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in grateful
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By David L. Flood

Chair, AHP Board of Directors



FROM THE CHAIR

A time for reflection and growth

Welcome to spring. Finally! Every season has its signature. Whether you are working within a traditional calendar year or subscribing to more of an academic calendar, spring is a bright and special time of year. Beyond the more pleasing climate, many of us enjoy some freedom from the shackles of budget planning, holiday distractions, evaluations and navigating our work around everyone's summer get-away planning (except our own!).

If you will allow me one cliché, this is a time when many of the seeds we have set into place throughout the year begin to blossom. Outside of some of the operational clutter that complicates most seasons, in the spring we often are free to better focus on that which defines the important work we do—the people, the relationships and the advancement of a unique mission toward the collective benefit of health care in our world.

This spring will be a particularly pivotal time for our association and for our future impact on health care, as we complete the final year of a historic and successful strategic planning cycle that was born in 2010—resulting in positive changes to our association's engagement and governance structures; greater definition applied to and published around contemporary fundraising standards; new and expanded educational offerings delivered through increasingly member-friendly platforms; and an emphasis on data sharing

We hope that you will share in defining our association's role through your ideas, while broadening our influence through your active involvement in growing and strengthening our association.

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and formalized benchmarking designed to provide AHP member institutions with a sophisticated compass to evaluate progress and direction.

As we wind down that plan and evaluate the many gains, trends and lessons learned since then, we also are starting to design and construct a new multi-year plan that will be unveiled this summer.

This new road map will incorporate a broad range of perspectives from AHP members, member institutions, partners and external resources that already have begun to define the future for our association—a future that includes greater need from fundraising professionals in ever-expanding health systems; calls for offerings that can build upon our accomplished hospital-centric identity to include growing specialty service lines and fundraising


functions; cultivating opportunities for new and innovative industry partnerships that can serve to broaden AHP's reach and resources; providing definition and representation to standards surrounding important industry issues; and continuing to meet member needs by delivering outstanding and timely educational programs, training and information.

I would like to take this time to acknowledge and thank those on the Strategic Planning Committee and other AHP members who currently are contributing to this important effort: **Mendal Bouknight; Amy Day; David Gillig, FAHP; John Graham, IV, FASAE, CAE; Sharon Jones, FAHP, CFRE; Mark Larkin, CFRE; Mitze Mourinho, FAHP, CFRE; Bridget Murphy, CFRE; Jory Pritchard-Kerr, FAHP, CFRE; Pamela Puleo, FAHP, CFRE; Thomas**

Sloan, CFRE, FACHE; Randy Varju, MBA, FAHP, CFRE; Sue Doliner, FAHP, CFRE; and Bill Littlejohn.

As you are keenly aware, today represents an exciting, important and uncertain time for health care. Philanthropy is being called upon in ways not previously seen or imagined.

It is the board's hope and request that you will share in defining our association's role through your ideas, while broadening our influence through your active involvement in growing and strengthening our association. There are many opportunities to be involved with new and existing programs and to make a meaningful impact on our profession. I hope you will take advantage of them.

Thanks for all you continue to do. It remains a privilege to serve you. 



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Investing in the future

“Let us cultivate our garden.” – Voltaire

Staff retention and development is a hot-button issue for many AHP member organizations. This issue of *Healthcare Philanthropy* features an article on what fundraisers can do to “manage up” and become leaders in their organizations. It’s also important for development shops to cultivate talent and provide fertile ground for staff to grow and succeed.

Business research indicates that succession planning and leadership development are a good idea at all levels of an organization, not just at the top. This should be a priority for any organization that wants to attract and keep high-quality staff. It’s especially important in philanthropy, where there is competition for top fundraisers and where long-term relationships with donors are crucial to long-term financial success.

Notable examples of the benefit of staff development can be found in the classic reference *Built to Last: Successful Habits of Visionary Companies*. Authors Jim Collins and Jerry Porras identified 18 organizations that led their industries for at least 50 to 100 years. They found that one of the key reasons for long-term success was a strong focus on succession planning and leadership development. Specifically, these organizations developed, promoted and carefully selected managerial

talent from inside the company—ensuring leadership continuity and excellence.

What makes a good leader in health care philanthropy? A study commissioned by AHP a few years ago shows that basic traits of an effective chief development officer include gift solicitation skills, communication skills and a talent for creating a culture of philanthropy.


However, development executives in the most successful programs also were able to effectively assess philanthropy’s return on investment, demonstrate solid management skills and establish ongoing relationships with hospital leadership and physicians. Relationships between foundation staff and physicians can sometimes be tricky; you will find information on breaking through barriers and getting physicians involved with philanthropy in our cover article.

You’ll also find articles in this issue where leaders have challenged their staff to reexamine the way they do business and look for new pathways to fundraising success—one with a fresh approach to major gift cultivation and another with an innovative plan to be a better asset to the community.

You can look to AHP for resources to help with staff development and training. Our education program is designed around a professional

Succession planning and leadership development are a good idea at all levels of an organization, not just at the top.

pathway concept. It is matched up to AHP learning opportunities to help staff at any level reach their career goals. You can learn more at www.ahp.org/careers.

Data from the *AHP Report on Giving* consistently shows that investing wisely in talent and compensating fundraisers fairly makes all the difference in generating high dividends for health care institutions. There is no doubt that people are your organization’s most valuable asset. Investing in staff demonstrates they have a future with your organization and builds a team of loyal, fully engaged high achievers. It is essential for organizations that want to be around for the long haul. 

