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AT DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOOD AND DRUG ADMINISTRATION

CENTER FOR BIOLOGICS EVALUATION AND RESEARCH

WORKSHOP:

RECRUITING BLOOD DONORS - SUCCESSFUL PRACTICES

Thursday, July 6, 2000

8:30 a.m.

MILLER REPORTING COMPANY, INC.
735 8th Street, S.E.
Washington, D.C. 20003
(202) 546-6666

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National Institutes of Health
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P R O C E E D I N G S

MR. CONLEY: Welcome to the Lister Hill Meeting Center. I have to say this is my first time in this room and it is going to work wonderfully for our meeting today, and I thank all of you for coming.

We will start off this morning with Dr. Epstein, Jay Epstein, who is the Director of the Office of Blood Review and Research at CBER. He would like to welcome you all and explain a little bit of why we are here.

Welcome

DR. EPSTEIN: Thank you very much, Gil, and good morning everyone. I am very pleased to see that we have good attendance here today, and I specifically want to extend a warmest welcome to donor recruiters and representatives of donor groups who are the real practitioners in this area and from whom we, the government, are hoping to learn.

This is one of a series of workshops on donor issues, and I would like to give you a little bit of perspective on why we are doing this, and where we have come from and where we are going.

Historically, FDA has mainly been concerned with the issue of undue incentives as that might affect blood safety. As you know, we addressed this issue in the 1970s,

which led to the labeling policy regarding paid donation. Then, more recently we have had workshops on incentives for volunteer non-remunerated donors in the effort to clarify that boundary and identify acceptable practices. That workshop was held in September, '96. Following that, the AABB issued a document summarizing suitable incentives, and the FDA is working toward a guidance document on suitable incentives for the volunteer non-remunerated donor.

Historically, then, attention shifted to concern over reexamining the scientific basis of the current donor standards, mainly focused on deferral standards. This was brought to our attention in a GAO study that was published in 1997, which particularly focused on the need for a uniform donor questionnaire, and toward that end FDA has also held workshops and also advisory committee meetings to look at elements of the donor questionnaire and elements of the current donor suitability standard. We had a BPAC meeting in March, '99. We have had workshops on specific donor suitability issues numerous times but including in November, '98 and December,'99. As part of the broadened scientific concern, we have also enlisted the support of the Centers for Disease Control, and just this last month we had a workshop at the CDC to try to reexamine the behavioral risk-based deferrals to attempt to perhaps

update them on a scientific basis and make things more flexible.

Now, there has been a more recent change in focus, which is concern over blood availability. This has come about for, I think, primarily two reasons, one of which has been the cumulative impact of donor deferrals, causing us to defer more donors and having an impact on supply. Probably the most important recent change affecting that dynamic is the policy of November, '99 where we request that persons with exposures in the United Kingdom between 1980 through 1996, when there was a peak epidemic of bovine spongiform encephalopathy, should be deferred because of the risk that they may be harboring new-variant CJD. That policy came at an estimated cost of 2.2 percent of donors, but since the guidance recommended that it be put in effect no later than, I think, April 17th, many centers have only implemented it in March and April so the full effect of the deferral has yet to be felt.

Additionally, the agency has become aware that a set of economic factors has been changing the industry and affecting the donor base. So, these combined factors have caused the agency and really the larger PHS to become concerned about availability as well as safety.

Now, the FDA, along with the sister agencies of the Public Health Service, has responded to these issues with an action plan by which we put forth to monitor and increase the blood supply. This is part of a larger blood action plan which was previously initiated by the FDA in July of 1998. It subsequently was adopted as a departmental plan and it has a very broad ranging agenda, including updating the regulations, improving strategies for dealing with emerging infectious diseases, addressing emergency situations and class I recalls, but also including most recently the agenda item to monitor and increase the blood supply.

In that area, the plan includes the following elements: These are to monitor the blood supply; to encourage more donations by eligible donors; to improve donor relations as part of recruitment and retention; to remove restrictions to safe donation; and to address economic issues facing the blood industry. We are here today to address the issue of bridges between encouraging more donations by eligible donors and improving donor relations as part of a recruitment and retention strategy.

Let me just note that we have been making progress in each of these areas. In the area of supply monitoring, the NHLBI has funded a contract with a research arm of the ABB, the National Blood Donor Research Center,

which is now carrying out surveillance in a number of sentinel collection sites in order to model the supply and ultimately also the utilization of blood components on a month by month basis. We have been acquiring data dating back to October '99, and we are now entering the mode where we are producing reports with a one-month lag from data collection.

In the area of encouraging more donations by eligible donors, the NHLBI did support a meeting in February of this year to explore the feasibility of certain studies and strategies, and this meeting came about partly as a result of those deliberations.

Additionally, the agency has committed itself to assist in encouraging donations by publishing a guidance document on suitable incentives for the volunteer non-remunerated donor, although that is still at an early stage of the work.

So, in terms of removing restrictions to safe donation, the FDA, as I said, has embarked, in close cooperation with the CDC, in reexamining the scientific basis of current deferrals in the hope of streamlining them, but we are also interested in perhaps streamlining the donor questionnaire, using abbreviated questionnaires, continuing to facilitate the use of the computer-assisted interview, and perhaps removing certain restrictive

standards. We have already taken a policy position that we would grant exemptions for donation by persons with hereditary hemochromatosis provided that there is no charge for therapeutic phlebotomy and certain other conditions are met. And, we will continue to examine all of the other various restrictions.

Additionally, we have been working with the department to try to examine and address economic issues facing the blood system, particularly the issue of remuneration for blood components by hospitals. We have already accomplished a change whereby HCFA has posted a new fee schedule for the outpatient blood unit, and we are working toward improving something along the lines of faster reimbursement for the inpatient component, although that is complicated because there is reluctance to separate blood components out of the current DRG system.

So, this gives you a picture of the broad spectrum of donor issues that we are attempting to address in this general area of monitoring and increasing the blood supply, and today's workshop then is one of the central elements of the plan, namely, to try to develop some consensus feeling of the best ideas and the best strategies for recruitment to try to talk with experts and gain a better feeling for what really works.

