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philanthropy

Creating better connections with your stakeholders

The relationship issue

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Connecting People • Enriching Lives

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By **Susan J. Doliner, FAHP, CFRE** | Chair, AHP Board of Directors

FROM THE CHAIR

We can do better

In every corner of our hospitals and health care organizations, we measure performance and benchmark against national standards as well as against peers. From cost, to quality, to patient satisfaction, and just about everything in between, we measure performance.

So why don't all development programs measure the same things the same way? Some development operations only benchmark against neighboring hospitals or other nearby community-based charities. Some just tally their own numbers and look for progress year after year.

Who is holding us accountable for the funds we are called upon to secure for our respective charitable institutions? Do they know that we can do better? And what does "better" actually mean? How can we best measure our performance?

AHP is setting the standards that we can all count on for assessing our performance. We owe it to our institutions and the patients we care for to measure our performance in a standard manner. It is measurement that allows us to examine our results and make the case for budget resources to expand on the tremendous return on investment that health care philanthropy demonstrates.

Without trusted and reliable data we cannot tout our results or blame the economy. Standards are important and being accountable is essential as we are spending our organization's valuable funds

> AHP is setting the standards that we can all count on for assessing our performance.

with an expected return on that investment.

As the debate continues regarding the financing of health care in North America, philanthropic support is increasingly being called upon to fill the gaps, to ensure continued high-quality patient care, ongoing technology advancements and research discoveries. If our respective charitable organizations are going to invest more in our efforts, they, and we, deserve comparable standards and high-quality educational resources to help us perform.

To these ends, AHP published this April the *AHP Standards Manual.* The guide outlines peer-defined definitions and provides consistent rules for reporting that will help us better communicate philanthropic impact to our boards, executive teams, donors and the public.

As part of the AHP Strategic Plan, AHP also is exploring new methods of providing educational resources to those of us in the health care philanthropy profession. Are we covering the right topics: annual giving, major gifts, planned giving and social media? How much can we comprehend in 90-minute sessions? Do we learn more through PowerPoint presentations or audience participation, in person or online? Do we have the philanthropy professional skill set needed to succeed?

And what are those skills? Listening, entrepreneurial, risk-taking, self-motivation, team player, competitive, writing, enthusiasm, persistence and creativity—can these skills be learned? Who are the best instructors: experienced practitioners or experienced faculty members? Are larger organizations better at philanthropy than smaller ones? What are the economies of scale in our profession?

At this point there remain more questions than answers, but stay tuned. You will be asked to participate as we review new opportunities and fine-tune your educational needs and the interests of our membership. Your perspective is important and valued. ⒶⒽⓅ

By William C. McGinly, Ph.D., CAE | AHP President, Chief Executive Officer

AS I SEE IT

Moving beyond the illusion

" *The single biggest problem with communication is the illusion that it has taken place."*
—George Bernard Shaw

Relationships. They are the cornerstone of successful fundraising—our connections with our donors and our stakeholders. We make these connections in a million different ways every day, but successful relationships fundamentally rest with our ability to communicate. Some of us are born with an innate ability to communicate in a way that is effective and that engages and bonds, but for most of us, it is a skill that we hone and strive to improve.

This issue of *Healthcare Philanthropy* is all about relationships—forging better ones with our hospitals' executives and enhancing those with our donors. And not surprisingly, you'll find throughout these articles discussions about effective and engaging communication, because often our outreach and messages have all the trappings, but we fall short. It can be just an illusion.

Betsy Chapin Taylor, MSJ, MBA, FAHP, reminds us to tell stories not about what interests us, but about what excites our donors, and to do so in a way that engages. I challenge you to read her article, "Powerful mission storytelling," and then review your brochures, websites and newsletters. And as you explore new and innovative ways to connect with your donors, I suggest you consider the message that Anne Firestone shares in her article, "What is it about a pie?" The best connections are often forged through simple acts. In Anne's shop, a single heartfelt

> As individuals, and in our messages, we must appeal to the interests and imagination of the "possible" in our stakeholders' minds.

gesture has been transformed into a fun and effective major gifts outreach program because it communicates the right message in her community. This is no illusion—it's the real deal.

Deene Morris, CFRE, in her article "Relationships matter," looks at the association between the development and hospital teams from the perspective of organizational behavior theory. Better understanding the "frame" from which our stakeholders and our target audiences operate is critical in creating effective communications. Too often, when it comes to hospital colleagues and the C-Suite, we fail to consider their "frame," and our communication efforts are truly just an illusion. We share what *we* feel is important about

fundraising performance.

In an interview with Michelle Campbell, FAHP, HMFIA, for her article in this issue on the hospital-foundation relationship, I noted that as a profession we need to get serious about how we measure and report performance; we need to bottom-line it for hospital CEOs and CFOs and give clear facts. It's about speaking their language and putting things in terms that will be meaningful for them. We also must present and frame our messages, surround them with enthusiasm and our presence, in a way that shows us to be approachable, likeable and memorable. As individuals, and in our messages, we must appeal to the interests and imagination of the "possible" in

our stakeholders' minds.

Of course, the key to effective communications is determining the right message and the right vehicle—finding out what is meaningful for our stakeholders. To do that, we can only ask, listen, test, make adjustments and then start all over again.

AHP has been doing quite a bit of sharing and listening as part of our strategic initiatives efforts during the past year. We've been asking what you want and need to do your jobs better and raise more funds for your communities. Using your feedback, AHP is busy making changes and creating new offerings—many of which will be released this year. We hope that you will share with us what you think. We're listening. ⚑
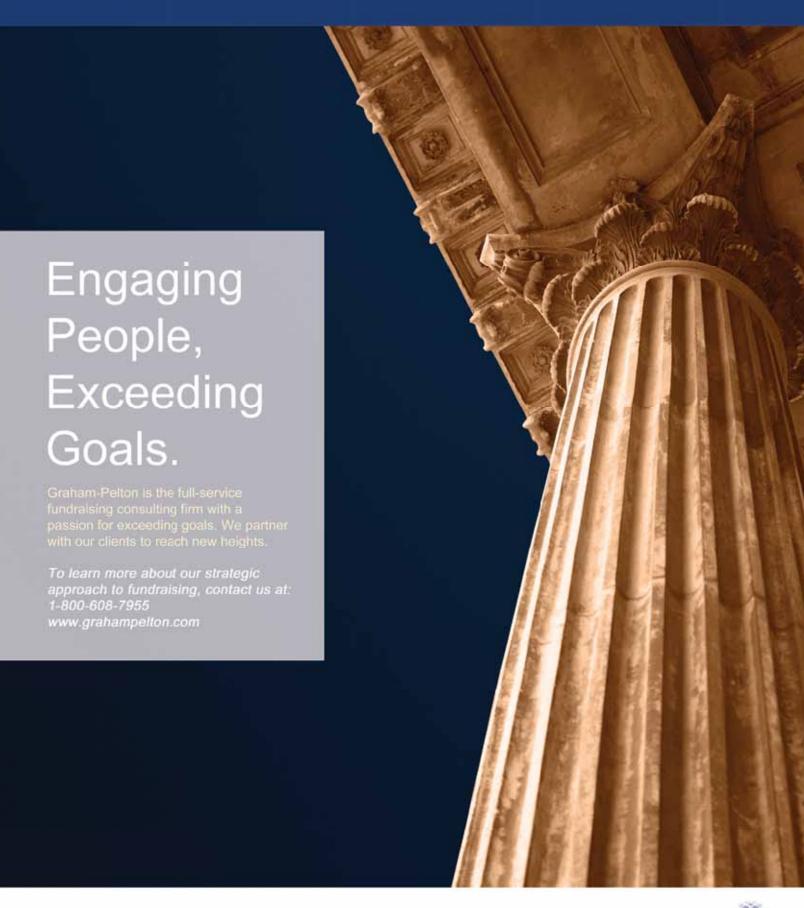
In search of a best practice model for the hospital-foundation relationship, Part II:

Continuing the dialogue

What is the most important relationship we manage as hospital development leaders? Most of us would be quick to say that our relationship with the donor holds that distinction. Yet one also can argue that the relationship of paramount importance is the one we need to manage *before* we even connect with a donor—the one with the hospital.