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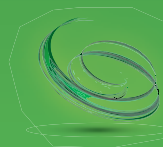
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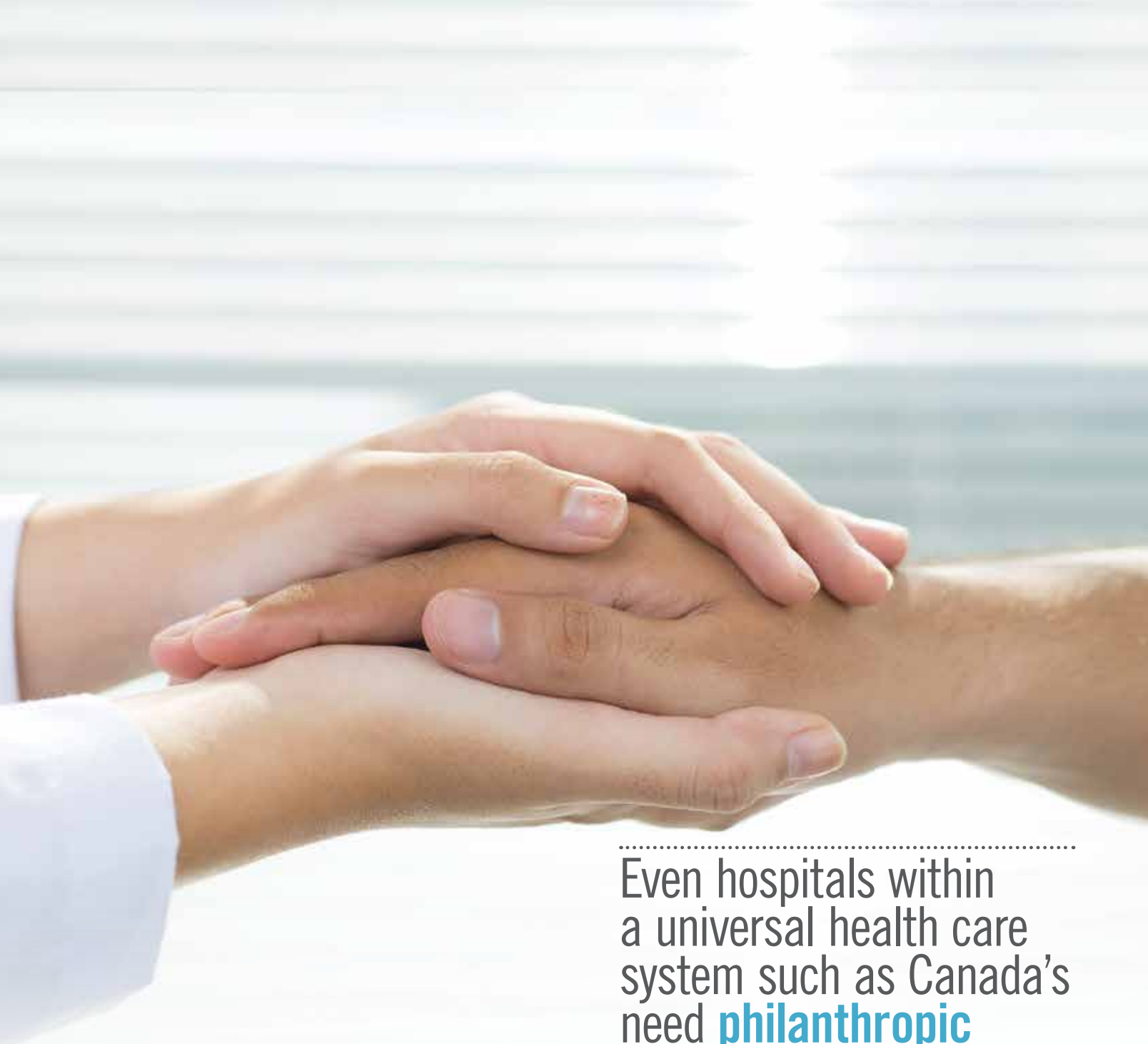


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The physician perspective on philanthropy

Fostering doctor-patient relationships and grateful patient gifts

Raising funds through philanthropy has become necessary for hospitals to augment their financial resources and implement important initiatives. Even hospitals within a universal health care system such as Canada's need philanthropic initiatives to carry out hospital-specific priorities in patient care, education and research. Philanthropic gifts from patients and their families are one of the most important sources of funds raised by hospitals.¹



.....
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Recognizing that patients often give to express gratitude for exceptional care from their physician,² many hospital foundations promote physicians' involvement in philanthropy. In fact, physician involvement in "grateful patient" philanthropy is known to increase the frequency and size of donations.^{3,4} Even so, very little information is available about physicians' relationships with hospital foundations and their attitudes about playing a role in philanthropy.

To gain further insight, the St. Michael's Foundation in Toronto, Ontario, decided to research the following questions:

- What are physicians' perceptions of their role in grateful patient philanthropy?
- What barriers prevent physicians from getting involved? What enablers promote their involvement?
- How do physicians perceive their relationship with the hospital foundation, and how does this relationship impact their involvement in philanthropy?

Finding key issues

St. Michael's Foundation provides financial support for the patient care, teaching and research activities of St. Michael's Hospital, a Catholic teaching and research hospital in Toronto. In 2012, the

foundation established the Physician Engagement Committee to enhance physicians' participation in philanthropic efforts. The committee is composed of 60 physicians at St. Michael's Hospital and is led by two senior physicians who consult with members of the foundation and foundation board for guidance. The committee meets twice a year to learn about recent fundraising successes, receive training and discuss ways to improve philanthropy strategies.

We undertook our study to help the foundation and Physician Engagement Committee pinpoint key issues and build goals to strengthen philanthropic efforts.

Among our key findings:

- The physician's role in the philanthropy process must be clearly defined—and must take into account physicians' comfort with fundraising involvement.
- Foundations must work with physicians to establish a feasible way to report information to physicians about patient donations.

In-depth interviews with physicians

Our qualitative study involved in-depth, one-on-one interviews with 16 physicians, whom we recruited by email invitation. To be eligible, participants had to work as full-time staff at St. Michael's Hospital during the study period. Participating physicians represented a range of specialties, had varying years of clinical and philanthropic experience, and were primarily male (62.5 percent). Twelve of the 16 respondents were members of the Physician Engagement Committee. See Table 1 for characteristics of participants.

Our researchers conducted a 20- to 30-minute telephone or in-person interview with each participant, using an interview guide containing

Table 1: Characteristics of physician informants

Characteristics	
Male (%)	62.5
Number of years in practice, mean (range)	22.6 (3-40)
Specialty (N)	
Cardiology	1
Emergency	1
General Surgery	1
Obstetrics/Gynecology	1
Oncology	2
Ophthalmology	1
Orthopedic Surgery	2
Neurosurgery	1
Pediatrics	2
Plastic Surgery	1
Respirology	2
Urology	1

Table 2: Percentage of the 16 respondents mentioning major themes regarding physician engagement in grateful patient philanthropy

Themes	Percentage of respondents referring to each theme (%)	Additional Quotes
1. Barriers to philanthropy conversations with patients		
Personal discomfort	81	"I've never actually said to a patient, 'Hey, you seem to like your care here. Have you ever thought of giving to the foundation?' I haven't approached that because I still have this sense that it broaches some moral/ethical line."
Perception of fundraising outcomes	38	"Many of them are uncomfortable about asking patients for money because they're not convinced that the hospital will spend the money in a way that is in their interests."
2. Communication regarding patient donations		
Need for regular communication	56	"That's where it's weak—I'll get a card saying my patient donated. I don't know how much and I don't know when and what it was used for. If you're in the loop, then you can participate more in the thank you."
3. Strategies for philanthropy engagement and success		
Philanthropy education and reminders	69	"One is to sort of work with people like me and get them on the agenda at our monthly meetings to talk to the group about what the foundation's doing and how it's relevant to them."
Managing potential donors	63	"I think that if there's some way you can get the physicians who aren't involved just to signal to the foundation who is a potential donor and let them handle it—which they are in the business of doing."
Increasing the visibility of philanthropy	44	"I wouldn't be averse to seeing the foundation imprint in the clinic. I don't think it's inappropriate for them to be in that setting. I think it's an opportunity to engage patients."
Division-specific fundraising campaign	38	"Having a fundraising campaign within a group of physicians for a specific project, I think you'll get much more bang for your buck in terms of getting people to ask for money."

closed- and open-ended questions we developed from relevant literature, discussions with foundation experts and a pilot survey of physicians regarding their engagement in philanthropy. The sidebar on page 14 contains sample interview questions.

