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philanthropy



Surviving a hospital merger

Best practices
for maneuvering
an often
tricky path

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22 Targeted solutions for small
shop capital campaigns

33 Making the case
for your cause



Benchmarking your way
to success **page 29**

Another Successful Partnership: Anne Arundel Medical Center Foundation and Heaton Smith Group.

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Mother in hospice in 2001. Email:
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Est. capacity: \$5,000.

Kevin Worthington

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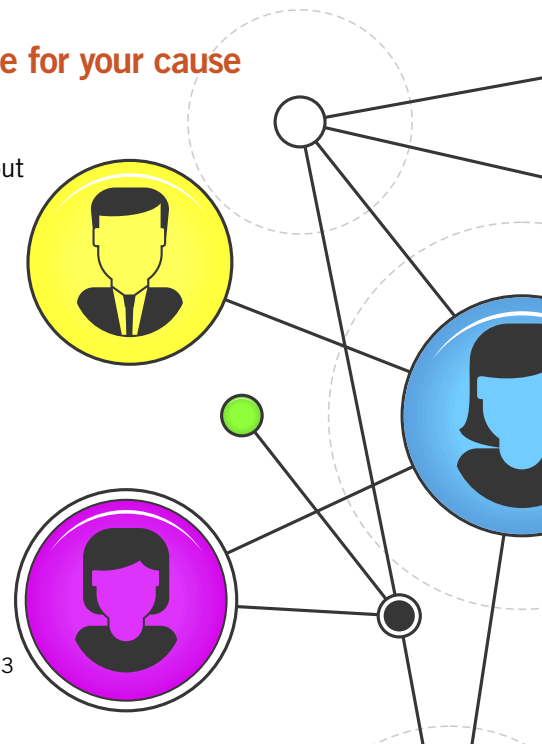
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AHP President, Chief Executive Officer

As health care philanthropy changes and evolves, it is necessary to invest in the structures that can build an effective, thriving fundraising program.

healthcare philanthropy

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By William S. Littlejohn

Chair, AHP Board of Directors



FROM THE CHAIR

Enterprise engagement

One of the three strategic priorities of Sharp HealthCare Foundation is “enterprise engagement” to drive high-performance major gift philanthropy. We realize that the success of the philanthropic program at Sharp is highly dependent upon engaging across the health care enterprise—executives, physicians, staff, board members—and those we serve. The same is true for AHP and our strategic initiatives. The future and success of health care philanthropy will indeed be driven by engagement across the AHP enterprise—members, colleagues, AHP associates—and the institutions and communities we serve.

Major gift training and development has frequently been built around the concept of being “donor-centric”—for good reason. Major gift success comes from strong and powerful relationships between the donor and the institution, often facilitated by philanthropy professionals. Yet, what makes health care philanthropy unique is the impact and influence of allied relationships on donors—most often as a result of the health care experience. So we have to be “ally-centric” in our roles as well.

The future of AHP will be built upon the ally-centric concept and enhancing enterprise engagement. We are all allies, no matter our

We are all allies,
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we engage
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institution, title, role or function. And the more we engage together, the greater success we will enjoy both professionally and where we work.

AHP recently launched www.ahp.org/yourahp to share the opportunities we have in enterprise engagement. There you can learn about face-to-face learning through unique educational opportunities, such as conferences on big ideas in health care philanthropy and forward thinking in leadership and management. Our convenient new e-learning opportunities are designed around staff competencies to help you sharpen your skills and grow your programs. And most importantly, there are new opportunities to get

involved with AHP in ways that fit your unique needs and those of our allies. We know the success of all these initiatives—especially in knowledge development and learning—are dependent upon strong enterprise engagement of members in both their design and facilitation. We learn best from each other.

Another fundamental for success I have learned in both my Sharp HealthCare and AHP experience is the role and value of sharing. When we embarked upon our Malcolm Baldrige National Quality Award journey at Sharp, we knew we needed to be a sharing organization—to learn from others and to share with others. That is a cornerstone of

the AHP strategic plan: becoming a stronger, sharing association—in person, virtually or just through association relationships. A colleague once remarked at a meeting that AHP member institutions are like snowflakes; no two are alike. That has resonated with me, leading me to understand that I have to engage more of my colleagues across the entire AHP enterprise to gain knowledge and skills.

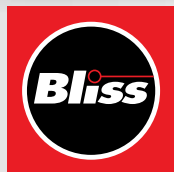
As philanthropy professionals, we spend a great deal of time training and preparing others to ask. Now we have to ask ourselves and each other: to get involved, to share with others, to be part of the future leadership of AHP—to engage across the enterprise. 

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AS I SEE IT

The future of health care philanthropy

Health care philanthropy is changing, especially in the U.S. With the passage of the Affordable Care Act (ACA), American health care organizations are facing an unprecedented array of challenges. The ACA will reduce payments by the federal government to hospitals by more than \$200 billion over 10 years. The fee-for-service model is shifting to an outcome-based reimbursement structure. At the same time, commercial payers are reducing annual rate increases and changing their reimbursement structures. Many members and hospital executives I speak with see the potential for a possible 15-20 percent reduction in government and commercial reimbursements over the next four to five years.

With the American Hospital Association estimating that hospitals will have to cut 93,000 jobs this year alone, health care executives have been developing their own initiatives to deal with the change. Many hospitals are instituting LEAN management programs to raise productivity and increase the morale of remaining staff. Hospital mergers and consolidations are on the rise again, as you will read in this issue's cover article. And there certainly is a new level of expectation being placed on our member executives and foundations to bring in money for hospital programs.

This is both a challenge and an opportunity. As hospital CEOs seek to use philanthropy to help the bottom line, this environment can lead to a more robust integration of philanthropy into hospital operations. And this reality will require not only a more integrated position for philanthropy, but also a growing specialty for development executives in health care and the need to demonstrate greater executive-

level skills. In building an effective, results-oriented fundraising program while taking advantage of the drive for more philanthropy dollars, there will be the absolute need to invest in the structures necessary to dramatically increase philanthropy.

What are the key strategies for growth for U.S. member organizations, as well as those in Canada and elsewhere abroad? Results from AHP's Performance Benchmarking Program in FY 2011 show that having the right programs and the right people in the right places is essential. High Performers in the program

What are the key strategies for growth?
Having the right programs and the right people in the right places is essential.

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raised nearly 11 times more in net production revenue than their All Other counterparts, with a direct staff size that outnumbered All Other organizations by 3 to 1. The High Performers also compensated their staff at higher levels. On average, professionals employed by High Performers earned \$157,000, compared to \$98,000 earned by their All Other peers. This salary gap contributes to major differences in the average amount raised per professional. For High Performers, the average individual return was \$11.46 for each (direct) compensation dollar spent, while the return for All Others was \$6.45.

A strong investment in philanthropy really pays off. Also according to the FY 2011 benchmarking data, those organizations that spent the most on total fundraising expenses (\$2 million-\$4.8 million) had a median net fundraising revenue of \$9 million—substantially higher than the median net fundraising


revenue of \$561,000 for those that spent the least on total fundraising expenses (\$59,000-\$428,000).

High performers had at least one full time equivalent (FTE) in each category of fundraising programs: major giving, planned giving, annual giving, special events and public support. If your organization is not yet at this capacity, start by focusing on the programs that are most successful in terms of return on investment (ROI): major gifts and planned giving. Fluctuations in the economy and localized factors (such as whether or not a capital campaign is underway) often affect the relative success of annual giving or the revenue raised from corporate grants and special events. However, benchmarking data consistently indicate the overarching effectiveness and efficiency of major gifts and planned giving.

What else can you do to build a strong and thriving development

program? Through the years, AHP has discovered that the following principles lead to the greatest success:

- Work toward integrating philanthropy as a core strategy at your health care organization.
- Adopt philanthropy reporting standards (benchmarking) to identify the factors that influence fundraising performance and maximize overall returns from philanthropic resource investments.
- Focus on ROI to measure fundraising effectiveness and look for areas of opportunity. Development experts agree that ROI is the most important metric in measuring fundraising performance, more so than cost to raise a dollar (CTRD).
- Execute a plan to communicate community benefit.
- And, as always, lead with your organization's mission.

Here's to a bright and healthy future for health care philanthropy. 