The appearance of documented legal cases of conflict between hospitals and foundations gave rise to the 2006 *AHP Journal* article, "In search of a best practice model for the hospital-foundation relationship"—an article that offered a best practice model for a hospital-foundation relationship that supports philanthropic success.

Six years later, the hospital-foundation relationship seems to be of even greater concern to health care development leaders. A 2010 survey by KCI, a fundraising consultancy in Canada, identified the relationship with the hospital as the *No. 1 issue of concern* among Canadian foundation senior leaders. What are the factors now present that have given rise to this growing concern?

Using results from a survey conducted for this article and personal field interviews with senior hospital development leaders from across North America, Australia and the United Kingdom, this piece will explore the specific challenges now being reported in the hospital-foundation relationship, and current thinking in the field that offers helpful strategies to those wanting to improve upon this critical relationship.

A best practice model
Research conducted for the 2006 *AHP Journal* article demonstrated that the highest functioning hospital-foundation relationships—ones that lead to better philanthropic outcomes—depended upon a number of essential elements being present in the relationship: effective structure and process between the two organizations, mutual trust, a common vision for philanthropy, strong and continuous communication and a shared view that the ultimate best interest is that of the donor's relationship to the institution.

Additionally, the overall success of the model was purported to rely heavily on a *shared leadership model* among three key leaders: the foundation CEO, the foundation board chair and the hospital CEO. The personal character and leadership style of the three leaders, and how they share decision-making for the philanthropic enterprise, was deemed an essential ingredient for success. The 2006 article also concluded that if the working relationships among any or all three key leaders are at odds with no meaningful effort to improve them, philanthropic success is doomed to suffer.

The current state of the relationship
To gauge the current health of hospital-foundation relationships across the sector, a follow-up survey was conducted in 2011 to capture the perspective of foundation leaders on this topic. It should be emphasized that the hospital perspective is also essential, and likely forms the next stage of the dialogue.

The survey was distributed to Canadian and American members of the Association for Healthcare Philanthropy (AHP), to Australian colleagues through the Fundraising Institute of Australia, and in the U.K. through the Association of NHS Charities. The survey also offered respondents an opportunity to participate in a secondary personal interview that tested deeper perceptions of the best practice model proposed in 2006, current issues impacting the relationship, and identified strategies for creating best practice in today's environment.

So what is the overall current status of the hospital-foundation relationship? When asked how they would characterize the relationship in terms of its impact on philanthropic success, 22 percent of respondents characterized their relationship as "*highly functional*," the majority of respondents characterized their relationship as "*functional*" (57 percent) and 21 percent viewed their relationship as "*dysfunctional*." If the ultimate goal is for hospitals and foundations to strive for a highly functional relationship to maximize philanthropic success, the cohorts that perceive their relationship as less than that merits concern. (Full survey results can be viewed at www.ahp.org/spring2012journal.)

> "You've got to have **support for the work of the foundation at the highest level** and recognition that the foundation isn't just a cow you can milk. If you don't have that support at the senior hospital levels, you're not going to get there."
>
> —Kevin Gardner, chief executive officer, Sydney Eye Hospital Foundation, Sydney, Australia
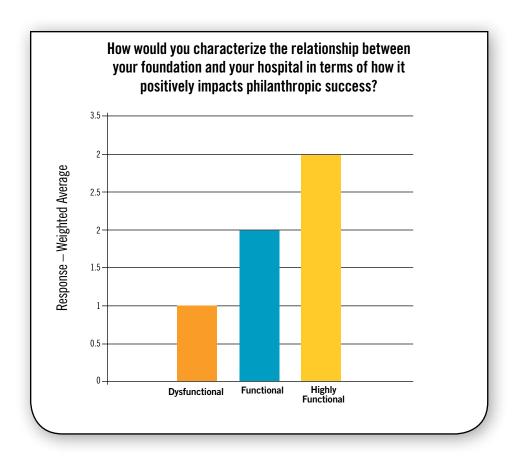
Increasing concerns

The importance of the relationship foundations have with their host hospitals is not contested. When asked to rate the importance of the relationship between the foundation and the hospital, respondents gave it an average rating of 9 out of 10. Survey results and follow-up field interviews confirm that the hospital-foundation relationship is now *more critical to manage than ever before.*

No doubt this increased concern is the result of the dramatic shift in the economy since 2008, which has exacerbated unresolved issues between hospitals and foundations and has created additional tensions in the relationship. During a time when philanthropic dollars flowed more easily, even those relationships with small "cracks" in them went unchallenged. Colleagues in the field report that there is now a degree of pressure on hospital foundations to perform like never before, and that this pressure is impacting not only the relationship, but also the way in which philanthropic work is conducted.

But economic issues aren't entirely to blame. Some of what is now surfacing in the hospital-foundation relationship has been a long time in coming, due in part to personality or philosophical differences between the partners—differences that weren't as much of an issue in better times. Marnie Spears, president and chief executive officer of KCI, noted that egos and personalities often drive differences, and foundations that have been around a long time often have taken on personalities of their own. "Hospital foundations by their very nature can create a maverick situation if they don't

How would you characterize the relationship between your foundation and your hospital in terms of how it positively impacts philanthropic success?

understand that the reason they were incorporated was to protect assets," she said. "You can't lose sight of who you're there to serve—the whole 'foundation' movement has largely been fueled by the notion of being separate."

A corresponding shift in the hospital environment also is impacting the relationship. The hospital leadership model has changed, with fewer physicians and more financial experts in charge, driving a new business model that has had both positive and negative implications for fundraising. There is a new focus on immediate bottom-line results, which can be at odds with the longer-term donor relationship building required in fundraising. However, on the positive side, this also means that hospitals are recognizing the financial potential of philanthropy—seeing the value in creating an equal partnership between hospital and foundation

for the philanthropic enterprise.

This changing hospital model has strained many hospital-foundation relationships—in part due to the perception of some that fundraising professionals have failed to keep pace with the shift. Neil Hannam, executive director of Campbellford Memorial Hospital Foundation in Campbellford, Ontario, Canada, noted that when looking at the composite of our sector, we have many foundation executives who have been in leadership positions for a long time, and while this depth of experience serves the professional well in many ways, in others it does not. "Foundation leadership grew up and cut its teeth in a very different time in hospitals. We're old school," he said. "Without enough churn in foundation leadership or experience with the new business model in hospitals, our best practices aren't where hospitals are right now."

The new best practice

Wisdom from the field would suggest that the following core principles are present in high-performing hospital-foundation relationships:

Awareness and stewardship of the relationship

Like any other relationship, simply focusing greater time and attention on the relationship itself can help to build the *mutual trust, respect and culture* needed for more positive outcomes. *Ongoing dialogue* within the relationship is essential, and ensures the philanthropic message is being heard.

"Constructive differences are healthy; *how* they agree to disagree is what matters. It's all about culture and engagement with one another," said Spears. Clarity around respective roles and commitment to one another is key. The foundation, while needing a margin of organizational flexibility and independence to do its work effectively, must be clear that it ultimately exists to serve the hospital. In turn, the hospital needs to do all it can to support a culture of philanthropy that enables foundation success.

In the survey, many colleagues expressed the need to build greater mutual understanding between the two organizational boards. While they may play unique roles individually, they must be inherently linked to one another through their work.