Three main themes emerged from the interviews, shown in Table 2. Here, we discuss them in more detail.

Barriers to philanthropy conversations

The biggest barrier to discussing philanthropy with patients is that it makes physicians feel awkward and uncomfortable. They worry that such conversations interfere with the doctor-patient relationship—which, in a universal health care system, does not typically involve discussions of money and is

primarily founded on trust and the moral imperative to care. Participants said that deciding whether a patient is an appropriate candidate to approach for philanthropic gifts is beyond their professional role. This is particularly true, physicians said, when patients are ill and at their most vulnerable.

Specific comments included

that broaching philanthropy with patients is “a conflict of interest” and “outside the doctor-patient relationship.” Another respondent said, “I don’t want to take advantage of patients when they’re receiving treatment...I don’t feel it’s my job to actually talk about giving gifts; my job is to treat them.”

Physicians’ concern that the money they raise will not have a beneficial impact on their patients, medical division or clinical practice is another barrier. As stated by one

physician: “It would be nice to be thinking that everybody’s altruistic and we just want to raise the money for the hospital...but when the money doesn’t affect you personally the natural tendency is to say, ‘Why would we care?’”

Communication regarding patient donors

The physicians stated that having regular communication with the hospital foundation was a key aspect of their involvement in

patient philanthropy. They can feel frustrated when they do not receive information about the amount and purpose of their patients’ donations, as demonstrated in this quote: “I’ll get an email saying, ‘Oh, so-and-so donated on [your] behalf.’ I don’t know where that money goes. I don’t know if that money goes to the division, I don’t know how much; it was just a gift given on my behalf. So the transparency is a problem.”

If a physician does not receive information about incoming

Sample questions from the interview guide

Physician experience with patient philanthropy:

1. Have you ever talked with a patient about making a contribution to support the hospital?

If yes:

- a. How did you start a conversation with your patients about giving to the hospital?

If no:

- b. Why not?

2. Are you able to recognize potential patient donors?
 - a. Are there specific cues you look for from patients? Please explain.
3. In your experience, how is your relationship with patients impacted by you talking with them about making a philanthropic gift to the hospital, if at all? Positively or negatively?
4. What is the hardest part about talking with patients about making a contribution to support the hospital?



Physician-foundation relations:

5. Have you ever received any support or training with respect to fostering patient philanthropy?
6. How could you be better prepared, if at all, to discuss donations with your patients?
7. When fostering philanthropic gifts from patients, do you encourage the gift to be donated to the hospital foundation or to your own personal clinical or research initiatives?
 - a. Do you feel there is tension between physicians and the hospital foundation regarding whether patient support should be used in support of the hospital priorities or clinicians’ own research/clinical initiatives?
8. How can the foundation engage physicians so they can work together to foster a successful culture of patient philanthropy at St. Michael’s?

donations, it can be upsetting because it prevents that physician from personally thanking his or her patient in a timely manner. One physician noted how embarrassed he felt when he belatedly discovered that one of his patients had donated \$1,000. “I must have seen him four times since then and I haven’t said a single thing to him about it, you know?”

Strategies for philanthropy engagement and success

Physicians who participated in the study suggested several strategies to help improve physician engagement in patient philanthropy and increase patient donations.

1. Give physicians philanthropy education and reminders. Most participants said they need help building basic skills to facilitate philanthropy conversations, as well as reminders about the importance of investing their time in philanthropy. It would be helpful for the foundation to educate physicians about how to promote philanthropy and about ways their involvement can be a “win-win” for both physicians and the hospital as a whole.

2. Make it easy for physicians to notify the foundation of potential donors. Most respondents do not solicit donations directly from patients unless patients say they wish to make a financial contribution—in which case, the physician directs the patient to the foundation. Physicians need a way to let the foundation know of patients who may be in a position to contribute but have not yet voiced their desire to give. That way, the foundation can step in and initiate the gift solicitation process.

As one respondent noted: “A lot of us are just completely focused on our medicine and are not in any

way prepared to talk and ask for a gift.” Therefore, physicians should be able to “tell somebody in the foundation that this person had a good treatment and is grateful and is a potential donor, so that the hospital can approach them directly.”

3. Increase the visibility of philanthropy within the hospital.

The foundation should do more to advertise the exceptional research and initiatives being carried out at the hospital, including putting

posters, brochures and other information in waiting areas.

4. Develop division-specific fundraising campaigns. Many respondents, acknowledging that some physicians have limited interest in becoming involved in philanthropy initiatives, suggested that the foundation help develop and implement division-specific fundraising campaigns. Providing an opportunity for physicians to support a project that is personal to their colleagues and patients will motivate them to speak with patients about making a financial contribution.

Challenges and complexities

Even though involving physicians in fundraising can be highly valuable, it’s a complex process. Our analysis, consistent with work

published elsewhere,^{1,5,6} revealed that ethical barriers can be a significant impediment to physicians’ participation in grateful patient philanthropy.

The American Medical Association states that physicians should avoid direct gift solicitations from their patients, especially during times of active medical treatment,⁷ because philanthropy conversations may violate the doctor-patient relationship. Consequently, many hospital foundations, including our own, now encourage physicians to

Open and ongoing communication with the foundation is **crucial to physicians’ comfort** in promoting grateful patient philanthropy.


identify prospective donors and then, with the patient’s permission, connect them with the foundation instead of soliciting donations directly.⁸

Hospital foundations must clearly articulate the expected role of physicians in grateful patient philanthropy and let them know how the foundation can support their efforts to cultivate donations. Foundations also must engage in open communication with physicians so they know about their patients’ efforts and do not feel alienated from the gift-giving process.

