

# HEALTHCARE philanthropy

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your favor

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### Also in this issue

- 18** Community giving program builds vibrant network
- 26** How to implement team performance metrics
- 30** Doctor-turned-fundraiser shares lessons learned
- 36** Using venture philanthropy to raise resources



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# CONTENTS



## FEATURES

### 12 **Service recovery**

By Kitty McKay

By adopting a “service recovery” mentality and working closely with the patient care experience team, health care fundraisers can shift how they receive negative feedback and respond to it in a more meaningful way.

### 18 **The Elf Workshop**

By Michael Campbell, Ph.D., and Samantha Garrett Klaff, M.S., CCLS

Find out how one hospital system established a community giving program to drive charitable giving during the holiday season. Each year, program leaders engage key stakeholders in an efficient process to meet the needs of children and build a philanthropic network of donors and volunteers.



### 26 **Fundraising the Cleveland Clinic way**

By Lisa McElhenny and Brad Millius

Learn how the Cleveland Clinic has implemented a team-based approach to health care philanthropy, a tactic that involves fundraisers working together through engagement with potential donors to move the gift conversation forward.

### 30 **Engaging physicians in philanthropy: Twelve years later**

By Clifford I. Harris, M.D.

Physician involvement in grateful patient philanthropy is a great way to boost hospital fundraising effectiveness. An experienced doctor-turned-fundraiser shares his top 10 “lessons learned” for successfully engaging physicians in health care fundraising.

# 36

## Risks and rewards of venture philanthropy

By Tanya Ickowitz

Some nonprofit organizations are testing venture philanthropy, which combines charitable giving with for-profit strategies that require an organization to function more like a business. While this strategy may not be the right solution for every project, it is a viable model that could serve as an extra vehicle to raise resources in certain settings.



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## DEPARTMENTS

### 4



#### From the Chair Honored to serve AHP

By Jory Pritchard-Kerr, FAHP  
Chair, AHP Board of Directors

Much has been accomplished over the past two years, setting the stage for an exciting future.

### 5



#### As I See It The future is bright for AHP

By Alice Ayres, M.B.A.  
AHP President and Chief Executive Officer

AHP's new leader supports health care philanthropy professionals in their drive to secure the future health of communities.

## 6 AHPNEXT

Raising awareness of career options via Philanthropy 2030 and tips for retaining young health care professionals.

# HEALTHCARE philanthropy

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The Association for Healthcare Philanthropy (AHP) is the health care development professionals' definitive source of thought leadership, connections to facilitate innovation, and tools to advance knowledge and elevate philanthropy. As the world's largest association for health care fundraising professionals, AHP represents 4,500 members who raise more than \$11 billion each year for community health services. Our mission is to inspire, educate and serve those transforming health care through philanthropy.

#### Healthcare Philanthropy mission:

*Healthcare Philanthropy* will be an authoritative resource for health care development professionals by providing a timely, informative and insightful collection of literature that will raise the standard of individual and organizational performance. Serving as the premier forum for health care philanthropy literature, *Healthcare Philanthropy* will educate, empower and inspire development professionals and, thereby, help strengthen the case for philanthropic support and the mission of AHP.





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## ADVERTISERS INDEX

<b>Accordant Philanthropy</b> .....	9
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<b>Blackbaud</b> .....	17, 41
800/443.9441, www.blackbaud.com	
<b>Borns Group/VDM</b> .....	33
Mark Makovec, 763/441-6709, www.VDM. bornsgroup.com	
<b>Campbell &amp; Company</b> .....	1
Adam Wilhelm, 877/957-0000 www.campbellcompany.com	
<b>CCS</b> .....	11, C4
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<b>Crescendo Interactive, Inc.</b> .....	C2
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<b>Graham-Pelton Consulting Inc.</b> .....	C3
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<b>Health Giving</b> .....	38
William Mountcastle, 877/500-5659 www.health-philanthropy.com	
<b>The Angeletti Group (TAG)</b> .....	43
Jay Angeletti, 973/540-1400, http:// theangelettigroup.com	
<b>Thompson &amp; Associates</b> .....	22-23
Bethany Witt Rozell, 615/369-1416 www.ceplan.com	

By Jory Pritchard-Kerr, FAHP

Chair, AHP Board of Directors



## FROM THE CHAIR


# Honored to serve AHP

What an honor it has been to serve AHP as its chair. When I started my career in health care philanthropy 30 years ago, I never dreamed I would be leading the organization I have come to depend on so heavily. I have enjoyed the past two years immensely and am excited about the direction in which AHP is moving. I feel much has been accomplished through the hard work and dedication of many AHP volunteers and our devoted staff.

I was thrilled that Sharon Jones, FAHP, CFRE, was recognized as the 2018 Harold J. (Si) Seymour Award winner. As director of the AHP Madison Institute, she has been instrumental in changing and growing the Institute. Under her leadership—and working with long-time Madison faculty member Jim DeLauro—the Institute launched the Health System Philanthropy Residency Program, a 15-month, comprehensive educational program designed to develop the next generation of system-level leaders. Her work with Janet DeWolfe, FAHP, CFRE, and the Accreditation Committee led to an in-depth study of the Fellows Program and then produced solid recommendations to help bring the program into the 21st century. The new Fellows Program, which will launch in 2019, will be a true standard for leadership and accomplishment in our profession.

At the core of AHP are its volunteers. Over the past 50 years, hundreds of volunteers have served AHP through educational offerings, committees and governance work. It seemed, however, that we continually went to the same corps of volunteers for assistance. As many key volunteers begin to exit our profession through retirement, we worried about engaging the next generation.

The new Forty Under 40 program recognizes the top young professionals in our field and promotes health care philanthropy as a long-term career option. There were dozens of nominations for this recognition award, which bodes well for the future of AHP and our culture of volunteerism. I can't wait to congratulate the winners at the 2018 AHP Annual International Conference in San Diego.

I end my term as your chair with excitement for the future of AHP and with my heartfelt appreciation to you, our members, for allowing me the honor to serve. 



## AS I SEE IT

## The future is bright for AHP


**H**ealth care is among the most honorable and critical industries in the world, and yet the financial health of our health care institutions is under siege. As an industry, we have cut and cut our way to bottom-line goals, but cost containment continues to top the list of strategies for our chief executive officers.

I was drawn to AHP because I see philanthropy as the curve bender. What each of you do every day makes a substantial revenue impact on our health care organizations, and that secures the future health of our communities, our friends and our neighbors. The important work you do safeguards the health of our organizations, which is why I am so honored to serve you as AHP's new CEO.

My mission, and that of AHP, is to support you in this work. Since my arrival, you have been generous with your time, your warm welcomes, your thoughtful advice and your feedback on what you need from AHP. You have shared your excitement for AHP's future and your eagerness to see AHP grow and adapt to serve the ever-changing needs of health care philanthropy professionals. You have expressed willingness to contemplate new directions, eagerness for more diversity and inclusiveness and the desire to volunteer your time and expertise to help AHP become even stronger. For all of this, I am enormously grateful and extremely energized.

I see immense opportunity for AHP to provide even greater support to you. The best practices and innovations in health care philanthropy lie within this membership. As we harness them, we will unlock the true power of our collaboration. Delivering best practices through new formats—digital, local events, train-the-trainers, webinars—will speed dissemination and exponentially expand our collective learning. The development of affinity groups within the membership will allow for even more meaningful networking and mentorship.

As we develop new and different ways to serve, my hope is you will feel comfortable to share your feedback with us—both complimentary and constructive. We want to learn and optimize to ensure we are best serving your needs.

This is a truly exciting time to be in health care—especially health care philanthropy. The sky is the limit on what we can accomplish together! 

### Welcome, Alice Ayres! AHP's New President and Chief Executive Officer

Alice Ayres, M.B.A., brings deep health care industry knowledge and strong marketing skills to the role of chief executive officer, both of which she will employ as AHP develops new educational opportunities and tools to support the important work of health care philanthropy professionals.

Ayres welcomes the opportunity to speak with AHP members, as she wants to ensure the association is best meeting the needs of those it serves. You can reach Ayres at 703/538-3140 or [alice@ahp.org](mailto:alice@ahp.org).



## Find new horizons

Navigating the changing health care philanthropy environment can be a challenge. The AHP Annual International Conference is your opportunity to stay up to date on the latest trends, best practices and hot topics in the field.

Designed to help you lead, focus, learn and connect:

- **Lead:** Rediscover your passion for philanthropy and return to the office invigorated. Accelerate your progress toward certification by earning up to 21 CFRE credits.
- **Focus:** Each educational session is specifically tailored to the health care philanthropy sector. Whether your top-of-mind issue is grateful patient giving, systemization,

physician engagement or all of the above, you'll find answers to your pressing questions.

- **Learn:** With more than 50 educational sessions and workshops exploring all aspects of health care fundraising, you'll be sure to find ideas you can apply right away.
- **Connect:** Expand your network of friends, colleagues and industry experts at the world's largest gathering of health care philanthropy professionals. Discover the techniques and tactics your fellow AHP members use to succeed.

Join us in San Diego this October and chart your course to fundraising success!

Register at [www.ahp.org/International](http://www.ahp.org/International).



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## Must-see attractions in San Diego

The AHP Annual International Conference is a great learning experience no matter where it takes place. But the right destination can make your experience exponentially better. This year, San Diego offers conference attendees a world-class destination city. Check out these must-see attractions:



### Balboa Park

Located in downtown San Diego, Balboa Park is home to more than 16 museums, botanical gardens, multiple performing arts venues, cafes, shops and many other recreational activities, including the renowned San Diego

Zoo. Spread across 1,200 acres, the zoo is one of the most popular attractions in San Diego. Visit [www.balboapark.org](http://www.balboapark.org) to view events and itinerary ideas.