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Surviving a hospital merger



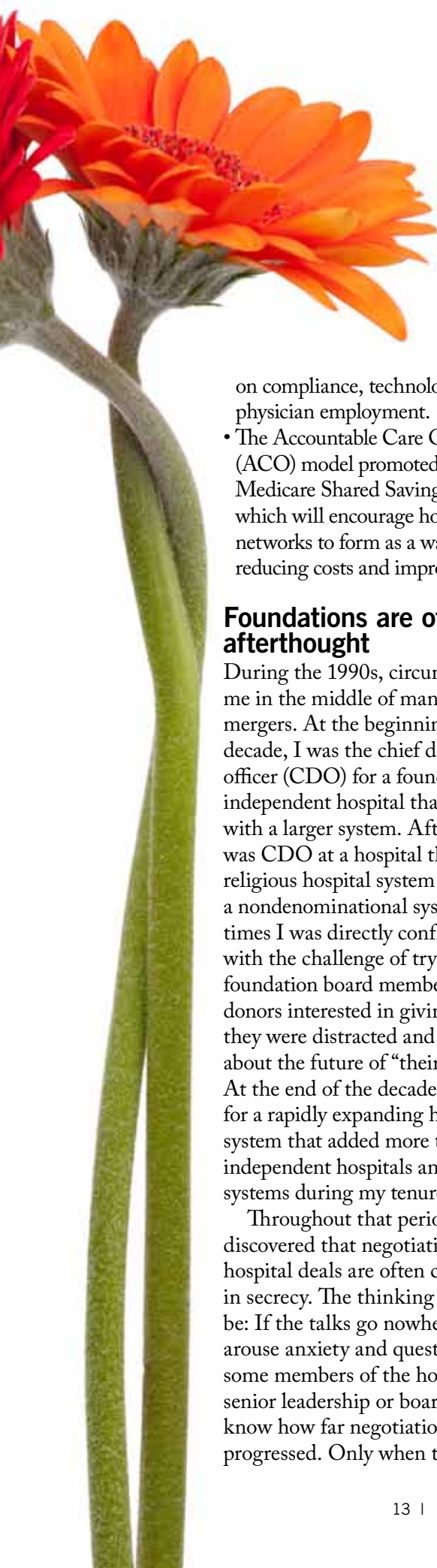
What does the upswing in mergers mean for foundations and development leaders?

Hospital mergers are on the rise again—climbing from 92 in 2011 to 109 in 2012, an increase of more than 18 percent.¹ During that same two-year period, 10 nonprofit hospital owners agreed to deals that changed the ownership of more than 160 hospitals, and the number of hospitals in merger and acquisition (M&A) deals rose from 212 to 352. This upturn represents a level of merger activity not seen since 2006, when access to low-cost debt drove a flurry of private-equity-fueled buyouts and mega mergers.²

Before that, a wave of merger activity occurred in the mid-1990s, driven by the threat of managed care and the power of larger health systems to negotiate favorable reimbursement rates with insurers. At the time, the growth of for-profit hospital companies was particularly dramatic and of great concern to nonprofit hospitals and their fundraising offices.

Now, according to an article in *Healthcare Financial Management*, three significant factors appear to be driving consolidation:³

- A decrease in payment rates, which will force hospitals to reduce costs in new ways and increase their negotiating clout with suppliers and payers.
- An increase in the cost of doing business, because hospitals will need to spend more



on compliance, technology and physician employment.

- The Accountable Care Organization (ACO) model promoted by the Medicare Shared Savings Program, which will encourage hospital networks to form as a way of reducing costs and improving quality.

Foundations are often an afterthought

During the 1990s, circumstances put me in the middle of many hospital mergers. At the beginning of the decade, I was the chief development officer (CDO) for a foundation at an independent hospital that affiliated with a larger system. After that, I was CDO at a hospital that left a religious hospital system and joined a nondenominational system. Both times I was directly confronted with the challenge of trying to keep foundation board members and donors interested in giving when they were distracted and concerned about the future of “their” hospital. At the end of the decade, I worked for a rapidly expanding hospital system that added more than 30 independent hospitals and small systems during my tenure.

Throughout that period, I discovered that negotiations for hospital deals are often conducted in secrecy. The thinking seems to be: If the talks go nowhere, why arouse anxiety and questions? Even some members of the hospital’s senior leadership or board may not know how far negotiations have progressed. Only when the deal is

developed to the point that leaders feel confident about an agreement do they let more people know what is being planned.

Unfortunately, hospital foundations are often an afterthought when negotiations are going on—and if they are small, with few assets, they are likely to be ignored completely. Perhaps it’s because the people involved in the negotiations are not particularly attuned to philanthropy, or because they think fundraising is a local enterprise and therefore will not be impacted by the new arrangement. No matter the reason, no one wants to risk ruining a deal involving several hundred million dollars in assets over a failure to agree on a small piece of the whole picture—the foundation assets.

If merging hospitals’ foundations have significant assets, their place in the future organizational structure is more likely to be a factor in negotiations. Sometimes a hospital foundation may be used as a safe haven to segregate assets from a merger. In that case, there is likely to be more emphasis on keeping the foundation “separate” from the assets merged into the system.

Some important points:

- CDOs must be aware that negotiations are happening before they can have any input about the future of their foundations.
- Even if no foundation exists, a potentially significant change in hospital identity, ownership or management causes internal

.....
Be proactive.

**Ask questions,
seek information**
and talk to as
many people as
possible—both
in your own
organization and
in the system you
are about to join.

and external anxiety that affects development efforts.

- Maintaining strong trust relationships with your hospital chief executive officer (CEO) and influential board members is always extremely important, but becomes essential when some kind of new relationship is being considered. If those leaders understand the importance of philanthropy to the institution and the importance of maintaining strong donor relationships, they will be more aware of the need to prepare the CDO for what may be coming.

Implications of for-profit conversion

Because it is engaged in promoting health, a nonprofit hospital is classified as a public charity (501(c)(3) organization). In exchange, the hospital is accorded tax-exempt status and allowed to grow without the burden of taxation, which is how the community invests in the hospital. A community board of trustees is appointed to oversee the community's ownership interest in the hospital.

To qualify as a 501(c)(3) organization, hospitals must do the following:

- Take care of everyone who comes in for treatment, regardless of ability to pay (provide charity care).
- Base decisions about their services on community need rather than profitability (the basis for the requirement for periodic community needs assessments).
- Reinvest any excess revenue (profit) in the business rather than benefiting owners or shareholders.

When a for-profit hospital system acquires a nonprofit hospital, community assets that have grown with the benefit of tax exemption will be sold and used to produce a profit for private investors. The public must be compensated for the

.....

A hospital decides to join or form a system as **a strategic action to preserve or strengthen its future**. The organizations we work for are struggling to survive in a turbulent time. As their agents and employees, our charge is to serve our organizations' best interests for the long term.

privatization of their public asset and proceeds from the sale must be used in a manner consistent with the acquired nonprofit's charitable purpose. To protect the public's interest, the state attorney general usually must approve sales of nonprofit hospitals to for-profit operators.

What does the change mean for hospital foundations that have supported their nonprofit hospital?

- Your hospital will likely no longer have public charity status.
- Your foundation will no longer be raising money to support your hospital; it will either cease to exist or have to develop a new purpose. Your mission will have to be redefined.
- If your foundation is to receive the proceeds of the sale, you will become a much larger, more independent and different type of organization.
- Your operating and legal structures may need to be different. Will you be a grant maker only, or will you operate programs? Will you continue to raise money?
- Your board and staff members may not be the right people for the new organization.
- You will have to buy all the support services you now get from the hospital, such as payroll, benefits, human resources, finance,

information technology support, office space, insurance, etc.

If you're the head of a foundation supporting a nonprofit hospital that is being acquired by a for-profit company, start planning as early as possible for a very different future. Engage competent legal counsel knowledgeable in nonprofit taxation issues. Important and legally complicated decisions must be made about your ongoing tax-exempt status. Will you try to meet the requirements to remain qualified as a public charity? Will you become a private foundation? The questions and considerations involved in planning for the conversion of an existing foundation are detailed in the chapter by Patricia M. Ashmore, *Best Practices for a Conversion*, in a book I edited for AHP in 1997 as part of a "think tank" on hospital M&A issues.⁴

Implications of a nonprofit merger/partnership

If your nonprofit hospital will become part of an existing nonprofit system or will be creating a new system by joining with another nonprofit entity, your considerations and challenges are totally different—but they may be no less daunting. In this situation:

- Your beneficiary hospital's nonprofit status will not change.

- Management and governance will probably change.
- Your hospital's name, identity and culture may change.
- Eventually, changes may occur in the services offered at your hospital.
- Your foundation's purpose will probably continue to be linked to the needs of your hospital.

Changes may happen rapidly or slowly, depending on characteristics of the joining organizations, but change is inevitable. In my experience:

- Independent hospitals joining mature existing systems are more likely to see changes sooner. If the system has incorporated new hospitals before, it is more likely to have a plan for handling staff department functions such as finance, human resources, planning and perhaps fundraising—especially if a system executive is leading the development effort.
- Independent hospitals in financial distress will also see changes sooner. More aggressive changes in staffing levels, pay scales, debt refinancing and other measures will be likely when hospitals and systems experience declines in profitability.
- The geography in which the system's member hospitals exist also impacts the pace of change.

Hospital partners in the same service area will find it easier to share staff and management and to consider centralizing service lines at one or another of the hospitals. Large systems with widely dispersed and rural hospitals will not have the same options.

- When there is no mature system or immediate financial distress, change is likely to start slowly and accelerate as the system matures.
- As the hospital system develops, strategic planning and administrative decisions are more likely to be made at the system level, which, of course, affects planning for fundraising and can

Foundation **separateness**

Whether your foundation is a subsidiary corporation of your hospital or a totally separate and self-sustaining entity, you are not really separate. Foundations exist to harvest goodwill created by their hospitals. Foundation executives and board members who believe that their separate corporate status insulates them from changing or agreeing to collaborative development programs have totally missed the symbiotic nature of their relationship.

