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## Hope is not a strategy

Investing in  
**high-performance**  
fundraising paves  
the way for success

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patient fundraising

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a great idea

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By Susan J. Doliner, FAHP, CFRE

Chair, AHP Board of Directors



FROM THE CHAIR

# Dream, inspire and make things happen

**W**hat does the management style look like at your organization: reactive, informative or proactive? Reactive philanthropic management only allows you to put out fires. It sets a narrow bandwidth on capacity and limits the scope for raising funds. Informative philanthropic management allows you to share opportunities with your CEO, board and donors, but it falls short on action, creativity, urgency, engagement and emotion. As development professionals, we must be proactive. It is our responsibility to make things happen, not just talk about them.

Many of us have enormous wish lists. So why don't all of those wishes come true? Perhaps we try to do too many things at once, losing focus on what's most important. We must zero in on the top strategic priorities that will resonate with our communities and donors, and proactively move our programs forward on behalf of our hospitals while remaining open to donor input and expectations of outcomes.

The worst thing we can say is, "This program is not for us. It's more than we can do right now or perhaps even in the future." If we are professional and doing our jobs well and consistently (and not jumping from one institution to another), then we will know our capacity. We will know when our donors are ready and what programs and projects will inspire them. Lastly, we will have proactively established a trusting relationship which will not waste their time, our time and that of our board or CEO.

Many of us have enormous wish lists. So why don't all of these wishes come true?

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Our work must be timely, creative, consistent, inspirational and tenacious. I don't buy it when I hear, "He hasn't called me back" or "She won't be interested in this project" or "They just supported something else in our community." The prospective donor hasn't had a chance to chime in, to get to know "us" and our impact. The slate is blank if we don't connect.

It's not luck or progression through the pyramid of giving that results in gifts. It's building trusting relationships and presenting solid opportunities that mean something. Most importantly, it's listening to our donors. We do our best when we capture someone's heart and imagination with what's possible through philanthropy.

At Maine Medical Center, the vision for our children's hospital came from our leadership team, our board and a remarkable donor. The Barbara Bush Children's Hospital at Maine Medical Center is one of the premier children's hospitals in the U.S., delivering high-quality health care that's accessible to thousands of children in a vast region. When naming the institution, we wanted to make sure it aligned with compassion, generosity and family-centered care, as well as a breadth and depth of services of national acclaim. Barbara Bush delivers on all counts. She greets each day with a "what can we do to improve the lives of others" attitude. Together, we dreamed of what could be and made it a reality.

Philanthropic support keeps dreams alive and flourishing every day. May you dream today and inspire tomorrow. But don't just dream. It's up to you to make things happen. 



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AS I SEE IT

## A profession to honor

As I was reading the cover article in this issue of *Healthcare Philanthropy*, I was encouraged to see the performance improvement principles of large manufacturing firms such as GE and Toyota being used by health care foundations with excellent results. Amazing, but not surprising.

Health care fundraising has grown tremendously as a profession since I began working at AHP in 1983. At that time, an overwhelming number of our members worked diligently to establish themselves as effective

fundraisers—often without integration into the overall hospital operation. They focused almost exclusively on the fundraising craft.

Today, the field of health care philanthropy has a vast and growing body of research on which to base its practices. It has a code of professional standards and conduct. It has professional certification programs, such as CFRE and FAHP designations. It also has financial clout. According to AHP's latest *Report on Giving*, nonprofit hospitals and health care systems in the U.S. and Canada raised more than \$9 billion in FY2010. For many health care providers today, philanthropy is providing that critical difference in programs and in the lives of patients.

Philanthropy is undoubtedly a vital and important revenue source for hospitals. As hospitals feel the financial crunch from a volatile economy, government budget cuts and shrinking insurance reimbursements, hospital executives are looking to philanthropic programs for significant, reliable and sustainable support.

Like all professions, those in the field of health care philanthropy are keenly interested in self-improvement and improvement of the profession. You see it in the smallest shops to the largest health care systems. You also see it in this journal, where your colleagues take the time to share what they've learned so everyone benefits.

For many health care providers today, philanthropy is providing that critical difference in programs and in the lives of patients.



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In the article “Hope is not a strategy,” Steven Reed shares his research on performance improvement initiatives such as Toyota’s “Lean” and GE’s “Six Sigma.” Reed shows how applying these principles—traditionally used in the manufacturing industry—to hospital fundraising efforts can reduce waste, make the best use of resources and lead to more fruitful fundraising efforts.


Lost major donors are a source of frustration for all development professionals. Jan Wood interviews four industry experts and picks their brains on the best ways to bring lost major donors back into the fold and maintain their interests and participation over the long term. With their combined

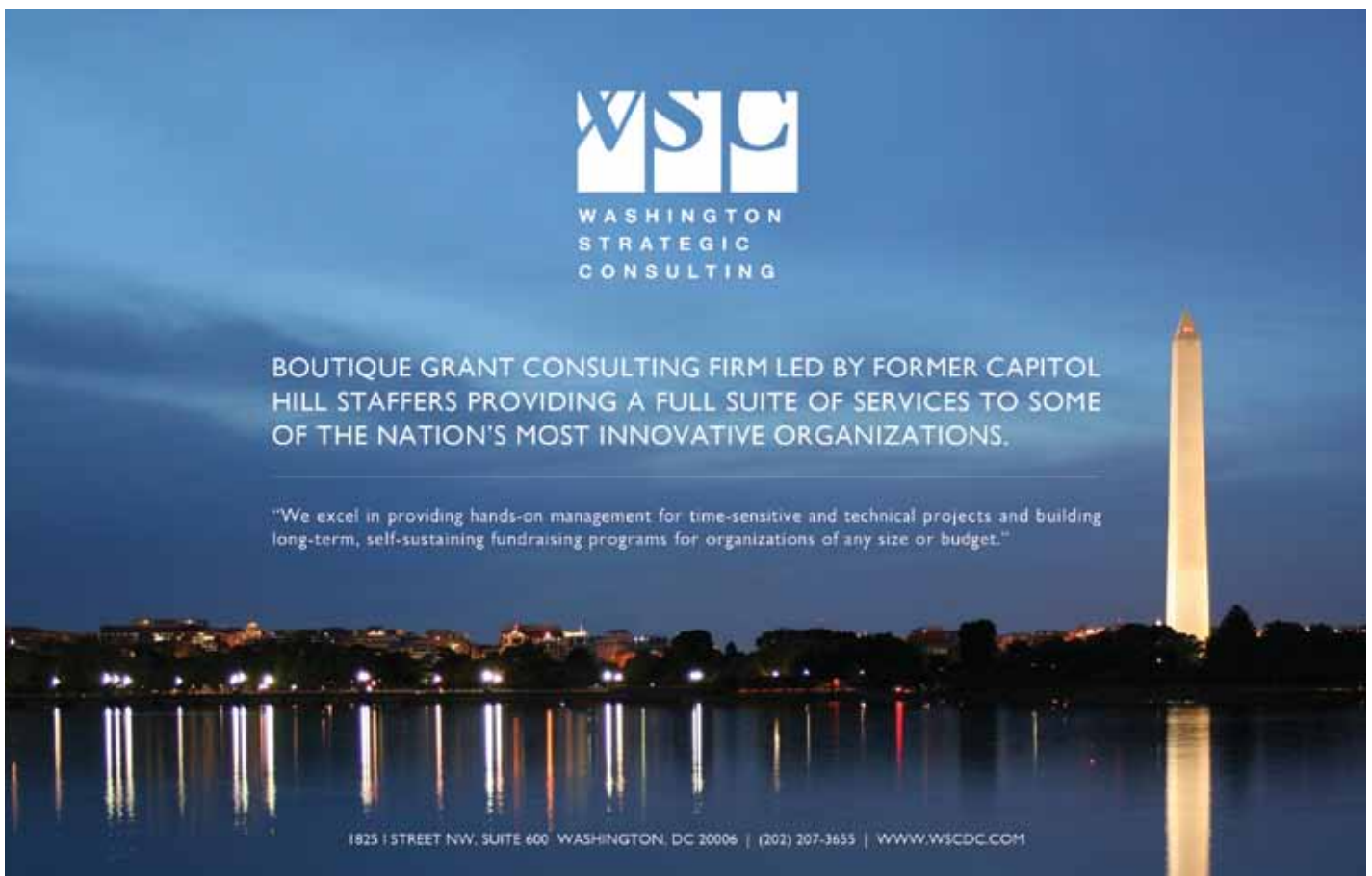
experience of more than 100 years in the field, you’ll want to hear what they have to say.

