://www.hud.gov/offices/cpd/communitydevelopment/programs/stateadmin/index.cfm>

### LOAN RESOURCES FOR CAPITAL PROJECTS:

**USDA Community Facilities Direct and Guaranteed Loan Program**

<http://www.rurdev.usda.gov/rhs/cf/cp.htm>

**USDA Business and Industry Guaranteed Loans**

[http://www.rurdev.usda.gov/rbs/busp/b&i\\_gar.htm](http://www.rurdev.usda.gov/rbs/busp/b&i_gar.htm)

**USDA Distance Learning and Telecommunications Grant and Loan Program**

<http://www.usda.gov/rus/telecom/dlt/dlt.htm>

**HUD 242 – FHA Mortgage Insurance Program**

<http://www.hud.gov/offices/hsg/hosp/hsgghospi.cfm>

**SBA Certified Development Company (504) Loan Program**

<http://www.sba.gov/services/financialassistance/index.html>

*If you are taking out a loan, partner with someone or work closely with a loan officer to help predict underlying to-dos. Also, always have a back up funding plan, and be aware that you may have to wait up to a year for grant or loan money to roll in.*

For a description and overview of all the above financial resources, consult the following article:

**“Finding Funds for Rural Health”,**

**Thomas D. Rowly Rural Health News, Vol 8,**

**Num 1, Spring 2001.**

[http://www.raconline.org/newsletter/web/spring01\\_vol8-1.html](http://www.raconline.org/newsletter/web/spring01_vol8-1.html)

Community Development Financial Institutions (CDFIs) also loan money to rural healthcare organizations looking to renovate or expand their facilities. CDFIs loan to and invest in organizations that are located in disadvantaged communities and are unable to find funding from traditional sources.

**To locate a CDFI in your area, visit** <http://www.cdfifund.gov>

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## → STEP 3

### **BUILD THE NECESSARY INFRASTRUCTURE TO SUPPORT A CAPITAL CAMPAIGN**

#### ROLE OF GOVERNANCE IN A CAPITAL CAMPAIGN

In order for a campaign to be successful, Board members should contribute not only their time, but also lead gifts to the campaign.

#### ROLE OF STAFF IN A CAPITAL CAMPAIGN

Staff members should fill the most important roles of the campaign because they have a vested interest in the organization and the project.

#### ROLE OF VOLUNTEERS IN A CAPITAL CAMPAIGN

Volunteers who give their time are just as important as those who give their money.

#### RESOURCES

- Board Member job description
- Website references



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## STEP 3: BUILD THE NECESSARY INFRASTRUCTURE TO SUPPORT A CAPITAL CAMPAIGN

When you have determined that a capital campaign is feasible in your community, you must make sure your Board and staff are equipped to undertake such an endeavor. Leadership and staffing are critical to the success of your campaign.

*Your Board and staff members must be fully committed to both the idea of a capital campaign, as well as the project you wish to fund with the money raised.*

Some questions to ask:

- Are your Board and staff influential, trusted, and well-known in the community?
- Is your Board of Directors willing to support your campaign financially in addition to acting as the face of the campaign?
- Do your Board members have diverse backgrounds?
- Are your staff members willing to work their own jobs in addition to taking on campaign team roles?
- Can you develop a compelling case for support for your proposed project?
- Do you have a strong group of volunteers(7)?

### UNIQUE ROLE OF GOVERNANCE IN A CAPITAL CAMPAIGN

Board members must be aware that they will not only be asked to perform their day-to-day duties as Board members, but may also need to serve as members of the campaign -- this may be an especially difficult task for organizations with Boards that are small or inexperienced.

*In order for your campaign to be successful your Board members should contribute not only their time, but also lead gifts to the campaign.*

The Board of Directors is meant to be the backbone and public face of the organization's capital campaign. Members of the Board must be unanimously committed to fulfilling the following duties:

1. Review the need for the campaign
2. Help develop the structure and timeline of the campaign
3. Be the first to give major gifts
4. Serve as the public face of the campaign
5. Assess the performance of the organization
6. Encourage staff and volunteers
7. Identify, cultivate, and solicit major gifts
8. Review all printed material
9. Review investment plans for funds
10. Be a positive example of a campaign volunteer (6)

### **What are the most desirable Board qualities during a capital campaign?**

The Board should be made up of influential community members who care about the project and organization and are willing to make a contribution. Board members should be well known in the community, and be able to articulate the importance of your project to community residents. It is helpful if Board members have experience in the fields of fundraising and project management. Ideally, Board members will also have connections to community members who are able to give major gifts.

Every Board member should be able to describe the organization and the capital campaign project in roughly two minutes. This should not just be basic details, but should include how the person you are talking to can get involved.

### **MENDOCINO COAST CLINICS: BOARD MEMBER JOB DESCRIPTION**

1. Find out everything you can about what the Clinic does: services available, people who perform the services, clients who come here, what we charge, how we're reimbursed, parts of the population whom you think may be underserved, needs the Clinic should try to meet, etc.
2. Commit to attending Board Meetings prepared, having read the minutes, being aware of all issues on the agenda.
3. Understand the financial workings of the Clinic so you can make wise and informed decisions about fiscal policy.
4. Help establish policies for the management of the Clinic: Personnel, Purchasing, Maintenance, Security, etc. Most policies will be drafted by the Executive Director or Staff for approval by the Board, but you should inform yourself about each item before endorsing it, because the Board is ultimately responsible for the operation of the Clinic.
5. Share the main business of the Board: Future planning. Day to day management, under the policies set by the Board, is the job of the Executive Director and Staff-and should be free of interference by Board Members. All orders (suggestions) to Staff must channel through the Executive Director, who alone is accountable to the Board.
6. Work with other Board Members as peers, dividing the tasks through committees, listening, sharing, and voting conscientiously on all issues in an atmosphere of mutual respect, candor and profound commitment.

## **POTENTIAL OBSTACLES/PROBLEMS:**

### **A Board member quits before the campaign has started.**

If a Board member quits right before the campaign is about to begin, it is vital that he/she be replaced as soon as possible. He/she should be replaced with someone who stands behind the vision of the campaign, is willing to give time and money, and is an influential member of the community.

### **Your Board is underdeveloped, small, or lacks prominent community members.**

If your Board is new, underdeveloped, small, or lacks influence in the community, it will be difficult for your organization to solicit campaign donations. Numerous workshops on Board development are available through the Non-Profit Resource Center in Sacramento, CA ([www.nonprofitresourcectr.org](http://www.nonprofitresourcectr.org)).

You may also try to add Board members who are prominent in the community and who believe in the project – try looking at past staff members, CEOs, or community members who work in a similar field. An influential community member may be willing to take an honorary position on the Board, and this may increase the prestige and status of the Board overall. They may serve as a campaign advocate and figurehead for the organization during the capital campaign.

### **Board members are not willing to donate to the campaign.**

It is imperative that Board members be the first to make a donation to the campaign. They do not necessarily have to give a major-gift, but they should give what they can – be it \$50 or \$50,000. Like any other potential donors, Board members should have options for giving, such as multi-year pledges and matching gifts. If one Board member steps up and gives a large donation, it is likely that others will follow. Don't hesitate to ask the Board for donations.

## **→ ROLE OF STAFF IN A CAPITAL CAMPAIGN**

### **What is the role of the Chief Executive Officer (CEO)/Executive Director (ED)?**

The CEO/ED works as both a member of the organization staff, as well as a member of the campaign staff. He/she should be able to both take direction from the campaign leader, as well as oversee all elements of the organization and its capital campaign. The CEO/ED works with the Board and senior management to determine if a capital campaign is necessary and what project the money will fund. The CEO/ED helps to develop the goals of the campaign, as well as:

- Communicate the goals to community
- Recruit and train staff for the capital campaign
- Solicit gifts from peers (6)

### **What is the role of the staff?**

Like Board members, staff may find themselves torn between day-to-day responsibilities and new campaign roles. This is especially true if your organization is unable to hire any new staff for the duration of the campaign. Staff members should be among the first to volunteer for jobs, as well as the first to give to the campaign.

Staff can serve as heads of committees, committee members, or volunteer for smaller jobs outside of the campaign team. They may also be called upon to solicit donations from community members.

*Staff members should fill the most important roles of the campaign because they have a vested interest in the organization and the project. The campaign leader, chief development officer, and heads of committees should be staff members who stand behind the mission of the organization and vision of the campaign.*

### **What is the job of the Campaign Leader/Campaign Chair?**

The Campaign Leader serves as the head of all aspects of the capital campaign. He/she should be fully committed to donating a large amount of time to the campaign and project, and should also be able to give a major gift. The Campaign Leader will oversee all elements of the campaign and, along with the Board of directors, approve all activities.

*It is important to note that the Campaign Leader position is a full-time job.*

**“When the Board and staff donate to your campaign, it makes a powerful argument for others to support your mission,”**

says Dean Germano of Shasta Community Health Center; the clinic raised \$250,000 from its staff alone.

Your organization may choose to reassign a staff member to the Campaign Leader position, or hire someone from outside the organization.

The Campaign Leader is the go-to person for all questions regarding the campaign. Duties include:

- Serving as the campaign's CEO
- Helping to hire committee heads
- Cultivating and soliciting donor prospects
- Serving as chair of the campaign steering committee and presiding over meetings
- Acting as campaign spokesperson for all news stories, campaign publications, special events, and other functions (6)

#### **What is the job of the Chief Development Officer?**

The Chief Development Officer (CDO) works in the background to be a primary support for the structure and direction of the campaign. The CDO will have his/her finger on the pulse of every element of the project and should be able to cultivate and solicit donor prospects, recruit volunteers, provide direction and support, and motivate the staff and Board. He/she should be able to work well with others, and both give and take direction (6).

#### **What kinds of committees are essential to the campaign and what are their functions?**

Delegation of tasks will ensure that no individual will become overburdened. Committees should be developed to the extent your human resources will allow. Some examples of committees that may prove useful include:

- Steering Committee: made up of staff and community volunteers, and acts as liaison between the organization and the community
- Financial Committee: In charge of developing the budget and allocating funds
- Capital Campaign Committee: helps Campaign Leader with delegation and campaign oversight
- Public Relations Committee: creates the "vision" and image of the campaign
- Special events committee: organizes special events to raise funds for the campaign
- Major gifts committee: in charge of soliciting major gifts
- Fundraising committee: in charge of soliciting non major gifts (7)

## **POTENTIAL OBSTACLES/BARRIERS:**

### **Too few staff with too little time to devote to campaign duties.**

Consider recruiting new staff that can devote their full attention to the capital campaign process, such as a Chief Development Officer.

### **Your organization cannot afford to hire outside staff.**

Where possible, relieve staff members from some of their regular responsibilities so that they may be part of your campaign team for the duration of your capital campaign. Rally the support of your staff by emphasizing their role in the success of your campaign and your proposed capital project. Volunteers can also be a vital resource for committee and campaign leadership.

### **A central campaign staff member quits during the campaign (CEO, CDO, campaign leader)**

Make sure that your supporting staff members are well-versed and updated in matters of your capital campaign so that they can take on the roles of any campaign staff that leave. If your CEO/ED or CDO leaves during the campaign, you will likely need to put your campaign on hold until a new CEO or CDO is in place.

## **→ ROLE OF VOLUNTEERS IN A CAPITAL CAMPAIGN**

Campaign volunteers can be especially helpful to an organization that lacks the ability to reassign staff to campaign jobs. Volunteers can serve as heads of committees, or take on short-term tasks such as making phone calls and mailing letters. Like the Board and staff, volunteers must believe in the mission of the organization and the vision of the campaign. The CDO or consultant can train volunteers to cultivate and solicit donors.

*Volunteers who give their time are just as important as those who give their money to your cause.*

### **Where do I find volunteers? How do I recruit them?**

Volunteers can come from your staff and community. Your Board of Directors and Campaign Leader should have the ability to recruit volunteers through their own commitment to the campaign and project, and through their connections within the community. Many organizations draw their volunteers directly from staff. These volunteers serve in both their occupational role and volunteer position throughout the duration of the campaign.

Volunteer recruitment hinges on the ability of the Board and staff to explain and market the vision of your capital campaign. Before recruitment begins, it is helpful to put together a volunteer packet with:

- Your case for support
- A campaign timeline
- A campaign organizational chart
- Campaign job descriptions
- Any other information that will inform and excite volunteers (7)

Volunteers can hold positions of varying levels of importance. Allow volunteers to use their expertise, and to take on roles that interest them.

Don't forget about the possibility of hiring interns! Many schools will give class credit for internships, saving you money and helping to engage community youth.

### **POTENTIAL OBSTACLES/BARRIERS:**

#### **Your community is small and volunteers are hard to find.**

It is often the case in small communities that there are simply not enough people willing to volunteer for your cause, regardless of how valuable your organization might be. If this is the case, you may try lightening the volunteer load, and offering small positions to a number of people. Every volunteer and every job is important – even a few hours of stuffing envelopes can help. Ask the volunteers you do have to help recruit their friends, even for minor jobs.

## CASE STUDIES FROM A RURAL AGENCY:

### **GOLDEN VALLEY HEALTH CENTERS**

Newman, CA is a small community of just over 7,000 people. When Golden Valley Health Centers (GVHC), a health clinic in Newman, committed to beginning a capital campaign, they had to strategize where the funds would come from in light of the fact that 42% of Newman residents are living at or below 200% of the Federal Poverty Level. GVHC began by soliciting a leadership gift of \$175,000 from the TIDES Foundation (a CA foundation that funds health care projects), and received over \$104,000 in pledges from GVHC staff members. GVHC also formed new relationships with community members, such as business owners and farmers to secure more pledges. Remember “health is a high priority for most people.” – Michael Sullivan, CEO of Golden Valley Health Centers.

### **MENDOCINO COAST CLINICS**

When Mendocino Coast Clinics (MCC) decided to embark on a capital campaign, they had to create a strategy for competing with other, often lower-budget community organizations for funds. MCC was able to gain support from the TIDES Foundation (a CA foundation that supports health care projects) in the form of a challenge grant where the TIDES Foundation agreed to match community donations up to \$65,000. Knowing that their donations would be doubled, community members were more eager to support MCC’s capital campaign. However, Paula Cohen, Executive Director of Mendocino Coast Clinics warns others regarding the difficulties encountered in meeting conditions imposed by a grant or loan: “When applying for grants and loans, there are always “six more string attached” to the process than you expect.

## → RESOURCES

WORLD WIDE WEB:

**“The Importance of Volunteers in a Capital Campaign,” Linda Lysakowski.**

<http://www.cvfundraising.com/articles/IJNVSM-Article.pdf>

Post your volunteer opportunities here: [www.volunteermatch.org](http://www.volunteermatch.org)

**“Getting to Yes: Strategies for Volunteer Recruitment,” Susan J. Ellis**

[http://www.girlscouts.org/for\\_adults/leader\\_magazine/2003\\_fall/getting\\_to\\_yes.asp](http://www.girlscouts.org/for_adults/leader_magazine/2003_fall/getting_to_yes.asp)



## → STEP 4

### **DEVELOP A CAPITAL CAMPAIGN PLAN**

#### CAMPAIGN PLAN BASICS

A campaign plan should answer any questions a potential donor may have regarding your capital campaign or your organization. It includes a case statement, a budget, a calendar and gift chart.

#### RESOURCES

- Sample case statements (Appendix B and C)
- Project and campaign fact sheet (Appendix D)
- Capital campaign expenses template (Appendix E)
- Sample resources and uses of funds (Appendix F)
- Sample integrated capital project calendar (Appendix G)
- Website references



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## STEP 4: DEVELOP A CAPITAL CAMPAIGN PLAN

*“Fundraising is three parts planning to one part doing”*

— National Philanthropic Trust, “10 Most Important Things to Know About Fundraising”(10)

It is critical to have a specific plan for identifying, cultivating, and soliciting donors. In order to achieve success, the right fundraiser must ask the right potential donor for the right amount at the right time.

### → **Your campaign plan will consist of the following:**

- Case statement
- Budget
- Campaign calendar
- Gift chart

The plan is also a marketing device that will answer any questions a potential donor may have regarding your capital campaign or your organization. Development staff and/or a consultant may put the campaign plan together. Oftentimes, a consultant will write the case statement for your campaign after performing the feasibility study for the campaign.

### **What is a case statement and what does it include?**

A case statement describes your proposed project, why it is needed, and who it will impact. The case statement is made up of numerous parts, including:

- Mission
- Vision
- History of the organization
- Programs and services offered by the organization
- Explanation of why you have chosen to implement a capital campaign
- Statement of need
- Goals of the campaign
- Strategies to meet these goals
- Board and staff involved in project
- Endowment
- Budget for your campaign
- Gift range chart
- Named-giving opportunities
- Opportunities for donors to participate (8)

**“If you can’t convey a sense of urgency and importance, you shouldn’t have a capital campaign.”**

—Linda Philips, St. Joseph’s Foundation



*Sample case statements from a rural community health center and a hospital are provided in appendix B and C of this guide.*



*See Appendix D - G for the following financial planning tools and templates:*

- Project & campaign fact sheet (item D)*
- Estimated capital campaign expenses template (item E)*
- Sample phase resources and uses of funds (item F)*
- Sample integrated capital project calendar (item G)*

## → RESOURCES

WORLD WIDE WEB:

### **Sample Capital Project Calendar**

[http://www.communityclinics.org/files/713\\_file\\_Sample\\_Capital\\_Project\\_Calendar.xls](http://www.communityclinics.org/files/713_file_Sample_Capital_Project_Calendar.xls)

### **Sample Integrated Capital Campaign Calendar**


[http://www.communityclinics.org/files/917\\_file\\_CCI\\_Integrated\\_Capital\\_Project\\_Calendar.xls](http://www.communityclinics.org/files/917_file_CCI_Integrated_Capital_Project_Calendar.xls)

### **Sample Capital Campaign plan outline**

<http://www.raise-funds.com/exhibits/exhibit53.pdf>

### **Sample fundraising plan outline**

<http://www.raise-funds.com/exhibits/exhibit04.pdf>



# II. IMPLEMENTING YOUR CAPITAL CAMPAIGN

## → STEP 5

### IDENTIFY DONOR PROSPECTS AND SOLICIT MAJOR GIFTS

#### WHAT IS A MAJOR GIFT?

Major gifts, also known as a “leadership” gifts are the larger gifts the organization receives. They represent 60% or more of the campaign goal.