Of growing interest is the use of memorandums of understanding (MOUs) or written agreements of association between hospitals and foundations. Such documents can provide a context for the relationship and outline the obligations each has to the other

> "The greatest strategy for building the hospital–foundation relationship is to deliver on fundraising results. We have to learn to transition philanthropy from 'nice to have' to 'need to have.' Projects will be better with us, rather than without us. We need to position ourselves to be integral to the project."
>
> —Lisa Froemming, president and chief executive officer, Columbia St. Mary's Foundation, Milwaukee

in the philanthropic enterprise. However, the 2011 survey shows their application can produce mixed results.

Of the small percentage of respondents who reported having such an agreement in place, only 32 percent of those with such agreements felt it had been helpful in creating a functional relationship; 16 percent felt it had not and a surprising 52 percent were uncertain whether having such an agreement had any desired impact. While the *process* of designing such agreements can be effective in itself by creating a forum for dialogue and for educating and orienting volunteers, it would appear that agreements themselves cannot replace the need for a deeper relationship, nor can they automatically generate one.

Greater alignment

The current climate is forcing hospitals and foundations to rethink their position vis-à-vis one another, and both are coming to the realization that *they're stronger if they are more aligned* with one another. Alignment requires a *common vision and direction for philanthropy* shared by both parties that meets donor interest *and* organization need.

As separately incorporated entities, foundations have their own boards of directors, their own staff and budgets, and as a result, they can function very separate and apart from their hospitals. Foundations need an arm's length relationship for legal, financial and ethical reasons that allow them to advocate for donors and the community. However, independence can contribute to a sense of separateness between the hospital and the foundation. By their very nature, hospitals and foundations are interdependent and *must coexist* in a symbiotic way, not as "two solitudes." Each must have a commitment to the success of the other. Why? *Because donors do not see the line between the two.* The foundation is the conduit for donors to give to the hospital they care about, and the hospital is the ultimate recipient. That fact alone means that both have a shared stake in success of the philanthropic mission.

Sonya McLelland, CFRE, administrative director of marketing and public relations at Cass Regional Medical Center in Harrisonville, Mo., noted that the push for independence can lead to unexpected problems. "If donors don't feel an organization has its

> "The current operating and financial environment in health care is challenging many institutions to resource the future. The cost of health care delivery, the economy and the borrowing environment create a dynamic where there is a rethinking of philanthropy as a reliable and sustainable source of funding in a much more strategic way than it has been in the past."
>
> —Bill Littlejohn, chief executive officer, Sharp Healthcare Foundation, San Diego, and AHP board chair-elect

act together and the hospital and foundation aren't consistently putting that message out together, it can negatively affect donor outcomes," said McLelland. "Foundations and hospitals can go two ways—they can in-fight with one another or circle the wagons. If they share a focus on mission and work together for the greater good, that's going to be a win-win for everyone."

So how *are* organizations achieving better alignment? Perhaps the most powerful and essential tool that organizations are using today is *joint strategic planning*. By developing a mutual understanding of opportunities, challenges and needs, the foundation and hospital build commitment and ownership in a joint vision. Without foundation engagement in the hospital's strategic plan, philanthropy will never be well positioned in the institution's psyche. The foundation's involvement also brings another voice to hospital organizational planning—the interest of the donor.

Peter Dalton, director of fundraising at Cambridge University Hospitals Foundation in Cambridge, U.K., voiced this sentiment well. "If you want to be a big player in philanthropy, you need to be at the big table—

when the institution is doing its planning. The hospital may have a preference of some areas over others and this can create some tensions. But if philanthropy is going to play a role in building the institution's future, it's really the donors as a stakeholder at the table that need to be part of the decision-making process, and that's difficult for some hospital leaders to accept."

Many leaders also are incorporating *simple, proactive and ongoing engagement strategies* to manage the health of the relationship. Joint annual retreats built around an agenda of mutual interest, biannual personal meetings between board leaders and educational opportunities for each board to build understanding of the work of the other, are all reported as effective starting points.

Some colleagues have used a task force approach to create a forum for dialogue about the relationship. Such a forum can be a powerful starting point for clarifying expectations, surfacing issues of concerns and recommitting both parties to a common vision.

Hospital boards can be viewed as disinterested nonparticipants in the philanthropic process by the foundation board. At the same time, foundation board members can feel resentful when they receive little support or recognition from the hospital for their work, or if they are not effectively engaged in the overall health care agenda. Bringing these two groups of community leaders together around a shared agenda is a critical first step.

Commitment to philanthropy at the hospital's highest levels

Many foundation leaders continue
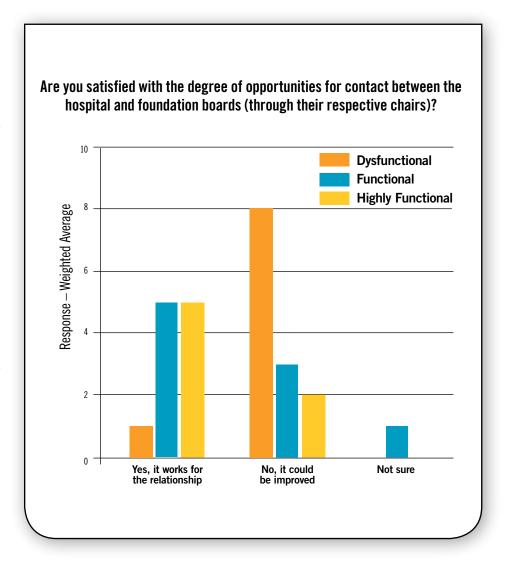
to report a perceived lack of commitment on the part of hospital CEOs and their boards to the philanthropic mission, yet overwhelmingly, colleagues report that to reach its potential within an organization, philanthropy *must* be well-positioned internally and have the advocacy and support of hospital leadership.

According to AHP President and CEO William C. McGinly, Ph.D., CAE, involvement of hospital leadership in philanthropy is a key factor in high-performing health care development organizations. "We consistently see in our AHP benchmarking program and in other research, that when there is awareness and importance placed on philanthropy by hospital leaders—where it's positioned differently and it's more important—that helps to advance fundraising programs," said McGinly.

An involved hospital CEO

The hospital CEO has always been, and continues to be, a key figure in philanthropic work and an important influencer in the hospital-foundation relationship. Fundraising theory dictates that the hospital CEO is, in fact, viewed as the chief representative of the organization's fundraising enterprise due to the importance placed on this high-profile leader in the mind of the donor. Not surprisingly, survey results also showed a strong correlation *between the degree of involvement of the hospital CEO in philanthropic work and the health of the hospital–foundation relationship.*

Increasingly, philanthropic objectives are being included in hospital CEO annual performance metrics, but the survey results would suggest that the jury is still out on
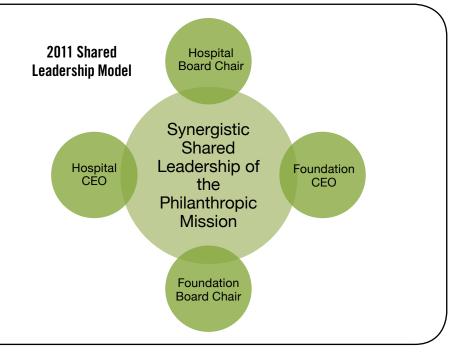
whether such metrics really improve upon the philanthropic involvement of this key leader. Of the respondents who did report having such metrics in place, 85 percent described themselves as being in either functional or highly functional relationships, but overall *76 percent of the functional or highly functional relationships did not use performance metrics.* The use of philanthropic objectives as part of the hospital CEO's performance would appear to be of strong interest to many development professionals in terms of a potential tool, but more work needs to be done to validate their effectiveness.