Steven Rum, M.S.A., and Scott Wright, M.D., share some of the first scientific evidence on what really works when involving physicians in grateful patient fundraising programs. Not content to rely on anecdotes and unsubstantiated information, they conducted a trial to test three educational interventions and determine which would be most effective in teaching physicians how to recognize potential grateful donors and provide qualified referrals.

Successful partnerships also are featured in this issue. Community benefit and health

care philanthropy can sometimes seem at odds, but the article by William Marty Martin, Psy.D., M.P.H., M.A., M.S., shows how they can support each other and help achieve strategic hospital-wide goals. And Dan Buck describes a successful fundraising program that grew from an alliance between a children’s medical center and a beloved baseball mascot.

Health care philanthropy is a profession to be proud of and truly appreciate. I encourage you to continue to improve your knowledge, expertise and skills to grow your programs and increase the benefit you provide to your community. Enjoy the “read.” 



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# Hope is not a strategy

## Applying performance improvement principles to health care fundraising

**A** recent confidential study my organization conducted within five major nationwide faith-based health systems revealed that the chief executive officers (CEOs) believe, on average, that they are raising half or less of the money they should be able to raise.

Those same CEOs expressed optimism about how much their organizations' philanthropy will improve. All but a handful expect to raise more money in the future—but they provided little rationale for this confidence other than that the need for philanthropy is increasing and the economy is likely to improve.

*Hope* appears to be their primary strategy for increased success in fundraising.

Hoping for better results doesn't work. Hospital leadership must invest in building an organization that focuses on high-performance fundraising.

### Adopting quality principles

Today, hospitals are embracing *process* as the key to improving quality, safety and costs, and they are beginning to adopt the quality improvement principles used in manufacturing, such as those employed in Toyota's "Lean" and GE's "Six Sigma" programs.

A Lean organization strives to cut waste and increase value for customers by creating an efficient flow of products and services. Six Sigma is a disciplined, data-driven approach to eliminate defects in any process. When you combine the methodologies, Lean Six Sigma emphasizes speed, reduced waste and making the best use of resources through a powerful data-driven system.

Virginia Mason Medical Center in Seattle—which, in 2011, was once again named a "Top Hospital" by the health care improvement coalition The Leapfrog Group—is known for applying Lean methods to improve health care services. Taking performance improvement even further, Virginia Mason has also applied Lean methods to fundraising—with excellent results.

The Virginia Mason Foundation was raising \$7 million annually in 2002 when its health system adopted Lean as a key transformation strategy. In its presentation at an AHP conference in 2011, the foundation reported raising \$15 million to \$20 million per year

with a staff of 24 and an annual budget of \$3 million, as well as dramatically reducing "time in process" for major gift solicitations, citing an average of less than one year and a 90-percent completion rate from prospect identification to solicitation.

We've seen similar results with our clients, first with the development of the "Core Process"—an early implementation of Lean principles—at the Florida Hospital Foundation, which, in 2007, completed a \$100-million campaign over goal and a year early.

### Do the math

Most hospital fundraising programs are underfunded and underperforming. And although performance improvement initiatives are increasingly common in hospitals, they are rare in hospital fundraising operations.

If you do the math, it's clear that investing in fundraising operations can really pay off. To demonstrate, let's compare investing in philanthropy with investing to build service line volume. Although profit margins vary from hospital to hospital—with many struggling to make two or three percent—for the sake of comparison let's assume that your hospital is netting five percent from service line operations.

Fundraising costs vary as well. Taking into account development staff time and associated expenses, the true cost can be as low as 20 cents per dollar raised, or less, in highly effective fundraising operations, to significantly higher amounts in fundraising operations that do not yield a good return on investment. Let's assume your hospital's fundraising operation is running a 25 percent cost ratio.

Based on these assumptions, what's the result if we invest \$1 million to increase service line revenue and another \$1 million to increase philanthropic revenue, and both efforts are successful? Through philanthropy, you need to bring in \$4 million in gifts to put \$3 million on the bottom line. Through service line

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If you do the math, it's clear that investing in fundraising operations can really pay off.



# 10 problems

## hope won't cure

Generalizations are always dangerous, but experience has led my organization to identify these key issues:

- Reliance on special events and annual giving as principal fundraising strategies, which results in a high cost-per-dollar raised as well as a smaller overall amount.
- Foundation boards not aligned to major gift fundraising, which orients the program toward only smaller gifts and relies on staff member solicitations.
- Executive and physician leadership not oriented to fundraising as a leadership responsibility, which leaves the fundraising staff without the influence that executives have in the community and that physicians have with grateful patients.
- Cases for support that are inwardly focused on meeting operational and capital needs seen by management and do not inspire the excitement necessary to attract high-dollar board members and donors.
- Inadequate stewardship programs, which lead to poor donor retention and a higher fundraising cost to acquire new donors.
- Staff organizational structures that promote neither effective teamwork nor performance-oriented specialization, causing inefficient and ineffective uses of time.
- Absence of multiyear strategic development plans and performance metrics, which leads to static or declining levels of investment and little or no year-to-year improvement.
- Disconnects between fundraising operations and the institutions they support, which lead to inappropriate goals and cases as well as organizational behaviors that do not support a climate for fundraising success.
- Lack of process, rigor and accountability resulting in wasted time, poor follow-up with potential donors and lackluster results.
- Relatively small staffs and inadequate resources compared to the potential that could be raised, which leads to leaving large amounts of money on the table.

operations, you need to earn \$60 million in revenue to get the same bottom line results.

So if you put a fundraising performance improvement initiative in place, and it yields an additional \$4 million in philanthropy, you achieve the same bottom line impact as increasing other revenue by \$60 million—or even more, depending on the service line's operating margin and the hospital's fundraising costs.

