2010

Characteristics of Fundraising for Nonprofit Hospital Organizations

Cathleen Owens Erwin
University of Alabama at Birmingham

CHARACTERISTICS OF FUNDRAISING FOR NONPROFIT HOSPITAL ORGANIZATIONS

by

CATHLEEN OWENS ERWIN

S. ROBERT HERNANDEZ, COMMITTEE CHAIR
JEFFREY H. BURKHARDT
PETER M. GINTER
THOMAS L. POWERS
RICHARD M. SHEWCHUK

A DISSERTATION

Submitted to the graduate faculty of The University of Alabama at Birmingham
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy

BIRMINGHAM, ALABAMA
2010

CHARACTERISTICS OF FUNDRAISING FOR
NONPROFIT HOSPITAL ORGANIZATIONS

CATHLEEN OWENS ERWIN

ADMINISTRATION – HEALTH SERVICES

ABSTRACT

This study addresses a gap that has been noted in the charitable fundraising literature, which is a scarcity of theoretically-based studies of fundraising by nonprofit organizations and the need to study fundraising within sub-sectors of organizations rather than the full nonprofit sector. The study uses institutional theory and strategic management constructs to examine the characteristics of the fundraising operations of nonprofit organizations. A categorization scheme is created based on nonprofit organizational effectiveness and performance characteristics to analyze fundraising by nonprofit hospital organizations as an organizational field. The categorization scheme identifies distinct clusters of organizations that are then investigated to determine if there are differences between them on the basis of structure (configuration and staffing), maturity (endowment status) and legitimacy (level of corporate and foundation support). Results indicate three distinct clusters that can be differentiated on staffing, maturity, corporate and foundation support but not on configuration. Profiles are then developed to characterize the three groups of organizations.

DEDICATION

This dissertation is dedicated to the people who have made a difference in my life and have lived this experience with me.

To my husband, Jeff, who is my biggest fan and is the love of my life. I cannot fathom having accomplished this without his support. I am truly the luckiest woman alive to have such a wonderful husband that always picks up the slack for me and never complains.

To my stepchildren, Blake, Tyler and Victoria, who are such a great source of joy and inspiration for me. I'm so thankful that you are a part of my life, and I hope that you will always pursue your dreams.

To the Owens family who has supported me in every endeavor I've ever undertaken. Thank you for your love and for listening to me during the stressful times I've encountered during this process. And, no Dad, I'm not going to law school after this.

To my closest friends and support network who have encouraged me when I was down, given me great advice along the way, and have celebrated every little victory with me.

To the great teachers that I've had the opportunity to study with and to the leaders that I've served under who have inspired me to embrace lifelong learning and to pursue my goals.

ACKNOWLEDGEMENTS

I want to acknowledge the University of Alabama at Birmingham for the extraordinary opportunity to pursue a doctoral degree while employed in the School of Health Professions. I would especially like to thank Dr. Harold Jones, Dean of the School of Health Professions, for his tremendous support and encouragement. I owe him a debt of gratitude not only for his support but also for teaching me so much about academe during the nine years that I worked for him. I would also like to acknowledge the late Dr. Kenneth E. Burke, Associate Vice President for Development at UAB for his support as well. Dr. Burke always showed a real interest in my studies, and I truly missed his guidance as I completed my dissertation.

I am eternally grateful to my dissertation committee including Dr. S. Robert Hernandez (Chair), Dr. Jeffrey Burkhardt, Dr. Pete Ginter, Dr. Richard Shewchuk, and Dr. Thomas Powers. Thank you for the time and effort you invested in me, and for your endless patience as I worked on my dissertation. Each of you has had a profound impact upon me as a doctoral student and as a colleague, and serves as a role model for my career as an academician.

I also want to thank the Association for Healthcare Philanthropy for generously allowing me to utilize the AHP membership survey data. Thanks also go to Dr. Michael Sherman with Association Research, Inc. for providing me with the dataset and being available to answer questions throughout this process.

Finally, I want to acknowledge my colleagues in the School of Health Professions, especially in the Dean's Office and in the Department of Health Services Administration, and my fellow doctoral students. I cannot begin to name all of the individuals who invested time and energy by listening, advising and cheering me on as I made this journey. Thank you for helping me to reach my goal!!

TABLE OF CONTENTS

Page

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS

AHP	Association for Healthcare Philanthropy
ANOVA	analysis of variance
FTE	full time employee
GDP	gross domestic product
LTC	long-term care
MIMNOE	Multidimensional and Integrated Model of Nonprofit Organizational Effectiveness
NPO	nonprofit organization
OEP	organizational effectiveness and performance

CHAPTER 1

INTRODUCTION

The purpose of this dissertation is to investigate the fundraising characteristics of nonprofit organizations. Specifically, organizations that participate in the same fundraising professional association will be examined to determine if there are distinct groupings within the sub-sector based on organizational effectiveness and performance characteristics. If distinct groups exist within these organizations, the groups will be further examined to determine if there are differences between them in terms of structure, legitimacy and maturity. The organizations that will be used for this study are in the nonprofit healthcare sector in the United States; the organizations are acute care hospitals and hospital foundations that are members of the Association of Healthcare Philanthropy.

Background

As the recognition of the importance of the nonprofit sector to the nation's economy has grown, so has the amount of empirical research on the strategic management of nonprofit organizations (Stone, Bigelow, and Crittenden, 1999; Stone and Crittenden, 1993). The growth of the nonprofit sector has brought about an increased scrutiny by the public and news media and a call for accountability among nonprofit organizations (Salamon, 1996). The need for competent leadership and strategic

management for nonprofit organizations has become widely acknowledged (Stone, Bigelow, and Crittenden, 1999; Bryson, 1995; Nutt & Backoff, 1992, 1993).

As Pfeffer and Salancik (1978) stated simply, "The key to organizational survival is the ability to acquire and maintain resources." For the nonprofit organization, charitable contributions of time, money and materials are the defining source of revenue although contributions may not be the principal or the largest source of revenue (Moore, 2000). Some organizations depend upon charitable donations as the principal source of revenue that is used to fund its operation, including both administrative and programmatic costs. Others acquire charitable donations for current program uses, endowments or capital projects in addition to generating revenue through fee for services, government contracts, and other sources.

Research on philanthropic fundraising has been growing, particularly since 1985 when a research agenda was proposed by Carbone (1986) as a part of a seminar involving academe and professionals from the field. The three major streams of research in fundraising set forth in Carbone's agenda include the philanthropic environment, specifically donor motivation; the work and careers of fundraisers; and the management of fundraising (Lindahl and Conley, 2002). Since that time, high quality studies have been conducted that have begun to provide much needed substantive, objective research to a field characterized by the casual acceptance of anecdotal evidence (Lindahl and Conley, 2002). Much of the research has been focused on donor motivation, with significantly less empirical research examining the strategic management of fundraising. It has been noted that one particular need is for organizational studies focusing on the manner in which fundraising efforts are structured and managed (Carbone, 1986).

According to Drucker (1978), managing a nonprofit organization is more difficult than running a profit-making organization. For many nonprofits, fundraising is one of the most troublesome aspects of management (Oster, 1995). This is due in part to increasing competition among nonprofits, a lack of enthusiasm for fundraising among executive directors and board members, and the light it sheds on the struggle over the mission and future direction of the organization that is often exacerbated by the various stakeholder groups (Oster, 1995; Pfeffer and Salancik, 1974). It is also difficult for nonprofit managers to determine how much of their resources should be allocated toward fund-raising activities (Thornton, 2006).

Institutional theory predicts that when there is uncertainty about the methods for achieving outcomes or when outcomes are difficult to measure, organizations are likely to focus on adopting a set of institutionalized beliefs or procedures to increase their legitimacy, resources and survival capabilities (Herman and Renz, 2008; DiMaggio and Powell, 1983; Meyer and Rowan, 1977). As organizations adopt institutionalized processes they become more similar. This propensity for organizations to begin to resemble each other is labeled as "isomorphism," which was defined by Hawley (1968) as "a constraining process that forces one unit in a population to resemble other units that face the same set of environmental conditions."

One mechanism through which nonprofit managers may seek to inform their strategic management decisions is through a social network such as a professional trade association. Trade associations often provide capacity and performance benchmarking information as well as professional development opportunities to improve and inform the management of fundraising for nonprofit organizations. According to institutional theory,

the network of contacts among organizations or their agents within a field drives organizations toward isomorphism (Moch and Seashore, 1981; Zucker, 1987; Galasckiewicz & Wasserman, 1989; Mizruchi, 1990; Galaskiewicz and Burt, 1991).

In their extensive review of the nonprofit organizational effectiveness literature, Herman and Renz (2008) noted that one of the major theses that emerged was the usefulness and, most likely, the necessity to differentiate among different types of nonprofit organizations when examining issues of nonprofit organizational effectiveness because of the heterogeneity among nonprofit organizations. This finding is consistent both with Weber's (1994) conclusion that the best comparisons are within-group comparisons that focus on organizations that are truly similar in important ways, and with the concept of the "organizational field" that is central to institutional theory (Scott, 1987, 1995). Across the nonprofit sector, organizations resemble each other in terms of their non-distribution constraint, but have been found to vary widely in terms of their different fields of activities. In a study of variations in overhead and fundraising efficiency, Hager, Pollack and Rooney (2001) found that organizations in different sub-sectors of the nonprofit sector exhibited different levels of efficiency. They concluded that generalized comparisons could not be made across the nonprofit sector, and that it would be more useful to further reduce the nonprofit sector to the sub-sectors of organizations that operate in similar industries.

Nonprofit healthcare organizations comprise an important sub-sector of nonprofit organizations, and are an attractive topic for researchers for numerous reasons (Gray and Clement, 2002). Nonprofit hospitals often have a significant economic impact on local communities as one of the largest employers; within the nonprofit sector, health care

organizations generate nearly sixty percent of total revenue among charitable organizations; and these organizations are a major component of an industry that accounts for about one seventh of the U.S. economy (Blackwood, Wing and Pollack, 2008; Gray and Clement, 2002). The topic of the role of charitable contributions for the nonprofit hospital has become more frequently discussed in scholarly and trade publications over the past few years. Some have suggested that charitable contributions are increasing in importance as a means for enhancing financial resources in an environment characterized by rising costs, shrinking reimbursements, and limited access to capital (Egger, 2000; Cleverley and Cleverley, 2005; Hall, 2005; Haderlin, 2006a, 2006b; Swayne, Duncan and Ginter, 2006; McGinly, 2008). The strategic role of fundraising has become a more frequent topic among hospital executives and boards; more hospital organizations are incorporating explicit expectations for fundraising into their financial planning, and now consider charitable donations as a "need to have" rather than a "nice to have" (Haderlin, 2006a, 2006b).

Study Purpose and Research Questions

The purpose of this study is to examine the characteristics of fundraising for nonprofit hospital organizations. The research questions to be explored are:

1. What are the performance characteristics of the fundraising operations of nonprofit hospital organizations?
2. Are there distinct groupings of nonprofit hospital organizations based on the performance characteristics of their fundraising operations?

3. Are there differences between distinct groups of nonprofit hospital organizations based upon the configuration of the fundraising operation in relation to the hospital organization?
4. Are there differences between distinct groups of nonprofit hospital organizations based upon the maturity of the organizations as defined by the adoption of an advanced administrative technology?
5. Are there differences between distinct groups of nonprofit hospital organizations based upon the legitimacy of the organizations as evidenced by the prevalence of particular types of donors?

The research questions will be examined utilizing data from an existing database of responses to an annual survey conducted by the Association for Healthcare Philanthropy (AHP) of its membership. Survey data from the years 2003 through 2007 will be used. The AHP is a not-for-profit international professional organization which has a membership of approximately 5,000 healthcare fundraising professionals representing more than 2,200 health care facilities in the United States and Canada (AHP, 2009). Members come from all aspects and levels of health care fundraising, including executive directors and chief development officers, major gifts officers, annual fund campaign managers, event coordinators, and grant writers, among others.

Assumptions

Because nonprofit organizations are a vital component of the economy in terms of delivering needed services and are dependent upon charitable contributions as a source of

revenue, it is logical to presume that management of the fundraising operation is of importance to nonprofit organization leaders and donors. In order to survive, nonprofit organizations must seek support from numerous external, and sometimes internal, constituencies (Crittenden, 2000; Bryson, 1989; Hatten, 1982). Therefore the broad constituency base results in accountability expectations from stakeholders (Crittenden, 2000; McDonald, 1997; Tassie, Murray, Cutt & Bragg, 1996). According to institutional theory, organizations in an organizational field will resemble each other as the organizational field matures and as the organizations conforms to the norms of the field. It is logical to presume that nonprofit organizations will have similar fundraising structure and performance, particularly organizations in the same nonprofit sub-sector who participate in some sort of formal network with like organizations. Further, organizations within an institutionalized field will become more similar as they develop through stages of the organizational lifecycle, the dynamics of which can be captured using a maturity model. Maturity models consist of a set of features and related set of levels or stages for each feature (Schuh and Leviton, 2006; Lesgold, 2003), and do not constitute a value judgment that more mature organizations are better than organizations that are less mature according to a particular maturity model (Schuh and Leviton, 2006).

These assumptions are supported theoretically by institutional theory and with findings in the nonprofit organizational effectiveness and performance (OEP) and organizational lifecycle literature.

Significance of the Study

The study addresses a gap that has been noted in the charitable fundraising literature, which is the scarcity of theoretically-based studies of the management of fundraising by nonprofit organizations. The study uses institutional theory and strategic management constructs to examine the characteristics of the fundraising operations of nonprofit organizations. It also extends previous fundraising management research as suggested to a specific subsector of organizations within the nonprofit sector. Previous studies have concluded that measures of fundraising management vary widely across the nonprofit sector and are best studied in nonprofit organizations that are similar in context. This study examines fundraising within a specific context, which is the nonprofit hospital organization, and explores the extent of similarities and differences in fundraising characteristics among the organizations in this specific sub-sector.

The study seeks to determine if there are distinct groupings or clusters of nonprofit hospital organizations based upon the performance characteristics of their fundraising operations. And, if so, if there are differences between these groups in terms of their structural characteristics or the level of maturity and legitimacy of the organizations as evidenced by the existence of a particular sophisticated fundraising mechanism and the presence of certain types of donors. In addition to testing the ability of institutional theory to predict organizational behavior, the study seeks to identify a classification scheme based upon fundraising performance characteristics and to construct a maturity model specific to the fundraising operations of nonprofit organizations.

This dissertation also provides an overview of the strategic management, organizational theory, organizational lifecycle and nonprofit organizational effectiveness literature that can inform research in fundraising management for nonprofit organizations. Results from the study will not only advance the academic literature but will also be relevant to the strategic management of nonprofit organizations. The study will provide information to educate and assist those responsible for the strategic management of fundraising for nonprofit organizations as well as to their boards and other organizational leadership. In the case of hospital foundations, this would include not only the top leadership team of the foundation and its board but also the board and executive leaders of the parent hospital organization.

Definitions and Key Terms

Isomorphism. Isomorphism is a key concept found in institutional theory that refers to the phenomenon of organizations becoming more similar in terms of structure, culture and outputs as a result of economic, social and cultural pressures and processes.

Nonprofit organization. A 501(c)(3) publicly-supported charity that is organized and operated exclusively for exempt purposes as set forth by the Internal Revenue Service (IRS), which includes charitable, religious, educational, scientific, literary, testing for public safety, fostering national or international amateur sports competition, and preventing cruelty to children or animals. Organizations, such as hospital foundations, are classified as a publicly-supported charity because they exist to support a nonprofit hospital. For the purpose of this dissertation, this does not include organizations classified as 501(c)(3) private foundations, which are organizations that typically have

one source of funding (e.g., single family or corporation) and exist primarily to provide grants to other charitable organizations and to individuals.

Fundraising. In the context of this dissertation, the term "fundraising" refers specifically to efforts to raise philanthropic support for nonprofit charitable organizations.

Not-for-profit hospital. The term "not-for-profit" is used interchangeably with the term "nonprofit" when referring to nonprofit hospital organizations with the IRS 501(c)(3) designation. This term more closely identifies these organizations in contrast to "for-profit" hospitals.

Fundraising unit. The unit or entity responsible for the fundraising efforts for a nonprofit organization. In the case of acute care hospitals this may be done through a hospital foundation or through an internal department or division of the hospital.

Hospital foundation. A 501(c)(3) organization that actively functions in close relationship to one or more existing not-for-profit hospitals. It is considered a non-private foundation, and therefore is not required to distribute a set percentage of its earnings each year which distinguishes it from private foundations. Non-private foundations must submit required documentation to the IRS to verify that it meets requirements for being excluded from the private foundation designation.

Plan of Work

Chapter One has presented an introduction to the topic as well as the purpose and research questions for the study. Background information on the problem and discussions of the assumptions and significance of the study were also provided. Chapter Two will review literature on institutional theory, organizational life cycle, organizational

effectiveness and performance, and philanthropic fundraising. It will also provide pertinent information on the nonprofit sector and nonprofit hospital institutions. Chapter Three discusses the research design and methodology. This discussion includes a description of the hypotheses, the study population, the source of the data, the variables and their measures, and the statistical modeling procedures used for the analysis. Chapter Four outlines the data and variable manipulation that was performed and presents the results of the analysis, which includes descriptive statistics of the not-for-profit healthcare organizations included in the sample. Chapter Five will contain a summary of the results and the conclusion, as well as a discussion of limitations and suggestions for future research.

CHAPTER 2

LITERATURE REVIEW

Introduction

This chapter reviews literature relevant to the proposed research study. First, the theoretical framework of institutional theory is discussed along with a review of literature of findings that are pertinent to the study, including the influence of normative and mimetic pressures within an organizational field that contribute to isomorphism. This is followed by a review of the literature for the key concepts of organizational lifecycle, organizational effectiveness and performance, and philanthropic fundraising. Finally, background information is provided for both the nonprofit sector and the sub-sector of nonprofit healthcare organizations.

Institutional Theory

Institutional theory has its origins in sociology and the concept of humans developing shared realities over time through social interaction (Berger and Luckmann, 1967). Meyer and Rowan (1977) further developed this concept in their seminal article that focused on the relationship of the organization to its external environment and the roles of formal structures in organizations. Institutional theory views the firm as being embedded in or influenced by an external environment (Corcoran & Shackman, 2007). Institutions face environments that are characterized by external norms, rules and

requirements that an organization must adopt in order to receive legitimacy and support (Alexander & Amburgey, 1987; Meyer & Scott, 1983; Scott, 1987; Shortell & Kaluzny, 2000). Institutional environments emphasize rewarding organizations for having structures and processes that conform to the environment (Shortell & Kaluzny, 2000). This conformance is sometimes termed "isomorphism" and occurs when organizations that face similar environmental forces and circumstances begin to resemble one another (DiMaggio & Powell, 1983; Fennel & Alexander, 1987). This conformance may explain what sometimes can appear to be irrational behavior from an efficiency standpoint (Meyer & Rowan, 1977). DiMaggio and Powell (1983) described this phenomenon as the "iron cage" that imprisons organizations in the same organizational field who choose to conform.

Environmental forces and/or actors may exert three types of pressures on an organization: (1) coercive (2) normative and (3) mimetic (DiMaggio and Powell, 1983). These pressures can be applied through regulation, including federal and state laws; through normative standards that dictate how an organization should behave; and through social recognition (Scott, 1995; Wells & Banaszak-Holl, 2000). DiMaggio and Powell (1983) identified the nation-state and professional organizations as the primary shapers of the contemporary institutional forms.

Coercive pressures occur in environments where there are agents in the sector or field who have enough power or authority to impose structural forms and practices on subordinate units (Scott, 1987). Pressures of this type can be seen in the imposition of structure through legislation and laws of the nation or state and in structural changes imposed upon existing or newly acquired subsidiaries by a corporation.

Normative pressures arise from professional standards and the influence of professional communities on organizational characteristics (Ashworth, Boyne and Delbridge, 2007). Norms are conveyed through the education and training of professionals and certification processes by accrediting bodies. Greenwood, Suddaby and Hinings (2002) suggested three reasons for the importance of professional associations: 1) they are arenas through which organizations interact and collectively represent themselves including establishing boundaries, membership and behavior, 2) they act as a means for representing themselves to others in the field, and 3) they can play a role in monitoring compliance with normatively or coercively sanctioned expectations. Professional associations are most often cited as serving a conservative role as a mechanism of reproduction (D'Aunno, Sutton, and Price, 1991; Oliver, 1997), but it has been noted that they may also become vehicles for the promotion of change or reform within a field (Greenwood, Suddaby, and Hinings, 2002).

Mimetic pressures result in an organization emulating or "mimicking" other organizations' activities, structures or systems, especially under conditions of uncertainty and when the characteristics are deemed to enhance legitimacy (Ashworth, Boyne and Delbridge, 2007). This may explain the adoption of management practices that have not been empirically proven to benefit performance, but that may be the fad or fashion of the time (Abrahamson, 1996). Organizations mimic others because they expect to achieve similar benefits, which could be legitimacy and/or economic benefits (Greenwood, Suddaby, and Hinings, 2002).

Central to institutional theory is the concept of the organizational field, which has been defined as "organizations that, in aggregate, constitute a recognized area of

institutional life" (DiMaggio and Powell, 1983). DiMaggio and Powell (1983) proposed that the process by which a field (a group of similar organizations, like hospital foundations) becomes organized involves four stages: 1) an increase in the extent of interaction among organizations within the field; 2) the emergence of well-defined patterns of hierarchy and control; 3) an increase in the information that members in the field have to contend; and 4) the development of an awareness among members in the field that they are involved in a common enterprise (Ashworth, et. al, 2007; DiMaggio and Powell, 1983). It is expected that organizational fields will have institutional logics upon which their organizing principles are based (Freidland and Alford, 1991). The more mature an organizational field, the more heavily "structurated" it will be by institutional norms and rules (DiMaggio and Powell, 1991). Structuration, however, doesn't signify that boundaries or behaviors are rigidly fixed or that the boundaries or behaviors are perfectly reproduced across the organizational field (Ranson, Hinings, and Greenwood, 1980; Goodrick and Salancik, 1996).

In the nonprofit organization literature, institutional theory has been used in studies that focus on the legitimacy of NPOs (e.g., Abzug & Galaskiewicz, 2001; O'Regan, 2001). Abzug and Galaskiewicz (2001) utilized institutional theory to explain how NPOs appear to be particularly susceptible to legitimacy demands of changing environments, and that nonprofit boards often serve the institutional purpose of affording legitimacy to the organization. Cao (2004) utilized institutional theory in a study of organizations in China and the adoption of merit-based reward and sanctioning practices from the West, and in a comparison of the levels of meritocracy in NPOs, government, joint ventures and indigenous private firms.

Institutional theory has been used as a framework for examining organizational change resulting from the influence of regulatory agencies and professional associations. Townley (2002) examined the influence of professional associations on the introduction of business planning and performance measures from the private sector into the public sector, specifically Canadian museums. Greenwood, Suddaby, and Hinings (2002) also examined the role of the professional association as a regulatory agent that helps theorize organizational change in a highly institutionalized field (public accounting) by hosting the process of discourse through which changes are debated and endorsed as well as through facilitating the reframing of professional identities. It has been used to show how macro-level factors affect donor behavior in the nonprofit sector (Barman, 2007), and the impact of competitive grant funding on public sector nonprofit volunteer organizations (Dolnicar, Irvine, & Lazarevski, 2008).

Institutional theory has been applied in the health care context in studies of innovation development (Van de Ven & Garud, 1994), efficacy of factors such as philanthropy and association membership as indicators of professional dominance within the industry (Scott, Ruef, Mendel & Caronna, 2000), the adoption of total quality management (Zinn, Weech, & Brannon, 1998), motives for providing uncompensated care (Rosko, 2004), hospital provision of prevention and wellness services as a response to community health concerns (Proenca, Rosko, & Zinn, 2003), adoption and institutionalization of organizational innovation (Levinson et al., 2002), knowledge creation strategies resulting from isomorphic pressures (Yang, Fang, and Huang, 2007), and the financial performance of hospitals in a health system or network (Bazzoli, Chan, Shortell, & D'Aunno, 2000).

A unique contribution of institutional theory is its emphasis on how cultural understandings shape the emergence and evolution of new populations of organizations (Meyer & Rowan, 1977; Wells, 2001) and why organizational populations evolve across different markets (Tolbert & Zucker, 1996). In the healthcare literature, institutional theory has been used to explain the effect of market size and regional characteristics on the emergence of new health care organizational forms (Begun & Luke, 2001). In their study of building legitimacy for health networks, Provan, Lamb and Doyle (2004) state that health care organizations typically must be far more responsive than other business organizations to their institutional environment. Wells (2001) proposed that institutional theory is especially well-suited for the study of health care organizations because their technical effectiveness is not always easily evaluated, and thus other actors' rely on the organizations' compliance to norms regarding structure and behavior. Those organizations that comply are deemed legitimate and gain critical resources.

This study extends the use of institutional theory to research at a functional-level of strategic management of nonprofit organizations and, specifically, to the context of the nonprofit hospital organization.

