Using Data to Find the Best Patient Prospects, and What HIPAA Has to Say

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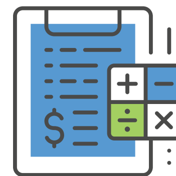
TABLE OF **CONTENTS**

WHAT'S THE BIG DEAL WITH DATA—DRIVEN FUNDRAISING?	4
WHAT'S THE MOST COMMON DATA HANG—UP?	5
SO WHAT ABOUT THE DATA?	7
USING DATA TO TRANSFORM HOW YOU FUNDRAISE	9
PRACTICAL EXAMPLES	12
A FEW WORDS ON HIPAA	13
CONCLUDING COMMENTS	15

Data-driven strategies continue to push our industry forward by ensuring we are speaking with the right donors at the right time. In the world of healthcare fundraising, understanding capacity, interest and connection to the cause is critical to develop communications strategies that will tap into your donors' hearts and minds. We sat down with some of our best experts in the world of fundraising intelligence for healthcare and outlined the important steps to take to empower your teams with the best in data intelligence and patient prospecting.

WHAT'S THE BIG DEAL WITH **DATA–DRIVEN FUNDRAISING?**



During the course of any given year, many patients come to our nation's health-care providers arriving with very different lifestyles and life experiences and engaging in a wide array of treatments—all resulting in quite different patient experiences. From a fundraising perspective, job #1 is figuring out which patients out of that large group could be interested in contributing to your cause… be it research in a given area, general health care for a community, or perhaps even raising up the under-resourced in one of our inner cities.

There are three critical pieces of information to figure out which patients to approach and what message to convey. Getting this right is essential to building an effective fundraising program. The three pieces of key information are each person's: (1) **capacity** (how much money they have), (2) **connection to your institution** (what was their experience with your provider side and have they subsequently engaged with your fundraising team—by maybe clicking on your newsletter or coming to an event), and (3) potential **philanthropic interest(s)** (what they care about).

Most health-care fundraisers have more than enough data to put this information together. But they don't do it. They often say it's too hard. Or too expensive. Or just not a priority. But when they do pull the data together, the results can be substantial. From our work in this area, we have seen impressive returns when this information is available:

+ Much higher yield rates on solicitations
+ Higher major giving ask amounts
+ Different "beat coverage": (because the areas that people intuitively think may be the best to focus on may actually not be the best)
+ Much higher acquisition rates on appeals
+ Much lower cost (vs. a screen-everybody-first approach)
+ More money raised at less cost

These results are substantial and something that we believe every health-care fundraiser should be working toward.

WHAT'S THE MOST COMMON **DATA HANG–UP?**

Historically, complex and "heavy" IT platforms were required for fundraisers to access and blend needed data from a combination of fundraising, patient, and financial systems. These heavyweight platforms took a lot of time and investment to get working. Then, when completed, they required IT programming skills to create the necessary metrics and scores and to support end-user needs to actually drill in and slice and dice the data to cut the lists that are needed for action.

We call this the "cycle of pain." And it refers to both (1) how to blend, synthesize, and run predictive models against the data to get the information into a form that is useful, and (2) how to actually slice and dice the data to get down to the desired output. With traditional data warehouse and reporting tools, trying to get lists out of the systems typically involves submitting a request to IT and then waiting a week or two to get the results . . . which may produce a list that was not quite what was expected, so another request is submitted . . . with another week or two wait . . . and so on and so on. Or sometimes, teams figure out how to download the data into Excel and then slice and dice it there. But rarely can you download everything that you want or need, so you get only a partial answer. And since it was hard to get the data into Excel, the spreadsheet is saved and a week or two later, the end user has old and outdated data.

Neither of these approaches is supportive of or empowering to the fundraising team that needs to be able to wade in to the data, validate or refute hypotheses, and easily cut lists for action. Traditional data warehouses and reporting and/or dashboard tools are designed for pushing out structured content, not for empowering teams to explore content, discover stories, and quickly cut lists.