#### WHO GIVES MAJOR GIFTS?

Board members should be encouraged to give major gifts and can help encourage major gifts from influential community leaders, foundations, and corporations, as well as co-workers and friends.

#### HOW TO IDENTIFY AND CULTIVATE PROSPECTIVE MAJOR GIFT DONORS

Cultivation may take months, so it is important to be patient with potential donors. Solicitation can only come after extensive donor research and cultivation.

#### RESOURCES

- Solicitation tips from Capital Quest, Inc.
- Communication materials and fundraising policy checklist (Appendix H)
- Donor expectations and prospects worksheet (Appendix I)
- Sample capital campaign gift charts (Appendix J and K)
- Website references



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## STEP 5: IDENTIFY DONOR PROSPECTS AND SOLICIT MAJOR GIFTS

The keys to successful gift solicitation are linkage, interest, and ability:

*The most likely donors are those who are somehow linked to your organization, are interested in your cause, and have an ability to give.*

### → What is considered a “major gift”?

The largest major gift, also known as a “leadership gift” is the largest gift an organization receives. Typically, a single major gift makes up roughly ten to fifteen percent of the total campaign goal. A major gift can sometimes also represent up to 80 percent of the campaign goal (9).

### → Who gives major gifts?

Board members should be encouraged to give major gifts (if financially feasible). Board members are often the first to not only give major gifts, but to help get major gifts. Board members may be able to leverage ties to co-workers, friends, and corporations for donations. Major gifts may also come from influential community leaders, foundations, or corporations.

**"I understand how busy you are, but this is very important to me. I guarantee you that after 30 minutes, you will learn some very interesting things about our community. I feel so strongly about it myself, that I am personally visiting with key community leaders. If I promise it will not take more than 30 minutes, would you agree to an appointment?"**

Sample Verbiage for Setting Up a Meeting with a Potential Major Donor, —From Solicitation Guide, Capital Quest, Inc.

### → How do I identify and cultivate prospective major gift donors?

During the “quiet phase” of your campaign, before it has been announced to the public, you will focus on soliciting major gifts from community members identified in your feasibility study as likely donors. Foundations and corporations both in and out of the community may also be sources of major gifts. Ideally, all of these major gifts will make up roughly 50 to 60% of your campaign fund goal.

*Cultivation may take months, so it is important to be patient with potential donors. Solicitation can only come after extensive donor research and cultivation.*

During the cultivation period of your campaign, donors are not asked to donate, but are given information about the campaign and an opportunity to meet with your organization's staff, Board and beneficiaries.

Through training, volunteers will learn how to cultivate established donor prospects. Donor prospects at this time (during the "quiet phase" before the campaign is unveiled to the public) should be potential major gift contributors. Start by contacting donors who have made substantial contributions to your organization in the past. Also seek out influential community leaders who may wish to have their name attached to the campaign through a large donation. Major gifts will persuade others to contribute to your campaign when it goes public.

## **POTENTIAL OBSTACLES/PROBLEMS**

**Your organization is in a small, low-income community that lacks potential major gift donors.**

If there are few individuals in your community able to give major gifts, try asking local or state-wide foundations and corporations for donations. The majority of donations made during your capital campaign will come from individuals, but major gifts from foundations and corporations will help you get started. Also look outside of your community for potential major gift donors who may have an interest in the organization. Make sure to offer payment plans for individuals wishing to give major gifts.



*To assist you with Step 5, see appendix H - K for the following fundraising tools:*

- Communication materials and fundraising policy checklist (Appendix H)*
- Donor expectations and prospects worksheet (Appendix I)*
- Sample capital campaign gift charts (Appendix J– I)]*

## SUCCESSFUL SOLICITATION TIPS

From Capital Quest, Inc. <http://capitalcampaigns.com/c3.htm>

**LEADERSHIP GIFTS FIRST:** Solicit and receive gifts that are either larger, or come from prominent people first. People follow leaders - secure the leaders' support and the other donors will follow.

**RECRUIT GREAT LEADERS:** People give to people, not necessarily to causes. If you get the right people involved (peers of potential major donors), major gifts will naturally follow.

**PEER SOLICITATIONS ONLY:** People respond best when asked by a peer to help a project. You don't want to intimidate the prospect by having him/her solicited by someone "superior" to them. Nor should someone who is "junior" in status or social standing solicit a "superior" prospect. Who asks is extremely important.

**SOLICIT ONLY IN PAIRS:** Face-to-face fund raising can be daunting and is accomplished more comfortably in pairs. By having two people on the solicitation visit, one is evaluating the reaction of the prospect while the other one is talking. If one solicitor forgets an important part of the process, the second one can jump in. The process works better in pairs.

**ONLY PERSONAL VISITS, NEVER SOLICIT OVER THE PHONE:** If it is important enough to ask, it is important enough to visit in person. If you are too busy to visit in person and explain the case fully, chances are the prospect won't take it seriously either. Solicitations over the phone cheapen the process.

**APPOINTMENT IN A QUIET PLACE:** Visit with the prospect in their home or their office (if it is a business gift). Avoid restaurants because there are too many distractions and no one is more likely to give because they feel guilty you bought them a \$15 lunch. Of course, the best place for a solicitation is your organization's central office - and include a tour. A tour is a powerful weapon when used correctly.

**ASK FOR A SPECIFIC GIFT:** Nothing is worse than asking for support, but not being specific. Let the prospect know what you would like them to consider, why you are asking for that amount, and how that gift would fit into the overall campaign. Spend as much time talking about the ask as explaining the case.

**OFFER COMMEMORATIVE OPPORTUNITIES:** Even when donors say that recognition doesn't matter, most people like to be recognized for helping a great cause. As a general rule, most people will not give you a gift just because they get something named for them. But if they believe in your case, they may give.

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## → RESOURCES

MORE DONOR AND SOLICITATION TIPS:

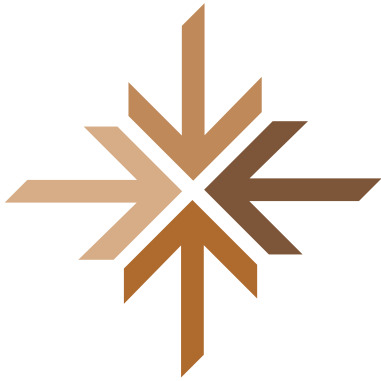
WORLD WIDE WEB:

**Solicitation Guide From Capital Quest, Inc.**

<http://capitalcampaigns.com/c5.htm>

**Soliciting Major Gifts From Capital Quest, Inc.**

<http://capitalcampaigns.com/pdf/Soliciting%20Major%20Gifts.pdf>



## → STEP 6

### **MAKE THE CAMPAIGN PUBLIC**

#### ANNOUNCING THE CAMPAIGN TO THE PUBLIC

The kickoff event for the public should not happen until at least 60% of the campaign goal has been reached.

#### MARKETING AND PR TOOLS TO UTILIZE

Develop marketing tools that present your campaign story in a way that will interest the media.

#### RESOURCES

- Sample Press Release (Appendix L)
- Website references



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## STEP 6: MAKE THE CAMPAIGN PUBLIC

After you have acquired major gifts, the next step is to make your campaign public. This may involve anything from a large kickoff event to general mailings. Showing the community that your entire organization is committed to the campaign is crucial.

### → How do we announce the campaign to the public?

Once major gifts are secured, you will announce your campaign to your whole community. Often times, a kickoff event is preceded by a number of more casual cultivation events that relay the importance of the campaign to the public. Cultivation events can range from information sessions to cocktail parties. These usually focus on one-on-one time between potential donors and volunteers.

Kickoff events are the primary mode through which organizations announce their campaign and engage their community. Such events are used to present the importance of the campaign and capital project to potential supporters. Kickoffs are also used to recognize supporters who have already donated to the campaign.

Invitations to your event should be unique and memorable. Don't do the same major events every year—keep your community on their toes—if your excitement about your event is apparent in your advertising, the community will be excited, too. Finally, remember that you aren't just trying to raise money—you are trying to save lives. Your capital campaign is only part of a greater cause.

*One of the most important things to remember is that the kickoff event should not happen until at least 60% of the campaign goal has been reached (primarily through major gifts). If the goal looks too distant, donors may be turned off to the idea of donating for fear of never reaching the goal.*

Make sure all events are positive and fun! Include donors who have already given to the campaign, and ask if a few of them might speak as to why they feel the project is important and how the organization helps the community (4).

### What sorts of marketing and PR should be utilized?

The marketing/PR committee of the campaign is in charge of developing:

- The campaign theme and logo;
- Printed materials (including letterhead, envelopes, letters of intent, fact sheets, etc);
- Videos and/or PowerPoint presentations;
- Press releases;
- Campaign speeches;
- Promotional items (4)

→ **How do we go about communicating with the media?**

The media is your friend! Be patient with and grateful for the media. Pitch your story in a way that will be useful to the media—research what kinds of stories get the most attention and make sure you are prepared with fact sheets, photographs and other appropriate material. Identify the best spokesperson to speak with members of the media –this should be someone who knows the ins and outs of the organization and project, and is an eloquent speaker. This could be an administrator, patient, board member, or volunteer.

**POTENTIAL OBSTACLES/PROBLEMS:**

**Organization is not well-known in community.**

If your organization's services are not utilized by many community members, or your organization is not known by the majority of your community, it is crucial that you publicize your name and mission before the start of a capital campaign. Public events, mailings, and word-of-mouth marketing can help increase awareness of your organization's services.

*Do not begin a capital campaign until you have been established as a reputable organization with valuable services to offer your constituents.*

→ **RESOURCES**

WORLD WIDE WEB:

**"Sharing Your National Service Story: A Guide to Working with the Media," Corporation for National and Community Service. July, 2005.**

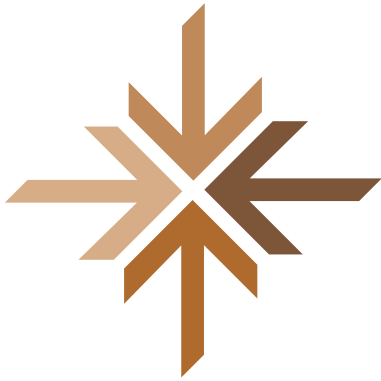
[http://nationalserviceresources.org/filemanager/download/marketing/CNCS\\_Media\\_Guide.pdf](http://nationalserviceresources.org/filemanager/download/marketing/CNCS_Media_Guide.pdf)

**"The 3 Most Effective Tools for Community Engagement"**

Hildy Gottlieb [http://www.help4nonprofits.com/NP\\_Mktg\\_3EffectiveTools\\_Article.htm](http://www.help4nonprofits.com/NP_Mktg_3EffectiveTools_Article.htm)

**Principles of Community Engagement**

<http://www.cdc.gov/phppo/pce/index.htm>



→ **STEP 7**

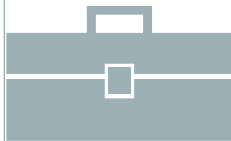
**SOLICIT NON-MAJOR  
GIFTS**

SOLICITATION METHODS

In-person solicitation is the best way to obtain donations.

DEVELOP A DONOR DATA BASE

A donor data base is an efficient way of organizing donors and funds.



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## STEP 7: SOLICIT NON-MAJOR GIFTS

Your Board of Directors, staff and volunteers can all help solicit campaign gifts. Good donor cultivation can turn possible prospects into probable prospects into willing donors.

*Ideally, anyone soliciting gifts should have already contributed funds to your campaign.*

**Don't underestimate the importance of non-major gifts.**

### → Solicitation Methods

In-person solicitation is the best way to obtain donations. By speaking to a potential donor in person, a solicitor can show their enthusiasm for your capital project and use campaign plan materials to help describe the importance of the campaign. If it is not possible to ask for a donation in person, you can solicit non-major gifts by phone. A letter should be sent before asking for a gift over the phone. The letter prepares the potential donor for a call, and informs them of your organization's mission and vision. The letter may also include a copy of the campaign plan so that potential donors have time to learn about the campaign and develop any questions they may have for the solicitor.

**"The most generous givers are usually the lower-income community members. They are closer to the frontlines, and understand the value of giving."**

—Linda Philips, St. Joseph's Foundation

Before making "the ask," consider the ability and interest of the prospective donor. Does the potential donor have a vested interest in the organization? Has he/she given previously? Does he/she have an ability to give? A donor should be asked to give a specific amount, and offered different payment options such as a multi-year pledge or matching gift.

### → How should we organize our donations?

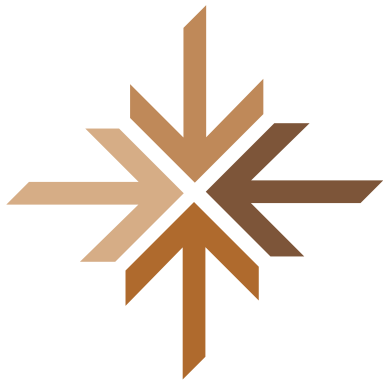
An easy way to organize both your donors and donations is by utilizing a donor database system. Costs for these systems vary, so it is important to do thorough research before committing to a database. A donor database is an efficient way of organizing both your donors and your funds. With many databases, you can also track your contact with donors as well as send HTML e-mails. A list of examples of donor databases is included in Appendix M.

There are multiple systems that may work for your clinic. Consider how many clients you serve, how much money you plan on receiving in donations, and how much you are willing to spend before purchasing a donor database.

### **POTENTIAL OBSTACLES/PROBLEMS:**

#### **Small or low-income community.**

According to the National Philanthropic Trust, 19% of families living on welfare gift an average of \$72 a year to charities. Just because there may not be any wealthy philanthropists in your community does not mean you cannot raise money. Make sure your volunteers and staff members who are soliciting donations are well-trained and are not afraid to make “the ask”, even when it looks like someone will not give. If your community is well-informed of the importance of the campaign and the dedication of your organization’s Board and staff, they will consider giving (4). Thomas J. Stanley and William Danko’s *The Millionaire Next Door* provides a look into what type of person donates, why, and to what causes.



→ **STEP 8**

**RECOGNIZE AND  
THANK DONORS  
AND VOLUNTEERS**

HOW TO THANK AND RECOGNIZE DONORS

A recognition program and/or plans for a recognitions event should be in place before your campaign starts. Keeping donors involved means they will be more likely to donate again in the future.



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## STEP 8: RECOGNIZE AND THANK DONORS AND VOLUNTEERS

Donors who feel like their money was used wisely, went to a good cause, and was valued will be more likely to donate again in the future. Others will also be encouraged to give when they see how appreciative your organization is of its donors.

### → How do we thank and recognize donors?

A recognition program and/or plans for a recognitions event should be in place before your campaign starts. Keeping donors involved means they will be more likely to donate again in the future.

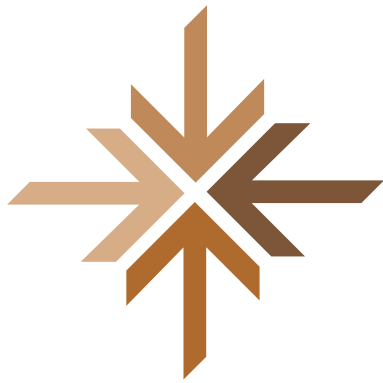
Make sure thank-you letters are sent no later than 24 hours after a donation is given. Every donor, regardless of the size of their donation, should be thanked and recognized in some way. However, the larger donations should receive larger forms of recognition. Such recognition may come in the form of a “Wall of Donors” featuring donor’s names on plaques, or a walkway with donors’ names on bricks.

Depending on the size of your organization, naming opportunities can be a good way to solicit donations as well as recognize substantial gifts. For example, by giving a specified minimum amount, a donor can have the chance to name a piece of the new building – like a room or wing. Of course, this name must reflect the values of your organization and keep with any traditions(9).



*The “Donor Bill of Rights” can educate solicitors on how to maintain a positive image with potential donors. Donor Bill of Rights is from the Association of Fundraising Professionals.  
[http://www.afpnet.org/content\\_documents/Donor\\_Bill\\_of\\_Rights\\_-\\_English.pdf](http://www.afpnet.org/content_documents/Donor_Bill_of_Rights_-_English.pdf)*

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## → STEP 9

### **CLOSE THE CAMPAIGN**

#### WHAT TO DO IF THE CAMPAIGN DOES NOT REACH FUNDRAISING GOAL

If the campaign goal is not met within the proposed timeline, the original plan may need to be modified. If a modified plan is not a possibility, there are options regarding the gifts already collected.

#### OTHER WAYS TO FUND MAJOR PROJECTS

The rolling capital campaign, grants and bank loans are possibilities.

#### HOW TO END YOUR CAMPAIGN

A campaign should be ended when the goals has been reached or when the campaign was scheduled to close.

#### RESOURCES

- Case study from a rural agency
- Website references



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## STEP 9: CLOSE THE CAMPAIGN

Educating the community on your project's progress, as well as maintaining connections with donors and volunteers after the campaign is completed, will build essential community ties and strengthen the image of your organization. Give donors and volunteers opportunities to get involved in your activities after the campaign is over, and keep them abreast of the progress of your capital project. An event like a groundbreaking ceremony or a grand opening helps to open the doors of your organization to community members.