### Gaslamp Quarter

The Gaslamp Quarter's 16.5-block district offers premier nightlife entertainment covered in rich Victorian architecture and history. Visit a variety of shops, art galleries, theaters and amazing restaurants, bars and clubs. It's the perfect place to let your hair down after spending the day learning and networking at the conference. View the various restaurants and shops at [www.gaslamp.org](http://www.gaslamp.org).

### USS Midway

The *USS Midway* is the longest-serving American aircraft carrier of the 20th century. This historical relic offers patrons the opportunity to explore 60 different exhibits and 29 restored aircraft, including some that have flown in World War II, Operation Desert Storm and the Korean War.

They offer tours and educational opportunities to immerse yourself in American history. Get tickets at [www.midway.org](http://www.midway.org).

### Coronado Beach

Coronado Beach—meaning “crowned one” in Spanish—provides a 1.5-mile-long shoreline, pristine sand, picturesque scenery and a peaceful atmosphere to unwind and relax. While you're there, you can explore the infamous Hotel del Coronado featured in Marilyn Monroe's 1958 film, *Some Like It Hot*.

### SeaWorld

San Diego's SeaWorld offers unlimited fun for all ages, including interactive sea animal experiences, thrilling amusement park rides and amazing shows and presentations. You can schedule a hands-on tour, meet a penguin, swim with dolphins or explore at your leisure. If you have an interest in sea animals, this attraction is a must-see. To purchase tickets and learn more, visit [www.seaworld.com/san-diego](http://www.seaworld.com/san-diego).





The Association for Healthcare Philanthropy 2018 Forty Under 40 program is designed to recognize the future leaders within the health care development community.

These 40 young professionals have demonstrated success in their careers and are shaping the future of the health care development industry. They will be recognized at the 2018 AHP Annual International Conference, where they will be honored during the Leadership Reception and throughout the course of the event.

Collectively, we are changing the world—one campaign at a time.

FIRST NAME	LAST NAME	TITLE	ORGANIZATION
Aaron	Peace	Vice President of Philanthropy and President of the Dignity Health Foundation - East Valley	Dignity Health
Aaron	Sanderson	Vice President, Philanthropy	Plan International Canada
Amanda	Stevens, MBA, CFRE	Foundation Executive Director	Hill Country Memorial
Anne	Cannon	Director, Events & Donor Relations	Norton Healthcare
Anne	Clouse	Vice President & Executive Director	INTEGRIS Foundation
Ashley	Blubaugh	Director of Development	University of Colorado Anschutz Medical Campus
Ashley	Nall	Senior Gift Officer	Johns Hopkins All Children's Foundation
Carmen	Shiple	Executive Director	St. Mary's Hospital Foundation
Chelsea	Moeller	Director of Philanthropy	MaineGeneral Health
Christy	Holtby	Vice President of Strategic Partnerships	University Hospital Foundation
Colin	Hennigar	Vice-President, Major Gifts	SickKids Foundation
Darina	Landa	Executive Director	Office of Advancement, Faculty of Medicine, University of Toronto
Erin	Hickey	Assistant Vice Chancellor for Development of Children's Health	UCSF & UCSF Benioff Children's Hospitals
Erin	Stitzel	Principal Consultant	Accordant Philanthropy
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Jennifer	Smith	Senior Executive Director	Hackensack Meridian Health Foundation
Jesse	Dees	Development Office	Collingwood General & Marine Hospital Foundation
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## Philanthropy 2030: Encouraging early health care development careers

By Deb Taft

**H**ealth care philanthropy has shown the largest absolute growth in number of employees of any nonprofit sector, and development professionals have never been more vital to health care. Yet demand for qualified development talent still far outpaces supply.

Without talent in the pipeline—either laterally or from the ground up—philanthropy will not reach its full potential in the 21st century. Making health care development a visible and desirable career choice would energize the economy, attract diversity and create societal impact—all high-impact benefits.

Enter Philanthropy 2030, a national advisory board comprised of leaders from health care, education, arts and national nonprofit organizations. The board's goal: to raise awareness of compelling career options in fundraising. Increasing awareness means helping people of all ages understand key components of philanthropy, fundraising and the broader field of advancement. Sharing a commitment to the profession, this dynamic group provides strategic direction and devises practical solutions to help nonprofits build their professional pipelines for the future.

Of particular interest to the board are millennials, America's largest living generation. With millennials surpassing baby boomers, and Generation Z right on their heels, the influence and participation of younger people in the health care development profession is more crucial than ever. Unfortunately, there are few formal training opportunities for prospective nonprofit health care development professionals at either the high school or university level, nor are there many welcoming pathways for midcareer changers.

Several generations and sectors of people may be perfect matches for the profession. Nonprofit health care organizations need to understand how to better reach them.

Here are some ways your organization can help build the talent pipeline:

- Encourage the students you know to request formal mentoring relationships with fundraisers.
- Recommend that recent university graduates consider how their skills can be used to build financial sustainability in nonprofit organizations.
- Know a high school or college career counselor? Talk to them about mentioning nonprofits when speaking with students about employment options.



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- Offer to speak at sororities, fraternities and community service clubs to plant seeds for students to consider a nonprofit career.
- Provide internships to local college students at your development office.
- Hire individuals with the skills and backgrounds to take fundraising to the next level, including a young person or person of color, to further the profession.

For more ways to help, please visit [philanthropy2030.com](http://philanthropy2030.com).

*Deb Taft is chief executive officer of Lois L. Lindauer Searches and convenes the Philanthropy 2030 Board. She previously directed all global consulting practices for Grenzebach Glier and Associates and held executive advancement roles for Tufts Medical Center, Dana-Farber Cancer Institute and Girl Scouts of the USA.*





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# Where is the love?

By James Green, M.B.A., CFRE

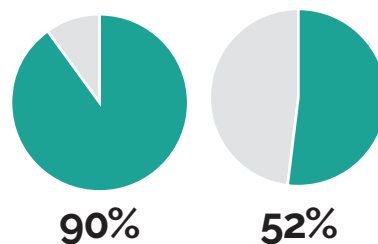
In the struggle to maintain a healthy relationship with early career fundraisers, nonprofits still have a commitment problem. Contrary to predictions of decline, the fundraising field is booming with qualified young professionals. The real issue is that new fundraisers are often not given the proper development tools to succeed. Even worse, nonprofits are typically unaware that they are not investing enough resources into their early career fundraisers.

To read tips on how to foster your relationship with your new fundraisers and keep them in your organization longer, check out the full article online at [www.ahp.org/resources-and-tools/ahp-connect-articles](http://www.ahp.org/resources-and-tools/ahp-connect-articles).

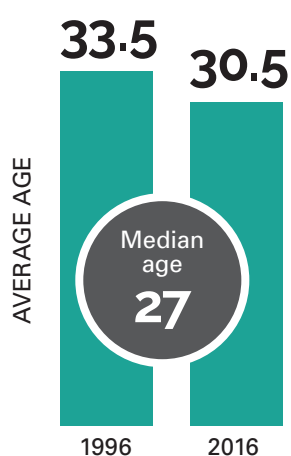
## State of the profession: millennial fundraisers and opportunity



Since 1995, the number of college-educated **fundraisers with a graduate degree** increased almost 9%.



Ninety percent of nonprofit CEOs believe their organization offers formal professional development opportunities, but **only 52% of their leadership teams agree.**



The average age of entry into the profession declined from 33.5 in 1996 to 30.5 in 2016, and the **median age of the first fundraising job is 27.**



**14.8%**

From 2016 to 2026, the fundraising occupation is expected to grow by 14.8%—nearly **double the average occupational growth rate.**



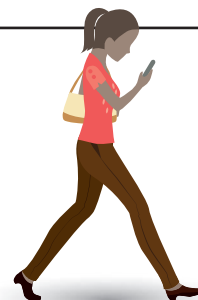
Funding for professional development and capacity building from foundations had **decreased from 1.24% of total awards to nonprofits from 1992 to 2011 to 0.8% by 2013.**



**Fifty-five percent** of emerging nonprofit leaders believe they need to leave their organizations to advance their careers.



Early career fundraisers (less than 10 years' experience) average merely **2 to 2.5 years per job.**





“

Working with CCS ensured a successful launch of the largest campaign in Dignity Health East Valley's history. The CCS team brought passion, insight, and tenacity to push our campaign forward and exceed our first-year campaign fundraising goals while building significant momentum for the coming years.

”

Aaron Peace, President/Chief Philanthropy Officer



## CCS CONGRATULATES DIGNITY HEALTH FOUNDATION EAST VALLEY ON THE LAUNCH OF A \$25 MILLION CAMPAIGN

Chandler Regional Medical Center, Mercy Gilbert Medical Center, and the community outreach programs managed by Dignity Health in the East Valley, are committed to delivering compassionate, high-quality, affordable health services; serving and advocating for the poor and disenfranchised; and partnering with others in the community to improve quality of life. In April 2017, Dignity Health Foundation East Valley retained CCS, and after a successful feasibility and planning study, the Foundation and CCS began implementing a five-year, \$25 million comprehensive campaign to construct two new medical facilities at Chandler Regional Medical Center and Mercy Gilbert Medical Center.

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# Service recovery

How dropped balls  
and angry donors can  
work in your favor

**T**he power of service recovery for turning around unfavorable incidents was demonstrated to me a few years back. As the director of foundation development at Carson Tahoe Health, at the time, I received a call from an enraged widower, expressing how “cruel” and “heartless” he thought we were. Apparently, a survey was mailed to his home, asking about his wife’s care experience, even though she had died. He was livid, having convinced himself that we knew she was dead and had sent it “intentionally,” “in contempt,” and that we “utterly lacked basic human decency.” This was back when we mailed surveys, and his wife had had two admissions close together. The survey he received had been mailed after discharge for her first visit, prior to her subsequent admission when she passed away. While initially taken aback by his furious attack, it seemed likely that his extremely escalated state was caused by intense grief.