Even if your foundation is a legally separate entity, it's unlikely to be functionally separate. You may get direct or indirect economic support, such as free or reduced-rate office space, inclusion in hospital benefits programs, and use of hospital facilities and services, for example. But even if your foundation is economically self-supporting, it requires other forms of support to be effective, such as:

- Access to the hospital's strategic plans.

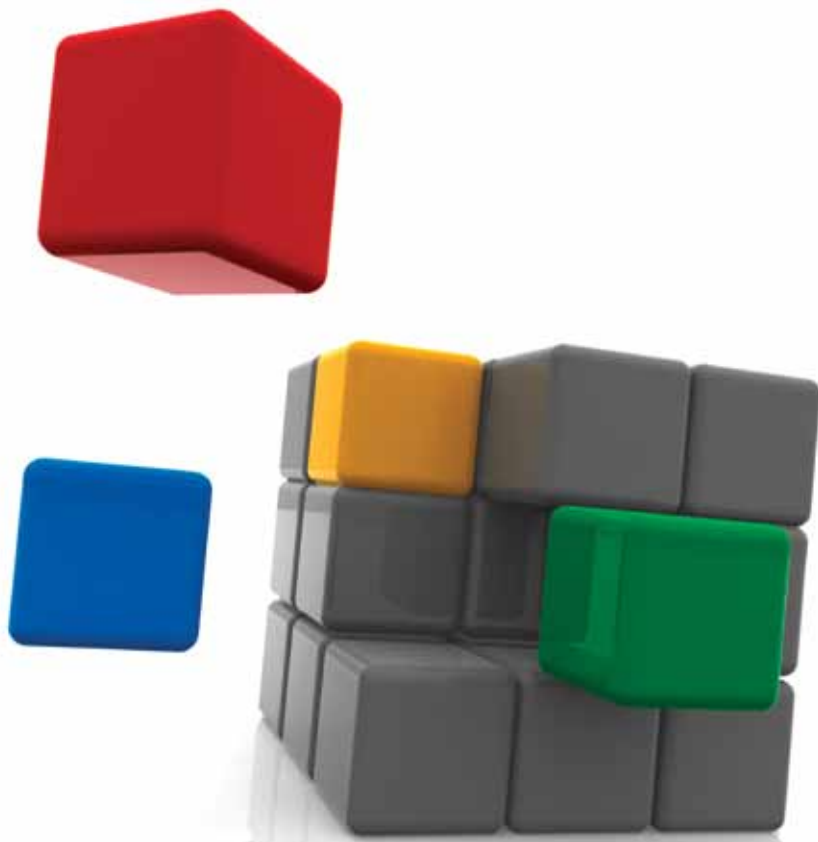
- Use of the hospital's name.
- Advance knowledge of publicity initiatives.
- Access to physician, patient and employee groups.

You function as the exclusive fundraising agent for your hospital because it benefits *the hospital*—and people donate to express support for the work of *the hospital*, not the foundation. Hospitals do not require separately incorporated foundations to receive or manage charitable support.

Because foundations have functionally dependent relationships with their hospitals and enjoy exclusive franchises, it's obvious that hospitals should seek, and foundations grant, reasonable involvement, communication and direction of the foundation's activities. If a system retains independent foundations, it gives them exclusive rights to raise funds for a specific hospital. The foundation also may continue



to administer significant assets that are in trust and intended to further the hospital's mission. In granting this exclusive franchise, the system can and should set requirements for the cost, quality, term and performance of the foundation's services.



Common terms for hospital deals

The chart below defines six terms frequently used to describe hospital deals. Other terms sometimes used are “amalgamation,” “partnership” and “alignment,” but these describe what are actually mergers, acquisitions or long-term leasing arrangements. Other terms such as “buy outs” or “takeovers” are routinely avoided because of their negative connotations and the public anxiety they might arouse.

DEAL TYPE	DESCRIPTION
MERGER	Two or more health care organizations combine to form a new entity
ACQUISITION	An existing organization is purchased
JOINT VENTURE	Two or more organizations combine resources on a specific project
AFFILIATION	An organization joins another for a specific purpose (such as contracting)
LEASING	Lease of facility with retained ownership
MANAGEMENT CONTRACT	Contract to manage with retained ownership

impact donor confidence and trust in your hospital’s leadership.

As soon as your foundation board, donors, employees and physicians learn of potential partnership discussions, they are likely to have concerns. You may call it a partnership rather than a merger, but they will understand instinctively that change is coming and the way things have always operated is not going to stay the same. If not managed carefully, their anxiety can have a paralyzing effect on their willingness to make donations. Some things to keep in mind:

- Your hospital’s leaders decided to seek a partner because the future did not seem viable as an independent entity. Is your community better served by a hospital that is part of a system, or by a closed hospital? That is the central issue. People will disagree about how dire the future really is as an independent entity, but the financial pressure on hospitals is real and increasing.
- As a foundation director and hospital executive, you are not being paid to preserve the past or serve your personal interest. Your job is to help your organization adapt to the future and stay true to donor intent. You may not look forward to the new world order or want to work in it. But even if your future diverges from that of the organization, the patients, the donors and the need for a solid philanthropy program will still be there after you are gone.
- Once the partnership decision is made, CDOs must be strong, positive advocates for the partnership if they are to have any hope of raising money through the transition. Expressing personal concerns about your future or role will worry board members and donors and give them a reason to

hold off on giving until they can see how things go.

Nonprofit merger: What to agree on

Foundation board members and donors have predictable, almost universal concerns about their donations when a nonprofit merger is on the horizon. The most common ones are discussed below. Rather than ignoring philanthropic considerations, it serves the interests of all parties to incorporate specific reassurances and guarantees in the memorandum of understanding (MOU) or whatever document will memorialize the partnership agreement. In my opinion, system development executives and hospital foundation heads alike should advocate for including provisions such as these in the MOU in order to reduce donor anxiety, minimize the

typical pause in giving and make the transition as smooth as possible.

Will the new health system raid our endowment funds for use elsewhere? As part of the partnership agreement, donor-designated endowment funds should be guaranteed for the uses intended by the donors. In the final MOU, clearly define the existing endowments and their donor-designated purposes—a practice that conforms with the ethical standards of AHP and most major fundraising professional organizations. Knowing that the use of these funds is guaranteed in writing is tremendously reassuring to interested parties and has great public relations value.

What will happen to other donor-designated funds? Similarly, the use of donor-designated funds should be guaranteed as intended by the donor. Make assurances that all

funds, including undesignated funds, will be spent at the local institution. Otherwise, you will shake donor confidence and cause concerns about the use of donated money.

What will become of the local foundation board's ability to make final decisions about fundraising initiatives and methods? Formulate a compromise position in which the local board retains decision-making authority regarding fundraising programs but conforms with existing system policies and consults with system leadership. The board will need to meet existing or future system policies on development program costs or productivity, which will directly affect the types of fundraising programs to be considered.

Can we maintain local control of assets? Foundation board



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members and staff often assert that their relationships with local banks and asset managers produce annual gifts and event sponsorships. The partnership agreement can allow local financial management to continue, as long as the local board carefully exercises its fiduciary responsibility to manage the assets prudently and at the lowest possible cost. If the new system has an investment program, you can easily compare investment returns minus management fees at local institutions with the system's programs and decide which provides the best total return.

Will the local foundation donate funds to the hospital on a regular and timely basis? Proceeds from endowments and current gifts should be granted according to an agreed-upon schedule, such as five percent of the value of endowment accounts and at least 50 percent of current funds granted each year, with transfer within 90 days of the close of the fiscal year.

Fiscal year and miscellaneous issues: From direct experience, I've learned that including the items below in the agreement can also avoid future problems:

- Make accounting and reporting

CEOs, attorneys and others who negotiate agreements need to understand **the powerful role foundation executives can play** in influencing community opinion-makers about the merger's desirability.

easier by having all foundations conform to the system's fiscal year.

- Specify that all foundations use a standard fundraising chart of accounts for budgeting and reporting, which allows an annual opportunity for internal benchmarking review.
- Have all parties to a partnership or merger agreement pledge that they will collaborate to improve fundraising capability throughout the system. A host of shared back-office services, training programs and best practices are possible when foundations or development offices work together.⁵

What's a CDO to do?

Anxiety and defensiveness tend to dominate the premerger atmosphere—and the joining

hospital's foundation executive is at the center of it all. How you manage your board and their concerns about the future determines how the entire relationship will unfold. I am convinced that foundation executives who are afraid for their own jobs and suspicious about what will happen create boards that are anxious and suspicious.

Unfortunately, development officers are often given little to go on about the merger arrangements. Thus, they are left to imagine the worst. Too often they lack a good trust relationship with their hospital CEO or do not have influential foundation board members with such relationships. As a result they have no accurate information about the future and no voice in helping to design it.

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who negotiate agreements need to understand the powerful role foundation executives can play in influencing community opinion-makers about the merger's desirability. Many of those opinion-makers probably sit on the foundation board. Because foundation executives are rarely brought into the loop, they are tempted to share fears with members of the board.