The need for foundations to abide by privacy laws—such as the Health Insurance Portability and Accountability Act (HIPAA) in the United States and privacy legislation enacted by provinces and territories in Canada—contributes to this challenge. Such laws can prevent hospital foundations from notifying

physicians about patients' financial contributions unless the patient gives consent. Hospital foundations and physicians must work together to establish a feasible action plan that allows physicians to learn of their patients' philanthropy in a way that

professional yields more qualified referrals from physicians than do email reminders or lecture presentations.³ Another effective way to nurture physicians' role in philanthropy is by developing physician committees that work

physicians and lead them toward future engagement in hospital-wide philanthropy programs. 

.....

The likelihood that individual physicians will become more involved in the fundraising process increases **if they first become involved in a hospital-supported, division-specific campaign within their department.**

complies with privacy legislation and preserves the integrity of the doctor-patient relationship.

Promoting physician philanthropy

Our findings support the idea that educating physicians is a powerful way to encourage their participation in grateful patient giving.^{3,8,9} To create a culture of philanthropy, physicians must grasp the importance of philanthropy to their organization and know what their role is expected to be.^{8,9} Physicians also must receive regular communication from the foundation reminding them to be involved and emphasizing how their involvement promotes hospital priorities.

To date, no established guideline spells out the best methods for educating physicians about grateful patient philanthropy. However, a recent study by Rum et al. indicates that one-on-one coaching from a development

collaboratively with foundation development professionals.⁹

Hospital foundations must recognize that individual physicians' fundraising priorities are sometimes misaligned with those of the hospital—and this misalignment can cause physicians considerable tension. Even when physicians acknowledge that the greater hospital priorities are important, some do not feel motivated to support fundraising programs that they perceive to be of little benefit to them or their clinical interests.

A good way to overcome this problem, our findings suggest, is for hospital foundations to encourage physician engagement in division-specific fundraising campaigns. The likelihood that individual physicians will become more involved in the fundraising process increases if they first become involved in a hospital-supported, division-specific campaign within their department. Such campaigns can create buy-in among reluctant

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Building a career in health care philanthropy

Seven industry experts provide
insights and advice



It's an exciting time to be in the field of health care philanthropy. While regulatory changes under the Affordable Care Act and organizational shifts under hospital consolidations present new challenges, they also present new opportunities for philanthropy departments—especially for young, emerging leaders who bring fresh eyes, a new perspective and a strong sense of mission to help health care institutions meet their philanthropic goals.


Continued on page 20.

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Continued from page 17.

But what trends can emerging leaders expect in the future? And what skills will be most valuable to a leader in the new health care landscape? To learn more, we asked some of the industry's top thought leaders what career advice they would give to today's young professionals. As expected, their answers were both insightful and inspiring.

Emerging trends and challenges in health care philanthropy

When asked what trends are on the horizon for emerging leaders in health care philanthropy, one thing became clear: The field is experiencing great change—change in the health care

As health systems expand and become more complex, **younger leaders will be expected to step up and take the reins in managing their work,** their teams and their own personal growth.

environment, in the donor base and in philanthropy departments across the country.

Hospital consolidations

Over the past several years, hospitals and health systems have been consolidating at a feverish

pace. According to a January report from Moody's Investors Service,¹ the health care industry will continue this unprecedented trend into 2015.

Many predict this growth will spill over to philanthropy departments. "As health systems

continue to grow, so will philanthropy,” says James Quinn, CFRE, chief development officer at Foundation for Morristown Medical Center in Morristown, N.J. “It also will lead to greater job growth and opportunities for upward mobility.”

But with consolidation comes complexity and a need to solidify philanthropy’s role in new, larger systems. “During a consolidation, it’s important to ask the question, ‘Where is philanthropy?’” says Douglas T. Picha, president of Seattle Children’s Hospital Foundation in Seattle, Wash. “It’s paramount for larger health systems to establish a culture of philanthropy so that everyone in the organization understands the crucial role it plays in their future.”

Hospital consolidations also may change the functions in the health care development field, according to Quinn. He predicts that as foundations grow, there will be a greater demand for more specialized (rather than generalist) positions—including database and prospect research management, communications and donor relations positions, and financial and accounting management along with major and planned giving officers. He also envisions the job of a health care fundraiser will change, requiring more travel, more remote working situations and greater accountability as health systems increasingly begin to rely on philanthropic support.

The ever-changing donor

According to the *Chronicle of Philanthropy*,² many philanthropy departments are experiencing a recession in giving. Research shows the wealthiest Americans—those making

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Younger staff can **bring a fresh perspective and new ideas to the table**, while current leaders can help lead by example and provide experience and insight.

more than \$200,000 annually—reduced the share of income they gave to charity by 4.6 percent from 2006 to 2012. Meanwhile, those making less than \$100,000 annually gave 4.5 percent more of their income in the same period.

“We are in a tug of war of taxation versus philanthropy,” says Stephen C. Falk, president of Northwestern Memorial Foundation in Chicago, Ill. “Many donors in higher-income brackets report their taxes are higher today compared to years past, and they do not have as much discretionary funding—a trend that will continue to be a hurdle for philanthropy departments.”

Stewardship vs. technology

In order to compete in a new donor landscape, maintaining and fostering strong relationships with donors will be more important than ever.

Many philanthropy departments are turning to technology as an innovative way to reach new donors—such as the Ice Bucket Challenge, the Internet sensation of 2014 that raised more than \$115 million for the ALS Association.

Meanwhile, others view technology as a piece of the larger puzzle. “Technology isn’t a silver bullet,” says Falk. “People are substituting technology for relationship building, but when all is said and done,

success in this field comes down to connecting with donors and building those personal relationships.”

Becoming a leader in health care philanthropy

In reviewing the challenges ahead, it is clear that being a leader in today’s landscape is challenging. It requires an ability to understand institutional needs, meet revenue goals, connect with donors and mentor staff members. So what skills do emerging leaders need to be successful in the field of philanthropy? What actions should they take to become a future leader?

Stay current

Whether reading up on the latest current events, learning about the newest tools and technology or even attending networking events, today’s philanthropy leaders understand how important it is to stay up to speed.

Ingrid Perry, president and chief executive officer of Mackenzie Health Foundation in Richmond Hill, Ontario, understands how important it is to be able to speak to a variety of topics, especially with donors. “In philanthropy, it’s important to be a generalist. You have to be able to talk a little bit about everything,” she says. In order to stay current, Perry encourages

her staff to read the newspaper or subscribe to daily newsfeeds to help keep up on current events.

Mark Kostegan, FAHP, chief development officer and senior vice president for development at Mount Sinai Health System in New York, N.Y., encourages staff members to constantly build their institutional knowledge base and work across departments. “Do it all, from public relations, to major gifts and to planned

giving,” says Kostegan. He also encourages staff members to stay up to date by attending conferences, networking and taking continuing education courses in areas where they may need improvement, such as reading a balance sheet or writing donor communications.