Realizing there was nothing I could say to make it better, and it would probably help to let him vent freely, I just listened. When he seemed to be calming a bit, I empathized by acknowledging how incredibly hurtful it must have felt to receive a survey like that after her passing. Then I apologized, earnestly, and thanked him for taking the time to share his painful experience because it made us aware that we needed to improve our process and that, thanks to his willingness to share, we could make it better for others. We spent a solid 15 minutes on the phone, and through my hearing, empathizing, apologizing, resolving and thanking him, his emotions de-escalated and his heart opened. He wound up thanking us for the truly outstanding and compassionate care his wife had received,

and then he made a \$500 contribution to the foundation. And while I have always been adept at mending fences, given the magnitude of this particular situation, I am certain that the positive transformation of his awful experience into a healing one was due in large part to how carefully I truly listened and then followed the progressive steps of our established service recovery process.

### **The power of prompt, effective response**

In hospitals, things can, and do, go wrong. Treating patients is complex, and the myriad of moving parts our caregivers have to juggle in order to deliver safe, compassionate and efficient treatment is immense. No matter how hard everyone tries, unmet expectations



come with the territory. While we can't eliminate every negative incident, we can shift how we receive feedback and respond to it, and we can begin to view these times as welcome opportunities.

Unlike other development professionals who support worthy causes, health care fundraisers face a unique challenge: Our existing and potential donors also receive services from us. And while the opportunity for a meaningful medical exchange that creates a grateful patient exists, so does the opposite. Our care team may drop the ball with a donor we've been stewarding for years, putting our relationship at risk. If you receive a stomach-turning call from a donor, take a deep breath and realize that each time we work to remedy a service breakdown, we have the chance to deepen our connection. Without slipups, the opportunity for developing a more meaningful bond might not otherwise occur. By dealing with issues earnestly and effectively, discontented donors often turn around and express appreciation for the extra caring demonstrated on their behalf. Through the process, they draw closer to our organization and become more engaged. The key to having a dropped ball work in your favor is to perform heartfelt service recovery—in the moment—elevating donor engagement.

One of the best descriptions of how a service breakdown can actually be a good thing comes from the founder of The Thriving Small Business website, who also is a Certified Manager of Quality and Organizational Excellence through the American Society for Quality: "Service recovery is a theory that suggests that a customer who has a bad experience and receives a prompt, effective response to their issues will be a more loyal customer than a customer who had no bad

experience at all. ... The reason is that a bad experience provides an organization the opportunity to demonstrate how valuable the customer is to them."<sup>1</sup>

In other words, when we work to remedy something that went wrong, our donors get to feel how much we value them, that we truly care. Who doesn't appreciate knowing they matter enough for someone to go the extra mile to make things better? As the director overseeing both the care experience and the foundation in our 240-licensed bed, independent health system in Carson City, Nevada, I regularly express to patients and family members that while "we may not always be perfect, we are earnest about making things right," and they get it. They forgive, and we connect more deeply. People understand that mistakes happen, and they will generally forgive a misstep, as long as the people involved are willing to truly listen and empathize with how the issue impacted them, then do their best to remedy the situation.

### **Integrating development into the care experience**

Overseeing development, as well as the care experience, offers unique benefits, especially in terms of nurturing a supportive environment for grateful patient giving. (For those of you without this integration, consider ways to collaborate with your patient experience team and experiment with innovative work flows that foster this mutually beneficial organizational goal.) In our system, both departments function as proactive ambassadors of goodwill, and by integrating fundraising efforts, along with strategies that elevate the patient and employee experience (patient and staff rounding, discharge calls, ongoing process improvement, employee giving initiatives and

enterprise-wide fundraising), our work is synergistic and significantly enhances the patient and donor experience.

When I was only overseeing the foundation, it was frustrating when a community member shared a bad experience with me—not only because it was beyond my control to remedy the source of the problem, but also because I did not have an effective step-by-step service recovery method that consistently turned things around. Then in 2014, we began working with Integrated Loyalty Systems, which helped guide us through a comprehensive cultural shift. One of the many tools provided was the service recovery process outlined in the sidebar on page 15. As a development professional, you may not have to perform service recovery that often—but when you do, consistently applying each step, in order, will help sustain a donor relationship that might otherwise be irreparable. In many cases, it may deepen your connection even further.

### **Additional benefits of service recovery**

Four years later, our original service recovery process is active in our outpatient settings. For inpatients, we use the H-E-A-R-T communication tools, supported by an integrated, electronic rounding tool. A recent example of a tracked service recovery from front-line staff in one of our outpatient imaging centers demonstrates the power of using H-E-A-R-T++, as well as how significant it is for customers to be made aware that, as a result of them speaking up, we will be acting on their feedback and applying it to our continuous improvement process.

#### **1. Describe the situation**

"A patient [who was due to have



# The 'how to' and tools of the service recovery process

Our message to staff: When we've fallen short of expectations, patients can still experience Carson Tahoe as an "excellent" organization when we demonstrate our willingness and ability to fix a situation. Service recovery begins with recognizing, or anticipating, a service breakdown, and then acting with H-E-A-R-T++.

## H-E-A-R-T++ Process

<b>H - Hear</b>	Listen actively, without interjecting defensively. Restate the situation to be sure you've heard everything.
<b>E - Empathize</b>	Focus on the "human" or "emotional" side of the interaction. You should be as concerned as they are upset. If a patient, customer or colleague is angry, showing little or no emotion (in an attempt to remain calm) will only make them angrier. Say things like, "I understand why you are upset." It's not a good idea to say, "Just calm down."
<b>A - Apologize</b>	It is OK to be sincerely sorry for the situation without accepting specific blame or fault. Remember, you should be sincerely sorry that the patient is upset, regardless of whether the problem is real or perceived, our fault or not.
<b>R - Resolve</b>	Bottom line: Fix it. Communicate how you will fix it. Provide whatever was rightfully expected in the first place. If there is a misunderstanding, provide information. If you are unable to do what is expected, explain why, and what you will do to get someone who can fix the problem.
<b>T - Thank</b>	Remember, most people don't complain; they just leave and tell everyone else not to come, or they post negatively on social media. A complaint is a gift, an opportunity to make it right. Say, "Again, I am very sorry this happened to you, and thank you for telling us; now we can try to make it better and work to keep it from happening to anyone else."
<b>+ Plus it up!</b>	After you meet the requested fix, do something extra, according to what you've discussed as a team. When appropriate, use note cards and/or gift cards available in your department.
<b>+ Plus: Track it</b>	Use the "Track It" form to track the situation for continuous improvement. Act to prevent the problem from occurring again. For continuity of care, communicate the event/service recovery at the next patient handover. Inform colleagues what happened.

At Carson Tahoe Health, service recovery toolkits are available in each department throughout the system and contain paper tracking forms, though 90 percent of reporting is submitted online. Note cards, gas cards, Starbucks gift certificates and café vouchers also are included in the kit, though they are seldom needed—because in so many instances, successful service recovery can be achieved simply with H-E-A-R-T communication.

surgery immediately after his sentinel node scan] shared that he was disappointed in the ‘cranky’ response from one of our people in scheduling when he called for clarification on the check-in time for his sentinel node scan. The patient stated he had been given multiple different check-in times, and when he called to clarify, he was told by someone in an irritated voice that if he didn’t check in by 8:25, his appointment would be rescheduled.”

## 2. Describe action: How did we fix it?

“I took extra care to explain the process for his scan and later surgery, to the extent of my knowledge, apologized for the miscommunication earlier and assured him that we would escalate his concern so that the scheduling employee might receive more training.” In addition to this patient feeling cared for in the face of a frightening procedure, he was assured that staff members are grateful for his feedback because he helped identify a coaching opportunity they might not otherwise have known needed attention.

This example of how staff handled service recovery is not rocket science. In fact, at the start of our journey, we were inundated with comments along the lines of, “I don’t get it; this stuff is common sense,” and “Why all the fuss?” This process is really effective, and it’s deceptively simple. It truly is common sense and common humanity; however, it isn’t *consistent practice* until you intentionally make it so.

## Committing to service recovery

The impact of creating awareness about the importance of communicating warmly, and then


coaching specifics as to how that looks and sounds, results in an empowered staff who become their own self-inspiring ambassadors. Systematic service recovery steadily improves the patient experience, while helping staff feel more engaged and fulfilled. It feels a whole lot better to act as a proactive problem solver than as a complaint dumping ground.

We also assure staff that, sometimes, despite our best efforts, we simply can’t make it better. Not all people are seeking achievable resolution. Some people seem more inclined to continue expressing outrage. On the rare occasion this occurs, leadership coaches the staff to accept the situation and move on. We can’t fix everything, though we can find comfort in knowing we made every attempt.

If you are going through your own organizational shift to communicating in a more patient-centric way, one that takes the time to be warm and patient, it helps to be realistic with expectations. This is no wave-of-a-wand fix. Implementing a service recovery process, systemwide, takes a lot of patience and the ability to celebrate baby steps. In our case, knowing that our resources are limited when it comes to auditing and coaching the systematic utilization of this process, one of the yard sticks we use to measure progress is not the total number of incidents tracked, but rather the following: Are we seeing signs of becoming more consistently kind communicators, housewide? And are we receiving and acting upon information that points to areas in need of improvement?

At the end of the day, if you have to choose that one big thing upon which to focus, it needs to be the “H” of the H-E-A-R-T++ service recovery process. Hear! Really listen without responding defensively—

just like with the widower on the phone. It can be torture to simply listen at times, especially if we are being wrongly accused of something. Yet it is the single most effective bridge to de-escalating and shifting anger to understanding. People want to feel fully heard, and there is a reason we have two ears and one mouth.