I guess it is important to make clear to you at the outset that FDA's goal here is not for the purpose of stepping up regulation in this area and telling you what to do. It is, in fact, to try to gain useful information and then to disseminate it so that more use can be made of it generally throughout the system.

So, I look forward to a productive meeting. I wish you well in the deliberations today and tomorrow, and let me just thank you on behalf of FDA and our partners at NHLBI for the effort that you have all come to put to this test. Thank you very much.

[Applause]

Introduction

DR. CONLEY: Thank you, Jay. My task now and in the next couple of minutes is to go over some housekeeping items, a little bit of direction and a little bit of focus. You will find that we will be pushing for time all day long. Two days is not enough to cover the topic but we are going to do it anyway.

First, the housekeeping announcements that are required by the meeting room -- one I already made, no food or beverages in the auditorium, please. The food and beverages at government meetings is actually a fairly new feature. They have loosened some of the rules. So, you all came with a continental breakfast this morning; there

will be another one tomorrow. There will be something at the break. So, thanks to Joe Wilczek for arranging that.

There is a message desk phone number. If you do not have a cell phone or a pager and need to use it, that number is 301-496-4062. Once again, 301-496-4062. Pay phones are out in the front lobby area, behind the visitors center.

When we are in discussion sessions you will not have to come to a microphone since all of you are seated in front of a microphone. In order to activate the audience microphones, there is a little mike button and a light comes on so you know your mike is activated. If you don't want to share any secrets with everybody else here, keep the light off during the day.

Speakers are welcome to check into our media prep room to prepare for your own talk, although we are doing almost everything, as far as I know, on Power Point today and we have it loaded on a couple of laptops up here. So, I am sure that we will be struggling with some of the new technology, and bear with us but, hopefully, things will go well.

Again, today it is going to be time, time, time. Hopefully, our speakers have all timed their talks and, if not, we will be encouraging them to move along. Part of this is conscious and deliberate. Hopefully, the best

ideas will bubble to the top very quickly as we go through this today.

Lunch -- there is a cafeteria down the steps, downstairs. There is another cafeteria in the building across the street, in the Natcher Hall where we will be meeting tomorrow. We will talk more about that a little bit later today.

I wanted to just give you an idea of who came to the meeting today. At the point when we cut off our pre-registration we had 81 people who had signed up, and they are the ones that are listed in your programs. We have had a couple of dozen additional contacts since then. So, we are anticipating somewhere around 100, 110 people will be attending throughout the two days. But I tried to break out, based on titles and addresses, where those people came from. Obviously, titles aren't always self-explanatory so this is probably hard statistics, but I counted 41 recruiters of the 81, and that delights me because that is exactly the audience we wanted to reach. I was equally delighted that there were at least three people who signed up who represented donor groups. These are the opinions that we most need to hear today. Between NHLBI and FDA, I think we had another 25 people, I counted four companies -- a couple from representative organizations, but the heart are the donors who are here today, representatives of the

donor groups and the recruiters, and I hope you will speak up. There will be ample opportunity for us to get things on the record about what donor recruitment practices really work.

For the meeting today, we need to agree here what we are talking about. Basically, all we need to agree on is that it is good to recruit more donors, and it is good to share approaches which have been successful for some people in donor recruitment. We are not going to talk about today and we are not going to debate if there is a blood shortage or not or if there is a need to recruit more donors; we are going to accept that as a fact. We are not going to spend time trying to place blame for any shortages that are out there. We are not going to debate reimbursement issues at this meeting, but we are going to accent donor recruitment systems that have worked in the past.

So, I want to encourage all of you to put in all that you can today and tomorrow, especially tomorrow. We are going to take your information to heart. We are going to record it; we are going to draft a document that gets that information out for public sharing as much as possible. Those of you who have been to other FDA workshops, often what we are doing, we are presenting our current thinking and asking for comment. Today we are

coming in blank slate, tabula rasa. We want to hear what you are doing that is working and then, hopefully, get that information out.

I am very appreciative that Richard Lewis, our Deputy Director in the Office of Blood, agreed to be our moderator today, and he will be ding the introductions. So, I will turn this over to Richard.

[Applause]

Introductions

DR. LEWIS: Thank you, Gil. Good morning. There is very little to add to what Dr. Epstein and Gill Conley have said this morning but from my own personal perspective, in some of the early discussions there was a recognition that the FDA didn't have that expertise in interfacing with the actual blood donor, and part of this workshop today is a recognition of your interface and your expertise in dealing face-to-face with donors.

Having said that, let me introduce our first speaker. We are going to hear his story of success, Mr. Brian P. Scully. He is currently the Director of Community Development at Florida Blood Services, Incorporated. This is in St. Petersburg, Florida. Mr. Scully joined Florida Blood Services in 1992, and some of his previous positions there were as a donor recruiter and director of donor

recruitment. From '67 through '91, he was employed in the financial industry in various executive positions there.

He attended Canisius College in Buffalo, New York and St. Bernard College in Cullman, Alabama. His is a Vietnam veteran. He is a 45 gallon blood donor. I should say that he is going to make a copy of his slides available to all of us this morning.

So, let me introduce him on donor recruiting at a blood center -- story of success. Good morning. Welcome.

Story of Success - Donor Recruiting at a Blood Center

MR. SCULLY: Thank you. I generally lose about 12-15 pounds of body fluid when I speak --

[Laughter]

-- you will excuse me as I go through a dozen or so tissues.

As I look out amongst you, I notice that either the seats are very low or you are a whole bunch of short people out there.

[Laughter]

In any event, I am glad to be here today to share my wisdom, as it were -- some call it wisdom; some call it other words that I won't discuss at this particular point in time.