### Basics of performance improvement

It's difficult to boil down to a few paragraphs how to apply Lean Six Sigma principles so fundraising processes are more effective and effort is not wasted. Here are a few basic steps:

- **Focus on major gifts.** A key principle of Lean is flexibly placing resources where they will generate the most value. Of course, you need a complete pyramid of fundraising strategies and methods, but if you focus on maximizing your major gifts program you can significantly increase your return on investment. A mark of a high-performing operation is a revenue mix of about 80 percent major gifts, which in number make up about 20 percent of total gifts.
- **Define your processes for relationship development from first introduction through gift agreement and into stewardship.** In Lean Six Sigma lingo this is called mapping your value stream. Essentially, you block out on paper all the key steps involved in the major gift process. Then go back and identify all the activities that take place between the key steps. Pinpoint the steps and activities that do not bring

actual value in the process. Can any of these be eliminated? Automated? Reassigned?

- **Shorten the solicitation process.**

This equates to the Lean Six Sigma concept of cutting waste and shortening cycle time, with a “cycle” being the time from the beginning to the end of a process. In a typical fundraising operation, a development officer might have a portfolio of 130 to 150 prospects, and the time from identification to solicitation and gift acquisition could take 18 months—or even up to three or more years. If you intensify the relationship-development process—which, among other things, involves reducing the size of the prospect portfolio to around 30 good, active candidates—you can shorten the cycle time to less than a year, increasing throughput and raising more money.

- **Develop stage-gate criteria to ensure that development officers spend time on the most likely prospects.** Stages are the various phases in a process, and the gates are review points between each stage where tough decisions are made about proceeding, reworking or stopping. If each gate has specific criteria, you can clearly assess when all criteria have been met—and only then move to the next stage. For each prospect, you move through specified stages and gates before reaching the “ask”—at which point, the prospect is well primed, and asking is only a formality.
- **Use high-cost, scarce resources to do only high-value work.** Good development officers are truly a scarce resource. They should focus on cultivating prospects, not on making database entries. Can a clerical staffer input the



The essence of a successful strategy is getting the right people doing the right things.

data instead? What about things such as routine reporting, other paperwork and thank-you letters? What can you do to increase the number of prospect-facing meetings per week?

- **Develop high-volume, point-of-entry activities and programs to create abundant prospect flow into the “pipeline.”** For example, in one model, the initial connector, often a board member, brings people to interesting events where they learn about new initiatives or treatment advances. Some become qualified prospects and move through the process. A good metric is, for every 10 people brought in by the initial

connector, one gives a gift at the target level.

- **Set multiple process measures, with emphasis on cycle time.** How many prospecting events will you hold each month? How many connections should you make at each event? How many prospects should you be cultivating at each stage? You must establish criteria to let you know how you’re doing, as well as a system for alerting you when a particular measure is or isn’t being met. For example, you can use a “dashboard” system where green means you’re on track, yellow is the continuous improvement zone and red calls for immediate attention because

can apply their experience and creativity to specific situations. You can then continuously improve that one way.

## The foundation of high-performance fundraising

For high-performance fundraising efforts to pay off, you must have these three basics in place:

- **A compelling, donor-centric case.** Although much has been written about the importance of developing a detailed rationale for supporting your organization, the role of the case in performance improvement tends to be overlooked. The essence of a successful strategy is getting the right people doing the right things. Achieving the right mix of fundraising methods requires the right case. Inwardly focused cases based on beneficiary needs are sufficient for annual fund solicitations, but often do not inspire the excitement necessary to attract high-dollar donors.

- **An effective fundraising board structure and composition.** Instead of the traditional small, governance-oriented board with members who have neither significant personal giving capacity nor the right connections, create a large, high-performance board composed entirely of donors. Treat the members as VIPs, offer them inside information about what is going on in the organization, and break them into working councils that meet only a few times a year—giving them a narrowly defined, less time-intensive but highly valuable role. Board members should be “connectors” who, as defined in Malcolm Gladwell’s book *The Tipping Point*, know many people in the community and are in the habit of making introductions.



Instead of simply measuring things at the end, such as how much money was raised or the total sum each development officer brought in, use measures that help you **see at key points whether you are on track** for a positive outcome.

you’re seriously behind where you need to be.

- **Measure early, and use metrics that correlate with success.** Instead of simply measuring things at the end, such as how much money was raised or the total sum each development officer brought in, use measures that help you see at key points whether you are on track for a positive outcome. Not only will you get what you

measure, you will build a reliable forecasting system. Your chief financial officer will love you.

- **Maintain a constant effort to eliminate out-of-bounds process variance.** Create your “way” of fundraising, so you have a tried-and-true baseline process that is ingrained in your culture. In other words, if you have four gift officers, you will still have one consistent way that your organization goes about acquiring major gifts, instead of four different ways with numerous variations from each. That one way should allow for a clearly limited degree of variance so your front-line people


*Editor’s Note: The concepts in this article are from **Hope Is Not a Strategy**, a book under development by the author.*



• **An organizational culture for philanthropy.** For a long time, development professionals have been talking about the necessity of having a “culture of philanthropy,” in which everyone throughout the organization sees the value of philanthropy and understands their role in it. But even more important is focusing on making your institution an attractive beneficiary for those who want to give. Raising substantial sums requires an investment, not only in terms of money but also

in an examination of how the organization regards fundraising and makes decisions that impact philanthropy. Fundamental change to encourage philanthropy may be required, as well as significant improvement within the fundraising operation itself.

High-performance fundraising isn't easy. It requires an investment and calls for changes in how things are done. Hope, on the other hand, allows organizations to maintain the status quo. But what would you rather do, hope

for better results or take concrete steps to achieve them? With an investment in performance improvement, there is good reason for hope. 



**Steven A. Reed** is the chairman and chief executive officer of Marketing Partners, Inc., which offers services for businesses and nonprofits, including branding, business planning, organizational development, market research and performance improvement. He is also president of the company's Performance Advantage subsidiary, which focuses on improving performance in health care fundraising through the use of Lean Six Sigma principles.

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# Lost major donors



The experts weigh in on why major donors leave and how to get them back

**H**ealth care fundraising professionals see it all the time. We look through our databases and spot former major donors who no longer take our telephone calls, let alone give to our health care organizations. On occasion, we try to find out why we lost them, with varying degrees of success. But more often than not, we write the donor off and concentrate on the next prospect—one who, we hope, does not have the baggage that accompanies the “lost major donor.”

And it happens to every health care nonprofit in every community. No matter what the organization's size, mission, professionalism or sophistication, and despite all the best efforts of a talented staff, every nonprofit loses reliable, committed major donors.

If a five percent increase in donor retention would increase our annual contributions by as much as 50 percent over two years, as noted in *Donor Centered Fundraising* by Penelope Burk, imagine the uptick in annual funds if we could recapture lost major donors, or even better, learn from our mistakes and not lose them in the first place. According to the AHP FY 2010 Report on Giving U.S. self-assessment spreadsheet, the median amount of total funds raised in 2010 was \$4,465,701 for institutions with more than 400 beds; for those with 200–399 beds, the median was \$2,794,924. Using these figures, the average institution with 400+ beds would see up to \$2.2 million in additional annual funding if it boosted donor retention by five percent, and the average midsize institution would see up to \$1.4 million.