Organizational Life Cycle

Institutionalization is an organic process through which an organization matures from being newly-formed into becoming an institution that has achieved legitimacy in the estimation of its stakeholder communities (Selznick, 1957; Scott, 1987). Studies of organizational life cycle have yielded a variety of maturity models of stages along the life span of organizations. Maturity models are used to capture the dynamics along the

organizational life cycle. A maturity model consists of a set of features and related set of levels or stages for each feature (Schuh and Leviton, 2006; Lesgold, 2003).

Maturity models can be developed for different sets or different numbers of features, and do not constitute a value judgment that more mature organizations are better than organizations that are less mature according to a particular maturity model (Schuh and Leviton, 2006). Organizations labeled as more or less mature in one area, may be found at a different level for another feature. Organizational development doesn't constitute that an organization is "better" or "worse" (Schuh and Leviton, 2006).

Maturity models have been used to develop a framework for assessing the development and capacity for nonprofit organizations. Organizational capacity can be defined as the ability to successfully implement and complete a new project or to successfully expand an existing one (Schuh and Leviton, 2006). It consists of two dimensions, individual expertise and organizational resources, that when enhanced or are more fully developed can improve an organization's ability to successfully implement programs (Letts, Ryan, and Grossman, 1999). Five features have been found to help determine the maturation of nonprofit organizations. These features include governance, financial resources, organizational development (i.e., structuration and differentiation), internal operations and core services (Schuh and Leviton, 2006).

Generally the organizational life cycle consists of four or five stages, which are often summarized as startup, emerging growth, maturity, revival, and decline (Miller and Friesen, 1984; Kimberly and Miles, 1980). According to Miller and Friesen (1984) the birth stage represents the period when a firm is attempting to become a viable entity, and is characterized by young firms that are simple, have informal structures and are

dominated by their owner/leader. The emerging growth stage is the period in which a firm has established its distinct competencies and enjoyed some initial success, and has adopted a functionally-based structure, delegated some authority to middle managers and formalized procedures. The maturity stage occurs when sales stabilize, level of innovation diminishes and a more bureaucratic organizational structure is established. Revival is characterized by diversification and expansion of the firm, and is a period when firms adopt more divisionalized structures for the first time as they face more complex and heterogeneous markets. This stage is associated with more sophisticated planning systems. The decline stage occurs when profitability drops as markets dry up as do the firms within the market.

Organizational life cycle theorists have predicted that within each stage, organizations will exhibit certain differences from other stages in terms of four variables: environment or situation, strategy, structure and decision-making methods (Miller and Friesen, 1984). In their longitudinal study of the corporate life cycle, Miller and Friesen (1984) found evidence to support the assumption of homogeneity within each stage and differences between stages. They also tested another assumption that organizations would tend to move along the lifecycle in a linear fashion, but did not find that organizations go through the stages in the same sequence.

Understanding the dynamics of the organizational lifecycle can assist human service organizations to formulate effective strategies, design adaptive structure and design responsive service delivery systems in the face of turbulent environments (Hasenfeld and Schmid, 1989). Criteria for the evaluation of effectiveness should vary with the organizational life cycle stage (Cameron and Whetten, 1981) and managers

should probably change their priorities as their organizations move through stages of the lifecycle (Smith, Mitchell and Summer, 1985).

Nonprofit Organizational Effectiveness and Performance

At the very core of both strategic management and organizational theory is organizational effectiveness and performance (OEP) (Baruch and Ramalho, 2006). The most frequently used and obvious approach to defining organizational effectiveness is to ask "to what extent does an organization reach its goals" (Herman and Renz, 1999). However, much of the literature on organizational effectiveness has focused on the development of and modification to the goal model (Herman and Renz, 1999). Herman and Renz (1999) note that it might be argued that the proliferation of academic debate about organizational effectiveness is of no real consequence because in the "real world" managers and investors uses simple measures like bottom-line profit to gauge the performance of the business. However, evidence does show that business managers do not rely on singular measures, but have developed many measures of business performance that take multiple goals and indicators into account (Meyer and Gupta, 1994).

In their comprehensive review of the OEP literature, Baruch and Ramalho (2006) analyzed the way in which academic studies measured organizational outcomes that are commonly reported as either organizational effectiveness or organizational performance. They contend that OEP is considered the ultimate variable for use in organizational empirical studies. OEP has been studied largely in the for-profit realm, but there are also many studies focusing on the nonprofit sector. Nonprofit organizations do not have a

goal of generating profits, but do have financial concerns and can make profits that may be reinvested in the organization (Henderson, Chase & Woodson, 2002; Mellon, 1998; Sandler & Hudson, 1998). Whether for-profit or nonprofit, OEP is about measuring the magnitude of the effect or impact the organization has on the object that is being analyzed, whether that is the employee, the competition, the community, the market or society at large (Baruch and Ramalho, 2006).

Organizational effectiveness research is plagued by controversy, including debates over the primary factors that should be used to constitute OEP as well as debates over the validity of measuring the construct (Sowa, Selden, and Sandofort, 2004). It has been said that there are as many models as there are studies of OEP (Herman and Renz, 1999). Nine theses have been identified by Herman and Renz (2008) in the general literature on OEP and the specialized literature on nonprofit organizational effectiveness, updating Herman and Renz's (1999) earlier work outlining six theses. These include:

- *Nonprofit OEP is always a matter of comparison;*
- *Nonprofit OPE is multidimensional;*
- *Boards of directors make a difference in the effectiveness of NPOs, but how they do is not clear;*
- *More effective NPOs are more likely to use correct management practices;*
- *Nonprofit OEP is a social construction;*
- *It is unlikely that there are any universally applicable 'best practices' that can be prescribed for all NPO boards and management;*
- *Responsiveness is a useful overarching criterion for resolving the challenge of differing judgments of NPO effectiveness by different stakeholder groups;*
- *It is useful to differentiate between different types of NPOs in assessing the merits of different approaches to understanding nonprofit effectiveness; and*
- *Level of analysis makes a difference in understanding effectiveness, and it is important to differentiate effectiveness at the program, organization and network levels.*

OEP scholars have found that, in general, NPOs that are more effective have similar management practices and certain structures and processes that are generally

agreed upon as “best” practices in their field (Sowa, Selden and Sandfort, 2004; Herman and Renz, 1998, 1999). In their multidimensional integrated model (MIMNOE), Sowa et al. (2004) capture two dimensions of nonprofit OEP: management effectiveness and program effectiveness. Both of these dimensions are further reduced to two components: capacity (structure and processes) and outcomes (Sowa, et al., 2004).

In the MIMNOE, the term “management” refers to organizational and management characteristics that encompass variables that tap capacity (structure and outcomes) and variables that represent outcomes of management systems and activities. “Program” is used to refer to the specific services or interventions provided by an organization. One of the principles employed in the development of MINMOE is that it should allow for organizational and programmatic variations within and between nonprofit subsectors (Sowa, et al., 2004).

The assessment of organizational performance can be accomplished by establishing a set of criteria and having a variety of knowledgeable individuals provide their perceptions of the organization’s accomplishments (Brown, 2005). Criteria could be varied and might include questions covering mission and goal attainment. Using key financial performance indicators is an alternative method that can be used to assess OEP (Brown, 2005). Based upon a review of financial performance measures used to assess nonprofit organizations, Ritchie and Kolodinsky (2003) suggested three financial ratios as viable performance indicators: fundraising efficiency, public support and fiscal performance.

Chief executives and board members regard the financial condition of an organization as a significant measure of the board’s effectiveness (Herman and Renz,

2008). In a study of board and organizational performance in nonprofit organizations, Brown (2005) found organizations that were perceived to be higher performing also reported to have higher-performing boards that provide strategic contributions. The literature on nonprofit OEP includes studies of the importance of top executives to financial performance. The intuitive style of nonprofit organization chief executives was tested to determine if there is a relationship with financial performance (Ritchie, Kolodinsky, and Eastwood, 2007). Ritchie et al. (2007) found executive intuition to be a significant and positive predictor of nonprofit financial performance.

The relationship between strategic process elements, funding and financial performance has been studied by Crittenden (2000) within the context of nonprofit social service organizations. The study found that financially successful organizations shared some strategic management attributes, including focused offerings, financial acumen, a marketing orientation, and diversification. Further, organizations that were less financially successful were similar in lacking some key strategic attributes, including weaknesses in strategy formulation and implementation. A tool that can be used by organizations to gauge their effectiveness is benchmarking measures from their organizational field. Benchmarking uses measures of comparative performance to help develop an understanding of what is possible. Performance benchmarking is a tool that can provide nonprofit organization managers with information to allocate human resources and program capital in order to maximize fundraising productivity (Smith, 2005).

Philanthropic Fundraising

Fundraising is a management function that is unique to the nonprofit organization (Burlingame, 1997). Fundraising and board-executive relations are seen by NPO chief executives as two crucial elements of NPO management (Herman and Heimovics, 1989). The term "fundraising" can be broadly defined to include political fundraising and raising capital for business ventures (Lindahl and Conley, 2002). In the context of this study, fundraising refers only to efforts to raise philanthropic support for nonprofit charitable organizations. Fundraising is a vibrant, innovative and highly professional industry (Andreoni, 1998). Fundraising for the nonprofit organization is focused on developing relationships between donor constituencies and the NPO that result in ongoing support, matching the interests of the donors with the mission and needs of the organization.

Terminology varies in describing or labeling the fundraising function of an NPO, including terms such as development and advancement. Regardless of what term is used, the key to fundraising success is relationship building (Burlingame, 1997). NPOs use a mix of internal capacities and external relationships to carry out fundraising (Hager, Rooney and Pollack, 2002). The use of fundraising staff is common, but much fundraising is still conducted by executive directors, volunteers and board members as well as by external entities like federated campaigns, support organizations and professional fundraising firms (Hager, Rooney and Pollack, 2002). Individuals responsible for fundraising for a NPO serve in boundary-spanning role between the organization and its environment.

In a handbook on nonprofit leadership and management, Herman and Associates (2005) write that fundraising as a management process utilizes the five activities of

classic management practice: analysis, planning, execution, control and evaluation. Effective fundraising staff are viewed as managers who ensure that discipline based on these five activities is applied to the fundraising process (Herman et al., 2005). It has been observed that nonprofits are often strongly led in terms of visionary leadership, but are under-managed (Stid and Bradach, 2009).

In their literature review on philanthropic fundraising research, Lindahl and Conley (2002) noted that high quality studies had proliferated in the sixteen years since Carbone (1986) assembled an agenda for fundraising research as a part of a scholarly conference in Washington, D.C. in 1985. They also noted that certain segments of NPOs were more involved in research than others, with higher education institutions and hospitals representing the focus of the most dollars spent on fundraising and the focus of much of the research. However, specific research focused on fundraising for hospitals was not cited in their review.

Carbone (1986) proposed a three-legged agenda for fundraising, which included the philanthropic environment, the career and work of fundraisers, and the management of fundraising. In his work to develop a theory of charitable fund raising, Andreoni (1998) noted that analysis of charitable fund raising was more frequently focused on the supply side of charity (donors) rather than the demand side (fund raisers). A wealth of research has focused on donor motivation, with most studies acknowledging that no single donor characteristic accounts for a donor's decision to give, and emphasizing a combination of psychological and sociological influences (Lindahl and Conley, 2002).

Research on the work and career of fundraisers has included studies focusing on leadership, including the role and the perceptions of the NPO chief executive officer. In a

study of presidents and chancellors of higher education institutions, Cook (1994) concluded that fundraising is a team effort, the president is typically the central player on the team, and fundraising differs from one institution to another and from one context to another. Studies have also focused on the demographic and personal characteristics of fundraising staff (e.g., Panas, 1989; Duronio and Tempel, 1997; Bila, 1991; Carbone, 1989), as well as the perceptions of fundraising staff about job performance, appraisals and rewards (Beem, 1991). In a study of compensation of fundraising officers, Hall (1999) found that although salaries in the nonprofit sector lagged behind those in the private sector, there was a growing demand for successful fundraisers and top executives and it was becoming more common to see the application of for-profit business management practices to NPOs.

The third leg of Carbone's agenda (1986) is the management of the fundraising process. This stream of research contains a broad range of studies on such topics as the comparison of different fundraising techniques and the determination of resource allocation among competing fundraising interests within a large NPO (Lindahl and Conley, 2002). Research has been conducted to determine which characteristics of the fundraising operation are most closely associated with fundraising effectiveness. The context used for these types of studies is often the higher education institution, which is understandable given the availability of data and the education and research emphasis of these institutions that enables higher education fundraising professionals to pursue doctoral education. Correlation studies have determined that institutional factors such as size of endowment, number of alumni, cost of attendance, graduate school attendance of alumni, size of school, general expenditures and fundraising expenditures correlate with

gift income (Pickett, 1977, 1982; Leslie and Ramey, 1985; and Duronio & Loessin, 1989).

Limited use of organizational and strategic management theories as a framework for the study of fundraising performance is evident. A few authors consistently introduce theoretical frameworks in their writings about fundraising. Kelly (1995, 1998) and Oster (1995, 1996) have written extensively about fundraising and fundraising management, and have integrated public relations and organizational theory into their work as a framework for understanding the nature of fundraising. However, it appears that few, if any, studies of performance explicitly integrate organizational and strategic management theories.

Research on the effectiveness and efficiency of fundraising in nonprofit organizations has included discussions of alternative methods for evaluating fundraising, including the use of simple financial ratios and adjusted performance measures (Brooks, 2004). The use of financial ratios for evaluating nonprofit financial success has a controversial history among scholars and practitioners (Brooks, 2004). The first use of financial measures in predictive modeling and performance evaluation appears to have begun with the work of Tuckman and Chang (1991) (Greenlee & Trussel, 2000; Hager, 2001; Brooks 2004). Some of the criticism of the use of financial ratios is that although easy to calculate, interpret and explain to managers and policymaker, these ratios don't necessarily reflect the effectiveness at the scale of the operations chosen by a nonprofit. It has been suggested that this type of analysis would be more informative if it was based on marginal returns (Brooks, 2004). Brooks (2004) also noted two additional criticisms found in the literature on the use of financial ratios, including the impact of differing

environment on nonprofits which limits the use of ratios in comparing NPO performance, and the lack of standardization of accounting practices among NPOs in terms of identifying the actual costs of fundraising.

The Center for Philanthropy at Indiana University along with the Urban Institute's National Center for Charitable Statistics conducted a comprehensive research project from 1994 through 2004 to study administrative and fundraising costs among nonprofit organizations (NCCS, 2009). In a working paper from the study, Hager, Pollack and Rooney (2001) reported preliminary findings that two financial efficiency measures commonly used for evaluating nonprofit organization, overhead ratio and fundraising cost ratio, vary in relationship to certain organizational characteristics. Their study focused on the organizational characteristics of size, age and nonprofit subsector, and found that there were differences among organizations based upon these factors. Larger and younger NPOs exhibited greater financial efficiencies, and efficiencies varied across different subsectors of NPOs. However, these characteristics did not account for much of the variation, and the authors concluded that other organizational and environmental characteristics could provide a better explanation for the variance and that different efficiency standards should be applied to organization sectors and types with different characteristics.

In a comprehensive effort to assess fundraising effectiveness in higher education, the Council for Advancement and Support of Education (CASE, 1990) with support from the Lily Endowment published benchmarking information for higher education institutions on the costs related to fund raising, alumni relations and other constituent relations. The study included fifty-one colleges and universities and found that among

these organizations that the fundraising efficiency was an average of sixteen cents spent for each dollar raised. The median was eleven cents, with a range from eight to sixteen cents for the middle 50 percent. Each fundraising professional was found to account for an average of $500,000 to $1.1 million in gift income, and salaries and benefits accounted for 63% of the fundraising budget accounting.

In a study of nonprofit fund raising in competitive donors markets, Thornton (2006) found that as markets become more competitive, nonprofits follow their private incentives by reducing fund-raising expenditures. He noted that this trend was important for two reasons: nonprofit firms appear to behave similarly to their for-profit counterparts, and even though per-firm fundraising expenditures decline as competition increases, aggregate fund-raising rises. Tinkelman (2004) found that typical fundraising elasticities in NPOs from seven different sectors ranged between zero and one, a result consistent with most nonprofit managers following intermediate strategies between maximizing net revenues available for program delivery and maximizing organizational size.

Fundraising performance is a component of organizational effectiveness and performance for nonprofit organizations. Fundraising performance can be difficult to evaluate because of the long delays associated with the cultivation and solicitation of gifts (Lindahl, 1994). For organizations such a hospital foundation which exist to develop resources to support a charitable organization or organizations, the effectiveness of fundraising performance is of primary importance. Fundraising is the focus of the organization's goals and therefore fundraising performance is a very important indicator of the overall organizational effectiveness and performance of the fundraising unit.

Nonprofit Sector

The nonprofit sector is growing faster than the business and government sectors (Wing, Pollack and Blackwood, 2008). Nonprofit organizations are recognized for providing services and accepting donations and grants, but they also include major employers that contract with the government and charge fees to provide many types of services, including education, health care, human services and others. Of the 1.4 million organizations registered with the IRS in 2005, over half a million collected $25,000 or more in gross receipts and were therefore required to file a Form 990. 501(c)(3) public charities and 501(c)(3) private foundations are required to register; all private foundations are required to file a Form 990-P regardless of gross receipts. Religious organizations are not required to register with the IRS, but many do so voluntarily (Giving USA, 2009).

Throughout this dissertation, the term "nonprofit organization" is used to specifically refer to organizations that are 501(c)(3) publicly-supported charities. Table 1 illustrates the dramatic growth of public charities, which includes the majority of U.S. non-profit organizations involved in the arts, education, healthcare, and human services. The number of registered 501(c)(3) public charities rose by 53% from 1995-2005, with a 56% growth in revenues and in expenses and nearly 87% growth in assets (after being adjusted for inflation) for those public charities who were required to file a Form 990. The non-profit sector is largely composed of small community-based organizations operating in resource-constrained environments (Crittenden, 2000).

Table 1
Size and Financial Scope of the Nonprofit Sector, 1995-2005

	1995	2000	2005	% change, 1995-2005	% change, 1995-2005 (inflation adjusted)
All nonprofits	1.1 million	1.3 million	1.4 million	27.3	-
Reporting nonprofits	431,567	428,154	530,376	22.9	-
Revenues ($)	802 billion	1.1 trillion	1.6 trillion	96.9	54.6
Expenses ($)	729 billion	984 billion	1.4 trillion	96.4	54.2
Assets ($)	1.5 trillion	2.4 trillion	3.4 trillion	125.6	77.1
Public charities, 501(c)(3)	572,660	690,326	876,164	53	-
Reporting public charities	187,038	245,749	310,683	66.1	
Revenues ($)	573 billion	811 billion	1.1 trillion	99.5	56.6
Expenses ($)	530 billion	731 billion	1.1 trillion	98.7	56
Assets ($)	843 billion	1.432 trillion	1.98 trillion	134.3	83.9

Source: Urban Institute, 2008[1]

Charitable giving in the United States was more than $307 billion in 2008, a 2% decrease in current dollars from 2007 (Giving USA, 2009). This marked the first decline in current dollars since 1987 and only the second recorded decline since 1956 when the Giving USA Foundation began publishing annual reports on charitable giving statistics (Giving USA, 2009). The decline in 1987 may have been precipitated by a change in the tax law in 1986 that prompted some people to "give early" in order to maximize their available deduction (Giving USA, 2009). The decline is 2008 is more likely to be attributable to the economic downturn. Charitable giving remains strong in the context of Gross Domestic Product (GDP), with estimates indicating that giving was 2.2% of GDP in 2008 and 2.3% in 2007 (Giving USA, 2009). The Giving USA (2009) annual report notes that two-thirds of public charities saw decreases in donations in 2008, with the

[1] Note: From *THE NONPROFIT SECTOR IN BRIEF Fact and Figures from the National Almanac 2008: Public Charities, Giving and Volunteering*, p. 2. Copyright 2008 by the Urban Institute. Reprinted with permission.

exception of organizations in the religion, public-society benefit and international affairs sub-sectors.

Nonprofit Hospitals

Nonprofit hospitals, which are often referred to as not-for-profit hospitals, are somewhat unique among nonprofit organizations in that they are situated in what has been termed as a "mixed-form" market, which is characterized by the co-existence of three types of providers – non-profit, for-profit and government (Marwell and McInerney, 2005; Steinberg, 1987). The topic of the role of charitable contributions for the not-for-profit hospital has become more frequently discussed in scholarly and trade publications in the past few years. Some have suggested that charitable contributions are increasing in importance as a means for enhancing financial resources in an environment characterized by rising costs, shrinking reimbursements, and limited access to capital (Egger, 2000; Cleverley and Cleverley, 2005; Hall, 2005; Haderlin, 2006; Swayne, Duncan and Ginter, 2006; McGinly, 2008). Studies show that the return on investment (ROI) from a well-run philanthropic foundation program (a common organizational structure for hospital fundraising) is often much higher than what can be achieved by a range of the hospital's standard services that constitute its core mission (Costa, 2005; Greenfield, 2005). In an survey conducted by the Healthcare Financial Management Association, hospital chief financial officers (CFOs) ranked its dependency on charitable contributions for current and future capital resources as fourth, up from six in a previous year's survey (Haderlin, 2006). CEOs indicated in 2003 that they planned to spend more

time on fundraising than they did three years before, recognizing that every dollar raised through philanthropy goes directly to the bottom line (Haderlin, 2006; HFMA, 2004).

In healthcare, it seems that change is inevitable. However, sometimes the more things change, the more they stay the same. Hospitals in the United States began primarily as religious and charitable institutions to care for the sick (Starr, 1982). Voluntary hospitals were deemed "voluntary" because they were financed by voluntary contributions rather than by taxes. Payment from patients was sought to make up the shortfall that was not covered by donations. As the cost of medical services grew and as charitable contributions diminished during the era of the Great Depression, private medical insurance and, later, public insurance programs became the dominant sources of revenue for hospitals. The government also stepped in to provide public-backed capital support for community hospital construction through the Hill-Burton Act in 1946. The introduction of private and public health insurance contributed to increased consumer demand for hospital services and to increased costs. Hospitals were reimbursed based upon the cost of providing services (Risse, 1999; Starr, 1982).

The era of financial constraints for not-for-profit hospitals began in the 1980s when reimbursements began to tighten with the introduction of the prospective payment system for Medicare. Subsequently, the Tax Reform Act of 1986 placed a cap on the amount of tax-exempt debt that states can issue to qualifying not-for-profit organizations, including hospitals (Ferris and Graddy, 1999). Since that time Medicare and Medicaid have been under pressure to control rising costs, health insurance premiums are continually on the rise as are the numbers of uninsured Americans, and hospitals have been faced with the need to make significant capital investments to stay abreast of

advancing technology and government-mandated regulations (Cleverley and Cleverley, 2005).

Organizational survival has been precarious for not-for-profit hospitals during the past twenty years in this very dynamic healthcare environment. In 2004, the Healthcare Financial Management Association reported two critical research findings for hospitals: Access to capital was tightening, and many hospitals faced significant capital needs because of rapidly aging facilities (HFMA, 2004). In a survey of U.S. hospitals conducted by Deloitte and Touche, (2006), less than two-fifths of the respondents reported a positive bottom line greater than 4%, which is a level that enables them to reinvest profits into the hospital enterprise. Twenty-nine percent reported a positive bottom line less than 3%; 14% reported breaking even; and 19% reported operating in the red (Deloitte and Touche, 2006).

It is for these reasons among others that charitable contributions have become increasingly important to the not-for-profit hospital. As noted earlier, a well-run fundraising operation can contribute much needed revenue to the bottom line of the hospital. Recently, a book examining the expanding role of health care philanthropy was published as a part of the *New Directions for Philanthropic Fundraising* series sponsored by the Center on Philanthropy at Indiana University and the Association of Fundraising Professionals. The volume discusses a number of major issues facing health care philanthropy, including the need to integrate philanthropy into the strategic initiatives and culture of the nonprofit health care organization, integrating fundraising into finance, and the need for healthcare organizations to regularly evaluate fundraising results to help forecast future income and to deliver maximum return on investment (McGinly &

Renzetti, 2005). Currently there is a lack of scholarly empirical research focusing on the management of nonprofit hospital fundraising.

Summary

This chapter reviewed literature on institutional theory, organizational lifecycle, organizational effectiveness and performance, and philanthropic fundraising. Background information for both the nonprofit sector and one of its sub-sectors, not-for-profit healthcare organizations, was also provided.

Institutional theory provides a lens through which the organization field of nonprofit hospital fundraising can be viewed. According to institutional theory, organizations in an organizational field will resemble each other as the organizational field matures and as the organizations conform to the norms of the field. Nonprofit hospitals organizations constitute an organizational field and therefore it could be assumed that the fundraising operations of those organizations should resemble each other, particularly those that actively participate in a formal network of hospital fundraising professionals. Any variability in the performance characteristics of these organizations should be related to the variance in the structure, maturity and legitimacy of organizations within the field.

