Inside the Minds:
Leadership Strategies for Charitable Organizations

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"Thought Leadership"

Goal Setting

Before a non-profit or for-profit business does anything else, I think it should ask "What do we want to achieve based on our mission?"

Non-profit organizations must have an overarching goal and a strategic plan that outlines the steps to achieve that goal. The vision must belong to the entire organization, not just the CEO, to ensure that volunteers and staff are working productively as a team and headed in a common direction. For example, for many years, the American Heart Association has had a mission to reduce disability and death from cardiovascular diseases and stroke.

In 1998, we took that to the next level by bringing representatives of our various constituencies together to develop a more focused, measurable, time-based Impact Goal — to decrease coronary heart disease, stroke, and risk by 25 percent by the year 2010 — and to create a strategic plan to achieve it. The highly collaborative process extended over a year and created a sense of ownership among staff and constituents.

Of course, after you've set your goals, the next question is, "What must we do to succeed?" At the American Heart Association, we've focused on these areas:

- Streamlining our structure and improving our processes
- Developing a sound strategic plan
- Attracting and developing the right volunteers and staff
- Enhancing relationships with customers
- Continuing to increase revenues through innovative yet cost-efficient strategies
- Growing the capacity of the organization.

We view these as the key drivers for accomplishing our ambitious health goals. Let me discuss each of them now.

Reorganizing for Success

The collaborative approach we have embraced is important but challenging in an organization with 3,300 paid staff and 22.5 million volunteers and donors. To help ensure that we could meet our Impact Goal, we focused on removing internal barriers and streamlining our infrastructure and decision-making processes to improve our ability to act quickly while maintaining the involvement of our volunteers and staff. Streamlining our organization also allowed us to capitalize on ever-shorter windows of opportunity.

Making changes of this magnitude is a challenge in a consensus-driven, risk-averse, and decentralized organization like ours. We began by consolidating what were essentially 50+ state-level, separately incorporated organizations into 12 regional affiliates under one corporate banner. We also formed several functional groups (advocacy, communications, development, etc.) consisting of representatives from the national organization and each of our affiliates to address issues, make recommendations and make efficient decisions; these representative groups help gain broad support for decisions.

We were also aware that our approach to governance was overly complex. We had operated for many years with a 176-member delegate assembly that elected the board and officers and developed the strategic plan. However, this assembly met only once a year, and this fact, along with the group's unwieldy size, hindered our ability to move quickly and make timely decisions.

To remedy this situation, we shifted responsibility for strategic planning and development of long-range goals to a much-smaller board of directors, which now meets five or six times a year. Our board of directors was reduced to 26 members from 42 and now consists of:

- 7 officers (chairman, chairman-elect, immediate past-chairman, president, president-elect, immediate past-president and secretary-treasurer)
- 12 affiliate members (1 from each affiliate)
- 2 science members
- 3 at-large members (chosen for their influence in key areas, such as corporate partnerships or government) and
- 2 committee chairpersons (from our American Stroke Association Advisory Committee and our Research Committee)

All our board members have staggered two-year terms. The affiliate, science and at-large members are eligible to serve two consecutive two-year terms.

The Board of Directors is responsible for approving the strategic plan and long-range goals, as well as the budget, and amendments to corporate policies and standards. Committees of the Board oversee various association functions or operations. These committees include the Science Advisory Coordinating Committee (which oversees research, scientific publishing, emergency cardiac care, etc.), the Communications and Marketing Coordinating Committee, the Advocacy Coordinating Committee, the Corporate Operations Coordinating Committee (which oversees finance, investments, etc.), and the Development Coordinating Committee.

The American Heart Association has the additional dimension of volunteers as well as staff employees, but the decision-making model is similar to a for-profit corporation. Staff are involved with the Board and committees to help them formulate and evaluate their policy and strategic decisions. Also, consistent with those policy and strategic decisions made by the Board and the committees, staff make decisions related to operations and implementing programs and

activities. There is a close working partnership among our officers, senior volunteer leaders and senior staff so that many decisions are collaborative.