The fabulous news about applying a more systematic service recovery approach in your own organization is that as a development professional you are brilliant, resilient and already adept at connecting with donors. The challenges you artfully navigate on any given day would make a mere mortal run for the hills. And while it’s not a viable moves management strategy to create problems in order to solve them, you can see how connecting more meaningfully with existing and potential donors, over inevitable service breakdowns, can foster the ultimate goal: deepening engagement. Find the aspects of service recovery that fit your culture and keep empowering your staff—and yourself—to embrace those dropped balls, perform the process of heartfelt service recovery and enjoy the rewards of enhanced donor relations. 

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# The Elf Workshop

## A children's hospital networking springboard to giving

It is well known that charitable giving peaks during the holiday season.<sup>1</sup> This philanthropic giving comes in the form of cash contributions and in-kind donations. Often these in-kind donations are labor-intensive and cumbersome, but in pediatric hospital settings they can be as good as cash when they come in the form of toys and supplies used to help care for the children being treated.

In the ever-shrinking landscape of health care funding, many health systems are grappling with the notion that philanthropy and charitable gift giving may be an increasingly important sector to explore in the search for revenue.<sup>2</sup> While politicians consider options for health care reform, health systems across the nation are struggling to find alternate sources of revenue to help bolster financial models in the health care sector that are weakening at best and crumbling at worst.

Philanthropy and volunteerism are gaining traction as two complementary opportunities to help stem the current health care financial instability.<sup>3</sup> They yield different sources of support but come from the same basic area of community engagement and giving.<sup>4</sup> Each has a fundamental drive to build successful models of networking in which the donor, compelled by internal desires to help, gives either time, money or both to help the mission of the health care system.<sup>5</sup> This networking strategy





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creates a feedback loop that promotes giving more and recruiting friends to the network to increase giving.<sup>6</sup> Engaging in the cultivation of donors for either philanthropy or volunteerism adds levels of complexity and cost<sup>7</sup>. Yet when exploring the costs versus gains, superimposed across a changing and uncertain health care marketplace, health care systems are increasingly opting to find ways to maximize those gains.<sup>8</sup>

As the aims for large donations gain traction, it is easy to see how small gift giving can be overlooked as a potential network-building funding stream.<sup>9</sup> These large donations can help hospitals to build new programs, attract world-class physicians or plan brick-and-mortar investments for years to come. As important as they are, large donations are elusive in an ever-competitive philanthropic space.

Small gifts, by contrast, are less competitive and more readily cultivated. It also has been argued that these small donations can add real value when managed well. Potentially more important is their ability to build a vibrant network that sustains brand loyalty<sup>10</sup> through the cultivation of goodwill.<sup>11</sup> In pediatric hospitals, these small gifts come in the form of cars, dolls and crayons, and these institutions naturally attract in-kind donations of toys and small gifts. This article explores how one pediatric hospital system created an “Elf Workshop,” which leveraged its combined stakeholders to engage community giving to meet the needs of the children, reduce costs and, most importantly, build a philanthropic network of donors and volunteers that return year after year to give not only during the holiday season but throughout the year.

## Elf Workshop

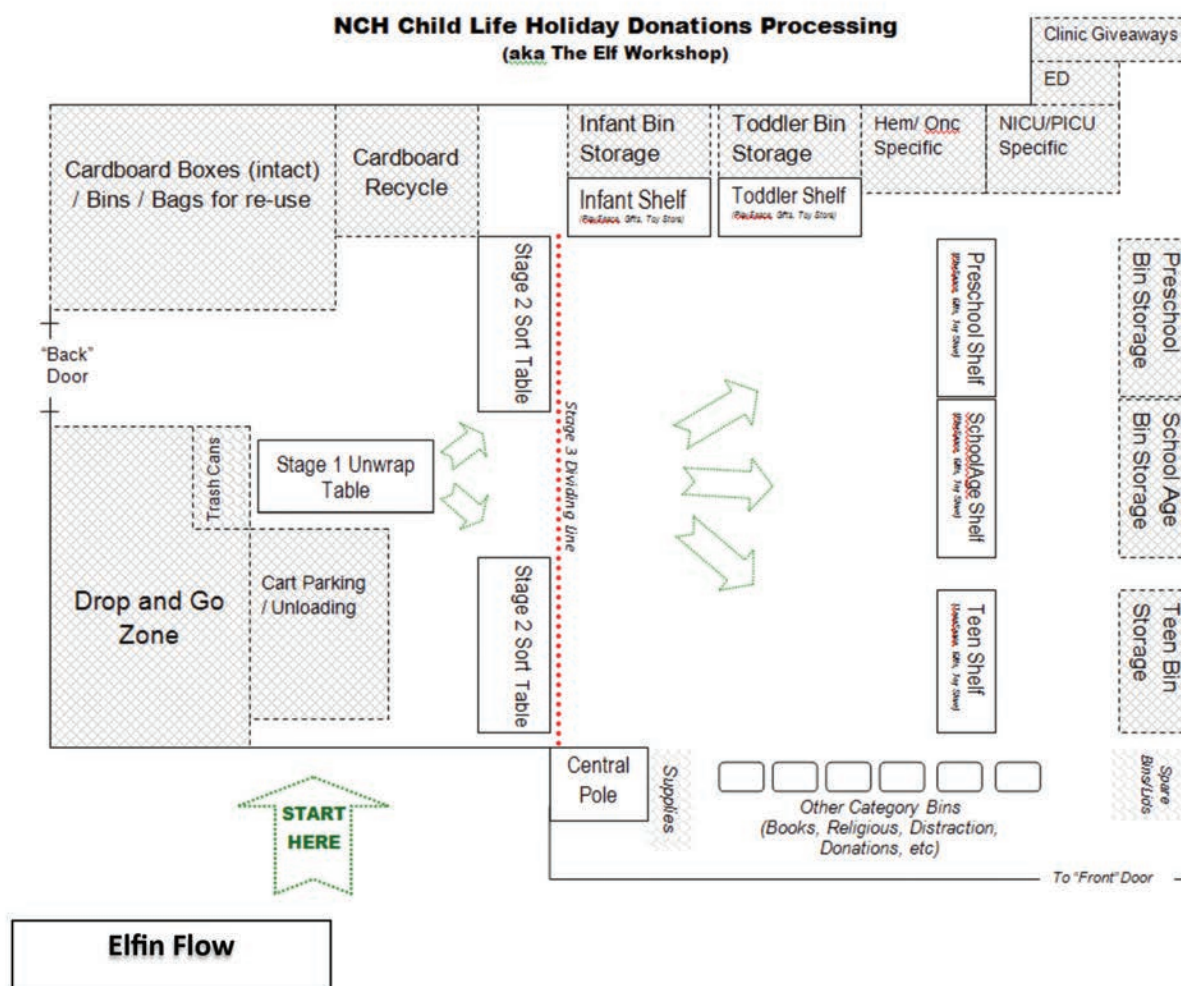
Nemours Children's Hospital opened in the fall of 2012 as a brand-new freestanding children's hospital. It is a comprehensive pediatric academic medical center with an adjacent suite of ambulatory subspecialty clinics and a fully functional emergency department and surgical center. The philanthropy department is only a decade old and has had to make inroads to cultivate donors in this highly competitive philanthropic space.

The Elf Workshop evolved

from the child-life program as the process employed to receive the considerable amount of in-kind donations that were received at this children's hospital. Child-life specialists wear many hats, and one of those hats is to network with the community for in-kind gifts like toys, supplies and services, such as magic shows and special guest appearances. In 2013, the child-life team quickly realized that it needed help during the holidays to manage this process and to capitalize on the networking opportunity.

A taskforce held a series of meetings after the first year to engage the philanthropy, child-life and volunteer departments as cofacilitators of the Elf Workshop. That taskforce was joined by the continuous improvement team that specializes in process improvement. One of the core aspects of change revolved around the intentional application of the 5S tenets (sort, set in order, shine, standardize and sustain) to help increase the relative return on investment with each rollout of

**Figure 1.** Diagram of holiday donations processing at the Elf Workshop.

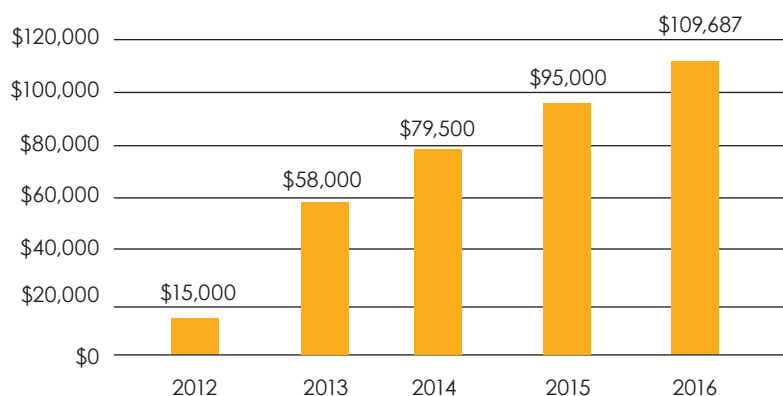


the Elf Workshop.<sup>12</sup> Together, the team developed the Elf Workshop to ensure that the network of donors and volunteers have a clear process for the management of holiday toy donations. Efficient processes for the intake of in-kind donations from the Elf Workshop have led to a robust network of donors with institutional brand loyalty and considerable tangible returns through small in-kind donations.

The team worked to create a clear visual for what team members or volunteers needed to do with the development office's effort to engage and direct donors, as well as how supplies to run the Elf Workshop are obtained and donations received to ensure a routine process. The processes were developed to minimize staff and volunteer time and effort while maintaining a high-touch experience for the donor. This included written directions with photographs explaining which donation items were kept for in-hospital use. Clear rubrics were created to outline the management of donations that were not to be kept by the hospital (i.e., items that did not meet infection control standards or posed a choking hazard). When possible, these items were to be shared with partner agencies in the local community or discarded if unsafe. The team worked to establish and sustain the process for volunteers and staff in setting up and taking down the Elf Workshop, which was deployed in varying spaces as the hospital evolved. (See Figure 1.)