How can a foundation executive serve the organization in those uncertain circumstances? Here are some attitudes and prescriptions that I think can work:

- **Be proactive.** Ask questions, seek information and talk to as many people as possible—both in your own organization and in the system you are about to join. Sometimes it's easier to do this unofficially rather than through official channels, since the general rule for negotiations seems to be not to say or explain anything until all is signed, sealed, and delivered and widely known in the community.
- **Work out requirements and freedoms in advance.** If the system already has an entity responsible for fundraising, go see them and ask how they're organized. Find out what plans, if any, they have for you and your board. If the system already has an organizational structure, will you be expected to conform to it? Find out what's flexible and what isn't.
- **Make an early decision.** Do you like the person in charge of development for the system? Could you accept working for him or her? If no one holds this position now, will someone be named? Will you have a chance at the position? Will your CEO or another CEO be heading the merged organization? The answer to the CEO question could make a big difference in your chances for the top development job. Think about your future and

decide what you want to do as early as possible. Could there be a growth opportunity for you as a part of the new organization? Would you want it, if it were there? If it looks like something is possible and attractive, get all the way on board, help smooth the transition and be positive about the new arrangement. If you feel you will not be happy or welcome as part of the new organization, start looking elsewhere.

- **Serve the institution, not yourself or the current board.** When the whole world changes, it's natural to think about how you're affected, and it's hard to imagine how anything can work out better if the board goes away or the hospital's name changes. You may feel the need to mourn the passing of the freestanding hospital you knew. It's a mistake, however, for development leaders to get too wrapped up in lamenting or resisting changes. No one can raise much money in an atmosphere of worry, doubt and pessimism—so don't foster that atmosphere.

A hospital decides to join or form a system as a strategic action to preserve or strengthen its future. The organizations we work for are struggling to survive in a turbulent time. As their agents and employees, our charge is to serve our organizations' best interests for the long term. 



James DeLauro, Ph.D., has worked in health system fundraising for more than 30 years. He was foundation head during the mergers of two independent hospitals into larger systems, was the lead health system development executive during the incorporation of 30 hospitals, and has consulted with many health systems over the past 12 years. His firm, DeLauro & Associates, specializes in strategic planning and management counsel for a range of clients, from complex organizations with multiple development offices to start-up fundraising programs.

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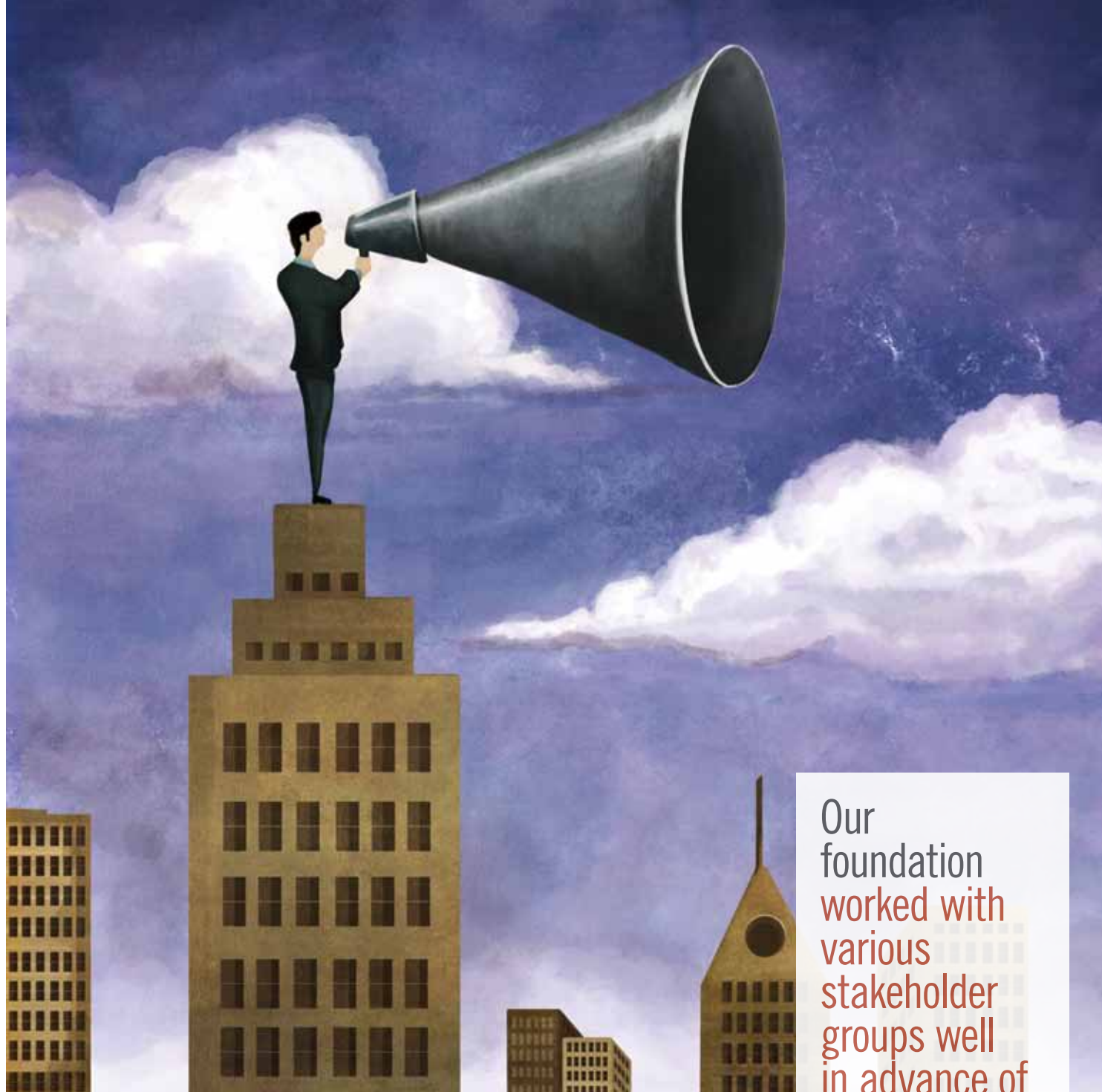
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Success with a small shop capital campaign

A cash-strapped hospital exceeds fundraising goals by defining clear objectives, cultivating personal relationships and using resources efficiently

“I didn’t know the hospital was a philanthropic cause. I guess I’ll put you eleventh behind the soup kitchen.” This donor prospect’s response to a proposed capital campaign for Catawba Valley Medical Center in Hickory, N.C., illustrates our starting point. Few were optimistic about our proposal to raise \$3 million to fund a new patient pavilion. Timing and conditions were bad; it was 2009 and the unfolding recession was devastating the wealth and industry in this one-time furniture-making capital of the country.



Our foundation worked with various stakeholder groups well in advance of the campaign kick-off to make sure they felt included and were well informed.

Not only was this to be the hospital's first capital campaign since its founding in 1967, it also was my first fundraising job—and not my only responsibility. As vice president of community services and chief development officer, I also had marketing, public relations, business development and physician recruiting under my direction. My “staff” consisted of a part-time administrative assistant.

And in our campaign study—in

which we conducted face-to-face interviews with prospective donors, including members of our board of trustees and foundation board as well as community leaders—we uncovered more bad news: 42 percent of our best prospects rated our medical center as low on their list of philanthropic priorities. Worse, many mistakenly believed county taxes funded the hospital.



Planning your own “small shop” campaign

These were the major factors that contributed to our success:

- **Make sure you have CEO support.** Your CEO must be involved and engaged.
- **Choose the right consultant.** To find the right person for your campaign, get recommendations and check references. But even more important, spend time with the consultant (and his/her team if there will be one) to see if they are people you can work with. Chemistry and trust are very important.
- **Strengthen the foundation board.** First, make sure you have the right people on your board—if your mission is to raise funds, you need members who are able to contribute as well as identify and cultivate prospective donors. Then work with your members to prepare them and their networks for the campaign before it begins.
- **Form a steering committee.** Our steering committee was vital to engaging our top potential donors and leaders.
- **Connect and share your message with your donors.** People don't give money because they like you or the organization. They give because you are serving a need that is important to them.
- **Maintain a manageable volume of activity and focus on one thing at a time.** Break the work down into manageable components and really take the time to do each step right.
- **Always follow up.** Good follow-up has been central to our campaign success. I've stayed in touch primarily via phone calls and letters with our donors and people who helped me connect to others.
- **Create a positive and meaningful experience for your supporters and volunteers.** Make it fun so people enjoy the process of doing a good thing.

Despite these challenges, we were able to leverage good relationships in the community, support from our chief executive officer (CEO) and strategies developed with the help of an excellent fundraising consultant into a robust, successful capital campaign. This article outlines our approach and offers useful ideas for other small shops to consider.

Preparation and planning

Our CEO, Tony Rose, was optimistic about the campaign. He recognized that our theme, “Building a Tradition: Caring for Your Future,” not only described this effort, but heralded a shift in our fundraising methods as charitable donation becomes an increasingly important revenue source for hospital funding. Tony believed the campaign would chart a new course for our foundation and be a good opportunity for us to build a larger network of friends and supporters.

From the beginning, we realized we needed to emphasize personal interactions to gain support—specifically, we needed to connect potential donors with something they care about in a meaningful way. To be successful, we would need to help donors understand why this project should proceed in the recession, why their giving was so important and how meeting this goal could fit into their personal values and priorities.

