Vibrant Vulnerability: Engaging Non-Fundraising Clinical Executives/Leaders

Synopsis of the new book *Vibrant Vulnerability: Mastering Philanthropy for Today and Tomorrow's Healthcare CEO* —written for CEO's to CEO's

By Randall Hallett

Philanthropy, in healthcare, will only go as far as our chief executive officers (and C-Suite) take it.

While an overly blunt statement, the truth is found within the words stated. The siloing effect of fundraising activities away from the chief executive officer and C-Suite has resulted in less-than-optimization of the philanthropic results within healthcare. And with hospital financial resources the way they are today, fundraising dollars have never been needed more.

- Healthcare Deserts
  - — Hundreds of hospitals closed in the last decade, both in rural and urban areas.
  - — Critical clinical services cease (maternity/birthing, surgeries, EDs, etc.), both in rural and urban areas, making people drive 50+ miles for basic healthcare needs
- Decreasing Reimbursement
  - — Pressure from the government and commercial payers as to what they are willing to pay for healthcare services, regardless of the actual cost

- Private Equitization of Services
  - The most "profitable" clinical services are being taken "out" of the hospital and into separate, private standalone facilities/organizations (e.g., orthopedics)

- Aging Population
  - The growing pressure to take care of the population most in need of healthcare (and most expensive) as its numbers grow each day

- Increasing Costs
  - From prescription drugs to employment through workforce shortages to overall inflation, the basic costs to provide healthcare are on the rise

While all of this is bad, it is only going to get worse over the next decade. And as if the healthcare philanthropic area didn't have enough to worry about, it is incumbent to teach our C-Suite leaders what they don't know....

Comparing the Healthcare Chief Executive Officer to Another Like Leader

There are such strong parallels between the history of healthcare and that of the higher education system in the United States.

- Both started exceedingly early in our country's history
  - Harvard in 1636[1] and Bellevue Hospital in 1736[2]

- Most facilities/organizations were started through philanthropy
  - Gifts from John Harvard[1] and Elihu Yale[3] created stability for their namesakes, while nuns, priests, ministers, and local leaders founded many of the early hospitals through the generosity of the community

- Growth in the mid-1800s happened because of governmental participation
  - The Morrill Act in 1862[4] for land grant colleges dramatically increased the number of higher educational schools, while states dramatically increased spending to care for Civil War wounded[5] and the US Army established the Hospital Corps[6]

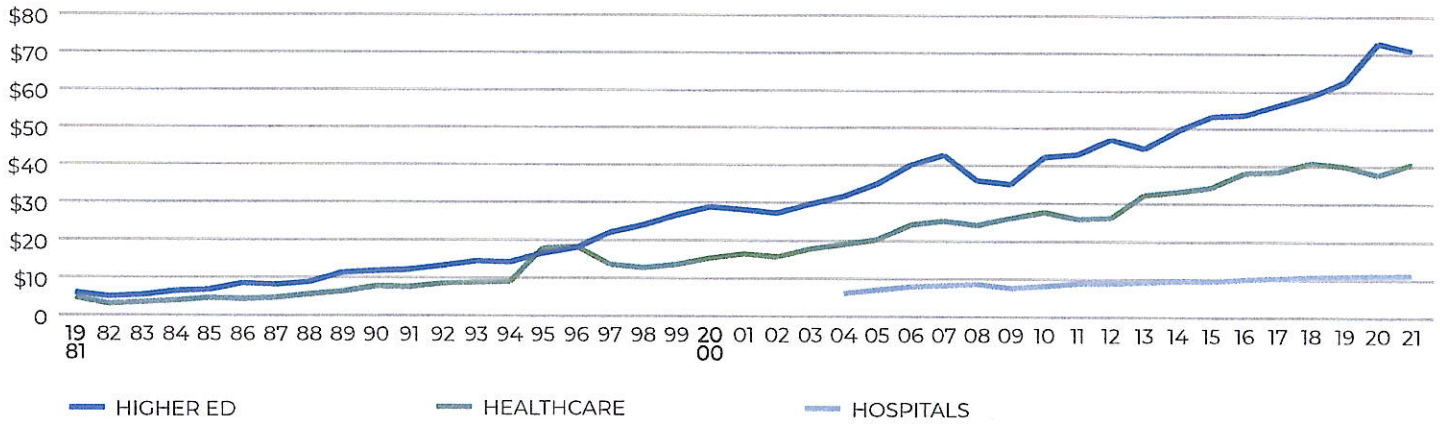
- Direct Federal Government influx of financial support led to explosions to the two nonprofit sectors after World War II
  - The Hill-Burton Act[7] provided billions for hospital growth, while the GI Bill provided direct access to college for millions of veterans[8]