All of these steps have enabled us to speed up decision-making while preserving the involvement and commitment of our constituents.

Strategic Planning

Since 1998, we have constructed a series of three- to four-year strategic plans to guide our work towards achieving our Impact Goal of reducing coronary heart disease, stroke and risk by 25 percent by 2010. The strategies in each of these plans have directed our work in areas such as

- Support of highly meritorious scientific research
- Advocacy for public policies that can improve health
- Quality improvement in health care
- Working in partnership with emergency response systems
- Providing educational information to patients and consumers

We also developed a number of measures to help us evaluate our progress toward our Impact Goal. I am pleased to say that we are well on our way to achieving our goal, including reducing such risk factors such as high blood pressure, high cholesterol, and smoking tobacco. However, we have a long way to go in reaching our goals to fight the alarming trends in the areas of obesity, diabetes and physical inactivity.

Work first began on the American Heart Association's strategic plan for 2006 to 2010 in October of 2003. Initially, we conducted exercises to understand the environment, including research into trends related to the future of health care and non-profits. Some of the areas we took into consideration included

- the growth of culturally diverse populations,
- changes in disease states and risk factors,
- new expectations for not-for-profits and philanthropy,
- the aging of Baby Boomers, and
- the emerging health economy.

After working with several different groups of volunteers and staff to assess the implications of these trends, we identified common themes that helped us formulate the most relevant goals and strategies for 2006 to 2010.

We began in April 2005 by presenting a first draft of the plan to the volunteer and staff leaders of our 12 regional affiliates, Scientific Councils and Interdisciplinary Working Groups (IWGs). Their comments led to refinements to the plan that we then shared with our national board for further discussion. Throughout the summer and early fall, we visited board meetings of each of the affiliates to present a nearly final version of the plan and gather additional comments. We also shared the plan with our science leadership.

The result of all this effort was that we received unanimous approval and positive support from our Board at its October meeting. A process that would have taken us over a year under the old structure took half the time with much greater involvement and input from all levels of the organization. It has resulted in a much higher level of understanding and commitment to our direction for the next four years.

The goals and strategies are organized into a "strategy map." It helps to show the linkages between goals that are focused externally, such as those in the areas of health outcomes,

customers, and revenue, and those that are internally focused, such as business processes and volunteer and staff competencies.

Our "Knowledge Impact Strategy" describes how we believe we can best accomplish our Impact Goal. The trends we reviewed earlier have led us to conclude that we must focus our efforts on improving health decision-making at all levels: society, health systems and providers, and individuals.

Five overall themes underlie this strategy:

- Providing lifesaving solutions
- Collaborating with key stakeholders
- Expediting the application of new knowledge
- Serving diverse populations
- Maintaining the highest standards of accountability and transparency

These themes highlight our most important areas of focus for the next four years. They are woven throughout all our goals and strategies. They also allowed us to align our resources for greater impact on our goal.

At the Health Outcomes level, our goals are divided into three categories:

- Knowledge Discovery,
- Knowledge Processing, and
- Knowledge Transfer.

In the "Knowledge Discovery" area, we are continuing to emphasize those goals that have always been our priorities: funding and influencing the funding of research, and supporting early career investigators. Collaboration and translational research are highlighted in response to two of our major themes.

"Processing," or packaging knowledge, is critical in science and a major focus for the American Heart Association. Much of our work in this area involves translating science into guidelines and statements, and expanding into new forms of guidance, such as case studies. We want to strengthen our knowledge management capabilities so we can use of our content more effectively. That includes using it to contribute meaningfully in the public-policy debate.

"Transfer," or distributing and delivering knowledge, focuses on three areas:

- Increasing adherence to the best available science, by working with providers, policy makers and individuals.
- Influencing society, the health system and providers — and empowering individuals — to make better overall health decisions.
- Devoting special attention to serving diverse audiences by influencing systems of care.