In two decades of fundraising for a variety of sectors, I've never been able to find concrete statistics on the attrition rate of major donors for nonprofit organizations. Yet I have seen the phenomenon of lost major donors in my own organizations and have heard colleagues lament the problem. I decided to go to the experts to ask for insights about how we lose, retain or reengage our valued major donors.

By telephone, I interviewed four of the industry's top fundraising consultants—Penelope Burk, Bruce Flessner, Robert Bull and Tony Poderis. With more than 100 combined years of fundraising research and experience, these experts had a lot to say about the art and science of major gift fundraising.



**In your experience, what percentage of health care organizations have “lost” more than one major donor in the last**

## 10 years? Is this number even quantifiable?

**Burk:** Virtually everyone loses major donors over time. And often we fear we have lost a donor when, in their minds, they are just waiting for the “right project” and they still feel committed to the organization. Our timing and theirs is out of sync, or they have not found a new project that has inspired them for the next big gift. Unfortunately, it is next to impossible to quantify this phenomenon, which is probably why no one has tried.



**Flessner:** A very high percentage of organizations see major donors move on. Those giving six-figure-plus gifts are statistical outliers by nature. They fall outside the normal donor trends because their gifts are often very personally motivated.

**Bull:** The economy over the last four years has heightened donor loss. Some organizations have lost as much as 15 to 20 percent of their major donor base because of real or perceived economic difficulties.

**Poderis:** When we lose a major donor, we almost always know right away. They tell us. When they do not tell us, we need to ask the question and leave with an understanding of why the donor is no longer interested in our organization. Rejections are excellent opportunities to correct problems. Meet with the “lost

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VICE PRESIDENT, DEVELOPMENT, CENTRACARE HEALTH SYSTEM

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# Meet the experts

1

## Robert Bull Jr.

has nearly 20 years of successful fundraising experience for nonprofit organizations, both as a development officer and consultant. He joined The Compass Group after a six-year career as a senior consultant with Ketchum, Inc., and has provided fundraising counsel to more than 100 nonprofit organizations.

2

## Penelope Burk

is a nationally recognized author and researcher with more than 40 years of nonprofit management and consulting experience. She is the author of two best-selling books, including *Donor Centered Fundraising*, and more than 50 articles, plays and seminars. Her firm, Cygnus Applied Research, Inc., conducts research used by nonprofits throughout the U.S. and Canada.

3

## Bruce Flessner

is a principal at Bentz Whaley Flessner and has served hundreds of clients in more than 25 years of consulting. Before founding his firm, he was vice president of the University of Minnesota Foundation, a role he assumed after serving as the annual fund director at Kalamazoo College in Michigan.

4

## Tony Poderis

is a veteran fundraiser with more than 35 years of experience, including 20 years as director of development for The Cleveland Orchestra. Since 1993, he has been a fundraising consultant for nonprofit institutions in social services, health care, education, religion and culture. He is the author of a guidebook for volunteer and professional fundraisers, *It's a Great Day to Fund Raise!*

donor” and ask directly what you can do to best steward them and renew their interest in supporting your organization.

### What are the primary reasons that major donors are “lost?”

**Flessner:** 1) A bad experience with the organization, such as poor performance, leadership change or time lapse from the experience that precipitated the first gift; 2) Social reasons, such as job loss, divorce, a medical issue or other change in circumstances and 3) Stewardship issues regarding how well or poorly the organization engages the donor and meets his or her needs. Number one is unique to health care. When a major gift is

precipitated by a highly emotional experience or life-changing health scare—the “grateful patient” syndrome—it goes against all the trends of traditional donors, who first give a smaller gift and then are cultivated to give increasingly larger gifts over time. Often the grateful donor gives a large initial gift and then decreasing amounts over time. We perceive that we are losing them when, in fact, it’s the natural flow of this type of major donation.

**Poderis:** Death, moving away, kids in college and other financial constraints are still the most common reasons why we lose major donors. These are circumstances you cannot control and objections not readily overcome.

**Bull:** Organizations and gift officers can underestimate the importance of leadership and vision. Very often, when leadership changes, major donors feel disconnected to the new leader and his or her vision. True major donors want “big” vision—they want to feel that their gifts have real impact. One of the most common mistakes by major gift officers is being afraid to truly think big and present the big idea that requires significant money.

**Burk:** In our conversations with major donors over the years, 45 to 60 percent say “lack of communication” is why they no longer feel connected to an organization. They do not feel well informed about how their money was spent. You also lose major

donors for the same reason you got them in the first place—they move on. It's the natural cycle of philanthropy, and not-for-profits are both beneficiaries and victims of donors' changing priorities. We have found that if gift officers continue to communicate with these donors even after they have left, they can sometimes reengage them as the cycle circles back to the institution's cause or vision.

**Bull:** The data shows a trend toward supporting fewer causes. Major donors are now looking at their top four or five causes to support, rather than the top 10 they supported in the booming economy.

**Burk:** This narrowing of philanthropic focus is especially true with middle-aged donors, who are now supporting half of

.....  
Virtually everyone loses major donors over time. And often we fear we have lost a donor when, in their minds, they are just **waiting for the "right project"** and they still feel committed to the organization.

the causes they used to support. This trend increases every year we conduct our research.

**Flessner:** When it comes to older major donors, never underestimate the importance of adult children. They will likely influence and even take over affairs for their aging parents, and they could play a key role in alienating their parents from

charitable efforts with you. Include them in stewardship efforts early so the philanthropic legacy to your organization is as important to them as it has been to their parents.

**Burk:** Turnover at the major gift officer level can be a primary cause for major donor attrition. The average tenure for a gift officer is 3.8 years. However, a



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The data shows a trend toward supporting fewer causes. Major donors are now looking at their **top four or five causes to support**, rather than the top 10 they supported in the booming economy.

new gift officer presents a special opportunity to connect with lapsed donors; he or she has a clean slate and is able to mend fences or provide what was lacking without guilt or worry.

**Q** How big a role does donor stewardship play?

**Flessner:** In many ways it's most important, because it's the factor we can control. A strong stewardship program has to go beyond newsletters, mailings and invitations to include consistent personal interaction. In a hospital setting, for example, strong stewardship of a major donor includes face-to-face meetings between the donor and key

physicians or administrators, as well as regular visits with the gift officer. A common problem is that CEOs and hospital leaders do not speak "donor-ese," so fundraising professionals must educate them about donors' interests and needs. We must help leaders understand that we are not just "throwing parties" and "having lunches"—we are enhancing our connection with the donor, which leads to future giving. We must also teach them how to speak in ways that are meaningful and inspirational to major donors, such as explaining how their financial gift impacts patient care.

**Burk:** Never cut ties with a donor even when you have

concluded they are "lost." These donors often become stunning prospects for planned gifts if you keep up the communication.