*If you do not reach your campaign goal by the decided end-date, stay positive and, with the aid of the Board and staff, make a decisive choice on what to do next. Keep donors, volunteers, and the community informed and involved, and review other possible options for funding your project.*

### ➔ **What if the campaign does not reach its fundraising goal?**

If, for some reason, your organization is not able to meet its goal within the preset timeframe, consider the following options:

- Continue with the original plan, but cut costs where applicable.
- Borrow money to finish the project.
- Break the project into phases and extend the timeframe.
- Extend the length of the campaign and secure new volunteer leadership.

If, after altering your plans, your organization is still not able to come up with the funds to complete the project, you can:

- Ask donors if their gifts may be used for another, similar, project – such as building a new wing instead of an entire new building.
- Return all donations.
- Hold on to the gifts, and begin a new campaign within the next few years. Make sure donors know about the change, and ask if they wish to have their donation returned (9).

→ **What are some other ways to fund major projects?**

If the campaign is not successful and not enough money is raised, other options include:

**The Rolling Capital Campaign:** Typically used if there is more than one building project that needs to be funded. A rolling campaign is focused on major gifts. Construction takes place as funds are raised for each new building or structural addition. As each segment of the campaign is completed, schedule dedication ceremonies and recognition events to keep morale high.

**Major Gifts Campaign:** Like a Rolling Capital Campaign, a major gifts campaign is focused only on major gifts but with only one building being built. Funds come from the quiet phase of the campaign, with each gift representing roughly 5 to 10 percent of the campaign goal. This type of campaign is good if there are a large number of major gift prospects.

**Equipment Campaign:** Used if only equipment is needed and there is no building construction. The effort to raise money for equipment could be integrated into your organization's on-going fundraising efforts. There may be a few donations made, or a limited number of corporations may be asked to underwrite the project.

**Bank Loans**

→ **How can we utilize a private foundation?**

A private foundation is considered by the IRS to be a non-profit organization, and comes in three different forms: operating private foundation, non-operating private foundation, and public foundation. It is tax-exempt under section 501(c)(3), but you must first file for tax exemption with Form 1023. All private foundations must file annual informational tax returns using Form 990-PF.

A private foundation, like the Henry J. Kaiser Family Foundation, can give out grants, as well as help fund their own projects. A private foundation can also receive gifts bequeathed upon death that can serve a hospital or clinic for years and years. There are numerous tax incentives for a private foundation, too. Individuals can deduct cash contributions of up to 30% of the donor's income; lifetime gifts can be deducted at cost; and public stock can be deducted at fair market value.

Starting a Foundation Board may be a good idea if your general Board of Directors does not have the time, capacity, or influence to fundraise for you. You may also wish to limit your Foundation Board's lifespan to the duration of the capital campaign.

## CASE STUDY FROM A RURAL AGENCY:

### GLENN MEDICAL CENTER

Glenn Medical Center in Willows, CA has a three-person governance Board and a fifteen member Foundation Board. The governance board oversees the general operation of the medical center, while the Foundation Board is used primarily to raise money.

**Glenn Medical Center's Foundation Board members are volunteers from all over the community. They have local connections, and are able to connect with influential and diverse community members such as bankers, and ranchers.**

#### How do we end our campaign?

There are two times when you can choose to end your campaign:

1. When your goal has been reached; or
2. When the campaign was scheduled to close, regardless of whether or not your goal has been reached.

If you choose **option 1**, you can end your campaign with a groundbreaking ceremony and recognition of donors and volunteers. Make sure to keep all donors, volunteers, and community members aware of your capital project activities. Maintain good community relations by creating opportunities to give again in the future.

If you choose **option 2**, have a celebration and continue raising money, either with an extended capital campaign, or one of the aforementioned options (9).

**"A capital campaign is not an easy task, but with a positive attitude and a good sense of humor, you can make the most of difficult situations. Have thick skin, and lots of patience!"**

— Michael Sullivan, Golden Valley Health Centers

### **Celebrate Victories!**

You will be turned down sometimes when you ask for donations, and you may not raise as much money as you hope, but remember to celebrate the good things that happen during your capital campaign – be it receiving your first major gift, holding a successful kickoff event, or broadening your horizons and reaching out to a larger pool of community members. A capital campaign is a time to raise money, but also a time to open your doors to your community. Even if you don't reach your fundraising goal, a capital campaign will help you publicize your organization's name and solidify the importance of the services you provide.

## **→ RESOURCES**

WORLD WIDE WEB:

#### **Info on Private Foundations from the IRS:**

<http://www.irs.gov/charities/charitable/article/0,,id=96114,00.html>

#### **Info on private foundations from Washington Grantmakers:**

[http://www.washingtongrantmakers.org/WG/Give/Start/Start\\_Index.asp](http://www.washingtongrantmakers.org/WG/Give/Start/Start_Index.asp)



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## CCI Building Capacities Self-Assessment Tool\* Instructions

There are ten survey worksheets (numbered 1 through 10) included in this survey tool. Click on the various tabs at the bottom of the screen to move through the various worksheets. The survey requests two types of answers: fill in the blank, and multiple-choice. To input your responses, click on the cell to the right of each question. (Answer cells are highlighted in yellow.) If the question is multiple-choice, you will see the following message when you click on the cell: "Click arrow to make selection." When you click on the arrow, you will be presented with your answer options.

- Worksheet 1: Contact information and financial data (for Executive Director only)
- Worksheet 2: Fundraising strategies (for Executive Director only)
- Worksheet 3: Access (for Executive Director only)
- Worksheet 4: Mission, vision, and planning
- Worksheet 5: Community engagement and collaboration
- Worksheet 6: Leadership ~ management team
- Worksheet 7: Leadership ~ board of directors
- Worksheet 8: Financial systems and position
- Worksheet 9: Fund development
- Worksheet 10: Data-informed decision making

In worksheets 4 through 10 you will see a number of assessment categories. For each assessment category, identify the description that best describes your organization's status or performance. **Please provide a rating for all of the assessment categories**; failure to do so will impact your summary scores. If an assessment category does not apply to your organization, select "N/A". Summary scores will calculate automatically. (Note: A "0" score on the summary page indicates that you missed a question.)

The first time you save the workbook file, you will be prompted to provide a name for the file. Use the name of your clinic for the name of the file.

To print the worksheets, right-click on any one of the worksheet tabs at the bottom of the screen, and click the "Select All Sheets" option. Then go to "File" and select "Print". **Be sure to ungroup the worksheets after you print**; to do this, right-click on any one of the worksheet tabs, and click the "Ungroup Sheets" option.

*Please proceed to Worksheet 1 to begin.*

*\*The Self-Assessment Tool is a derivative product of the Capacity Assessment Tool created by McKinsey & Company for Venture Philanthropy Partners ([www.vppartners.org](http://www.vppartners.org)), and published in Effective Capacity Building in Nonprofit Organizations (2001). Six questions (numbers 4.1, 4.2, 4.3, 4.4, 4.6, and 5.2) have been reprinted directly from the McKinsey tool, with the permission of Venture Philanthropy Partners.*

This is an interactive tool that may be filled electronically at  
[http://www.communityclinics.org/files/531\\_BC\\_SelfAssessmentTool.xls](http://www.communityclinics.org/files/531_BC_SelfAssessmentTool.xls)

- CONTACT INFORMATION & FINANCIAL DATA -

Survey Respondent Contact Information	
First name of person completing survey	
Last name of person completing survey	
Title of person completing survey	
Phone number (enter numbers only, without spaces)	
Email address	
Clinic Name	
City	
Executive Director Name (if not the person completing survey)	

Others Involved with the Assessment Process	
Name	
Title	
Name	
Title	
Name	
Title	
Name	
Title	
Name	
Title	

Revenues & Expenses	
When did you complete your most recent fiscal year (mm/dd/yy)?	
Do you own or lease your buildings?	
<i>Please tell us about your revenues and expenses for your most recently completed fiscal year:</i>	
Net patient service revenue (patient fees, Medi-Cal, Medicare, Healthy Families, etc.)	
Contributions / fundraising revenue	
Foundation income / grants (including CCI)	
Government contracts (not including patient service revenues such as Medicare, Medi-Cal, & Healthy Families)	
Other revenue	
TOTAL REVENUE (this number will be calculated automatically)	\$ -
TOTAL OPERATING EXPENSES	

*Please proceed to Worksheet 2.*

~ FUNDRAISING STRATEGIES ~

One of the key ingredients of a successful community organization is the capacity to implement a broad base of fundraising strategies, from grantwriting for foundation and government grants, to individual donor solicitations, to marketing and communication strategies. To help us better understand your current capacity to raise money from private sources, please respond to the questions below.

Number of full-time equivalent (FTE) staff at your clinic corporation dedicated to fund development—including grantwriting, donor relations, etc.:	
Is your organization currently working with a consultant (or consultants) to assist with fund development?	

Fundraising Strategies	Indicate the frequency with which your clinic corporation utilizes these strategies— never, occasionally, or at least annually (click on cell to change default answer):
Direct mail appeal to <i>current donors</i> —those who have contributed to your clinic during the last fiscal year—for <i>general operating support</i>	Never
Direct mail appeal to <i>prospective new donors</i> for <i>general operating support</i>	Never
Direct mail campaign for a <i>special program or initiative</i> (as opposed to general operating support)	Never
Fundraising event to raise money and/or to strengthen relationships with current and prospective donors	Never
Board and/or staff personal solicitations of existing individual donors	Never
Collecting online donations via a website	Never
Appeals to corporate foundations/donors for <i>general operating support</i>	Never
Solicitation of corporate sponsors for special events or for a special campaign or initiative	Never
Sales of products (such as t-shirts)	Never
Solicitation of donations through United Way campaign	Never
Concluding speaking engagements to community groups with a pitch for donations	Never
Solicitation of patients for donations	Never
Solicitation of board members for donations	Never
Other (specify in cell B21)	
Other (specify in cell B22)	
Other (specify in cell B23)	
Please indicate your top two fundraising strategies:	

Board Fundraising	
What proportion of your board made an individual contribution to the clinic during the last fiscal year?	
Does your board have a standing fundraising committee?	
What proportion of your board actively assists in soliciting individual donations?	

*Please proceed to Worksheet 3.*

~ ACCESS ~

One of the long range goals of the Community Clinics Initiative is to increase access to comprehensive, quality health care services. Listed below are many components of access that CCI will be tracking over the next five years. Please give us your best estimate for your clinic corporation during the last fiscal year.

Number of sites	
Combined number of exams rooms across all sites	
Number of new patients (those not seen in previous years)	
Number of established patients	
Unduplicated patient count (this number will be calculated automatically)	0
Total number of patient visits	
Total number of hours that your providers—MDs, NPs, PAs, Dentists, Dental Hygienists, Nutritionists, Pharmacists, etc.—delivered services to patients during the last fiscal year (not including administrative time)	
Total number of hours of operation for the year across all sites (please account for days the clinic was closed for holidays or other reasons)	

Services	Indicate the extent to which your clinic corporation provides these services—at all sites, at some sites, or at no sites:	If provided at some sites, specify the number of sites:
Primary care for children		
Primary care for adults		
Family planning services		
Prenatal care		
OB deliveries		
Specialty medical services		
Dental care for children		
Dental care for adults		
On-site pharmacy		
On-site radiology		
Optometry		
Mental health services for adults		
Mental health services for children		
Substance abuse services		
Health education		
Nutrition		
Chronic disease care management		
Other (specify in cell B31)		
Other (specify in cell B32)		
Other (specify in cell B33)		

Languages	Are you able to provides services in the following languages at least 80 percent of the time—without accessing outside translation services (click on cell to change default answer)?
Spanish	No
Mandarin	No
Cantonese	No
Cambodian	No
Tagalog	No
Vietnamese	No
Hmong	No

~ ACCESS ~

Other (specify in cell B43)		
Other (specify in cell B44)		
Other (specify in cell B45)		

<b>Other</b>	
Do you provide space for any other organizations or programs that provide services for your clients, such as Women, Infants, and Children (WIC); Medi-Cal; outside pharmacy, or community mental health services?	
...If so, which ones?	
<i>How often does each client eligible for WIC services receive each of the following:</i>	
...written information about the benefits of WIC?	
...referrals to WIC sites?	
...written information on the location and times of WIC services?	
...follow-up on WIC referrals?	
Do you offer onsite enrollment for Healthy Families?	
...If so, how many children did you enroll during your last fiscal year?	
Do you offer onsite enrollment for MediCal?	
...If so, how many clients did you enroll during your last fiscal year?	

*Please proceed to Worksheet 4.*

~ MISSION, VISION, & PLANNING ~

Assessment Categories (7 questions)	LEVEL ONE: Clear need for increased capacity	LEVEL TWO: Basic level of capacity in place	LEVEL THREE: Moderate level of capacity in place	LEVEL FOUR: High level of capacity in place	Input Selection in This Column
1. <i>Mission (clinic's reason for existence)</i>	Mission not re-visited recently and may not be as relevant today; Very few staff can articulate the mission and it is rarely referred to	Mission reflects clinic's values and purpose, but may lack clarity or currency; Few staff, primarily those with long tenure, are familiar with it; Lacks broad agreement and is rarely referred to	Mission is a clear expression of clinic's reason for existence that reflects its values and purpose; Held by many within clinic and often referred to	Mission is a clear expression of clinic's reason for existence that describes an enduring reality and reflects clinic's values and purpose; Broadly held within clinic and frequently referred to; Used to prioritize programs	
2. <i>Clarity of Vision (clinic's long-term goals for itself &amp; its community)</i>	Little shared understanding, even among top management, of what organization aspires to become or achieve beyond the stated mission	Somewhat clear understanding of what clinic aspires to become or achieve; Held only by top management or "on the wall," but rarely used to direct actions or set priorities	Clear and specific understanding of what clinic aspires to become or achieve; Held by top management and many others within the clinic and often used to direct actions and set priorities	Clear, specific, and compelling understanding of what clinic aspires to become or achieve; Held by most to all staff and consistently used to direct actions and set priorities	
3. <i>Strategic Plan</i>	Medium- to long-term strategic plan either non-existent, unclear, or incoherent (largely set of scattered initiatives); Strategy has no influence over management decisions.	Medium-to-long-term strategic plan exists but is either not clearly linked to mission, vision, and overarching goals, lacks coherence, or is not easily actionable; Strategy is not broadly known and has limited influence over management decisions	Coherent medium-to-long-term strategic plan has been developed and is linked to mission and vision and a clear timeframe but is not fully ready to be acted upon; Strategy is mostly known and management decisions partly guided by it	Clear, coherent medium-to-long-term strategic plan that is actionable and linked to overall mission, vision, and overarching goals in a clearly defined timeframe; Strategy is broadly known and consistently helps guide decisions at all levels of organization	
4. <i>Strategic Planning Skills</i>	Limited ability and tendency to develop strategic plan, either internally or via external assistance; if strategic plan exists, it is not used	Some ability and tendency to develop strategic plan either internally or via external assistance; Strategic plan roughly directs management decisions	Ability and tendency to develop and refine concrete, realistic strategic plan; Some internal expertise in strategic planning or access to relevant external assistance; Strategic planning carried out on a near-regular basis; Strategic plan used to guide management decisions	Ability to develop and refine concrete, realistic and detailed strategic plan; Critical mass of internal expertise in strategic planning, or efficient use of external, sustainable, highly qualified resources; Strategic planning exercise carried out regularly; Strategic plan used extensively to guide management decisions	
5. <i>Performance Targets</i>	Targets are non-existent or few; Existing targets are vague or either too easy or impossible to achieve; Not clearly linked to aspirations and strategic plan; Targets largely unknown or ignored by staff and board	Realistic targets exist in some key areas, and are mostly aligned with aspirations and strategic plan; May lack milestones, or mostly focused on "inputs" (things to do right), or often renegotiated; Staff and board may or may not know and adopt targets	Performance targets in most areas; Linked to aspirations and strategic plan; Mainly focused on "outputs/outcomes" (results of doing things right) with some "inputs"; Typically multiyear targets, though may lack milestones; Targets are known and adopted by most staff who usually use them to broadly guide work; Board evaluates performance based on targets	Limited set of quantified, demanding performance targets in all areas; Targets are tightly linked to aspirations and strategy, output/outcome-focused (e.g., results of doing things right, as opposed to inputs, things to do right), have annual milestones, and are long-term nature; Staff consistently adopts targets and works diligently to achieve them; Board evaluates performance based on targets	

~ MISSION, VISION, & PLANNING ~

<b>Assessment Categories (7 questions)</b>	<b>LEVEL ONE: Clear need for increased capacity</b>	<b>LEVEL TWO: Basic level of capacity in place</b>	<b>LEVEL THREE: Moderate level of capacity in place</b>	<b>LEVEL FOUR: High level of capacity in place</b>	<b>Input Selection in This Column</b>
<i>6. New Program Development</i>	No assessment of gaps in ability of current program to meet recipient needs; Limited ability to create new programs; New programs created largely in response to funding availability	Limited assessment of gaps in ability of existing program to meet recipient needs, with little or limited action taken; Some ability to modify existing programs and create new programs	Occasional assessment of gaps in ability of existing program to meet recipient needs, with some adjustments made; Demonstrated ability to modify and fine-tune existing programs and create new programs	Continual assessment of gaps in ability of existing programs to meet recipient needs and adjustments always made; Ability and tendency to create new, highly innovative and effective programs to meet the needs of potential service recipients in local area or other geographies; Continuous pipeline of new ideas	
<i>7. Operational Planning</i>	Organization runs operations purely on day-to-day basis with no short- or longer-term planning activities; No ability or experience to conduct data-based operational planning	Some ability and tendency to develop operational plan either internally or via external assistance; Operational plan loosely linked to strategic planning activities and used roughly to guide operations; Operational planning not based on trend data	Ability and tendency to develop and refine concrete, realistic operational plan, linked to annual budget and trend data; Some internal expertise in operational planning; Operational planning carried out on a regular basis; Operational plan linked to strategic planning activities and used to guide operations	Clinic develops and refines concrete, realistic, and detailed operational plan linked to annual budget and trend data; Has critical mass of internal expertise in operational planning; Operational planning exercise carried out regularly; Operational plan tightly linked to strategic planning activities and systematically used to direct operations	
<b>Comments:</b> Type comments (if any) here.					