I would like to start with a short story. I did get cut about five minutes but I don't think that my

presentation as I am given time. One bright sunny morning, Sunday morning, as members of a small Midwestern congregation were settling into their pews, a ball of fire appeared followed by a thunderbolt, and Lucifer himself descended upon the altar. Immediately, everyone in the small church rushed to the exists to escape the evil incarnate, everyone but one frail old woman. Now, the devil was somewhat taken aback by this woman's actions and he said to her, "do you know who I am?" And the woman replied, "sure, do." At this, the devil became somewhat agitated and he bellowed, "aren't you afraid of me?" The woman looked up and said, "sure ain't." The devil was now livid with anger and he stomped across the altar and stood in front of the woman. "And why," he demanded, "aren't you afraid of me?" The old woman slowly looked up from the pew and softly said, "I've been married to you brother for 46 years."

[Laughter]

I am here this morning to tell you the story of Florida Blood Services and the transformation from a net importer of blood to a fully self-sufficient blood center. What I will impart to you this morning is not a panacea. It may not work for all blood centers but it is my fervent hope that you will take something away from this

presentation that will benefit you in your quest for self-sufficiency.

This is my first attempt at a Power-Point presentation and I hope that you will be kind to me in the event that all does not proceed as planned. I have also left my reading glasses back in Tampa so I may be a little bit slower -- on my lanai, down by the Bay. My recommendation is that you concentration on what I am saying and less on what I am doing up here. I will, as earlier indicated, provide each of you with a detailed handout during our first break. Please feel free to contact me if you have any clarifications or any questions that you might want to ask. I do believe that my presentation in print form will have my phone number. If not, just round me up here and I will give it to you.

As you are keenly aware, the need for blood is slowly surpassing our ability to collect it. We, at Florida Blood Services, have had the good fortune of steadily increasing our collections over the past six years, and this is our story.

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Here we go. Yogi Berra once said, "you've got to be very careful if you don't know where you're going, because you might not get there." When Florida Blood Services was initially formed in 1993 by a merger of three

community blood centers and three hospital blood centers, it quickly became apparent that we did not know where we were going. The initial reorganization of staff placed one person in charge of each department, with one notable exception. During the first year of our merger, over one million dollars in blood and blood products had to be imported to support our local needs. Senior management pondered and pondered, and soon someone uttered the famous word, "duh" --

[Laughter]

-- in order to collect blood, we must have donors and in order to have donors, we have to recruit them -- recruit, recruit, recruit. So many blood centers over the years, at least the years I have been in this business, have put recruitment on the back burner. The recruitment department has to be on the front burner because, as I just indicated, without donors we don't have blood.

Senior management immediately appointed a new vice president with responsibility for recruitment, marketing and collections. She promptly appointed one director of recruitment as well as a director of marketing.

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The subsequent results are depicted on this graph. As you can readily see, blood collections have increased every year since 1994. Whole blood collections

have increased from 130,000 units in 1994 to over 157,000 units in 1999. Transfusible units have increased from 130,000 units to 151,000 units, an overall increase in the last six years of 16 percent, and we are very proud of that.

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Florida Blood Services serves a population of over two million residents in a three-county area in west-central Florida. FBS provides blood and blood components to 34 hospitals and over 70 ambulatory healthcare facilities. In addition, FBS also collections over 15,000 units of platelet apheresis annually. We have 500 employees, 11 fixed-site donor centers, 18 blood mobiles and 3 portable units which we take into buildings. Our annual budget is $38 million.

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The hospitals that we serve include Tampa General Hospital, the only level I trauma center in west-central Florida. Last year Tamp General handled over 2600 major traumas, including 1600 air-lifted by Med-Evac. They performed 675 open heart surgeries, 48 heart transplants, 47 liver transplants and 185 kidney transplants.

We also have two of the largest VA hospitals in the United States who last year treated over 1.5 million outpatients. We have a regional medical center in Pasco

County, which performs over 5500 open heart surgeries annually, 15-18 open hearts every day of the week, 7 days a week. We also have a state-of-the-art children's hospital with a pediatric oncology center, and world renowned cancer institute and also a Shriner's hospital.

Several of these hospitals maintain teaching associations with the University of South Florida College of Medicine. The advanced medical capabilities that characterize the hospitals provide residence and visitors with some of the finest medical services in the world. Typical of many large metropolitan communities, these advanced medical services draw patients from a much expanded geographical area including, in our case, the Caribbean Basin. Most of these folks don't bring any blood with them nor do they bring people who want to donate blood for their benefit.

In spite of t he great demand, Florida Blood Services has been self-sufficient since 1994. We also regularly share blood and apheresis products with blood centers and hospitals in Texas, New York, Florida, Virginia, North Carolina and New Jersey. This has been averaging over one million dollars per year and has made the difference in making Florida Blood Services a profitable non-profit blood center.

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How did we get to this point after a new disastrous start? There were ten methods employed by us to be where we are today. They are a marketing team and with a marketing plan; media sponsored promotional blood drives; recruiting with patient testimonials; partnerships with local businesses, attractions and sports teams --

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-- the integration of telerecruitment and database marketing; an emphasis on extraordinary customer service; a focus on the basis of recruitment --

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-- a focus on media and public relations and donor retention programs. Let's examine each one in detail.

[Slide]

This is a snapshot of four of our donor recruiters after consultation with our marketing team. At Florida Blood Services, our marketing team is a across-departmental team comprised of --

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-- the manager of marketing, the director of donor and patient services which is our collection group, our technical writer, manager of telerecruitment and database marketing manager --

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-- the marketing director of Florida Blood Services Foundation, the manager of apheresis and major corporate accounts, the manager of recruitment, the vice president of community development and --

[Slide]

-- me, the director of community development. All of you out there who are familiar with Florida Blood Services can readily identify who that is nipping at my heels.

[Laughter]

[Slide]

"The best way to predict the future is to invent it." This dedicated, committed and creative team has a two-fold purpose -- blood on the shelf and marrow donors in the national registry. They are fervent believers of "the best way to predict the future is to invent it."

We hold monthly meetings to devise strategies and implement subsequent actions. The strategies are part of the marketing plan which is regularly monitored and revised to meet the changes in the marketplace. In addition, we have established separate teams with sub-goals to carry out. They include the apheresis recruitment team, the database marketing team and the minority recruitment team. I am in meetings about 23 hours a day with all these teams. All of these subgroups report to the vice president of

community development. We meet every month for three to four hours, and every six months we meet off campus for a full day for the purpose of long-range planning.