- Reduction in government support began a radical change to financing healthcare and higher education in the early part of the 21st Century
  - The Higher Education Reconciliation Act slashed direct aid but increased student aid programs[9] and states began to reduce annual state-allocated dollars to public universities, while the Affordable Care Act began the reduction of reimbursements for healthcare[10]

But higher education began a leadership pivot, starting in the last decade of the 20th century. By the mid-2010s, a study done by Robert L. Jackson of Murray State University found that the "CEO" of public universities had shifted responsibilities away from operations and looked outward into the community. Higher education presidents/chancellors were....

- Spending 6.7 of 21 business days per month on fundraising efforts[11]
- Devoting 3.85 days per month traveling to conduct fundraising activities[11]
- Meeting with their Chief Development Officers two to three times per week[11]
- Committing 5.27 days each month to hosting/attending dinners/receptions with major donors[11]

HEALTHCARE, HIGHER EDUCATION AND HOSPITAL FUNDRAISING[12]



Higher education leaders shifted to where the money was...philanthropy. And when looking at the numbers overall in the industry, one can see the outcome of this modification. In 1995, healthcare, overall, outraised higher education. As of recent days, higher education fundraising results overshadow all healthcare and dwarf that of hospitals.

Seeing these results, and looking for even greater opportunities, universities took another step by hiring "CEOs" with no academic experience but with the perfect skill set to leverage possible philanthropic relationships—nearly 40% of chancellors/presidents are now considered "nontraditional" by historical definition.[13] They are not professors or deans but come from the political and business world because of their fundraising and communication acumen. Consider this list of just public higher educational institutions (a similar list for private schools is much longer):

- University of Oklahoma–David Boren, former United States Senator[14]
- University of Nebraska–Walter "Ted" Carter, retired U.S. Navy Admiral[15]
- University of Iowa–J. Bruce Harreld, corporate executive at IBM and Kraft[16]
- University of Missouri–Tim Wolfe, former president of Novel Americas[17]
- University of Colorado–Bruce Benson, former oil and banking executive[18]
- University of Florida system–Ben Sasse, former United States Senator[19]
- University of Texas–Rex Tillerson, former United State Secretary of State and former Chief Executive Officer of Exxon[20]

It's Not Their Fault

While University leaders (CEOs) have pivoted their calendars to be ladened with philanthropic related daily activities, healthcare chief executive officers have, for the most part, stayed very traditional to the role found in hospitals 30 or 40 years ago.... high level of concentration on operations and internal matters. But consider when philanthropy enters the career of a university president compared to that of a hospital chief executive officer.

Philanthropy activities and responsibilities formally enter into the learned experience of a university leader sometime around their appointment to being department chair or assistant dean—and potentially even before if that individual has an endowed chair. It's at those points that the higher education fundraising professionals begin the relationship building process with internal leadership to harness their connections and their expertise. By the time a university leader becomes Dean, a good

percentage of their time overall is spent on fundraising related activities, including being included in job descriptions and part of the evaluation process and bonus structure.

When thinking about the community hospital chief executive officer of today, their career path probably started on the floors of the hospital or a back office, grew into leadership in a department, then possibly a director of some sort, then a chief "area" officer in the C-Suite, then they become chief executive officer. And nowhere in their career trajectory do they interface with philanthropy at a high level.