Research examining the relationship between nonprofit organizational structure and performance is limited in the context of nonprofit hospital organizations. Fundraising performance is a component of nonprofit organizational effectiveness and performance. This study will develop a classification scheme using nonprofit organizational effectiveness and performance characteristics that will be used to determine if there are

distinct groups of nonprofit hospital organizations based upon the characteristics of their fundraising operations. And, if so, to determine if there are differences between these distinct groups in terms of structure, maturity and legitimacy.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

Introduction

This chapter reviews the research methodology used to empirically test the research questions outlined in the previous chapter. First, the research questions are reviewed, the constructs for the basis variables used in the clustering analysis of the organizations are discussed, and hypotheses are presented based upon the constructs of structure, maturity and legitimacy. Second, the study population and data are described. The operationalized variables used for the cluster analysis and for each of the hypotheses are then explained. Finally, the research methodology that will be used to test the hypotheses is discussed.

Research Questions

According to institutional theory, organizations in an organizational field will resemble each other as the organizational field matures and as the organizations conform to the norms of the field. If nonprofit hospitals organizations constitute an organizational field then the fundraising operations of those organizations should resemble each other, particularly those that actively participate in a formal network of hospital fundraising professionals.

The research questions that will be addressed are as follows:

1. What are the performance characteristics of the fundraising operations of nonprofit hospitals?
2. Are there distinct groupings of nonprofit hospital organizations based on the performance characteristics of their fundraising operations?
3. Are there differences between distinct groups of nonprofit hospital organizations based upon the configuration of the fundraising operation within the hospital organization?
4. Are there differences between distinct groups of nonprofit hospital organizations based upon the maturity of the organizations as defined by the adoption of an advanced administrative technology?
5. Are there differences between distinct groups of nonprofit hospital organizations based upon the legitimacy of the organizations as evidenced by the prevalence of particular types of donors?

Organizations will be clustered according to nonprofit organization effectiveness and performance measures. The groups will then be tested to determine if there are differences between and within groups in terms of structure, legitimacy and maturity as evidenced by configuration and staffing of the fundraising unit, the level of support received from corporate and foundation donors and the status of the organization's adoption of an advanced strategic administrative technology used in fundraising, which is the endowment fund. Profiles will then be developed to classify the groups according to their OEP and other characteristics. Both the clustering and classification criteria and the hypotheses for the study are based on a theoretical framework drawn from institutional

theory and the literature on organizational life cycle and NPO effectiveness and performance measures that are salient to the fundraising operation.

Hypotheses

The constructs and hypotheses used in the study are as follows.

Nonprofit Organizational Effectiveness and Performance

Nonprofit OEP can be measured in numerous ways. As discussed in the literature review, there are two dimensions of nonprofit OEP: management effectiveness and program effectiveness (Sowa, et al., 2004). The focus of this study is on management effectiveness of the fundraising operations of nonprofit organizations, and will include measures of efficiency, productivity and complexity.

Efficiency. The fundraising cost ratio (fundraising expenses/contributions) is an often used measure of efficiency of fundraising. Based upon professional and expert opinion, normative pressures associated with watchdog organizations have established the acceptable level of fundraising efficiency at .35. Mature organizations with complex and sophisticated fundraising programs could be assumed to have a lower fundraising cost ratio than less mature organizations that may have higher overhead costs because of investments being made to implement more complex fundraising programs and build its reputation among external stakeholders.

Productivity. Fundraising productivity can be measured in many ways, and is often used in order to benchmark an organization's performance either against itself as an annual evaluation or against the performance of comparable organizations. As an organization matures in its fundraising capabilities and capacity it should be able to be more productive in terms of the level of giving from donors and return on the investment made in its fundraising staff. For this study, the productivity measure of contributions raised per full-time fundraising professional has been chosen based upon its appearance in the benchmarking report provided by the Association of Healthcare Philanthropy (AHP) to its members who participate in its annual survey. A second measure of productivity that will be used is the average contribution per donor. This differs from the measure of average gift to the organization, which is a ratio of the total funds raised and the number of gifts. Because a single donor may give multiple gifts or make multiple pledge payments during the year, this study is utilizing the measure of average contribution per donor to indicate the average level of support an organization is able to cultivate from its donors.

Complexity. Complexity refers to the types of contributions and fundraising mechanisms employed by the organization. Planned giving programs are considered to be the vehicle through which donors make their most substantial and sometimes most complex gifts. Organizations that are more mature could be expected to have a more diverse portfolio of gifts that would include planned gifts because they possess a higher level of expertise in the solicitation and stewardship of such complex gifts.

H1: There are distinct groupings of nonprofit hospital organizations based on organizational effectiveness and performance characteristics of their fundraising operations.

Structure

Structure refers to the internal characteristics of an organization that can be used as a means for assessing and comparing organizations. Two structural dimensions that are appropriate to this study are configuration and staffing.

Configuration. Configuration has to do with the placement of the fundraising unit in relationship to the hospital organization. Placement of the fundraising unit varies within the nonprofit hospital industry, with some units being set up as a separate 501(c)(3) organization called a foundation and others being located within the hospital as a department or division. The foundation configuration is popular in the nonprofit hospital industry, and it can be assumed that organizations conforming to industry norms would adopt this configuration.

H2: There are differences between groups of nonprofit hospital organizations based on the configuration of the fundraising operation.

Staffing. Human resources are one of the largest investments made in a service industry like healthcare. In terms of this study, staffing refers to the number of full-time employees in the fundraising unit. As an organization matures and grows in its operations, it will begin hiring more specialized personnel to perform unique activities required by the organization. Organizations that have implemented complex and sophisticated fundraising programs could be assumed to employ a higher number of

personnel in its fundraising unit. This includes full-time fundraising professionals to handle various aspects of fundraising as well as support staff to handle more routine tasks so that the fundraising professionals can focus their time and attention on cultivation and solicitation activities.

> H3: There are differences between groups of nonprofit hospital organizations based on the level of staffing employed in the fundraising unit.

Maturity

Organizations that are more advanced in the institution-building process will have greater fundraising capabilities (Hopkins and Friedman, 1997). Nonprofit organizations evolve at different rates and in different ways; some may move quickly from birth to maturity on one issue and yet lag behind on other issues (Werther and Berman, 2001). Therefore, it has been suggested that criteria for the evaluation of effectiveness should vary with the organizational life cycle stage (Cameron and Whetten, 1981).

Werther and Berman (2001) note that the lifecycle of nonprofit organizations can be determined through two dimensions: strategic and operational. At the operational level, issues like services, funding, procedures and employee relations become more varied and complex as the organization matures. Funding evolves from being opportunistic to becoming more repetitive to finally becoming institutionalized as the organization moves along the lifecycle stages. In the early stages, organizations receive contributions in a "hit or miss" fashion then progress to more repetitive sources and finally move into a stage where funds are more or less forthcoming from reliable sources such as endowment income (Werther and Berman, 2001).

One of the more advanced administrative technologies employed in fundraising by nonprofit organizations is the endowment fund (endowment). An endowment is a permanent savings vehicle for nonprofits that affords the organization greater security for sustainability and dealing with uncertainty in cash flow. Philanthropic contributions to an endowment fund validate that donors and funders view the organization as legitimate (a permanent and stable fixture and a critical part of the community), and that the nonprofit organization is sufficiently competent to solicit and manage endowment gifts (Fisman and Hubbard, 2003). Organizations can be categorized as more or less mature based upon whether or not they have established an endowment fund.

> H4: There are differences between groups of nonprofit hospital organizations based upon the status of the adoption of an endowment fund as a fundraising technology utilized by the organization.

Legitimacy

Legitimacy is an asset that sustains the flow of resources from the environment to the institution (Hannan and Freeman, 1989). Organizations that appear stable and exhibit appropriate operating practices are more likely to be supplied with resources from its stakeholders (Parsons, 1960). For example, it has been found that the amount of money a nonprofit organization receives from corporate contributors is a function of the organization's and its fundraising staff's legitimacy or reputation among those who direct corporate gifts (Galaskiewicz and Wasserman, 1989). A nonprofit organization's image and reputation has also been found to exert a strong influence on donor behavior (Bennett and Gabriel, 2003).

Organizations that have achieved legitimacy should be more successful in obtaining a higher percentage of total contributions from corporations and foundations. Corporations and foundations are assumed to have a more formal approval process for determining entities that will both benefit from and be good stewards of the gifts than will individual donors. Thus, corporations and foundations will be more likely to direct their funds toward organizations they perceive to be more legitimate.

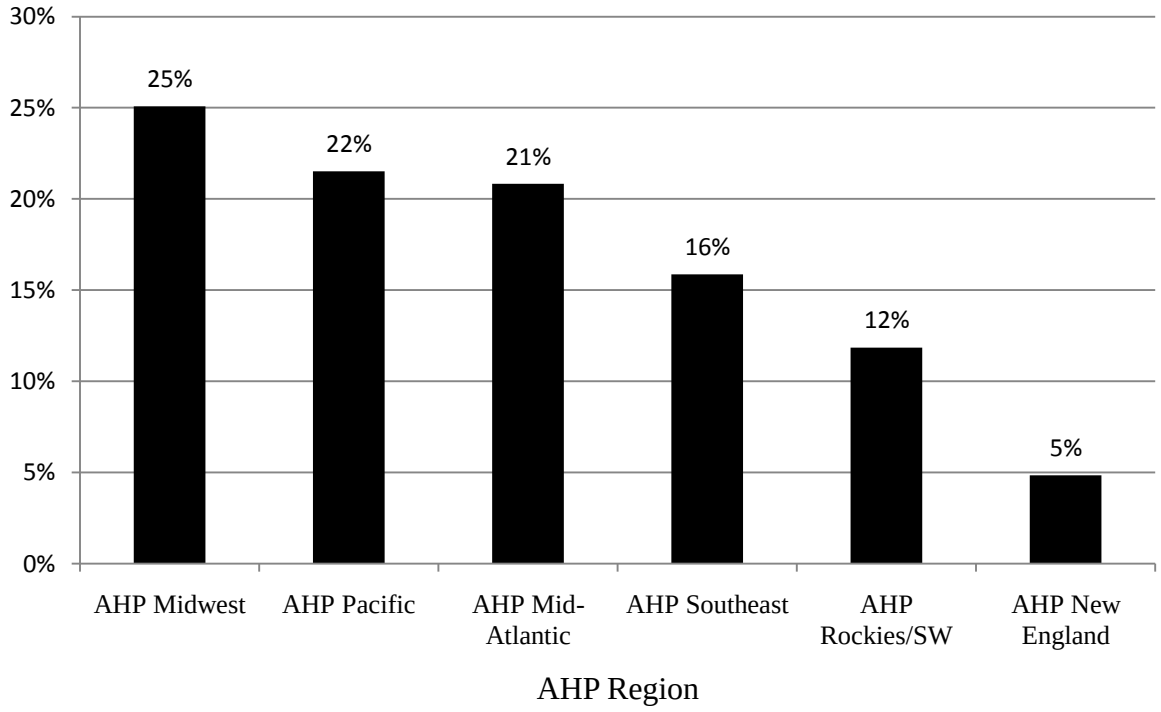
H5a: There are differences between groups of nonprofit hospital organizations based upon the level of support received from corporate donors.

H5b: There are differences between groups of nonprofit hospital organizations based upon the level of support received from foundation donors.

Study Population and Data

The research questions will be examined utilizing data from an existing database from an annual survey conducted by the Association for Healthcare Philanthropy (AHP). The AHP is a not-for-profit international professional organization which has a membership of more than 5,000 healthcare fundraising professionals representing more than 2,200 health care facilities in the United States and Canada (AHP, 2009). Members come from all aspects and levels of health care fundraising, including executive directors and chief development officers, major gifts officers, annual fund campaign managers, event coordinators, and grant writers, among others. The AHP has approximately 4,200 members in the United States, which are grouped geographically by region as illustrated in Figure 1.

Figure 1
Geographic Distribution of AHP Member Organizations in U.S.



The survey instrument includes questions about the demographics of the organizations as well as financial performance data. AHP compiles and distributes a summary report to its membership based upon the survey data. Organizations that participate have the option to disclose their identity in order to receive the complete results from the survey. Survey data drawn from multiple response years from 2003 through 2007 will be used.

According to documentation from AHP, for each of the survey years included in the study a link to a web-based questionnaire was e-mailed to AHP members at U.S. institutions by an independent survey research company that works exclusively with nonprofit organizations. Follow-up reminders were sent to non-respondents and the final response rates for useable surveys are listed in Table 2.

Table 2
AHP Survey Response Rates, 2003–2007

Survey Year	Number mailed	Useable surveys received	Response Rate
2003	1290	260	20.1%
2004	1110	291	26.2%
2005	1268	327	25.8%
2006	1199	291	24.3%
2007	1,875	460	24.5%

After examining and cleaning the data, which will be described in detail in Chapter Four, the study sample consists of 401 organizations comprised of not-for-profit acute care hospitals and foundations that exist to raise charitable contributions for an acute care hospital organization. Included among the hospitals are community hospitals, children's hospitals, academic medical centers, and public/governmental hospitals. Non-hospital healthcare organizations were excluded from the study sample.

Operationalization of the Variables

NPO Effectiveness and Performance

The following measures of efficiency, productivity and complexity will be used in the cluster analysis.

Fundraising cost ratio. The fundraising cost ratio is a measure of efficiency that calculates the amount of money an organization spends to raise one dollar in contributions. This is calculated by dividing the total funds raised (gifts plus secured pledges) by the total expenses (indirect and direct) for the fundraising unit.

Funds per Donor. The funds raised per donor is a measure of productivity that can indicate the effectiveness of the organization in cultivating financial contributions from its donors. It is calculated by dividing the total funds raised (gifts and documented pledges) by the total number of donors that gave one or more gifts to the organization.

Funds per FTE. The funds raised per full-time employee is another productivity measure that is an indication of return on investment in human resources and the effectiveness of the employees. The ratio is calculated by dividing the total funds raised (gifts and documented pledges) by the number of full time employees in the fundraising unit.

Planned Gifts. Complexity will be measured using the total funds raised (gifts and documented pledges) that are attributable to planned gift pledges secured but not paid, as reported by the organization on the survey instrument.

Structure

Structure refers to internal characteristics of the organizations that can serve as a means for comparing strategic choices the organizations have made in structuring their internal operations. Two structural measures will be used in the clustering analysis.

Configuration. The corporate structure of the fundraising unit in relation to the nonprofit hospital it serves varies among organizations. Some are configured as a separate 501(c)(3) nonprofit organization while others exist as an internal department or division of the hospital organization. The four structural configuration choices in the survey include foundation, stand-alone department, division, and other. For the study, the stand-alone department and division have been recoded to "other" reducing the variable to two categories: foundation and other. Both the stand-alone department and the division configuration can be considered as internal to the hospital organization, whereas the foundation can be considered as external or separate from the hospital organization.

Staffing. The structure of the organization in terms of staffing will be measured as the total number of full-time employees working in the fundraising unit (this includes fundraising professionals and support staff).

Maturity

Maturity models can be developed for different sets or different numbers of features, and have been used to help assess development and capacity of nonprofit organizations. Characteristics of internal operations and core services are two of the features that have been found to help determine the maturity of nonprofit organizations (Schuh and Leviton, 2006).

The status of the endowment (has an endowment v. doesn't have an endowment) will be used as a measure of maturity for the fundraising operations of the nonprofit organizations in the study. Endowments are considered to be an advanced technology used in fundraising for nonprofit organizations. Organizations that report having an endowment will be considered as being more mature than organizations that report not having an endowment.

Legitimacy

Legitimacy refers to the way that the organization is viewed by individuals and other organizations. For example, it has been found that the amount of money received by a nonprofit organization is a function of the organization's legitimacy or reputation among those who direct charitable contributions from corporations. The following variable will be used to measure legitimacy:

Corporate and Foundation gifts. The organizations in the study population report the percentage of their total charitable contributions that are attributable to corporations, foundations, and individuals. Each of these variables will be calculated as the percentage

of total contributions (gifts and pledges) received by the NPO that are attributable to corporations and to foundations.

Table 3 provides a summary of the operationalized variables that will be used in the analysis.

Table 3
Operationalized Variables

Construct	Measure
Nonprofit Effectiveness and Performance	Fundraising cost ratio (expenses/funds raised) Funds per donor (funds raised/# of donors) Funds per FTE (funds raised/# of FTEs)
Complexity	Planned gifts (% of total funds raised)
Structure	Configuration (Foundation or other) Staffing (FTEs)
Maturity	Endowment status (established, not established)
Legitimacy	Corporate support (% of total funds raised) Foundation support (% of total funds raised)

Methods of Analysis

Statistical analyses will be conducted using SPSS statistical software. Two-step cluster analysis will be used to group the organizations according to the organizational effectiveness and performance variables. Cluster analysis is a mathematical process that sorts data into groups to maximize the similarity of the observed variables within the same group and minimize the similarity of the observed variables between different groups. Cluster analysis is often used in strategic management research to identify

organizational configurations or groups of organizations that have a common profile based upon conceptually different variables (Ketchen and Shook, 1996; Meyer, Tsui, and Hinings, 1993; Miller and Mintzberg, 1989). In their meta-analysis of the use of cluster analysis in strategic management research, Ketchen and Shook (1996) note that cluster analysis has been conducted under many labels including strategic groups, organizational typologies, taxonomies and archetypes, but the underlying assumption is the same. This assumption is that "configurations represent a way to meaningfully capture the complexity of organizational reality" (Ketchen and Shook, 1996).

After the organizations are clustered, each group will be classified according to the predominant OEP characteristics. Analysis of variance (ANOVA) will be used to verify that the clusters are significantly different with respect to the means of the basis variables used to create the clusters.

Chi-square analysis will be used to determine if the clusters of organizations can be further differentiated based on the structure of the fundraising unit (foundation or other) and the status of their endowment (established v. not established). Chi-square analysis is a non-parametric technique that is ideal for data that is ranked on a nominal (categorical) scale. The chi-square test for independence will be used to determine if the clusters are related to the categorical variables of interest.

One-way between groups analysis of variance (ANOVA) will then be used to compare the mean scores of the groups to determine if there are statistically significant differences between the clusters in terms of the staffing in the fundraising unit and the levels of support received from corporations and from foundations as percentage of total funds raised. Post hoc tests will be used to determine which of the groups differ.

Descriptive statistics for all of the variables will be analyzed, and preliminary assumption testing will be conducted to check for normality, linearity, univariate and multivariate outliers, homogeneity, and multicollinearity.

Summary

The methodology used for the study was discussed in this chapter. First, the research questions and hypotheses are reviewed. The hypotheses were organized by constructs common to the study of strategic management and organizational studies. Next, the study population and data were described, and the operationalized variables were explained. Two-step cluster analysis, analysis of variance, and chi-square test for independence were identified as the primary statistical methods used to cluster the organizations and test the hypotheses.

CHAPTER 4

RESULTS AND FINDINGS

The following chapter explains the results of the analysis used to answer the research questions and hypotheses. First, a description of the data and variable manipulation is reviewed. Descriptive statistics about the respondent organizations are provided in tabular and graphical form, followed by a description of the cluster analysis and other statistical analysis that was performed. The results are then presented in various tabular and graphical formats, including how these results correspond to the hypotheses. The chapter concludes with a summary of the findings for each cluster of organizations.

Data and Variable Manipulation

The data used in the study was an existing data set acquired from the Association for Healthcare Philanthropy, which conducts an annual survey of its membership utilizing an independent research firm that specializes in working with nonprofit organizations to distribute, collect and compile the data. The data set included survey responses for each of five years: 2003, 2004, 2005, 2006 and 2007. Organizations that were identified in the survey as being primarily acute care facilities were retained for the study. Organizations that were not clearly identified as acute care were removed; this includes organizations

such as hospice, long-term care facilities, health charities, and rehabilitation hospitals, among others.

In the original dataset, organizations were not given any type of unique identifier that would enable organizations to be matched across multiple survey years. Only those organizations that self-disclosed their identities could be examined to determine which organizations had participated in the survey for more than a single year. The percentage of identifiable organizations among respondents ranged from 46% - 57% for the five survey years, which is depicted in Table 4.

Table 4
AHP Survey Response Rates with Self-Identified Organizations

Survey Year	Number mailed	Useable surveys received	Response Rate	Surveys with self-identified organizations	Percentage self-identified among useable surveys
2003	1,290	260	20.1%	149	57%
2004	1,110	291	26.2%	139	48%
2005	1,268	327	25.8%	189	57%
2006	1,199	291	24.3%	134	46%
2007	1,875	460	24.5%	230	50%

Upon further examination, I determined that there was a pattern of missing variables that greatly reduced the size of the sample for any given year. I noted that the organizations that self-disclosed their identities were most likely to have completed the majority of the questions in the survey. Based upon these findings, I decided to use

survey responses from the full five years of data to create the study sample and to include only those organizations that were identifiable based upon self disclosure.

The organizations that self-disclosed their identities were compiled and then matched across years using their organization name. For organizations that had similar names, I examined the state that each reported as their location and did an internet search of their web addresses to verify if the organizations were separate organizations or were the same organization that had been inconsistently identified across the survey years. For those organizations that completed the survey for more than one survey year, I retained the survey data for only the most recent response year. Before removing an organization that had responded for multiple years, I examined the organization's survey responses to verify that there was consistency across the years in order to determine that the survey that was retained appeared to have been completed without error.

It is important to note that I conducted the process to match the organizations at first with the intention of conducting a longitudinal study, but determined that there was not an adequate sample size to conduct a longitudinal study. Therefore the study was designed as a cross-sectional study.

After compiling the dataset as described in the preceding paragraphs, I did additional data cleaning to obtain a complete and useable sample. This included removing any organization that was not clearly identifiable as an acute care facility, did not report a bed size, or did not report current funds raised, which is the primary financial variable of interest in the study.

After reducing the sample size as described above, the data was further examined to determine if there was any other evidence of completion error by the survey

respondents. In particular, the current funds raised and current expenses variables were examined as the two monetary variables of importance. While working with the data, I noticed that it appeared that a few respondents may possibly have reported current expenses for the entire organization's operations instead of the current expenses associated with the fundraising unit as requested. If the current expenses reported on the survey were grossly in excess of funds raised then the organization was removed from the sample.

Finally, I examined the data to determine if any outliers in the variables of interest were due to survey completion error or were justifiable based upon the size of the organization and its fundraising operation. I determined that two organizations appeared to have incorrectly answered several of the survey questions, primarily by reporting organizational level data when asked to report data at the level of the fundraising unit. Three organizations were removed because it appeared that the number of gifts reported were possibly in error after comparing these numbers to the levels of the organizations' other variables. The number of gifts was grossly in excess of what could reasonably be expected based upon the corresponding level of funds raised and number of donors. This could possibly be attributable to data entry error or survey response error.

Once the manipulations were completed as described above, the remaining sample consisted of 401 organizations. After the initial cluster analysis, which will be described in Chapter 4, the sample was reduced to 328 organizations that had valid responses for all of the basis variables. Seventy-three organizations were initially excluded from the clusters because there were missing responses among the four basis variables, which in most instances was either the funds per donor ratio because the

number of donors was missing from the survey response or the planned giving percentage. I examined the organizations excluded from the clusters to determine if the cluster they belonged to could be easily identified. I did this by looking at the patterns of the available data to determine if there was a match with other organizations that had been clustered. The 73 excluded cases were then coded with the cluster number that most closely matched the pattern of available data. This resulted in 10 organizations being added to Cluster 1, 33 organizations added to Cluster 2, and 30 organizations added to Cluster 3.

Because two of the variables of interest were monetary and the sample was drawn from a multi-year period, two new variables were calculated to convert the values to 2005 dollars. In order to convert to 2005 dollars, the amount of current funds raised and current expenses were each divided by the Consumer Price Index conversion factor for the reporting year using the CPI-U-X1 series for 2005 (Sahr, 2006). For example, $1,000 dollars in 2003 equals $1034 in 2005 ($1,000/.967).

Several variables are ratios based upon either current funds raised or current expenses. New variables were calculated using the current funds raised and current expenses that were converted into 2005 dollars. These new variables include funds raised per donor, funds raised per FTE and the fundraising cost ratio (expenses/funds).

For the survey question regarding number of full time employees in a support position in the fundraising unit, a no (blank) response to the question was replaced by a zero (0) response if the respondent had provided an answer to the corresponding question regarding the number of full time employees employed in a fundraising professional position in the fundraising unit.