Additional rubrics, with pictures, were created to sort the donations that were kept for hospital use. These rubrics defined the placement/organization of the gifts by age group, by type of

**Table 1.** Elf Workshop Donations (2012-2016)



application or by the location for their use within the health system. In total, these rubrics served to provide routine and clarity of process, which helped to ensure that staff and volunteers were sorting donations in a standard way. At the end of each holiday season, the standard process was revisited to provide opportunity for consolidation, change or reflection on how items were sorted and used. Finally, a formal system of assessment and reassessment was conducted to review both process compliance (audits of the cleaned workspace) and outcomes (routine cataloging of gifts received as well as resources invested in terms of both time and supplies).

## Results

A review of data collected from the initial year, 2012, indicates that the child-life team independently ushered in approximately \$15,000 in in-kind donations. The team estimated that to ensure smooth receipt of donations that year, team members invested more than 75 hours of their time, which netted about \$11,650 dollars' worth of toys and supplies after deducting the cost of their time.

The following year, 2013, the departments collaborated on a new

system that leveraged 5S principles and a cleaner system for receiving; they also engaged an enthusiastic group of volunteers and catalogued and cultivated a donor network for brand marketing. In 2013, team members increased their receipt of in-kind and cash donations to an estimated \$58,000, which was 3.86 times the prior year's intake. Each year since, they have seen at least a 15 percent increase in giving as the network of engaged donors and volunteers continues to grow (see Table 1). Couple this increased intake with the inclusion of volunteers to manage the intake process, reducing the institution's investment of staff time in the Elf Workshop, and the hospital estimates that over the five years of collected data (2012-2016), it has received nearly \$347,000 in net proceeds from the Elf Workshop. The tangible gains are clear, but so, too, are the intangible benefits of a growing network of volunteers and donors who, with each added toy or art supply, grow stronger in brand loyalty and thus more tightly connected to the network of giving.

## Conclusion

As the literature on philanthropy grows, it is increasingly clear that



A muscular arm is shown from the side, holding a thick red ribbon that stretches diagonally across the frame from the bottom left towards the top right. The background is a clear, solid blue sky. The arm is dark-skinned and very muscular, with the hand gripping the ribbon firmly.

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donor support, especially in the health care sector, will remain a critical source of tangible and intangible backing. In children's hospitals across the country, philanthropy programs are scratching their collective heads to find new and innovative ways to engage their local communities in partnership to care for children's needs. Internally, they strive to build partnerships with key departments, such as volunteers and child-life departments, to help deliver on this need.

As these data suggest, in-kind gift giving is a clear way to engage a donor base with each small step, though it is important to note that this process is highly labor-intensive and requires clear processes. As this article points out, when key stakeholders join forces to improve communication and integrated workflows, then "many hands can make light work." This is especially true when hospital volunteers are paired with meaningful roles that help deliver

on the institution's mission. These clear and meaningful roles help volunteers to play an active role in the care delivery systems in what the Institute for Healthcare Improvement calls its "Triple Aim": improving the patient experience of care, improving the health of populations and reducing the per-capita cost of health care in hospital settings.<sup>13</sup> However, in situations where there is lack of clarity, accountability and ownership for donation receiving, the institution risks alienating the very volunteer and donor network they wish to cultivate.

In pediatric hospitals, the community is eager to find ways to support the sick children in the local area. This excited energy, especially present during the holiday season, provides philanthropy departments in these institutions with a tailor-made opportunity to grow their network of donors one toy at a time. This energy comes with

some strategic risks. These well-intentioned donors often want to see the look of joy on the faces of the children as their gifts are delivered; however, patient privacy concerns, as well as the health conditions of some immunocompromised children, often make these interactions impossible. Additionally, these donors may be unaware of the health risks that certain toys or supplies may pose for the children cared for in the hospital—for example, dust and other contaminants on stuffed animals destined for children with respiratory conditions or games with small pieces that pose a choking hazard for small children. The system has to be prepared to manage these expectations, ensure safety for the children and create an environment where all volunteers and donors are appreciated not only for their donation but also for the intention of the donation.

Despite these challenges, the




philanthropy team can coordinate with volunteers to cheerfully receive the gifts and inform donors they will reach children in need. During the two weeks before Christmas, community partners and community members flood the greeter desk with gifts and overwhelm the day-to-day operations. At the Elf Workshop, volunteers were vital in the initiation of a donation welcome table. Volunteers, in partnership with the development office and the team, energetically welcomed donors, accepted donations and assisted in providing the donors with confirmation of their gifts before they left the facility.

In addition to the welcome table, volunteers assisted in writing thank-you notes to donors. The power of a personalized thank you card process helps the development team with the retention and recruitment of donors. Each donor was mailed a handwritten thank-you card with a standardized response and a photo of a “thank-you banner” that showcased artwork from the children in care. The incorporation of the children’s artwork was essential to link the donors to an emotional connection with the institution, and volunteer involvement in the standardized thank-you card process assisted in reducing the time spent sharing excessive appreciation to individual donors during the busy holiday/donation season.

The child-life team plays a pivotal role in helping to safeguard the process by sorting the toys in a way to ensure health effects are mitigated for all in-kind gifts received by the hospital, and in ensuring that any toys that may be unsafe for the hospital are directed to other community organizations. Volunteers can be trained in the

sorting process to assist the child-life team in ensuring that all items received are appropriate for a hospital setting.

When the philanthropy efforts in children’s hospitals have active internal and external networks and partners, there is a wealth of good to be achieved in the advancement of institutional aims, collaborative practice across disciplines, recruitment and retention of passionate volunteers and, most importantly, improved care and outcomes for the patients and families for whom they all serve. 

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# Fundraising the Cleveland Clinic way

Exploring the benefits of implementing team performance metrics within a group practice

In his book, *The Cleveland Clinic Way*,<sup>1</sup> former Chief Executive Officer and President of Cleveland Clinic Toby Cosgrove, M.D., highlights stories of collaboration where, without egos and red tape, the group practice model at Cleveland Clinic saved lives and engaged in medical breakthroughs. He also describes the skepticisms of a group practice. He cites the “Lone Ranger mentality” and explains, “... some doctors continue to believe that their individual brilliance will be stifled in a collaborative setting; others maintain that getting doctors to agree and work together is a hopeless task” (p. 9).

Fundraisers are not all that different. Characterized as type-A, goal-oriented road warriors championing their cause, it is easy for fundraisers to work individually, walking alongside a prospective donor through every step of the cycle and fearing that colleagues might throw a curveball or distract the conversation.

At the Philanthropy Institute at Cleveland Clinic, we designed a team to overemphasize the idea of a group practice and found that this model, colloquially known as “teamwork,” was just as effective in raising money as it was in saving lives.

Most large nonprofit organizations are divided into teams and departments, and the traditional major gift officer is measured on individual performance metrics. In September 2016, we created a team within our larger department, called the Central Fundraising Team, made up of four major gift officers, each responsible for managing their own portfolio of donors, prospects and territories across the country. However, instead of emphasizing their individual metrics, the Central Fundraising Team was given team performance metrics. The goal of these collective performance metrics was to motivate the gift officers to do whatever it takes to best serve the



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donor and move the gift conversation forward, including involving another gift officer in the relationship.

For example, a gift officer on this team, “John,” spent months building a relationship by phone with a new potential donor who lived on the other side of the country. The type of gift discussed warranted a visit, but John was unable to coordinate a trip to the region. To help the team reach its goals and do what was best for the organization, John connected the potential donor with his colleague, “Jane,” who happened to be heading to that part of the country. John prepared a proposal, and the two teammates spent time strategizing in preparation for the solicitation visit. During the visit, Jane secured the gift. This process could have been held up as John continued to wait for his own opportunity to visit the donor, concerned with his individual performance. However, both gift officers were

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This model, colloquially known as “teamwork,” was just as effective in raising money as it was in saving lives.

motivated by the team’s goal and the organizational mission instead of their own recognition.

This consistent focus on doing what is best for both the donor and the organization led us to be more successful than expected. We raised more than \$12 million in new philanthropic commitments in 2017, with an initial goal of \$7 million. Each gift officer experienced significant growth in his or her fundraising activity and performance, and deepened his or her level of engagement

within the department. This momentum has continued into 2018: The team had raised \$15 million by the end of the second quarter.

Cosgrove’s book further describes the desire for autonomy among doctors: “They like their independence. The medical profession attracts smart, capable, self-driven individuals. They can and do enjoy successful careers managing their own affairs in private practice” (p. 7). Those words can easily be transferred to describe an advancement professional. It feels good to secure a major gift, to experience the reward of knowing you played a role in making that happen, and hours of cultivating and strategizing set something significant in motion. We recognize the timeless adage in our field: *People give to people*. We build meaningful and sometimes life-long relationships with our benefactors. It is through trust and familiarity that we are positioned to ask for transformational gifts. But there’s a catch. We do not do what we do for ourselves. The beneficiaries of a team approach to fundraising are the donor and the organizational mission.

A team approach to fundraising requires a common goal, trust and humility. To make this work, we started with a team goal. We huddled every Monday, inviting each member of the team to share what he or she had accomplished in the previous week that pushed the team closer to the goal and what they had planned for the upcoming week. The rhetoric during these Monday morning huddles focused on the collective goals of dollars raised, number of visits, number of new donors and number of solicitations. These regular updates reminded

**Table 1.** Questions and answers regarding team metrics

How Does It Work?	
Do the gift officers have individual metrics as well as team metrics?	Yes. Gift officers set individual metrics with their manager each year, but these are not included in their annual performance review, so they serve as personal goals. Formal reviews are based on qualitative standards like teamwork, fundraising activity and strategy. Personal goals are typically number of visits, number of new donors identified, dollars raised and number of solicitations.
Can credit be shared between gift officers?	Yes. If more than one gift officer played a role in securing a gift, we encourage gift officers to share credit.
When the gift officers visit in pairs, who gets credit?	Both gift officers receive credit for shared visits. We believe training opportunities are invaluable and want to recognize the time individual gift officers spend helping each other.

each team member what is most important and prevented the temptation of trying to be a “lone ranger.”<sup>1</sup> Together we celebrated milestones, and this weekly meeting provided a sounding board for new ways to approach a prospective donor when the conversation was stalled.