CAREER TRAJECTORY	HIGH EDUCATION	HIGHERED PHILANTHROPY ENGAGEMENT LEVEL	HEALTHCARE	HEALTHCARE PHILANTHROPY ENGAGEMENT LEVEL
EARLY CAREER	Assistant Professor	*Position might be funded with philanthropic dollars. Possible some reporting on work due to donors*	Front Line Worker/Nurse	*Not discussed at all*
FIRST MAJOR RESPONSIBILITY	Professor	*Position might be funded with philanthropic dollars. Possible some reporting on work due to donors. Possible outreach to limited alumni*	Assistant Manager	*Not discussed at all*
FIRST LEADERSHIP	Department Chair	*Small part of the job formal description. Possibly part of the budgeting process*	Manager	*Might come up periodically during the year*
PREPARING FOR HIGHER LEADERSHIP	Associate Dean	*Part of the job description and small part of the evaluation. Part of the budgeting process*	Assistant Director	*Might come up periodically during the year*
FIRST MAJOR LEADERSHIP	Dean	*Major part of the job description and evaluation. Part of the budgeting process*	Service Line Leader/ Director	*Possibly asked to spend raised funds*
PREPARING FOR ULTIMATE LEADERSHIP	Provost	*Part of the evaluation process for deans. Part of the budgeting process for colleges and entire university*	COO/CMO/ CNO/CFO	*Slightly discussed and small part of planning*
PROFESSIONAL LEADERSHIP HIGH POINT	Chancellor/ President	*A large percentage of the daily job, direct responsibility, and accountability*	CEO	*Discussed more regularly. Possibly not even mentioned in their job description. Most likely not part of their evaluation*

Within a few days of ascending into the position of chief executive officer, there is a meeting with the chief development officer to discuss a subject that they have no knowledge, wisdom, or experience with anywhere in their career development.

How can you blame a leader who does not want to assume responsibility for something they have never had to learn about, been asked to do, embrace, and/or succeed at?

Embracing Vibrant Vulnerability

At the same time, hospital chief executive officers are almost like submarine captains.... supposedly all-powerful. Everyone looks to them for every answer with the anticipation that the chief executive officer has it. Whether it is position power, medical mystique power, or institutional power, ignorance or equivocation may be viewed as a sign of weakness and make them a target for blame. That is a lot for a chief executive officer to bear. And "begging" for money from the community doesn't add to the list of being "powerful."

However, the best leaders connect to the aspect of "vulnerability" as a way to learn and grow. Jack Welch, the former chief executive officer of General Electric, said about leaders, "Keep learning; don't be arrogant by assuming that you know it all, that you have a monopoly on the truth; always assume that you can learn something from someone else."

To learn, when powerful, takes a sense of vulnerability; the willingness to admit that someone else might have the answers that are necessary to solve the problem. Being "vibrant" is about being enthusiastic about it. And when combined (Vibrant Vulnerability), this is what provides the avenue philanthropy is looking for from chief executive officers (and the C-Suite). But to get there, leaders in philanthropy have to "teach" philanthropy's value in simple details that lead to amazing success.

What's Needed/What to Teach

There are five key areas to help our chief executive officers (and C-Suites) understand and embrace the value of philanthropy... the rationale for their time and interest regarding something that is quite foreign to them.

ROI

What financially comes from philanthropy is worth exponentially more than what might come from the "net revenue" of clinical operations. Consider the following, assuming a 1-3% operating margin for clinical services and a cost-to-raise-a-dollar in philanthropy of $.25.

It will take the operational side of a hospital years to find a "new" $10 million to invest in that piece of equipment or bringing in that new physician to build out the needed clinical service. But philanthropy operating at an average return will have that money five times (5x) faster and at a fraction of the cost. Ask a CEO the following, "where can you go in 90 minutes and come back with $1M in 'profit?'" The answer is not another internal meeting with Finance.

Chief executive officers understand this concept. It parallels that new surgeon they might need/want. They ask the question about how many surgeries can they do, at what payer mixes, what are the costs (salary, benefits, space, equipment), and eventually how long until the investment of the new surgeon will take to start "turning a profit." The same philosophy applies to the overall question of philanthropy vs. clinical operation in comparing net revenue. Chief executive officers get it, but rarely is it explained to them in this manner.