**Poderis:** Stewardship is critical, but it should be multifaceted. Bring the donor to the organization; go out to meet the donor; look for ways to help the donor, such as facilitating business and social contacts; find ways to connect donors with particular programs and staff; always thank donors quickly and accurately for their generosity and provide information about the use and impact of their funds and be sure to recognize donors in ways they approve of. Some people need fanfare, while others would rather not have it.

**Q** When we lose a donor, is our time best spent trying to "get them back" or focusing on the next prospective major donor?

**Burk:** Timing is everything. Someone may not be giving at the same level as in the past because they have been wooed by another



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organization. But things may happen with that organization to negatively impact the relationship, and they may become dissatisfied there—in which case, you may be able to reengage them if you have maintained your efforts to communicate. Conversely, our research has shown that a satisfying philanthropic relationship with one not-for-profit can lead donors to expand their activities, both upwards—giving more to the same cause—and outwards—supporting other not-for-profits. For example, donors who give to a cancer program at a hospital because of a positive experience there may be inspired to give to the American Cancer Society or support a cancer walk.

**Bull:** We should always try and “save” the donor if at all possible, but often we move into action too late. Identify the signs of waning commitment—such as ceasing to take your calls or attend donor events—early enough to reverse the trend. The important question is not “if” we should reconnect with the donor, but “how.” Too often we try reconnecting through events, newsletters or lunches where we do not address the issue. Instead, the major gift officer should speak to the donor on a direct, interpersonal level. Get to the heart of the matter in a kind and genuine way. “It seems as though you may be feeling less connected to our organization. If that’s true, can you tell me why? What we can do to better serve

*Editor’s note: We gratefully acknowledge the strong support of Gonser Gerber Tinker Stubr, and their longtime sponsorship of the AHP Professional Paper Competition.*

your needs and inspire you as a donor?” Ask the question, but do not accuse or sound defensive. Ask in a sincere manner that demonstrates your commitment to make it right.

**Flessner:** The reason they are disconnecting from your organization should determine if and how you follow up. If they have moved on because of proximity, such as snowbirds retiring to warmer climates or moving closer to family, or because of a long-term change in economic status, it makes sense to keep them on mailing lists, especially for annual giving. However, cut your losses in terms of the major gift officer’s time and effort, because these folks are not likely to be future major donors. If the issue is stewardship or current interest level, reconnect quickly and personally for the best chance of reengaging them. They just may not be aware of all the new things happening in your organization that could interest or inspire them.


### What other words of advice do you have?

**Bull:** Examine the big picture. We sometimes lose major donors because we have not done a good enough job creating a culture of philanthropy throughout our organization—where all levels understand the importance of philanthropy to the organization’s success and their role in philanthropy.

**Burk:** Beware the perils of stratifying donor levels. Creating “giving societies” based on amounts donated or demographics doesn’t seem worth the time and money. Our research has found

that even donors whose gift values put them at the top of the list are far less influenced by arms-length recognition—a society lapel pin or a special newsletter—than by personal stewardship. Individual relationships addressing donor interests and needs are still the most effective means of securing and retaining major donors.

**Flessner:** Maximize your touch points. Look at your 25 top donors and make sure they have at least seven strong relationships connecting them to your organization in a meaningful way: several people in your foundation or development office—not just the assigned gift officer—several from your board or volunteer leadership, and at least two from your administrative team, preferably including the CEO. The major donor should know all these people by name and feel comfortable phoning them. The loss of a major donor can often be traced back to staff or volunteer turnover, so relationship redundancy is critical.

**Poderis:** Remember the three basic truths of donor loyalty: 1) Organizations are not entitled to donor loyalty—they must earn it and constantly re-earn it; 2) Building donor loyalty is not magic—it is simply hard work by thoroughly prepared people and 3) You don’t wait for the “right” time to build donor loyalty. You do it all the time. 



**Jan W. Wood** is the director of major gifts for the Anne Arundel Medical Center Foundation in Annapolis, Md. During her 28-year career, she has been involved in raising funds for dozens of health care and educational nonprofit organizations and institutions.

# Teaching physicians grateful patient fundraising

Evidence shows that **one-on-one coaching** and follow-up by development professionals yields a high number of qualified referrals.

Of the \$4.8 billion that people donated in 2009 to U.S. academic medical centers, health systems and community hospitals, nearly \$1 billion came from grateful patients.<sup>1</sup> Given the strain the recession has placed on hospitals, the steady decrease in research funds from the National Institutes of Health (NIH) and leaner reimbursements from insurers, philanthropy has become increasingly important—including gifts from grateful patients. But what strategies are effective for cultivating such gifts?

Although many institutions have developed guidelines that suggest ways for physicians to interact with patients who offer gifts or express gratitude,<sup>2-4</sup> evidence is lacking about what really works. Thus, we conducted a study, published in *Academic Medicine* in January 2012,<sup>5</sup> to generate data on the relative effectiveness of educational approaches used to increase

academic physicians' involvement in grateful patient fundraising.

Because physicians interact directly with patients, they are central to grateful patient fundraising, but most physicians have never been trained how to respond to grateful patients' inquiries about philanthropy, nor have they learned how to partner with development personnel.



## Finding evidence

In 2008, Johns Hopkins University concluded a nine-year capital campaign that generated \$3.7 billion in gifts and pledges. Of this total, Johns Hopkins Medicine raised \$2.1 billion, a record in academic medicine.<sup>6</sup> Afterwards, while conducting a year-long review of the gift sources and making projections for the future, it became clear that our institution needs, but lacks, a systematic, effective method to increase the number of grateful patient prospects. When we searched the literature, we found almost no empirical research into grateful patient philanthropy and only anecdotes suggesting that collaborations between physicians and development professionals can result in successful fundraising from grateful patients.<sup>7-10</sup>

To guide our own practices and gain credibility with physicians and institutional leaders, we set out to generate sound evidence of approaches that work well for involving physicians in grateful patient fundraising. An interactive, one-on-one coaching relationship between a development professional and a physician, we hypothesized, would yield more qualified

referrals than would more passive approaches, such as lectures or emails. We designed a randomized comparative effectiveness trial, which we conducted in 2010 to determine which of three educational interventions best involves academic physicians in grateful patient fundraising.

## Email, lecture and coaching

“Effectiveness,” the primary outcome our trial focused on, was measured by the number of qualified referrals that participating physicians made to development professionals. We defined a qualified referral as an individual or family capable of making a minimum gift of \$25,000 over five years. Although philanthropic fundraising can take years from start to fruition, particularly when it targets large, individual gifts, our study needed to fit a reasonable timeframe, so we designed it with a three-month intervention period and six-month data collection period. In addition to qualified referrals, we tracked monetary gifts pledged and received for six months.

To be eligible to participate, physicians had to have ongoing involvement in direct patient care but no previous experience

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Although many institutions have **developed guidelines** that suggest ways for physicians to interact with patients who offer gifts or express gratitude, evidence is lacking about what really works.