We also encouraged shared visits. Each member of the team traveled with a manager and was invited to travel with his or her peers. Two people means four ears. We had tremendous success because we were paying more attention to the donor, listening to the donor’s subtle hints about his or her goals and passions. Furthermore, it provided an opportunity for colleagues to learn from each other and experience how they respond to a donor’s questions, pitch a certain project or pivot a conversation.

Perhaps the most important outcome of conducting visits in pairs was building a sense of trust in each other. Seeing a colleague’s capabilities first-hand built an

awareness that even if another professional might handle a situation slightly differently, the goal was still the same: Secure the largest possible gift to the greatest joy of the donor with the greatest benefit to the organization’s mission (see Table 1). Once we were able to establish this trust, it became natural to bring in a colleague who, for one reason or another, was better positioned to handle the next step with the potential donor.

In one example of a shared visit, Jane had been actively working with a potential donor for many months but was having difficulty finding a project that matched the potential donor’s passions. Jane asked her colleague, John, to join them on their next visit. During the meeting, the potential donor shared insights that led the conversation to specific questions on medical education programs. It just so happened that John was familiar with a philanthropic initiative related to the donor’s newly revealed interest and was



able to articulate the needs of that area. The potential donor agreed to make a gift to support the initiative. John provided invaluable perspective and a new level of awareness of the potential donor's interests and passions that allowed both Jane and John to secure the gift.

When describing *The Cleveland Clinic Way*, Cosgrove emphasizes the importance of specialists coming together for the patient's benefit. In the group practice model, it is never about the caregiver; it is about the patient. In our work, it is never about the development officer; it is about the donor and the mission. With humility, we can take ourselves out of the equation and ask, "What needs to happen to strengthen the relationship between this prospective donor and the organization?" Frequently, the answer involves ourselves, but often it requires a team. Any size department could benefit from focusing on a team effort. With a small staff, consider sharing goals with the proposal writer and the program officer and bringing them along for celebrations. It becomes easier to embrace collaboration when each person is working toward a common goal.

As a team, we emphasized humility and were held accountable for continuous improvement. We organized

monthly training sessions on specific aspects of our role, such as securing visits and managing donor meetings. These sessions were led by experienced colleagues outside of the team to gain further exposure to different styles and approaches. Also, because so much of fundraising is improvising, we gathered as a team to role play donor scenarios and practice out loud. These improv-style training sessions enable gift officers to think on their feet and be prepared for any direction a gift conversation may go. Equally as important, the improv-style trainings allow each member of the team to be vulnerable. We have found that this vulnerability and willingness to learn has furthered the sense of humility on our team and enabled team members to more willingly ask for help.

Achieving trust and humility requires the right people. Cosgrove echoed these thoughts when he wrote, "Being the best... [is] about having the right players with the ability and desire to work together"<sup>1</sup> (p. 34). We were fortunate that each member of our team embraced this new perspective and desired to work together for the benefit of the donor and the organization. We began 2017 with a four-person team within our larger department with experience levels ranging

from two to seven years. Over the course of the year, we conducted 172 visits in pairs (926 overall), qualified more than 1,100 new potential donors and conducted 174 solicitations with the support of our team members. With a spirit of collaboration, we exceeded our fundraising goal by \$5 million in 2017 and have since doubled into a team of eight gift officers (see Table 2). Our newest team members have transitioned into their role at an exponential rate as a result of the shared visits and mentorship within the team. We believe this team-based approach, closely aligned with the group practice model described in *The Cleveland Clinic Way*, will continue to enable us to truly work together for the benefit of our donors and, ultimately, our mission. 

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**Brad Milius**, senior director of development at Cleveland Clinic, manages the overall Central Fundraising Team and has been serving as a development officer at Cleveland Clinic for more than five years. He earned a bachelor's degree in management from Purdue University and graduate degrees in philanthropic studies and in nonprofit management at Indiana University.



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**Table 2.** Growth in performance using a team approach

Team Performance		
	2016	2017
Number of visits	460	926
Number of solicitations	125	174
Dollars raised	\$6,325,856	\$12,208,935
Number of prospects qualified	689	1,165

# Engaging physicians in philanthropy: Twelve years later



# A doctor-turned-fundraiser shares tips for collaborating with physicians

**T**he year 2006 seems like a long time ago, doesn't it? The biggest event from 2006 that sticks in my memory is when the International Astronomical Union downgraded Pluto from planet to dwarf planet. The second biggest event I recall from that year is when I published an article in this journal, called "Engaging physicians in philanthropy: A peer to peer approach." In that article, I described my transition from primary care doctor to full-time medical fundraiser, my early efforts to engage physicians in fundraising at Children's Hospital Oakland and my work founding a Medical Philanthropy Council to facilitate communication between the development office and the medical staff. While my article made no measurable impact on the nomenclature of the solar system, it did stimulate some fruitful conversations about doctors and fundraising.

Shortly after publishing the article, I left Children's Hospital and came to Stanford Medicine, where I carved out a unique role for myself as faculty liaison for development. In addition to managing a portfolio of major gift prospects, I am now in charge of designing and delivering training programs to help our doctors be successful in grateful patient fundraising. Over the years, my understanding of engaging physicians in fundraising has evolved. Through my work at Stanford and through my consulting work at academic and community hospitals, I've had many conversations with fundraisers and physicians; despite the differing cultures of these hospitals, common themes and lessons have emerged.

Today, a dozen years since my first article appeared in this journal—with a lot less hair, and with my bifocals and hearing aids comfortably in place—I'd like to share with you my top 10 lessons learned on this topic.

**1. Have compassion for doctors.** They are under an amazing amount of pressure. I am intimately familiar with the incredible stress of practicing medicine; it propelled my decision to retire from clinical practice and seek an alternative role in health care. Interestingly, after I hung up the stethoscope, I was able to see the magnitude of that stress even more clearly. Those who work in administrative roles with doctors, as we development professionals do, need to



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# I have found that two principal factors determine a physician's willingness to participate in fundraising: motivation and ease.

base all our interactions with doctors on compassion. Having lived both kinds of life (the physician's life, where a mistake can kill someone, and the fundraiser's life, where a mistake might mean, at worst, that a donor gets upset and doesn't make a gift), I can tell you that the degree of complexity and strain in the daily life of a doctor cannot be overstated. I have heard gift officers say, "Doctors just don't 'get' fundraising." No. The problem is that fundraisers often don't "get" doctors. If it takes four emails, three phone calls and camping out in front of a doctor's office to get him or her to review that stewardship letter, do it. Then smile and thank the doctor sincerely.

**2. Make it easy for them.** I have found that two principal factors determine a physician's willingness to participate in fundraising: motivation and ease. Their motivation will be highest if they have a big project of their own that needs funding. Note that the doctor's motivation is not something we as development officers can do much to change. If a doctor has taken some preliminary steps to partner with the development office (e.g., make prospect referrals), an acknowledgement from the department chair or dean can boost motivation a little. But for the most part, doctors' motivation will be determined by their needs; either they are eager to secure

philanthropic support—or they are not.

In contrast to this, the other factor, ease, is something very much in our control. Even in the face of high motivation, action is unlikely if it's too difficult. Therefore, our goal should be to do everything we can to make it easy for physicians to participate. Examples of such tactics include:

- Setting up hotel space for a development officer to work in the clinical area to facilitate meetings with doctors and to encourage the doctors to keep fundraising in mind.
- Giving doctors the cell phone number of their assigned development officer so they can text or call right away when they have a referral or question.
- Making fundraising a part of the doctors' monthly clinical department meetings so development officers can provide ongoing training and support.

This way, even those with only moderate motivation will take action because it's just so darn easy. I use this rubric to judge new ideas for physician engagement strategies in the development office: I ask, "Will this strategy make it easier for doctors to participate?" If the answer is no, then I do not recommend proceeding.

**3. Make philanthropy a solution to their problems.** So, doctors are

stressed and they are ridiculously busy ... and you want them to carve out time to meet with you? To do something extra? Something new and uncomfortable? Not likely. But you might have a chance if you present philanthropy as an untapped source of revenue that will help doctors achieve their own goals. I have seen many development professionals frustrated by physicians who won't participate in fundraising for the general good of the hospital or for institutional priorities that will only affect the doctors peripherally. There will always be a few Eagle Scout doctors who will find energy to help you out with broad initiatives. But to engage most physicians, you must make it clear that your services are an answer to the challenges that keep them awake at night. Allow physicians to direct grateful patient gifts to their own projects. Give them a seat at the table when setting the fundraising priorities. Make clear to them "what's in it for you," and they just might take your meeting.

**4. Think twice before you ask doctors for their own gifts.** Most physicians are not viable donor prospects. First, their income has been stagnant for decades, leaving them feeling poor. They grew up seeing physicians in their community at the top of the economic ladder and now, after all those years of training, they may be struggling to afford a home. Unlike the doctors of their parents' generation, today's doctors see higher incomes going to people who studied far less than they did—people in finance, technology, insurance and real estate professions. Add to that an increasingly busy clinic schedule, electronic medical record stresses and insurance companies second-guessing their decisions. It's no surprise they are

not feeling charitable. That's why I strongly recommend avoiding any discussion of physician giving, especially when just beginning to engage the medical staff in philanthropy.