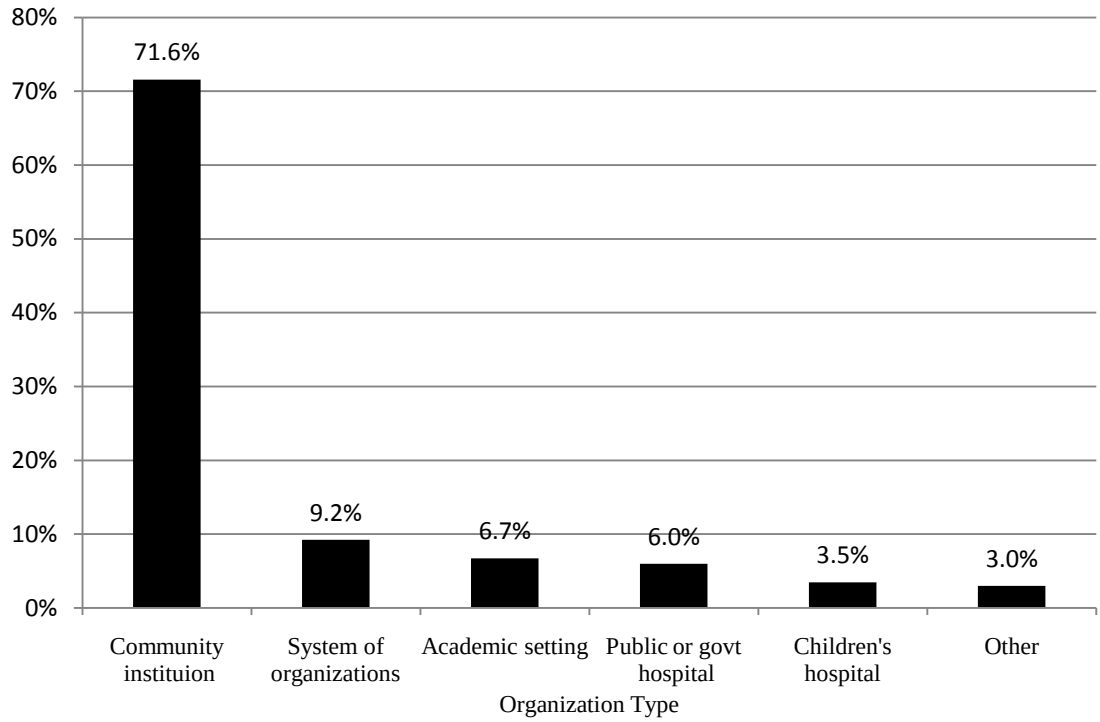
Descriptive Statistics

Institutional Demographics

Characteristics of the organizations responding to the survey were evaluated. Figures 2-8 graphically depict institutional demographics including the type of organization, hospital size, geographic scope of fundraising, population served by the organization, geographic distribution of organizations, and the age of the fundraising office.

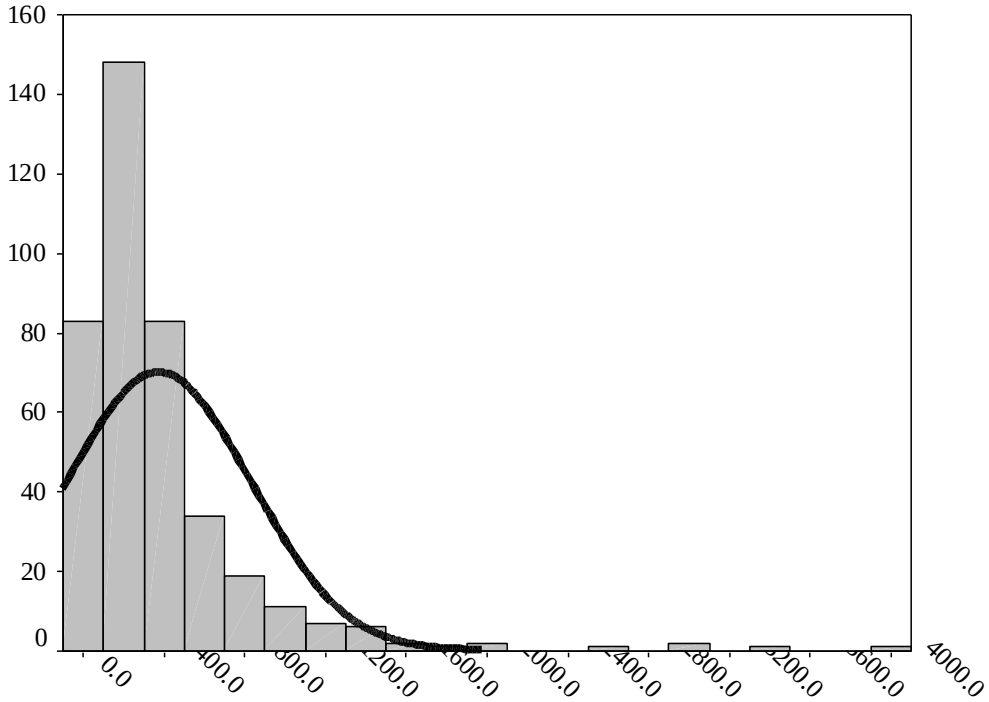
Type of Acute Care Institution. Of the 401 organizations included in the study sample, 287 (71.6%) identified their organization as a community institution (hospital, medical center, etc.), 27 (6.7%) as a university-based medical center or hospital, 14 (3.5%) as a children's hospital, 24 (6.0%) as a public or government hospital, 37 (9.2%) as a system of institutions or organizations, and 12 (3.0%) as an "other" type of organization. The respondents that classified themselves as an academic setting, system of institutions, or other were examined individually to verify that the organizations were acute care facilities. This frequency data for the type of organization is depicted in Figure 2.

Figure 2
Type of Acute Care Institution



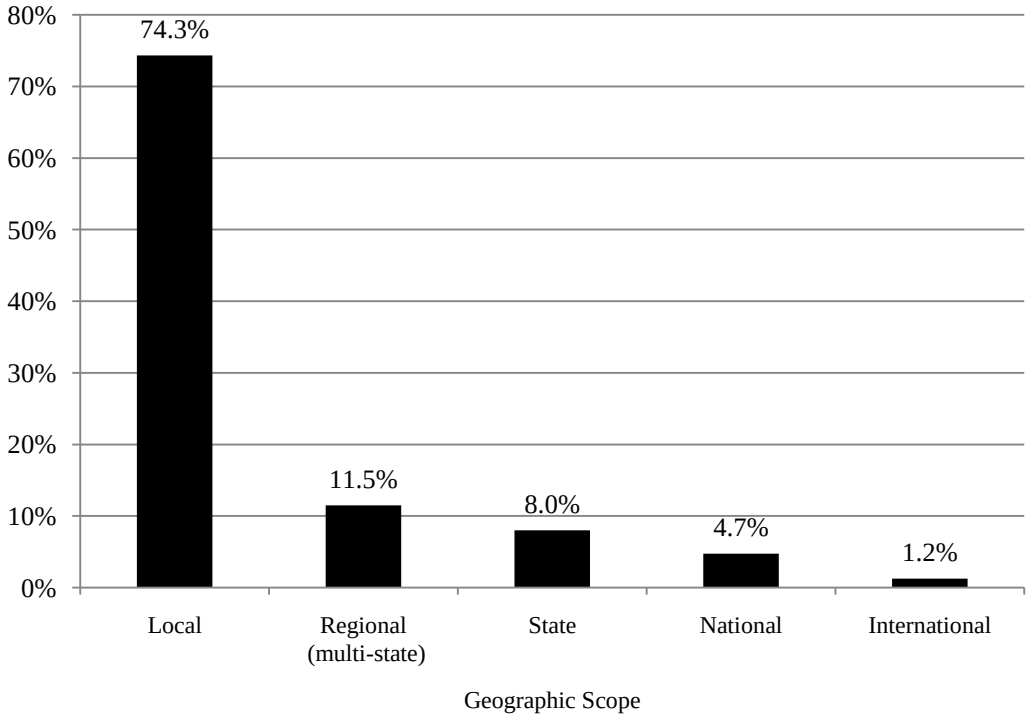
Organization Size. The size of the sample organizations ranged from 9 to 4,000 licensed, staffed beds, with a mean size of 377.5 (*SD*=456.53) beds. Approximately 50% of all organizations in the sample have fewer than 264 beds. The distribution of organizations by bed size is shown in Figure 3.

Figure 3
Organization Size



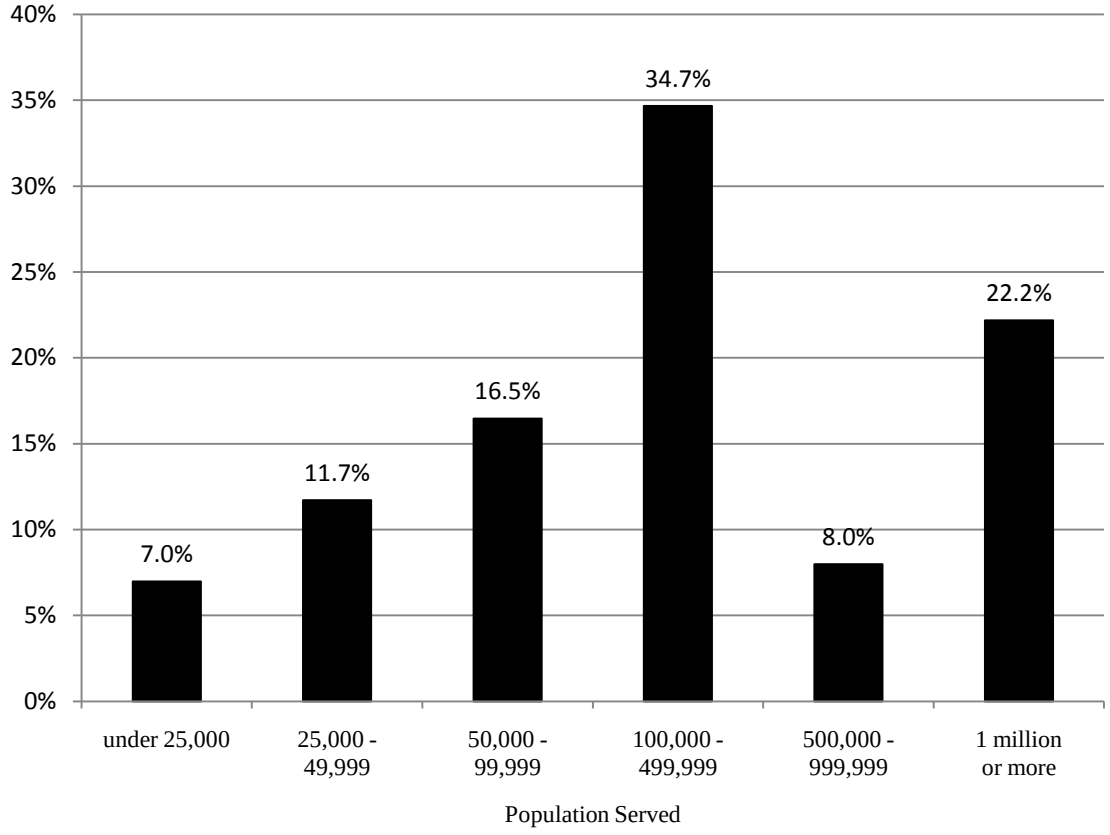
Geographic Scope of Fundraising. Of the 401 organizations in the sample, 298 (74.3%) indicated the geographic scope of their fundraising activities as local, 46 (11.5%) indicated regional (multi-state), 32 (8.0%) indicated statewide, 19 (4.7%) indicated national, 5 (1.2%) indicated international, and 1 had no response. The geographic scope of fundraising is depicted in Figure 4.

Figure 4
Geographic Scope of Fundraising



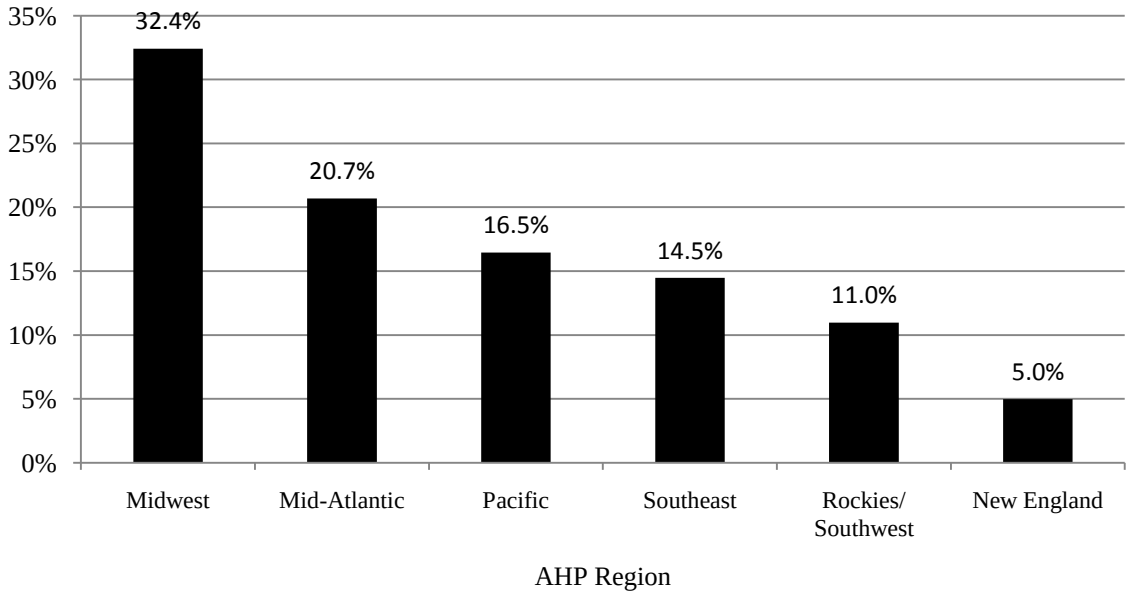
Population Served. Organizations were categorized according to the population served ranging from 25,000 and under to 1 million or more. The population category of 100,000-499,999 was most frequently chosen at 34.7% of the organizations. The distribution of organizations by categories of population served is depicted in Figure 5.

Figure 5
Population Served by Organizations



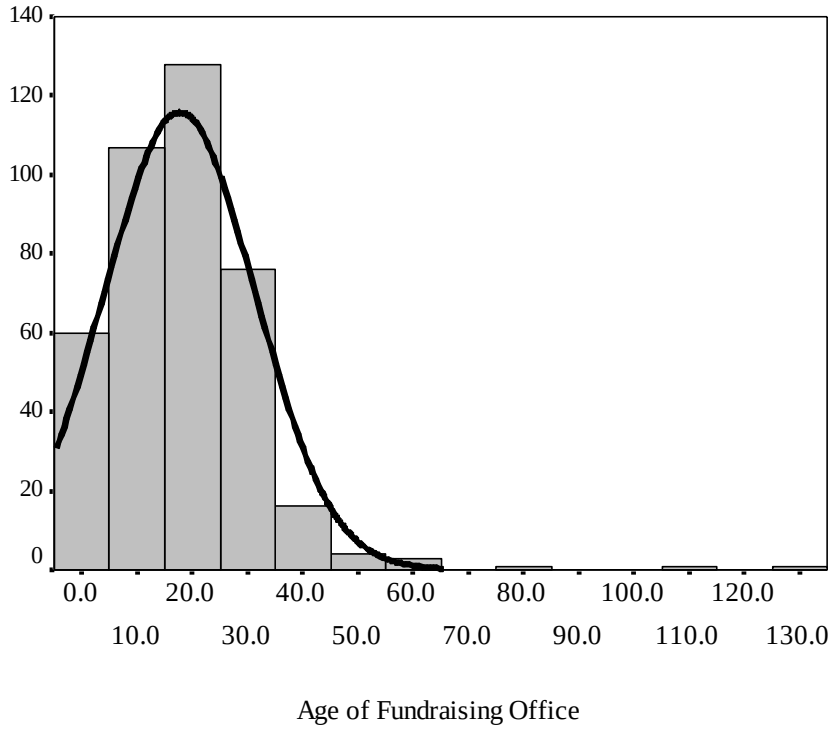
Geographic Distribution. The sample organizations are located throughout the United States. The AHP categorizes organizations by multi-state regions. Organizations in the Midwest accounted for 32.4% of the sample, Mid-Atlantic for 20.7%, Pacific for 16.5%, Southeast for 14.5%, Rockies/Southwest for 11.0%, and New England for 5.0%. This is a similar distribution to the overall population for the AHP, which was depicted in Figure 1 earlier in the dissertation. The distribution of the sample organizations is shown in Figure 6.

Figure 6
Geographic Distribution of Sample Organizations



Age of Fundraising Unit. The number of years the organizations reported having a fundraising office ranged from 1 to 133 years, with the mean age of 17.72 years (*SD*=13.65). Seventy-five percent of the organizations indicated having a fundraising office for 25 years or less.

Figure 7
Age of Fundraising Unit



Sources and Types of Gifts

As a part of the survey, organizations were asked a series of questions regarding the sources and uses of funds raised as well as information about their donors. The information available for the sample organizations is presented in table and graphical form.

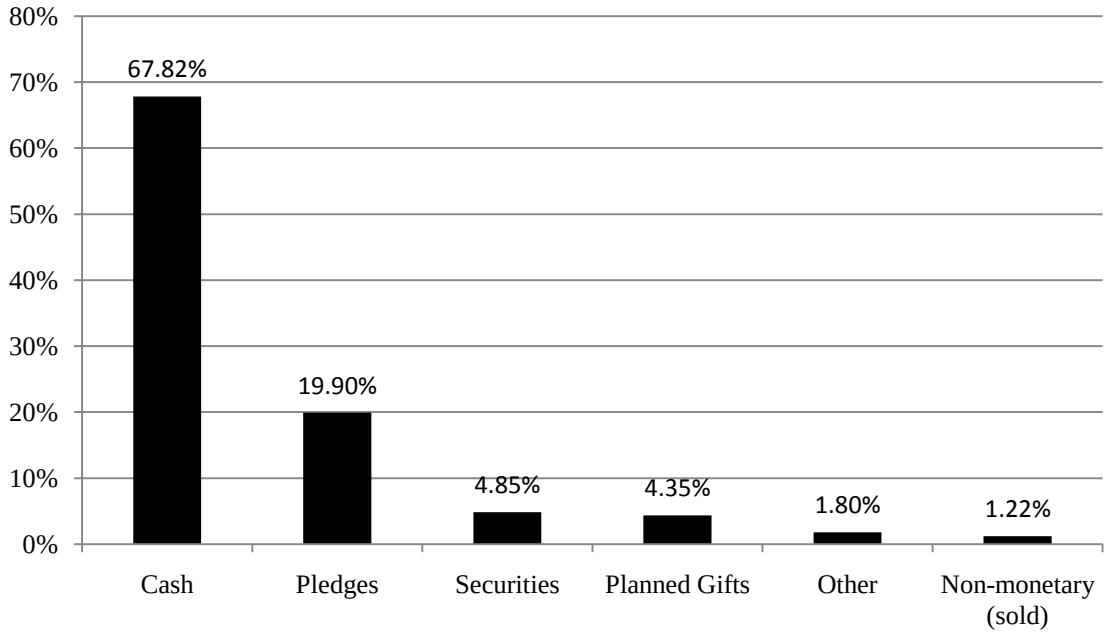
Sources of Funds Raised. Each organization was asked to provide a categorical break out of total funds raised, which includes cash gifts plus documented pledges. Cash gifts could be categorized as cash, value of securities sold during the year, and value of non-monetary gifts sold during the year. Pledges could be categorized as pledges secured

but not yet paid, planned gifts secured but not yet paid, and other assets received. Organizations were asked to indicate the percentage of total funds raised attributable to each category. The descriptive statistics for the funds raised are presented in Table 5 and the mean for each category is graphically depicted in Figure 8.

Table 5
Funds Raised (Gifts & Pledges)

	N	Mean	Median	Standard Deviation	Minimum	Maximum
Cash	354	67.82	74.00	26.95	0.00	100.00
Securities	354	4.85	.96	11.70	0.00	95.00
Non-monetary (sold)	354	1.22	0.00	6.13	0.00	89.00
Pledges	354	19.90	11.00	22.58	0.00	95.00
Planned Gifts	354	4.35	0.00	11.05	0.00	78.00
Other	354	1.80	0.00	9.29	0.00	100.00
Missing	47					

Figure 8
Funds Raised (Gifts & Pledges)

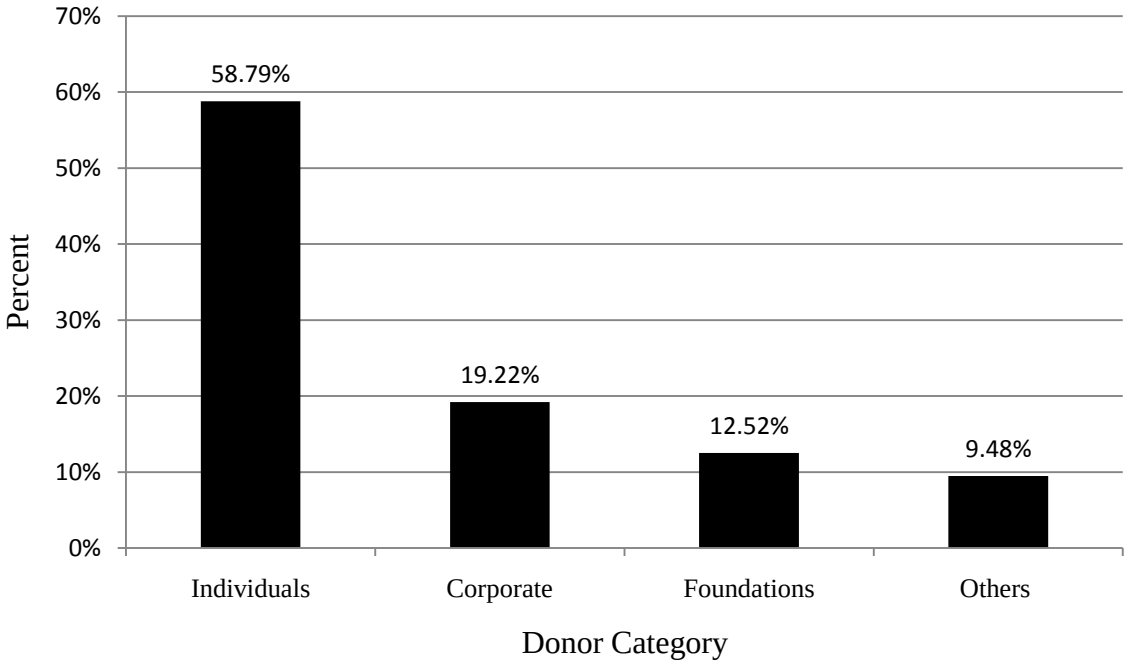


Organizations were asked to indicate the percentage of funds raised that were attributable to 4 categories of donors, which included individuals, corporate (including corporate foundations), foundations (excluding corporations), and others (e.g., hospital auxiliaries, public agencies, civic groups, etc.). Among the sample organizations, 362 organizations provided this information. Funds raised from individuals accounted for the greatest percentage at approximately 59% of total funds raised. The descriptive statistics for the funds raised by donor category are presented in Table 6 and the mean for each category is graphically depicted in Figure 9.

Table 6
Percentage of Funds Raised from Donors by Category

	N	Mean	Median	Standard Deviation	Minimum	Maximum
Individuals	362	58.79	60.00	24.78	3.00	100.00
Corporate	362	19.22	15.00	17.04	0.00	80.00
Foundations	362	12.52	6.00	13.52	0.00	85.00
Others	362	9.48	5.00	16.52	0.00	85.00
Missing	39					

Figure 9
Percentage of Funds Raised from Donors by Category

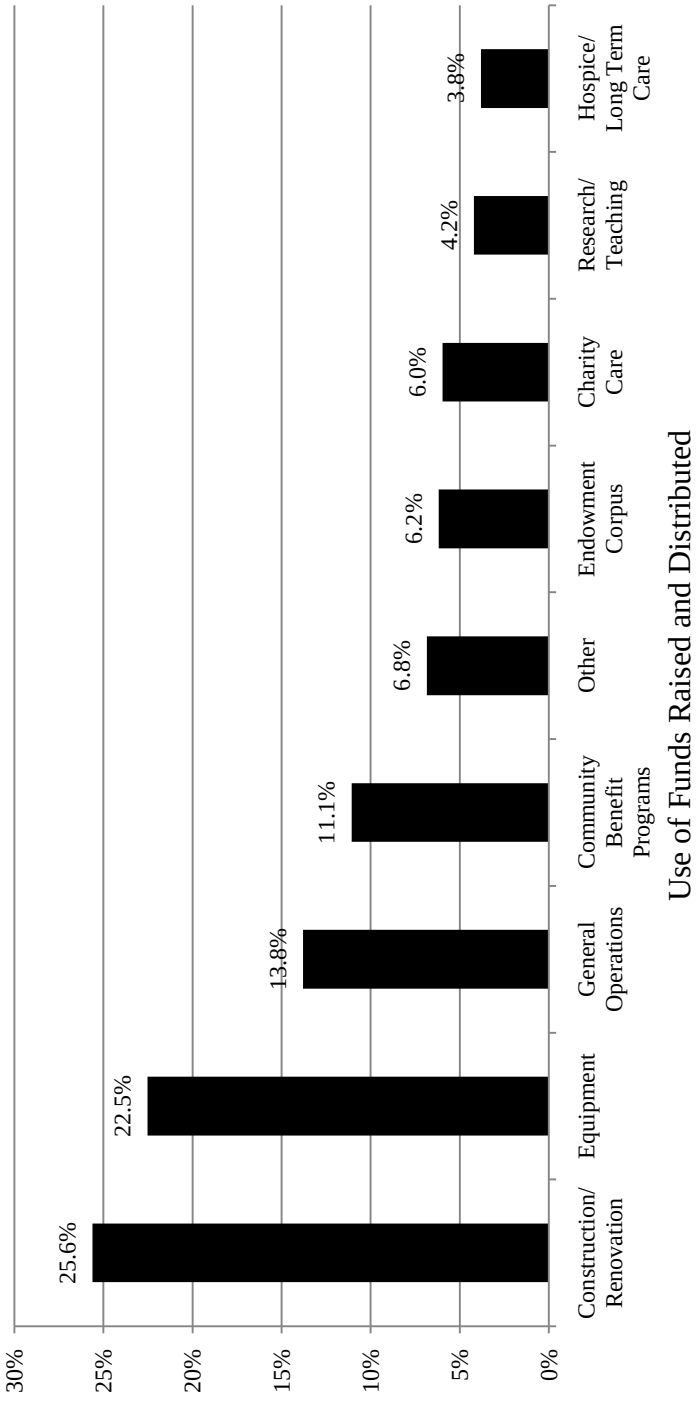


Use and Distribution of Funds Raised. Funds raised by nonprofit hospital organization are used in variety of ways. Organizations were asked to indicate the percentage of funds raised and distributed by categories that included charitable care, community benefit programs, construction and renovation, endowment (gifts added to the corpus), equipment, general operations, hospice/long-term care/nursing care, research and teaching, and other. The descriptive statistics for the use and distribution of funds raised during the year are presented in Table 7 and the mean for each category is graphically depicted in Figure 10.

