There is no shortage of bad financial news in health care. But many leaders are so busy wringing their hands over value-based purchasing initiatives that have the potential to hurt reimbursement — not to mention lackluster reports regarding the recovery of our nation’s economy — that they fail to realize there is plenty they can do to shore up their financial big picture.

First and foremost, leaders should focus on running the best possible hospital. This will improve patient experiences and clinical quality, which are proven to go hand in hand. These, in turn, will maximize reimbursement and generate referrals. At the same time, they automatically will see gains in an area that can go a long way toward strengthening the bottom line: fundraising.

**Fundraising’s Potential**

Not only has charitable giving remained strong despite the poor economy, it provides tremendous bang for the buck. Remarkably, annual hospital giving only decreased by 11 percent in 2009 when the recession was at its peak — the same time frame when unemployment nearly doubled. Charitable giving also quickly rebounded: in 2010, nonprofit hospitals’ annual donations increased by 8 percent, with individual donors making up more than half of all contributions, according to the Association for Healthcare Philanthropy. This is especially astonishing considering that the U.S. Census Department reported that median household income continued to decline, with a 2.3 percent drop between 2009 and 2010.

The reality is that increasing hospital income — whether through operations, debt or sale of assets — cannot continue indefinitely. Fundraising is the only capital-raising source that can continue to grow and produce higher returns.

Many hospital foundations have well-defined fundraising programs: direct mail solicitations, golf outings, annual dinners and the like. These programs are useful for finding one-time donors or those willing to contribute time and money to a singular cause; however, they do not usually identify the types of donors who are able or willing to make substantial contributions that are needed for long-term investment and planning. The challenges lie in finding a program that yields major donors, creates a high return on investment and aligns with the hospital’s mission. The goal is to hit the philanthropic trifecta commonly recognized as affinity, ability and linkage: those who are aligned with your mission, have the financial ability to contribute and have a personal link to the organization.

While hospitals can’t impact donation ability, they can foster affinity and linkage; in other words, donation desire. Many hospital foundation professionals believe that fostering affinity and linkage involves myriad complicated strategies and an increase in investment. All of this takes the focus away from a hospital’s overall mission of providing excellent care.

The good news is that when service excellence is increased, affinity and linkage grow naturally and organically. That means excellent patient ex-
periences are the key to fostering donations and ultimately improving the bottom line. However, those who bestow gifts are not always those who directly received the care.

**Not Necessarily Patients**
Since 1980, PRC has conducted surveys about health care experiences to determine what drives patients’ perceptions and actions, what influences their loyalties and how physicians and employees impact all of this. In 2009, PRC conducted its inaugural study to further understand what influences hospital loyalty, surveying 1,000 consumers on their perceptions and subsequent actions regarding hospitals. As an aspect of loyalty, this research also sought to determine what prompted hospital donations, and the 2012 follow-up study further clarified donors’ actions.

Generally, it is assumed that donors are former patients, but PRC’s research found this is not necessarily the case. In fact, the studies showed that donors are more likely to be a close friend or family member of an inpatient or emergency department patient. While patients are the ones undergoing procedures and receiving care, the often-times surreal nature of the hospital experience does not lend itself to the affinity relationship needed to encourage giving. On the other hand, patients’ family members and friends, removed personally from the care but very present as observers and advocates, are more likely to seek ways to show appreciation.

The research also revealed that when friends and family see service excellence at the forefront, they are more likely to donate. On average, one in five consumers has made a charitable gift to their preferred hospital. When its competitors lies in how they are treated from a service standpoint. This is how they evaluate overall quality of care, and something friends and family understand, too.

What’s more, not all aspects of care are perceived by patients as equally important. In general, aspects of care that include interactions with patients, such as communication and friendliness, carry more weight in a patient’s perception of their overall experience than do items such as cleanliness and noise levels.

Hospital leaders and trustees must be the driving force in fostering the connection between service excellence and philanthropy.

Hospital leaders and trustees must be the driving force in fostering the connection between service excellence and philanthropy. The good news is that there is a roadmap for trustees committed to this journey. According to health care consultancy Studer Group, most health care leaders are familiar with the tactics that get results. And most have had the experience of implementing a new behavior and getting surges of improvement here and there. The challenge is getting people to practice those behaviors consistently so that the results stay improved.

This is why the most important thing a health care organization can do to create and sustain service excellence is not simply implementing proven tactics. Rather, it is creating a culture of accountability among the organization’s leaders, which assures that the aforementioned tactics are implemented by every staff member, with every patient, every time.