To achieve these critical health goals, we must focus on the needs and expectations of our customers, our positioning as an organization, and generating the funds needed to carry out our work. Of particular note is our desire to achieve $1 billion in total annual revenue by 2010 to help ensure that we have the funds we need to achieve our health goals. (For more on this, see "Fund Raising.") And none of these goals can be accomplished unless appropriate internal business processes, as well as volunteer and staff competencies, are in place.

During the next four years of our plan to reach our 2010 Impact Goal, we will begin looking ahead to what our goals should be for the period beyond 2010, up until 2020.

Why do we consider a goal so far in the future? Because planning is not so much about predicting the future, even for short-term goals, as it is about being ready for whatever unfolds.

We want to develop a sense of direction now so we can be better prepared to take the next step once we reach 2010.

The process of developing the 2020 goal will include examining our current mission to ensure that it will still be relevant 15 years from now. We will also be securing external expertise to help us formulate a global strategy and a knowledge management strategy to guide our future work.

We also want to allow sufficient time for meaningful input from all levels of the organization, including our 13 scientific councils and three Interdisciplinary Working Groups (IWGs). (The councils and IWGs have a combined membership of 24,500 and provide expertise in various areas of cardiovascular science.) The Board has extended the Strategic Plan Task Force's commission until 2007 to complete this work.

Staff Development

Achieving goals also requires having the staff with the right skill set. That's why we devote a considerable amount of energy to staff development. We took a careful look at our talent pool within the organization, performing 360-degree assessments of staff members, creating development plans for individuals, and devoting time and resources to develop staff talents. We are committed to constantly raising the bar at our organization. Having each staff person each year identify personal competencies and training needs and then create development plans to build those skills makes every staff person a continuous learner. And it reinforces our organizational value and competitive advantage of being a "learning organization."

Successfully leading an organization in some ways is like being the head coach of a football team. You have to evaluate the talent you have, train team members to achieve their maximum potential and bring in new players that have different or better skills than the members of your current team.

The framework we use to do this is the evaluation and development system outlined in Brad Smart's book *Topgrading*. We assess our staff and rate each person as an A-, B-, or C-level player.

- **C-level players** are those who do not now and never will have the skills or emotional makeup to perform their job at the high level needed for us to reach our organizational goals. They need to be moved into a job in which they can succeed, or they need to be removed from the organization.
- **B-level players** do their jobs well and have the ability to keep growing as their job evolves. A "B-level" employee is approaching that top performance level but needs some polishing and stretching to become an "A-level" player.
- **A-level players** perform at an exceptionally high level and have clear potential to assume greater responsibility. An "A-level" employee is a superior performer who can and will make a substantial difference for the American Heart Association. They are the stars in our organization.

There are no quotas at any level.

Bradford D. Smart, Ph.D., writes that, "simply put, topgrading is the process of packing your organization with 'A' players . . . (it is) the enabler of all corporate initiatives to improve performance, because 'A' teams make initiatives successful and lesser teams don't."[1]

Tiger Woods exemplifies an A-level performer in the sports world. A few years ago, he was the No. 1 professional golfer in the world a few years ago. Many were calling him the best

of all time. He knew he could do better, so he got a new coach, modified his swing, and improved even beyond his past excellent performance. Woods' game dropped off temporarily while he was perfecting the new swing, but once he conquered it, he raised his performance to an entirely new level. He proved it's not necessary to wait until something is broken to fix it.

I want the American Heart Association to follow that same model: Even those at the top of their game can improve.

Some business observers argue that superior talent is the last significant way to rise to the top in a competitive market. We're in an intensely competitive market now, that's not going to change, and we're determined to reach the top and stay there.

Specific core competencies define the skills and behavioral traits we need to implement our strategy. These include:

- Intelligence
- Judgment/decision-making
- Integrity
- Initiative
- Organization/planning
- Customer focus
- Communication
- Team builder/collaboration
- Strategic skills
- Coaching/training
- Performance management
- Selecting "A-level" players by selectively adapting topgrading

We are looking for leaders at all levels who will be accountable for measuring effectiveness, enabling others to reach their potential, and assessing and evaluating employees. Error-free hiring is our goal. To that end, we recruit both from within and outside our sector — looking for the top 10 percent of talent available for the supervisory and professional level skills required for our organization.