Table 7
Use of Funds as a Percentage of Funds Raised and Distributed

	N	Mean	Median	Std. Deviation	Minimum	Maximum
Construction/Renovation	345	25.61	10.00	30.66	0.00	100.00
Equipment	345	22.53	10.00	28.86	0.00	100.00
General Operations	345	13.79	3.00	21.39	0.00	100.00
Community Benefit Programs	345	11.07	5.00	17.01	0.00	100.00
Other	345	6.84	0.00	18.34	0.00	100.00
Charity Care	345	6.18	0.00	14.20	0.00	100.00
Endowment Corpus	345	5.96	0.00	14.42	0.00	89.80
Research/Teaching	345	4.20	0.00	10.11	0.00	72.00
Hospice/Long Term Care	345	3.82	0.00	10.58	0.00	93.00
Missing	56					

Figure 10
Use of Funds as a Percentage of Funds Raised and Distributed



Operationalized Variables.

Descriptive statistics for the continuous variables used in the cluster analysis and in the subsequent hypotheses testing are presented in Table 8 and the frequencies for the categorical variables used in the hypotheses testing are presented in Tables 9 and 10 and graphically in Figures 11 and 12. Missing responses are listed for corresponding variables. A correlation matrix for the operationalized variables is provided in Table 11.

Table 8
Descriptive Statistics for Continuous Variables for Sample Organizations

	N						
	Valid	**Missing**	**Mean**	**Median**	**Std. Deviation**	**Minimum**	**Maximum**
Funds Raised per FTE	400	1	$608,260	$386,870	$849,371	$673	$11,153,907
Funds Raised per Donor	356	45	$2,552	$1,185	$4,921	$46	$61,412
Fundraising Cost Ratio	401	0	.47	.27	.81	0.00	7.00
Planned Gifts	354	47	4.35%	0.00%	11.04%	0.00%	78.00%
FTEs	400	1	7.56	3.50	11.05	.50	101.00
Corporate Donor Support	362	39	19.21%	15.0%	17.04%	0.00%	80.00%
Foundation Donor Support	362	39	12.52%	6.0%	16.52%	0.00%	85.00%

Table 9
Fundraising Unit Structure Frequencies for Sample Organizations

	Frequency	Percent
Foundation	307	76.56%
Other	94	23.44%
Total	401	100

Figure 11
Fundraising Unit Structure Frequencies for Sample Organizations

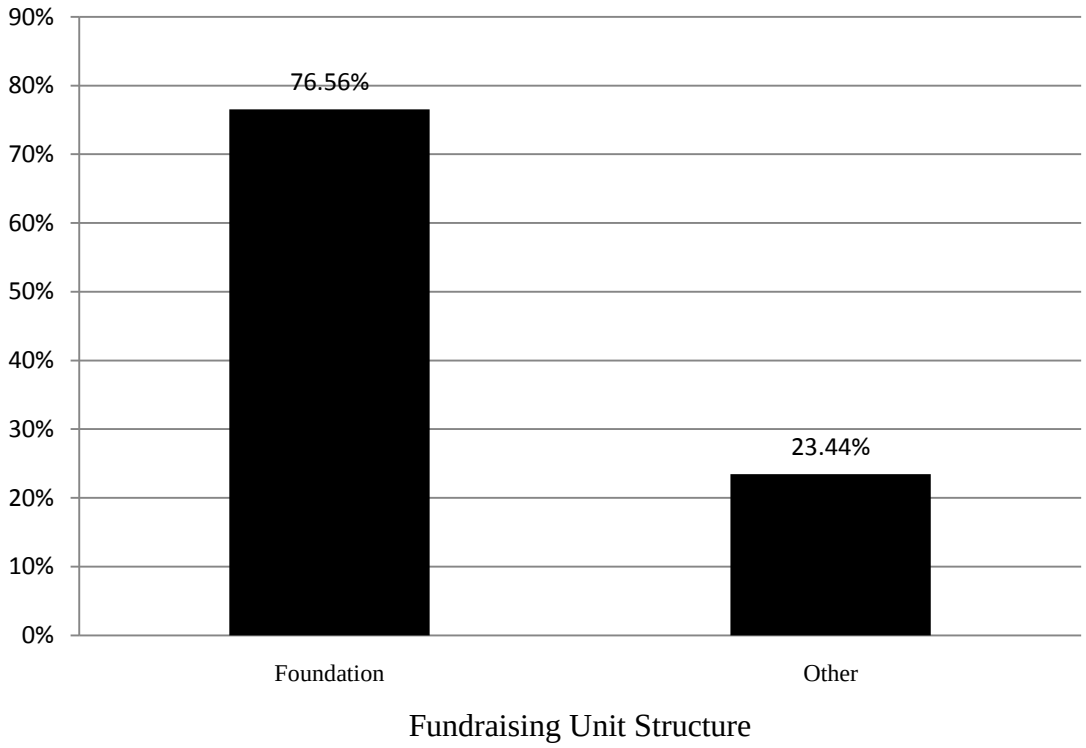


Table 10
Endowment Status Frequencies for Sample Organizations

	Frequency	Percent
Yes	279	69.6
No	122	30.4
Total	401	100.0

Figure 12
Endowment Status Frequencies for Sample Organizations

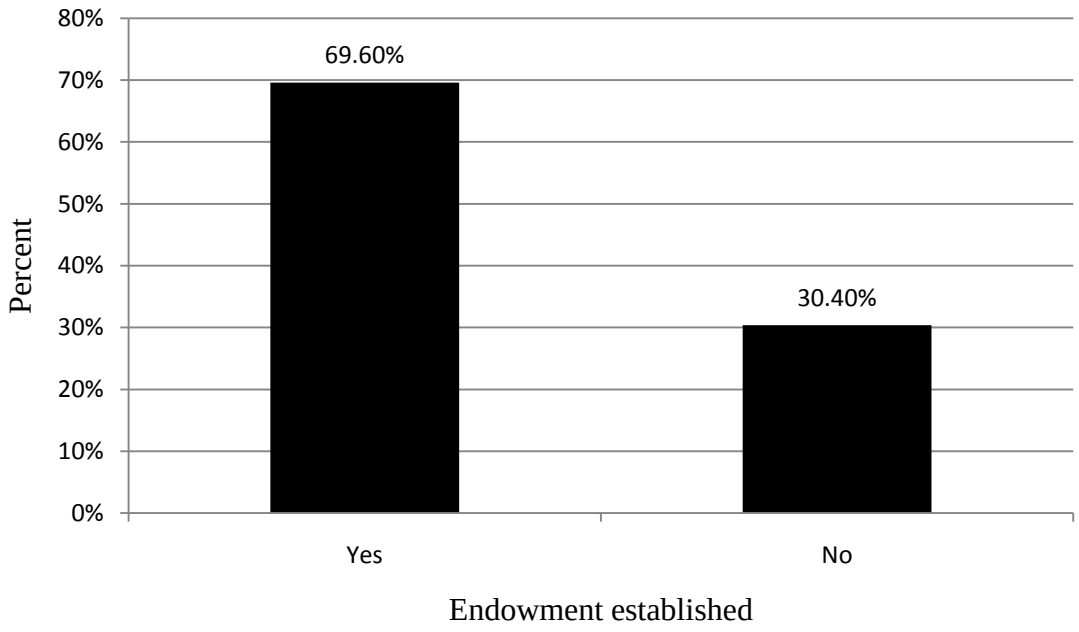


Table 11
Correlation Matrix for Operationalized Variables[a]

		Mean	s.d.	1	2	3	4	5	6	7
1	Funds Raised per FTE	624171.30	863762.90							
2	Funds Raised per Donor	2590.79	5047.00	.44**						
3	Fundraising Cost Ratio	.46	.81	-.22**	-.14*					
4	Planned Gifts	4.62	11.58	.04	-.01	-.02				
5	Endowment Status			-.11	.06	.16**	-.07			
6	Structure			.13*	.03	-.05	.09	.04		
7	Corporate Support	19.58	17.13	-.21**	-.17**	.13**	-.09	.09	.10	
8	Foundation Support	12.86	17.02	-.16**	.10	.03	-.09	-.08	.04	-.18**

**Correlation is significant at p<.01
*Correlation is significant at 0<.05
[a] Listwise N=315

Statistical Analyses

Cluster Analysis

Two-step cluster analysis was performed on the sample organizations using the OEP variables of funds raised per FTE, funds raised per donor, fundraising cost ratio, and the planned gifts percentage as the basis variables. Prior to completing the clustering, the four variables were converted to categorical variables to control for outliers. The three ratio variables (funds per donor, funds per FTE, and fundraising cost) were grouped into tertiles for the purpose of categorizing the cases according to the rank among low, mid, and high levels for each of the variable metrics. The overall descriptive statistics and the cut points calculated for the tertiles are shown in Table 12.

Table 12
Descriptive Statistics and Tertile Cut Points for Ratio Variables

		Funds Raised per FTE	Funds Raised per Donor	Fundraising Cost Ratio
N	Valid	400	356	401
	Missing	1	45	0
Mean		$608,260	$2,553	0.47
Median		$386,870	$1,186	0.27
Std. Deviation		$849,372	$4,922	0.81
Minimum		$673	$46	0.00
Maximum		$11,153,907	$61,412	7.00
Percentiles	33.33333	$246,500	$839	0.17
	66.66667	$592,089	$1,899	0.39

Because the percentage of planned gifts for a number of the cases was zero, the planned giving variable was re-coded into three categories so that all of the cases with zero were placed into the low group. The remaining cases (108) for which the planned giving percentage was greater than zero were separated into two groups (mid level and

high level) on the basis of the median percentage of planned gifts for the non-zero cases, which was 7%.

The two-step cluster analysis using the four categorical basis variables resulted in three clusters of organizations. Hypothesis One was supported. The distribution is shown in Table 13. Seventy-three cases were initially excluded on the basis of missing data in one or more of the variables.

Table 13
Initial Cluster Distribution with Exclusions

		N	% of Combined	% of Total
Cluster	1	80	24.4%	20.0%
	2	151	46.0%	37.7%
	3	97	29.6%	24.2%
	Combined	328	100%	81.8%
Excluded Cases		73		18.2%
Total		401		100%

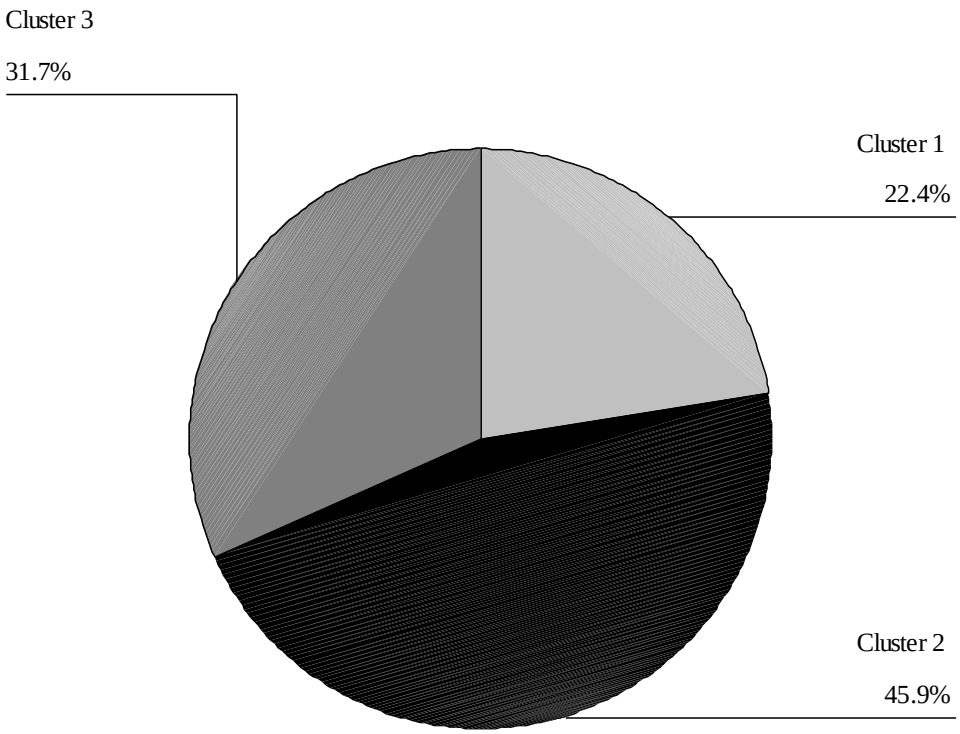
After adding the excluded cases to the clusters as described earlier in this chapter, the resulting distribution is shown in Table 14 and in Figure 13.

Table 14
Final Cluster Distribution without Exclusions

		N	% of Combined	% of Total
Cluster	1	90	22.4%	22.4%
	2	184	45.9%	45.9%
	3	127	31.7%	31.7%
	Combined	401	100%	100.0%
Total		401		100%

Figure 13

Cluster Size



The distribution of cases grouped according to the low-, mid- and high-levels of each basis variable are shown in Tables 15 – 18.

Table 15
Observed Cluster Frequencies for Funds Raised Per Donor Tertiles

			Funds Raised Per Donor			
			Low	**Mid**	**High**	**Total**
Cluster		1	0	0	84	84
		2	47	89	25	161
		3	71	30	10	111
		Combined	107	108	113	356
Valid	N=356					
Missing	N=45					

Table 16
Observed Cluster Frequencies for Funds Raised Per FTE Tertiles

		Funds Raised Per FTE			
		Low	**Mid**	**High**	**Total**
Cluster	1	0	0	90	90
	2	37	104	43	184
	3	96	30	0	126
	Combined	133	134	133	400
Valid N=400					
Missing N=1					

Table 17
Observed Cluster Frequencies for Fundraising Cost Ratio Tertiles

		Fundraising Cost Ratio			
		Low	**Mid**	**High**	**Total**
Cluster	1	67	23	0	90
	2	46	111	27	184
	3	20	0	107	127
	Combined	133	134	134	401
Valid N=401					
Missing N=0					

Table 18
Observed Cluster Frequencies for Planned Gifts Percentage Tertiles

		Planned Giving Percentage			
		Low	**Mid**	**High**	**Total**
Cluster	1	50	23	13	86
	2	92	31	40	163
	3	104	1	0	105
	Combined	246	55	53	354
Valid N=354					
Missing N=47					

The descriptive statistics for the original basis variables for each cluster are shown in Table 19.

Table 19
Descriptive Statistics of Basis Variables for Clusters

	N	Mean	Median	Standard Deviation	Minimum	Maximum
Funds per FTE						
Cluster 1	90	$1,494,431	$1,032,677	$1,384,388	$594,158	$11,153,907
Cluster 2	184	$467,315	$418,507	$312,777	$1,159	$2,491,273
Cluster 3	126	$181,104	$157,355	$128,226	$673	$556,797
Cluster Total	400	$608,260	$386,870	$849,371	$673	$1,153,907
Funds per Donor						
Cluster 1	84	$7,169	$4,241	$8,526	$1,899	$61,412
Cluster 2	161	$1,327	$1,097	$957	$120	$8,022
Cluster 3	111	$838	$648	$745	$46	$4,477
Cluster Total	356	$2,522	$1,185	$4,921	$46	$61,412
Fundraising Cost Ratio						
Cluster 1	90	0.13	0.11	0.09	0.00	0.39
Cluster 2	184	0.33	0.26	0.51	0.00	4.90
Cluster 3	127	0.91	0.58	1.18	0.00	7.00
Cluster Total	401	0.47	0.27	0.81	0.00	7.00
Planned Gifts (%)						
Cluster 1	86	5.24%	0.00%	13.08%	0.00%	78.00%
Cluster 2	163	6.63%	0.00%	12.58%	0.00%	52.00%
Cluster 3	105	0.07%	0.00%	0.00%	0.00%	7.00%
Cluster Total	354	4.35%	0.00%	11.05%	0.00%	78.00%

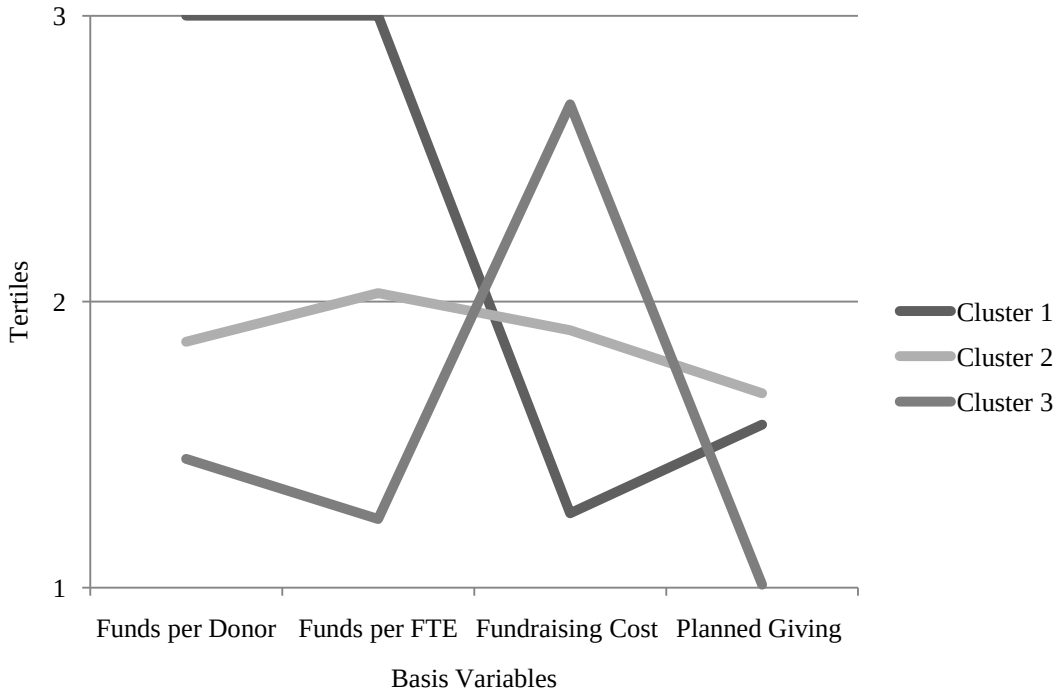
A one-way between groups analysis of variance (ANOVA) was conducted to verify that the clusters were significantly different with respect to the means of the original basis variables upon which the tertiles used to create the clusters were derived. There was a statistically significant difference at the $p<.05$ level for funds raised per

donor [F(2, 353)=66.718, p<.001], funds raised per FTE [F(2, 397)=101.394, p<.000], fundraising cost ratio [F(2, 398)=34.535, p<.001], and planned gifts percentage [F(2, 351)=12.404, p<.001] for the clusters. The effect size, calculated using eta squared, indicated that the actual difference between mean scores for the funds raised per donor (eta squared=.27), funds raised per FTE (eta squared=.34), and fundraising cost ratio (eta squared=.15) was large, and the difference between the planned gifts percentage (eta squared = .067) was medium. This interpretation of the strength of the eta squared values is based on the guidelines from Cohen (1988).

Levene's test for homogeneity of variances was significant (p<.001) for each of the variables, suggesting that the variances for the three groups are not equal. Because of the violation of the assumption of homogeneity of variances, additional nonparametric tests were conducted. A further examination of the Welch and Brown-Forsythe tests for equality of means, which are more robust and do not assume equal variance, were statistically significant for the funds raised per donor. Additional post hoc tests that do not assume equal variance were also conducted, including Tamhane, Dunnett T3, Games-Howell, and Dunnett C, and each indicated that the clusters were statistically significantly different at the p=.05 level with one exception. The exception was for the Planned Gifts variable, which was statistically significantly different between Cluster 1 and Cluster 3 and between Cluster 2 and Cluster 3, but not between Clusters 1 and 2.

Figure 14 graphically illustrates the levels of each variable for each of the clusters. The levels of the variables correspond to the tertiles established for each of the basis variable that sets those with low levels at 1, mid levels at 2, and high levels at 3.

Figure 14
Basis Variables Levels for Clusters



Chi Square and ANOVA Analyses

The remaining hypotheses were tested using the chi-square test for independence for the categorical variables of configuration and endowment status and ANOVA for the continuous variables of staffing, corporate support and foundation support.

Configuration. A chi-square test of independence was performed to examine the relationship between the configuration of the fundraising unit and the clusters of organizations. The results are depicted in Table 20. The relationship between these variables was not significant, X^2 (2, N = 401)=1.472, p=.479. The proportion of fundraising units organized as foundations from the proportion of fundraising units not

organized as foundations is not significantly different among the three clusters. Hypothesis Two was not supported.

Table 20
Chi-square Analysis Results: Configuration

	Cluster 1	Cluster 2	Cluster 3
Foundation	74.4%	75.0%	80.3%
Other	25.6%	25.0%	19.7%

Chi-square statistic = 1.472
Degrees of freedom = 2
Possibility of chance = .479

Staffing. A one-way between groups analysis was conducted to determine if the clusters of organizations could be further differentiated on the level of staffing in the fundraising unit as measured by the total number of FTEs, which includes professional and support staff. Table 21 contains the results of the ANOVA test for hypothesis 2. There was a statistically significant difference at the $p<.05$ level in FTEs for the three clusters of organizations [$F(2, 397)=8.319$, $p<.001$]. Although the differences are statistically significant, the actual difference in mean scores between the groups was relatively small. The effect size, calculated using eta squared, was .04. Post-hoc comparisons using the Tukey's HSD test indicated that the mean score for Cluster 3 (M=4.10, SD=6.34) was significantly different from Cluster 1 (M=9.90, SD=14.74) and from Cluster 2 (M=8.79, SD=12.80). Cluster 1 and Cluster 2 did not differ significantly with each other. Hypothesis Three is partially supported.

Table 21
One-Way ANOVA Results: FTEs in Fundraising Unit

	D	Sum of Squares	Mean Square	η^2	F
Between Groups	2	2279.68	1139.838	.04	8.319*
Within Groups	397	54394.49	137.014		
Total	399	56674.16			

*p<.01

Endowment Status. A chi-square test of independence was performed to examine the relationship between the endowment status and the clusters of organizations. The results are depicted in Table 22. The relationship between these variables was significant, X^2 (2, N=401)=14.547, p = .001. The proportion of organizations with an endowment to organizations without an endowment was found to have a statistically significant difference among the three clusters. Hypothesis Four is supported.

Table 22
Chi-square Analysis Results: Endowment Status

	Cluster 1	Cluster 2	Cluster 3
Endowment	70.0%	77.7%	57.5%
No Endowment	30.0%	22.3%	42.5%

Chi-square statistic = 14.547
Degrees of freedom = 2
Probability of chance = .001

Corporate Support. A one-way between groups analysis was conducted to determine if the clusters of organizations could be further differentiated on the level of support received from corporations as measured as a percentage of total funds raised. Table 23 contains the results of the ANOVA test for Hypothesis 5a. There was a

statistically significant difference at the p<.05 level in corporate support for the three clusters of organizations [$F(2, 359)=12.034$, p<.001]. The effect size, calculated using eta squared, was .06, indicates that this is medium sized effect according to Cohen (1988). Post-hoc comparisons using the Tukey's HSD test indicated that the mean score for Cluster 3 (M=25.15, SD=21.72) was significantly different from Cluster 1 (M=13.93, SD=13.71) and from Cluster 2 (M=17.99, SD=13.62). Cluster 1 and Cluster 2 did not differ significantly from each other. Hypotheses 5a is partially supported.