Interestingly, I have found doctors at community hospitals to be somewhat more willing to give than their academic counterparts. But even there, I recommend proceeding with caution. Over time, a physician who is an active participant in grateful patient fundraising may come around to consider giving. However, if the development officer brings up the topic too soon, irreparable damage can be done.

**5. Recognize that individual coaching is best.** In 2012, Steve Rum and Scott Wright, M.D., from Johns Hopkins Medicine published a fascinating article

in a medical journal<sup>1</sup> comparing methods for coaching doctors in grateful patient fundraising. They came to the conclusion that the most effective method is to offer one-on-one coaching sessions. This study nicely confirmed what my own experience had shown. I had been presenting detailed and carefully rehearsed fundraising lectures, going department by department at Stanford, but was only seeing behavioral change (i.e., doctors making referrals) in those instances when the doctor was getting personalized follow-up and coaching from a gift officer. This prompted me to adapt my strategy. Now, we send the doctors a link to watch a video of my presentation on their own time, then schedule confidential, individual sessions to review the content, discuss the doctors' needs and objections and

conduct role playing with sample scripts—a vital pedagogical step, but something that most people are unwilling to do in a group setting.

**6. Address doctors' number 1 objection: "I don't want to ask anyone for money."** When you speak with doctors, emphasize that the development officers, and not the doctors, will do the asking. We simply want the doctors to help identify prospective donors, to talk about their work in a compelling way, and to provide impactful stories about the difference that philanthropic support makes in advancing science or improving patients' lives. Make it clear that there will be many steps of cultivation before any ask occurs, and when it does, it will be the professional fundraisers (or appropriately trained institutional

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leadership) who do it. I tell doctors, “I want you to learn what to listen for, and learn how to respond and connect prospective donors to the development office to take the next steps.”

## **7. Address doctors’ number**

**2 objection: “Administration is going to steal the gift.”** Many institutions have stories about a wealthy grateful patient who wanted to help an individual doctor, but the administration redirected the gift toward naming a building or some other institutional priority. This kind of entrenched negative “urban legend” can be hard to combat. And the truth is often complex and subtle. For example, the grateful patient may initially have expressed a desire to help his doctor, then later learned about an opportunity to get his name on a building, which was actually more important to him. I have found reluctant doctors may soften after a few modest grateful patient gifts go smoothly and efficiently into their account. From that base of trust, they should be more open to a donor-centric approach. Most often, gifts made to institutional priorities will be made in addition to the gifts toward the referring doctor’s research. It’s not either/or, it’s and. Hopefully, you have the ability to tell your doctors sincerely that the prospects they identify will always be given the opportunity to support the doctors’ work. If your institution doesn’t allow you to say that, I’m guessing you don’t get many prospect referrals from doctors.

## **8. Address doctors’ number**

**3 objection: “I don’t want to compromise the doctor/patient relationship.”** Respecting and protecting the sanctity of the doctor/patient relationship is paramount. Doctors need to know that we

will always respect their instincts and honor their concerns about communication with their patients. Some doctors will worry about us offending a patient by asking them for money. My response is to explain that the development office should never ask anyone for money if that person is not interested in giving money. This may sound like circular logic, but the idea here is to emphasize that a skilled development officer will move carefully toward a solicitation, gauging interest and inclination through thoughtful listening and conversation, before deciding if it is appropriate to present a proposal. I tell doctors that when development is done right, there are no surprises, and with no surprises, it is unlikely that anyone will get offended. Also, you can never go wrong following the guideline to separate the solicitation as much as possible from the clinical encounter. For a detailed analysis of the ethics of grateful patient philanthropy and protection of the doctor/patient relationship, read Stacey Tovino’s detailed analysis, “Giving Thanks: The Ethics of Grateful Patient Fundraising.”<sup>2</sup>

**9. Understand that physicians prefer to learn from other physicians.** The medical profession is a venerable, consecrated endeavor with highly intellectual and spiritual aspects. Yet it also is a trade. Accordingly, medical training is an apprenticeship, with probates learning under the watchful eye of a master, in a hierarchical, almost military structure. As a result, doctors are accustomed to learning from other doctors—even when they are learning about nonmedical topics, such as fundraising. Not surprisingly, it is easier for me (or other doctors who provide development coaching) to get


doctors to listen to our message and take it to heart. Moreover, the grueling and emotionally taxing process of medical training is a ring of fire that all doctors must jump through. This leaves doctors with a sense that they are in a secret guild, bonded in a special way with all other doctors. This helps me tremendously in my work. I even bring in other doctors to help me communicate the concepts of grateful patient development. For instance, I made a video of a Stanford doctor telling a story about how hard it was for him to learn to listen and respond appropriately when grateful patients ask how they can help. I frequently use this video clip in my physician coaching work, and I find it is one of the most impactful tools in my box. Doctors need to know that their fellow doctors are active in grateful patient fundraising, too.<sup>3</sup>

**10. Recognize that every medical development office needs a doctor on staff.** As I outlined above, the main reason for my effectiveness as a fundraising coach and partner for doctors is that I’m one of them. That’s why I believe that every hospital should have a doctor working in their development office. Perhaps it will be difficult to find a doctor ready to devote 100 percent of his or her time to fundraising. But I feel strongly that every hospital should be able to find a physician partner who has the skills, personality and perspective to be an effective and happy liaison between the medical staff and the development office. I’m not talking about a volunteer doctor who may help out now and then. I’m talking about a formal, administrative position in which the doctor is paid a portion of his or her salary to work one or two days a week as a member of the development



team, as the medical director of philanthropy or some such title. The return on investment can be huge. Of course, it will be more affordable for the development office to match the salary level for an internist or infectious disease specialist, for example, than for a cardiac surgeon or ophthalmologist, whose income expectations are significantly higher. But if the perfect candidate for this work is a surgeon at your institution, you still might be able to work out a mutually beneficial arrangement—don't say no for the prospect! Note that I do not recommend putting into this role the lovable, retired physician who everyone adores, and is willing to totter in every Monday afternoon for a small stipend. Such appointments belittle the importance of philanthropy and hinder progress in energizing the medical staff. Create a formal job description for a midcareer, active

clinician, and do your due diligence by getting confidential opinions from the medical staff before hiring them. The right doctors for these roles are out there. I am not as much of an anomaly as you may think.

As our nation grapples with the challenge of providing quality, affordable health care for an aging population, and federal research dollars grow increasingly tighter, philanthropy is becoming an increasingly important funding source. Physician involvement in grateful patient philanthropy is a tremendous way to boost the fundraising effectiveness at every hospital, and it's an opportunity waiting to be seized. I hope the recommendations I have outlined will be of service to help you engage your physicians. If you have other insights or questions about this, I'd love to hear from you. 

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# Risks and rewards of venture philanthropy

Alternate avenues for philanthropically minded individuals or foundations to simultaneously give, invest and impact social good are emerging trends

As the charitable giving landscape becomes increasingly more competitive, many forward-thinking nonprofit organizations (NPOs) are seeking to attract new sources of philanthropic giving that are as innovative as the projects they curate. With limited funding from the government and insurance payments, NPOs are often accustomed to struggling to meet the bottom line to accomplish primary missions and face many obstacles in taking on new ventures. As a result, available funds are typically earmarked for initiatives with measurable and predictable outcomes, leaving riskier groundbreaking and revolutionary concepts on the cutting-room floor.





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Venture philanthropy offers a solution to this predicament. In the past, philanthropists have traditionally maintained a distanced relationship with recipient organizations, expecting that the nonprofit will aggregate funds in the areas where they are most needed and anticipating generalized metrics that substantiate the effort. However, venture philanthropists extend the benefactor/beneficiary relationship by combining charitable giving with implementing for-profit strategies that require the organization to function more like a business. In exchange for their contributions, donors not only get to provide critically needed early support for causes about which they are passionate, but also have the

opportunity to see substantial returns on investments—whether through measurable social impact, involvement in future research or, in some cases, even financial returns through the more formal alternative funding vehicle of impact investing.

### **History of venture philanthropy**

Venture philanthropy began in the 1990s as a way to describe savvy donors who recognized great potential in applying business principles and tactics to charitable giving, with an ultimate goal of impacting global or local problems. The term is derived from the risk-taking venture capitalists willing to contribute large amounts of money into revolutionary enterprises that show



game-changing potential in their respective fields. The concept encourages nonprofits to create highly effective fundraising systems that function more like businesses, utilizing the diversity of expertise within their network of external business and financial advisers to acquire new partners, explore alternate approaches and define and analyze metrics. In addition to traditional monetary contributions, major donors subscribing to the venture philanthropy ideology offer diverse forms of support, such as offering low-interest loans to jump-start a project, serving on boards and providing management or marketing advice.

Devin Thorpe, journalist, author and speaker on entrepreneurial finance and social

good, views venture philanthropy as a vehicle for providing new ways to address old problems.

“It’s a new model for philanthropists to fund new projects by serving as an incubator or accelerator to back innovative concepts early with little evidence,” he said.

He explains that by expanding networks and merging resources, donor entities can help enhance supply chains, diversify boards and form strategic relationships that might not have otherwise been possible by the nonprofit on its own.

The shift represents a departure from the mindset of simply providing a donation to establishing resources to garner growth and success for innovative initiatives. Although measurements are established, the practice is still philanthropic because the recipients are the primary decision makers in choosing the milestones and benchmarks and leading the research and development.

### What projects attract venture philanthropists?

Looking through the lens of the increasingly savvy investor, venture philanthropists give preference to supporting projects that affect greater social impact. These donors will not necessarily be the same investors that have participated in traditional giving opportunities. Much like their venture capitalist counterparts rooted in the technology boom, they often seek to disrupt the normative constructs of charitable giving by supporting underrepresented populations and cutting-edge research and innovation.