*Please proceed to Worksheet 5.*

~ COMMUNITY ENGAGEMENT & COLLABORATION ~

<b>Assessment Categories (3 questions)</b>	<b>LEVEL ONE: Clear need for increased capacity</b>	<b>LEVEL TWO: Basic level of capacity in place</b>	<b>LEVEL THREE: Moderate level of capacity in place</b>	<b>LEVEL FOUR: High level of capacity in place</b>	<b>Input Selection in This Column</b>
<i>1. Assessment of Community Needs &amp; Clinic Environment</i>	Planning is not supported by systematically collected data about community needs or clinic's external opportunities and threats; Clinic has very few connections to community members and opinion leaders that could help clinic leaders understand evolving community needs	Clinic uses some data about community needs, opportunities, or external threats to inform planning although collection is haphazard; Clinic has some connections to community members and opinion leaders who inform clinic leaders about evolving community needs	Clinic uses some data about community needs and clinic's external opportunities and threats to inform planning; Data collected and used systematically to support planning effort and improve it; Clinic has multiple connections to community members and opinion leaders with whom clinic leaders regularly communicate about the evolving community needs	Clinic has clear, formal systems for assessing community needs and external opportunities and threats; Data used systematically to support planning and improve it; Clinic has many connections to community members and opinion leaders with whom clinic leaders regularly communicate about the evolving community needs; Communication is two way (community leaders often initiate communication)	
<i>2. Local Community Presence &amp; Involvement</i>	Clinic's community presence either not recognized or generally not regarded as positive; Few members of local community (e.g., patients, business leaders, other nonprofit leaders) constructively involved in the organization	Clinic's presence somewhat recognized, and generally regarded as positive within the immediate community (e.g., potential patients); Some members of larger community (e.g., business, civic, and/or other nonprofit leaders) constructively involved with the organization	Clinic reasonably well-known within community beyond just potential patients, and perceived as open and responsive to community needs; Members of larger community (e.g., business, civic, and/or other nonprofit leaders) constructively involved in organization	Clinic widely known within larger community, and perceived as actively engaged with and extremely responsive to it; Many members of the larger community (e.g., business, civic, and/or other nonprofit leaders) actively and constructively engaged with organization (e.g., board, fund-raising)	
<i>3. External Relationship Building (partnerships &amp; collaboration)</i>	Limited use of partnerships and alliances; Some coordination with other clinics in areas such as resource development, but few or no formal relationships	Early stages of building relationships and collaborating with other stakeholders; Coordinates primarily with other clinics but also is working to build relationships with other community-based organizations; Coordination focused primarily on influencing public policy and/or resource development, but also is beginning to discuss coordinating things such as patient care, staff training, etc.; May belong to clinic consortium, but activities focused primarily on information sharing as opposed to collaborative work	Effectively built and leveraged some key relationships with several types of relevant parties (for-profit, public health, and nonprofit sector entities); Belongs to a clinic consortium and actively coordinates work with other clinics; Coordination happens in areas such as business/operations, patient care, advocacy, and public policy, understanding patient populations, population health, and clinical issues; Contributes disease registry data to a disease collaborative; Recognized for effective alliances	Built, leverages, and maintains strong relationships with variety of relevant parties (local, state, and federal government entities as well as for-profit, other nonprofit, and community agencies), including membership in a consortium and disease collaborative; Relationships anchored in stable, long-term, mutually beneficial collaboration; Integrates/shares some business operations to take advantage of economies of scale Coordination exists around understanding patient populations and population health, improving individual patient care, influencing public policy, and resource development	
<b>Comments:</b> Type comments (if any) here.					

*Please proceed to Worksheet 6.*

~ LEADERSHIP: MANAGEMENT TEAM ~

<b>Assessment Categories (5 questions)</b>	<b>LEVEL ONE: Clear need for increased capacity</b>	<b>LEVEL TWO: Basic level of capacity in place</b>	<b>LEVEL THREE: Moderate level of capacity in place</b>	<b>LEVEL FOUR: High level of capacity in place</b>	<b>Input Selection in This Column</b>
<b>1. Management Team Composition</b>	Senior management responsibilities concentrated primarily in Executive Director position; Some functions (e.g., operations, development, finance, IT, personnel, community outreach, patient services, including dental and/or mental health) outsourced; Medical Director is uninvolved in management	Senior management responsibilities shared by a management team that is interdisciplinary; Members of the team represent different areas of the organization (e.g., operations, development, finance, IT, personnel, community outreach, patient services, including dental and mental health); Medical Director is relatively uninvolved in clinic management	Senior management responsibilities shared by a management team that is interdisciplinary; Most areas of the organization (e.g., operations, development, finance, IT, personnel, community outreach, patient services, including dental and mental health) are represented on the team; Medical Director actively participates as member of management team	Management team is interdisciplinary; All areas of the organization are represented (e.g., operations, development, finance, IT, personnel, community outreach, patient services, including dental and mental health), including active participation and leadership of the Medical Director and other appropriate clinical managers	
<b>2. Management Communication &amp; Coordination</b>	Executive Director and senior managers meet infrequently and irregularly; Management team members know almost nothing about the priorities and activities in departments beyond their own	Management team meets as needed on an infrequent and irregular basis; Team members communicate individually between meetings; Members know what the most urgent issues are in all departments but not other department's goals and priorities	Management team meets on a regular basis; Frequent communication among members between meetings; Members know key issues and goals of other departments and how they affect their own work	Management team meets frequently and regularly; Frequent and open communication between meetings; Members have strong understanding of issues, future plans, and goals in each department and how they affect the whole organization, as well as their own department.	
<b>3. Management Decision-making</b>	Decisions made largely on an ad hoc basis by the Executive Director and/or whomever is accessible; Virtually all decision making authority is centralized in one or two people; Divisions of roles and responsibilities among team members are neither formalized nor clear	Process for management team's decision making often breaks down and not always inclusive; Management team authorized, but unlikely to make key decisions in Executive Director's absence; Most roles and responsibilities among team members are not formalized	Clear, inclusive systems for team decision making but decisions are not always appropriately implemented or followed; All roles and responsibilities among team members are formalized, but may not reflect organizational realities	Clear, formal lines/systems for decision making that draw upon expertise and input of all team members; Roles and responsibilities among team members are formalized, clear and compliment each other	
<b>4. Management Experience &amp; Expertise</b>	Senior managers have very limited experience in clinic or other health related organizations; Managers have very limited capabilities or track record of managing large-scale projects (e.g., IT, capital, medical record system conversion, implementation of pharmacy or dental services); Limited track record of learning and personal development; Combined length of service at clinic less than 5 years	Senior managers have some experience in clinic or other health related organizations; Some managers have limited capabilities and track records of managing large-scale projects (e.g., IT, capital, medical record system conversion, implementation of pharmacy or dental services); Good track record of learning and personal development; Combined length of service around 5 years	Management team has significant experience in clinic or other health related organizations; Team members have relevant capabilities and track records of managing large-scale projects (e.g., IT, capital, medical record system conversion, implementation of pharmacy or dental services); Good track record of learning and personal development; Combined length of service more than 10 years	Management team highly experienced in clinic and other health related organizations; Team members have outstanding capabilities and track records of managing large-scale projects (e.g., IT, capital, medical record system conversion, implementation of pharmacy or dental services); Outstanding track record of learning and personal development; Combined length of service more than 15 years	

~ LEADERSHIP: MANAGEMENT TEAM ~

Assessment Categories (5 questions)	LEVEL ONE: Clear need for increased capacity	LEVEL TWO: Basic level of capacity in place	LEVEL THREE: Moderate level of capacity in place	LEVEL FOUR: High level of capacity in place	Input Selection in This Column
5. Management Team Collaboration & Leadership	Management team members work independently more than together; Little trust among team members and team members sometimes undermine team decisions; Meetings are inefficient	Management team members have built some trust and respect for each other; Sense of their role as a part of a team is still in development; Team meetings often have a simple agenda and are reasonably efficient but lack clear facilitation; Follow-up action items aren't always clear; Other staff are unfamiliar with or indifferent to the role of the management team	Management team members trust and respect one another and understand their responsibilities as a team; Meetings are well-planned and efficient and often have assignment of action items and responsibilities at the end, and team processes are still evolving and improving; Other staff recognize individual team members as leaders, but are unclear on the role of the management team	Management team members function well as a team and respect and trust one another; Team meetings are well-planned, efficient, and effectively facilitated; Each meeting ends with clear assignment of action items and responsibilities; All team members stand by team decisions; Management team members are respected by staff and board as organizational leaders and all understand the role the management team plays in organizational leadership	
<b>Comments:</b> Type comments (if any) here.					

*Please proceed to Worksheet 7.*

~ LEADERSHIP: BOARD OF DIRECTORS ~

Assessment Categories (6 questions)	LEVEL ONE: Clear need for increased capacity	LEVEL TWO: Basic level of capacity in place	LEVEL THREE: Moderate level of capacity in place	LEVEL FOUR: High level of capacity in place	Input Selection in This Column
<i>1. Board Composition &amp; Commitment</i>	Consumer members are not fully utilized or integrated; Membership drawn from a narrow spectrum of constituencies; Little or no relevant experience; Low commitment to organization's success, vision, and mission; Meetings infrequent and/or poorly attended	Consumer members not fully utilized or integrated; Membership represents a few different constituencies (e.g., attorneys, accountants, community-based organization leaders, faith-based organization leaders, other health care providers, local business owners); Moderate commitment to organization's success, vision, and mission; Regular, purposeful meetings are well-planned and attendance is good overall	Consumer members well-integrated and remaining members come from diverse fields of practice and expertise (e.g., attorneys, accountants, community-based organization leaders, faith-based organization leaders, other health care providers, local business owners); Membership represents most constituencies; Good commitment to organization's success, vision, and mission; Regular, purposeful meetings are well-planned and attendance is consistently good	Consumer members well-integrated and remaining members come from broad variety of fields of practice and expertise (e.g., attorneys, accountants, community-based organization leaders, faith-based organization leaders, other health care providers, local business owners); Strong commitment and proven track record of investing in learning about the organization and addressing its issues; Outstanding commitment to the organization's success, mission, and vision; Regular, purposeful meetings are well-planned and full-attendance is the norm rather than the exception	
<i>2. Board Governance</i>	Board roles and responsibilities are not clearly understood by members; Board does not review budgets, audits or regulatory and licensing reviews, does not set performance targets and hold CEO/ED accountable, or does not operate according to formal procedures	Understanding of roles and responsibilities of board and management varies; Board functions according to by-laws, reviews budgets, and occasionally sets organizational direction and targets, but does not review CEO/ED performance or its own functioning; Does not review audit or regulatory and licensing reviews comprehensively	Roles and responsibilities of board and management are clear and function well; Board reviews budgets, audits, regulatory and licensing reviews; Size of board set for maximum effectiveness with rigorous nomination process; Board sets performance targets, but does not regularly monitor them; Board does not systematically review CEO/ED's or their own performance	Board and management work well together from clear roles; Board fully understands and fulfills fiduciary duties; Size of board set for maximum effectiveness with rigorous nomination process; Board actively sets performance targets and regularly monitors performance; Periodically evaluates itself and formally evaluates CEO/ED on an annual basis	
<i>3. Board Training &amp; Orientation</i>	No plans for Board recruitment, orientation, or training; No formal training available and no new board member orientations	No plans for Board recruitment; Board training occurs 'on the job' rather than through any formal training sessions; Some formal training provided on an ad-hoc basis upon request; Limited orientation for new members	Board recruitment and training plans developed; Some formal training for all Board members loosely based upon a curriculum; Orientation for new members occurs and is supported by written materials	Board recruitment occurs according to plan; All Board members receive formal training; Board training needs assessed annually and training plan and curriculum developed annually; Comprehensive Board orientation for all new Board members occurs and is supported by written materials	

~ LEADERSHIP: BOARD OF DIRECTORS ~

Assessment Categories (6 questions)	LEVEL ONE: Clear need for increased capacity	LEVEL TWO: Basic level of capacity in place	LEVEL THREE: Moderate level of capacity in place	LEVEL FOUR: High level of capacity in place	Input Selection in This Column
<i>4. Committee Structure &amp; Participation</i>	Generally, board members do not contribute additional time to participate in committees; Most standing committees are inactive and lack relevant expertise; Standing fund development committee does not exist	Most standing board committees have some activity, although with varying levels of effectiveness; Some committees include members with relevant expertise to help inform decision making; Standing fund development committee does not exist	Board functions through stable and active standing as well as ad hoc committees meeting regularly and reporting to board; Most committees include some members with relevant expertise to help inform decision making; Standing fund development committee is active and includes members with some expertise in raising funds from private sources	Board functions through stable and active standing as well as ad hoc committees charged with clear roles and responsibilities; All committees include members with relevant expertise necessary to fulfill responsibilities and make sound decisions; All committees meet regularly and present reports to the board; Fund development committee active and expert in all types of fundraising, including raising funds from private sources	
<i>5. Board Fundraising</i>	Most members do not recognize fundraising as one of the board's roles and responsibilities; No goals or plans for board-driven fundraising activities exist	Members accept that the board has some fundraising responsibilities, but concerns exist regarding ability of consumer boards to be successful in this area; One or two members have financially contributed to the clinic; Board fundraising activities not yet underway	Many members embrace fundraising as one of the board's core roles and responsibilities; Core group of board members consistently participates in fundraising; Realistic and appropriate board fundraising goals and plans exist; Majority of members have made financial contributions; Fundraising activities are underway	Majority of members embrace fundraising as a core board role and responsibility; Most board members have made financial contributions to the organization; Realistic and appropriate board fundraising goals and plans are in place; Board is actively fundraising and has achieved measurable progress towards goals	
<i>6. Strategic Planning Role</i>	Plans to address community needs are developed by clinic staff, without a structured process for board input; Insights about the community's current and future needs are not solicited by clinic staff or offered by board members during planning process; Board's strategic planning role limited to ratifying staff's plans; No process for board's regular review and updating of plan	Structured process for community-based board to have input and approve clinic's strategic plan exists, but is not always followed; Board members' insights about community's needs and strategies to address them are drawn upon informally, often on an individual basis, for planning purposes; No process exists for board's regular review and updating of plan	Clinic follows a structured process for community-based board to have input and approve clinic's strategic plan; Process includes solicitation of members' insights about the community's needs to inform develop of clinic's goals and plans; Board regularly reviews and updates strategic plan	Clinic follows a structured process for community-based board to have significant input and approve clinic's strategic plan; Process includes solicitation of members' insights about the community's current and future needs to inform develop of clinic's goals and plans; Board utilizes data about the community's health status in planning process; Board regularly reviews and updates strategic plan	
<b>Comments:</b> Type comments (if any) here.					

*Please proceed to Worksheet 8.*

~ FINANCIAL SYSTEMS & POSITION ~

<b>Assessment Categories (5 questions)</b>	<b>LEVEL ONE: Clear need for increased capacity</b>	<b>LEVEL TWO: Basic level of capacity in place</b>	<b>LEVEL THREE: Moderate level of capacity in place</b>	<b>LEVEL FOUR: High level of capacity in place</b>	<b>Input Selection in This Column</b>
<b>1. Bottom Line</b>	Revenues have exceeded expenses in zero or one of the past 3 years  (Positive operating margin in 0-1 of the last 3 years)	Revenues have narrowly exceeded expenses in two of the past 3 years  (Slightly positive operating margin in 2 of the last 3 years)	Revenues have exceeded expenses in two of the past 3 years  (Positive operating margin in 2 of the last 3 years)	Revenues have exceeded expenses in all of the past 3 years  (Positive operating margin in 3 of the last 3 years)	
<b>2. Cash Flow</b>	On average, clinic does not have enough cash available to pay all of its monthly bills  (Approximately <30 days cash on hand)	On average, clinic has just enough cash available to pay its monthly bills, but not enough to cover any unforeseen expenses  (Approximately 30-45 days cash on hand)	On average, clinic has enough cash available to pay its bills, and enough additional cash on hand to cover modest unforeseen expenses  (Approximately 46-60 days cash on hand)	On average, clinic has enough cash available to pay its bills, and enough additional cash on hand to cover significant unforeseen expenses  (Approximately >60 days cash on hand)	
<b>3. Diversity of Revenue Sources</b>	Clinic highly dependent on a few government grants and contracts, which make up over 50% of clinic revenue; Remainder of budget derived from foundations and a limited amount of patient revenue; Clinic highly vulnerable to fluctuations in government funding priorities	Clinic's revenue primarily derived from government and foundation grants and contracts (over 50% of revenue from these two types of sources); Remainder of budget derived from patient revenue; Clinic vulnerable to fluctuations in government and foundation funding priorities; Clinic aware of need to diversify funding but lacks understanding and skills to do so	Clinic has grants and contracts from a variety of government and foundation sources, which together account for less than 50% of its revenues; Just under half of its revenue is derived from patient revenue (approx. 40%); Successful efforts are underway to develop private sources	Clinic has grants and contracts from a variety of government and foundation sources, which together account for less than 50% of its revenues; Half or more of its budget is derived from patient revenues (50%); A growing portion is derived from private sources other than foundations (about 5%); Diversity of funding sources provides insulation from fluctuations in government and foundation funding priorities	
<b>4. Financial Planning &amp; Budgeting</b>	Very limited financial forecasting; General budget developed and approved by board of directors; Performance against budget loosely or poorly monitored	Limited financial forecasting, ad hoc update; Annual budget utilized as operational tool; Used to guide/assess financial activities; Some attempt to isolate divisional (program or geographical) budgets within central budget; Performance-to-budget monitored periodically	Solid financial forecasts, updated at least semi-annually and discussed with management team, staff, and board; Annual budget utilized in operations; Reflects organizational needs; Solid efforts made to isolate divisional (program or geographical) budgets within central budget; Performance-to-budget monitored at least quarterly	Very solid financial forecasts, continuously updated; Annual budget updated regularly, reviewed monthly by management team and board, and utilized in daily operations; As strategic tool, it develops from process that incorporates and reflects organizational needs and objectives; Well-understood divisional (program or geographical) budgets within overall central budget; Performance-to-budget monitored on a monthly basis	

~ FINANCIAL SYSTEMS & POSITION ~

Assessment Categories (5 questions)	LEVEL ONE: Clear need for increased capacity	LEVEL TWO: Basic level of capacity in place	LEVEL THREE: Moderate level of capacity in place	LEVEL FOUR: High level of capacity in place	Input Selection in This Column
5. Use of Financial & Operations Data	Occasionally produces some basic financial management reports, such as budget-to-actual financial reports, cash flow, and/or accounts payable/accounts receivable; Reports produced upon request, rather than at any regular time interval, and primarily reviewed by Executive Director	Regularly produces basic financial management reports, such as budget-to-actual financial reports, cash flow, and/or accounts payable/accounts receivable; Occasionally produces more sophisticated financial reports on request such as cost center reports, administrative/overhead, and/or cost reporting/FQHC/cost reconciliation; Financial reports reviewed by Executive Director at least quarterly and by the Board at least twice per year	At least quarterly, produces basic financial management reports, such as budget-to-actual financial reports, cash flow, and/or accounts payable/accounts receivable; Produces some more sophisticated financial/operations reports such as cost center reports, administrative/overhead, cost reporting/FQHC/cost reconciliation, inventory, and/or personnel tracking; Reports include data from previous time period for comparison; Financial reports reviewed by Executive Director monthly, and by the Management Team and Board at least two times per year	Produces comprehensive financial management reports (budget-to-actual financial reports, cash flow, and/or accounts payable/accounts receivable, cost center reports, administrative/overhead, cost reporting/FQHC/cost reconciliation, inventory, and/or personnel tracking) with trends information that are reviewed and discussed by management team on a monthly basis and shared with the Board at least quarterly; Information from the reports feeds directly into planning, decision-making, and adjustments in operations	
<b>Comments:</b> Type comments (if any) here.					