Engaged hospital board of directors

Increasingly, hospital boards are now being viewed as an essential, untapped partner in an organization's philanthropic success. While the primary role these volunteers play within the institution is different, it does not mean that they cannot also be knowledgeable about fundraising priorities, advocate for them in the community, ensure the involvement of the hospital CEO and even help to open donor doors.

There is consensus in the field that the shared leadership model proposed in 2006 is *no longer a trio, but a quartet* of key leaders, with the hospital board chair

Are you satisfied with the degree of opportunities for contact between the hospital and foundation boards (through their respective chairs)?

2011 Shared Leadership Model

Hospital Board Chair

Synergistic Shared Leadership of the Philanthropic Mission

Hospital CEO

Foundation CEO

Foundation Board Chair

now an important addition to the model. The hospital board chair is now viewed as a stronger, more influential voice that can be utilized to support and advance the philanthropic agenda, both internally and externally.

Strong working relationship among the operational leaders

Another modification to the model proposed in 2006 is the current view that the two operational leaders—the hospital and foundation CEOs—play *more* of a leadership role within the model. Volunteer chairs hold time-limited roles, and it falls to the paid, operational leadership to provide the consistency and stability in the relationship for it to work. It is incumbent on these two leaders in particular to have a strong working relationship with one another, and to work together to ensure the health of the organization-to-organization relationship, and also to identify relationship challenges before conflict develops.

Common language for communicating performance

Not a part of the model itself,

but a key leader referenced by many colleagues, and one not to be overlooked, is the hospital chief financial officer (CFO). The hospital CFO needs to be a close, internal ally because the CFO has a broad view of the financial picture, perhaps more so than the CEO. It is critical that the foundation leadership creates and maintains that relationship and that the CFO understands the potential of philanthropy as part of the financial mix.

To achieve this goal, it is important that the CEO and CFO understand what constitutes fundraising performance and that there is a common understanding around terminology. "Finance people do not necessarily understand relationships, and may only understand something that has a number in front of it," said Peter Fletcher, CFRE, a health care development professional with 15 years of experience in both

Australia and the U.K. "On the other side, we have fundraisers who can only speak in terms of relationships. We're not always communicating well with one another because we're not speaking the same language."

That also means we need to get serious about how to measure and report on our performance, and educating hospital leadership to that end. McGinly agreed that this is an area of engagement in which we can do a better job. "In dealing with hospital CEOs and CFOs, we need to bottom-line it and give them the clear facts," said McGinly. "It's about how to get their attention and speak their language. Put things in terms that will be meaningful for them. We need to get better at that."

Environment for fundraising success

On an encouraging note, the degree to which hospitals are providing support services for the philanthropic enterprise is impressive. More than 80 percent of respondents enjoy a degree of infrastructure support from their hospitals, ranging from information management to office space, communications and even operating funding.

There appears to be some correlation between having strong infrastructure support (at cost or no cost) and enjoying either a functional or highly-functional relationship (78 percent). Not surprising, those who perceive their relationship with the hospital as being dysfunctional report having the least amount of such support.

Foundation's commitment to the hospital
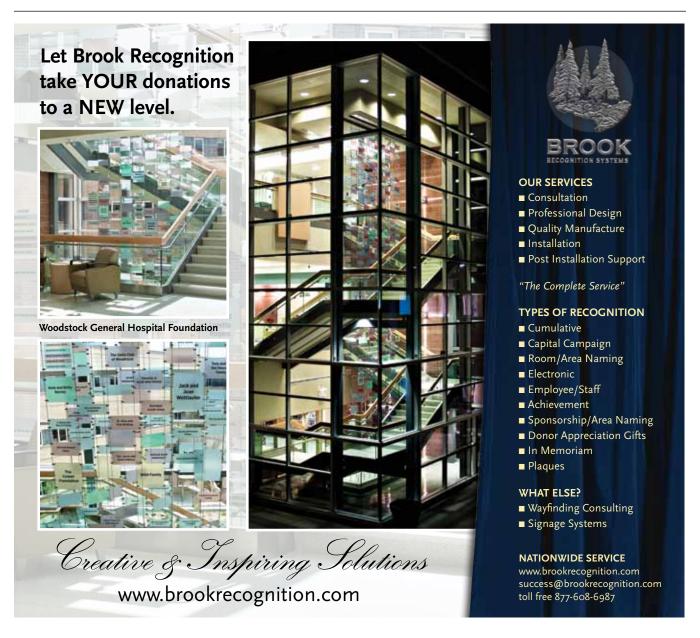
Foundations, too, must be clear on their purpose—to raise and grant funds to support the hospital's mission—and must move away from any culture of "separateness" and realize that greater success lies in alignment with the hospital. Consensus from the field is that development leaders must think much more broadly about the role they play in the organization from a strategic perspective, rather than a tactical one.

A silver lining of the recent economic turbulence may be that it has helped to forge new opportunities for alignment. As Marilyn Geiger, vice president of philanthropy for Mercy Health System in Oklahoma City, Okla., shared, many hospitals haven't traditionally viewed philanthropy as a strategic revenue source. "They viewed it more as a source of funding for the 'warm fuzzy' things," said Geiger. "Now, hospitals are asking their foundations, 'What are you going to do to fund the strategic plan?' We've been looking for a seat at the table and asking the hospitals to come to us before the shovel is in the ground. We're now being offered the chance to be strategic partners."

For many foundations, it has long been considered best practice for the foundation CEO to be included as a member of the hospital management team—but it is not enough simply to be there. Foundation leaders must make a true effort to become fully engaged in the dialogue, to work to deepen their own understanding of the hospital's challenges and to work
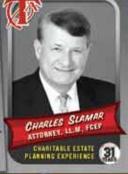
LOOK WHO IS HITTING HOME RUNS!

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MARK LARKIN, CFRE
VICE PRESIDENT, DEVELOPMENT, CENTRACARE HEALTH SYSTEM

Thompson & Associates
on course for tomorrow

from that hard-won seat at the table to be a help to that agenda.

Colleagues noted that it is time for the hospital development profession to step up its game, either in being recognized for what it has done, or what it has the potential to do. The greatest way to do that, and to improve upon the relationship itself, is to continue to improve upon foundation performance.

Improving foundation performance means stretching our own professional view of what constitutes success. Some colleagues note that it is easy to be content with a slow and steady rise in performance, or attaining their market share year after year. Colleagues reference the need to abandon old-school thinking and realize that we need to set our own sights higher in terms of what philanthropic investment can do for both our donors and our hospitals.

A shared commitment

The relationship with our hospitals is the one from which we garner our very existence, our case for giving and the primary reason donors support what we do. Yet it is a relationship we may not devote as much attention to as we should. We need to apply the same donor-centered approach we claim to champion with donors, as equally to our relationship with the hospital.

That means clarifying expectations, building mutual understanding, nurturing the relationship and ensuring an environment of trust, just as we would any other relationship. Hospital foundations simply cannot grow, or even function well, without a common platform of understanding, respect and alignment with the hospital for which it raises funds.

If philanthropy is to reach its full potential within a hospital organization, it is the obligation of *both* the hospital and the foundation to work together for that mutual purpose. It takes the resolve and commitment of both partners to create that culture, but the payout in the end will be worth the journey.
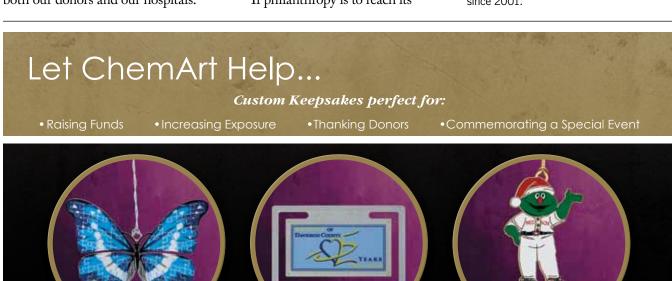
Editor's Note: The 2006 article, "In search of a best practice model for the hospital-foundation relationship," can be downloaded from the AHP website at www.ahp.org/spring2012journal.