**Table 1. Characteristics of participating academic physicians (N=51)\***

Physician Characteristics	Email Arm N= 14	Lecture Arm N= 18	Coaching Arm N= 19	Total N= 51
Male, N (%)	8 (57%)	14 (78%)	16 (84%)	75%
Female, N (%)	6 (43%)	4 (22%)	3 (16%)	25%
Age (Mean)	47	49	48	48
<b>Race, N (%)</b>				
White non-Hispanic	9 (64%)	15 (83%)	16 (84%)	78%
Hispanic	**	--	**	6%
African-American	--	--	**	2%
Asian	**	**	--	8%
Other	--	**	**	6%
<b>Division, N (%)</b>				
Cardiology	--	**	**	12%
Internal Medicine	**	--	**	10%
Neurology	6 (43%)	10 (56%)	10 (53%)	51%
Oncology	5 (36%)	5 (28%)	4 (21%)	27%
<b>Academic rank, N (%)</b>				
Instructor / Assistant Professor	5 (36%)	6 (33%)	7 (37%)	35%
Associate Professor / Professor	9 (64%)	12 (66%)	12 (63%)	65%
<b>Years at Johns Hopkins, N (%)</b>				
<5 years	5 (36%)	**	4 (21%)	22%
5+ years	9 (64%)	16 (89%)	15 (79%)	78%

\*N indicates number of individuals, \*\*Indicates ≤3 individuals (number not presented to protect participants' anonymity)

with grateful patient fundraising. We targeted physicians from the departments of neurology, oncology, cardiology and internal medicine because they see their patients repeatedly over time. Out of 74 potentially eligible physicians, 51 agreed to participate. One quarter were female, 65 percent were at or above the rank of associate professor and 80 percent have practiced at our institution for more than five years. Table 1 summarizes the participating physicians' characteristics.

Each participating physician was randomly assigned by a computer program to one of three groups:

- **Group 1, the email arm.** These physicians received 11 email messages that included news clippings highlighting large gifts, general information about

philanthropy in the U.S. and articles about giving in medicine. Emails were sent weekly for three months. (We do not otherwise send routine emails regarding philanthropy or philanthropic gifts to physicians.) At the start of the study, each physician also received a copy of the book *The Millionaire Next Door: The Surprising Secrets of America's Wealthy*,<sup>11</sup> which presents research on affluent Americans and emphasizes that it's not possible to recognize many of them by outward appearances.

- **Group 2, the lecture arm.**

Physicians attended a one-hour training session in a hospital conference room and were given time afterwards to ask questions of the presenter. We offered three separate sessions, each taught by a

physician who had a long history of successful fundraising at our institution—having collectively raised more than \$100 million for their departments. They shared their own approaches and talked about what worked for them. They also presented fundamentals of successful fundraising, including the importance of:

- 1) Delivering outstanding care to every patient;
- 2) Cultivating close relationships with patients;
- 3) Listening carefully for cues of interest in philanthropy and
- 4) Thoughtfully considering, in advance of the discussion, answers to questions that patients might have about ongoing initiatives and philanthropic needs.

The presenters also discussed ethical considerations that emerge when interacting with grateful

patients, personal stories about processes for securing gifts and time commitments. Participants in the lecture arm received *The Millionaire Next Door* and the same weekly emails as Group 1.

• **Group 3, the coaching arm.**

Physicians received one-on-one training from three development professionals (“coaches”) with over 70 combined years of fundraising experience who worked with them individually to prepare them to collaborate in grateful patient fundraising. To ensure consistency, we developed a coaching curriculum (see sidebar on page 28). Coaching was initiated with a one-hour training session in a discussion-based, question-and-answer format, followed, flexibly, by in-person meetings, phone calls and emails—an average of 15 separate contacts per physician over the

“Working with **Steve Rum** was an eye opener for me. I am usually very hesitant to approach patients about philanthropy, but while working with Steve I learned that discussing my research with the patients was actually very helpful for them. Currently, we do not have very effective therapies for patients with peripheral neuropathies. Discussing ongoing research from our laboratories here at Hopkins as well as collaborators at other institutions informs my patients and gives them hope about future therapies.”

—Ahmet Hoke, M.D. (Group 3 participant)

course of the three-month study. To respect physicians’ time, these subsequent contacts were brief, focusing on identifying prospects and reinforcing the curriculum’s content. Physicians in the coaching arm also received the

weekly emails and *The Millionaire Next Door*.

To receive referrals, we asked the participants to think about patients they had seen in the past three to six months who might be donor prospects. Physicians provided

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## Coaching curriculum and approach

Our coaching was modeled after the same principles as investment coaching from a financial advisor or fitness coaching from a trainer—

teaching the physicians about best practices in fundraising and providing specific tips, tools and insights. We taught them how to look for hidden cues that a person is interested in their research, such as asking, “What is your research about?” as well as signs that, despite outside appearances, a person has wealth, such as mentioning, “I’ll be away at my summer house in Paris.” We also emphasized the importance of tapping a potential donor’s passions and personal experience—which, in the case of grateful patients, could be, “I’m grateful for the good care I received and I want to learn more about related research.”

Here are the curriculum topics we covered:

- Overview of philanthropy at our institution (general level).
- Factors that motivate people to give, such as having a personal experience that helps them relate to your goal.
- Cues possibly indicating that an individual may want to offer financial support.
- The difficulty in trying to guess who has giving potential.
- Ethical considerations regarding asking for money while a person is under your care.
- Barriers to fundraising and strategies for overcoming obstacles.
- The value of stewardship.
- Action plans for specific next steps.

patients’ names to the development professionals either by telephone, email or conversation. The development team then researched each referral to verify a match with the qualification criteria. We were careful to conform to U.S. HIPAA (Health Insurance Portability and Accountability Act) requirements for confidentiality.

### Key findings

We found that when development officers spend one-on-one time with physicians to teach them fundraising best practices and how to recognize potential grateful donors, they are more likely to collaborate with the development team and provide qualified referrals.

- **In the coaching arm**, 17 of 19 physicians, or 89 percent, referred one or more qualified potential donors—an average of 2.1 qualified referrals per physician. Altogether, these physicians generated 63 referrals, of which 41, or 65 percent, were deemed to be qualified. Within the study period, these referrals led to five separate gifts totaling \$219,550.
- **In the lecture arm**, physicians made a total of three qualified

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referrals, all within two weeks of the lecture, and no new gifts or pledges resulted.

- **In the email arm**, physicians made no qualified referrals.

The coaching method, applied to randomly selected physicians who lacked prior experience with philanthropy, yielded impressive results, but even more exciting is the greater success possible if we can involve the most beloved physicians or those with the highest satisfaction ratings from their patients.


The skills and techniques that physicians learned in the coaching arm continue to have an impact. In the last fiscal year, after our study was completed, faculty in the neurology department made 150 referrals of potential donors, whereas this same group made approximately 15 referrals just two years earlier—a 900 percent increase in activity.

Now, part of each department's work plan at Johns Hopkins Medicine is to measure the number of interactions between physicians and gift officers as well as the number of referrals of potential donors so that these metrics can be reported to the clinical director at the end of each year. Clinical directors incorporate development activity as part of the annual review of their physician group.