Expanding staff was not an option, but Tony supported our hiring a consulting firm, Corporate DevelopMint, LLC. Lead consultant on this project was their Vice President, Dan Rogge (now head of Rogge and Associates). His firm provided

guidance and experience in best practices to build stronger donor relationships, develop campaign infrastructure, facilitate meetings and formulate strategy. Working with Dan's firm during our three-month planning process also helped us determine that they would be a good fit for helping us manage the campaign.

In addition, Tony released additional funds when necessary for items such as an event we did not plan on, donor recognition, etc. He saw these expenditures as important investments in the medical center's future and they made a tremendous difference at key points in the campaign.

Clear objectives

Dan emphasized setting clear objectives to guide our campaign

plans. Working together, we created a three-part approach:

Part one: Limit the scope of the campaign to the best and most promising donor prospects.

We focused on the top donors first—those who could provide the first 70–80 percent of our goal in the shortest time. These top prospects were identified through a long and broad cultivation process and were qualified through direct conversations and screening and rating sessions conducted with community leaders. We did not rely on wealth screening and physician referrals to the extent that hospital systems in larger and more transient communities might; we had personal connections to our potential donors, so we qualified

them not just for their capacity to give, but for their perceived willingness as well.

Part two: Engage in intensive personal and group cultivation to create more favorable circumstances for better giving.

Our foundation worked with various stakeholder groups well in advance of the campaign kick-off to make sure they felt included and were well informed. These groups included:

- **Community leaders:** To clarify funding misconceptions and outdated knowledge of the medical center, the foundation embarked on a six-month cultivation campaign of key people of influence—including county politicians and



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administrators, major donor prospects and community leaders in geographic areas of interest. Our CEO, board chair and I personally conducted tours and visits for these individuals.

Developing these relationships helped us learn more about potential donors and connect them to causes that were important to them. One couple toured our Neonatal Intensive Care Unit (NICU) and the wife came out with tears in her eyes after seeing the tiny preemies. They

prospected of the new facility, most board members were uncertain of their role in the proposed campaign.

We developed and shared an “elevator speech” and FAQs for the campaign, and also presented an overview of potential objections and responses board members might encounter as they discussed our goals. In addition, we provided solicitor training (conducted through role playing) to help board members become

During our campaign planning phase, we formed a 15-member steering committee—a temporary team of recognized and respected community leaders whose major goal was to generate and cultivate top donor prospects, as well as provide input during our campaign preparations. These individuals worked together for nine weeks, helping us to develop the case from a donor perspective, identify possible donor questions, determine primary themes that would resonate with the community, develop a campaign slogan and identify potential donors who were likely to support and contribute to our efforts. Steering committee members developed a deep commitment to our campaign; giving from this group was generous and 10 of our top volunteers agreed to serve on our campaign cabinet.

After the steering committee phase was completed, we developed our 14-member campaign cabinet, which operated during the campaign. This was the group we relied on to solicit donations from prospects identified by the steering committee. They secured gift commitments from our top donors, eventually raising more than 70 percent of our final contributions.

Because our staff was so small, we were not able to directly engage as many donors as a more traditional campaign might. Instead, we concentrated on strengthening key relationships with donor leaders who played significant roles in the campaign.

pledged a quarter of a million dollars soon after that visit, realizing what a difference they could make by helping us expand the NICU from 1,500 to 15,000 square feet.

more comfortable with fundraising activities. We met with members regularly throughout the campaign and key leaders from both boards gave generously and helped us to engage major donor/leader prospects in the community.

- **Our board of trustees and foundation board:** The chairman of the board of trustees also serves as the chair of the foundation, and both boards are composed of individuals dedicated to helping our medical center provide high-quality, compassionate health care services to our community. While they were excited at the

- **Top prospects:** Because our staff was so small, we were not able to directly engage as many donors as a more traditional campaign might. Instead, we concentrated on strengthening key relationships with donor leaders who played significant roles in the campaign.

- **Mid-level prospects:** During the last three months of the campaign, board members and volunteers hosted a series of “Cocktails & Conversations” events for our mid-level prospects, to connect with them and make them more familiar with our efforts.

- **Employees:** We wanted employees to feel ownership for the campaign and also have opportunities for meaningful involvement. We organized focus groups around the hospital system to identify motivators, such as how employees would benefit from the new facility. An employee campaign committee reviewed the findings from these focus groups and assisted in determining messaging, promotion and key campaign-planning activities.

We also made sure employees were informed about our strategy and plans. If community members asked why we were building a new facility if we couldn't afford it without donations, or wondered how the project might benefit them and their families, our

employees were prepared to discuss these issues.

Part three: Be very efficient in the use of campaign activities to ensure a close correlation between donor identification and the levels of the gift table. For this objective, we organized campaign phases and activities to use our resources sequentially. First, because many key individuals told us they would likely only help with one to three prospects, we sought to raise more than half of our goal through recruiting our leader volunteers, identifying the most promising donors and securing their major gifts. Following these activities, we concentrated on larger events for mid-level donors. Later outreach included the sessions for employees.

The campaign and our results

The official campaign goal was set at \$3 million (toward a \$34 million Patient Pavilion building). Over a two-year period, we raised \$3.6 million. Our campaign costs—including a portion of my and my staff assistant's salaries, consultant fees, marketing materials and functions for donor cultivation—totaled approximately \$250,000.

Here is a breakdown of our campaign contributions by category:

- Physicians—Gave more than \$1,070,000 in gifts.
- Administration—The CEO, VPs and directors have given more than \$410,000.
- Auxiliary—Contributed the largest single gift, \$1,000,000.
- Board of trustees and

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foundation—Contributed \$418,000.

- Employees—Committed \$117,448.
- Campaign cabinet—Total gifts of \$310,000 (exempting physicians and board members, reflected in previous entries).
- Community—Community donors have donated \$871,510 and the number is climbing.

We were delighted that our physicians gave more than \$1 million, a result that really demonstrates their support for the hospital and an understanding of the importance of philanthropy to its future. They were very involved in the planning and design of the new pavilion, so they knew what a difference having this state-of-the-art facility tailored to their needs would make in their ability to care for patients. During


the planning phase, physicians and staff were really invested in the details. For instance, they would run drills to see how fast they could get patients from the new pavilion to some operating rooms that remained in the older facility. Their support and input were key.

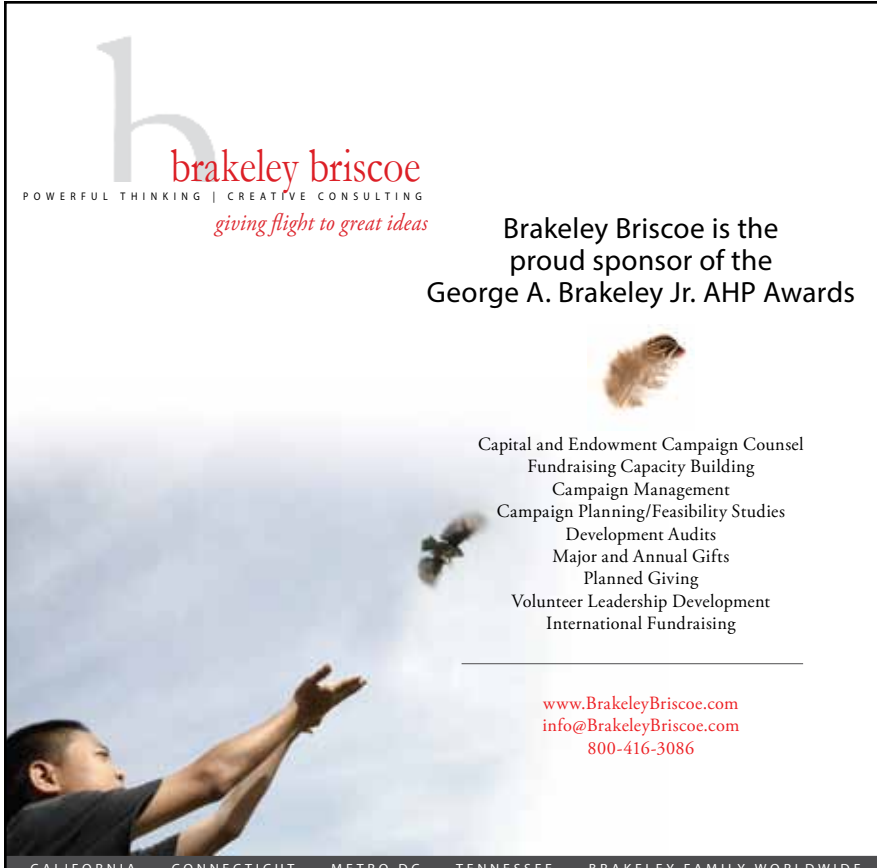
Our employees really stepped up at all levels and seem to see their gifts as an investment in their workplace and in themselves.


What's in our future

When our pavilion opened in January of 2013, we held a celebration that included a cocktail event for donors who gave \$10,000 or more. We conducted VIP tours of the new facility, which houses our brand new level-3 NICU, our women's and children's birthing center, the inpatient oncology department


and our infusion center (which formerly was located two miles away from our facility). In addition, we hosted a dedication ceremony for public servants, staff and community leaders. With these campaign celebrations behind us, our attention has turned to stewardship and creating a robust annual campaign to raise money for programs, capital needs and equipment.