Others, like Carla O’Malley, executive director and president at Oakwood Healthcare Foundation in Dearborn, Mich.,

and vice president of operations and specialty programs at Beaumont Health in Troy, Mich., seek employees who have a curiosity for learning. O’Malley often encourages employees to keep learning to stay cutting edge, so they can apply those new skills and use them within the organization.

Seek mentors

Today’s philanthropy leaders

If you could go back and offer your younger self any advice, what would it be?



“Stand by your values. Philanthropy is a wonderful profession, but you have to always stand by your values regardless of outside pressures.”

—**Stephen C. Falk, president, Northwestern Memorial Foundation, Chicago, Ill.**

“Don’t sweat the small stuff. Always be optimistic and look to the big picture. No one will remember today’s crisis. Reflecting back, you will often think, ‘Why was I so worried about that?’”

—**Ingrid Perry, president and chief executive officer, Mackenzie Health Foundation, Richmond Hill, Ontario**

“Put in the hours. Development work is not just 9 to 5. To stand out in this field, you not only have to do your homework, you have to put in the time.”

—**James F. Quinn, CFRE, chief development officer, Foundation for Morristown Medical Center, Morristown, N.J.**

“Build a knowledge base and be true to it. Learn as much as you can. Work across the entire philanthropy department. Learn new skills that enhance your career. Identify mentors and communicate with them regularly. If you’re learning and doing the right things, be confident you’re on the right track.”

—**Mark Kostegan, FAHP, chief development officer, senior vice president for development, Mount Sinai Health System, New York, N.Y.**

“Build a path and make a commitment to it. Look to other leaders in the field and see what guidance they can provide. Then make a commitment to credentialing. This will help you build and demonstrate a body of knowledge.”

—**Pearl F. Veenema, FAHP, CFRE, president and chief executive officer, Hamilton Health Sciences Foundation, Hamilton, Ontario**

“Ask more questions and listen to the answers. If you ask more questions and you listen more, it will serve you well.”

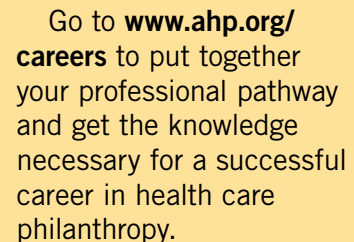
—**Douglas T. Picha, president, Seattle Children’s Hospital Foundation, Seattle, Wash.**

“Be a risk taker. I didn’t start out in development. I began my career in nursing, then hospital administration, and then I moved to philanthropy. My advice to young people is to stay open, be proactive and be a risk taker.”

—**Carla O’Malley, executive director and president, Oakwood Healthcare Foundation, Dearborn, Mich., and vice president, operations and specialty programs, Beaumont Health, Troy, Mich.**

For example, when hiring new candidates, Falk looks beyond resumes and credentials to seek candidates who have displayed strong character and

In addition to managing up, Veenema recommends that young professionals manage their own personal and professional growth. She suggests that emerging leaders be proactive and start a personal development plan to help map their goals both personally and professionally.



O'Malley also encourages her staff to create a personal development plan, no matter where employees are in their career. In her opinion, a personal development plan isn't just a road map to the next promotion, but a way for staff members to expand their thinking, identify goals and create action plans for success. "Great leaders understand themselves and develop

themselves first,” says O’Malley. “Only then can they help develop others and manage talent.”

Show results

In today’s philanthropy environment, nothing stands out more than results. Although many leaders agree resumes are important and continuing education shows a commitment to the field, what they are truly seeking from new candidates and current employees are solid results in the field.


When hiring new candidates, Picha says, “At the end of the day, I hire on the basis of portfolio and how effective someone was in past jobs.” At Seattle Children’s Hospital, he ensures his staff uses targeted metrics to show results. These metrics are vetted internally and externally and adhered to by team members throughout the year. “Pick six numbers and stick to those numbers,” Picha says. “Year in and year out, don’t lose sight of them.”

The future is bright

Without a doubt, the future of health care philanthropy is bright. Many philanthropy departments are expanding, leading to new opportunities for job growth and upward mobility.

And as many leaders note, it also offers a fun and rewarding career. When Picha reflects on his career, he often asks himself if it checks three boxes: Is it challenging? Is it rewarding? And is it fun? For him, philanthropy meets all three of those criteria.

Kostegan appreciates most the people he has met, the relationships he has made and the mission he works toward every day. “This is a great and

rewarding profession, and it’s rewarding because of the things that last longer than a paycheck—the relationships.” 

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For more insights into individual, corporate, and foundation giving; trends in planned giving and bequests; and more; download the *Snapshot of Today’s Philanthropic Landscape* at http://go.ccsfundraising.com/share_2014_landscape_full_report. To learn more about CCS, contact us at 800-223-6733 or info@ccsfundraising.com.





Philanthropy lessons from pie baking

A recipe for a major gift

Recently I offered to teach a close friend, new to baking, how to make pie crust. My friend wondered aloud how the mound of dry crumbs I was beginning with could come together successfully to make dough—in fact, she asked if we should throw it all out and start over! She was surprised to see that when I sprinkled the unsightly mixture with ice water and worked it in carefully, the crumbs eventually turned into a dough that rolled out smoothly and baked into a delicious pie.

I thought about what had happened in the kitchen as if I had been with a donor. Hadn't there been gifts that appeared to have fallen apart? And wasn't it with a steady hand, low pressure and a positive attitude that I had managed to salvage a relationship I might have abandoned and cultivate it into a meaningful giving experience?

These challenging experiences remind me that there is an art to philanthropy. People who gravitate to our profession often seem to innately possess qualities that are essential in working with donors—including intuition, enthusiasm, authenticity, a genuine interest in human beings, creative problem-solving skills, the ability to listen to the words that are said and the feelings that drive those words, passion for a cause and the willingness to be vulnerable within appropriate boundaries.

But just as a mound of crumbs alone is not enough to make a pie crust, in addition to these interpersonal skills we need knowledge of helpful practices and strategies for donor cultivation. And we must also have a road map—a business plan that is our recipe for the step-by-step cultivation of a gift.

How do we blend the magic and the methodology to create a “sweet dessert” of successful philanthropy? Mission Hospital in Mission Viejo, Calif., an institution with a long history of successful fundraising, elected to try a new major gift approach that melded the art of philanthropy with strong business principles. Under the leadership of then-Foundation Senior Vice President Winnie Johnson, and with the help of Jennie Dillon, a fundraising coach, this new approach resulted in a 122 percent increase in gifts



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Talking too much is probably the fundraiser's most common error; if we are truly donor centered, we should strive to listen at least 80 percent of the time.

of \$50,000 and higher from fiscal year 2012-2013.