Michelle Campbell, FAHP, HMFIA, is the president and chief executive officer of the St. Joseph's Health Care Foundation, and vice president of fund development for St. Joseph's Health Care London, in London, Canada. A senior professional who has spent her entire fundraising career in hospital philanthropy, she is also an honorary life member of the Fundraising Institute of Australia, having served on the international faculty of the Madison Down Under program since 2001.

Relationships
matter

Recognizing the differences in organizational cultures can lead the way to better communication and understanding between development and health care organizations.

"No offense," said a health care colleague, "but your department will always be the sidecar because you're not related to the mission." Not related to the mission? I thought. The sole purpose of a development department is to serve and support an organization's mission. Why was this not abundantly clear to my colleague and others in administration whom I greatly respected?

This discussion came during a turbulent time for my U.S.-based health care provider—an organization deeply committed to serving the poor and vulnerable and providing excellent quality outcomes for all patients. However, we also were facing significant Medicare cuts that would impact our ability to break even financially. As a result, I was asked to cut a position from the development department to help reduce overall expenses. Yet to sustain the charitable contributions expected, I needed my entire team.

The development department was one of the few in the organization that generated significant profit, and our outcomes met or exceeded national benchmarks—clearly, we were doing the right things in the right way. Yet despite a plethora of evidence to

demonstrate the negative consequences of a position cut, I could not persuade the appropriate people that the short-term savings would have long-term consequences of decreased charitable contributions.

Despite my diligent efforts to communicate the principles and best practice for fundraising, leaders in my organization seemed mystified by the operating values of the development department. I was a seasoned fundraising professional and communicator. What was I missing? Confused and frustrated, these questions led me to explore the communication gap from a broader perspective by understanding different organizational cultures and their characteristics—the systems that frame the everyday snapshots within which we operate. With the results of this inquiry, I hoped to develop the insights to bridge the divide. While this situation occurred some years ago, the challenge remains relevant to our profession today.

The holographic image of an organization

When an organization is functioning at its best, it can be thought of as a holograph, where every part contains the reflection of the whole. This image represents a cohesive and unified organizational culture, a corporate DNA, where, as organizational theorist Gareth Morgan has shared, the "vision, values and sense of purpose that bind an organization together can be used as a way of helping every individual understand and absorb the mission and challenges of the entire enterprise." [1]

In my organization, we were all unified around the mission to serve the most vulnerable and provide the best quality of care. Yet, while the development department's primary method of supporting the mission was by creating long-term and fruitful relationships, the health care organization quantified success through short-term, patient episodes with positive outcomes. Without an appreciation for the different methods needed to achieve our goals, the development department truly functioned as a sidecar: We were not integral to the holographic design of the organization.

Frames of reference

Many of us are familiar with Myers-Briggs, the Enneagram and other similar personality inventories used in the work environment to facilitate a greater understanding and appreciation for differences in personal styles. Just as individuals have varying personalities, so, too, do organizations function from different operating systems.
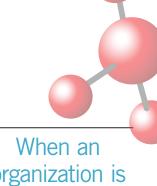
In the field of organizational theory, these systems are called organizational frames, images or metaphors. Each frame describes a specific set of values and behaviors, and these together define the culture—or the cognitive maps that structure and guide daily business operations.[2] There is never one right way, but rather different combinations of frames that successfully meet the specific and changing needs of an organization. Some of the most widely used organizational frames of reference include the structural, human resource, political and symbolic frames.

The structural frame—organization as a machine—addresses how to organize and structure people and groups to perform their job requirements and tasks most efficiently. There are layers of rules, policies and procedures along with a strict division of labor and a hierarchical system. This system is widely employed when technical proficiency is critical to success, and the auto industry was the first to adopt this management style, followed by health care.

The human resource frame—organization as a caring family—seeks to provide the opportunity for employees to meet their needs, grow in skills and relationships and experience empowerment in their daily work. In organizations where this frame functions as a priority, employees are considered to be the most valued resource.

George Zimmer, founding chairman

When an organization is functioning at its best, it can be thought of as a holograph where every part contains the reflection of the whole. This image represents a cohesive and unified organizational culture, a **corporate DNA**.

Each frame contains strengths and weaknesses; therefore, it is never sufficient to view a problem or growth opportunity through only one lens. To the contrary, different combinations of frames are required to successfully meet varying challenges.

and chief executive officer of Men's Wearhouse, a publicly traded company, describes his commitment to the human resource frame: "Our business is based upon faith in the value of human potential." He continues: "We're not in the suit business, we're in the people business… I spend most of my time trying to ensure not only that the experience of our workforce is positive, but that it improves year by year… When you interact with salespeople who seem content as well as professional, you know you've found a company that is doing something right."[3]

In contrast, **the political frame**—organization as a jungle: only the strong survive—is a system of competition for scarce resources where conflict and a struggle for power are inherent in the communication process. While the political frame is often viewed as negative, it is not inherently destructive or ineffective—our democracy is founded upon this process. As a nation, and as a world, we have limited resources and therefore must bargain, compete and compromise to reach resolution.

Finally, **the symbolic frame**—organization as a temple or theater—seeks to create meaning in chaos and provide purpose beyond the stability of a regular paycheck. The symbolic frame builds a cohesive, organizational community through stories, legends, awards and ritual. One well-known company that embraces the symbolic frame is Starbucks. Its mission captures the breadth of its commitment to an entire cultural system: "To inspire and nurture the human spirit—one person, one cup and one neighborhood at a time."[4]

Each frame contains strengths and weaknesses; therefore, it is never sufficient to view a problem or growth opportunity through only one lens. To the contrary, different combinations of frames are required to meet varying challenges. For example, as Lee Bolman and Terrence Deal describe in their 2008 book, *Reframing Organizations*, when there is a high level of uncertainty, the political frame is naturally dominant in order to allocate scarce resources. However, the symbolic frame will provide a necessary balance by seeking order, meaning and purpose within the chaos. In contrast, when goals are clear and the environment is reasonably predictable, the structural frame, which supports efficient task performance, is complemented best with the human frame, which values employee satisfaction and growth.

A challenging culture

Looking at my health care organization within the context of these frames, I realized that the *political frame* was a dominant operating system due to the constant threat of financial loss; therefore, there was an urgent need to allocate scarce resources. The strengths of leading through the political frame include the ability to access the distribution of power and needs, and the skillful building of networks and key stakeholders for success.

I also discovered that the *structural frame*, with well-defined goals, objectives and control mechanisms, was equally dominant in our organization— and appropriately so. Given the copious documentation required by Medicare for financial reimbursement and benchmark data, and given that the recovery of every patient is dependent upon a highly complex delivery system of care, health care cannot function efficiently and effectively without the structural frame.

Yet as necessary as these frames are to organizational success, when the political and structural frames become the dominant components in an organizational culture, the unintentional consequences can include unresolved conflict, anxiety and employee burnout. What is needed is equal attention to people and culture, so that stress and conflict can serve as a fertile opportunity for creativity, growth and transformation.

The development department framework

In contrast to the political and structural frames that dominated

the organizational culture of my health care organization, our development department had a very different organizational framework. Specifically, when the efforts, focus, dedication and energy of individuals are essential to success, the human and symbolic frames are naturally dominant.

When viewed through Maslow's Hierarchy of Need, the *human frame* offers employees an environment to move beyond the basic needs of a paycheck and safe work environment to actualize higher potential through social belonging, the development of self-esteem and the fulfillment of a vocational potential. As development professionals, we embrace this frame because this is what we offer our donors: the opportunity to actualize dreams and visions for a better world. And it is our "people skills" that ultimately lead to our success.