The good news is that modern data discovery and analysis tools have changed the game by killing the "cycle of pain" and empowering end users. These new tools can easily access and blend data from multiple systems, and they can be up and running in 8 to 12 weeks at much lower total cost. They provide a totally different and much more flexible and empowering approach than the traditional heavyweight tools. Both the Gartner Group and Forrester have reports detailing the advantages of using data discovery and analysis tools for situations like this.

And more good news is that while in the past HIPAA disallowed the use of patient encounters data in fundraising, in January of 2013 this was all changed by ruling §164.514(f)(1). Today many health-care fundraisers use their patient encounters data on a daily basis to find and approach the best patient prospects. Leveraging patient encounter data is key finding the best patient prospects. (More on HIPAA to come.)

SO WHAT ABOUT THE DATA?

Most health-care fundraisers actually have or can get access to the data that they need to become fundraising leaders. The historic challenge has been how to blend, synthesize, and model it . . . and then push it out to the teams so they can easily work with it on a day-to-day basis. So let's take a look at what it takes by focusing on the three core dimensions: capacity, connection, and interests.

Starting with capacity, what often happens is fundraisers send a daily or weekly patient file out for wealth screening to a third party. Then the patient list comes back with a variety of stats on how much wealth or capacity each person has. This is not a bad thing to do, but can be somewhat costly and by itself only tells part of the story. (We will argue in a minute that there are more cost-effective ways to get at this information than simply screening everybody. So sit tight!)

The patient connection dimension is hugely helpful . . . because different experiences create vastly different degrees of connection to any health-care provider. It matters a lot who the actual doctor was, what facility and area the treatments were in, how intense the interaction was (for example, how many visits in the past year or two), how far the patient came for his/her treatments, how long ago the last visit was, and so on. In the extreme, if somebody comes into the ER one time from a nearby neighborhood with a broken arm, they will have a much lower connection than somebody who flies in from Chicago 6 times to the pediatric oncology area over a 12 month period. The good news is all of this content is stored in provider patient encounters systems, and HIPAA now allows you to use much of the content for your fundraising operations. Even better, the rapidly evolving technology landscape now includes lightweight data discovery tools complete with augmented intelligence (AI) and predictive modeling that make it super easy to score all patients every day on, for example, a 0-100 scale and then group them into half a dozen "patient connection segments." This capability did not exist until recently.

In a similar fashion, these new technologies can mine your events, newsletter clicks, giving data and the like, to again score and group people into "advancement engagement groups" on a daily basis. For example, a person who gave a $100 gift and has clicked on two newsletter articles in the past six months, in addition to attending to your oncology research dinner last year, is clearly much more connected than someone who did not engage at all and also gave a $100 gift.

Overall connection is the combination of both the patient connection and also the advancement connection factors.

Figuring out interest can be a bit more challenging. But it can be inferred out of a combination of things—for example, which area(s) the treatments were in, what other types of philanthropies the person gives to, which types of articles they click on in your newsletter, which types of events they come to, and so on. In a similar fashion, these new AI and predictive modeling technologies can translate the data into interest areas that can then be used in your messaging and approaches. In addition, we've been able to use Acxiom data to better understand where individuals have given in the past in order to identify people predisposed to give to various health-care causes.

USING DATA TO TRANSFORM **HOW YOU FUNDRAISE**

Once you've created a capacity score, a patient connection score, and an advancement engagement score, what do you do with it all? We recommend using these three dimensions to group prospects into a set of segments. Picture a grid where the horizontal axis represents capacity with low on the left, medium in the middle, and high on the right. Then the vertical axis starts at the bottom with low patient and also low advancement scores. The middle row is high patient but low advancement, and the top row is high advancement scores. Seeing the results in this way will help drive focus and also separate what you can cultivate (advancement engagement) from what you can't cultivate (capacity and patient connection).