And, also T-shirt designs. I will get into this a little bit later. We provide T-shirts to all of our registered donors and have since 1995. We found that it has been very effective. We have about 300 designs from employees and from donor groups, donor chair people and from donors. We try to change them every month. We go through about 18,000 T-shirts a month because we register that many people.

[Slide]

Secondly is our media sponsored promotional drives. Since Florida Blood Services were formed, we have had the good fortune to have "Dan the Blood Man" Eberts is the manager of our marketing department. Many of you know Dan. Dan is a one-person department and the only staff person solely responsible for the marketing function. Dan's primary job is to work with local TV and radio stations with which we spend approximately $300,000 annually on advertising to co-sponsor blood drives. These regional blood drives are held at such varied venues as Barnes and Noble, Subway Sandwich Shops, WalMarts, Targets, Hooters --

[Laughter]

-- and that was a tough one to get by Carolyn, I will tell you, but they are very, very successful and Hooters is very, very supportive of our blood drives, the local Renaissance festival, Sams clubs, AMC and Regal theaters, Home Depot and Lowes. They attract anywhere from 200 to 700 donors per drive. The drives that have radio support with public service announcements and live remotes are the most successful. In 1993, these drives collected approximately 8000 units of blood. This past fiscal year we collected over 20,000 units in promotional blood drives -- quite an increase. Many of the drives are targeted for holidays and the summer, traditional times of shortages for all blood centers. They are also used as fillers for times when regular blood drives are at a minimum. Dan does a terrific job with our corporate folks in putting together drives on short notice when we are going down the tubes, for lack of a better term.

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Number three, partnerships -- we are constantly analyzing the Tampa Bay area to identify potential partners. A few recent examples are:

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The Tampa Ban Buccaneers, our professional football team who, by the way, beat the Redskins last year in the playoffs --

[Laughter]

-- actually, I am a Buffalo Bills fan but we won't go there. Last year, Tayoka Jackson, a defensive end for the Bucc's came to FBS with an idea. Tayoka had heard a plea for marrow donors during the off season, while driving around in his home town of Baltimore, Maryland, and he wanted to do something. Tayoka purchased 24 tickets to every home game during the 1999 season. In order to distribute the tickets, he held four blood drives with fellow ball players signing autographs for all donors. At the completion of the drive he would pick six names and present them twelve tickets to an upcoming game. The other twelve tickets were given to local marrow patients in waiting and their families. This way, donors and future recipients were joined together for a good time.

The Tampa Bay Devil Rays hold four blood drives during the year for us and give us four first pitch opportunities, and we have a drawing at our drives for that opportunity, and they provided us with a bus wrap, as you can see. This is a bus that used to be white and used to just say "blood mobile." This now, hopefully, attracts more donors although we get people coming in, wanting to buy tickets for the next game --

[Laughter]

Shells Restaurant is a local restaurant of some fame. It holds an annual "Don't be shellfish" blood drive. This is emblazoned on all of our T-shirts during that month.

The Marriott also holds corporate blood drives for us on a regular basis, and recently their employees association came up with the funds to do a bus wrap for us also. That is presently being completed and, unfortunately, I don't have a picture of it.

The Tampa Bay Lighting is our hockey team -- they attempt to play hockey. We have multiple blood drives at the hockey games. They also set up TVs so that when people are donating they can watch the game as the are donating. They are also doing a bus wrap for us which also is in the process of being completed as I speak. And, they provide PSAs, including the hockey players, which also benefits us greatly.

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The University of Tampa has several well attended blood drives each year, and every year a fraternity provides us with an annual contribution for our marrow typing program of approximately $5000.

This is a picture of our donor room at the Baxter facility. Baxter Manufacturing opened a 900 sq.ft. 4-bed donor room at their Amicus manufacturing facility, at an

annual rental to us of one dollar. They collect an average of 60 whole blood units per month and approximately 80 apheresis units per month. This is the facility that manufactures the Amicus. It is kind of an on-site training for them, trouble-shooting, what-have-you. They have it right on their premises.

The JFK exhibition at the Florida International Museum -- they provided us with free tickets for all of our donors to attend for the balance of this year.

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The Lowry Park Zoo, a local zoo obviously, provides us with free passes and often gives us buy-one/get one free passes.

Met Life, our good friends, have purchased us a PMU truck and also hold blood drives on a regular basis.

Here comes our Dunkin' Donuts bus. This is our most recent bus wrap, provided by our friends at Dunkin' Donuts. They also provide a free coupon for a Koolada, which is some kind of a slushy drink that the make in various flavors. They also provide a coupon for a free dozen donuts if you donate at one of our fixed sites. They are also, this fall, going to be providing donuts at all of our high school blood drives, and you know how the high school kids love to eat anything.

[Slide]

Number four, recruiting with patient testimonials -- our vice president of community development emphatically states that donors give blood for people, and that we should emphasize real people who have benefited from blood and blood products in all of our literature, posters, fliers and mailings. So, several years ago we embarked on an ambitious program in conjunction with local hospitals to obtain pictures and stories of successful transfusion recipients, and here are some of them: upper left-hand corner, the Alfonso twins who were born prematurely and required many or numerous transfusions. Next is Alonzo Atwater, a well-known local restauranteur who was shot during a robber and required many transfusions. The young lady on the bottom left is Monica Rozier, a marrow recipient from Detroit who recently had a reunion in St. Petersburg with the donor, and we went through a lot of boxes of Kleenex on that one, folks. She met the man who donated platelets to keep her alive, and it was a wonderful day. The young lady on the bottom right is Erica Balkwill. She and several of her friends were broad-sided by a school bus last year. She was in a coma for four days and required four blood transfusions. And, Lowell Kennedy, upper right, is an 89-year old multi-gallon donor who also has used blood and blood products over the course of time.