Hiring managers begin the process by analyzing jobs against the backdrop of the American Heart Association's strategic goals and organizational culture. Then, in plain language, the hiring manager summarizes the job requirements and lists the behavioral competencies required. We create and maintain this kind of job analysis description for every position. We also rigorously apply the specific job competencies as we evaluate employees and prospects.

Two important tools are part of the topgrading process — the career history form and the Chronological In-Depth Structured (CIDS) interview. Every candidate receives the career history form and must fill it out and return it to the hiring manager before the formal interview. This form should reveal every full-time job the candidate has held. The hiring manager reviews it carefully before conducting a CIDS interview.

Hiring managers come to their interview sessions armed with a sure knowledge of the job description, the competencies required, and specific information gleaned from the career history form. Applicant interviews are conducted by two people and run two to four hours.

We open with a chronological, event-driven conversation, starting with the applicant's dreams, hopes, and aspirations in high school and college. Then we ask about each job: the applicant's expectations, experiences, challenges, scope of responsibility, significant accomplishments, biggest disappointments, etc. We look for a great deal of detail and clear evidence of competencies. We want managers who set high standards and goals, who are willing

to lead and who have a positive attitude.

Managers learn far more job-relevant information through the CIDS process than they would during traditional interviews. This substantially reduces the chances of something slipping by the hiring manager.

I was the first American Heart Association executive to go through the topgrading review, oral 360-degree evaluations and the feedback process. Other members of the corporate team followed. Top field executives and some mid-level managers were CIDS-assessed and coached. All embraced individual development plans.

We launched a train-the-trainer model for spreading topgrading. Our human resources staff conducted topgrading "boot camps" throughout the United States.

"Trio visits" were a key to understanding and acceptance. These are visits to affiliate executive vice presidents (EVPs) from three national center staff: the chief operating officer for field operations, the vice president of human resources, and the chief executive officer (me). Our trio meets annually with each affiliate EVP to ensure that progress is under way toward having nothing but "A-level" players throughout the organization. In addition, we conduct a trio visit where we include two affiliate EVPs in the discussion of National Center leadership. Standard practice is to hire and promote people only within the established guidelines.

In the trio visits, we ask executive leaders to rate their various staff and then question them about their ratings. Over time, we learned to ask better questions, and now all our affiliate and national leaders understand our organizational definition of an "A-level" employee. This has improved accountability and also brought some high-performing staff members to our attention who we might otherwise not have known about. At least two of them have since been promoted to lead affiliates and are doing exceptional jobs. In 1998, 20 percent of the top 250 managers were judged to be either "A-level" or "A-level" potential. By 2004, 60 percent were "A-level" players.

The early response to topgrading was mixed. Some managers felt the interviews were too long, but hiring managers and internal recruiters soon broadcast success stories and published our hiring scorecard. This convinced the doubters to get on board. We quickly learned the value of holding jobs open longer so we could hire "A-level" talent. Pressure often was intense to accept a "B-level" player, but when we finally found the "A-level" player we needed, hiring managers soon realized the talent was worth the wait.

We also learned to topgrade with an emphasis on our mission to save lives and reduce disabilities. Managers know their career is going to be more successful when they topgrade, but working for a bigger purpose helps them justify the tough people decisions we expect our leaders to make.

In filling management positions, most non-profit organizations look for a proven track record (albeit not necessarily in the precise job under consideration), high energy, and a willingness to work long hours. We also seek bright risk-takers who are willing to drive change, who have excellent people skills, the ability to juggle multiple projects simultaneously, a strong work ethic and high moral standards.