So the top-right Segment A represents your best major giving prospects: people who have high capacity and also high advancement engagement. And it's even better if they also have high patient connection. This group should be researched and assigned out to the major gifts team in portfolios of 75 to 125 patients. And then they should be managed with a team-oriented, shared best practices approach using performance drivers that include the likes of:

+ **Prospect Assignments:** Are all of our highest capacity and most engaged prospects staffed? Are pools reasonably sized?
+ **Penetration:** Is our pool of assigned prospects being connected within a 12-month period?
+ **Movement:** Are we moving prospects forward at a reasonable pace?
+ **Solicitation Levels:** Are our asks at the right level relative to capacity and attachment?
+ **Yield:** Are we closing solicitations at an aggressive level?

There is quite a bit of research and use-case examples on effective major giving metrics and change management tools at www.AdvizorSolutions.com/resources. Getting an effective and empowering process that focuses on sharing best practices can have a huge impact on both revenue and ROI of your major gifts program.

Segment B prospects are one row down on the right: high capacity and high patient connection, but lower on advancement engagement. This is the prime target group for a leadership annual giving program. And if your advancement engagement scores are well structured, you'll be able to see where each prospect is falling short and what might be done to cultivate them. For some, that might mean getting them to an event focused on their area of interest or maybe on a volunteer committee for a particular cause. For others, it might mean approaching them for a $15,000 gift as a next step in the process. The goal here is to build their connection to your cause, move them through a mid-level giving program, and ultimately transition them to Segment A.

Segment C prospects are on the bottom right with strong capacity, but they haven't had a significant patient experience and also are not engaged with your advancement efforts. This group is like Segment B but less likely to convert.

The other segments are all annual giving targets, with the higher conversion rates likely to come from the upper rows. The bottom-left segments clearly should get less effort—and maybe not even be appealed to depending on budget and resources. In most cases, teams are better off focusing efforts on driving more appeal touches to the more connected segments vs. diffusing the messaging and budget across a larger group of less likely prospects. We have one client that solicited 50% fewer prospects, but they were able to increase their touches and conversion rate and doubled their revenue in over a two-year period.

Another cool thing about creating these segments is that you can actually save money on wealth screens. Want to know how? Well, we have clients that use public domain information—such as wealth by ZIP code—as a rough-cut wealth indicator. Along with their internal data for patient connection and advancement engagement, they can pretty quickly identify Segment A and B prospects. Only those prospects are screened, and that data is then used to refine the segmentation. There's no reason this process can't be automated and done on a daily basis. Then, if/as additional budget money is available, teams can consider screening more of the high patient connection and/or advancement engagement score prospects.

Additionally, these scoring metrics can be used to calculate a Projected Dollar Value for each prospect, which can be used to target your ask amounts. For example, a prospect who has a $5M capacity, has a patient connection score of 40, an advancement attachment score of 60, but has not made a major gift in the past five years might have a Projected Dollar Value of $2.5M. If, then, the gift officer was talking about a $500K ask, then there should be a rich discussion about whether that amount is enough.

Another prospect with the same $5M capacity who has a low patient score of five along with an advancement score of five would likely flag as a $20K ask.

PRACTICAL EXAMPLES

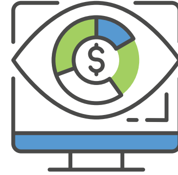
How you present this information to your team is critical. Whatever you do, the output needs to be simple, making it easy to see the stories in the data. There are a number of data discovery tools (our Advizor product line is one) that have simple visual presentations, which also enable ad hoc discovery and easy drill down and slicing and dicing of lists (which can be exported to Excel or another spreadsheet tool for action).

Here's an example. One of your gift officers is working up to an ask and is meeting with the lead provider in your pediatric oncology area. During a discussion, she wants to grab all guarantors of patients for the past two years who have a high patient connection score, and who have also engaged with advancement and also live in wealthy areas around Charlotte, North Carolina. When the list comes back with only 15 guarantors, the provider suggests looking at D. C. instead. That list has 50 names and is exported with all the relevant detail so that an event can be designed for them to focus on the provider team's leading-edge research and its hope for the future. All of this happens in seconds while the gift officer is in dialog with the provider.