*Please proceed to Worksheet 9.*

~ FUND DEVELOPMENT ~

Assessment Categories (3 questions)	LEVEL ONE: Clear need for increased capacity	LEVEL TWO: Basic level of capacity in place	LEVEL THREE: Moderate level of capacity in place	LEVEL FOUR: High level of capacity in place	Input Selection in This Column
1. Fund Development Strategy & Activities	Board leadership and Executive Director not focused on diversifying revenue sources; Fund development strategy not well articulated and focuses on one type of development such as grant writing	Board leadership and Executive Director recognize need to achieve a diverse balance of revenue sources; Fund development activities somewhat opportunistic, not organized in a coherent strategy; Activities go beyond grant writing to include marketing and communications, direct mail, personal solicitation or planned giving efforts; Clinic does not strategically target new revenue sources	Board leadership and Executive Director are committed to diversifying revenue sources; Fund development strategy includes multiple components (e.g., grant writing, marketing and communications, direct mail, personal solicitation, planned giving); Clinic is actively identifying and pursuing new revenue sources, including targeting private funding sources (other than foundations and contracts); Has a short, but good track record of successful fundraising from private sources	Board leadership and Executive Director are committed to maintaining a diverse revenue base; Well developed fundraising strategy and systems to achieve and maintain a diverse balance of revenue sources; Fund development strategy includes several complimentary components (e.g., marketing and communications, direct mail, personal solicitation, planned giving); Strategy includes identifying and pursuing new revenue sources, including significant effort to target private funding sources (other than foundations and contracts); Proven activities and skills for generating funding from private sources	
2. Fund Development Staff, Budget, & Skills	No dedicated fund development staff and no budget for development; Generally weak grantwriting and fundraising skills and lack of expertise (either internal or access to external expertise)	Some staff time and budget dedicated to fund development; Regular development needs covered by internal staff, who also do other jobs, but have some experience/training in grantwriting; Occasional access to some external grant writing and fundraising expertise	Some dedicated fund development staff who have professional training/experience in grant writing and fundraising; Main development needs covered by some combination of internal skills and expertise, and access to some external grantwriting and fundraising expertise	Fully staffed professional fund development team with development budget; Highly developed internal grantwriting and fundraising skills and expertise in all funding source types to cover all regular needs; Access to external expertise for additional extraordinary development needs	
3. Private Revenue Sources (non-foundation or contract)	Clinic has no experience with or commitment to raising funds from private sources such as individuals and/or corporations; Less than 2% of the clinic's annual revenue comes from private charitable donations (other than from philanthropic foundations)	Board leadership and ED do not put high priority on private fundraising; Clinic does not have an annual fundraising campaign; Solicitation of private contributions is infrequent and somewhat haphazard; Between 2% and 3% of the clinic's annual revenue comes from private charitable donations (other than from philanthropic foundations); The amount of revenue from private sources is inconsistent from year to year	Board leadership and ED prioritize private fundraising; Clinic consistently has annual fundraising campaigns; Development team includes staff experienced in individual donor relations; Between 3% to 5% of the clinic's annual revenue comes from private charitable donations (other than from philanthropic foundations); The amount of revenue from private sources is consistent, but not increasing year to year	Board leadership and ED put high priority on private fundraising; Clinic has ongoing strategies and systems for soliciting private donations and communicating with donors; Development staff are expert at relations with individual donors; More than 5% of the clinic's annual revenue has come from private charitable donations (other than from philanthropic foundations) for at least three years; The amount of revenue from private sources has consistently increased year to year	
<b>Comments:</b> Type comments (if any) here.					

*Please proceed to Worksheet 10.*

~ DATA-INFORMED DECISION MAKING ~

Assessment Categories (3 questions)	LEVEL ONE: Clear need for increased capacity	LEVEL TWO: Basic level of capacity in place	LEVEL THREE: Moderate level of capacity in place	LEVEL FOUR: High level of capacity in place	Input Selection in This Column
1. <i>Data Analysis Skills &amp; Staff</i>	Limited capacity to work with research data; Only sporadically uses data from outside sources to support proposals or program decisions; Little understanding of where to find useful data or how to assess its quality	Often uses simple data from internal or outside sources to support fund development and/or advocacy; Can read research reports and evaluate the quality of data but does not rely on data as part of regular decision making; Familiar with one or two sources of public health data especially relevant to community clinics; Little capacity to analyze raw data or present it in graphical, engaging ways	Familiar with relevant sources for public health data that are regularly consulted to support decisions, proposals, or advocacy; Can determine data quality, manipulate data from existing data sets, and make generalizations about the validity of findings for community clinics and/or the local population; Some staff members have research and data analysis skills, though this may be only part of their job descriptions; Some staff capacity to conduct basic primary research such as surveys; Can effectively present data using charts, tables, and graphics for a variety of audiences	Respected by peers as both a consumer and producer of research data; Staff positions are dedicated to research and data analysis; Regularly scans public health research for relevant and valid data to support program planning and advocacy; Regularly works with management staff to identify important organizational questions and answer them through research, either collecting data from outside sources or conducting primary research; Strong relationships with other researchers in the public health arena, and/or at other clinics	
2. <i>Use of Clinical Data</i>	Minimal and haphazard tracking of basic clinic management data such as patient demographics; Reports can be produced upon request, are produced irregularly and reviewed by the Medical Director; Cannot identify patients by different types of diseases	Tracks basic clinic management data such as patient demographics, utilization of different services and/or provider productivity; Produce reports at least twice a year that are reviewed by the Medical Director; Reports do not include trend information comparing current data to previous time periods	Regularly tracks clinic management data such as patient demographics and provider productivity, and maintains at least one disease registry; Reports are produced at least quarterly and are reviewed and discussed by the Medical Director, Executive Director, and Management Team; Can identify patients by different diseases and Medical Director requests this data on an occasional basis, but not regularly; Has occasionally conducted some small analyses of patterns in patients' health but does not do so on a regular basis	Tracks clinical data such as service utilization by different demographics, quality assurance, and/or utilization reports with trend information; Small number of clear, measurable, and meaningful key performance indicators; Reports are produced at least quarterly and are reviewed and discussed by the Medical Director, Executive Director, and Management Team; Program planning and/or adjustments are made based upon information from the reports and impact of changes is also tracked by reviewing changes in these data; Maintains multiple disease registries; Can conduct sophisticated analysis of patient population health and chronic disease management and adjust services appropriately	

~ DATA-INFORMED DECISION MAKING ~

Assessment Categories (3 questions)	LEVEL ONE: Clear need for increased capacity	LEVEL TWO: Basic level of capacity in place	LEVEL THREE: Moderate level of capacity in place	LEVEL FOUR: High level of capacity in place	Input Selection in This Column
3. <i>Performance Management: Benchmarking</i>	Rarely compares performance data such as financial performance, patient demographics, service utilization, or population health status to other clinics or any objective standards	Some efforts made to benchmark performance against the outside world; Compares financial performance, patient demographics, and/or service utilization with local clinics and/or consortia members on an irregular basis but at least once per year; No comparisons made to any objective standards, such as Federal or local/regional primary care standards	Benchmarking of financial performance, patient demographics, and/or service utilization occurs at least once per year, but driven largely by top management; Comparisons made to local/regional clinics as well as to other clinics statewide, but no comparisons made to any objective external standards (e.g., Federal benchmarks, local/regional primary care standards, MGMA standards, etc.); Learnings from these activities shared with all staff and often used to make adjustments and improvements	Comprehensive external benchmarking part of the culture and takes place up to four times per year; Performance compared to objective external standards (e.g., Federal benchmarks, local/regional primary care standards, MGMA standards, etc.) as well as to other clinics; Benchmarking used by staff in target-setting and daily operations; High awareness of how all activities rate against internal and external best-in-class benchmarks; Systematic practice of making adjustments and improvements on basis of benchmarking	
<b>Comments:</b> Type comments (if any) here.					

*Your survey is complete. Thank you!*

## Organizational Capacity Grid Summary

*Please print this worksheet for future reference.*

	Individual Assessment Category Ratings	Average Ratings for Each Capacity Area
<b>MISSION, VISION, &amp; PLANNING</b>		
Mission (clinic's reason for existence)	0	<b>0.00</b>
Clarity of Vision (clinic's long-term goals for itself & its community)	0	
Strategic Plan	0	
Strategic Planning Skills	0	
Performance Targets	0	
New Program Development	0	
Operational Planning	0	
<b>COMMUNITY ENGAGEMENT &amp; COLLABORATION</b>		
Assessment of Community Needs & Clinic Environment	0	<b>0.00</b>
Local Community Presence & Involvement	0	
External Relationship Building (partnerships & collaboration)	0	
<b>LEADERSHIP: MANAGEMENT TEAM</b>		
Management Team Composition	0	<b>0.00</b>
Management Communication	0	
Management Decision-making	0	
Management Experience & Expertise	0	
Management Team Collaboration & Leadership	0	
<b>LEADERSHIP: BOARD OF DIRECTORS</b>		
Board Composition & Commitment	0	<b>0.00</b>
Board Governance	0	
Board Training & Orientation	0	
Committee Structure & Participation	0	
Board Fundraising	0	
Strategic Planning Role	0	
<b>FINANCIAL SYSTEMS &amp; POSITION</b>		
Bottom Line	0	<b>0.00</b>
Cash Flow	0	
Diversity of Revenue Sources	0	
Financial Planning & Budgeting	0	
Use of Financial & Operations Data	0	
<b>FUND DEVELOPMENT</b>		
Fund Development Strategy & Activities	0	<b>0.00</b>
Fund Development Staff, Budget, & Skills	0	
Private Revenue Sources (non-foundation or contract)	0	
<b>DATA-INFORMED DECISION MAKING</b>		
Data Analysis Skills & Staff	0	<b>0.00</b>
Use of Clinical Data	0	
Performance Management: Benchmarking	0	

## SHASTA COMMUNITY HEALTH CENTER

Redding, California

### Challenge

Without building a new health center, Shasta County's primary source of health care for the working poor and indigent, Shasta Community Health Center, will close.

Since its beginning in 1988, Shasta Community Health Center (SCHC) has leased part of the old county hospital building from Shasta County. In 1998, Shasta County made the strategic decision not to renew the lease, effective June, 2001, so that the building could be used for other county purposes.

This closure will create a crisis in the healthcare delivery system in Shasta County. SCHC patients (one in four residents in the county) would not receive timely care for illness, disease and preventive health services. Patients who do not need the intensive services of an Emergency Room would be forced to use these expensive facilities, creating delays for those who truly need emergency services. Patients would wait longer for primary health care, creating sicker patients, longer hospital stays and more tests and avoidable health services. Communicable diseases, especially among children, would not be diagnosed as early, posing community health risks.

Shasta Community Health Center is not a "free clinic." All medically uninsured patients pay based on a sliding fee basis, taking into account the family's financial situation, however, no one is ever refused needed care solely because of the lack of financial resources.

### Why The Community Should Care

Why should every person in Shasta County care whether the health center's patients receive health services?

Almost half of SCHC's adult patients have jobs and are considered "working poor." These patients, for the most part, have jobs, but do not receive health insurance from their employers and do not make enough to afford health care. Without Shasta Community Health Center, they would not be able to receive regular preventive and on-going health services.

This group of working families will increase even more as the affects of welfare reform are felt throughout the county. These families, who previously receive some health care insurance as part of their public assistance benefits, are now working - yet, in most cases have no health insurance for themselves or their children. Regardless of whether an individual is on public assistance or part of the working uninsured, SCHC has been there to make medical care services available and affordable.

Fully 80% of SCHC's patients have lived in the county for at least five years, and more than half have lived here all their lives. SCHC's patients are friends and neighbors who are hard working members of our community, raising families in an increasingly expensive health care environment. While SCHC serves all who need it, less than 3% of the active patient base are transient or homeless.

Infants and children represent over 50% of the patients served by Shasta Community Health Center. All of the area schools depend on Shasta Community Health Center to work closely with them supporting children with serious learning and/or physical disabilities. Moreover, over 90% of all the medical and social "high-risk" newborns discharged by area hospitals are directly referred to Shasta Community Health Center for follow-up care and support. The only health care many of these children receive is through Shasta Community Health Center. In addition, Shasta Community Health Center has taken a leadership role in coordinating the enrolling of many hundreds of previously uninsured children of working families into the new federal/state funded program called Healthy Families. For many of these children, the program makes it affordable for them to access primary and preventive health, dental and vision care.

Emergency Rooms will be swamped by these 40,000 patients if SCHC is forced to close. The Emergency Room is the most expensive way to treat a patient and should be reserved for truly life-threatening illness. Because hospitals are required by law to treat anyone that shows up in the Emergency Room, the costs of treating the uninsured are passed on to all of the hospitals' clients through higher bills.

Shasta County's hospitals cannot absorb this influx of patients and they are not staffed nor equipped to provide primary health care to thousands of people. Besides the cost issues, the hospitals simply cannot provide the follow-up care necessary to insure good health and preventive health care. It would be inordinately expensive, and impractical, for patients to be treated, and followed-up with, in the emergency room of local hospitals.

In addition to the increased costs, there would be added delays and waiting for any member of the community who faces a true medical emergency. Over-utilization of the emergency room system, and a lack of timely health care, will also create a ripple effect throughout the hospital system leading to increased waiting times for such hospital services as lab work, radiology and even in-patient care.

The fact remains that the most cost-effective way to provide basic, primary health care to those who don't have health insurance, is through outpatient community health centers. In Shasta County, that means Shasta Community Health Center. Without SCHC, patients will not get regular health care. Without regular health care, patients are sicker, more costly to treat and the chance of a negative outcome is higher.

Perhaps most seriously, lack of regular health care creates a community health hazard. Who is sitting next to your child and grandchild in school? If that child has not seen a doctor in years, is it possible that your child's school friend has a communicable, airborne childhood disease . or even something more serious?

### **Summary**

Shasta Community Health Center provides primary health care services to 40,000 patients in Shasta County - fully one in four of the county's residents . Over 80% of the working poor and indigent in the community receive their primary health care from Shasta Community Health Center.

Shasta Community Health Center works closely with physicians in the community. Many of these physicians treat SCHC patients on a reduced or no fee basis as part of their commitment to the community.

There are currently 10 staff physicians, 6 nurse practitioners/physician assistants practicing at Shasta Community Health Center. Additionally, there are 34 medical specialists providing specialty care to this under-served population. Through a unique partnership, medical specialists in the community offer their specialty at the clinic a few hours or days each month.

Shasta Community Health Center provides primary health care through three specific medical practices:

#### *Family Practice*

Providing a wide-range of health services, these family physicians, physician assistants, and nurse practitioners provide quality health care to over 25,000 adults and children each year. Additionally, the Family Practice Residency Program allows first, second and third year family practice residents the opportunity to work hands-on with patients, under the supervision of a specially-trained physician. These six resident physicians see 7,000 patients each year.

#### *Pediatrics*

Specializing in childhood illness and injury, these pediatric physicians, physician assistants, and nurse practitioners provide quality health care to 13,000 infants and children each year.