Getting Buy-In from the Community

People have two ears and one mouth. Normally, they are not used in that proportion. Key to helping chief executive officers (and the C-Suite) is the understanding that people with resources, heads of companies, philanthropists, community leaders, or politicians, come to nearly

Realized Net Return	Patient Services Expenses to Get Return	Time to See Return (from zero) from Patient Revenue	Total Fundraising Expenses to Get Return	Time to See Return (from zero) from Fundraising
$10 million	$323 million – $990 million	*3-5 years*	$3.89 million	*1-2 Years*
$5 million	$162 million – $495 million	*3-5 years*	$1.94 million	*1-2 Years*
$1 million	$32 million – $99 million	*3-5 years*	$280,000	*1 Year*

any situation with an opinion. And while that viewpoint may not be correct or accurate, since it is their money, for philanthropy to work we need the community's buy-in.

That means listening and taking time to build trust. It means considering other's thoughts even though the chief executive officer might just be the content expert. Not every idea has to be accepted, but each idea might bring that person financially into the project/need.

"Let's say a health system is having a great year. They're going to close the fiscal year with a positive 5% margin. Even at that level of success, to generate the equivalent of a $50 million gift, you would have to increase revenue by $1 billion. I don't know many CEOs, no matter how good, who can do that."

— Marc Harrison,
Former CEO of Intermountain Health

If there is a healthcare essential need, instead of the chief executive officer taking the entire 100% completed project plan to potential donors, take only 40% of the strategy and 100% of the problem and *ask* the business owner, donor, or community leader what they think...and do so with openness. Give them a chance to feel and believe that they are part of the solution. This can be done with a community board, a foundation board, or just a small group of unofficial "advisors," all who can give great insight into the community's overall regard for philanthropy and/or the hospital. Doing this takes the time of the chief executive officer, but it builds trust with those who can leverage philanthropy at much higher levels.

An old, but critical fundraising reminder, good for any chief executive officer or executive to know: *If you ask someone for money, you get advice. If you ask for their advice, you get their money.*

Sharing the Right Data

Chief executive officers and executives believe in data and dashboards. Not only do they believe in them, but they live with them meeting to meeting. Quality scores, patient satisfaction scores, financial indicators, sentinel events, and many more are just some of the normalized "dashboards" they rely upon to make major decisions. In addition, all of these examples have national benchmarks that allow any good chief executive officer to know where they stand

"You have to establish trust with your community. They have to trust that you are there and that you have a good product. You have to convince them that what you're doing is critical to the health of the community, and that they can be a part of it."

—Sue Andersen,
CEO of Marian Medical Center

within their own system, state, or overall in the country.

Philanthropy also survives by keeping and utilizing data. In fact, the kind of data philanthropy tracks, at a high-level, is the exact kind of data a healthcare leader not only needs to know but wants to see because it will make sense.

By creating a simple dashboard that tracks the most important data, compares to timeframes like last year, the five-year average, and where possible to national benchmarks, it empowers the chief executive officer (and C-Suite) to better understand how we measure philanthropy. In addition, maybe when numbers don't compare favorably, it also allows for a robust, active, and engaged discussion about "why" fundraising isn't meeting expectations and what can be done

	THIS FISCAL YEAR	LAST FISCAL YEAR TO DATE	YEAR PREVIOUS FISCAL YEAR TOTAL	PREVIOUS 5 YEAR AVERAGE	AHP NATIONAL BENCHMARK
Dollars Raised (Cash)	$4,573,234	$3,987,323	$3,234,549	$3,931,702	Available
Dollars Raised (Cash and Pledges)	$5,873,258	$5,129,458	$3,873,431	$4,958,716	Available
# Number of Donors Above (MG Level -$10k)	45	34	25	34.7	
# of Donors Above (Another Level) - $100k or $250k)	9	8	5	7.3	Available over $1M
# of Outstanding/Not Realized Yet Solications for this Fiscal Year (Above MG Level)	24	12	34	23.3	
# of Total Donors (all giving)	4,349	4,148	3,245	3,914	Available
Cost to Raise a Dollar (or ROI Production)	$0.23	$0.24	$0.23	$0.28	Available
Direct FTE's	8	7	8	8	Available

to see improvements (much like any clinical dashboard result discussion).