From a grand perspective, the practice is more inclined

to backing mission-related versus project-related proposals that generate a larger impact on a community as a whole rather than addressing acute needs of a singular entity. Funding construction projects with naming opportunities or securing a new MRI machine would provide an ideal giving environment to reach out to traditional private or corporate donors. By contrast, venture philanthropists would seize an opportunity to back a project promoting cutting-edge pharmaceutical studies, bringing new IT wearables to the market or expediting emerging pediatric research. In return for their donations, they expect nonprofits to be more accountable and more measurable, but they are also willing to be more involved in assisting NPOs in satisfying these criteria.

### Pros and cons of venture philanthropy in a health care setting

Pam King Sams is an international relationship development expert who helps organizations and companies build relationships and create successful partnerships in the Middle East. In her experience with forging relationships between high-profile donors and prospective recipients, Sams has identified several pros and cons for health care development practitioners considering an integrative approach to introducing venture philanthropy into a fundraising strategy. On the positive side, Sams notes that hospitals can use venture philanthropy as an extra vehicle to raise resources. They can also diversify resources by taking advantage of corporate



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knowledge and relationships afforded by their connection to the donor. Nonprofits such as hospitals may even find rewards from reversing roles, serving as donors by investing in startups with similar missions and enjoying returns on investment resulting from their success.

On the contrary, Sams acknowledges venture philanthropy might not be the right solution for every project. She says successful implementation of the venture philanthropy model “relies on the ability to network with other entities, so if the project’s beneficiary is more singular in nature, traditional fundraising may be a better fit.”

She also notes that some sectors or organizations may struggle because they are harder to measure, which might leave out smaller, unstructured organizations that are founded by passion.

## Implications for hospitals and health care facilities

Based on data presented in the *2017 AHP Report on Giving*, hospitals not only primarily engage in traditional fundraising methods, but they also allocate the largest portion of donated funds to traditional projects. According to survey participants representing typical responding health care organizations in 2016, construction and renovation accounted for the largest use of funds (22.3 percent), followed closely by capital equipment expenditures (19 percent). This correlation makes sense given that buildings and large equipment purchases offer major donors attractive incentives such as naming opportunities.

## Recommendations for development practitioners

Health care development experts interested in incorporating venture philanthropy principles into their fundraising strategy should consider the following information when structuring donor proposals:

**Promote innovation.** Traditional donors gravitate toward traditional projects. Attract venture philanthropists by inviting them to participate on the forefront of cutting-edge projects that have the potential to redefine standard procedures and approaches. Outline any potential return on investment associated with backing the project in its early phases.

**Demonstrate impact and scale.** Venture philanthropy revolves largely around the concept of investing to create social good. Be prepared to show the project’s impact outside of the host organization. Consider partnering with unaffiliated NPOs to extend the organizational reach farther into a community. Connect the community benefits to any related savings to the organization’s overall bottom line.

**Make it measurable.** To be successful, show how you will define success. Articulate specific parameters that you will use to measure milestones, metrics and accountability.

**Build a diverse network.** Since venture philanthropy mirrors constructs rooted in the business world, including multiple entities from a range of backgrounds is essential. Form a research consortium and board comprised of diverse members. Create an unbiased management group that sits outside of the project to consult with, evaluate and advise the project team.

Likewise, the AHP report also states that education, research and community support—prime initiatives for support by venture philanthropists—make up only 12.1 percent of the use and distribution of donor funds. With this in mind, the concept of venture philanthropy, which involves taking risks on innovative and often unsubstantiated and collaborative projects, would be a radical departure for some hospitals because it benefits the community and not necessarily the hospital directly. The mission of health would have to supersede the individual benefits, with the understanding that with great risks comes the potential

for great rewards.

Ernie Vargo, CFRE, president and chief executive officer of the Eskenazi Health Foundation, estimates that nearly 89 percent of all philanthropic giving comes from individual donors, making the prospect of diverting existing development efforts and resources to nontraditional sources all the more daunting. This fundamental transformation requires a willingness to consider a holistic approach to community health care, examining which factors outside of medicine can truly make an impact. Programs that emphasize prevention and awareness, such as nutrition, exercise and family support, can really affect public health on a



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broad scale while simultaneously impacting the bottom line.

Vargo noted that in the health care sector, risk tolerance can tend to be fairly low to avoid lawsuits, loss of future donors and risk of reputation. In an environment that expects outstanding results with minimal overhead, no marketing budget and guaranteed success, he recognizes the difficulty in approaching donors armed with the reality that “we have a chance to change the world, but we also might fail.”

### **Successful application of the venture philanthropy model**

Located in Indianapolis, Indiana, the new Sandra Eskenazi Center for Brain Innovation is transforming the approach to patient care for individuals diagnosed with brain conditions such as Alzheimer’s disease, dementia and schizophrenia. While traditional cure-oriented research studies are often supported by federal and private funding, the evidence-based science discovered in the process can take an estimated 17 years to be implemented at a patient’s bedside. During its inception, the center’s founders sought to provide a more immediate impact by treating patients and caregivers as a team and expediting the introduction of cutting-edge technology through rapid translational and implementation science.

From a fundraising perspective, focusing on the revolutionary combination of patient care, familial support and real-time research posed unique challenges when approaching the capital campaign phase. The center would not primarily aim to

Although venture philanthropy is still in its infancy, a gradual transformation is beginning to emerge in which NPOs are reassessing what it means to really make change.

find a cure, but rather to provide care for the whole person—mind, body and family—and expedite the translation of best practices discovered in the lab directly to patient care. With a mission that does not guarantee quantitative metrics, the Eskenazi team hoped to attract risk-taking donors willing to contribute transformative gifts.

As the daughter of Sidney and Lois Eskenazi, founders of the Eskenazi Health Foundation, Sandra Eskenazi was accustomed to a culture of philanthropic giving. However, it was her work as a physician’s assistant that motivated her to become involved in supporting the brain center early in its inception. Her first-hand observation of the stigma and lack of resources associated with mental health issues compelled her to make a \$5 million donation to the fledgling project that ultimately created a snowball effect. Eskenazi’s involvement and willingness to take a leap of faith in hopes that significant changes could be made in the areas of Alzheimer’s, dementia and schizophrenia provided credibility for the initiative and served as an impetus for future fundraising.

With her support, the team was able to hire a diverse interdisciplinary body of researchers who collaborated and

recommended additional sources of grant funding that lowered the dependence upon private donations.

“We especially wanted to bring scientists together who were working either on dementia or schizophrenia. They soon discovered that their respective research was applicable to the other,” Vargo said. “As a result of this initial work, a business model that anticipated \$5 million in grants has resulted in more than \$42 million.”

The success of the campaign, originally expected to raise \$50 million and run from 2015 to 2020, has been a welcome surprise for Vargo.

“We are close to reaching our goal,” Vargo said. “The philanthropic goal has been revised to \$13.5 million as a result of increased grant funding. The total project will exceed \$50 million in total support.”

The Sandra Eskenazi Center for Brain Innovation also serves as an example of how venture philanthropy promotes and nurtures contemporary approaches that generate significant social impact and reform standards of care.

“The Center is providing a model of care that is having dramatic results in keeping patients [with Alzheimer’s] from long-term care facilities and

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enabling caregivers to have a balanced life and mitigate their mental health issues,” Vargo said. “This model of care is now being replicated. The early psychosis clinic is now the hub of care for the state of Indiana, and the Eskenazi Health physicians are remotely consulting with clinicians and patients around the state.”

### Offering multiple ways to give: A win-win situation

Vargo believes that although venture philanthropy is not perfect for every project or every donor, it is a viable model that represents a shift in strategic plans.

“Health care should be at the forefront of this movement,” Vargo stated, citing the many failures pharmaceutical researchers endure before successfully developing life-saving and life-altering medications. Although venture philanthropy is still in its infancy, a gradual transformation is beginning to emerge in which NPOs are reassessing what it means to really make change.

“Donors have been willing to give away their assets their whole lives, and by nature they want you to succeed,” Vargo said. “We just have to encourage risk-takers and educate the donor community on the power of transformative gifts as a viable alternative to traditional philanthropy.” 



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and working with organizations in the finance, education and nonprofit sectors.

## SPONSOR SHOWCASE



### Venturing off-course: navigating complex gifts to stay on track

When organizations become more donor-centric, everyone thrives. The donor feels heard, energized and properly stewarded. As a result, you may witness some of the most transformative gifts of your entire career.

However, an increase in donor-centric approaches—including venture philanthropy—may lead to an increase in the number of complex gifts you might have to exercise judgment upon. Here are five techniques to consider and put into place now, even before that tricky gift crosses your threshold:

1. Be mindful of who you need to involve when considering a gift. It may vary depending on the gift but know your organization's gift acceptance committee. This is a formal committee that includes executives from the organization and the board of trustees. It cannot be up to the development officer to accept or deny complex gifts.
2. Your gift acceptance committee needs to make decisions ahead of time, so you are prepared to respond to individual donors and do what is best for your organization. For example, does your organization count bequests in a campaign?
3. Next, be aware of the gift acceptance policies that are in place to govern what development officers can do and what gifts you can and cannot accept. These should be written, board approved, and part of the ongoing operation of the institution. This way, when a donor proposes a complicated gift, you have a document you can point to. If an exception is to be made, the committee must approve it.
4. How important is it to your organization that you raise cash for this project? Your answer to this will help you decide whether you can accept a donor's proposal or if you should only accept outright gifts or long-term pledges.
5. Determining your campaign counting guidelines before the effort gets underway not only makes your life a lot easier, it is also best practice.

*Stuart Sullivan, senior vice president with Graham-Pelton, provides senior level counsel on campaigns, strategic planning, various forms of giving and management of programs and staff. Stuart has served in executive positions at numerous well-known institutions, including Children's Hospital of Philadelphia and several top universities. Reach him at [ssullivan@grahampelton.com](mailto:ssullivan@grahampelton.com) or by calling 800/608-7955.*



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