### *Medical Specialty Program*

Often patients of Shasta Community Health Center require health care that requires a medical specialist. Because of this, SCHC has created a partnership with 34 medical specialists in the community that provide 18 different medical specialties at the clinic. Shasta County, like many rural communities, face an acute shortage of medical specialists. Through this program, SCHC addresses an unmet need. The specialties provided at SCHC are:

- Ear, Nose and Throat
- Endocrinology
- Gastroenterology
- General Surgery
- Gynecology
- Neurology
- Neurosurgery
- Orthopedics
- Pediatric Cardiology
- Pediatric Neurosurgery
- Pediatric Orthopedics
- Plastic Surgery
- Podiatry
- Proctology
- Pulmonary
- Rheumatology
- Urology
- Vascular Surgery

Sadly, patients must often wait as much as two years to see a medical specialist . Presently, one of the greatest barriers to additional specialty care is the lack of space in the current facility. Each of the specialists can access only two examination rooms, instead of the more efficient three exam room set-up seen in most physician offices. **Moreover, other specialists throughout the community have offered to assist in this program, but SCHC has had to turn down their assistance because of limited space .**

A new facility will alleviate these problems . Shasta Community Health Center has a plan to bring more primary care practitioners (physicians, nurse practitioners, and physician assistants) and medical specialists to the community, but there is no room at the present health center for additional practitioners .

Reasonable access to quality health care in Shasta County can only be solved by a new facility, specifically designed to create an efficient delivery system. As the population of uninsured continues to grow, many with low-paying, limited-benefit jobs, the crisis in healthcare in Shasta County will also continue to grow. With a new facility, SCHC is ideally poised to help the growing number of working, uninsured residents of Shasta County.

### **The Capital Campaign**

In 1999, the Shasta Community Health Center Board of Directors determined, after a professional feasibility study, to launch a \$4,000,000 capital campaign to build a permanent health center. This new facility will insure that the working poor (one in four people in Shasta County) can receive timely, high-quality care.

Shasta County has also agreed to make available 6.5 acres of land it owns along Radio Lane for the site of the new clinic.

The funds raised will pay for construction of the new clinic and the necessary equipment to provide health services to those that need it. The campaign will focus on receiving gifts from foundations, corporations, small businesses, physicians and individuals. A full copy of the feasibility report is available upon request.

## The New Facility

After a review of available buildings, the Board of Directors of Shasta Community Health Center determined that there is no building that could be adapted to the health center's unique needs for a reasonable cost. There are no suitable 35,000 square foot buildings available for purchase or lease in SCHC's service area.

Through the generosity of Shasta County, 6.5 acres of land along Radio Lane is available at virtually no cost to the health center. With this gift of land, Shasta Community Health Center's board of directors has determined that building a 35,000 square foot facility is the most economically feasible plan.

The new health center will be able to serve more patients more efficiently. The larger health center will allow for an additional 10 medical specialists, 2-3 family practice providers, 1-2 general internists, and 1-2 pediatric providers. The new health center will be able to accommodate 10,000 additional active patients.

Perhaps most importantly, the new health center will enable each physician to have three examination rooms, meaning that more patients can be seen more efficiently by each physician.

The new health center will house three clinical areas and ancillary services, including:

1. **Primary Care** . This clinical area will house all of the primary care services including the Family Practice and Family Practice Residency Program. Included in this area will be all of the Family Practice practitioners (physicians, nurse practitioners and physician assistants), including the unique Family Practice Residency program, where first, second and third year medical students will treat patients under the direct supervision of teaching physicians.

The Family Practice Clinical Area will allow 3 additional family practice providers to be hired and would include room to increase the number of residents from 6 to 12 residents.

2. **Specialty Care** - Current space limits prevent an expansion of Shasta Community Health Center's unique Medical Specialty Program. Even though several physician specialists in the county have indicated an interest and willingness to bring their services to the health center, there is no room for these specialists to see patients.

The new health center will have its own specific clinical area for these specialists, including three exam rooms for each specialist on-duty. These additional exam rooms will allow specialists to see more patients in the same timeframe, which, more than anything, will dramatically reduce the up to two-year wait to see a specialist.

3. **Pediatrics** - Over half of the patients seen by medical professionals at Shasta Community Health Center are under the age of 18, and 35% are under the age of ten. Yet these children must often wait weeks to see a physician and, because of the contagious nature of many of their illnesses, the community as a whole is at risk.

Providing care to children in their formative years is particularly important. Care received during the early years prevents more serious health problems in later years. Without early childhood medical care, child development is affected.

The new health center will include a Pediatric Clinical Area, which will enable SCHC to add 2 pediatric health care providers as well as provide each physician with three exam rooms, thereby increasing the number of patients each physician can see in a single shift.

4. **Ancillary Health Services** . The health center may also house several Ancillary Health Services including a full-service lab, pharmacy, isolation room, patient teaching areas, chronic disease education areas and administrative support. A networked computer system will allow all dictation and patient records to be available electronically.

## What About Operating Support After the Clinic is Built?

- Over 80% of the operating revenue of SCHC comes from stable federal and state sources.

- The remaining 20% comes from sliding fee scale payments and from state, local or private grants.
- Pro-forma budgets indicate that SCHC's operating revenues can support the operations of this size clinic.

### **Building Costs**

The total cost for the new 35,000 square foot Shasta Community Health Center is estimated at \$4,000,000.

### **History**

Shasta Community Health Center was founded in 1988 by a partnership that included the Shasta Trinity Medical Society, Redding Medical Center, Mercy Medical Center and the County of Shasta after the closing of Shasta General Hospital.

Over 54,000 individuals within Shasta Community Health Center's service area are low-income, and 20,000 of these live below the federal poverty level (\$17,010 household income for a family of four). 40% of the targeted families in the service area are uninsured.

Like many mainly rural counties, Shasta County has a large population of what is best termed the "working poor." These are individuals that have full or part-time employment, but do not usually have any health insurance and, because of what they are paid, cannot realistically afford to pay for health care. About 45% of the adult patients seen at Shasta Community Health Center have some form of employment.

**SCHC is the only large-scale primary care provider offering sliding fee discounts for the low-income, uninsured, working residents.**

Since 1988, SCHC has provided 500,000 patient visits, and in 1998 alone, provided over 70,000 patient visits.

### **Benefits of a Successful Campaign**

- A new health center will allow space for two to three additional Family Practice physicians. This will dramatically reduce the waiting list and waiting time for appointments. Each Family Practice physician will be able to care for 2,000 patients each year.
- A new health center will allow for the addition of one to two general internists to help care for the growing elderly population served by SCHC. Each internist can care for 1,500 patients each year.
- A new health center will also allow an additional Pediatric physician, which is desperately needed. This Pediatric Physician will be able to care for 2,000 children each year.
- A new health center will allow for the Family Residency program to be expanded, allowing more low-income families access to medical residents working under the supervision of SCHC staff physicians.
- The unique medical specialty program, whereby local medical specialists work part-time for the health center to provide specialized medical services, can be increased to accommodate all of the specialists who want to participate, but must currently be turned away for a lack of space.
- New diagnostic equipment, including such basic services as an ultrasound, mammogram, fetal ultrasound, general x-ray, health central laboratory, and pharmacy, can be made available in one convenient location.
- 120 full-time jobs will be saved. Economic models show that these jobs and the operating expenses of the health center supports over 300 other jobs in the community.

## CARONDELET HEALTH CARE

St. Mary's Hospital - St. Joseph's Hospital

Tucson, Arizona

### Historical Perspective

For 111 years, the Sisters of St. Joseph of Carondelet have been a part of Tucson in its move from pioneer, frontier medicine to modern technology with all its scientific knowledge and medical advances. Changes have occurred and expansion has taken place, adding new areas of patient care in an ever more complex setting. Innovative programs, as much a part of vision as of necessity, have continually been undertaken in response to personal and community needs.

In 1880 the call for medical service was answered by the physicians and the sister-nurses who cared for the injured employees of the Southern Pacific Railroad, the poor and medically indigent patients, and everyone who came to the small twelve-bed hospital named St. Mary's. It is answered today by physicians, nurses, therapists and technicians working on shifts that punctuate the hospital's twenty-four hour availability.

In 1870, seven Sisters of the Congregation of the Sisters of St. Joseph of Carondelet made an arduous journey from St. Louis, by way of San Francisco, Los Angeles, and finally through the "trek" across the desert to Tucson. Their mission was to answer the plea of the newly appointed Vicar Apostolic of Arizona, Jean Baptiste Salpointe to teach at the Mission School in Tucson. The Sisters quickly expanded their work beyond the school to include an Indian school at San Xavier, a hospital in Prescott for men injured in mining accidents, and a school in Yuma. By 1880, the Sisters of St. Joseph of Carondelet were an established part of life in Tucson.

In 1877 Bishop Salpointe faced a dilemma. He was erecting a trade school for the Indian youth of the area and, with the Indians help, the building was almost complete. However, there was also no questioning the need for a hospital for the community and railroad workers. The painful decision was made - the trade school, named The Mission School, was postponed and the building was turned into a hospital with the Sisters agreeing to staff the new facility. St. Mary's Hospital was dedicated on April 24, 1880 and received its first eleven patients on May 1. It is Arizona's longest continually existing hospital.

The past century has seen St. Mary's pioneer many aspects of health care with numerous "firsts." During the frontier days, the hospital provided such revolutionary services as a separate Isolation Cottage for patients with communicable diseases, a separate surgical area, and a Sanatorium. The Sisters also pioneered firsts for Arizona in the area of Nursing Education and Professional Standards for Physicians. The hospital provided Arizona with its first X-ray machine, Intensive Care Unit, and open heart surgery. St. Mary's Burn Center is still the only such facility in southern Arizona.

Throughout the years, during wars and peace, during good times and bad, the Sisters of St. Joseph of Carondelet offered the citizens of Tucson such cutting edge technology as the first

electroencephalogram (EEG) machine. From the original eleven patients, St. Mary's Hospital grew to 374 beds to be the fourth largest hospital in Arizona and the second largest in Tucson. It offers a full range of medical services.

In 1961, the Sisters of St. Joseph of Carondelet recognized that the city of Tucson was growing at such a rate it was difficult for the residents on the fast-growing east side to utilize the services of St. Mary's Hospital on the west side. The Sisters then built St. Joseph's Hospital and created a two hospital system to maximize health care coverage and reduce expenses. Carondelet St. Joseph's Hospital is a 338 bed, comprehensive general, acute-care facility with a major emphasis on ambulatory care. It offers complete OB-GYN services, O'Rielly Care (an eighteen-bed substance abuse treatment center), a comprehensive Cardiac Rehabilitation Center, a Diabetes Care Center, Home Health Care services and a full range of rehabilitation programs. It also provides southern Arizona's Regional Eye Center and Regional Hand Center.

Incorporated in 1983 as Carondelet Health Care Corporation, today the health care system includes Holy Cross Hospital in Nogales, Arizona and Holy Family Center, an extended care facility in addition to St. Mary's and St. Joseph's.

### **The Situation Today**

Today Carondelet Health Care is the largest health care provider in southern Arizona with three hospitals (Holy Cross in Nogales, Arizona and Holy Family Center, a long term care facility) was added to the system in 1987), two hospices, fourteen wellness centers, and a host of outreach programs designed to meet the healthcare needs of the community. Today Carondelet Health Care:

- Has 755 beds available for patient use.
- Will admit over 27,000 patients this year.
- Will treat an additional 50,000 people on an outpatient basis.
- Will deliver over 2, 000 babies this year.
- Will treat over 60,000 people through its 24-hour Emergency Departments.

Of Carondelet Health Care's 27,000 admissions, almost 14,000 of those will be on some type of government assistance program.

Yet even with this tremendous volume, Carondelet retains the mission of the original Sisters to provide quality healthcare for all the people of Tucson.

St. Mary's Hospital serves the "western corridor" of Tucson and gives special attention to minorities and those with lower incomes. It is the only private hospital serving the west side population. Carondelet Health Care provides over \$10,000,000 per year in charitable care to persons who would not otherwise be able to afford quality healthcare.

Both Carondelet St. Mary's and Carondelet St. Joseph's retain a commitment to providing the most technologically advanced healthcare in Tucson. Specialized services provided by Carondelet Health Care include:

- The Burn Center: The first and only fully accredited burn center in southern Arizona serving the immediate area, surrounding states and Mexico.
- Hospice: The first facility in southern Arizona serving the needs of the terminally ill and their families in a compassionate, Christian environment.
- Cardiac Rehabilitation Program: Southern Arizona's largest rehabilitation service for victims of heart problems.
- Diabetes Care Center: Arizona's only Medicare and American Diabetes Association certified care center.
- Heart Surgery: Carondelet Health Care system performs more heart surgeries than any other area institution - over 325 this year.
- Regional Eye Center and Low Vision Clinic: Carondelet St. Joseph's is home to southern Arizona's only Eye Center providing a full range of surgical, laser, ocular prosthetics and low vision services.
- Regional Hand Center: Carondelet St. Joseph's is home to southern Arizona's only center specializing in the treatment of disorders of the hand.
- O'Rielly Care: Specializing in the treatment of alcohol and substance abuse patients.
- Nurse Case Management: Carondelet St. Mary's was selected on January 1, 1991 by the General Mills Foundation to work with thirteen other hospital's in a National Chronic Care Consortium to develop programs dealing with geriatric chronic care.
- Community Health Care Centers: Are located throughout Tucson serving those who do not have ready access to healthcare providers.

### **The Challenge Facing Carondelet Health Care**

After intense study by experts within and outside the hospital family, Carondelet Health Care has identified the two most pressing healthcare issues which face the citizens of southern Arizona.

1) Maternity and Delivery Services: Currently Carondelet Health Care delivers approximately 2,200 babies each year. This is the maximum number of births the present facilities can accommodate. Carondelet continues to provide the maternity and delivery services to the community, often despite the patients ability to pay. Carondelet Health Care provides well over \$1,000,000 in charity care to maternity patients who cannot afford this health care.

Carondelet provides this service to the community, in spite of the adverse financial effects, because of the Sisters' commitment to Christian family values.

2) Outpatient Rehabilitation and Surgical Services: Currently in Tucson and southern Arizona there is no comprehensive outpatient rehabilitation service facility. Additionally, Carondelet St. Mary's and the west side of Tucson lack necessary outpatient surgical facilities. This lack of outpatient services on the west side presents a burden on the very people who are least able to acquire medical care.

One major trend in health care in the 1980's and 1990's is the move toward outpatient services. A procedure performed on an outpatient basis traditionally costs 30% less than a similar procedure on an inpatient basis. This simple economic statement is the underlying reason insurers and third

party payors are insisting on more outpatient services and even refusing to reimburse the total inpatient costs in many cases.

Additionally, the project at Carondelet St. Mary's Hospital will include a surgical center that will add four inpatient and four outpatient surgical rooms and create a larger recovery room. A gastroenterology laboratory and laser treatment room will also be added. These additions will enable Carondelet Health Care to continue to meet the healthcare needs of the citizens of Southern Arizona.

Because of the location chosen for the new outpatient center, a new chapel will need to be constructed and many of the furnishings of the soon to be displaced St. Catherine's Chapel will be used in the construction of the new chapel.

### **Carondelet's Urgent Response**

The Sisters of St. Joseph of Carondelet are still responding to the healthcare challenges of the community. To meet the growing needs of the southern Arizona community, Carondelet Health Care has committed to two exciting and important capital projects. For Carondelet St. Joseph's Hospital a commitment has been made to reconstruct the maternity facilities to create a new Labor, Delivery, Recovery, and Post Partum (LDRP) Program. At Carondelet St. Mary's Hospital, a commitment has been made to construct an entirely new Comprehensive Outpatient Rehabilitation Facility (CORF) and Outpatient Surgery Center.

Carondelet St. Joseph's Hospital and Carondelet St. Mary's Hospital serve distinct communities. The physicians are, for the most part, geographically divided between the two hospitals with less than 10 percent of the active physicians practicing at both. Despite these differences, both hospitals are managed with the same commitment to quality and excellence and are governed by a single board of directors.

To meet the growing need for outpatient services on the west side of Tucson, Carondelet Health Care has chosen to construct an outpatient facility on the campus of Carondelet St. Mary's Hospital. The facility will be the:

#### 1) Comprehensive Outpatient Rehabilitation Facility (CORF)

Carondelet Health Care is the primary provider of rehabilitation services in Tucson and southern Arizona.

While Carondelet St. Mary's Hospital was the first accredited rehabilitation center in Tucson, it has, over the last 50 years, performed these services through traditional inpatient facilities. In effect, the outpatient services are "fit in" around inpatient operations, lacking adequate space and equipment to meet patient needs.

CORF will create the only comprehensive rehabilitation location in southern Arizona. It will be Medicare certified. It will be located on the first floor of a two story building located next to the hospital. Included as part of the Comprehensive Outpatient Rehabilitation Facility will be

Physical Therapy, Occupational Therapy, Speech-Language-Hearing, and Psychological Counseling Services.

The Comprehensive Outpatient Rehabilitation Facility (CORF) will create a center where the treatment plan for each patient's physical therapy, occupational therapy, and speech therapy will be coordinated and managed together, instead of separately.

CORF will also expand Carondelet's rehabilitation programming to include clinics to treat chronic diseases such as Multiple Sclerosis and arthritis. CORF will also create an Educational Resource and Technology Center where patients can borrow rehabilitation equipment and receive education on their particular condition and treatment program.

The major difference between the new and the old is the comprehensive nature of CORF. Currently, other rehabilitation facilities for other hospitals are spread throughout the medical center campus' or even the community. The problem this creates is fairly obvious. People who seek rehabilitation services (for treatment of stroke, head and spinal cord injuries in particular) need to attend one area for speech therapy another area, often outside the hospital, for physical therapy, and a third area if they need occupational therapy.

The rehabilitation services of Carondelet Health Care are perhaps its finest example of commitment to maximizing the quality of a patients life and lifestyle.

What good does it do a patient, and in turn society, if we save the lives of stroke victims, heart attack victims, car accident victims, and, by the very act of saving their life, we condemn these people to a life of uselessness and limitations to the point where they are reliant on other people for the basics of life such as eating, drinking, personal hygiene, and other functions we take for granted each day?

Rehabilitation services are good for the patient and the community as well. Experience shows that every year one in twelve Arizona workers is involved in an occupational injury and, on average, 19 work days are lost for each injury.