## Suggestions for success

Having “philanthropic coaches” who guide physicians through sound principles and skills, and who check in with physicians

regularly to promote accountability, is a successful approach to help doctors raise gifts that are important to their work. Our major suggestions are:

- Deploy development professionals as one-on-one coaches to bring about behavioral changes among physicians.
- Ensure consistency of interventions through a standardized curriculum and training approach, especially when diverse development professionals at various institutions are involved.
- In educating physicians, share real success stories of gifts made to the institution and how the process was shaped.
- Help physicians understand how to listen for clues that the issue of philanthropy can be raised, such as when a patient expresses interest in the physician's work or asks questions about what's being done about the disease in general. The doctor can then mention that lack of funding for his or her project is an obstacle to success.
- Have development officers and physicians work together on a regular basis to identify and qualify potential donors and follow up with them. 

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# Community benefit: Friend or foe?

Both philanthropy and community benefit must be part of the strategic plan for nonprofit health care organizations.

**I**f you're part of a nonprofit health care organization, here's a question some of your potential donors may struggle with: Does this hospital need my money when it is giving away money as part of its community benefit program?



Maybe donors become confused when they receive a request for a contribution and then read in the news how much free care, medical education and funded research your health care organization has donated to the community. Or maybe they drive by your brand new, state-of-the-art facility and wonder why the doctors' parking lot is full of BMWs, Mercedes and Jaguars—and hardly any Hondas or Fords.

Donors who are especially savvy may search websites such as GuideStar ([www.guidestar.org](http://www.guidestar.org)), which gathers and publicizes information about nonprofits, and learn how much your health care organization contributes to charity care and community benefit, as disclosed on the new U.S. Internal Revenue Service (IRS) Form 990 Schedule H or the Canada Revenue Agency (CRA) Form T3010-1. Which, of course, may trigger the question that kicks off this article—and prompts me to ask you this: Are community benefit and health care philanthropy in your organization friend or foe?

According to the American Hospital Association, the U.S. has more than 5,700 hospitals, and of these, 2,900 are nongovernmental nonprofits.<sup>1</sup> This article explores the relationship between community benefit and health care philanthropy in U.S. nonprofit institutions, including the ways they are at sometimes at odds, and how they can complement each other.

## The community benefit landscape

The Catholic Health Association of the United States defines community benefit as “programs and services designed to improve health in communities and increase access to health care.”<sup>2</sup> Nonprofit hospitals must provide a community benefit to qualify for tax exemption under section 501(c)(3) of the U.S. Internal Revenue Code. In the past, the types of activities that qualified as community benefit were not clearly delineated, but the IRS changed that in 2009 by introducing

Form 990 Schedule H. The form's purpose is to give the agency a more accurate picture of the nonprofit hospital sector and help it assess nonprofit institutions' compliance with the community benefit standard.

Schedule H asks for information on the cost of charity care, unreimbursed Medicaid, health improvement services, health professions education, research, contributions, activities that address the root cause of community health problems and bad debt expenses. According to a study published in 2009 about the effects of filing new community benefit reports in Maryland,<sup>3</sup> which has had requirements similar to those in Schedule H since 2004, officials remain uncertain about how to classify community benefits and they tend to adopt a managerial approach to charitable activities by focusing on complying with requirements rather than commitment. They take a short-term accounting view that looks at profit or loss rather than emphasizing a long-term investment in the community.

The U.S. Patient Protection and Affordable Care Act (PPACA), signed into law by President Barack Obama on March 23, 2010, and largely upheld by the U.S. Supreme Court on June 28, 2012, will have a considerable effect on the community benefit programs of nonprofit health care organizations because the estimated 30 million people without health insurance—many of whom have received charity care—will have coverage by 2014. The law calls for opening state health insurance exchanges, expanding of Medicaid and providing federal subsidies to pay for premiums.

## Fundraising becomes essential

As the *Wall Street Journal* reported on August 8, 2011, nonprofit hospitals' revenue is growing at the slowest rate in 20 years—a four percent median growth rate.<sup>4</sup> Given the increasing financial pressure these institutions are facing, fundraising is becoming more important than ever. According to Jane Haderlein, vice president of philanthropy at Huntington Hospital, “Philanthropy was once considered simply



Linking executive compensation with community health goals can demonstrate organizational commitment to community needs.

'nice to have,' but discussions regarding the role and strategic imperative of philanthropy can now be heard regularly at both the management and board levels."<sup>5</sup> Now, she said, nonprofit hospitals see fundraising as essential to their survival. As an example, plastic surgery departments in academic institutions are establishing formal philanthropic efforts to support education, research and clinical programs.<sup>6</sup>

The amount that nonprofit hospitals and health care systems raised in FY 2010 increased eight percent over the previous year, according to the FY 2010 AHP Report on Giving—U.S.<sup>7</sup> Overall, \$8.3 billion was raised in FY 2010. The report found that nearly 60 percent of the total dollars raised came from individual donors. The largest source of funds was annual giving (20 percent), followed by

major gifts (17.1 percent), capital campaigns (15.4 percent), special events (14.8 percent) and planned gifts (9.5 percent). The donated funds were used for construction and renovation projects (22 percent), new and upgraded equipment (20.6 percent), general operations (17.6 percent) and community benefit programs (10.7 percent).

### **Inclusion in strategic plans**

In times of declining revenue, internal competition for limited resources increases, including competition for money, time and staff. Also, development staff may report to entirely different leaders than staff involved in providing community benefit programs—which can result in lack of coordinated effort between the philanthropic and community

benefit programs and conflicting messages being sent to the public.

A key problem is that far too many health care organizations fail to include health care philanthropy in the strategic plan.<sup>8</sup> In my experience as a health system board member and former hospital executive, this failure extends to community benefit, too. Community benefit and health care philanthropy must be strategic priorities that are clearly delineated in the strategic plan, operational plan and budget. When you examine these three documents, you should be able to see that community benefit and philanthropy support each other, rather than compete for resources. Unfortunately, I've found that these initiatives often are not aligned—and are not even included in the strategic plan.

Another issue is the failure of



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executive performance indicators and compensation to be tied to philanthropy and community benefit. During my years as a human resources professional in health care, as a member of a large health system's executive compensation committee and as a graduate educator in compensation, I've found that executive compensation is where the rubber hits the road in terms of how well aligned the organization's mission, values and strategies are with day-to-day decision-making and resource allocation. Executives largely follow the incentives that are put in place by executive compensation committees.

According to a 2009 National Center for Healthcare Leadership report, *Navigating in a Shifting Executive Compensation Environment*, "Increasingly, critics of executive compensation are questioning the perceived disconnect between compensation packages and organizational results and community benefit."<sup>9</sup> The report recommends that, when health care organizations determine incentives and adjustments to compensation, "the process should heavily weight mission attainment and community benefit outcomes as well as financial viability."

An article in *Health Progress* looking at the role of governance in managing community benefit recommends that chief executive officers (CEOs) be accountable to the board for community benefit activities and that specific criteria for improving community health status be included in the CEO's performance review.<sup>10</sup> "Linking executive compensation with community health goals can demonstrate organizational commitment to community needs," the authors state.