Our goal is to build stronger organizational capability, so we aren't satisfied by hiring those who we think are the best people. Continuous improvement requires an integrated, ongoing approach to our key management practices. With the CIDS interviewing system, our hiring decisions continue to improve, and our annual performance management discussions lead to yearly individual development plans. As noted earlier, we reinforce this by offering education and training programs that support employee career planning. And as part of our annual

organization-wide review, we identify and develop high-potential employees and also address succession-planning issues. We really have an eight-step process of:

- Goal setting, which starts within a few weeks of employment
- Identifying competencies in each job description
- Assessment and feedback, which may include 360-degree review and immediate feedback
- Talent development plans written and done yearly
- Coaching and mentoring on a day-to-day basis to help staff develop their skills
- Performance appraisal, which happens twice a year
- Counseling about career paths
- Leadership development to help guide staff with high potential for moving up in the organization

As we focus on hiring top talent, enhancing our current strengths and addressing developmental needs, we are operating better, raising more money and reducing costs. This clears the path to delivering outstanding Customer service. We try to develop staff under the overall umbrella of our principles, philosophies and concepts as outlined in our strategic plan.

Once we got our internal house in order, we were better able to focus externally. Since then, we have formed alliances with other foundations, non-profits and for-profit companies to raise money and address issues related to our goal of reducing heart disease and stroke. We try to add value to the external world. If our association can't make a difference, then it should cease to exist.

1. Smart, Bradford D., Topgrading: How leading companies win by hiring, coaching, and keeping the best people. Portfolio, a member of Penguin Group (USA) Inc.1999, 2005, p xviii.

Customer Focus

Within the past five years, we have placed a greater emphasis on understanding the needs of our Customers and designing programs, products, and services to meet their needs. This is a shift from our historical focus on the development of products as a primary focus with Customers considered in a secondary role. Part of this transition in thinking has included defining six markets that represent our key Customer segments:

- Patients
- The General Public
- Researchers & Scientists
- Healthcare Providers
- Public Officials
- Donors

The staff who are assigned to each market have worked to build a profile of their Customers that describes their key attributes and interests. This helps us develop strategies attuned to the needs of each market.

As we evaluated future trends in preparation for developing our latest strategic plan, we recognized that the American Heart Association will need to play a key role in providing information to patients and consumers to help them answer questions about how to most effectively manage their health. This will put more demands on our organization to respond to requests for information and support through our Web site and call center. We will also need to

build our capacity to develop and deliver a wide range of deep content that is relevant to our Customers' health needs. Some of this is work we can do ourselves, and in other cases, we will need to build partnerships and alliances to leverage our resources.

To ensure that we maintain our Customer focus, we have established a major objective to increase Customer loyalty.

To this end, we are now annually measuring the level of engagement of our Customers and partners. We have established specific goals to improve that level of engagement and are holding ourselves accountable for improvement. Our focus is on 100 percent Customer engagement and increased Customer loyalty. To increase engagement and loyalty, we believe we must:

- Build confidence with Customers by improving trust and delivering on our promises.
- Build integrity with Customers by improving the fair treatment of our Customers and resolving problems when they occur.
- Build pride in Customers by improving the overall experience and treating Customers with respect.
- Build passion in Customers so that our Customers can't imagine the world without us and creating the feeling that we are the perfect organization for them.

We are developing strategies to address the factors that have the greatest influence on Customer loyalty, such as the quality of our programs and services, our level of Customer service, and the degree of employee engagement that we have. We are also increasing the urgency of our efforts to reach audiences that are culturally and ethnically diverse – people who often need our information and support the most.

Because of the overlap among our Customer markets, we also spend a lot of time on integration and collaboration internally. We want to be sure that we are taking all possible steps to eliminate duplication of effort while providing the best possible experience for our Customers. To that end, we are creating a set of "Customer pathways" to better define how we bring Customers into the organization and increase their involvement with us over time, based on their needs and preferences. We believe that this attention to detail will pay off in the form of stronger relationships that expand our organizational capacity to accomplish all of our goals.