Another example might be finding the answer to questions like: "I wonder what the total projected value of our unassigned Segment A prospects is?" "What areas have they had their most significant patient experiences in?" These answers would take a couple of clicks to get some totals and a rough cut of the distribution. You would quickly see that, for example, 60% of the value is in 3 provider areas and 100 prospects make up 70% of the potential dollar value—and the list could be quickly exported out to Excel. With this data, you'd be able to frame up campaign potential and presumably justify additional staff to monetize the potential.

A third example of how this information could add value would be to examine how strong the team's actual solicitations are compared to Projected Dollar Values. In most cases, the data will show a distribution across the team with some gift officers asking at appropriate levels and some under-asking. Typically with under asks, the yield rate (or close rate) will be high, but at the same time, money is left on the table. This is a case where the data can drive some rich discussions around HOW some gift officers are asking at aggressive levels AND getting the gifts closed.

A FEW WORDS ON HIPAA



The good news is that back in January of 2013, the HIPAA privacy rule was changed so that patient encounters (visits) data could be used for fundraising. Prior to that, a hospital could only use limited demographic information about its patients for fundraising purposes. After that change in 2013, information about the type of department a patient was in within the hospital, who their physician was, and when their visits occurred could finally be used for fundraising. This came about because:

MANY HOSPITALS HAD AN INTEREST IN TARGETING FUNDRAISING BASED ON THE NATURE OF THE SERVICES A PATIENT RECEIVED OR WHO THEIR DOCTOR WAS, AND HAVING DOCTORS MAKE PERSONAL APPEALS TO THE PATIENTS, OR TARGETING, SAY, CANCER FUNDRAISING AT PEOPLE WHO HAD BEEN TREATED FOR CANCER. THEY REALLY WERE NOT PERMITTED TO DO THAT UNDER THE PRIOR RULE."

- ADAM GREENE, PARTNER, DAVIS WRIGHT TREMAINE LLP, AND FORMER SENIOR HEALTH IT AND PRIVACY ADVISER IN THE OFFICE FOR CIVIL RIGHTS)

Here's what the new rule actually says:

§164.514(f)(1) A covered entity may use, or disclose to a business associate or to an institutionally related foundation, the following PHI for the purpose of raising funds for its own benefit, without authorization:

+ Demographic information relating to an individual, including name, address, other contact information, age, gender, and date of birth;
+ Dates of health care provided to an individual;
+ Department of service information;
+ Treating physician(s);
+ Outcome information;
+ Health insurance status.

This allows health-care fundraisers to create the factors to feed a patient connection model—and then to also slice and dice the data in an ad hoc manner the way we described in the examples outlined previously. Typical explanatory factors measure things like intensity, area, distance, and the like, and are represented by some of all of the following:

Most Recent Area Visited; which varies A LOT by provider, such as:	+/-
Urology	+
Dermatology	+
ENT Surgery	+
Age	+ from 40 to 70
# Visits Overall	+ up to 25
Most Recent Facility Visited	+/-
Distance from Hospitals	+/log
First Area Visited	+/-
Time between First & Last Visit	+
Most Recent CPT Group	+/-
# Other Patients Related To	+/Cube Root
# Distinct Areas Visited	+
Last 12–24 Mo.	
Last 3 Mo.	
Last Visit Was in Last 6 Mo.	+

Today the use of patient encounters data for fundraising purposes IS allowed in the United States under HIPAA. Unfortunately, a number of providers still seem unaware of this 2013 change and/or are concerned about the implications for their organization. The good news, though, is more and more providers are becoming aware of this change and their fundraising efforts have benefited. And many of them are visible leaders who can and should be role models for others.

CONCLUDING **COMMENTS**

Leading health-care fundraisers are using detailed patient encounters data to inform their fundraising efforts, and it's been transformative. That detailed data provides a rich description of both the intensity and nature of each patient's interactions with the provider. It allows fundraisers to segment out who should be their top targets, how much they should be expected to give, and what their interest areas might be.

The big hold-up to more widespread use of this data appears to be a combination of lack of clarity around what HIPAA allows, misplaced concern about the ramifications of using patient encounters data, and trying to structure and mine this data in older and heavyweight tools not designed for this purpose. Many industry leaders have been and are using that data, and it's making a world of difference.

Let us know if you'd like to learn more.

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