As development professionals, we also employ the *symbolic frame* to create meaning and purpose for our donors. According to Bolman and Deal, when organizations successfully embrace the symbolic frame, "they use dramatic symbols to get people excited and to give them a sense of the organization's mission. They are visible and energetic. They create slogans, tell stories, hold rallies, give awards… they articulate the organization's unique capabilities and mission."[5]

The *structural frame* also is essential to a development team as we manage budgets, analyze direct mail results and quantify efforts for major gifts. However, we are most successful when we focus on the longevity of relationships by building trust and loyalty.

Organizational structure

In addition to the operating frames that make up an organization's culture, the work environment also is influenced by the employee positional structure, which affects lines of authority, communication and interaction. In contrast to the hierarchical structure often found in health care organizations, the structure of a development department is more decentralized and flat to allow for a fluid exchange of information about our donors.

As defined by Sally Helgesen in her book, *Web of Inclusion*, a decentralized structure "serves and promotes relationships above all."[6] Lest this web of inclusion be seen as less efficient or successful than a hierarchical structure of control, Helgesen provides numerous examples to demonstrate that strong relationships, supported

by clear values and highly trained individuals, are key to survival in today's rapidly expanding economy. She cites success stories from technology (Intel) to the newspaper business (*Miami Herald*), and suggests that a more lateral structure "recognizes that the periphery and the center are interdependent, parts of a fabric, no seam of which can be rent without tearing the whole."

The development sidecar

Examining and comparing the organizational frameworks of my health care organization and the development department provided insights and awareness. However, it did not immediately bring solutions. It appeared that the hierarchical, politically and structurally framed culture of the health care organization almost reflexively rejected the web-like, human and relationship-based culture of the development department.

The development team was indeed a sidecar, being pulled along in the same direction with the rest of the organization, but without a meaningful link for communication and shared leadership. Was there a path leading toward integration? What was needed to build this bridge?

Awareness: our uncomfortable responsibility

Living in the awareness of different perspectives is not comfortable. In times of pressure, we often long for simple, black-and-white answers, and short-term fixes regardless of the long-term consequences. As eloquently observed by Robert Greenleaf, a retired AT&T executive and mentor in the field of leadership, "Awareness is not a giver of solace—it is just the opposite. It is

a disturber and an awakener. Able leaders are usually sharply awake and reasonably disturbed."[7]

Without the discomfort that acknowledges complexity in all situations, there is a danger of groupthink mentality where unanimous agreement is accepted as a higher priority over problem solving and debate. The risks of groupthink are revealed in the weaknesses inherent in each frame of reference.

For example, an overzealous use of the structural frame can, as Bolman and Deal note, result in dismissing everything that "falls outside the rational scope of tasks, procedures, policies and organizational charts." Exclusive use of the human resource frame can idealize the potential for every employee and ignore the realities of limited resources and inherent conflict, while heavy reliance on the symbolic frame can result in all talk and no action, providing little credibility to the organizational stories. Finally, a soured political frame creates divisions and distrust.

It can be challenging for large, complex organizations to manage structure and metrics and include the other organizational frameworks. Yet, as revealed in the book, *Firms of Endearment*, the most successful organizations value relationships highly. To become a firm of endearment, an organization had to be loved by all its stakeholders: employees, investors, vendors and customers alike. There was a common thread and value among these companies. Not only did they focus on relationships—"It's not share of the wallet anymore, it's share of the heart"—but in doing so, they significantly outperformed Good to Great and S&P 500 companies over a 10-year period.[8]

In summary, all four frames are important for a healthy

organization. When there is an imbalance of frames, companies will make critical mistakes that could have been avoided by approaching problems from a broader view. What is necessary, therefore, is an awareness of which frames are most critical to meeting the goals of a particular environment or job objective. By valuing the relevance of all frames, an organization positions itself so that its holographic image contains the reflection of every department.

The challenge and responsibility of the minority voice

In my organization, the development department was clearly a minority in the organization, and we struggled to find our voice. Yet, as ethicist Craig Johnson reminds us: "The difficulty of standing alone should not be an excuse for keeping quiet instead of speaking up."[9] The minority voice increases the effectiveness of a team, even when consensus is not reached, because it challenges the team to consider broader possibilities and outcomes. Disaster analysis reveals that overconfidence, narrow-mindedness and group pressure are indicators of groupthink and contribute to disasters on the magnitude of the *Challenger* and *Columbia* shuttles. Therefore, speaking up as the minority voice is not just good practice; it is a leadership responsibility.

Well-known organizational leadership authors James Kouzes and Barry Posner stress the importance of teamthink where the "intuitive understanding [that] a single thing…could be many things, depending upon how you look at it, is central to the learning climate created by leaders."[10] Teamthink behaviors include

The minority voice increases the effectiveness of a team, even when consensus is not reached, because it challenges the team to consider broader possibilities and outcomes.

balancing emotion with reason, trying to understand the other's perspective through inquiry, active listening and valuing of the other's opinion. As development professionals, we understand many of these skills because our success demands open inquiry and active listening to match the dreams of our donors with the needs of our organization.

Small gains and incremental change

Successful change is incremental, as expressed in the African proverb: Never test the depth of the water with both feet. Kouzes and Posner suggest that the ability to affect change "[is] not necessarily about go-for-broke, giant leap projects. More often than not, it's about starting small and gaining momentum."

Through my research, I had come to understand that the stress of balancing the bottom line had led to the dominance of the political and structural frames in my health care organization, and therefore, the

vision, values and purpose of the development department seemed an unquantifiable luxury.

Did my new insights allow me to build a bridge between these two cultures? Ironically, it was not benchmarks that allowed me to successfully advocate and retain the major gifts position that I was being asked to cut. Instead, it was the combination of metrics *and* my commitment to speak as the minority voice that persuasively bridged the communication gap.

Time and circumstances have changed, but I have a continued awareness of the complexity of development's relationship to its health care organization. Compared to the highly measurable outcomes of health care, the values of development may appear unquantifiable—even expendable. If we do not employ the measurable tactics of the structural frame, then we are guilty as charged. If we do not understand that scarce resources define the operations of health care, then we are irresponsibly naive. But if we diligently measure

our activity and results, we can be confident knowing that by valuing relationships, we are doing the right thing for our donors *and* for our health care organization.

As development professionals, it is reassuring to know that heart matters, within the context of our work and the work of our organization. In fact, as a profession, we embrace the values of the most profitable companies, because "share of the heart" is indeed the key to "share of the wallet." Relationships matter. ▰

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Powerful mission
storytelling

Stories can be a compelling tool in engaging donors in your mission—if you follow the "truisms" for telling stories well.

Stories create powerful connections between donors and the missions they care about by providing an emotional experience to inspire giving. Stories tap into a basic human inclination to connect emotionally to other people, and stories deftly illustrate the human impact of your healing work.

Stories also provide donors who have not had a personal care encounter with a rich, emotional and sensory experience of your mission in action. Given the impact a story can have, it is essential to know the "truisms" for telling stories well.
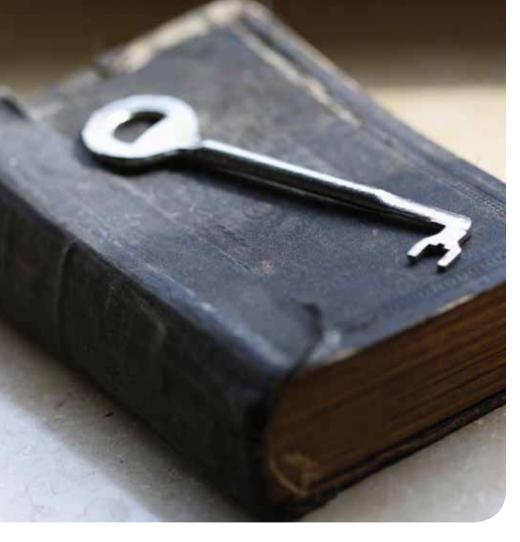
TRUISM ONE: Emotion trumps reason

The field of psychology called behavioral economics says *people do not behave rationally*; rather, *people behave irrationally in predictable ways*. For that reason, our emotional and intuitive right brain makes decisions for us. Then our analytical and logical left brain collects evidence to support the decisions we've already made. That means it's very important to make an emotional connection first—people must feel something. Then they will want to find out more or get engaged.