Fund Raising

The key to our success in fund raising is our focus on a few areas where we are able to execute extremely well. For instance, we conduct three special events across the country that raise almost $200 million of the $650 million we generate as an organization. On the other hand, we recognize that some donors prefer to give in other ways, so we also offer opportunities to contribute through direct mail, memorials, major gifts and planned gifts. About 85 percent of our revenue comes from public contributions and bequests. Each year issues arise that affect our fund raising in some areas, but these are usually overcome by other communities exceeding expectations in new revenue. In fact, our average annual campaign growth over the past five years has been about 7.5 percent. We pride ourselves on identifying and communicating organizational best practices that drive a consistent approach to how we raise funds in every community.

To monitor our goals and accomplishments from a strategic standpoint, national and regional affiliate executive leadership meet regularly. Revenue goals are included in the performance standards of all of our senior executives, and we also have an incentive plan that is

based in part on our fund-raising results.

One of the most important roles of a new CEO is to challenge the management team to think about how they can set stretch goals that will expand the organization's capacity in a meaningful way. For instance, several years ago I asked our group what it would take for us to increase our walk income from $12 million to $30 million. Many explained why we couldn't raise that much. Ultimately, we adopted a target of "$30 million dollars in 30 months" – and we reached that goal in 18 months. That success generated momentum that continues to build. Today the Heart Walk event is our largest fundraiser, generating nearly $100 million annually. I believe that if a CEO raises the bar, the staff can realize successes that they did not know they were capable of.

We are also focusing much more on developing relationships with foundations that share our desire and may support our efforts to fight cardiovascular diseases and stroke.

In the next few years, we will be facing changes in fund raising that will cause us to stretch again. Trends in philanthropy and different attitudes about giving that exist among the Boomers and subsequent generations will affect how we raise funds. Increasingly, donors are demanding that organizations provide evidence of tangible results that make a difference in their local community. They want hands-on involvement in enabling creative solutions that improve the quality of life for their fellow citizens. Our challenge as a national organization is to demonstrate our continuing relevance in the face of these expectations.

I am confident that we are up to the challenge because of the quality of our people and because we have taken steps to develop a strategic plan specifically for revenue generation that identifies a number of innovative new strategies that respond to these trends and expectations. In the next 4–5 years we will be placing greater emphasis on enhancing the donor experience and communicating clearly about how their dollars are truly making a difference. We will explore new opportunities for generating revenue. I am optimistic that the American Heart Association will continue to be viewed as a model for other nonprofits.

Expanding Organizational Capacity

As a non-profit, we need to think laterally as well as linearly. Raising money and increasing our volunteer base is important to expanding our influence and effectiveness, but we can expand our reach much more through partnerships and other collaborative efforts. In recent years, we have been working more and more with others to reach mutually shared goals. Partners include organizations from the world of foundations, corporations, media, federal agencies, other non-profits and the healthcare system as noted below.

Childhood obesity is a national epidemic. Fighting it alone would consume more resources than we have available. However, by joining with the Clinton Foundation and forming the Alliance for a Healthier Generation, we are able to enjoy synergies that increase our impact exponentially. We believe that we are creating a comprehensive, pragmatic initiative that will help prevent childhood obesity by helping children make healthier choices, develop healthier lifestyles and ultimately live healthier lives. The initiative will help kids by focusing on these four areas:

- Industry, such as restaurants and food manufacturers
- A "by kids, for kids" movement that makes being healthy cool
- Healthcare providers
- Schools

Our Go Red For Women movement, an award-winning national campaign that is dramatically raising awareness that heart disease is women's No. 1 killer, is another example of expanding our impact by involving others. Partners include Macy's and Pfizer, which have helped with both fashion and funding, as well as many other companies that have linked products to the cause. In addition, more than 9,000 corporations have held events for employees, raising money to support the campaign.

To show the scope of Go Red For Women, in its first two years roughly 10 million red dress pins were distributed, 300,000 women joined the movement through its Web site and the campaign had 2.3 billion media impressions.