Three ingredients for success

Dillon challenged the major gifts team to move from a hospital-centric approach to one focused on the spiritual, psychological and business needs of the donor.

Proven sales principles borrowed from the business world overlaid this donor-centered program.

“Jennie Dillon provided a unique opportunity for us to learn from her combined expertise as a hospital executive, a regional sales manager for a major U.S. corporation and a volunteer doing humanitarian work in

an underdeveloped country. I envisioned our major gift group would sharpen its skills and the foundation would implement structural and strategic changes that would focus everyone on measurable goals,” observed Johnson, who recently retired from Mission Hospital.

Mission’s new approach introduced numerous new principles and behaviors; this article will focus on three of them.

The first ingredient: Uncovering the need behind the need

First, the team embraced these two concepts: “It is all about donor need” and “Donors live in their story, not yours or the hospital’s.” By asking probing, open-ended questions and engaging the donor to understand his or her familial, social, business, financial, spiritual and emotional needs, the major gift fundraiser acts as a resource, consultant or catalyst to help the donor identify and manifest his or her deepest desires.

Experts in the field of philanthropy Penelope Burk and Jerold Panas make repeated reference to meeting donor need. Fundraisers usually are adept at identifying the donor’s stated or surface need; helping the donor uncover the “why” behind a stated need is the greater challenge and opportunity.

For example, donors usually are quite open about their interest in honoring a loved one, ministering to the underserved, securing a safety net for their own health care or practicing gratitude as grateful patients. But what is the emotion or story behind this stated need? The need behind the need is based on feelings, not facts; it correlates to donor essence, answers the donor’s

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Touching the donor’s heart and tapping into what is most essential to him or her encourages a lifetime of giving and support.

larger life goal and drives the donor to give again and again.

To learn about the need behind the need, we must be excellent listeners. Talking too much is probably the fundraiser’s most common error; if we are truly donor centered, we should strive to listen at least 80 percent of the time. Panas, in his book *ASKING: A 59-Minute Guide to Everything Board Members, Volunteers, and Staff Must Know to Secure the Gift*, says that fundraisers should talk about solutions only 11 percent of the time, at the end of the conversation. The fundraiser’s main goal is to know the donor, not tout the latest piece of hospital equipment or elaborate on the multitude of hospital or community needs.

The second ingredient: Generating solutions on two levels

The second ingredient is “donor need + solution = the gift.” We tend to think of solutions in limited ways; examples might include recognition opportunities, participation in events, planned giving vehicles, a particular type of gift or a major gift pledged over time. But just as needs operate on two levels, so do solutions. There is a solution to the stated need, as well as a solution to the need behind the need.

For instance, a donor with the stated need of giving to the underserved may respond well to a solution that allows his or her gift to fund a community benefit program. A skilled fundraiser guides the conversation to propose this solution, but must “dance” around the solution to the deeper need—which may involve potentially powerful donor emotions. Perhaps the donor was very poor and insecure as a child, with a mother frequently absent from working multiple jobs; part of the donor’s motivation may be making his or her mother proud of the accomplishments she had encouraged.

To acknowledge this need, the fundraiser might use the following statement: “*Your mom was an amazing woman who would be proud of what you have done with your life helping the less fortunate. Am I right about this? When she realizes you have named this program in her honor, she will be so proud of you and what you are doing to help our local children today and into the future. It is a testament of her strength, perseverance and strong values—and honors you for the love and gratitude you are showing her.*”

Touching the donor’s heart and tapping into what is most essential to him or her encourages a lifetime of giving and support.

An obstacle to discovering this



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An obstacle to discovering deeper solutions may involve our own experiences and assumptions. We have a tendency to fall back on what we know or what is true for us, but we must remember that our donors are different from us and from each other.

deeper solution may involve our own experiences and assumptions. We have a tendency to fall back on what we know or what is true for us, but we must remember that our donors are different from us and from each other. Not all donors are motivated out of gratitude, were prior patients or want excellent health care for themselves or a loved one. Some motives may seem very non-altruistic—and it is not our role to judge, but to understand and work with donors on those business, financial or other personal goals that may seem to have nothing to do with heart-driven philanthropy.

For example, a donor who has started a string of successful businesses may state a need to have a quality hospital nearby for the family's personal use. However, after asking probing questions and deep listening, the fundraiser learns the donor has an unfulfilled need to participate in an enterprise whose vision is to change the delivery of health care for the community. The hospital becomes a springboard to improve the donor's standing in the region and help position him as a political force for the future. Although not altruistic, this vision benefits the donor as well as the hospital.

Remember, donors live in their

own story—not the fundraiser's or the hospital's. Focusing on the donor need and then tying that need to a gift-giving solution is what delivers a clear "gift" back to the donor.

The third ingredient: Incremental asking

"Asking is the unnecessary art" is the concept that underlies our third ingredient. In philanthropy, the best chance for success occurs when the donor and fundraiser are in total agreement on the donor's participation; when a donor who is completely engaged asks how he or she can best support the hospital; or when the right time to ask for a gift flows naturally into the conversation. The appropriately timed and executed gift request is liberating, energizing and self-empowering to all parties.

But what about those scenarios where the donor resists making a commitment? How do we recognize the donor who will never give, so we know to release ourselves from the relationship early in the process? *The answer is that asking for the gift, or the close, must occur incrementally throughout the gift-giving process.* This means the outcome of each visit needs to be a donor commitment to move the gift process forward mutually and incrementally.

For example, the fundraiser might say, "From this conversation, I gather that you are interested in pursuing the idea of contributing to our new center. May we agree to meet again in six weeks and include your wife and financial advisor in that meeting?" Some commitments will be high action with a steep donor commitment, and some may be small and modest. What is important is that progress

is consistent and the level of commitment increases over time.

Up to this point we have focused on the art of philanthropy, which involves understanding our donors, exploring their needs and crafting solutions to those needs. We will now turn to the “science” side of philanthropy, where we use a business plan to manage and execute the gift-giving process.

The business plan

Sometimes we resist thinking of philanthropy as a business, yet we generate significant income for our hospitals. To ensure sustainable gift giving, we must strategize and measure progress using a business plan.

Traditionally, business plans were developed to secure capital. For our purposes, the business plan serves as the operating tool to secure donor gifts, manage the donor portfolio and communicate the status of a relationship to others within the organization. An objective review of the business plan shows areas of weakness and strength in the donor relationship and areas where resources may be needed; it also identifies problems before they emerge. As an operating tool, the plan helps us strategize and develop tactics to accomplish business goals.