In a culture of accountability, each leader has specific, measurable, time-bound goals they are accountable for achieving. These goals, which are carefully balanced and cascade from the operational goals of the organization, comprise their annual evaluation. This system ensures that measures of service excellence receive appropriate focus alongside other important metrics of financial performance, quality of care measures, employee and physician engagement, and so forth.

Unfortunately, many hospitals evaluate leaders using obsolete tools that reward effort and competency rather than outcomes. This results in a disconnect between the organization’s priorities and the focus of its leaders (something that is rather obvious when an organization does not achieve its goals), yet the majority of its leaders receive above-average evaluations. Instead, leaders should be evaluated with a tool that is objective, measurable and weighted. To be fair, it must also include annual goals, 90-day plans and a monthly report card.
A director of nursing, for example, might have 20 percent of his annual evaluation based on improving a specific measure of service excellence within his area of responsibility, 40 percent based on clinical quality and 40 percent based on departmental financial performance. The result of this fact-based approach to evaluations is that the leader has personal responsibility for the outcomes of the work, not just the tactics. Shifting to a focus on outcomes encourages leaders to focus on the frequency and quality of the tactics being employed, using problem-solving and teamwork to overcome barriers and avoid excuses.

A well-designed evaluation system has other benefits as well. For instance:

- **It creates alignment and equity across the organization.** Nothing happens in a vacuum. If the organization truly intends to make forward progress, many dots need to be connected in many different areas. That’s why organizations need to be aligned in their goals — not just from top to bottom, but horizontally as well.

Take the emergency department, for example. If the ED director looks at her division vertically, she can clearly see that there are specific metrics — including door-to-doc time and the percentage of patients who left without being seen — that impact performance. Yet she also needs to look horizontally at other departments that connect to the ED. She needs to ask, “Should the inpatient nurse manager have a ‘door-to-floor’ goal?” “Should the hospitalists be held accountable for rounding on the med-surg unit first in order to clear the beds?”

- **It forces organizations to prioritize.** Many organizations use evaluations as a catchall. They put everything for which a leader is responsible on the evaluation and expect him or her to focus on all of it. This doesn’t work. The weighting aspect of an objective system allows organizations to strategically create urgency around the right things. Studer Group finds that leaders do best when they have between four and eight metrics on their evaluation. Anything above that causes their weights to become so diluted that they’re ineffective.

- **It drives people out of their comfort zones.**

By adding weights to evaluation metrics, a leader will spend more time working on a goal she needs to work on, rather than on one she wants to work on.

- **It lets leaders report real information in real time to those who need to know it.** A manager who goes into her annual evaluation and gets feedback that doesn’t match what she’s been told throughout the year will feel confused and blindsided. Senior leaders who must answer to the CEO, and CEOs who must answer to the board feel the same way when they don’t have clearly defined goals.

A well-designed evaluation system gives clarity to the performance of individual leaders and the organization as a whole. Because it requires very specific quantified goals, leaders know what’s expected of them and exactly how they’re performing. This objective information also means supervisors can clearly see results. There’s no ambiguity around whether performance is improving.

A solid leadership evaluation creates excellent leadership practices. These result in excellent employee experiences, which in turn produce excellent patient experiences. And when a patient has an excellent experience, family members and other loved ones are forever grateful.

**Investments in Excellence**

The connection between patient experience and donations could not come at a more fortuitous time. Because of the government regulations that tie Medicare reimbursements to patients’ experiences through HCAHPS, the financial future of hospitals across the country is already greatly dependent on their ability to achieve service excellence.

Knowing that service excellence pays off in so many ways should solidify trustees’ resolve to make strategic financial investments that build a culture that supports it. Hospitals that incentivize leaders and empower employees to provide excellent service potentially can more than double their donor rolls.

Of course, not only will installing the framework that creates a culture of accountability shore up your financial future, it will enable your organization to live up to its mission to provide the very best care to patients and, by extension, peace of mind for their loved ones. That alone is reason enough to do so. — J.L.B. and C.E.D.

Janna L. Binder, M.B.A. (JBinder@PRConsulting.com), is director of marketing and public relations, Professional Research Consultants, Omaha, Neb. Craig E. Deao, M.H.A. (Craig.Deao@studer.com), is senior leader, Studer Group, Gulf Breeze, Fla.

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