Perhaps most impressive is the fact that a single dollar spent on rehabilitation saves up to \$30 in disability payments.

The CORF will focus on new approaches in therapy utilizing specially designed spaces and equipment including:

- the addition of biofeedback capabilities
- aquatic therapy
- a fully equipped apartment for those who will need to relearn the basics of living.
- The CORF will consist of a variety of therapy programs that will encompass the therapy needs of virtually every patient. The CORF has been designed to optimally meet the goals of comprehensive rehabilitation. It will include:
- a state-of-the-art speech-language-hearing clinic with three separate speech therapy treatment rooms

- an aquatic therapy area to provide an alternative environment for exercise to benefit patients with special needs.
- a large, fully carpeted conjoint occupational and physical therapy room.
- a "work hardening" clinic where specialized work injury management programs will be designed to provide services to major employers.
- individual treatment rooms for physical and occupational therapy with specialized areas for orthopedic and manual therapy, splinting and cognitive evaluation.
- an area for specialty team programs utilizing coordinated interdisciplinary approaches for arthritis, strokes, brain injuries and other disabilities.
- whirlpools for hydro-therapy
- a fully equipped apartment for those people who will need to relearn the very basics of living such as cooking, cleaning, etc.
- rooms for group and individual psychological counseling with a state of the art biofeedback program.
- community education and resource center with accommodations for support groups and seminars.
- "noisy" area for patients who need "work hardening" involving heavy equipment or shop-type trade skills.
- a technology center with loaner adaptive equipment for the physically challenged.

Perhaps the greatest benefit to the community is that the CORF is one of the few improvements in medical treatment that will offer better efficiency and service at lower costs.

Additionally, beginning in 1992, the United States Congress has mandated, through the American Disabilities Act, that all businesses must accommodate physically-challenged employees. Carondelet Health Care, through its rehabilitation services, will offer to southern Arizona's employers services that will enable the employers to be in compliance with this act.

In essence, the CORF will provide southern Arizona residents with a rehabilitation center that can accommodate, in one location, all the tools necessary to fully rehabilitate all patients to their fullest potential.

As part of Carondelet's commitment to outpatient care, plans also include construction of a new Outpatient Surgical Center which will add four inpatient and four outpatient surgical rooms, enlarge the recovery room, and add a gastroenterology laboratory and laser treatment room.

## 2) The Labor, Delivery, Recovery and Post-Partum (LDRP) Program

The opportunities at Carondelet St. Joseph's Hospital are primarily family oriented. Carondelet Health Care, in large part because of the Catholic mission of the Sisters of St. Joseph of Carondelet, is committed to providing an alternative birthing facility for Carondelet's traditional market.

Meeting the expectations of our patients and their families and efficiency of service and staff are the guiding principles behind Carondelet St. Joseph's new LDRP concept. Under the LDRP program, the entire maternity experience takes place in one room with one or two nurses

throughout. This concept allows the mother and family to avoid the inefficiency and inconvenience of being moved from room to room during the birthing process. The entire process (labor, delivery, recovery, and post-partum) is done in the same room, which allows for more time for the new mother and family to learn about the care of their new baby.

Each room is especially designed to create a comfortable and relaxing home-like atmosphere with the latest in technology. Included in the rooms are television/VCR's for the family to use with special educational videotapes supplied by the hospital. This concept combines the comforts of home with the medical technology and safety of the hospital environment.

During fiscal year 1988-89, Carondelet St. Joseph's hospital provided obstetrical services for 2,200 Tucson families. Over the last several years, families selecting the services of St. Joseph's have grown from an average of 60 to over 200 deliveries per month. The need for these services will continue to grow over the years until Carondelet may not be able to provide maternity services to all members of the community regardless of their ability to pay without expansion.

Carondelet St. Joseph's provides comprehensive high technology services as well as family centered care. These service include 24 hour coverage by anesthesiologists, neonatologists, perinatologists, neonatal nurse practitioners and clinicians, and a highly advanced special care nursery.

To continue to provide this quality service, the administration and boards of Carondelet have chosen to convert two wings of its Obstetrical Unit into 25 LDRP rooms to meet growing needs. The Labor Delivery Recovery Post-Partum (LDRP) concept provides for a reduction in the cost of delivery and care of newborn babies. By cross-training the nursing staff the family receives the full attention of their own personal nurse and support staff. The cost is further contained due to the fact that, under the LDRP concept, more deliveries can be handled in the same amount of physical space.

For example, under the current delivery system, St. Joseph's is delivering about 2,200 babies per year. Under the LDRP concept, approximately 3,400 newborns can be delivered with a minimum increase in hospital staff and no increase in square footage. In essence, the family and baby benefit from the closer experience and the community will have additional resources available to them through contained costs.

### **Program Financing**

The cost of constructing the LDRP at Carondelet St. Joseph's Hospital will be paid through the Foundation for St. Joseph's Hospital, a non-profit organization which raises funds for the hospital.

The primary funding for the construction of St. Mary's Outpatient Facility will be a bond issue of approximately \$20,000,000. This bond issue will cover the 80% of the cost of constructing 1) a two-story building consisting of the CORF (first floor) and physician's offices (second floor), 2) a 500 car parking structure for Carondelet St. Mary's Hospital, and 3) an Outpatient Surgery Wing adjacent to Carondelet St. Mary's Hospital. St. Mary's Second Century Foundation will

raise an additional \$2.4 million to cover the cost of equipping the CORF and building a new chapel.

Both foundations have combined efforts to launch a \$5,000,000 fund raising campaign. The funds raised will be spent as follows:

- Comprehensive Outpatient Rehab. Facility Equipment \$1,900,000
- Construction of New Chapel \$ 400,000
- Renovation and Construction of LDRP \$1,900,000
- Creation of Endowment for Carondelet St. Mary's Hospital \$ 350,000
- Creation of Endowment for Carondelet St. Joseph's Hospital \$ 350,000

### **A Special Financial Appeal**

Carondelet Health Care, through the Foundations of the two hospitals, has chosen to launch a \$5,000,000 capital campaign to support construction of the LDRP and purchase necessary equipment for CORF and the Outpatient Surgical Center.. From June, 1990 through June, 1991, executives of Carondelet Health Care and the trustees of the foundations have conducted in-depth planning and study to determine both the necessity and feasibility of conducting a successful campaign.

The feasibility of raising the money was studied. Detailed meetings and interviews were held with community, corporate, business, foundation, and government leaders. Much care and planning went into whether a campaign for Carondelet could succeed. Many obstacles needed to be overcome including a slowdown in the southern Arizona economy, the competition for charitable dollars, and the lack of major, capital fund raising experience on the part of Carondelet Health Care.

# CCI Project and Campaign Fact Sheet

Date: \_\_\_\_\_

Name of Organization: \_\_\_\_\_ Year Est: \_\_\_\_\_

Contact person/title: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

## Health Care Information

	Year _____	Year _____	Year _____
Patient Visits	_____	_____	_____
Unduplicated Visits	_____	_____	_____
Patient Mix:	Medicare _____ %	Non-paying _____ %	
	Medicaid _____ %	Insured/private pay _____ %	

## Architectural Plans

Project costs are based on what level of architectural plans:  
(check one)

<input type="checkbox"/> Conceptual	Date was/will be completed (mo./yr.) _____
<input type="checkbox"/> Schematic	_____
<input type="checkbox"/> Design Development	_____
<input type="checkbox"/> Construction Documents	_____

If multiple contracts are involved, please provide a schedule for each component.

## LEED certification (if applicable)

Date registered with U.S. Green Buildings Council for LEED Certification: \_\_\_\_\_ mo./yr.

Check level of LEED Certification planned:

<input type="checkbox"/> Certified
<input type="checkbox"/> Silver
<input type="checkbox"/> Gold
<input type="checkbox"/> Platinum

## Funds Available (as of April 1, 2007)

Show only formal commitments.

Private funds (amounts >\$1000 only)

Staff/trustees	\$ _____
Businesses/Corps.	\$ _____
Individuals/Families	\$ _____
Foundations	\$ _____
Other	\$ _____
_____	\$ _____
Government	\$ _____
Long-term financing	\$ _____
Equity	\$ _____
Other (identify):	\$ _____
_____	\$ _____
Other (identify):	\$ _____
_____	\$ _____
<b>Total Funds Available</b>	\$ _____
<b>Balance Remaining</b>	\$ _____

## Project Timetables

General construction contract was/will be signed:	_____ mo./yr.
Project start:	_____
Project completion:	_____
Building purchase:	_____
Land purchase:	_____
Equipment purchase:	_____
<b>Regulatory Approvals</b>	_____ mo./yr.
Zoning:	_____
Certificate of Need:	_____
Historic Preservation:	_____
Environmental Impact:	_____
Other (identify):	_____
_____	_____
Fundraising for private gifts began (date):	_____
Date of formal commitment of loan issue (date):	_____

## Please list all foundations and corporations and detail the status of the request in the appropriate column:

Name of Organization	Amount Committed	Amount of Pending Request	Amount Targeted
(e.g.) ABC Foundation	\$125,000		
(e.g.) XYZ Corporation		\$250,000	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Estimated Capital Campaign Expenses: Sample Template					
Campaign Length (Number of Years, Dates):				4	
Campaign Goal:					
Total Project Cost:					
<b>Salaried Personnel</b>		FTE	Annual	# of Years	Total
Executive Director		10%		4	
Director of Development		85%		4	
Campaign Associate		50%		3	
Subtotal Salaries					
Fringe Benefits		26%			
<b>Subtotal Salaried Personnel</b>					
<b>Consultants</b>					
Feasibility Consultant					
Capital Campaign Counsel				2	
<b>Subtotal Consultants</b>					
<b>Campaign Materials</b>					
Design and Printing				3	
Postage and Mail Services				2	
Architectural Drawings					
Electronic Materials					
<b>Subtotal Campaign Materials</b>					
<b>Hospitality and Travel</b>					
Meetings				3	
Food and other Hospitality				3	
Travel					
<b>Subtotal Hospitality and Travel</b>					
<b>Donor Recognition</b>					
Design					
Hard Costs					
<b>Subtotal Donor Recognition</b>					
<b>Database</b>					
Software					
Training & Troubleshooting contract				3	
<b>Subtotal Database</b>					
<b>Subtotal Campaign Costs</b>					
<b>Overhead (office expenses)</b>		10%			
<b>TOTAL CAMPAIGN COSTS</b>					
Cost of Campaign as percentage of Goal (Note: Usually 12-15% of Campaign Goal)					%

SAMPLE Phased Sources & Uses of Funds (with insured tax-exempt bonds)						
Phase I: Predevelopment/Start Capital Campaign - January 2002-February 2005						
Phase II: Closing of Tax-Exempt Bond Issuance - February 2005						
Phase III: Construction - March 2005-May 2006						
Phase IV: Move-In and End Capital Campaign - June 2006				1/02--2/05	2/05	3/05--5/06
						6/06
			<b>Total</b>	<b>Phase I</b>	<b>Phase II</b>	<b>Phase III</b>
						<b>Phase IV</b>
<b>SOURCES OF FUNDS</b>						
INTERIM LOANS:						
Predevelopment Loan		400,000		400,000		
Bridge Loan against Capital Campaign		500,000			500,000	
Subtotal Loans		900,000		400,000	500,000	-
PERMANENT FUNDING:						
Organizational Equity		250,000		150,000		100,000
Capital Campaign		1,750,000		162,832	1,087,168	500,000
Tax Exempt Bonds		8,000,000			8,000,000	
Subtotal Permanent Funding		10,000,000		312,832	9,087,168	100,000
<b>TOTAL SOURCES WITH LOANS</b>		<b>10,900,000</b>		<b>712,832</b>	<b>9,587,168</b>	<b>100,000</b>
<b>USES OF FUNDS</b>						
LAND						
Land Cost		419,877		25,000	394,877	
Taxes		14,421			14,421	
Off site improvements		11,800			11,800	
Subtotal Land		446,098		25,000	421,098	-
PREDEVELOPMENT						
Architectural Contract		443,675		393,675		50,000
Survey and Engineering		3,139		3,139		
Appraisal Costs		9,418		9,418		
Interest: Predevelopment loan		24,000		24,000		
Legal/Broker/Title Fees		3,924		3,924		
Environmental and Soils Reports		10,595		10,595		
Interior Design Costs		25,443		25,443		
Subtotal Predevelopment		520,194		470,194	-	50,000
NEW CONSTRUCTION						
Site Work		138,281				138,281
Structures		4,316,095				4,316,095
General Requirements		356,350				356,350
Contractor Overhead		133,631				133,631
Contractor Profit		133,631				133,631
Subtotal New Construction Costs		5,077,988		-	-	5,077,988
Construction Contingency	10%	507,799				507,799
Subtotal New Construction		5,585,787		-	-	5,585,787
CONSTRUCTION RELATED						
Construction insurance		98,102				98,102
Permits and Fees		68,672				68,672
Construction testing		25,507				25,507
Developer fee		220,000				220,000
Construction manager		21,190				21,190
Subtotal Construction Related		433,471		-	-	433,471
FINANCING COSTS						
Costs of Issuance		354,500			354,500	
Lender Certification and Inspection fee		32,000			32,000	
Upfront Insurance premium		533,718			533,718	
Subtotal Financing Costs		920,218		-	920,218	-
OTHER						
Furniture, fixtures & equipment		301,480				301,480
Moving costs		15,000				15,000
Capital Campaign Costs		312,175		156,088		156,088
Soft cost contingency		35,000		11,550	11,550	11,900
Subtotal Other		663,655		167,638	11,550	469,468
<b>TOTAL USES</b>		<b>8,569,423</b>		<b>662,832</b>	<b>1,352,866</b>	<b>6,538,725</b>
FUNDED RESERVES						
Debt Service Reserve Fund		605,577			605,577	
Capitalized Interest (20 months)		800,000			800,000	
Repairs/Maintenance Reserves		25,000				25,000
Subtotal Funded Reserves		1,430,577		-	1,405,577	-
<b>TOTAL USES WITH FUNDED RESERVES</b>		<b>10,000,000</b>		<b>662,832</b>	<b>2,758,443</b>	<b>6,538,725</b>
LOAN REPAYMENTS						
Predevelopment Loan		400,000		50,000	350,000	
Bridge loan against capital campaign receipts		500,000				500,000
Subtotal Loan Repayments		900,000		50,000	350,000	-
<b>TOTAL USES WITH LOAN REPAYMENTS</b>		<b>10,900,000</b>		<b>712,832</b>	<b>3,108,443</b>	<b>6,538,725</b>
<b>SURPLUS/(DEFICIT)</b>		<b>-</b>		<b>-</b>	<b>6,478,725</b>	<b>(6,438,725)</b>
Starting cash		-		-	-	6,478,725
Ending cash		-		-	6,478,725	40,000

**\*SAMPLE\***  
**INTEGRATED CAPITAL PROJECT CALENDAR**

		Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Jun-08	Sep-08	Dec-08	Mar-09
<b>Design &amp; Construction; Collaborations</b>																				
Task Name	Duration	Start	Finish																	
Obtain use permit	1 day	Start of project	3/1/2007																	
Collaborative housing partner applies for tax credits	1 month	3/1/2007	3/31/2007																	
Finalize and sign revised MOU	1 day	3/1/2007	4/5/2007																	
Complete schematic drawings	6 months	4/15/2007	10/15/2007																	
Design Development Drawings	6 weeks	5/15/2007	6/30/2007																	
Contractor RFQ and Selection	1 week	7/1/2007	7/7/2007																	
Construction contract negotiation and sign	1 week	7/8/2007	7/15/2007																	
Cost estimate finalized	4 months	11/1/2007	3/1/2008																	
Construction documents	1 month	11/15/2007	12/15/2007																	
Hire interior design consultant for FF&E	6 weeks	11/15/2007	12/31/2007																	
GMP Contract	6 weeks	12/1/2007	1/15/2008																	
Construction bids	3 months	12/1/2007	2/29/2008																	
Permit processing	1 day	3/1/2008	3/1/2008																	
<b>Groundbreaking</b>	1 year	3/1/2008	3/1/2009																	
Construction period	3 weeks	6/1/2008	6/21/2008																	
Begin design and purchase of FF&E																				
<b>Short Term &amp; Long Term Financing</b>																				
Task Name	Duration	Start	Finish																	
Determine initial sources & uses and update numbers ongoing	Start of project	Start of project																		
Retain underwriter and Hire bond and corporate counsel	Start of project	Start of project																		
Finalize structure & borrower issues with Lender/Credit Enhancer and bond counsel	Start of project	Start of project																		
Feasibility study	3 months	1/1/2007	3/31/2007																	
Obtain short term predevelopment loan	4 weeks	2/1/2007	2/28/2007																	
Prepare application to Lender/Credit Enhancer	4 weeks	3/1/2007	3/31/2007																	
Select issuer, prepare and submit application	1 month	4/1/2007	4/30/2007																	
Submit application to Lender/Credit Enhancer	1 day	4/30/2007	4/30/2007																	
Select additional financing team members	1 month	5/1/2007	5/31/2007																	
Identify bridge financing source and apply	1 month	8/1/2007	8/31/2007																	
TEFRA hearing	1 day	9/5/2007	9/5/2007																	
Meet with construction team re: lender needs	2 weeks	9/15/2007	9/30/2007																	
Complete appraisal	1 day	10/15/2007	10/15/2007																	
Lender Loan Committee	3 weeks	10/7/2007	10/31/2007																	
Bond Document process begins	1 day	11/15/2007	...																	
Due Diligence and board resolution	1 month	11/15/2007	12/15/2007																	
Close bridge financing	1 day	3/15/2008	3/15/2008																	
CLOSE PERMANENT FINANCING	1 day	3/20/2008	3/20/2008																	
Trustee disbursements ongoing	ongoing	3/1/2008	...																	
<b>Capital Campaign</b>																				
Task Name	Duration	Start	Finish																	
Hire campaign consultant	Start of project	Start of project																		
Determine campaign plan; create gift chart; identify prospects ongoing	Start of project	Start of project																		
Finalize case statement and foundation proposal boilerplate	2 months	1/1/2007	2/28/2007																	
Hire campaign support staff	ongoing	1/1/2007	...																	
Submit capital campaign proposals to foundations and corporations	2 days	3/14/2007	3/15/2007																	
Meet with Board Development Committee	6 weeks	4/1/2007	5/15/2007																	
Form capital campaign committee	ongoing	5/1/2007	...																	
Capital campaign committee meetings	1 week	5/15/2007	5/22/2007																	
Complete collaterals for individual campaign	1 day	6/1/2007	...																	
Planning, prospecting and cultivation of individuals begins	ongoing	10/1/2007	...																	
Active solicitations to individuals through May 2009	1 month	10/1/2007	10/31/2007																	
Apply to Kresge (if appropriate) for March docket	6 weeks	2/1/2008	3/15/2008																	
Form Art committee for purchase of artworks	16 months	3/1/2008	6/30/2009																	
Kresge Challenge period	1 day	3/15/2008	3/15/2008																	
Public kick-off	1 month	3/1/2008	3/31/2008																	
Finalize naming opportunities	16 months	3/1/2008	6/30/2009																	
Continue found/coop. fundraising for bldg & art to 6/30/09	16 months	3/1/2008	6/30/2009																	
Continue ind. donor soliciting for bldg & art to 6/30/09	1 day	5/15/2009	5/15/2009																	
Complete donor wall	1 day	6/30/2009	6/30/2009																	
Meet Kresge Challenge	1 day	6/30/2009	6/30/2009																	
End campaign	1 day	6/30/2009	6/30/2009																	

**\*\* NOTE: This is a sample calendar and does not include all required activities for any given project. It is provided ONLY as one example of how to integrate different kinds of activities in one calendar. Adapted from Integrated Capital Project Calendar by © Capital Incubator - <http://www.capitalincubator.org>**

# MARIA GITIN & ASSOCIATES

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## **Communications Materials and Policy Checklist**

**Maria Gitin, CFRE**

### **Priority campaign materials**

1. Comprehensive case statement with talking points
2. Proposal templates for foundation grants and corporate giving programs
3. Fundraising brochure and remittance envelope with giving & recognition levels
4. Website with donation information if support systems are available

### **Fundraising Policies**

We recommend taking an inventory of current policies and prioritizing ones needed as part of the Campaign Plan. Consultants can provide models and orientation towards use, however human resources and legal advisors should review prior to adoption.