Table 23
One-way ANOVA Results: Corporate Support

	df	Sum of Squares	Mean Square	$\acute{\eta}^2$	F
Between	2	6589.22	3294.61	.06	12.034*
Within Groups	359	98288.80	273.785		
Total	361	104878.0			

*p<.01

Foundation Support. A similar one-way between groups analysis was conducted to determine if the clusters could be further differentiated on the level of support received from foundations as measured as a percentage of total funds raised. Table 24 contains the results of the ANOVA test for Hypothesis 5b. There was a statistically significant difference at the p<.05 level in corporate support for the three clusters of organizations [$F(2, 359)=7.280$, p=.001]. The effect size, calculated using eta squared, was .04, indicates that this is small- to medium-sized effect according to Cohen (1988). Post-hoc comparisons using the Tukey's HSD test indicated that the mean score for Cluster 1 (M=18.19, SD=20.23) was significantly different from Cluster 3 (M=9.79, SD=16.28) and

from Cluster 2 (*M*=11.36, *SD*=13.65). Cluster 2 and Cluster 3 did not differ significantly with each other. Hypothesis 5b is partially supported

Table 24
One-way ANOVA Results: Foundation Support

	df	Sum of Squares	Mean Square	η^2	F
Between Groups	2	3841.69	1920.85	.04	7.280*
Within Groups	359	94717.12	263.836		
Total	361	98558.81			

*p<.01

Summary of Hypotheses Results

Based on the findings obtained through chi-square and ANOVA analysis, support or partial support was found for five of the six hypotheses tested in this study. The nonprofit hospital organizations could be grouped based on effectiveness and performance characteristics of their fundraising operations. The groups were then found to be different in terms of staffing, maturity and legitimacy, but not in terms of configuration of the fundraising unit. The results are outlined in Table 25.

Table 25
Summary of Results by Hypotheses

	Hypotheses	Supported (Yes/No)
H1	There are distinct groupings of nonprofit hospital organizations based upon the organizational effectiveness and performance characteristics of their fundraising operations.	Yes
H2	There are differences between groups of nonprofit hospital organizations based upon the organizational configuration of the fundraising unit.	No
H3	There are differences between groups of nonprofit hospitals organizations based upon the level of staffing in the fundraising unit.	Yes (partial)
H4	There are differences between groups of nonprofit hospital organizations based upon the status of the adoption of an endowment fund as a fundraising technology utilized by the organization.	Yes
H5a	There are differences between groups of nonprofit hospital organizations based upon the level of support received from corporate donors.	Yes (partial)
H5b	There are differences between groups of nonprofit hospital organizations based upon the level of support received from foundation donors.	Yes (partial)

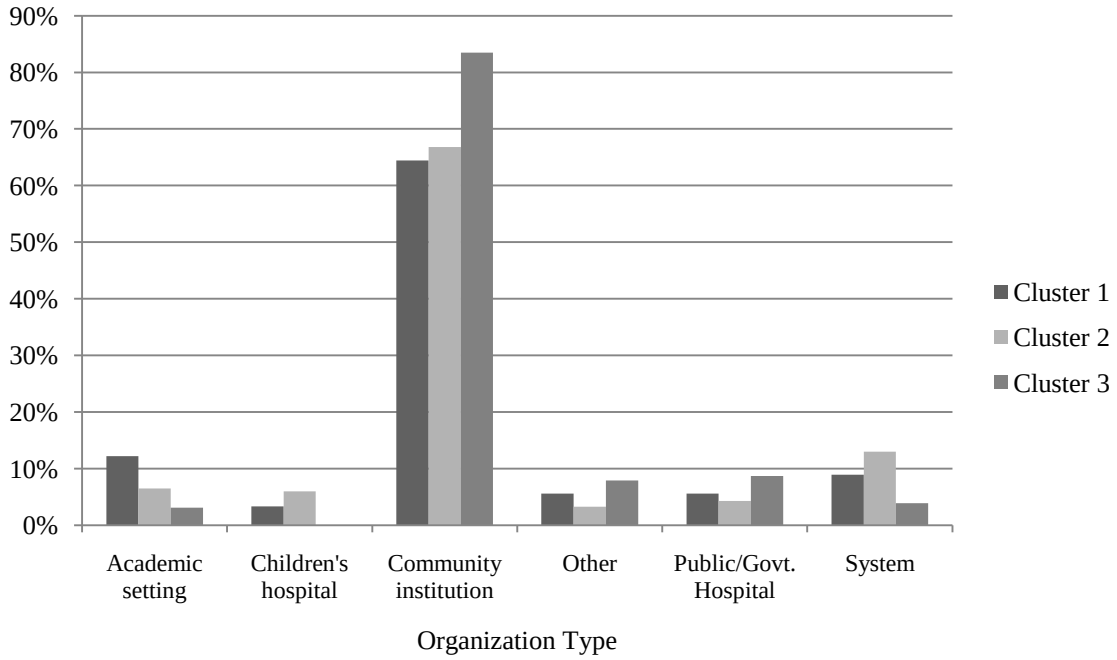
Additional Analyses

The remaining section of this chapter focuses on additional analyses conducted to assist in developing a profile for each of the clusters. This entails additional chi-square and ANOVA analyses to determine if the three clusters differ significantly on other variables of interest that were listed in the aggregate earlier in the chapter, including

organizational size, age, geographic location, organizational type, and sources and uses of funds, among others.

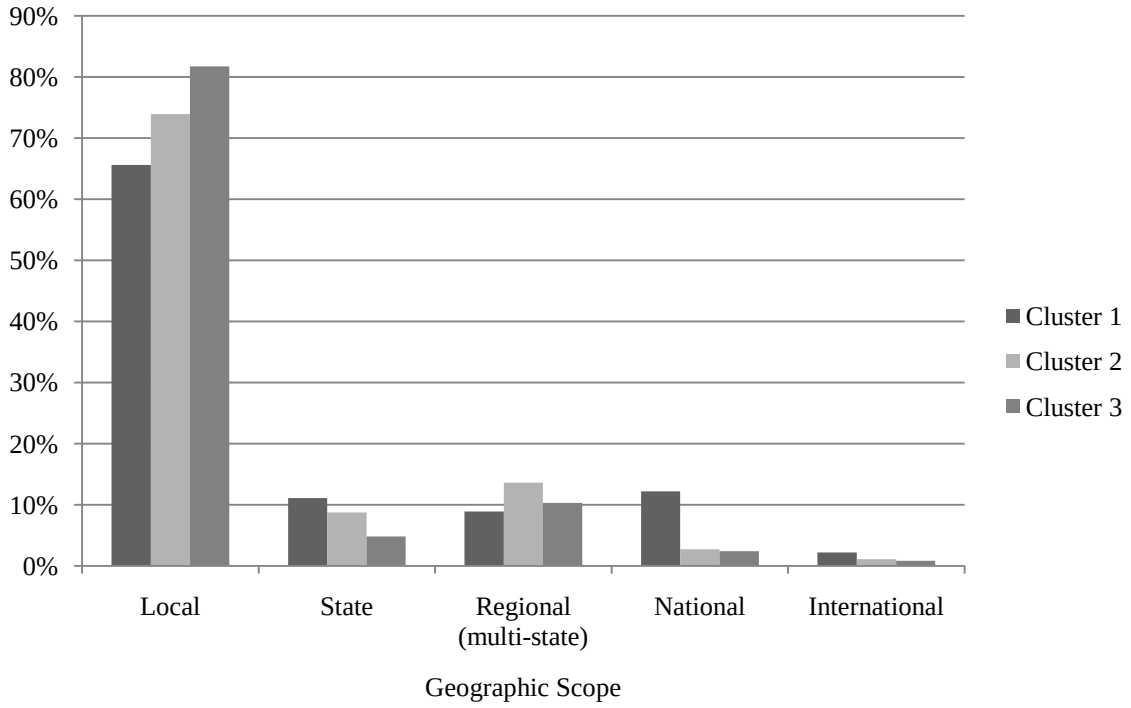
Organization Type. A chi-square test of independence was performed to examine the relationship between the organization types and the clusters of organizations. The relationship between these variables was significant, X^2 (10, N=401)=31.107, p = .001. This indicates that the distribution of organizations by organization type was statistically significantly different among the three clusters. Figure 15 graphically depicts the distribution of organization types included in the sample by cluster. The graph displays the percentage of the organization types from the sample populations that are represented within each cluster. Community institutions are the predominant type of organization within the sample. It is interesting to note that none of the Children's Hospitals in the sample are in Cluster 3, the majority of Academic Setting organizations are in Cluster 1, and the highest percentage of Public Hospitals are in Cluster 3.

Figure 15
Distributions of Sample Organizations by Type within Clusters



Geographic Scope of Fundraising. A chi-square analysis was conducted to examine the relationship of the geographic scope of fundraising categories and the clusters. The relationship between these variables was significant, X^2 (8, N=401)=20.696, p= .008. This indicates that the distribution of organizations by geographic scope of fundraising was statistically significantly different among the three clusters. Figure 16 graphically compares the distribution of organizations by geographic scope of fundraising within each cluster.

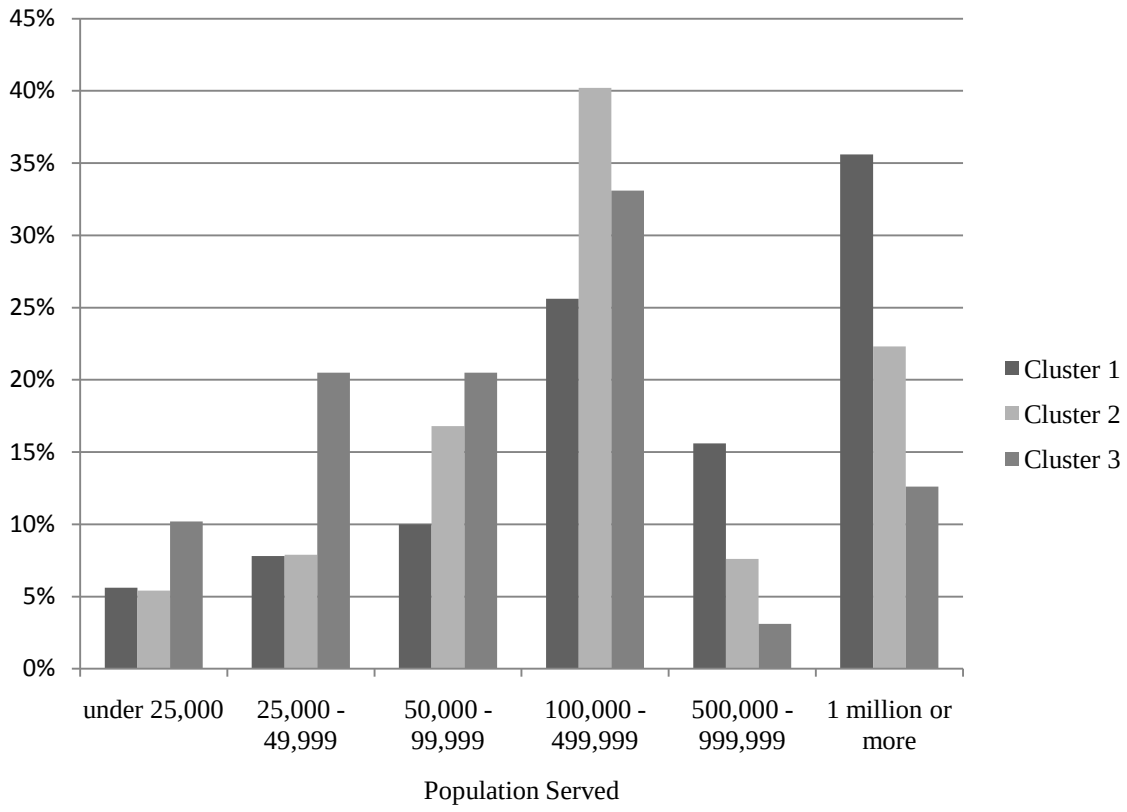
Figure 16
Distribution of Sample Organizations by Scope of Fundraising within Clusters



Organizations reporting a local focus of fundraising represent the majority of organizations in the sample and within each cluster. Cluster 1 has the highest percentage of organizations in the sample that report having a national scope for fundraising. Cluster 2 has approximately half of the organizations from the sample that report a statewide focus and with a regional (multi-state) focus. Clusters 1 and 2 have the most distinctive patterns of fundraising scope, with Cluster 1 having more nationally-focused organizations, and Cluster 2 having more organizations with a local, state or regional focus. Cluster 3 does not have more than 30 percent of organizations from any category of scope, indicating no particular pattern of fundraising scope as being prevalent among this particular cluster.

Population Served. A chi-square test of independence was performed to examine the relationship between the population served categories and the clusters of organizations. The relationship between these variables was significant, X^2 (10, N=401)=45.118, p < .001. This indicates that the distribution of organizations by population served was statistically significantly different among the three clusters. Figure 17 graphically depicts the distribution of organizations included in the sample by cluster by population served.

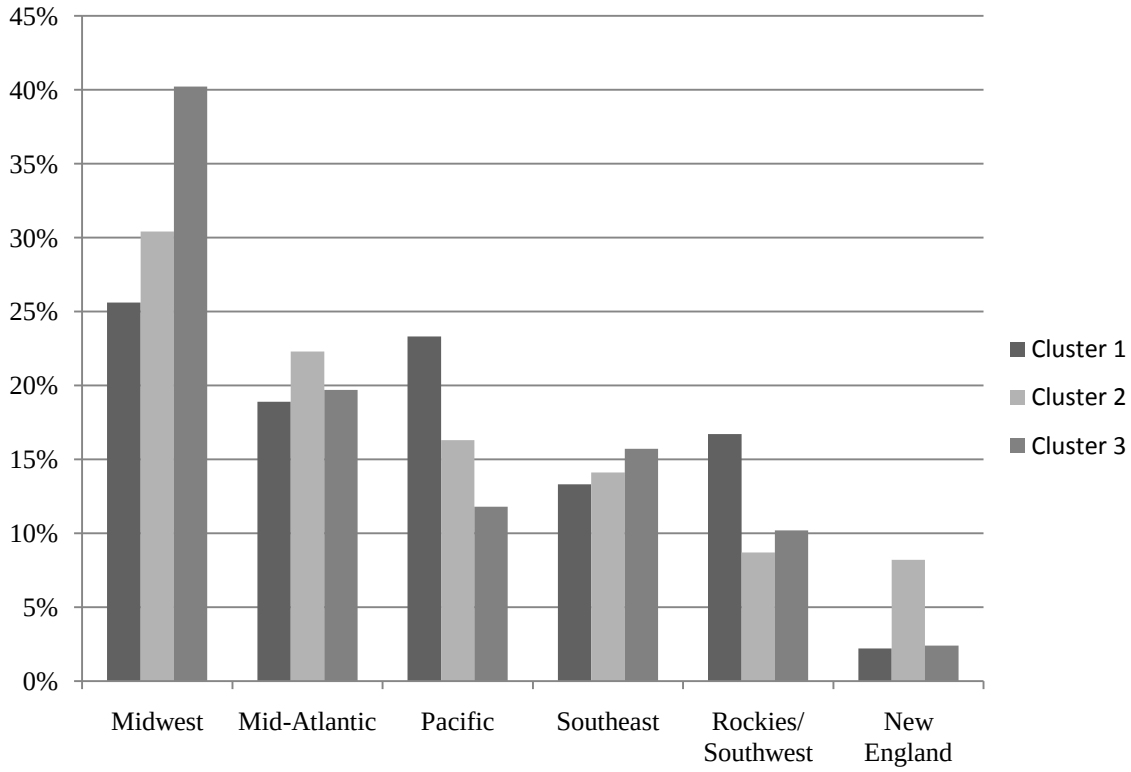
Figure 17
Distribution of Sample Organizations by Population Served within Clusters



Cluster 1 is populated by organizations that typically serve larger population bases, with 35% reporting to serve more than 1 million and nearly 75% of the organizations reporting to serve 100,000 or more. Cluster 2 also contains a high percentage of organizations that report serving larger population bases, with 40% of the organizations within the cluster in the 100,000-499,999 range and more than 20% in the 1 million or more range. Cluster 3 has a higher percentage of organizations reporting to serve smaller communities than the other two clusters. Just over half of the organizations in Cluster 3 report serving populations of less than 100,000 and another one-third report to be in the 100,000-499,999 range.

AHP Region. A chi-square test for independence was conducted to observe the relationship between the clusters and the geographic region of the country in which the organizations are located. The relationship between these variables was significant, X^2 (10, N=401)=19.219, p = .038. This indicates that the distribution of organizations by region was statistically significantly different among the three clusters. Figure 18 graphically depicts the percentage of organizations by region included in the sample found within each cluster.

Figure 18
Distribution of Sample Organizations by AHP Region within Clusters



Organizations from the Midwest represent the largest percentage of organizations in each of the three clusters, and comprise 40% of the organizations within Cluster 3. The majority of organizations from New England are found in Cluster 2. The Mid-Atlantic and Southeast regions are close to equally represented in each cluster. Cluster 1 has a higher percentage of organizations from the Pacific and Rockies/Southwest regions.

Organization Size. A one-way between groups analysis was conducted to determine if the clusters of organizations could be further differentiated on the basis of organization size in terms of the number of staffed beds. There was a statistically significant difference at the $p<.05$ level in bed size for the three clusters of organizations

[*F*(2, 398)=8.459, p<.001]. Although the differences are statistically significant, the actual difference in mean scores between the groups was a small to medium effect size, based on the eta squared of .04. Post-hoc comparisons using the Tukey's HSD test indicated that the mean score for Cluster 3 (*M*=247.1, *SD*=234.96) was significantly different from Cluster 1 (*M*=480.13, *SD*=551.88) and from Cluster 2 (*M*=417.32, *SD*=500.85). Cluster 1 and Cluster 2 did not differ significantly with each other.

Age of Fundraising Unit. A one-way between groups analysis was conducted to determine if the clusters of organizations could be further differentiated on the basis of the number of years the organizations reported having a fundraising office. There was a statistically significant difference at the p<.05 level in bed size for the three clusters of organizations [*F*(2, 398)=4.114, p<.017]. Although the differences are statistically significant, the actual difference in mean scores between the groups was very small. The effect size, calculated using eta squared, was .02. Post-hoc comparisons using the Tukey's HSD test indicated that the mean score for Cluster 2 (*M*=19.29, *SD*=16.02) was significantly different from Cluster 3 (*M*=14.9, *SD*=10.87). Cluster 1 (*M*=18.51, *SD*=11.21) did not differ significantly with either Cluster 2 or Cluster 3.

Funds Raised (Gifts and Pledges). A one-way between groups analysis was conducted to determine if the clusters of organizations could be further differentiated on the basis of the distribution of funds raised by source, which includes cash, securities, non-monetary items sold, pledges, planned gifts, and other.

There was a statistically significant difference at the p<.05 level in the percentage of cash gifts for the three clusters of organizations [$F(2, 351)=35.984$, p<.001]. The effect size, calculated using eta squared, was .17, indicating a large difference. Post-hoc comparisons using the Tukey's HSD test indicated that the mean scores for all of the clusters were significantly different from each other, including Cluster 1 (M=52.59, SD=28.06), Cluster 2 (M=66.40, SD=22.03), and Cluster 3 (M=82.72, SD=22.032).

Funds raised from pledges was also statistically significantly different at the p<.01 level for all of the clusters [[F(2, 351)=29.454, p<.001]. The effect size also indicated a large difference at eta squared equal to .14. Post-hoc comparisons indicated that the mean scores were statistically significantly different among all of the clusters, including Cluster 1 (M=28.49, SD=39.72), Cluster 2 (M=15.02, SD=20.96), and Cluster 3 (M=7.63, SD=14.81).

The difference among the planned gifts was discussed earlier in the chapter. The clusters were not significantly different in terms of percentages of funds raised from securities, non-monetary assets sold, and other assets.

Use and Distribution of Funds Raised. A one-way ANOVA was also conducted to determine if the clusters could be further differentiated in terms of the use and distribution of funds raised. The test shows that there was not a statistically significant difference for charity care, community benefit, endowment corpus, general operations, research/teaching, and other. The analysis did indicate a statistically significant difference for three categories: construction/renovation [F(2,342)=13.747, p<.001],

equipment [F(2, 342)=4.842, p=.008], and hospice/long term care [F(2, 342)=3.254, p<.05].

The results of the additional ANOVA analyses for size, age, source of funds, and use of funds are summarized in Table 26.

Table 26
One-way ANOVA Results: Variables of Interest

	df	Sum of Squares	Mean Square	$\acute{\eta}^2$	F
Beds	2	3399160.40	1699580.22	.04	8.46*
Age of Fundraising Office	2	1509.16	754.58	.02	4.11**
Cash	2	43584.67	21792.34	.17	35.95*
Securities	2	316.68	158.34	.00	1.15
Non-monetary sold	2	113.06	53.53	.00	1.51
Pledges	2	25853.74	12926.87	.14	29.45*
Other	2	178.21	89.10	.00	1.04
Charity Care	2	890.32	445.16	.01	.11
Community Benefit	2	612.74	303.37	.00	1.06
Construction/Renovation	2	24062.89	12031.45	.07	13.74*
Endowment Corpus	2	758.45	379.23	.01	1.83
Equipment	2	7887.41	3943.71	.03	4.84*
General Operations	2	1082.11	541.05	.00	1.18
Hospice/Long term Care	2	718.92	359.46	.01	3.25**
Research/Teaching	2	562.35	281.17	.01	2.78
Other	2	270.07	135.04	.00	.40

*p<.01
**p<.05

Cluster Descriptions

Cluster 1. Cluster 1 is the smallest cluster, comprised of 90 (22.4%) organizations. The cluster has the highest level of funds raised per FTE at approximately $1.49 million on average and the highest level of funds raised per donor at approximately $7,169 on average. The organizations also exhibit the most efficiency in terms of the

fundraising cost ratio, which is .13 on average. The organizations have the second highest percentage of funds raised attributable to pledges from planned gifts, which is 5.24% on average; it also has the greatest variance of planned gifts percentages at 78.

Cluster 1 has the highest level of staffing among the three clusters, which differs significantly from Cluster 3 but not Cluster 2. Interestingly, Cluster 1 has the lowest average level of corporate support among the three clusters, but the highest level of foundation support on average. Approximately 70% of the organizations in Cluster 1 have established an endowment, which is slightly above the average for the sample of organizations.

Cluster 1 has the largest bed size on average at 480. It has an average fundraising age of 18.51 years. Neither of these variables are significantly different from Cluster 2, but are statistically significant in difference from Cluster 3. Cluster 1 reports the lowest percentage of cash among its total funds raised at approximately 53%, and highest level of pledges at 34%. Both of these variables are statistically significantly different from both Cluster 2 and Cluster 3. Finally, Cluster 1 reports the highest percentage of funds raised used for construction at 40%, which differs from both of the other clusters; the least for equipment at 14.8%, which differs from Cluster 3; and the least for hospice or long term care at 1.28%, which differs from Cluster 2.

Cluster 1 is populated by organizations that identified themselves as community institutions, which accounts for 64.4% of the group. The cluster has the 40% of the institutions reporting an academic setting. The majority of the organizations at 65.6% report a local scope to their fundraising, but the cluster does contain nearly 58% of

organizations that reported a national scope. The organizations in the cluster are fairly balanced across the different AHP regions.

The descriptive statistics for the cluster variables for Cluster 1 as well as the other continuous variables that were found to be statistically significant are shown in Table 27.

Table 27
Cluster One Descriptive Statistics

	N	Mean	Standard Deviation	Minimum	Maximum
Basis Variables					
Funds per FTE	90	$1,494,431	$1,384,388	$594,158	$11,153,907
Funds per Donor	90	$7,169	$8,525	$1,899	$61,412
Fundraising Cost Ratio	90	0.13	0.08	0.00	.39
Planned Gifts	90	5.24%	13.08%	0.00%	78.00%
Hypotheses Variables	90				
Staffing	90	9.9	14.74	.50	101.00
Corporate Support	87	13.93%	13.71%	0.00%	69.00%
Foundation Support	87	18.19%	20.23%	0.00%	85.00%
Other Variables					
Beds	90	480.13	551.88	25	3437
Fundraising Age	89	18.51	11.21	1	60
Cash	86	52.59%	28.06%	10%	100.00%
Pledges	86	34.11%	26.18%	0.00%	87.00%
Construction	79	40.04%	33.64%	0.00%	100.00%
Equipment	79	14.82%	22.15%	0.00%	100.00%
Hospice/Long Term Care	79	1.28%	2.98%	0.00%	14.50%

Cluster 2. Cluster 2 is the largest cluster being comprised of 184 organizations, which accounts for 46% of the clustered organizations. This cluster is characterized by the highest level of planned gifts percentage among the organizations, with an average of 6.63% of funds raised attributable to pledges from planned gifts. This does not differ

significantly from Cluster 1, but it does differ from Cluster 3. Cluster 2 is in the middle level on all other variables, with an average funds raised per FTE of $467,315, an average funds raised per donor of approximately $1,326, and a fundraising cost ratio of .32.

Cluster 2 has a staffing level of 5.8 FTEs on average, which differs from Cluster 3 but not Cluster 1. It is at the mid-level for corporate support, differing from Cluster 3 but not Cluster 1, and for foundation support, differing from Cluster 1 but not Cluster 3. Cluster 2 has the highest percentage of organizations with an endowment at 77.7%. This is well above the average for the sample population, and above both Clusters 1 and 3.