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In the upper right-hand corner is Dick Beuchat, a heart attack victim who required numerous transfusions during his surgery. The young lad, top left, is Christian Morrisette who has a life-threatening condition requiring regular blood transfusions, and I can't pronounce what the condition is but believe me. The young lady on the bottom is Angelia Rubeck who required a liver transplant several years ago and, again, required many units of whole blood. These people add a human touch to our advertising and a tug on the heart which gives donors a positive identification with real-life, local patients. We find if we use local patients people often call us and ask us if these people are real, and we have the permission of their families to give out that information and people do respond to real-life people who have used our blood and blood products.

[Slide]

Number five is recruiting with donor gifts. I go back to our T-shirts, and this is just a sample of some of the T-shirts that we have come up with over the years. Starting from the top left, our frog T-shirt with "jump up and give blood." The next one is "you otter be a blood donor." The next is, "share the koala-tee of life," and several of our donors called us and told us that we misspelled quality --

[Laughter]

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Our first venture was "iguana give blood," which was quite popular down our way. The owl T-shirt and the Christmas, we had "seal a gift from your heart," also "bear a gift," around Christmas type; a Wizard of OZ type, "courage, heart and brains -- use yours; give blood." Bottom left is a design that a gentleman from Czechoslovakia came up with some time ago, and we used those for millennium T-shirts and also on a lot of our mailings. The newest one, which is coming up, is "we're out for blood," and our current T-shirt is the "starve a mosquito, donate blood." In Tampa, that is very appropriate.

[Slide]

Every registered donor at FBS receives a T-shirt, in addition to a food and/or event coupon which are donated to us. These include sandwiches, donuts, hot dogs, refreshments and admittance to the zoo, museum or aquarium. We also have drawings for airline tickets in the winter and summer. They are each a three-month promotion so a registered donor has about a 1/55,000 chance or winning. We believe that a policy offering these gifts to every registered donor prevents any fabrication in medical history screening since the donor does not have to actually donate to receive the gift. Numerous surveys and focus

groups done by FBS have shown that donors do not donate for one reason only, but many.

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They donate because they know the need. They donate because they want to feel good. They donate because they want to achieve gallon levels and we are now seeing, because of apheresis being every two weeks, 50- and 60-gallon donors. We had to order all new license plates and pins -- it is fascinating. We have a 63-gallon donor.

[Slide]

They also donate to get out of history class or any other class. They donate because someone asked. They donate because they like the T-shirts and, by the way, the T-shirts are a walking billboard for us. We see them everywhere. We see them in the airports; we see them in the malls. I see them when I am walking along the Bay. It does a lot of good for us. And, they donate because a family member of a friend is in crisis and we see that very often.

[Slide]

Number six is the integration of telerecruitment and database marketing. This is something that we put together some years ago which has been incredibly, incredibly successful for us. We have 24 telerecruiters who last year made over 480,000 phone calls. They come in

late in the afternoon. They are generally in on weekends. They make calls from a preselected list of donors, and I will get into that in a few minutes. We have determined over the course of time that we cannot mail or phone all 400,000 people on our donor list on a regular basis.

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But through the use of parameters the donor base can be segmented. An example is the lapsed donor calls and mailings. We define this in a variety of ways: those who have donated in the past 12 months but not in 6 months, or donated in the last 6 months but not in 3 or 4 months -- trying to get the individual who donated 6 months ago or 4 months ago but has not donated since.

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Segmenting donors even further, we can generate a list through donor frequency. For example, a list of donors who gave whole blood 3 times in the past 12 months, or a list of donors who gave whole blood only once in the past 6 months. We can identify them by the last donation site, date, the last donation type, the last collection site and the donation date ranges. So, we have a myriad of tools here to identify donors and try to determine why they haven't come back, and if we can determine that, hopefully, we can get them back in the fold.

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Continuing our data mining a list can be generated of fixed site donors, promotional donors, mobile donors, rare donors, apheresis donors or any combination of the aforementioned.

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We tried one of our first database mailings to high school donors by inviting them to a Regal Cinema blood drive of the July 4th weekend. The parameters were all eligible high school donors who gave blood even once during the school year. I am sure all of you recruiters out there know how difficult it is to recruit high school donors during the off season. This proved to be very successful. This past weekend, July 4th weekend, we registered 750 donors on July 2, 3 and 4. We don't know how many of those were high school students. That is something that is being generated as I speak but I am sure it was a great number of them. They love to go to the movies.

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This slide shows a postcard for our Largo branch, which is located in a Baxter manufacturing plant. The parameters for building the list were all donors who ever gave at Baxter previous to the opening of the donor room and donors who worked in zip codes adjacent to the plant.

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As in the movie, "Field of Dreams," the people of St. Petersburg believe that if you build it they will come. In our case, it took four years to build a stadium and to obtain a major league team. Unfortunately, it is not a major league team yet --

[Laughter]

-- we are still working on it. This slide shows the postcard sent to Tampa Bay Devil Rays fans and donors who gave blood at previous ball game blood drives.

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Through a good relationship with our printing vendor we have the ability to back print as many postcards as possible. We print 80,000 shells of 4 different cards for a total cost of 34 cents per card for printing and mailing. That includes 6 cents for the card itself, 15 cents for typesetting, 12.5 cents for the mailing cost. It is a total of 34 cents.

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This is what we have learned after two years of integrating telerecruitment and database marketing: We can call the high priority donors, such as rare donors, apheresis donors, donors for granulocytes and donors for quality control for our lab. For mailings it is more effective to target groups, such as promotional donors,

reminder cards after 56 days, lapsed donor mailings and campaigns.

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We are also pursuing generation X, thought to be lazy, confused and slackish. We have found that most have college degrees, a mortgage, a career and they donate blood. They are becoming one of our largest donor groups.

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We are also in the process of recruiting generation Y donors. They generally have two e-mail accounts, a laptop, a cell phone and a palm pilot. So, they are real easy to get in touch with if their phone is not busy.

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Number seven is our emphasis on extraordinary customer service. This is internal and external. Last year I was at a seminar at the AABB in San Francisco and somebody asked if they had ever experienced good customer service anywhere, and a gentleman stood up who was from Texas and told everyone that he experienced his finest customer service at Florida Blood Services in St. Petersburg, which obviously made my day.