Our capital campaign was an amazing experience and a real lift for a community that has experienced some economic stresses in recent years. It felt like a significant step toward creating a positive vision for our community's future. I don't know if we will get the additional foundation staff members we've requested, but I no longer worry about having good volunteer partners in fundraising and networking. And now I'm sure that our community believes our medical center is a highly valuable and worthy philanthropic cause. 




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Guy J. Guarino Jr., M.B.A., M.H.A., FACHE, joined Catawba Valley Medical Center as vice president for strategic management and development in 2003. He currently serves as the chief development officer with responsibilities over marketing and public relations and the Catawba Medical Foundation. Guarino earned his Masters of Business Administration and Masters of Health Administration from Pfeiffer University. He also is a fellow of the American College of Healthcare Executives.



Dan Rogge is president of Rogge & Associates, a consulting firm providing collaborative capital to help national, regional and community NPOs advance their mission by funding facility, endowment and operational revenue aspirations. With 15 years of consulting experience, Dan founded Rogge & Associates in 2013 to create the next generation of client services characterized by quality, flexibility, thoughtfully assembled resources and personal attention.

Taking the mystery out of metrics

Three AHP members discuss the value and practical uses for shops of all sizes



No matter the size of your development program, data can be your strongest ally and most valuable asset. It can help you make the case for growth and expansion, including the need to invest in more staff. It can show if your programs are headed in the right direction and where to make changes for greater success. Perhaps most important, data that's presented the right way can increase your credibility with your C-suite and make a compelling case to donors.



Business leaders in all industries use benchmarking data to inform decisions, set goals, monitor progress, measure performance and embark upon change and growth. Three veterans in the field of health care philanthropy share how they use benchmarking and demonstrate its value and impact on their organizations' success.

"Data is extremely important in all business, and I think that's especially true in health care," says Mark Larkin, CFRE, vice president of philanthropy at CentraCare Health in Saint Cloud, Minn. Larkin is responsible for 15 FTEs and a \$7.2 million budget, supporting his 600-bed health system.

"Benchmarking gives us instant credibility with the C-suite and our colleagues," Larkin says. "In health care,

every service line leader uses benchmarks—whether it's for cancer care or behavioral health—especially with a focus on quality. Why shouldn't philanthropy?"

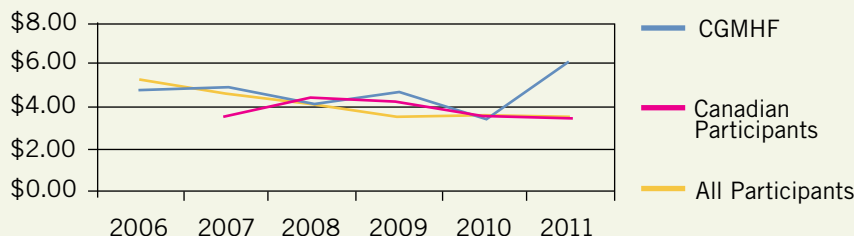
Randy Varju, FAHP, CFRE, chief development officer and foundation president of Advocate Health Care in Park Ridge, Ill., also says that senior leaders see him and his team in a more credible way due to benchmarking.

"It broadens their understanding of the important measures in philanthropy and connects us to the other successes of the organization," he explains. A large and growing health system with more than 3,500 beds, Advocate Health Care has 35 FTEs for development.

Credibility with donors is another value of

Dashboard: Collingwood General & Marine Hospital Foundation

**Collingwood G&M Hospital Foundation
Median Production ROI—5 Year History**



"This chart shows our board comparative data that focuses on year-over-year improvement. In 2006, we invested in a small planned giving/endowment campaign with a goal of increasing our gift expectancies. We saw a better ROI on production around planned gifts, but our major gift pledges fell off. In 2010, the board agreed to launch a capital campaign based on 2008 data. We told the board there would be a drop in production ROI during the planning phase in 2010, but that it should rebound significantly in 2011. All of this is shown on the chart."

—Jory Pritchard-Kerr, FAHP, CFRE, executive director of Collingwood General & Marine Hospital Foundation in Collingwood, Ontario

benchmarking, according to Jory Pritchard-Kerr, FAHP, CFRE. Pritchard-Kerr is the executive director of Collingwood General & Marine Hospital Foundation in Collingwood, Ontario, and oversees a staff of five FTEs for a foundation supporting a 70-bed community hospital.

"Our major gift donors are surprised when we pull out our graphs and explain where we are and where we want to go," she says. "Donors are impressed we can show the hard data and that we are looking at all the aspects. More and more donors are going to be expecting this type of data."

"Once we could show data, we were finally viewed as a genuine business unit or service line," adds Larkin. "It really comes down to credibility. We are now viewed as a viable, critical part of the organization."

What to measure

Tracking and comparing data metrics is good business sense.

Start with your own, the experts say, but be aware of the industry data that is available through organizations such as the Association for Healthcare Philanthropy, the Health Care Advisory Board, the Committee Encouraging Corporate Philanthropy (CECP) and others for comparative and trending purposes. When beginning your data tracking and benchmarking, avoid recreating the wheel. Explore available resources and options to ensure you're building your program correctly from the beginning and that you will be able to make effective comparisons.

Pritchard-Kerr, Larkin and Varju concur that return on investment (ROI) is the most important metric in your benchmarking.

"Return on investment is a critical success factor in our ongoing plan," says Larkin. "If you can show ROI, in particular, to a board of business professionals, they understand it."

Cost to raise a dollar, net dollars raised, major gifts, planned gifts, annual gifts and event revenues are also important and typical metrics

in fundraising. Staff allocation and productivity are additional valuable metrics.

"Benchmarking allows you to drill down into the variables and examine other measures, such as the number of new donors in a year," says Pritchard-Kerr. "The metrics allow you to make informed decisions, not just kneejerk reactions."

You don't have to measure everything, however. The most important step in benchmarking is making sure your metrics are targeted to and aligned with your goals and objectives.

Varju says benchmarking has been helpful in educating others on which variables are important. "We have a good baseline to illustrate improvements and the efforts we are making that impact bottom line results. The tracking over time shows the value in the decisions we are making."

He advises streamlining your metrics and even the terms you are using to report information to ensure everyone is on the same page. "Benchmarking data drives symmetry in reporting and nomenclature. It's a reassurance that we are looking at industry standards and is another valuable resource we can offer to our own organization."

Planning for growth

Hard data is extremely valuable when making the case for growth and expansion; it can be a catalyst for change. Pritchard-Kerr says by comparing her small foundation to other similarly sized, high performing shops, she was able to defend her request for more clerical and administrative staff to free up time of the fundraising professionals. On another occasion, she justified adding a staff person dedicated for planned giving.

Larkin doubled his staff in a three-year plan supported by his

board, thanks to benchmarking data. “Each time we’ve wanted to add staff, we’ve backed up the request with benchmarking data. It provides credibility when asking for more FTEs.”

Programmatic changes can be supported by benchmarking data, too. At Advocate Health Care, the foundation board took a closer look at the role of major gifts with the aid of benchmarking data.

“We refined our focus to develop deeper portfolios,” explains Varju. “This was done with far more strategy than before, thanks to the data available to us.”

Larkin says data also has helped him illustrate to his board and leadership what’s realistic. “We were able to convince the board we could double or possibly triple our fundraising per year; however the market numbers would not justify a six to eight fold increase that the CEO was challenging us to raise. By presenting the data it moved an emotionally charged discussion into a logical one.”

“In the end, we all want to see net revenues growing,” contends Pritchard-Kerr. “We can use benchmarking data to decide on whether to invest in staff or make tweaks to programs to achieve that end goal.”

Preparing for challenges

While the benefits are many, there are some challenges with benchmarking. Being aware of them and preparing in advance can go a long way in lessening the degree of difficulty.

“Benchmarking is a fairly rigorous undertaking,” Varju warns. “The key is to anticipate that on the front end.”

There’s also an investment required—of time, personnel and dollars. Appropriate internal resources need to be allocated to set up your system. “The first year is the

Dashboard: CentraCare Health

Results and Benchmarks	CentraCare Foundation Fiscal Year 2011	AHP Benchmarks Median			
		System Foundations (4 orgs.)	Overall data base (58 orgs.)	Staff Size 8-10 (13 orgs.)	Size of Expenses Budget 1.5 to 2.5 M (15 orgs.)
Funds Raised	\$7.8M	\$6,227,786	\$3,788,643	\$6,547,973	\$8,631,507
Net Returns	\$6,097,371	\$4,175,006	\$2,798,600	\$5,091,895	\$6,988,426
FR Expense	\$1,691,710	\$1,737,992	\$1,060,179	\$1,456,078	\$1,643,082
ROI	\$4.60 to \$1.00	\$3.05 to \$1.00	\$4.06 to \$1.00	\$4.88	\$5.34
CTRD	\$0.22	\$0.33	\$0.25 (25th percentile = \$0.20)	\$0.32	\$0.31
Direct Fund Raising FTEs	8.9	9.25	5.13	7.53	7.31

“This dashboard compares CentraCare’s fiscal year 2011 with four different cohorts, including institution type, staff size and budget. We use it in reports and strategy discussions with our executive leadership.”