A 2011 Harvard University article by Ron Ritchhart, "Of dispositions, attitudes and habits: exploring how emotions shape our thinking," shares more: "Our first 'read' of a new situation is always centered in our emotions, feelings and attitudes.…When we feel empathy for another's plight, our emotion may help us to direct our energies to doing something about the situation.…Our emotions act as magnets to either pull us into action or channel our energies in a particular direction."

For example, participants in a behavioral study conducted in 2004 by Deborah Small, George Loewenstein and Paul Slovic were given an appeal for an international children's organization. One group was told an emotional personal story, while a second group was given the story along with detailed statistical information about the 17 million people who were impacted. Then both groups were asked to consider making a charitable gift.

So, how did they respond? Those who had *just the story* gave 66 percent more than those who had detailed data and information. In other words, the

emotional story inspired a stronger response than the rational case for giving.

Princeton psychology professor Danny Oppenheimer summed it up in his 2010 article, "How charities get you to give": "People give less when they are thinking analytically." So, if statistics reduce empathy and willingness to give, health care organizations should carefully select key facts to elucidate the case or to give credibility for the proposed solution without getting bogged down in statistics for the sake of statistics.

The caveat with building emotion is that you must know where the line is. The emotions of fear, pity and guilt have all been shown to increase the number and size of gifts, but efforts to produce these emotions must be handled carefully.

In their 2010 book, *Fundraising Principles and Practice*, Adrian Sargeant and Jen Shang note that the use of emotions "should be strong enough to demand action, but not so strong that they become personally distressing to the donor. At this point, stimulating emotion becomes counterproductive and donors deal with their distress not by giving but by avoiding the communication."

TRUISM TWO:
The power of one
More than 500,000 people died in the Darfur region of the Sudan in Africa between 2003 and 2009. The scene was mass genocide with bodies piled on roadsides and discarded in ditches. While it was a scene of immense horror, organizations raising money to alleviate suffering found little support. It was not that people

did not know conditions were atrocious or even that they did not find the issue important. The lack of support was likely because people couldn't emotionally connect with—or even conceive of—500,000 dead.

Nicholas D. Kristof of *The New York Times* wrote an editorial in 2007 about the phenomenon called "Save the Darfur puppy." In the piece, he talked about a series of studies by psychologists who tried to understand why "good, conscientious people" were not moved by the genocide. He said, "Time and again, we've seen that the human conscience just isn't pricked by mass suffering, while an individual child (or puppy) in distress causes our hearts to flutter." He says activists for particular causes often share the dramatic scale of mass human tragedy—likely in hope of shocking people into action—while not understanding that "the more victims, the less compassion" because of "psychic numbing" that limits human capacity to feel.

An article in *Wired Science* about a study of jury verdicts further reinforces this phenomenon for people charged with exposing others to toxic substances. The 2010 study by Jess McNally found that the *more* victims there were, the *less harsh* the sentence was for the crime.

It's called the "scope-severity paradox." Psychologist Paul Slovic of the University of Oregon, in commenting on the study, says it "shows that as the number of people who are victims of some problem *increases*—whether it's a crime or a famine—the responsiveness to it, and the likelihood of taking action to

Secrets to great mission stories

- **Get personal.** One person's individual story creates the strongest emotional connection.
- **Be resonant.** Tell stories that connect with people's values and beliefs.
- **Don't resort to drivel or shock factor.** Use emotion without being so sappy or upsetting that donors shut down.
- **Be authentic.** Be genuine and trustworthy in the stories you tell. Feature stories of identifiable, real people in your community.
- **Be relevant.** Make stories relevant to donors; show them why they should care and show them what's in it for them and their community.
- **Tell it well.** Great stories move on the power of action, not adjectives.
- **Be specific.** Give people a specific, concrete, understandable way to help.
- **Skip the jargon.** It's more accessible but no less authoritative to say "cancer" instead of "oncology."
- **Don't be too politically correct.** "Poor" says more than "disadvantaged." People connect with and understand "poor."
- **Walk the fine line between problem and dream.** Most organizations have a gap between their reality and their dream, so it doesn't take away from the current care to point out opportunities for a higher standard.
- **Do it right.** Ensure compliance with HIPAA in sharing patient stories.

reduce the problem, *decreases*." He continues, "It has to do with the way empathy works. People empathize with people by putting themselves in the other person's shoes. The more shoes there are, the harder it is to empathize with any single individual. People don't multiply their feelings of empathy by the number of people involved."

Whatever the rationale may be for why people respond this way, the implications are clear: Stories should revolve around a single individual that donors can relate to and connect with on a very basic human level.

TRUISM THREE:
Find a good hero

Good stories need good heroes. While it can sound cold, there is selectivity that needs to go into choosing a hero or victim for your story that your audience will feel is "innocent" in terms of the situation you are relaying. To use an obvious but extreme example, you would never tell the story of a patient who sustained life-threatening injuries following a car accident caused by driving under the influence of alcohol.

Likewise, there are diseases and injuries where heroes or victims can be less appealing because their condition could have been created or influenced by lifestyle choices or poor decisions. Research supports that donors respond most to someone they feel is suffering from consequences beyond his or her control. Donors will rally and fight for a victim who is relatable and who inspires empathy.

TRUISM FOUR:
Focus on the benefits

Many times when we tell a story—especially about an innovative piece of technology—we tend to talk about features that are explained by a lot of numbers. For example:

The compact CT scanner provides 256 slices per rotation, has a gantry rotation of 0.27 seconds and delivers 120 kW power. X-ray tube technology enhances spatial resolution.

This excerpt is adapted from a real description of a piece of technology. While such features may interest a very slim audience, a description like this leaves most laymen with more questions than answers, and it sure would not tell you the real benefit of having one of these scanners. A donor reading a case statement about the acquisition of this piece of

equipment would really want to know the benefits this technology would offer in improving care to people.

To get you thinking from the right viewpoint, imagine a pair of sunglasses and the words you would use to describe their features. The words might include:

• Black.
• Plastic.
• Dark-colored lenses.

Now think about the benefits the sunglasses provide. For example, they:

• Protect your eyes from UV rays.
• Make it more comfortable to see without glare.
• Make you look stylish.
• Help you escape the clamor of the paparazzi.

So, back to our CT scanner—while donors may not care about the number of slices or the gantry rotation, they will care that having more images can enable a better diagnosis that will help someone to get better faster. They may also care that the CT scanner has a faster scan time, which means a person doesn't have to stay still for long so the experience will be more comfortable. They would also likely care that it would limit the radiation, so the scan would be safer.

TRUISM FIVE: Happy endings are not required

Health care marketers tend to tell stories that resolve with everyone living happily ever after. However, most stories in real life do not resolve themselves so neatly. And stories that resolve neatly leave nothing for a donor to do to help since there is no unresolved threat. A story that is unfinished or unresolved shows a person who still needs help and allows donors an opportunity to step forward and do something meaningful to change the end of the story.

Think of a typical story of a woman diagnosed with cancer. She possibly started with surgery and has since gone through rounds of chemotherapy and possibly radiation. She's already made a long journey to get to the point that the doctor finally tells her there's no further evidence of disease—and it feels like a huge victory. However, before she walks out the door, the doctor tells her she has to come back in six months for another scan to ensure her cancer is still gone. Then, she will likely have to come back still again even if it is clear.