The four principles of focusing on the customer are dependent on each other and must all be pursued simultaneously. First, FBS made marketing an integral part

of the blood center's activity and a focus on delivering superior service to our customers. Marketing is the way of doing business throughout a world class blood center. In a blood center committed to the marketing concept, the customer's interests are always first.

Secondly, we try to hire and retain blood center staff who truly enjoy working in a blood center, in the not-for-profit environment because generally -- and we all know this -- salaries and wages are lower than in the for-profit corporate world. In addition, most blood centers operate 7 days a week, 24 hours a day, and not everyone is suited to work in this type of environment.

The third piece of focusing on the customer is to recognize individual performance and contributions. At Florida Blood Services we give recognition for a specific activity or result in the form of a certificate, a movie pass, a personal note from a vice president, mall certificates, dinner certificates and Excellence in Action awards. These are awards where people are nominated by anyone in the blood bank. We have a committee that reviews them and either approves or disapproves them, and the award is presented in person by our CEO at our bimonthly management meeting, which is always a thrill for the recipient.

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The former chairman of Herman Miller once said, "the first responsibility of a leader is to define reality and the last is to say thank you." We also link pay and performance. We pay for what we want to happen. Every department is rated monthly on both internal and external customer service. If extra money is above a certain level or available, it is shared with the employees depending on this measurement and others linked to performance.

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Rewarding the customer is everyone's job, and rewarding those who reward the customer is management's job. At Florida Blood Services we have created an environment where employees can excel, where employees are educated on data collection and analysis, net income, operating data and performance, expenses over revenues, etc. Our employees know where we are going; what the goals, objectives and business strategies are.

A former executive of America West Airlines once said, "you take care of your people and they'll gladly take care of your customer." In other words, guarantee exceptional customer service to donors and hospitals through education, empowerment and recognition of your most valuable assets -- your employees. Employee satisfaction with the way they are treated is directly linked to donor satisfaction and your blood center's success.

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Number eight, emphasis on the basics of recruitment. This includes accurate projections by recruiters which are the key to efficient collections, knowing your blood groups and reviewing past drive statistics so we don't send a big bus out to see three people and a small bus out to see 26 people.

Efficient scheduling, utilizing equipment wisely. This is something that we have developed over the course of years where we would be sending one bus out for two or three hours and it was back for the day. We are now piggy-backing drives, doing two- and three-hour drives during the course of the day. We also have a small unit that goes out on its own with phlebotomists and they kind of do their own recruiting while they are out also.

Relationship building with CEOs, donor chair people and particularly the collection staff -- this is one of the things that I am really big on, going out to a bloodmobile or going to a fixed site and talking to the collection staff and telling them just how incredibly important they are, what a terrific job they are doing, in front of the donors. I often tell the donors, oh, you guys lucked out, you got the A team today. I don't care who it is, what team it is, how bad I might know they are, as far as I am concerned they are the A team. It makes them feel

good; it makes the donor feel good; and it does nothing but increase our donations going forward because they will go in and talk to their associates, and tell them that they have the A team out there and that these folks really know what they are doing.

Our recruiters work on busy, new and promotional drives by greeting donors, registering donors, stripping and sealing blood where qualified, and they also assume crowd control and public relations. A lot of our drives, especially down in Florida when it is 98 degrees out in the hot sun, we have to entertain people. We have recently put some tents to put up, just to keep them out of the sun, but we need somebody walking around, giving them something to drink to keep them comfortable and they also, obviously, do on-site recruitment, which I am sure most of you do also.

We also call our donor chairperson 24 to 48 hours before a drive to confirm sign-ups, drive times and parking instructions. If you have bloodmobiles, you know how important parking instructions are and how many times we hear from our drivers that they didn't know where to park -- they were told to park here, park there, and we end up losing a lot of blood donors because we are not there at the time that we say we are going to be there.

They also develop new accounts through memberships and local civic organizations. We have also

developed a speakers bureau. We kind that the Kiwanis Club and the Certoma Clubs, Lions Clubs -- everybody needs speakers. Of course, they usually need them at 6:30 in the morning but that is all right because we usually get a free breakfast. Getting out in the community, giving the talk, letting people know what our situation is obviously is key to our survival.

Last but not least, and I don't have it on here, is the association with the ADRP, the Association with Donor Recruitment Professionals. Every one of our recruiters is a member of the ADRP. Trust me, everybody here who is not or management here who has not seen fit to send their folks to the annual convention, it is a group of recruiters who are very dedicated and who have a lot to share and, believe me, when our folks come back they all make a presentation to our board about what they have learned at the ADRP, and I would highly recommend it. What is it? -- $40 a year now? I forget. Excuse me, $45 and that is quite a bargain. It is in Salt Lake City this year. In any event, I highly recommend that organization, not because I am on the board but because I think it is really a great organization.

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The recruiters work three months out to fill calendar holes so we don't have any surprises. Over the

course of time we have determined that we just can't go from month to month. We actually have a calendar that goes out an entire year but, as you are all aware, during the course of time drives fall off; things change and all of a sudden you see a week where there are about half as many drives as there should be. So, we now go out three months just to make sure that that doesn't happen and we call on our good friend, Dan Eberts, to put together some promotional drives. They are detail oriented, as in correct directions for the collection staff. Our recruiters are passionate about their work. They are flexible. They focus on goals. They are all team players and they all have a great deal of initiative. I find that true with any donor recruiter that I have ever met in my time in this business. They are unique individuals. They are caring. They are just swell people. I enjoy working with them, and I was one of those swell people earlier myself. They also work with the marrow department to sponsor joint whole blood and marrow drives. We find that those are always very successful also.

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Number nine is our focus on the media and public relations. Unlike many blood centers, Florida Blood Services has incorporated paid advertising as part of its annual budget. We have to get out to the citizenry.

People have to know what is going on, and our PSAs that show at two o'clock in the morning don't do us a whole lot of good. Our senior management group is very far-sighted in giving us dollars to go out and put things on the air. We produce our own TV spots at a very, very minimal cost and they are very, very effective. We currently spend $400,000 on newspaper, radio and television advertising, which is only 1.1 percent of our annual budget. Actually, because of our relationship with the media, we end up with two or three being put on as opposed to one, and that increases the growth to $600,000 to $800,000 per year.