## Culture can promote alignment

Organizational culture can make it difficult to align fundraising and community benefit with strategic priorities. Organization development consultants have a saying, "culture kills strategy," which means that the way an organization makes decisions and allocates resources is often in opposition to its articulated mission, strategies and values.

In a 2006 article in *Health Affairs*, Jane Haderlein points out the power of chief executive officers (CEOs) to mobilize leadership and staff to build an internal culture of philanthropy. Among her suggestions:

- Write articles and op-ed pieces from the CEO about the importance of philanthropy in the community.
- Include fundraising performance on dashboard measurements, similar to the way scores are tracked for patient satisfaction.
- Mention at internal meetings and public appearances the important role of philanthropy in helping the organization fulfill its mission.

## Goal alignment

The hospital board and senior leadership must view community benefit and health care philanthropy not as two separate organizational functions but as two institutional resources which, together, can help achieve strategic hospital-wide goals. Such goals may include:

- Raising financial capital and social resources, such as expertise for the public good.
- Identifying common needs among diverse stakeholders in the community and allocating

appropriate resources to address them.

- Improving health outcomes at the individual, family, community and population health level.

Examples of health care institutions that align philanthropy and community benefit with strategic goals are not easy to come by. One good example is Children's Hospital of Orange County (CHOC), which has "Focus on Financial Stewardship" as one of its six strategic goals. The goal says, "The ability of

CHOC to execute on current and future initiatives is contingent on achieving financial targets in areas such as profitability, bond ratings and philanthropy. Through efficient management of resources and an emphasis on philanthropy, CHOC will further reinvest in its facilities, programs and capabilities.”<sup>11</sup>

Catholic Health Initiatives, a national nonprofit health organization headquartered in Colorado, has “creation of healthier communities” as part of its mission.<sup>12</sup> In 1996, it established a Mission and Ministry Fund through which it awards grants to serve disadvantaged populations, help improve health and prevent violence. Over the years it has supported hundreds of projects, including reducing congestive heart failure readmission rates in London, Ky., and improving the safety of a playground in Oakes, N.D.


## Ways to be friends

Both of the institutions cited above provide examples of how philanthropy and community benefit can be friends, not foes. Another is the Parkview Hospital Foundation, part of Parkview Health in Indiana, which coordinates the Community Health Improvement Program and was established in 1998 to provide support to the community through collaborative partnerships. In 2012, Parkview Hospital donated more than \$500,000 to organizations such as Cancer Services of Northeast Indiana’s client advocate program and Super Shot Inc.’s children’s immunization program.<sup>13</sup> Each hospital in the Parkview system gives back 10 percent of its annual operating surplus by carrying out community health

improvement initiatives in the categories of primary health care, health screening and prevention, centers of excellence and disease management and health innovation, education and research and development.<sup>14</sup>

There are many reasons why community benefit and philanthropy must be friends who work collaboratively for the good of the institution and the people it serves. Both efforts do the following:

- Place an emphasis on complying with the legal and regulatory aspects of nonprofit and tax-exempt status.
- Concentrate their efforts on the interface between the internal organization and the external community.
- Rely heavily on disseminating information about the health care organization’s role as a steward of organizational and community resources.
- Demonstrate to stakeholders that their respective functions provide a benefit in return for taxes not paid and money received from donors.
- Engage with external stakeholders using influence and collaboration rather than command and control.

Although they are separate efforts, community benefit and health care philanthropy should come together as two interlocking pieces to address the health and well-being of individuals, populations and communities. 

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Rally visits with a patient at the SSM Cardinal Glennon Children's Medical Center.

# A cute, cuddly squirrel leads to a great idea

What better charitable match-up than a beloved mascot and the kids of SSM Cardinal Glennon Children's Medical Center?

There were “sightings” in past seasons at Busch Stadium in St. Louis, Mo. Then, the break-out event. It was the fifth inning of Game Four in the 2011 National League Division Series: A squirrel darted across home plate, launching the St. Louis Cardinals comeback rally against the Philadelphia Phillies. It ignited a love affair between St. Louis baseball fans and a common, gray squirrel aptly named Rally.

Before Game Five on Friday, October 7, 2011, Cardinal Glennon Children's Foundation communications manager Rose Fogarty was wrapping up her day when I came to her with an idea. I wanted to create a way to donate to the SSM Cardinal Glennon Children's Medical Center through Rally Squirrel charity apparel, including shirts, hats and trading cards. What better charitable match-up than a cute, cuddly squirrel and Cardinal Glennon kids?

Long-time Cardinal Glennon supporter Anheuser-Busch was on board by Sunday with a \$30,000 grant. In roughly two days, we had produced 5,000 t-shirts and Foundation staff worked feverishly to create an in-house distribution center.

We recruited 12-year-old Hodgkin's lymphoma survivor Lauren Lee as Rally Squirrel's spokesperson. Lauren unveiled Rally's charity apparel on local television stations at 7:30 a.m. that Monday morning.

The first shipment of Rally Squirrel merchandise to 12 locations sold out in 45 minutes. The next shipment sold out quickly and my Foundation team realized that keeping up with the enthusiastic demands of Cardinals fans was not going to be easy.

In just four days, Rally Squirrel's charity apparel generated more than \$150,000 in donations. With this news, Rally decided that it was time to visit his biggest fans—patients and families at the medical center. Rally strolled through the child patient rooms, giving out trading cards and hugs.

## Rally keeps spirits high

After this visit, Rally knew he needed to do something to keep the patients smiling when he wasn't around. He announced that the money raised would be used to build an outdoor playground at the medical center. With this, Rally declared himself the official mascot of the medical center, which made staff and all the kids erupt with joy and anticipation.

After the adventures of Rally's first 12



days, the Foundation staff decided that Rally fever would continue through the World Series—with a new shirt. The new "Squirreled Serious" shirt depicted a more fearless Rally Squirrel with his foot firmly planted on home plate.

I believe that the spirit of Rally Squirrel was sent from God. Every member of the Foundation was involved throughout this entire effort and we were certain we were getting divine support.

Soon after the Cardinals captured the World Series championship, Rally and Lauren appeared in front of Anheuser-Busch Headquarters atop the Clydesdale-drawn wagon, announcing the grand total raised: a whopping \$470,000. By the time the playground opened on April 12, 2012, that number had grown to \$500,000.

The Cardinal Glennon Children's Foundation is continuing its charity efforts through its new Homers for Health program, in partnership with the St. Louis Cardinals. For more information, visit us at [www.glennon.org](http://www.glennon.org).

Left to right: Dan Buck, patient Lauren Lee, Dave Peacock, former president of Anheuser-Busch, and hospital mascot Rally Squirrel.

In just four days, Rally Squirrel's charity apparel generated more than **\$150,000** in donations.



**Dan Buck** is the executive director of Cardinal Glennon Children's Foundation at SSM Cardinal Glennon Children's Medical Center. Each year, the Foundation raises more than \$11 million to help more than 200,000 children needing specialized pediatric care. Prior to joining SSM Cardinal Glennon, Buck served for eight years as chief executive officer of the St. Patrick Center, the largest homeless services agency in Missouri.

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