Cluster 2 has an average bed size of 417and has an average fundraising age of 16.02 years. Neither of these variables are significantly different from Cluster 1, but are statistically significant in difference from Cluster 3. Cluster 2 reports receiving 66% of its funds raised in cash and 18% in pledges. Finally, Cluster 2 falls in the middle of the three clusters in terms of the percentage spent on construction and on equipment, but the highest on hospice/long term care.

Cluster 2 is also populated by organizations that identified themselves as community institutions, which accounts for 66.8% of the group. The cluster has nearly 80% of organizations that reported to be children's hospitals and 65% of the organizations that identified as a system of institutions or organizations. The majority of the organizations at 73.9% report a local scope to their fundraising, but the cluster does contain more than 50% of organizations that reported a regional scope and 50% of organizations reporting a statewide scope. Forty percent of the organizations in Cluster 2 serve a 100,000-499,999 population base, and the Cluster also contains the highest percentage of organizations reporting to serve 1 million or more. The organizations in the

cluster are fairly balanced across the different AHP regions. Cluster 2 contains a higher percentage of organizations from all of the AHP Regions when compared to Clusters 1 and 3, including 75% of organizations from New England.

The descriptive statistics for the cluster variables for Cluster 2 as well as the other variables that were found to be statistically significant are shown in Table 28.

Table 28
Cluster Two Descriptive Statistics

	N	Mean	Standard Deviation	Minimum	Maximum
Basis Variables					
Funds per FTE	184	$467,315	$312,777	$1,159	$2,491,273
Funds per Donor	184	$1,326	$957	$120	$8,022
Fundraising Cost Ratio	184	0.32	0.51	0.00	4.94
Planned Gifts	184	6.63%	13.08%	0.00%	52.00%
Hypotheses Variables					
Staffing	184	5.80	8.80	.50	63.00
Corporate Support	164	18.00%	20.23%	0.00%	75.00%
Foundation Support	164	11.36%	16.65%	0.00%	66.00%
Other Variables					
Beds	184	417.32	500.85	15	4000
Fundraising Age	185	19.29	16.02	1	133
Cash	163	66.40%	24.26%	.50%	100.00%
Pledges	163	18.00%	19.24%	0.00%	95.00%
Construction	157	24.00%	28.20%	0.00%	100.00%
Equipment	157	22.65%	27.52%	0.00%	100.00%
Hospice/Long Term Care	157	4.96%	11.73%	0.00%	93.00%

Cluster 3. Cluster 3 is comprised of 126 (31.7%) organizations. This cluster is characterized as having organizations with the highest fundraising cost ratio, which is .91 on average. The cluster also exhibits the lowest levels of funds raised per FTE at $181,104 on average and funds raised per donor at $837 on average. The vast majority of

organizations in the cluster reported no planned gifts as a percentage of total funds raised, however there is at least one organization within the cluster that reported having funds raised attributable to planned gifts. The resulting average planned gifts percentage for the cluster is .07%.

Cluster 3 has the lowest level of staffing among the three clusters at 4.1 FTEs on average. Cluster 3 has the highest average level of corporate support among the three clusters at 25.16%, but the lowest level of foundation support at 9.79% on average. Approximately 57% of the organizations in Cluster 3 have established an endowment, which is below the average for the sample of organizations and the lowest among the clusters.

Cluster 3 has the smallest bed size on average at approximately 247. It has an average fundraising age of 14.90 years. Both of these variables are significantly different from Cluster 1 and Cluster 2. Cluster 3 reports the highest percentage of funds raised attributable to cash at approximately 83%, and lowest level of pledges at 11%. Both of these variables are statistically significantly different from both Cluster 1 and Cluster 2. Cluster 3 reports the lowest percentage of funds raised used for construction at 17%, which differs from both of the other clusters; the most for equipment at nearly 28%, which differs from Cluster 1; and approximately 4% for hospice or long term care, which does not significantly differ from the other two clusters.

Cluster 3 is populated by organizations that identified themselves as community institutions, which accounts for 83.5% of the group. The cluster has the nearly 40% of the institutions reporting to be a public or government hospital. None of the children's hospitals appear in this cluster. A large majority of the organizations at 81.1% report a

local scope to their fundraising; approximately 10% report a regional or multi-state scope of fundraising. The organizations in Cluster 3 appear to serve smaller population bases with 84% reporting at less than 500,000. The organizations in the cluster are fairly balanced across the different AHP regions, with 40% reporting to be in the Midwest.

The descriptive statistics for the basis variables for Cluster 3 along with the other variables of interest that are statistically significant are shown in Table 29.

Table 29
Cluster Three Descriptive Statistics

	N	Mean	Standard Deviation	Minimum	Maximum
Basis Variables					
Funds per FTE	127	$181,104	$128,226	$673	$556,797
Funds per Donor	127	$837	$745	$46	$4,477
Fundraising Cost Ratio	127	.91	1.15	0.00	7.00
Planned Gifts (%)	127	.07%	.07%	0.00%	7.00%
Hypotheses Variables					
Staffing	126	4.10	6.34	.85	55.00
Corporate Support	111	25.16%	21.72%	0.00%	80.00%
Foundation Support	111	9.79%	16.28%	0.00%	80.00%
Other Variables					
Beds	127	247.1	234.95	9	1112
Fundraising Age	126	14.9	10.87	1	50
Cash	105	82.72%	22.03%	.50%	100.00%
Pledges	105	11.22%	18.56%	0.00%	82.00%
Construction	109	17.47%	28.20%	0.00%	100.00%
Equipment	109	27.94%	33.63%	0.00%	100.00%
Hospice/Long Term Care	109	4.02%	12.03%	0.00%	80.00%

Summary of Statistical Analyses

A summary of the differentiation between the three clusters on the basis of the OEP characteristics as well as other variables of interest that were found to be statistically significant is depicted in Table 30. The additional variables of interest include environmental/organizational characteristics and sources and uses of funds. Only those characteristics that significantly differentiated the clusters were included in the table.

Table 30
Cluster Comparison

	Cluster 1	Cluster 2	Cluster 3
OEP Characteristics			
Productivity	High	Mid	Low
Efficiency	High	Mid	Low
Complexity	High	Mid	Low
Structure (staffing)	High	Mid	Low
Maturity	Mature	More Mature	Less Mature
Legitimacy	High (Foundations) Low (Corporations)	Mid	High (Corporations) Low (Foundations)
Environmental/Organizational Characteristics			
Population Served	Larger Base	Larger Base	Smaller Base
Organization Size	Larger	Larger	Smaller
Fundraising Age	Older	Older	Slightly Younger
Sources & Uses of Funds			
Funds–Cash	Low	Mid	High
Funds–Pledges	High	Mid	Low
Use–Construction	High	Mid	Low
Use–Equipment	Low	Mid	High
Use–Hospice/LTC	Low	High	High

CHAPTER 5

SUMMARY AND CONCLUSIONS

Introduction

The purpose of this study was to investigate the fundraising characteristics of nonprofit hospital organizations. The organizations were clustered into homogenous groups on the basis of productivity, efficiency and complexity measures, and the groups were then examined to determine if there were differences between the clusters in terms of structure, legitimacy and maturity. Other factors such as organizational size, age, and various characteristics of the fundraising operation were also examined to determine if there were other significant differences that could be useful in developing an organizational profile for each cluster. Relatively little theoretically-based research has been conducted on charitable fundraising in general and in the healthcare context specifically. This study addresses an issue that has been raised in the literature, which is the need to study the management of fundraising in nonprofit organizations and to do so within a specific context or organizational field. It also can provide information that is useful to those who evaluate and manage fundraising in the nonprofit hospital industry.

Conclusions and Implications

The first two research questions focused on identifying the fundraising performance characteristics of nonprofit hospital organizations and determining if distinct

groupings of nonprofit hospital organizations can be identified on the basis of these characteristics. Previous studies of fundraising for nonprofit organizations have recommended that organizational characteristics other than age and size should be used to evaluate and compare nonprofit organizations. This study identifies and explores the differences among the fundraising operations of nonprofit organizations on the basis of several performance characteristics. The fundraising performance characteristics identified included measures of productivity, efficiency and complexity. The cluster analysis on the basis of the productivity, efficiency and complexity measures resulted in three clusters of organizations. Subsequent questions explored the differences between the clusters in terms of structure, maturity and legitimacy as well as several other characteristics, which resulted in some mixed results. For most of the variables tested, the cluster with the lowest productivity level and highest fundraising cost ratio (Cluster 3) was significantly different from the other two clusters (Cluster1 & Cluster 2). However, the other two clusters were not always significantly different from each other. In other words, there was evidence of a higher level of isomorphism among the organizations in Clusters 1 and 2. This was evident in staffing, endowment status, corporate support, size, age and distribution of funds raised.

Additional organizational characteristics were then explored to examine the differences between groups of organizations with similar performance characteristics. Hypotheses Two and Three sought to determine if there were differences between clusters based upon the structure of the fundraising unit. This included the configuration of the fundraising unit in relationship to the hospital organization, and the level of staffing in the fundraising unit. Fundraising for hospitals is often conducted through a

separate 501(c)(3) foundation, but may also be conducted by a department or division within the hospital. The foundation structure was the prevalent structure among the sample organizations at nearly 77%, but there was not found to be a significant difference among the clusters on the basis of structure. The other structural measure focused on the number of full time employees in the fundraising unit, which included both fundraising professionals and support staff. The level of staffing was found to be significantly different in Cluster 3 in comparison to Clusters 1 and 2, but not different between these two clusters.

The third research question asked if there were differences between the groups of organizations in terms of maturity. The existent literature indicates that maturity models can be built on a number of different features and do not constitute a value judgment. Organizations can be considered to be mature in one area, but not in another. One of the most advanced technologies used in the field of fundraising is the endowment fund. A maturity model based upon the presence of an endowment was used for this study, with those organizations reporting to have established an endowment being labeled as more mature and those without as less mature. Hypothesis Four explored the status of the endowment within the clusters to determine if there was differentiation among them. This hypothesis was supported, indicating that there was a significant difference among the clusters in terms of the percentage of organizations reporting to have an endowment. As might be expected, Cluster 3 had a much lower percentage of organizations than either Cluster 1 or 2 that reported having an endowment fund. These findings lend support to the suggestion that the status of the endowment fund is a viable measure of fundraising maturity.

The last two research questions focused on the differences among the groups of organizations in terms of legitimacy. For this study, legitimacy was measured as the level of support received from corporate and foundation donors as a percentage of total funds raised. This is based upon findings in the literature indicating that organizations considered to be more legitimate, including its fundraising staff, are more successful at securing corporate support. It is also based on the understanding that foundations have more stringent criteria for selecting organizations to support, and therefore would be more likely to support organizations that are considered to be more legitimate. Hypotheses 5a and 5b focused on the legitimacy of the organizations as evidenced by the level of corporate and foundation support received as a percentage of funds raised. Interestingly, Cluster 3 was significantly different from the other two clusters and had a higher average level of support from corporations than the other two clusters. Cluster 1 differed in terms of foundation support and had the highest level of foundation support among the clusters.

There were differences among the clusters based upon the level of corporate and foundation support, but the findings were not exactly as expected. These measures of legitimacy might be more effective in studies that compare nonprofit organizations of different types that are in competition with one another for charitable dollars. Nonprofit hospital organizations by nature may be perceived as more legitimate than some other charitable organizations in their communities, and therefore may receive higher percentages of corporate and foundation support than some other types of NPOs.

Based upon the findings from the statistical analysis and from the academic and practitioner literature, the following are profiles of each of the clusters including

assumptions about the nature and focus of the fundraising operations of the NPOs within each cluster.

Cluster Profiles

Cluster One – Mature, complex, highly productive, and highly efficient. Cluster 1 could be characterized as a group of hospital organizations with mature, efficient and complex fundraising operations that are highly productive. The organizations tend to be larger in terms of bed size and to be located in more densely populated areas. The organizations in Cluster 1 tend to have higher number fundraising staff members who are highly productive and have been successful in cultivating a high level of average giving from donors. This high level of productivity has been achieved at a low fundraising cost, at a cost of 19 cents per dollar raised on average. This is well below the standard of .35 set forth by the Better Business Bureau's Wise Giving Alliance. Not surprisingly, this cluster has the most diversified portfolio of funds raised, with a balanced mix attributable to cash, pledges and planned gifts.

Cluster 1 also had the highest level of giving attributable to foundations, which may be indicative of organizations that have larger, more specialized staff that includes personnel experienced at cultivating and soliciting grant support from foundations. Although the majority of the organizations were identified as community institutions, Cluster 1 did contain the highest percentage of the organizations identified as being in an academic setting and organizations that reported having a national scope for their fundraising. Academic institutions and institutions that are nationally-known may often be the recipients of sizeable grants from foundations, therefore this might be one of the

contributing factors in the high level of foundation support received on average by organizations in this cluster. Cluster 1's high level of foundation support might also be an explanation for its high levels of productivity. It is possible that these organizations may have received some very sizeable foundation gifts that would drive up the funds per donor and funds per FTE ratios.

Because of the higher productivity levels, lower fundraising cost ratio and the higher percentage committed to construction, it is possible to assume that these are well-known and well-respected organizations that are adept at cultivating major gifts from a well-established donor base in addition to larger foundations.

Cluster Two – Mature, complex, less productive, and less efficient. Cluster 2 could be characterized as being very similar to Cluster 1 in a number of ways. Cluster 2 also consists of organizations that are large in size and appear to have mature, efficient and complex fundraising operations. Cluster 2 includes almost 50% of the organizations from the sample, and could be characterized as the middle or average group in terms of productivity and efficiency with levels that are closest to the averages for the overall sample population. This cluster is significantly different from Cluster 1 in terms of productivity and efficiency, exhibiting lower productivity levels and a higher fundraising cost ratio. However, at an average fundraising cost ratio of .32, the organizations are below the threshold set by watchdog groups. Interestingly, the proportion of organizations reporting to have an endowment is highest in Cluster 2 at 77%.

Based upon the performance and other organizational characteristics, it appears that organizations in this cluster have a balanced and diverse fundraising operation that is

working with an established donor base but are not as successful at raising significant major gifts as Cluster 1. This might be attributable to a number of factors, including environmental factors such as the giving capacity of donors in their geographic area or the focus and/or ability of the fundraising staff to cultivate major gifts or pursue foundation support, among others.

Cluster Three – Less mature, less complex, least productive, and most inefficient. The cluster that is most consistently different from the other clusters on most variables of interest is Cluster 3. This cluster is comprised of organizations that on average have a much lower level of productivity and are well above the fundraising cost ratio threshold of .35. The fundraising units in these organizations could be characterized as being the least complex because of the lack of evidence of planned gifts, a much lower percentage of organizations with endowments, and a higher level of funds raised as cash gifts. The organizations in Cluster 3 have the least number of full time employees on average, which would be expected given the lower average bed size of the organizations. The organizations in Cluster 3 have a slightly younger fundraising operation on average than the other clusters. One of the interesting characteristics is the level of corporate support, which is the highest on average among the clusters at 25%. It is possible that this is attributable to the size and location of the organizations as smaller organizations that are situated in smaller communities where giving is more heavily solicited from local businesses, including those owned by board members.

Because of the prevalence of cash gifts and corporate contributions, it might be surmised that these organizations, which are typically smaller in size and located in

smaller communities, are very reliant on fundraising through special events and annual fund solicitations. Corporate sponsorship is often a major emphasis for special events, and special events can be expensive and time consuming which could also contribute to the lower productivity levels and higher fundraising cost ratio. These organizations also typically have smaller staffs and are therefore not as well-equipped to effectively focus on cultivating major gifts or planned gifts given the amount of time and resources necessary to run special events and annual fund campaigns.

Contributions of the Study

This study offers both practical and theoretical implications. The study contributes to the field of nonprofit OEP research and healthcare management research by applying a theoretical framework to the study of fundraising and by examining fundraising within the health care field. Previous research identified the need for more in-depth studies of fundraising management, and for the research to be conducted within sub-sectors of the larger nonprofit sector. This recommendation is supported by the concept of the organizational field, which is central to institutional theory. This study identifies nonprofit hospital organization fundraising as an organizational field.

Previous studies have concluded that organizational characteristics other than age and size should be examined to differentiate and evaluate nonprofit organizations, and that fundraising characteristics for nonprofit organizations vary widely across the nonprofit sector and therefore are best studied within specific sub-sectors of nonprofit organizations. Findings from this study suggest that comparisons of fundraising for nonprofit organizations may best be done within sub-sectors of organizations as

recommended by other studies, but there is still variability in performance characteristics within a sub-sector. Therefore, this study may help provide a better understanding of fundraising performance characteristics and the categorization of organizations on the basis of those characteristics that can be applied across sub-sectors of nonprofit organizations.

Another contribution of the study is the development of a maturity model that can be used to evaluate fundraising for nonprofit organizations, which is the adoption of the endowment fund. The findings of this study indicated that there was a significant difference among clusters of organizations in terms of the levels of adoption of the endowment fund.

One of the practical contributions of the comprehensive analysis of fundraising is that it may be useful to nonprofit hospital organization leaders as they evaluate their organization's fundraising activities in comparison to organizations that are similar on the basis of performance, structure, maturity and legitimacy, and not just on demographic characteristics such as size, geographic location and population served. The study analyzes the AHP data in a way that differs from the manner in which it is typically reported to its member organizations. And, it makes this information available to a wider group of organizations, both within and outside of the healthcare context..

In addition to these contributions, this study helps bring attention to the sophisticated and highly productive fundraising that is being conducted throughout the country by nonprofit hospital organizations. As noted in the first chapter, many individuals have written about the increasing importance of charitable contributions for nonprofit hospitals, but few have seemed to recognize that those who are working as

fundraisers in nonprofit hospitals are already well aware of this and are managing significant fundraising operations.

Limitations of the Study

The limitations of the study include the problems that are always inherent when working with survey data. Some of the questions in the survey may have some reliability and validity issues due to what appears to be some inconsistency in the answers and some questionable levels of measurement. This might indicate the respondents were not able to answer some questions or provide some of the data as requested. This was addressed during the data cleaning process, and cases were removed when it was apparent that the survey was most likely answered in error.

The AHP dataset included cases that were missing many of the variables of interest. Only those organizations that self-identified were kept in the sample, thus significantly decreasing the sample size. In order to acquire a suitable sample size, panel data was used to build a cross-sectional study and monetary variables were converted using a CPI index conversion. Although the survey questions appeared to be simple computations of percentages, some organizations appeared to have difficulty fleshing out the categories of some of the fundraising results questions or simply didn't want to take the time to do the calculations.

Another limitation is the subjectivity used to manually place 73 of the cases into the clusters after the initial two-step cluster analysis. The excluded cases were carefully examined and compared to the organizations within the clusters, but it is possible that errors of judgment may have occurred in the selection of the appropriate cluster.

However, the descriptive analysis of the clusters prior to and after adding the 73 cases were compared to determine if there had been significant changes among the variables and none were found.

Finally, another limitation of the study is the nature of fundraising itself, which is typically not a linear process. Therefore, results from a cross-sectional study of fundraising are a snapshot in time and different results might be found if another time frame had been chosen. A more ideal study of fundraising would look at an average over a longer period of time, perhaps 3-5 years, to investigate measures used in this study. Cross-sectional studies can be useful in identifying associations among variables that can be more rigorously investigated in future studies.

Recommendations for Future Research

This study is an exploratory analysis of fundraising management in the nonprofit hospital industry, and provides several avenues for future research. This includes testing the measures of productivity, efficiency, complexity, maturity and legitimacy in other sub-sectors of nonprofit organizations. It would be useful to compare the results within and between sub-sectors of nonprofits, particularly for the endowment as a measure of maturity and the level of foundation and corporate support as measures of legitimacy.

Further exploration of the role of the endowment as a measure of maturity could include the development of a metric to compare organizations and their endowments on the basis of both age and size of the endowment. Organizations may report that they have established an endowment, but may not have been successful in building the endowment. This could be a further indication of mimetic isomorphism that occurs when a practice is

implemented because of another organization's success even though there is no other basis for the implementation when the organization is not equipped to use it.

Within the hospital fundraising context, a next step would be to examine additional characteristics of the clusters of organizations, including organizational culture, mission, goals, board composition and characteristics, and leadership characteristics. Having information about the environment and the level of expertise of staff and involvement of board members could provide a more complete understanding of what truly differentiates higher performing from lower performing organizations. This could be useful in management in understanding what can and cannot be controlled, and in setting realistic expectations for fundraising outcomes and investments. This would probably be best accomplished by a qualitative study involving a few organizations from each cluster. This in turn might lead to the development of an instrument that could be effective in capturing additional data from a larger population of organizations.

One area of research of interest is comparing the financial data in the survey responses with the financial data reported in the IRS Form 990-H for the organizations that self-identified to determine if the information is comparable. An additional area of interest is in comparing these organizations survey responses pre and post 2008 when the Form 990-H was redesigned with a more clear definition of what can be counted as charity care and as community benefit to see if there were significant changes in percentage of funds used for these two categories.

Summary

As the nonprofit sector continues to expand, so does the need for competent leadership and strategic management to address the public demand for accountability. Because fundraising is one of the most troublesome aspects of management for nonprofit organizations, it is important that nonprofit leaders, board members, and fundraising staff understand the nature of fundraising and why certain strategic choices may be made by organizations concerning fundraising. Research on the management of fundraising in nonprofit organizations is scarce, particularly for sub-sectors other than higher education. Previous studies have concluded that management of fundraising varies widely across the nonprofit sector, and is best studied in nonprofit organizations that are similar in context. This study attempts to extend a small but growing body of research to gain a better understanding of the nature of fundraising and fundraising management among nonprofit hospital organizations. This is a preliminary step toward helping the nonprofit hospital leader to better evaluate the fundraising operation in comparison to organizations that are truly alike, and to set realistic fundraising goals and expectations in strategic planning for their organizations as they go forward.

REFERENCES

Abrahamson, E. 1996. Management fashion. *Academy of Management Review*, 21(2): 254-285.

AHP; Association for Healthcare Philanthropy; http://www.ahp.org, 2009.

AIP. 2009. Criteria: American Institute of Philanthropy.

Andreoni, J. 1998. Toward a theory of charitable fund-raising. *Journal of Political Economy*, 106(6): 1186-1213.

Ashworth, R., Boyne, G. & Delbridge, R. 2009. Escape from the iron cage? Organizational change and isomorphic pressures in the public sector. *Journal of Public Administration Research and Theory*. 19(1): 165-187

BBB Wise Giving Alliance; Standards for charity accountability; http://www.bbb.org/us/Charity-Standards/; October 19, 2009.

Barman, E. 2007. An institutional approach to donor control: From dyadic ties to a field-level analysis. *The American Journal of Sociology*, 112(5): 1416-1457.

Baruch, Y., & Ramalho, N. 2006. Communalities and distinctions in the measurement of organizational performance and effectiveness across for-profit and nonprofit sectors. *Nonprofit and Voluntary Sector Quarterly*. 35: 39-65.

Bazzoli, G. J., Chan, B., Shortell, S. M., & D'Aunno, T. 2000. The financial performance of hospitals belonging to health networks and systems. *Inquiry-the Journal of Health Care Organization Provision and Financing*, 37(3): 234-252.

Beem, M. J. 2001. Fundraising in the balance: an analysis of job performance, appraisals and rewards. *International Journal of Nonprofit and Voluntary Sector Marketing*, 6(2): 164-171.

Begun, J. W. & Luke, R. D. 2001. Factors underlying organizational change in local health care markets, 1982-1995. *Health Care Management Review*, 26(2): 62.

Bennett, R., & Gabriel, H. 2003. Image and reputational characteristics of UK charitable organizations: An empirical study. *Corporate Reputation Review*. 6(3): 276-289

Berger, P. C. & & Luckman, T. *The social construction of reality: A treatise in the sociology of knowledge*. London: Penguin.

Bila, T. 1991. *Certified fund raising executives: their profile and the approaches they have used to obtain their current employment*. Unpublished dissertation, Southern Illinois University at Carbondale.

Blackwood, A., Wing, Kennard T., & Pollack, Thomas H. 2008. The nonprofit sector in brief: Facts and figures from the Nonprofit Almanac 2008: 7. Washington, D.C.: The Urban Center.

Brooks, A. C. 2004. Evaluating the effectiveness of nonprofit fundraising. *Policy Studies Journal*, 32(3): 363-374.

Brown, W. 2005. Exploring the association between board and organizational performance in nonprofit organizations. *Nonprofit Management and Leadership*, 15(3).

Bryson, J. 1995. *Strategic planning for public and nonprofit organizations* (revised ed.). San Francisco: Jossey-Bass.

Bryson, J. M. 1989. *Strategic planning for public and nonprofit organizations*. San Francisco: Jossey-Bass.

Bryson, J. M., Ackermann, F., & & Eden, C. 2007. Putting the resource-based view of strategy and distinct competencies to work in public companies. *Public Administration Review*, 67(4): 702-717.

Buehrle, J. & Gordon, B. 2007. Partnering with finance: a successful model for collaboration. *AHP journal/Association for Healthcare Philanthropy*: 18.

Burlingame, D. 1997. *Critical Issues in Fund Raising.* New York: John Wiley & Sons, Inc.

Cameron, K. S. & Whetten, D.A. 1986. Perceptions of organizational effectiveness over organizational life cycles. *Administrative Science Quarterly*. 26(4): 525-544.