In addition, we have a local billboard company that charges us only for the printing and placing of ads at critical times of the year. We have 37 billboards in our three-county area. If they are empty for a month, they put one of our signs up, and there are times when we have 25 or 30 billboards up. They are very bright and colorful, very red, and we have terrific locations where people are driving to work or driving home from work. Our TV and radio sponsored drives, as previously descried, are a result of the monies spent on advertising.

In addition, we regularly cultivate a relationship with the local media. FBS was one of the first blood centers in the country to have a website, which is www.fbsblood.org, which is currently being redesigned

for the third time. It averages 10,000 hits a month and in the near future we hope to make it a more important point of contact with the donor base. We have the mobile schedule three weeks out. We have stories about local patients. We have a blood watch which we update on a daily basis, and all of our press releases also.

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And this, ladies and gentlemen, is the infamous Grand Czarina. Everyone who knows Florida Blood Services knows who this is. Every ad, brochure, press release, direct mail piece, and patient testimonial is developed by our technical writer. Recently, about six months ago, we hired a technical writer who does all of our brochures, does all of our press releases. He is magnificent. He did most of this program. He did my Power Point for me. He has been a Godsend for us. He is the gentleman to the left and I am the gentleman to the right. When these are all written and done, they are reviewed by me and, lastly, by our vice president. This is to ensure that the integrity of our image is maintained.

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Number ten is our donor retention program. The components include contacting first-time donors by phone, mail and e-mail the day after their donation to simply say thank you. We started this up about a year ago. We don't

ask them about donating again. We don't ask them anything. We call up and we say thank you very much for your donation. We appreciate it; you made a big difference in many lives and we hope you come back. And, that is the end of the conversation. A lot of people have called us back and said we really appreciate the fact that you are not hounding us, that you simply called to say thank you. It has been very successful for us.

We obviously have gallon level recognition, as I am sure you all do. We have a registered brass key chain for people who have reached a gallon level. We also have license plates, pins, plaques, etc., etc.

We have a public recognition with the Tampa Bay Devil Rays, mostly because they can't get anybody to come to their games any other way --

[Laughter]

-- all ten gallon-plus donors receive two vouchers at the end of the season. They can be used for any game during the season.

We provide staff training, both collection staff and recruiters, and they are constantly training on a regular basis. We provide exceptional customer service which is regularly audited by surveys. We thank donors and ask them to return. We make apheresis appointments while the donor is still in the chair. We target telerecruiting

and direct mail pieces and, last by not least, we have regular surveys and focus groups to stay in tune with the changing times.

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George Romney once said that "there is nothing so vulnerable as entrenched success." We, at Florida Blood Services, cannot and have not become complacent, nor are we resting on our laurels. We continue to do research, revise recruitment strategies and target our markets. Projects we will implement in the near future include --

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-- a CEO program, such as our friend Rolf Kovenetsky pioneered at the New York Blood Center; e-mailing donors and donor chair people; minority focus groups; development of more patient testimonials; maximizing the potential of existing donor groups; providing advance training for our recruiters; redesign of our website; focusing on X and Y generation donors and implementing a frequent donor program.

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"Between tomorrow's dream and yesterday's regret is today's opportunity." We must seize today's opportunities or there will be no tomorrows. In addition, we are in the throes of losing one of our most dedicated and loyal donor groups. A recent American Legion report

stated that World War II veterans are leaving us at a rate of 1000 per day. Down in Florida that is a great, great portion of our donor group, we are losing them at a very rapid rate and we are having a difficult time replacing them.

Corporate down-sizing has also curtailed or totally halted blood drives and blood drive participation by many major employers. It is imperative that we cultivate our younger population by every means possible to avert a crisis of cataclysmic proportions.

We can do all this by being proactive, by coloring outside the lines, by being imaginative, by courting the media, and by utilizing today's technology in informing our donors and non-donors of their responsibilities to the patients in our hospitals.

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I would like to take this time to ask you to go back to your blood centers and thank your recruiters, telerecruiters, collection staff, administrative services support staff, etc. Buy them a box of candy; buy them a Coke; write them a note of encouragement. Tell them how very important they are to the health and well being of their community. Praise them for making a difference in so many lives.

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The next time you are in the Tampa Bay area and you happen to pull up behind me on the highway, you will know that I never stop asking. Ladies and gentlemen, thank you very much for your attendance and I look forward to the rest of the conference.

[Applause]

DR. LEWIS: Thank you very much. For your first Power Point presentation, you started off very well.

One comment, in your registration packets there are pieces of paper for questions. If you feel later that you would be shy about asking questions out loud, please write them down as you think about them. We will collect them and we will address some of these questions during the discussion period at the end of the morning.

Our next speaker is Brian Koski. Mr. Koski is currently a consultant to independent blood centers and certainly has the appropriate credentials to work in that capacity. He began his career in 1970 as assistant director of donor recruitment with the American Red Cross Blood Program in Hartford, Connecticut. In 1978, he became the director of donor resources development and public relations of the American Red Cross in Madison, Wisconsin. While in Madison, he was involved in the blood donor behavior and motivation research, conducted by Jane Piliavin, and participated in the development of the book,

Giving Blood, the Development of an Altruistic Identity and, while in Wisconsin, participated in the political arena to help enact the 17-year old donor bill in Wisconsin. Prior to his current activities, he was a director of donor resources and marketing at the Rhode Island Blood Center. This morning he will give us a donor perspective on what should work in theory and research.

What Should Work - Theory and Research

MR. KOSKI: I want to thank Gil Conley for inviting me to this meeting and giving me the opportunity, and certainly all the students who participated in the research study, and I also want to thank Brian Scully for being first to try out the technology of this.