There are two parts to the business plan: metrics and strategy. Metrics is the objective data generated by a database (such as Raiser’s Edge) folded into a working document; strategy is the plan for closing each potential donor within the current fiscal year. Metrics includes donor name, financial goal, two- to three-year gift history, inclination, capacity, target ask date, amount, date closed and final amount. Metrics also can be divided into A, B

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and C donors based on target ask date, pipeline (one to two years out) and annual/event donors. The business plan strategy includes the tactics, current status and next steps for all donors with target ask dates for a rolling 18 months.

A business plan needs to be a living and breathing document that fundraisers review daily and alter as new data becomes available. All activities and meetings of a solicitation should align with the strategies and tactics in the business plan—and if that is not happening, we need to ask why. Does the plan need massaging to reflect changing circumstances? Have we veered from a well-constructed strategy? Must we now rededicate to it?

Planning is the key to success

Sometimes we rely too heavily on our relationships with donors without utilizing a clear, well-thought-out business objective. Panas believes that preparation through pre-planning is key to a successful donor interaction. We need to regard creating a business strategy as a core management function.

For purposes of the business plan, the term “strategy” will be used as the master general plan,



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long-term goal or objective for each donor. It always includes a projected dollar amount of the gift and the projected date to close. A “tactic” is a step in how the strategy will be achieved and it should be business related. For example, “Invite donor to an event” is not a philanthropic business tactic. A more appropriate tactic would be “Gain ABC donor as a champion by deepening his commitment through hospital activities.”

Consistent planning and execution are key indicators for success in fundraising. A daily business plan review to ensure that the day’s, week’s and month’s activities are focused on achieving the strategies for each donor is vital; marshalling all appropriate resources and communicating needs to management will ensure continued success.

Conclusion

We have talked about both the art and the science of philanthropy and how the successful fundraiser has learned to dance between both. But we must remember that although we can benefit greatly from integrating business practices into fundraising, our primary business always is going to be the business of people. It is our wonderful, generous donors who make it possible for us to generate the data we use and allow us to learn from it.

To return to our baking analogy: To feel appreciated, there’s nothing like a pie made especially for you with special attention and care. As fundraisers, we continue to nurture relationships with love—giving of ourselves to touch another’s heart, while also borrowing tools from the business world to produce the sweet dessert we call philanthropy. 



Anne Firestone graduated from University of California, Berkeley, with a bachelor’s degree in English. She founded a large community lecture series before becoming associate director, western region, for Ben Gurion University of the Negev for eight years. She was executive director of the Orange County Jewish Community Foundation for

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Today she builds and motivates nonprofit teams to over-achieve financial goals by applying business principles to the art of philanthropy.

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Foundation 2.0

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Our health care world is changing rapidly and dramatically, and one major driver is the increasing emphasis on population health management. Forward-thinking institutions are becoming more proactive about identifying ways to contribute to the well-being of the communities they serve. Additionally, evolving reimbursement policies are focusing more on wellness—we are in the early stages of being rewarded for keeping people healthy.

At HealthEast Care System in St. Paul, Minn., we are changing our models and methods to thrive in this dynamic new world. Our chief executive officer, Kathryn Correia, led us to adopt a bold new vision, “Optimal health and well-being for our patients, our communities and ourselves.” To us, this vision signals not only a significant shift in health care delivery, but also a shift from health care philanthropy that is transactional (focused on internal operations and services) to health care philanthropy that is transformational. Our long-range goal is to help create a healthy and vibrant St. Paul East Metro community.

Naturally, our foundation is an integral contributor to this vision. But as HealthEast evolves into an engaged and focused community partner, what does philanthropy look like? How can our foundation help mobilize support for our institutional vision and be a lever for real improvements?

Under the visionary leadership of Correia and with the invaluable assistance of 30-year veteran health care philanthropy consultant Gary Hubbell, we are developing a new approach we call “Foundation 2.0.” Foundation 2.0 encompasses both long-range thinking and innovative practices that are helping us become a catalyst for significant, lasting community change. As you read about our transformation, keep in mind that HealthEast Foundation is classified as a publicly supported organization; it is not a supporting organization. Check your organization’s tax status to determine parameters for grant making.

The evolution of an idea

When she joined our organization as chief executive officer in 2012, Correia began to ask big-picture questions that challenged our assumptions about the roles and responsibilities of health care enterprises in the communities they serve. She said, “I’m not sure where the early adopters will arise within the system, but I’m looking to run with any and every one who emerges.” Foundation leadership was among the first to ask, How can our area, philanthropy, be a motivator and driver for institutional and community change?

HealthEast serves more than one million people in an area comprising three counties that vary greatly in wealth and resources. We quickly realized that, although needs are diverse and moving toward “optimal health and well-being” may begin in a different place in Ramsey County than it does in Washington County, HealthEast is a *community-wide* asset that will best serve our entire area when we see ourselves *as a partner*. As our vision became more detailed, it was clear that creating new and significant social/community change initiatives was going to be much bigger than our past outreach programs, clinic operations and community health needs assessments.

Up to this point, our foundation was a standard development operation with a focus on events, major gifts and episodic capital campaigns. Buildings were built and programs benefiting HealthEast were funded in what we deemed a successful manner. But with our new vision in place, foundation leadership sensed a

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seismic shift in our worldview and the ways we could leverage our assets. The foundation already possessed an external perspective, a relationship orientation and a long-range/big-picture view. However, to emerge as an effective health system partner and a credible leader, we would have to adapt our

was big-picture optimal health and well-being, the fundamental question that would shape all our early efforts became, “How do we ‘disturb’ an entire community (within our health system and in the larger arena) toward the goal of thinking and acting differently?”

We realized that to understand

reported health and well-being, uncompensated health care, philanthropic investment in the community, intentional collaboration, post-secondary degrees, supportive services society provides to vulnerable people and child poverty.

- Using a **vision deployment matrix** to help the organization understand the current reality, the desired future reality, the gaps between the two and the actions that should be taken to close the gap.
- Articulating a clear and compelling **theory of change** for the health system/foundation vision—what HealthEast believes the current situation of well-being is generally in the East Metro area, and the gaps that exist. We discussed the preferred ways to address key gaps and accelerate health and well-being for more people, especially those in the greatest need.
- Using a **scenario thinking process** with system and community leaders to reimagine the future, resulting in four viable scenarios of the East Metro’s state of health and wellness in the year 2030. With the help of many assembled community leaders, we also identified potential signals of change in the coming years.
- Charting the imagined **behavior over time of key indicators per each of the four hypothetical future scenarios** mentioned above. We extended our key indicators into the future by 20 years (to the best of our collective imaginations) to see how these indicators might react in each of the four possible futures.
- Inventorying and mapping the existing East Metro **well-being community assets and relationships using social network analysis**. Through

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If we truly see ourselves as a community asset, we need to explore being a partner with the community, instead of trying to do things to the community or asking people to focus only on our hospitals’ needs. **We need to view philanthropy as a catalyst for lasting change**, as opposed to simply an ATM for hospital capital projects and programs.

models and methods. Early on, Correia stated, “The foundation’s uniqueness lies in the fact that its work is at the nexus of community health needs and health system resources.”