#### Fund Development Policies may include:

Authority for Fund Development (who can raise funds, how, what channels?)

Management of Fund Raising Activity

Public Solicitation procedures

Gift Acceptance policies

Gift Processing procedures

Gift Acknowledgement procedures

Honors and Recognition policy

Corporate Contributions policy (including types of corporations not allowed to contribute)

Other Financial Policies may include:

Budget Policies (some groups for example have a zero based budget policy, or a no-deficit policy)

Contract and Grants Administration

Accounting policies and procedures including legal responsibilities for reporting

Planned Giving program policies

Investment and Endowment policy

MARIA GITIN  
  
 ASSOCIATES

**Donor Expectations: Preparing the Organization for Philanthropy**

Philanthropists from private foundations, individuals and corporations have different expectations and needs than funders of government contracts or payers of fees for service, membership and admissions. Successful fund development rests almost entirely on three elements in this priority order:

1. **Values Match.** The donor/funder believes in the cause/need and the way the organization meets needs and matches donors values.
2. **Relationships.** Donors seek identification and affiliation with the organization, through individual staff, board members, community leaders and other donors/funders.
3. **Strategies.** Each funder/donor group has different interests, requirements and preferred methods of solicitation. Strategies and materials must be tailored appropriately.

**Community and Private Foundations expect:**

- Applications for funding that demonstrate understanding of the purpose of the project and document how it fits within funder criteria.
- Grant applications that meet guidelines, timelines, formats and standards with all elements in their specific required formats.
- Transparency, accountability, timely reports on use of funds and requests for any changes in use.
- Documented evidence of outcomes, often by external evaluation consultants
- Grant developers will attend grant application workshops, ask questions, stay in contact before, during and after the grant and respond to requests for revisions promptly.

**Corporate and Business Contributors / Sponsors Expect:**

- Evidence that the organization knows their business, giving interests and capacities, guidelines and deadlines
- Concise, professional presentation of a case for support that indicates how and why their involvement is important
- Significant, public professional quality market exposure and recognition

**Major Donors expect:**

- Quick, accurate and timely information, attractively and clearly presented
- An approach that demonstrates that the solicitor understands them, their needs, interests and capacities

- Easy access to top leaders
- Opportunity to network with peers, people they respect and want to build relationships with
- Interactive experiences, "high touch" /connection with an organization
- Behind the scenes, 'insider' information
- Appropriate recognition and generally, more recognition at higher giving levels
- Knowing and hearing from peers that the group they give to is well run, respected
- Annual reports and access to quality audits from a respected regional firm
- Control over acknowledgement, use of their name and how often they are contacted and in what form

**Community Donors expect:**

- Integrity, good reputation 'on the street' and in the media
- To see where their money goes, direct impacts
- Access to agency leaders with accurate and timely information
- Opportunities to volunteer and meet other people they like and respect
- Collaborative spirit and actions that 'enlarge the pie', bring more funds to the community
- Culturally appropriate, enjoyable, affordable ways to participate in fundraising
- To be valued, appreciated and thanked in ways that are meaningful

**Internet Donors expect:**

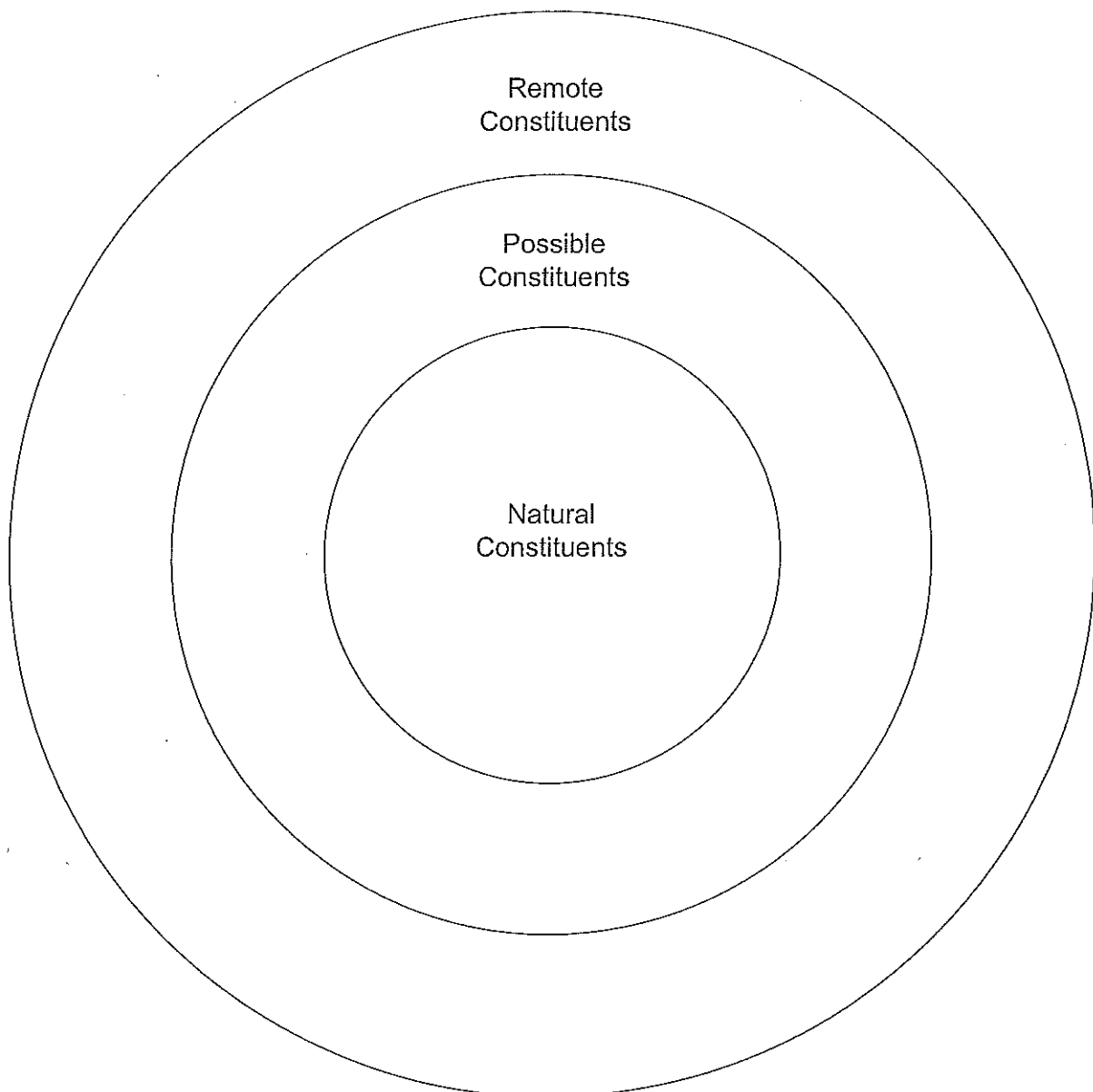
- Accurate, timely and personally tailored information
- Ability to opt in or out of various mailings and services
- Easy to use and guaranteed privacy donation options
- Immediate, personalized acknowledgement and receipts
- Frequent updates, changes in messages and images

Maria Gitin, Certified Fund Raising Executive  
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## Prospect Worksheet

- Natural Constituents:** Current funders, current and former staff and board, former clients, alumni, vendors and others touched by your institution in a personal way
- Possible Constituents:** Businesses, civic, ethnic, faith based groups, donors to similar causes
- Remote Constituents:** People with no current connection to but with known interest in your kind of health clinics and a history of philanthropy



## Capital Campaign Gift Charts

The format for these two Gift Charts are adapted from The Kresge Foundation's required Gift Charts. They are both excellent tools to track the progress of your campaign and to use in proposals and reports to donors.

Name of Organization \_\_\_\_\_

Date of Report \_\_\_\_\_

### Scale of Gifts by Size Range

Gift Ranges	Number of Prospects and Total Campaign Dollar Goals		Gifts Received Including Formal Written Pledges		Balance of Prospects and Balance of Dollars to Raise	
	Number	Dollars	Number	Dollars	Number	Dollars
\$300,000 or greater					0	0
\$100,000 - 299,999					0	0
\$50,000 - 99,999					0	0
\$25,000 - 49,999					0	0
\$10,000 - 24,999					0	0
\$5,000 - 9,999					0	0
\$1,000 - 4,999					0	0
\$500 - 999					0	0
Less than \$500					0	0
Government Sources					0	0
Long Term Debt Financing					0	0
Organization's Funds					0	0
<b>TOTALS</b>	0	0	0	0	0	0

### Gifts by Source

Donor Category	Number of Prospects and Total Campaign Dollar Goals		Gifts Received including Formal Written Pledges		Balance of Prospects and Balance of Dollars to Raise	
	Number	Dollars	Number	Dollars	Number	Dollars
Trustees					0	0
Staff					0	0
Corporations					0	0
Individuals					0	0
Foundations					0	0
Government					0	0
Long Term Debt Financing					0	0
Organization's Funds					0	0
Bequests					0	0
Other:					0	0
Other:					0	0
<b>TOTALS</b>	0	0	0	0	0	0

The Totals of the *Scale of Gifts by Size Range* and the *Gifts by Source* should equate.

The development of this tool was funded by the Community Clinics Initiative, a joint project of the Tides Foundation and The California Endowment.

Adapted by Capital Incubator from The Kresge Foundation Gift Charts

M A R I A G I T I N  
&  
A S S O C I A T E S

**MODEL CAPITAL CAMPAIGN GIFT CHARTS**

<b>TRADITIONAL CAMPAIGN \$3,000,000 Goal</b>				
<b>Advance Campaign</b>	<b>Range</b>	<b># of Gifts</b>	<b># of Prospects</b>	<b>Amount</b>
Lead Gift	300,000 & over	1	4	300,000
Strategic Gifts	250,000 & over	2	8	500,000
	100,000 & over	3	12	300,000
Major Gifts	50,000 & over	6	18	300,000
	25,000 & over	18	36	450,000
	10,000 & over	40	80	450,000
				2,250,000
<b>Community-Wide Campaign</b>				
Named Campaign	10,000 & under	25-30	100+	250,000
General Gifts	1,000 & under	500	500-1000	500,000
				750,000
<b>Total</b>				<b>\$3,000,000</b>

**Lead Gift** Public funding or foundations, people with strong identification with project and capacity to give, desire for permanent and significant commemoration.

**Strategic Gifts** Individuals, corporations and foundations that traditionally support this type of project in this range. Have a positive relationship with the institution and cause.

**Major Gifts** Individuals, businesses and smaller foundations that can be cultivated.

**Named Gifts** \*Naming opportunities for this range may be in the form of a donor wall, tiles or plaques whereas larger gifts permit naming of rooms, features, areas and gardens. Gifts generally solicited in person, smaller ones by mail or telephone and at events.

**General** Individuals contacted through mail, phone, special events, media and mass appeal fund drives, online solicitation and special events.

*Traditional campaigns begin with the lead gift, gift of land or building, or with prospect for a challenge grant for 30% or more of the goal. Advance Gifts, usually 50%+ of the goal, are secured before public announcement of the campaign.*

## Chart for Small Population or Non-Traditional Regional Campaign

CONTEMPORARY CAMPAIGN GIFT CHART - \$3,000,000 Goal				
\$3,000,000 Goal				
Advance	Gift Range	# of Gifts	# of Prospects	Total
Lead Gift	300,000 & over	3	9	900,000
Strategic Gifts	250,000-299,000	4	8	1,000,000
	100,000-249,000	3	9	300,000
				(2,200,000)
Major Gifts	50,000 & over	3	12	150,000
	25,000 & over	10	40	400,000
	10,000 & over	10	40	100,000
				(650,000)
<b>Community Campaign</b>				
Named Campaign*	Under 10,000	10	100 +	150,000
Community Gifts	Under 1,000	500	2000	100,000
				(150,000)
			<b>Total</b>	<b>\$3,000,000</b>

**Lead Gifts** Same sources, although more likely to be foundation and public funding rather than individuals. May require multiple asks or grants rather than pledges.

**Strategic Gifts** Often secured in advance of public campaign. Individuals, smaller foundation grants, individuals who like to invest in community. It is essential to offer significant naming opportunities along with a solid business plan including the entire project budget which is likely to include loans or other financing.

The remaining categories are the same as in a traditional campaign. The biggest difference is that there needs to be more lead money and from more sources. Confidence in success will build after the lead gifts are secured, equaling 30% of goal. In some communities, the campaign may need to be announced before lead gifts are secured, in order to attract lead donors.

*This information is based on material from the University of Indiana Fund Raising School and the experience of Maria Gitin, Certified Fundraising Executive (CFRE), Maria Gitin & Associates © 2003*  
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**Sample Press Release**

FOR IMMEDIATE RELEASE  
Friday, October 14, 2005

CONTACT: Name  
Phone #

**Highland Hospital Kicks off \$10 Million Capital Campaign**

Rochester, NY -- Highland Hospital announced today a five-year \$10 million capital campaign to better serve the Rochester community by expanding and renovating its Emergency Department. The Capital Campaign will also enable Highland to upgrade patient floors and invest in new innovative equipment throughout the hospital. So far, \$5.4 million has been raised toward the capital campaign.

Highland's Emergency Department, last updated in 1975, is the fastest growing emergency department in the region. It has experienced a significant growth in patient visits of more than 67 percent over the past six years. Last year, more than 27,000 patients visited Highland's emergency department. Construction is expected to begin in 2006 and be completed by 2008.

Virginia Cornyn, co-chair of the Highland Hospital Capital Campaign, says the Capital Campaign is vital for Highland Hospital to continue serving patients in the Rochester community.

"Highland has demonstrated a strong financial performance for six consecutive years. We are very pleased with Highland's overall performance. However, it is not enough to fund the additional improvements we need to make to continue to accommodate the growing patient volume. The Capital Campaign will provide us with the funds to make the necessary equipment and facility upgrades that are needed at Highland," Cornyn said.

Highland's Capital Campaign is off to a great start thanks to a \$3 million dollar grant from New York State. The money was secured earlier this year for the Highland Emergency Department expansion project by New York State Senator Joe Robach and Assemblywoman Susan John.

All of the new design features of the Emergency Department are focused on providing efficient, high quality care to patients. Highlights of the new Emergency Department include:

- Expanding the ED from 7,000 square feet to 16,751 square feet.
- Renovating 14,842 square feet of the hospital.
- New construction of 1,909 square feet.
- Expanding from 18 beds to 25 beds.

The new design of the Emergency Department includes a central nursing station, new, state-of-the-art information system, a trauma room, gynecological room, decontamination room, a treat-and-release area and a private family room.

John Hilmi, M.D., medical director of the Emergency Department, says all of these improvements will help patient flow and reduce wait times.

"Central workstations for staff will move them closer to their patients and new, innovative technology will allow us to monitor the status of test results from the lab. These new enhancements will greatly improve the delivery of emergency medicine and help save lives," Dr. Hilmi said.

For more than 115 years, Highland Hospital has provided innovative, high quality patient care for the Rochester community. Today, Highland is a 261-licensed acute care bed facility known for its comprehensive women's services, nationally ranked geriatrics program, the Evarts Joint Center, regional leading gastric bypass program and extensive network of primary care physicians.

For more media inquiries, contact John Turner at (*contact information*).

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