—Mark Larkin, CFRE, vice president of philanthropy at CentraCare Health in St. Cloud, Minn.

most difficult,” Pritchard-Kerr says. “It requires a lot of time, but gets easier every year.”

There’s also a financial cost involved if you are participating in industry benchmarking programs, but it’s not cost prohibitive, she says. “For a small foundation, without dedicated financial analysts and staff, we think it is completely worth it. The real value lies in how you use the data.”

In this current environment of mergers and expansion, cultural issues can present challenges, too. “Integration of a new hospital means a new level of variability,” explains Varju. “Cultures are different.”

Michael Boersma, director of prospect development and analysis on Varju’s team, says you have to make sure all your different development offices are using the same definitions. “We had to do some recalibration to accommodate the parameters of our reporting and to ensure we had a common understanding among our team of the reporting definitions.”

Another challenge in

benchmarking, according to Boersma, is capital campaigns. “They are difficult in comparisons. You need to make adjustments to allow for those special campaigns.”

What may seem to be a given challenge doesn’t always have to be: staff accountability. Measuring staff resources and productivity can make people nervous. However, at CentraCare Health, Larkin says it is the accepted way of doing business.

“They like the clarity and depth,” Larkin says of his team. “If you take a balanced look, over time, it is more valuable.”

“Is being accountable stressful? Absolutely,” he adds. “But it’s used as a guide, not a club. There is some comfort in that guidance.”

Varju and his team agree the worth of the data far outweighs any angst associated with it. “Benchmarking has helped us build efficiencies with staff allocation; it has helped us identify what is necessary and required to meet our goals.”

Benchmarking wisdom

- **Embrace the data.** Don't let a fear of not measuring up impede learning and process improvement.
- **Dedicate and invest the appropriate resources**—personnel and time—to get proper systems in place for collecting benchmarking data.
- **Focus on the key metrics** that will help you achieve your goals. You don't have to measure everything.
- **Analyze data annually.** The accumulation of data over time adds value and provides data points for progress checks.
- **Think of benchmarking as a journey, not a destination.** You'll be continually refining and adjusting as years go by.

"It's not just the foundation as a whole stepping on the scale, it's also each individual team member," he says. "The data determines the timing and dosage of any necessary changes and drives the outcomes we can then celebrate."

A good fit for all sizes

Benchmarking has no size boundaries. Pritchard-Kerr says her foundation is the smallest

Canadian organization participating in AHP's benchmarking service, yet still benefits greatly. "We are benchmarking against ourselves, year after year, but also other Canadian hospitals." She's been participating in the service since 2007.

"Don't let size or fear hold you back," Larkin advises. "We have to get beyond the idea that the data will be used against us. If we want our field to have credibility, we need to

recognize this is business. Choosing to benchmark is a sound business decision that will lead you to more sound decisions."


"Not everyone who participates is exactly alike," adds Boersma. "Given that, we're still able to glean valuable information about ourselves and other systems."

A solid reputation

Benchmarking can be important to successfully integrating philanthropy with the overall business and strategic plan of your organization. Benchmarking your program's successes—and shortcomings—can solidify your reputation as a business professional.

"If you use benchmarking the way it is intended, you'll be very successful in launching your organization—and your personal career—to new heights," says Larkin. "People think fundraising is about glad-handing and parties; they don't always see it as part of the strategic mission."

Larkin says he's always amazed when colleagues complain about chief financial officers not understanding what they do. "If you are benchmarking, you can speak their language. The entire concept is grounded in business practices and principles."

He says he takes great pride when a volunteer comments on the running of CentraCare's development department. "They are successful business people. They understand data and how we are using it and engaging them on planning and strategy. I take their positive comments on our benchmarking as the highest compliment." 

SPONSOR SHOWCASE

How does your organization measure up?

In the crowded nonprofit industry you need to stay ahead of the competition for donors, grants and mindshare. Understanding a few key trends should help you prepare for success:*

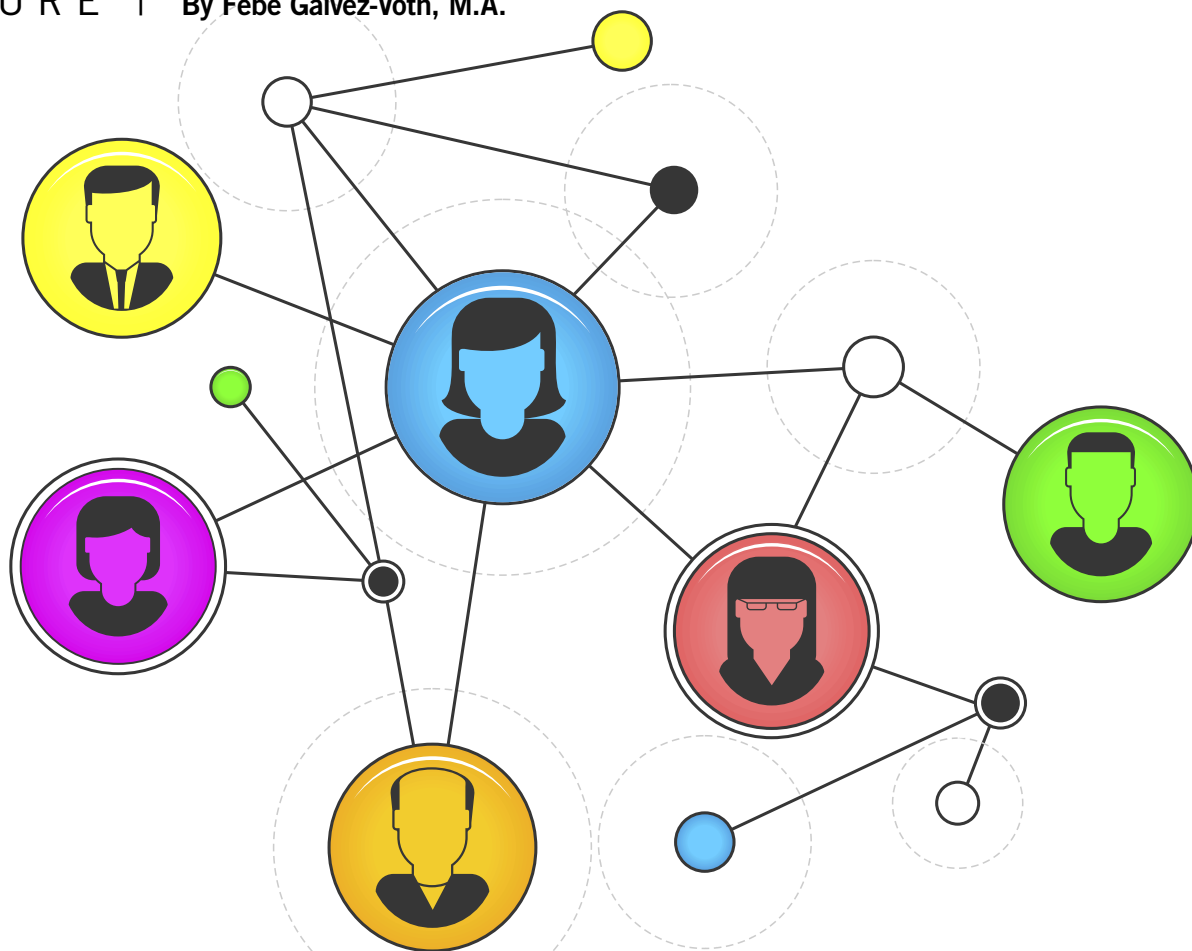
- At hospitals and other care facilities, after declining through much of 2012, fundraising revenue grew through the latter part of the year and the early part of 2013, dipping slightly in the spring. Health care organizations rely heavily on major gifts, which are far more dependent on the stock market. When people are feeling confident in their investments, and they have the resources, they're much more generous with big gifts.
- Overall giving for health care organizations in recent months has been relatively flat, while online giving has grown by double digits. Organizations should consider integrating online giving channels (such as email marketing, online donations and peer-to-peer fundraising) into their marketing and fundraising strategy to capture and retain more donors.
- An important way to gauge how your fundraising stacks up to your competition is by benchmarking your organization against your peers. The insights gained can help you fine-tune your fundraising strategies for future success.

* Statistics highlighted are from Blackbaud's new specialty index focused on fundraising revenue for hospitals and other health care centers. The new health care index is drawn from The Blackbaud Index (www.blackbaud.com/blackbaudindex), which provides the most up-to-date information on charitable giving today, tracking approximately \$12 billion in US-based charitable giving on a monthly basis.

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Nancy Plemens Mayes, APR, is a communications consultant with more than 20 years of experience in the nonprofit health care industry.



Make a remarkable case for your cause

Inspire your donors
to become your
advocates

My husband and I recently attended a party; it was our realtor's show of appreciation for his long-time clients. His sprawling estate, aglow in candlelight, looked like a page out of *House and Home*, and the food and wine were worthy of a feature in *Wine Spectator*. The setting and ambiance were truly memorable—remarkable, even.