Changing our mental models

The Gary Hubbell Consulting team began its engagement with us in early 2013 and, after an intense two-day round of probing questions, we became aware of some of the cultural issues and challenges that we would have to navigate. People at every level in our organization were locked into outdated mental models of how a hospital and its foundation worked. The Hubbell team helped us realize that if our declared intent

how we might focus the human and financial resources of HealthEast in the most impactful ways, we had to learn from the past and plan for the future. Under Hubbell’s guidance we engaged a broad group of leaders from the community (in sectors such as business, social services, education, philanthropy, government and religious groups), plus our boards and foundation and HealthEast System staff, and took them through a series of exercises over a six-month period. These exercises included:

- **Charting the behavior over time** (last 30 years) of key indicators of community well-being and philanthropy, including community livability, health infrastructure, individually

this process we developed a community asset database and map that visually depicts the successful community strengthening organizations and initiatives. We also identified the strongest community networks and relationships, as well as areas that HealthEast and our foundation can leverage to achieve its vision-driven initiatives.

- Developing a three-year **foundation strategic plan** that includes new metrics and structure for staff along with a re-engaged board of directors currently developing new roles, structure and goals.

The information we gained from these exercises gave us a more detailed analysis of our task and a more focused game plan.

Reframing the work of the foundation

In our health system, organization-wide collaboration and collective action with the community has not really been a cultural competency, although it does exist within specific outreach projects. Viewing the foundation's and HealthEast's roles through a wider lens has allowed us to consider various ways we can be effective in addressing challenging social issues and help improve conditions. At times HealthEast may serve as a leader, a convener or a funder. Or we may simply be at the table, providing input and expertise.

In the past, our foundation's grant making was 100 percent internally focused. A goal in our new strategic plan is to invest 50 percent of our funding into partnership initiatives between HealthEast and organizations in the community. We may also have the opportunity to collaborate with these organizations to

Reframing philanthropy at HealthEast: **Foundation 2.0**

Using our new approach, our foundation:

- **Leads** and partners with the Neighborhood Integration team to help build neighborhood relationships that enhance optimal health and well-being, act as catalysts and activate community solutions.
- **Advances** activities that build neighborhood connections and HealthEast connections.
- **Supports** HealthEast Neighborhood Integration through the Community Innovation Fund.
- **Broadens** potential range of interests to donors.

help generate other innovative funding, as some of them already are tackling issues at a grassroots level and have connections and organizational structures in place. It is clear that much of our future work will be done in the community, which is where we see ourselves having the greatest impact on the future.

"We want to partner with others to be part of a lasting solution," says Correia. "Simultaneously we earn our right to provide clear leadership where we have the specific grounding and expertise to credibly lead others."

Neighborhood integration becomes a strategic priority

Our next steps included developing the purpose, objectives and guiding principles for a strategy that would help us become more integrated into the community. We established a cross-functional Neighborhood Integration team that includes representatives from various divisions of our health system (physicians, operations, clinical, foundation, community outreach, etc.).

This team helped define Neighborhood Integration as a

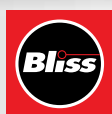
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strategic priority, with its purpose “to harness HealthEast enterprise and community assets into a focused approach to optimize the health and well-being of our communities.”

Conversations in the community

Members of the foundation and the Neighborhood Integration team, as well as health system leadership, have been conducting conversations in the East Metro community over the last year. So far we have discussed a wide range of issues and concerns with nearly 100 community members, and we have targeted over 600 more to approach. We see learning about community needs from within as an ongoing, never-ending process.

We are tracking the themes and topics of these conversations and categorizing them using criteria such as the populations they are concerned with and challenges they face. Using this data we will evaluate community needs and discuss opportunities, always making sure we are aligning with our stated vision and its objectives.

Talking to donors

Although we are in the very preliminary stages of sharing our new goals, we are challenged to be visionary with prospective donors in ways that we haven’t been before. The foundation will be taking the lead as some donor relationships evolve into community-focused relationships.

As we mentioned previously, foundation staff already has a relationship orientation, which will certainly continue as we share more about our vision and get input about how it may be relatable and have personal value to donors. So

far, some of our donors have been very receptive and have offered to help us tap into relationships in the community, serve as members of an advisory committee, etc.

Deploying pilot programs

Our foundation board has established the Community Innovation Fund, which will accelerate our efforts and impact. Our initial pilot partnerships and experiments are currently being developed, and we are excited and encouraged to see our vision becoming a concrete reality as we progress through 2015.

Foundation 2.0 emerges as a catalyst

Further embedding our health care enterprise into the community is slowly changing our internal and external dialogues. Having navigated years of professional angst about fostering a “culture of philanthropy” that never seemed to fully take root, we are now joining with health system leaders to develop authentic relationships with community change agents. We have moved from thinking about the foundation’s work as complementary to the system to now being truly integrated with it.


We still need reminders and coaching to feel comfortable in this new role. Because we have primarily seen ourselves as “fixers,” we often are tempted to focus on quick solutions instead of listening and learning; early on, we sometimes caught ourselves thinking, “Why are we talking with all of these people about crime and poverty and bike paths and food access? How does this fit with our work?”

But if we truly see ourselves as a community asset, we need to explore being a partner *with* the

community, instead of trying to do things *to* the community or asking people to focus only on our hospitals’ needs. And we need to view philanthropy as a catalyst for lasting change, as opposed to simply an ATM for hospital capital projects and programs.

“The foundation is now front and center, partnering with operational and strategy leaders in the creation of interwoven plans to change our system, in order to live into our vision. Philanthropy is becoming integrated into the whole system,” says Correia.

We will continue to use the power of philanthropy in targeted, intentional collaboration that leads to a broad, shared vision to catalyze well-being in the East Metro area in the next 10 to 15 years. We are seeing the future through the eyes of those whom we serve. In retrospect, the most challenging part of this endeavor was to transcend our traditional ways of thinking, and begin.

So, we’ve begun. 



John Swanholm has served HealthEast since 2003, the last five years as system vice president and executive director of HealthEast Foundation.



Kathryn Correia became HealthEast’s president/ chief executive officer in January 2012 and is actively engaged in whole systems community change.



Gary Hubbell is president of Gary Hubbell Consulting, working to strengthen adaptive organizations for inevitable change and greater impact.

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