Yet another example is our partnership with *Parade Magazine*, the most-read magazine in the United States. *Parade* designated 2005 as The Year of the Heart and has highlighted cardiovascular diseases in five issues with circulation of about 37 million readers per issue.

We partnered with the Centers for Disease Control and Prevention (CDC) to identify specific opportunities for joint efforts and activities to develop a comprehensive national health strategy to prevent heart disease and stroke.

We also partnered with the American Cancer Society and American Diabetes Association on an "Everyday Choices" campaign. It conveys to consumers that simple health decisions they make every day in areas like food, exercise, smoking, etc., have major long-term health consequences.

Finally, partnerships work in professional education as well as public education. An example is Get With The Guidelines. More than 1,000 U.S. hospitals (20 percent of the market) are using this quality improvement program to provide heart and stroke patients with a proven standard of care to reduce their risk of a future attack. Get With The Guidelines has the potential to save 80,000 lives annually, and the program was awarded the "2004 Innovation in Prevention Award" from former Health and Human Services Secretary Tommy Thompson.

"The Future"

Challenges to Being CEO

Many people think that the non-profit sector has lower standards and a slower pace. Similarly, many think that the non-profit CEO is the boss of the organization and has all the answers. We dispel those myths immediately. Most of our staff members come from the for-profit sector and are accustomed to that mindset and pace. We believe that the CEO must work in a collaborative team environment. These days, a non-profit CEO can't create results through mandate; it's important to build commitment, create consensus, and be active on the front line. Constantly driving change in the organization is a given for this kind of proactive leadership.

Non-profit CEOs not only need knowledge about leadership issues but must also have in-depth understanding of their organization's sub-sector. They must be informed, strategic, and yet hands-on. The environment that non-profits function in today calls for far more accountability and transparency with the general public, regulatory bodies, and the organization's staff and constituencies.

Many of the challenges we will be facing in our sector over the next few years relate to our role in ensuring that patients and consumers have access to the information and care that they need to lead the healthiest possible lives. Our society will be contending with rapidly increasing

medical costs and disparities in access to quality health care. This will intensify the demand for information at all levels – societal, governmental, healthcare systems, and from individuals. In many cases, patients and consumers will be looking to the American Heart Association as the trusted source of information, guidance, and support, and we will need to be prepared to respond. This will require us to significantly grow our capacity as an organization, not only internally, but also through partnerships and strategic alliances that enable us to extend our reach.

Raising the Bar

Non-profit organizations must focus externally, on customer needs. It's easy to get stuck in day-to-day minutiae, so it's important to return to the strategic goal. If an organization's soft resources — relationships, trust, and team-building — are solid, it's much easier to move hard resources, such as people and dollars. And by focusing on the overarching goal, we can concentrate our efforts and make the best decisions about how to allocate our limited resources.

It's important that an organization focus on differentiating itself externally and not internally. If an organization optimizes each of its separate components internally, it sub-optimizes the whole and will ultimately fail. Many organizations, particularly national non-profits, spend a lot of time differentiating internally (between functions and geographically) rather than externally (identifying where we add value).

Increasingly, the lines are becoming blurred between non-profits and for-profits. For example, people who go to the Web for information seek solutions not from a non-profit, but from whoever can supply the answer they need. Given this increasing competition, it's even more important for non-profits to be clearly branded in the consumer's mind, focus on their value-added differentiation and to collect substantially more customer data than ever before.

Keeping the Edge

Non-profit CEOs keep their edge by reading book reviews, perusing the business journals such as the *Harvard Business Review* and the electronic *Board Source*, and interacting with peers regularly. CEOs often belong to organizations such as Independent Sector and the National Health Council to keep up with best practices. In addition, they and their senior staff frequently attend national meetings, such as the World Business Forum, which can provide new insights.

There are also internal drivers to keep management up to date. Many non-profits have very strong management teams where everyone challenges each other to work harder, think smarter, and keep their edge. Similarly, when our management staff attends external meetings, we spend time afterward debriefing about how the information and perspectives that were presented can help us do our jobs better.