So, her story did not end. Her fight is not over. She is better—for now—but the threat is not entirely resolved. It's OK tell this story with the unfinished ending; it allows

someone to see the point of wellness to which she has travelled and the continued possibility that someone will need to intercede to keep her well.

TRUISM SIX: Be relatable

There is a video called "Historia de un Letrero" or "The Story of a Sign," which Producer Alonso Alvarez Barreda originally presented in the 2008 Cannes Film Festival's Short Film Online Competition. It's the story of a man sitting on a sidewalk in a park with a sign asking people for financial help. People continue to walk by and look at the man, and some throw coins into a tin can in front of him. However, nobody seems moved by his plight to do more than throw pocket change. The sign the man holds says, "Have compassion, I am blind."

Soon, a man walks by, sees the blind man's sign, stops and comes back. He picks up the sign and flips it over to write on the back. He hands the sign back and leaves. After the sign is changed, many, many more people stop and put dollars and money in the can until it is overflowing. At the end of the day, the young man who changed the sign walks by again. The old man asks him what he did to the sign, and the young man replies, "I wrote the same, but in other words." The new sign says, "It's a beautiful day, and I cannot see it."

The lesson is simple—to touch others, our message must be relatable. Most of us have never been blind, so we cannot easily put ourselves in the blind man's shoes. However, most of us have experienced the beauty of a sunny day, and it would be hard to imagine no longer having that simple joy as part of your human experience.

So, in that context, each of us understands the blind man's plight.

TRUISM SEVEN: Be specific

Jennifer Aaker and Andy Smith from Stanford University wrote a book in 2010 called *The Dragonfly Effect*. In the book, they talk about a successful social media campaign that secured 24,000 bone marrow donors in a short 11 weeks. The campaign focused on two men—Samir and Vinay—who had both been diagnosed with leukemia. However, because of their Indian descent, there were very few probable donor matches for them in the bone marrow registry. So, their friends launched a social media campaign to tell the story of these two young men and their loving families to let people know of the seemingly insurmountable

situation faced by two relatable young family men.

A pivotal element in the success of the campaign was that people were given a very specific and understandable call to action: Get registered as a potential bone marrow donor to see if you are a match to save the lives of one of these young men. It's not enough to say, "Please help." It's not enough to say, "We hope you will do what you can." People need a specific, concrete and understandable way to exercise their desire to help.

Be yourself

While it doesn't rise to the level of being a truism, there is another opportunity here to share your own genuine passion. Most of us have a personal reason we care deeply about the health care mission we represent. You don't come to health care lightly; you come to health care because you care about the plight of other human beings, or you are interested in the way medicine can create miracles. However, many of us have also had health care touch our own lives or that of a family member in a way that our life was impacted or transformed. If your life has been touched, one of the most credible things you can do is share your own story. It gives you unsurpassed credibility when others realize the reason you do what you do is rooted in your heart and in your beliefs, rather than just being a job you are paid to do.

Well-crafted mission stories can be a powerful tool in engaging others in advancing your mission, and these stories happen within the walls of your health care organization each day. Great stories share the real, human, emotional, relatable impact of your healing mission. Great stories wrap a compelling and urgent vision and a clear call to action in an emotional narrative that resonates with a donor's values. As a development leader, you play an essential role in uncovering and refining the stories of people whose lives were or could have been saved or transformed. **AHP**

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What is it about a pie?

Fundraisers are most effective at inspiring others to express their love of humanity when we give of ourselves: real people relating to other real people.

WHEN WE TOUCH PEOPLE'S HEARTS, WE CREATE THE KIND OF RELATIONSHIP THAT CAN TRANSLATE TO PHILANTHROPY.

One day, carrying a miniature homemade apple pie, I showed up at the door of an elderly man who was recently widowed. His face lit up with surprised delight and he invited me to share it with him. In those moments I became the daughter he had never had, bringing love, comfort, companionship and connection—all wrapped up in a homemade pastry he never expected to receive. We went on to develop a close relationship and shared more pie together, and ultimately he created a significant legacy gift.

My bringing him that first pie was an impulsive act of kindness that sprang from my empathy for his special brand of loneliness, absent the connection of family. Over time I came to see how much pleasure could come from the personal gift of a home-baked pie, made by me specifically for another, as an expression of love. And so what began as an impulsive gesture evolved into my standard way to thank a donor. Donors

who make a $100,000 or larger gift receive from me their favorite pie, baked the old-fashioned way and given with love.

I am now known as "the pie baker." Donors ask their friends if they have received one of my pies yet—shortcut for, "Have you made the same kind of contribution I have made?" They offer to talk to their friends about what they need to do to receive a special pie—the most expensive pie they will ever eat. And they jokingly tell me it was all over for them when I asked them to name their favorite kind of pie.

The funny thing is, they always tell me. No one ever says, "Why do you ask?" They simply tell me, usually with a faraway look in their eyes. Some know immediately, and it is only one kind. Others struggle to choose among several favorites. My CPA gave me a list of eight—prioritized.

So what is it about a pie? I wondered if anyone else had ever pondered "the meaning of pie" and in a Google search discovered Kelly Yandell (themeaningofpie.com), who put it so well:

"Pie is imbued with an old style of homey grace…it produces smiles…it inspires friendly conversation. It brings a little moment of community…Pie… is a symbol of Americana and our food heritage. It is about food, love, family, memories…It is not really about 'pie'

> A pie is not only homemade, it is handmade. It is the embodiment of love.
>
> —Kelly Yandell

literally, but the feelings that pies evoke…the pictures they conjure in one's head of grandmas, windowsills, warmth, love and family…Pie is an idea as well as a dessert. Pie means comfort, home, love, grandmas, warmth, perfect imperfection. Pie is life…there is something true and honest about pies…it has to do with the love we give it from our hands…You have to touch it, get to know it, work with it…A pie is not only homemade, it is handmade. It is the embodiment of love."

In my more than eight years at Mission Hospital Foundation, I have developed close relationships with 35 families that have resulted in gifts of $100,000 or more, each one thanked with a pie. Larger donors have now earned a "pie in perpetuity"—I gave them their own pie dish, which I refill every year at Christmas. Many of these donors have asked for pie baking lessons, which I have taught them in their own kitchens. In addition, I donate one pie every month for a year to the family who purchases this item at the silent auction for our annual gala, which nets

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$1 million. So pies are an integral part of how I steward donors.

Why do pies naturally fit with fundraising? Do we not strive to relate to the people we meet with "an old style of homey grace"? Do we engage people in "friendly conversation" with "smiles," "love" and "warmth"? Are we not trying to know people in the context of "family"—to learn about their families and to bring them closer to our organizations? Isn't a planned gift in its essence something "handmade"—the result of our "getting to know" and "working with" people over a long time—a unique work of art that reflects love?

Perhaps the very essence of a pie—a work of love, a "perfect imperfection," something

that creates connection and community, that brings warmth and comfort, that helps us relive family traditions—touches on so many aspects of relationships nurtured over time to produce a gift in the service of humanity. Philanthropy means "the love of humanity." Those of us in the development field strive to inspire others to express their love of humanity. And it is my belief that we are most effective when we ourselves express our love for our donors.

We do this best when we give of ourselves, when we are real people relating to other real people, each of us a "perfect imperfection." It is that kind of giving that transcends the professional need to articulate the mission and make the case for support. It is when we touch people's hearts, get to know them, work with them, that we create the kind of relationships that can translate to philanthropy.

When we work with donors in this appropriately intimate way, we are creating a "pie," lovingly crafted with warmth. When we enjoy that pie together with our donors, we connect with them to produce philanthropy, the sweetest taste of all. AHP

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