Consider this...C-Suite leaders come and go. Does the organization change the reporting of the balance statement or income statement when there is a new Chief financial officer? Does patient satisfaction methodology dramatically change with a new chief medical officer or chief nursing officer? Chief development officers/ chief philanthropy officers also change...but great dashboards and their data should remain, just like other key metrics that inform the chief executive officer of overall health of the hospital.

Realization of a Chief Executive Officer's Best Friend

C-Suite life can be very much like a grown-up version of "King of the Hill," with each executive having an aim at the top target–the chief executive officer. In fact, almost everyone reporting to the chief executive officer might have looked in the mirror that morning and seen a "future chief executive officer." Minus one: the chief philanthropy/development officer. We are not trained to run a hospital. We don't have the experience. We don't have the education.

Chief executive officers need to understand that the number one daily responsibility of any good chief philanthropy officer/chief development officer is to support the chief executive officer and make them look good. When they look good, normally there is more philanthropic support from the community. It is to set the chief executive officer up (or other healthcare leader) for the most positive conversations and situations. When the chief executive officer is with a donor or prospect, while it might not produce a million-dollar gift every time, it should be the best part of their day. No one is asking them to cut budgets or lay-off someone or settle an internal political fight. What philanthropy needs is for them to tell the story of the hospital, why healthcare is critical to a community, and listen to what the prospect/donor thinks about related issues/items.

This all comes down to trust. If the chief executive officer trusts the chief development officer/chief philanthropy officer, they listen more intently to the viewpoint of the chief development officer/chief philanthropy officer, allocate more time for meetings (internal and with donors), give the chief development officer/ chief philanthropy officer more direct access to their calendar, and make sure they are part of all critical meetings with other members of the executive team.

Part of Strategic Planning

Philanthropy is not turned on and off like a water faucet. But sometimes chief executive officers and other non-fundraising executives believe that to be the case. This is why it is critical for the chief development officer/chief philanthropy officer to be a full and active member of the executive team and a fully participating member of the strategic planning group/committee (if different). All too often, the foundation or development office is "informed" of the need for philanthropy well-after the plan for new piece of equipment or new program has already been decided. Maybe a project has been started or a piece of equipment was purchased without philanthropy being included or considered. Philanthropy is not considered as a strategy.

For philanthropy to be used strategically, time is critical. The more time philanthropy has to engage potential donors, test a community's interest in a project/need, or even find influential volunteers to advocate for improvements, the more effective the fundraising outcome. Moreover, not every need is truly philanthropic. By being part of the strategic planning process, an honest assessment of what is more "appetizing" for fundraising success can be included in the hospital's planning, including knowledge of what projects/needs are not potential philanthropic projects at all (e.g., increase parking).

To survive, the role of the chief executive officer will have to change. Higher education realized

this nearly 40 years ago. University leaders embrace the idea that others can best manage the internal operations of the college: faculty, students, classes, finances. But only the "chief executive officer" (chancellor/president) can articulate the vision of what might be possible for the university, its alums, and the community. Hospital CEO's will have to embrace the same, as they are best to create a picture of what healthcare can and should be and how that has a great effect on the future of the local society.

As Marc Harrison, former chief executive officer of Intermountain Health, said when asked how important it is for the chief executive officer to ACTIVELY be involved with philanthropy: *"It's essential."* ■

For 25+ years, Randall Hallett has engaged in and led philanthropic engagement. From multiple eight and nine figure capital campaigns to leadership as a chief development/philanthropy officer in large fundraising shops, Randall has spent his entire career either as a practitioner or consultant with nonprofits. In just the last decade as a consultant, Randall has worked with health systems, hospitals, universities, social service agencies, school districts, and more on four continents. He is a sought-after speaker where he constantly challenges the "status quo."

Randall is the chief executive officer/founder of Hallett Philanthropy and has a passion for helping organizations seek funding to meet their mission—and he believes giving is good for one's emotional and physical well-being.

Endnotes

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