Drawing upon information resources and others on the team keeps me mentally challenged and engaged. But beyond that, true stories about people touched by heart disease or stroke bring home the importance of our work. Such stories give an important emotional edge to our work.

Here's an example of what I mean. It helps to illustrate why our work is so urgent.

Jeannie was born Feb. 3, 1986. She was to be given up for adoption at birth, but the people who were to get her backed out because she had a serious heart defect. A second family, the Bornemanns, accepted her and saw her for the first time when she was just three days old.

Their first words to her were, “Hi, teenie Jeannie! Mommy and Daddy are here!” Despite the IVs in her head, her chest, both hands, both feet and tubes in her nose, their tiny daughter smiled.

Jeannie was diagnosed with transposition of the great vessels, pulmonary stenosis and a ventricular septal defect, an extremely rare set of conditions. The chambers and arterial vessels of her heart were reversed. At that time, not much was known about this condition, so more research was needed. All the doctors could do was insert a shunt (a flexible tube used to increase blood flow) and hope Jeannie gained size and strength.

Despite regular monitoring, Jeannie didn’t grow normally. Doctors were against surgery or a heart transplant until more research and knowledge of her condition was available. When she was five, she weighed 22 pounds and was 29 inches tall. She was strong enough for corrective surgery.

After her surgery, Jeannie’s quality of life improved greatly. She went to school, played T-ball and soccer, and despite severe hearing impairment, she developed a fanatic love of music, especially Elvis. She loved life and people and followed her medical instructions without a complaint. She looked like a normal, healthy kid, who happened to be hearing impaired, legally blind, undersized and who also had a heart defect. She was full of life.

In 1999, when Jeannie was 13, she was looking forward to going to a camp where kids with heart disease can meet and make friends and experience a week away from home. The kids can hike, fish, ride a horse, make crafts and sing around the campfire while being supervised by doctors, nurses and other volunteer camp counselors. Swimming is particularly popular, because no child has to be embarrassed about the scars from their surgery — the kids even compare scars!

The day before leaving for camp, Jeannie fell from a tree and broke her collarbone. She still went to camp.

By early 2000, Jeannie’s health began to decline. The corrective surgery done nine years before was giving out. Her parents were afraid, but not Jeannie. Her cardiologist felt a heart transplant was now possible, in part because of research advances. The night before Jeannie was scheduled to go back to camp, the Bornemanns got the call for the transplant. Jeannie missed camp that year, but she got her new heart.

After the transplant, Jeannie had severe complications and spent 13 of the next 36 months in the hospital. Between hospital stays, Jeannie lived as full a life as she could. She sang on stage in high school, performed with a performing arts group, went to two homecoming dances and traveled.

At age 17, Jeannie became very sick. While she was in the hospital, Jeannie wrote a short note recounting the good times she’d had at camp making friends, doing crafts, hearing silly jokes and singing a song that closed like this:

“When the bugs bite, when the bees sting, when I’m feeling sad,
I simply remember my Boggy Creek things, and then I don’t feel so bad.”

Jeannie Bornemann died in 2004. American Heart Association research and programs helped her live 18 years, but then our knowledge ran out and the miracle of her life ended. Her parents say that if she were alive today, Jeannie would say, “Thank you from the bottom of my new heart.”

There are lots of Jeannies and other people alive today because of American Heart Association research and programs. I believe our work gives meaning to Jeannie's life and provides hope for millions of people, throughout America and across the world. It's personal stories like these that make each of us committed to doing our best at our work every day.

Deaths like Jeannie Bornemann's make me sad and angry. At the American Heart Association, I believe dissatisfaction with the status quo should be part of our corporate culture. The hopes and lives of many people we will never meet rest upon our shoulders, and we must continually challenge ourselves to do more. We need to keep re-assessing our structure, our volunteer and staff talents, our fundraising goals and procedures, and our impact. People are suffering and dying every day from heart disease and stroke, and we must do all we can to save them.