About 50 guests filled the rooms of the home. We heard stories of properties purchased and sold, and we also heard many inspiring stories of philanthropy.

One couple had made multiple trips to Africa where they support an orphanage. Most recently, they had helped to fund and build an extension to a facility that was home to children orphaned by the HIV/AIDS epidemic. The couple shared their heart for the work along with a now-funny story of how the husband had fallen into crocodile-infested waters. Their enthusiasm made me want to join their adventure, although I would pass on the encounter with the crocodiles!

Another couple spoke of their commitment to help erode the stigma that is still attached to mental illness and to help ensure that families faced with this challenge receive the care and support they need and deserve. This couple spoke with passion about using their home and their voice in the community to raise significant funds to advance the work of their chosen charity.

And so it went. One couple after another told remarkable stories about charitable work they believed in, invested in and were passionate about. We encountered philanthropic missionaries that evening.

I left that event wondering why those specific causes had made their way into our conversations. After all, there are hundreds of charities in the area. Of course, with only 50 attendees the capacity for charitable representation was limited. But the question of why those specific causes rose to the fore, while others were overlooked, is an important one for anyone who works in the charitable sector. For whatever reason, the causes were remarkable (literally worthy of a remark) to those individuals that evening.

What if your donors had been at the party? Would they have been talking about your cause? Is your case close enough to their hearts that they would remark on it? Are they your evangelists, your missionaries—in their workplace and their social sphere?

It is through our discourses—the sharing of ideas, stories and experiences—that a cause or an organization advances. If we accept the notion that to thrive, our organizations and our causes must be *remarkable*, then the challenge for a nonprofit is to put forward a case for support that will get people talking—*remarkably*.

Being the topic of conversation at next year's party is not the point. That is the result. The point is for the cause and the case to be so *remarkable* that they become the topic of conversation at gatherings, dinner tables and boardroom tables throughout the year.

Converting donors into advocates

So how do we inspire our supporters to do more than write a check a few times a year? How can you present your charity in ways that will motivate donors not only to give regularly, but to be so engaged, so all-in that they become your advocates? Here are a few ideas.

Create a strong value alignment

People give to advance the things they value. If a donor is looking to infuse his or her retirement years with purpose and meaning, a message about how a piece of medical equipment will reduce wait times will not resonate. The values are misaligned.

In *The Realm of Rhetoric*, Chaim Perelman, philosopher and expert on rhetoric, identifies two kinds of values: concrete and abstract. Concrete values, simply put, refer to things you can touch—such as a home or even a spouse. Abstract values refer to intangibles like love, health, freedom, purpose, solidarity and relationships. Abstract values, says Perelman, “serve more easily as a basis of critiques of society, and can be tied to a justification for change, to a revolutionary spirit.”¹ The point here for a fundraiser

Carefully crafted narratives
whisk new life into familiar
ideas and **present them in a way
that stimulates the imagination.**
And when your donors view your
cause in fresh ways, they may
be inspired to support them
more actively.

is to identify the values inherent in his or her cause, to know what donors value and to align the two—paying particular attention to abstract values.

You do this by knowing your donor. An easy way to find out what motivates someone to give is simply to ask. Donors will appreciate your curiosity and interest in their giving. What a person talks about, how they spend their time and money, how they dress and what they drive can also provide insight on what they value. A donor who has weekly dinners and annual vacations with children and grandchildren is likely to value family, for example.

In health care philanthropy, passion for the cause

can be born from personal experience. For example, a real estate developer whose elderly father has been treated in a crowded emergency room following a horrific car accident is invited to join the hospital foundation's property committee. He becomes a champion for a new emergency room.

Equipped with knowledge and information about what your donors value, you can begin to engage them in exactly the ways they want to be engaged.

Take a risk

Another strategy is to take a risk, to be bolder in the way you present your cause. In his book *Purple Cow*, marketing expert Seth Godin tells the story of how he and his family saw cows grazing in picturesque fields and started to “ooh” and “aah” over the visual feast.² After they watched the cows for a while, though, the scene became familiar and less interesting. Although the animals were charming, there was nothing extraordinary about them.

However, Godin says, if in the midst of the field they had seen a purple cow that would have been something. A purple cow would have caused them to sit up, pay attention, stop the car, take a picture and release it into the world of social media.

The point of marketing is to differentiate your cause from other like causes. When a cause is presented much like every other, it blends into the landscape and few stop and take note (or pictures). How can your cause become the purple cow that your donors will notice and remark about?

I recently worked with a team to create a short video that was used to open a gala fundraiser for a hospital foundation. The footage featured an ambulance, sirens blaring, making its way to the hospital through the familiar streets of the community. When it arrived, the attendants stepped out of the cab and opened the back doors. The stretcher was pulled out. On it, in a tuxedo, was the evening's master of ceremonies: a local TV personality, all smiles. From the stretcher, he welcomed guests to the gala. We took a risk and included a fun element of surprise. That short clip got people talking and laughing, and it set the stage for the evening.

Change your words, change your world

French philosopher and social theorist Michel Foucault defines discourses (narratives) as “socially constructed knowledges (plural) of some aspect of reality.”³ Foucault's message is that if you change your discourses—your messages—you will change the impact you have. How we present our case will

determine how people understand our vision, our mission and our way of operating. Ultimately our narratives can inspire our donors to action (or not).

Make it about the donor. In *East of Eden*, John Steinbeck writes, “If the story is not about the hearer, he will not listen.” From this I extrapolate that if the case for your cause is not about the hearer, he will not support it.

I recently reviewed a case narrative that was written from the perspective of the organization. It was all about its programs, accomplishments and funding needs. As I read it, I was struggling to stay engaged. Yet if the narrative had told stories about people whose lives had been changed by skilled and talented individuals, how donors stepped up to lead the way, how programs and, most importantly, families and society are benefiting—in other words, if it had had more direct appeal to the reader—I would have been much more interested and inspired.

Make it solution-focused. Donors want to invest in the promise of something better, not in a sinking ship. Though it may be tempting to focus on the less-than-state-of-the-art operating room, for example, place the emphasis on the potential and promise of a new,

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modern facility and you will experience a change in the mood of your narrative.

Make the donor feel something. A giving decision is made with both the head and the heart, which means the case for your cause must appeal to both. To make the case appeal to the head is relatively easy and can be done by presenting such things as demand for service, population growth, availability of new technology, aging infrastructure, etc. To appeal to the heart takes more thought and creativity, and it links to Perelman's advice on appealing to abstract values.

I once worked on an appeal to raise funds for a new swallowing station for a hospital's occupational therapy department. The draft appeal letter focused on the new technology and what it could do for patients. It was an okay letter, but it lacked emotion. One of the big problems for a patient who can't swallow is ingesting medicine. With this in mind, we framed the appeal around the song "Just a spoonful of sugar makes the medicine go down." We tapped into childhood memories and launched a happy tune in the mind of the reader. That inclusion reinforced the need for the equipment, added emotion and changed the mood of the appeal from impersonal to sing-along friendly.

Carefully crafted narratives whisk new life into familiar ideas and present them in a way that stimulates the imagination. And when your donors view your cause in fresh ways, they may be inspired to support them more actively.

The power of story

By our nature, we are curious about each other; we like to hear each others' stories. One of the most effective ways to present information about your cause and to demonstrate results is to share stories, because we can often relate to what someone else has experienced.

In the New York Times Bestseller *Made to Stick: Why Some Ideas Survive and Others Die*, authors Chip Heath and Dan Heath assert that: "The story's power... is twofold: It provides simulation (knowledge about how to act) and inspiration (motivation to act)."⁴ Notice how both benefits—knowledge and motivation—point toward action.

Few things demonstrate philanthropic impact like a story of a life changed or a community altered. A Vancouver-based nonprofit had contracted with a big-deal, high-priced speaker to address donors at an event. When the speaker cancelled at the last minute, the nonprofit's executive director scrambled to fill the agenda with meaningful content. In an act of desperation that turned out to be a stroke of genius, he took a video

camera and asked people who had been helped by the charity, which worked with the homeless community, to share their stories. He edited the footage of formerly homeless interviewees on his laptop and showed the amateur but heart-touching piece at the event. The result: an unexpected flood of donations.

Engage your donors


The people I spoke with at the party, the ones who were remarking about their charitable work, were in the story. They were on the ground, building. They were in their community, using their voice and their influence. They were in, wholeheartedly. To be truly remarkable, charities need to facilitate this type of engagement. It won't be through key messaging (although staying on message is important). It won't be by writing a dynamite thank you letter (although that is important, too). And it won't be by developing a five-step strategic plan (although that may be an important factor as well). It will happen by being an agent who cultivates a pervasive, integrated culture for engagement. It will require a fundamental shift from "we are raising funds for such and such" to a mindset of "we care about such and such; if you do, too, let's do this together."

Your "remarkable" cause and case

How does your charity become an ongoing topic of conversation? By continually exploring ways to engage your donors so your cause is in their hearts as well as their minds.

If your charity is already the talk of the town, keep up the good work. But if more airtime around dinner tables and boardroom tables will advance your cause, I challenge you to examine your case and decide to give donors something remarkable to talk about.

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