Cao, Y. 2004. Behind the rising meritocracy: Market, politics and cultural change in urban China. *Social Science Research*, 33(3): 435-463.

Carbone, R.F. 1986. *An Agenda for Research on Fundraising*. College Park, MD: Clearinghouse for Research on Fund Raising.

Carbone, R. F. 1989. Fund Raising as a Profession. College Park, MD: Clearinghouse for Fund Raising Research.

CASE. 1990. Expenditures in fund raising, alumni relations, and other constituent (public) relations. Washington, D.C.: Council for Advancement and Support of Education.

Chait, R., Ryan, W., & Taylor, B. 2005. *Governance as leadership: Reframing the work of nonprofit boards*: Wiley.

Chang, D. I. 2006. Applying lessons learned In communities to programs and policies at the federal level. *Health Affairs*, 25: W192-W194.

Cleverley, W. O. & Cleverley, J. 2005. Philanthropy: the last frontier for capital funding. *Journal of Healthcare Management*, 50(5): 290.

Clohesy, W. W. 2003. Fund-Raising and the Articulation of Common Goods. *Nonprofit and Voluntary Sector Quarterly*, 32(1): 128-140.

Cohen, J. 1988. *Statistical power analysis for the behavioral sciences.* Hillsdale, NJ: Erlbaum.

Colwell, P. 1983. Set up a foundation to aid hospital fund raising. *Fund raising management*, 14(4): 28.

Cook, W. 1994. *Courting philanthropy: The role of university presidents and chancellors in fund raising*. Unpublished dissertation, University of Texas at Austin.

Corcoran, D. J. & Shackman, J. D. 2007. A theoretical and empirical analysis of the strategic value of beyond compliance occupational health and safety programs. *Journal of Business Strategies*, 24(1): 20.

Costa, N. G. 2005. Integrating fundraising into finance. *New Directions for Philanthropic Fundraising*, 2005(49): 13-27.

Crittenden, W. F. 2000. Spinning Straw Into Gold: The Tenuous Strategy, Funding, and Financial Performance Linkage. *Nonprofit and Voluntary Sector Quarterly*, 29(suppl_1): 164-182.

D'Aunno, T., Sutton, R., & Price, R. 1991. Isomorphism and external support in conflicting institutional environments: A study of drug abuse treatment units. *The Academy of Management Journal*, 34(3): 636-661.

Deloitte & Touche, 2006. The future of health care: An outlook from the perspective of Hospital CEOs, *2005 Biennial Survey*, 10th ed.: 15: Deloitte & Touche USA LLP.

DiMaggio, P. J. & Powell, W. W. 1991. *The New Institutionalism in Organizational Analysis*. Chicago: University of Chicago Press.

DiMaggio, P. J. & Powell, W. W. 1983. The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. *American Sociological Review*, 48(2): 147-160.

Dolnicar, S., Irvine, H., & & Lazarevski, K. 2008. Mission or money? Competitive challenges facing public sector nonprofit organisations in an institutionalised

environment. *International Journal of Nonprofit and Voluntary Sector Marketing*, 13(2): 107-117.

Drucker, P. F. 1978. Managing the third sector, *The Wall Street Journal,* October 3, p. 26.

Drucker, P. F. 2006. *Managing the non-profit organization: practices and principles*: New York: HarperCollins Publishers.

Duronio, M. A. & Loessin, B. 1989. Fund Raising Outcomes and Effectiveness in Private and Public Institutions. ASHE Annual Meeting Paper.

Duronio, M. A. & Tempel, E. R. 1997. *Fund Raisers: Their Careers, Stories, Concerns and Accomplishments*. New York: Jossey-Bass.

Egger, E. 2000. Market memo: Fundraising no longer just 'icing on the cake' for hospitals. *Health Care Strategic Management*, 18(7).

Fayol, H. 1949. *General and Industrial Management*. New York: Pittman.

Fennel, M. & Alexander, J. A. 1987. Organizational spanning and institutionalized environments. *Academy of Management Journal*, 30: 456-476.

Ferris, J. M., & Graddy, Elizabeth A. 1999. Structural changes in the hospital industry, charity care, and the nonprofit role in health care. *Nonprofit and Voluntary Sector Quarterly*, 28(1): 18-32.

Fisman, R. & Hubbard, R. G. 2003. The role of nonprofit endowments. In *The Governance of Not-for-profit Organizations*. Glaeser, E. ed. Chicago: University of Chicago Press.

Friedland, R. & Alford, R. 1991. Bringing society back in: Symbols, practices and institutional contradictions. In W. W. Powell & P. DiMaggio (Eds.), *The new institutionalism in organizational analysis*. Chicago: University of Chicago Press.

Frumkin, P. & Galaskiewicz, J. 2004. Institutional isomorphism and public sector organizations. *Journal of Public Administration Research and Theory*, 14(3): 283.

Galaskiewicz, J. 1985. Professional networks and the institutionalization of a single mind set. *American Sociological Review*, 50(5): 639-658.

Galaskiewicz, J. & Burt, R. S. 1991. Interorganization contagion in corporate philanthropy. *Administrative Science Quarterly*. 36(1): 88-105.

Galaskiewicz, J., Bielefeld, W., & Dowell, M. 2006. Networks and organizational growth: A study of community based nonprofits. *Administrative Science Quarterly*, 51(3): 337-380.

Galaskiewicz, J. & Wasserman, S. 1989. Mimetic Processes within an Interorganizational Field: An Empirical Test. *Administrative Science Quarterly*, 34(3).

Giving USA, 2009. Giving USA: Center for Philanthropy at Indiana University.

Goodrick, E. & Salancik, G. 1996. Organizational Discretion in Responding to Institutional Practices: Hospitals and Cesarean Births. *Administrative Science Quarterly*, 41(1).

Gray, B. H. & Clement, Jan P. 2002. Databases for research on nonprofit health care organizations: Opportunities and limitations. *American Behavioral Scientist*, 45(10): 1550.

Greenfield, J. M. 2005. Hardwiring for maximum fundraising return on investment. *New Directions for Philanthropic Fundraising*, 2005(49): 61-85.

Greenlee, J. S. & & Trussel, J. 2000. Predicting the financial vulnerability of nonprofit organizations. *Nonprofit Management and Leadership*, 11: 199-210.

Greenwood, R., Suddaby, R., & Hinings, C. R. 2002. Theorizing change: The role of professional associations in the transformation of institutionalized fields. *Academy of Management Journal*,45(1): 58-80.

Guo, C. & & Acar, M. 2005. Understanding collaboration among nonprofit organizations: Combining resource dependency, institutional and network perspectives. *Nonprofit and Voluntary Sector Quarterly*, 34(3): 340-361.

Haderlein, J. 2006a. Can you bank on philanthropy? *Healthcare financial management: Journal of the Healthcare Financial Management Association*, 60(5): 102.

Haderlein, J. 2006b. Unleashing the untapped potential of hospital philanthropy. *Health Affairs*, 25(2): 541-545.

Hager, M. A. 2001. Financial vulnerability among arts organizations: A test of the Tuckman-Chang measures. *Nonprofit and Voluntary Sector Quarterly*, 30(2): 376-392.

Hager, M.A., Rooney, P., & Pollak, T. 2002. How fundraising is carried out in US nonprofit organisations. *International Journal of Nonprofit & Voluntary Sector Marketing*, 7(4): 311.

Hager, M. A., Pollack, Thomas, and Rooney, Patrick. 2001. Variations in overhead and fundraising efficiency measures: The influence of size, age and subsector. Overhead Cost Study Working Paper. National Center for Charitable Statistics.

Hall, H. 2005. Historical perspectives on nonprofit organizations in the United States. In R. D. Herman (Ed.), *The Jossey-Bass handbook of nonprofit leadership and management*, 2nd ed. San Francisco: John Wiley & Sons.

Hall, H. 1999. Wanted: Big-Gift Fund Raisers–Dearth of senior-level applicants is taking a major toll on charities. *Chronicle of Philanthropy*: 3.

Hannan, M. T. & Freeman, J. 1989. *Organizational Ecology*. Cambridge, MA: Harvard University Press.

Hasenfeld, Y. & Schmid, H. 1989. The life cycle of human service organizations. *Administration in Social Work*, 13(3-4): 243-269.

Hatten, M. L. (1982). Strategic management in not-for-profit organizations. *Strategic Management Journal*, 3:89-104.

Hawley, A. H. 1968 Human ecology. In David L. Sills (Ed.), *International Encyclopedia of the Social Sciences.* New York: McMillan.

Henderson, D., Chase, B., & & Woodson, B. 2002. Performance measures for NPOs. *Journal of Accountancy*, 193(1):63-68.

Herman, R. D. & Heimovics, R. D. 1989. Critical Events in the Management of Nonprofit Organizations: Initial Evidence. *Nonprofit and Voluntary Sector Quarterly*, 18(2): 119-132.

Herman, R. D. & Associates. 2005. *The Jossey-Bass handbook of nonprofit leadership and management* (2nd ed.). San Francisco: Jossey-Bass.

Herman, R. D. & Renz, D. O. 2008. Advancing nonprofit organizational effectiveness research and theory: Nine theses. *Nonprofit Management and Leadership*, 18(4): 399-415.

Herman, R. D. & Renz, D. O. 1998. Nonprofit organizational effectiveness: Contrasts between especially effective and less effective organizations. *Nonprofit Management & Leadership*, 9(1): 23-38.

Herman, R. D. & Renz, D. O. 1999. These on nonprofit organizational effectiveness. *Nonprofit and Voluntary Sector Quarterly*, 28(2): 107-126.

HFMA. 2004. Financing the Future II, *Financing the Future*. Westchester, IL: Healthcare Financial Management Association.

Hopkins, K. B. & Friedman, C. S. 1997. *Successful fundraising for arts and cultural organizations*: Oryx Press.

Kelly, K. S. 1995. Utilizing public relations theory to conceptualize and test models of fund raising. *Journalism and Mass Communications Quarterly*, 72(1): 106-127.

Kelly, K. S. 1998. *Effective fund-raising management*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Ketchen, D. J. & Shook, C. L. 1996. The application of cluster analysis in strategic management research: An analysis and critique. *Strategic Management Journal 17(6): 441-458.*

Kimberly, J. & Miles, R. H. 1980. *The Organizational life cycle : issues in the creation, transformation, and decline of organizations* (1st ed.). San Francisco: Jossey-Bass Publishers.

Leiter, J. 2005. Structural isomorphism in Australian nonprofit organizations. *Voluntas: International Journal of Voluntary and Nonprofit Organizations*, 16(1): 1-31.

Lesgold, A. 2003. Detecting technology's effects in complex school environments. In G. Haertel & B. Means (Eds.) *Rigorous Research Designs to Evaluate Technology Effects*, New York: Teachers College Press.

Leslie, L. & Ramey, G. 1988. Donor behavior and voluntary support for higher education institutions. *The Journal of Higher Education*, 59(2): 115-132.

Letts, C., Ryan, W. P. & Grossman, A. 1999. *High Performance Nonprofit Organizations: Managing Upstream for Greater Impact*. New York: Wiley.

Levinson, W., D'Aunno, T., Gorawara-Bhat, R., Stein, T., Reifsteck, S., Egener, B., & Dueck, R. 2002. Patient-physician communication as organizational innovation in the managed care setting. *American Journal of Managed Care*, 8(7): 622-630.

Lindahl, W. E. 2007. Multiyear evaluation of fundraising performance. New Directions in Philanthropic Fundraising, 1994(3): 77-93.

Lindahl, W. E., and Conley, Aaron T. 2002. Literature review: Philanthropic fundraising. *Nonprofit Management and Leadership*, 13(1): 91-112.

Marwell, N. & McInerney, P. 2005. The Nonprofit/For-Profit continuum: theorizing the dynamics of mixed-form markets. *Nonprofit and Voluntary Sector Quarterly*, 34(1): 7.

McDonald, C. Government, funded nonprofits, and accountability. 1997. *Nonprofit Management & Leadership*, 8: 51-64.

McGinly, W. C. 2005. Hospital quality is directly related to success in philanthropy. *AHP Journal*: 28.

McGinly, W. C. 2008a. AHP benchmarking program: findings and observations. *AHP Journal*, 35: 37.

McGinly, W. C. 2008b. The maturing role of philanthropy in healthcare. *Frontiers of health services management*, 24(4): 11.

McGinly, W. C. & Renzetti, K. (Eds.). 2005. *Expanding the role of philanthropy in health care*. (Vol. 49). Indianapolis: Wiley Periodicals.

Mellon, E. (Ed.). 1998. *Not-for-profit organizations*. Oxford, UK: Blackwell.

Meyer, A. D., Tsui, A. S., and Hinings, C. R. (1993). Configurational approaches to organizational analysis. *Academy of Management Journal*. 36(6): 1175-1195.

Meyer, J. W. 1977. The institutionalization of institutional theory. *American Journal of Sociology*, 84: 340-383.

Meyer, J. W. & Gupta, V. 1994. The performance paradox. In Straw, B. V., & Cummings, L. L. (Eds.) *Research in Organizational Behavior,*Vol 16: 309-69. Greenwich, CT: JAI Press.

Meyer, J. W. & Rowan, B. 1977. Institutional organizations: Formal structure as myth and ceremony. *American Journal of Sociology*, 83: 340-383.

Meyer, J. W. & Scott, W. R. 1983. *Organizational environments: Ritual and rationality*. Beverly Hill, CA: Sage.

Miller, D. &Friesen, P. H. 1984. A longitudinal study of the corporate life cycle. *Management Science*, 30(10): 1161-1183.

Miller, D. & Mintzberg, H. 1983. The case for configuration, in G. Margan (ed.) *Beyond Method* (pp. 57-73). Beverly Hills: Sage.

Mintzberg, H. 1973. *The Nature of Managerial Work*. New York: Harper & Row.

Mizruchi, M. S. 1990. Cohesion, structural equivalence and similarity of behavior: An approach to the study of corporate political power. *Sociological Theory*. 8(1): 16-32.

Moch, M. & Seashore, S.E. 1981. How norms affect behaviors in and of corporations. In P. C. Nystrom & W. H. Starbuck (Eds.) *Handbook of Organizational Design*. Vol. 1: 210-237. Oxford: University Press.

Moore, M. 2000. Managing for value: Organizational strategy in for-profit, nonprofit and governmental organizations. *Nonprofit and Voluntary Sector Quarterly*, 29(1): 183-204.

Mulligan. 2007. What's good for the goose is not good for the gander: Sarbanes-Oxley-style nonprofit reforms. *Michigan Law Review*, 105(8): 29.

NCCS (National Center for Charitable Statistics), 2009. Fundraising and administrative costs: Benchmarking and best practices; http://nccsdataweb.urban.org/FAQ/index.php?category=40; October 19, 2009.

Nutt, P. C. & Backoff, R. W. 1992. *Strategic management of public and third sector organizations*. San Francisco: Jossey-Bass.

Nutt, P. C. & Backoff, R. W. 1993. Transforming public organizations with strategic management and strategic leadership. *Journal of Management*, 19(2): 299-348.

O'Regan, A. 2001. Contexts and constraints for NPOs: The case for Co-operation Ireland. *International Journal of Voluntary and Nonprofit Organizations*, 12(3): 239-256.

Olden, P. C. & Clement, D. G. 2000. The prevalence of hospital health promotion and disease prevention services: Good news, bad news, and policy implications. *The Milbank Quarterly*, 78(1): 115-146.

Oliver, C. 1997. The influence of institutional and task environment relationship on organizational performance: The Canadian construction industry. *Journal of Management Studies*, 34: 99-124.

Oliver, C. 1991. Strategic Responses to Institutional Processes. *Academy of Management Review*.

Oster, S. M. 1995. *Strategic Management for Nonprofit Organizations: Theory and Cases*. New York: Oxford University Press.

Oster, S. M. 1996. Nonprofit organizations and their local affiliates: A study in organizational forms. *Journal of Economic Behavior & Organization*, 30(1): 83-95.

Page, K. A. 2008. Philanthropy revisited. *Frontiers of Health Services Management*, 24(4): 27-29.

Panas, J. 1989. Born to Raise: What Makes a Great Fundraiser: What Makes a Fundraiser Great: Chicago: Pluribus Press.

Parsons, T. 1960. *Structure and Process in Modern Societies*. New York: John Wiley.

Pfeffer, J. & Salancik, G. R. 1978. *The External Control of Organizations: A Resource Dependence Perspective*. New York: Harper & Row.

Pfeffer, J., and Salancik, G. R. 1974. Organizational decision making as a political process. *Administrative Science Quarterly*, 19: 232-240.

Pickett, W. 1977. *An assessment of the effectiveness of fund raising policies of private undergraduate colleges*. Unpublished dissertation, University of Denver.

Pickett, W. 1982. What Determines Fund-Raising Effectiveness? *CASE Currents*, 7(1): 22-25.

Pink, G. & Leatt, P. 1991. Fund-raising by hospital foundations. *Nonprofit Management and Leadership*, 1(4): 313-327.

Proenca, E. J., Rosko, M. D., & Zinn, J. 2000. Community orientation in hospitals: An institutional and resource dependence perspective. *Health Services Research*, 35(5): 1101-1135.

Provan, K. G., Lamb, G., & Doyle, M. 2004. Building legitimacy and the early growth of health networks for the uninsured.(care and treatment of the uninsured). *Health Care Management Review*, 29(2): 117(112).

Ranson, S., Hinings, B., & Greenwood, R. 1980. The structuring of organizational structures. *Administrative Science Quarterly*, 25(1): 1-17.

Risse, G. B. 1999. *Mending bodies, saving souls: A history of hospitals*. New York: Oxford University Press.

Ritchie, W. J. & Kolodinsky, R. W. 2003. Nonprofit organization financial performance measurement: An evaluation of new and existing financial performance measures. *Nonprofit Management and Leadership*, 13(4): 367-381.

Rosko, M. D. 2004. The supply of uncompensated care in Pennsylvania hospitals: Motives and financial consequences. *Health Care Management Review*, 29(3): 229-239.

Sahr, R. C. 2006. Consumer Price Index conversion factors 1800 to estimated 2015 to convert to dollars of 2005 [web site]. Revised 4/11/2006. Available at http://oregonstate.edu/cla/polisci/faculty-research/sahr/cv2005rsx1.pdf. [Accessed 5/1/2010].

Salamon, L. M. 1996. The crisis of the nonprofit sector and the challenge of renewal. *National Civic Review*, 85(4): 3.

Sandler, M. & & Hudson, D. 1998. *Beyond the bottom line*. Oxford, UK: Oxford University Press.

Schuh, R. G., and Leviton, L. C. 2006. A framework to assess the development and capacity of non-profit agencies. *Evaluation and Program Planning.* 29(2): 171-179.

Schulte, M. 2008. Philanthropy in healthcare. Strong leadership and vision drive success. *Frontiers of Health Service Management*, 24(4): 1-2.

Scott, W. R. 1987. The adolescence of institutional theory: Problems and potential for organizational analysis. *Administrative Science Quarterly*, 32: 493-512.

Scott, W. R. 1995. *Institutions and Organizations*. Newbury Park, CA: Sage.

Scott, W. R., Ruef, M., Mendel, P. J., & Caronna, C. A. 2000. *Institutional Change and Healthcare Organizations: From Professional Dominance to Managed Care*. Chicago: The University of Chicago Press.

Selznick, Phillip. 1957. *Leadership in Administration*. New York: Harper & Row.

Shortell, S. M. & Kaluzny, A. D. 2000. Organization theory and health services management, Chapter 1, *Health Care Management: A Text in Organization Theory and Behavior*, 4th ed. New York: Delmar.

Sloan, F. A. H., Thomas J.; Morrisey, Michael A.; Hassan, Mahud. 1990. The Demise of Hospital Philanthropy. *Economic Inquiry*, 28(4).

Smith, K. G., Mitchell, T. R., & Summer, C. E. 1985. Top level management priorities in different stages of the organizational lifecycle. *Academy of Management Journal*, 28(4): 799-820.

Smith, S. R. 2005. Performance benchmarking: Lessons on using performance benchmarks to maximize fundraising results. *New Directions for Philanthropic Fundraising*, 2005(49): 109-119.

Sowa, J. E., Selden, S. C., & Sandfort, J. R. 2004. No longer unmeasurable? A multidimensional integrated model of nonprofit organizational effectiveness. *Nonprofit and Voluntary Sector Quarterly*, 33(4): 711-728.

Starr, P. 1982. *The Social Transformation of American Medicine*. New York: Basic Books.

Stid, D., & Bradach, Jeffrey. 2009. How visionary nonprofit leaders are learning to enhance management capabilities. *Strategy and Leadership*, 37(1): 35-40.

Stone, M. M., and Crittenden, William. 1993. A guide to journal article on strategic management in nonprofit organizations, 1977 through 1992. *Nonprofit Management and Leadership*, 4(2): 193-213.

Stone, M. M., Bigelow, Barbara, and Crittenden, William. 1999. Research on Strategic Management in Nonprofit Organizations: Synthesis, Analysis, and Future Directions. *Administration & Society*, 31(3).

Swayne, L., Duncan, J., and Ginter, P. 2006. *Strategic management of health care organizations* (5th ed.). Oxford, England: Blackwell Publishing.

Tassie, B., Murray, V., Cutt, J., & Bragg, D. 1996. Rationality and politics: What really goes on when funders evaluate the performance of fundees? *Nonprofit and Voluntary Sector Quarterly*, 25: 347-363.

Tempel, E. & Duronio, M. 2007. The demographics and experience of fundraisers. *New Directions for Philanthropic Fundraising*, 1997(15): 49-68.

Thornton, J. 2006. Nonprofit fund-raising in competitive donor markets. *Nonprofit and Voluntary Sector Quarterly*, 35(2): 204-224.

Tinkelman, D. 2004. Using nonprofit organization-level financial data to infer managers' fund-raising strategies. *Journal of Public Economics*, 88(9-10): 2181-2192.

Tolbert, P. S. & Zucker, L. G. 1996. The institutionalization of institutional theory. In S. R. Clegg & C. Hardy & W. R. Nord (Eds.), *Handbook of Organizational Studies*. Thousand Oaks, CA: Sage.

Townley, B. 2002. The role of competing rationalities in institutional change. *Academy of Management Journal*, 45: 163-179.

Tuckman, H. P. & & Chang, C. F. 1991. A methodology for measuring the vulnerability of charitable nonprofit organizations. *Nonprofit and Voluntary Sector Quarterly*, 20: 445-460.

Urban Institute.2008. *The Nonprofit Sector in Brief: Facts and Figures from the National Almanac 2008: Public Charities, Giving and Volunteering.*

Van de Ven, A. H. & Garud, R. 1994. The coevolution of technical and institutional events in the development of an innovation. In J. A. C. Baum & J. Singh (Eds.), *Evolutionary Dynamics of Organizations*. New York: Oxford University Press.

Weber, N. 1994. Misusing charitable statistics in evaluating fundraising performance. *New Directions for Philanthropic Fundraising*, 3: 115-128.

Wells, R. & Banaszak-Holl, J. 2000. A critical review of recent US market level health care strategy literature. *Social Science & Medicine*, 51: 639-656.

Wells, R. 2001. How institutional theory speaks to changes in organizational populations. *Health Care Management Review*, 26(2): 80-84.

Werther, W. B. & Berman, E. M. 2001. *Third sector management : the art of managing nonprofit organizations*. Washington, D.C.: Georgetown University Press.

Wing, K., Pollack, Thomas & Blackwood, Amy. 2008. *The nonprofit almanac*. Washington D.C.: The Urban Institute.

Yang, C.W., Fang, S.C., & Huang, W.M. 2007. Isomorphic pressures, institutional strategies, and knowledge creation in the health care sector. *Health Care Management Review*, 32(3): 263(268).

Young, D. 2006. *Financing nonprofits: Putting theory into practice*: Altamira Press.

Zinn, J. S., Weech, R. J., & Brannon, D. 1998. Resource dependence and institutional elements in nursing home TQM adoption. *Health Services Research*, 33(2): 261-273.

Zucker, L. G. 1987. Institutional theories of organization. *Annual Review of Sociology.* 13: 443-464.

APPENDIX

INSTITUTIONAL REVIEW BOARD APPROVAL

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

Institutional Review Board for Human Use

DATE: 1/25/10

MEMORANDUM

TO: **Cathleen Erwin**
Principal Investigator

FROM: Sheila Moore, CIP
Sheila Moore, CIP
Director, UAB OIRB

RE: Request for Determination—Human Subjects Research
IRB Protocol #N100110001 – Isomorphism in Nonprofit Hospital Organization Fundraising

An IRB Member has reviewed your application for Designation of Not Human Subjects Research for above referenced proposal.

The reviewer has determined that this proposal is **not** subject to FDA regulations and is **not** Human Subjects Research. Note that any changes to the project should be resubmitted to the Office of the IRB for determination.

SM/cro

470 Administration Building
701 20th Street South
205.934.3789
Fax 205.934.1301
irb@uab.edu

The University of
Alabama at Birmingham
Mailing Address:
AB 470
1530 3RD AVE S
BIRMINGHAM AL 35294-0104