My presentation, of course, is going to be a lot more academic and a little bit dry but I think what you are going to find is, as you listen to the presenters during the course of this conference, and I think Brian was a good one to start it off, there are going to be some common themes to the blood centers that have successful stories, and what exactly it is that they have done. There is a common theme in many of the elements that they are using that are creating the successes that they are having, and the various programs that they have designed are well documented and supported by the research that was done by Dr. Piliavin and her students, and in cooperation, I guess,

with myself and the Badger Region of the American Red Cross during the years that the study was done, also the blood center in Milwaukee and a number of international blood centers that participated in the donor surveys.

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I will attempt to discuss the research findings and their significance, and I will also try to give you some ideas on how you might use that information as opposed to the actual programs, such as Brian discussed and many of the other people through the course of the conference will discuss.

There are a number of other research spinoffs that took place during the course of the blood donor behavior and motivation study, which was about 12 to 13 years long by the time all the data had been analyzed and we were through collecting it. The other areas had to do with very specific elements about either types of donations, such as bone marrow and apheresis, to certain elements of the process, such as fainting and deferrals. I will bring in a few of those elements but primarily what I want to talk about is the regular whole blood donor and what we know about that person.

My job really was to do the analysis of the mountains of data that was collected, and try to keep it simple and develop effective strategies that could be used

for blood centers in a variety of ways. I stayed on to help Jane and her group of Ph.D. candidates as they wrote the book so that it did not become the number one insomnia cure. So, as I through what the findings are in the various areas that we are going to cover, as I said, I will try to bring it around to elements that you can implement in your own marketing strategies, recruitment strategies, retention strategies and, hopefully, you will see how exactly they do work.

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About the vision, how did all the research get started? Well, first of all, I didn't get involved until 1978 so I have to go back before that and relate a story that was told to me. It started when Jane Piliavin, who is a social psychologist at the University of Wisconsin, in Madison, had a group of students, and one in particular, Miss Evans, was worried about what it was she was going to do for her thesis. School was about to start. She only had a few weeks left, and she really didn't even have a clue, and she comes from a small town in Georgia. So, while she is pondering what it is that she is going to do, she went down one day and there was a blood drive in her community, at the local church, and she went to donate blood. She was laying down and donating blood and, as she puts it, it was like a vision that came to her because

there was this big, stained glass window, with the sun shining through -- she was laying there, donating blood, and she is looking around and she sees all these people doing the same thing, and she says, "why are they here?" And, then it came to her -- "that is really kind of where I need to start, I think I really need to know why am I doing this. Why are all these other people doing this."

So, at that point, that was when she had the vision and she brought it back to Jane and said what I want to do is figure out why did these people come back -- why did they come to begin with and why do they keep coming back, because when I talked to people in the refreshment area I found out there are a lot of people out there that are gallon donors, 45 gallon donors, people who were just coming in for the first time -- a variety.

So, they got together and they decided that if they were going to do this and do this right, they needed some money and the best way to try to approach this was to try to get a grant.

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Since they lived in Madison, which is that greater area supplied by the Red Cross, Jane went over and approached Dr. Gary Becker who was the head of the blood center at the time, and suggested that they put together a research project that would bring in joint funds. So, a

matching fund grant was put together. I won't go into all the details but it was the American National Red Cross and NIH Heart, Lung and Blood Institute. So, they came up with these research goals as the purpose for the research and to get the funding. Obviously, these are pretty clear and direct in that they wanted the supply of voluntary donated blood to be increased. They wanted to help stabilize the supply, and they wanted to make recruitment efforts a good deal more efficient than they were currently.

Keep in mind, again, this is 1978. So, this is also pre-AIDS coming on the scene. Hepatitis was the biggest problem. The shelf life of components was a problem. So, these were the issues that were at hand. At that point I got brought into it because I was there as the director of donor recruitment and their public relations effort. So, we had further discussions and essentially through those discussions over the course of time a sub-agenda started to evolve.

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We decided that if you refine it a little bit we really are talking about effective strategies for the expansion of the donor base. It became even more evident as AIDS became kind of a silent problem. People didn't show up because of their fears. The number of people who were able to pass through the medical history, which was

becoming more expensive and more personal, was decreasing. And, the days of giving blood being up there with mom and apple pie were long gone. So, without a focused effort on expansion of the donor base we were all going to be in trouble.

Improving the rate of retention -- can you get people to come back? That really had to be another focus. Boosting the donation frequency, which ultimately, if you have a stable of medically eligible good donors, and you have the frequency at the right level -- and, I think you are going to see an excellent example of that in one of the presentations, and I don't remember if Brian has statistics but I would guess that part of the reason for the increase in the numbers, if you took a look where they were in '93 versus now, you would notice probably a significant increase in the donation frequency of the regular donors.

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Getting back to vision and the initial question to develop the research and what it was all about, this is from the donor's perspective and it was coming from the donor since Miss Evans was donating blood at the time. So, in order to find this out, there are a number of areas that would need to be researched. There were some 5000 donors that were either interviewed or who filled out questionnaires. It was probably actually over 5000, as I

said, in a number of blood centers -- mostly the Badger region but also the greater Milwaukee area, and there were a number of international blood centers that also gathered information for us.

The issue is, as she pointed out, why did these people come back, and what is it we are going to have to take a look at? Then, of course, the corresponding question is why do people come in at all? So, in terms of who comes back, you need to address questions of advertising, maybe the number of friends that they have who donate blood, their age group, the community they live in, the size of the community, whether or not they hold blood drives or they don't in terms of their history, also their history of success depending on where you are -- are you associated with a successful blood drive or is it viewed as one that doesn't quite meet goals? The length of time that a blood drive has been established is also a consideration. Then, we also looked at gender. We also looked at education level as to whether or not people would come back.

In terms of people who said they had not given blood and what their reasons might be, some had heard negative stories. The greatest thing is the fear of the needle. The sight of blood was a turnoff for a lot of people. Misinformation, particularly as we moved into the

age of AIDS, became a big problem. Also, I have to point out that advertising and the way things were marketed in those days had a major influence on the perceptions of people. Whether or not the donation site is convenient, how much time it might take to get there, to actually donate and can I get back to the things that I am doing, was another big issue. Then, of course, one that we had known about all along -- as I said, one of my roles was to try to take all this social psychological jargonese and boil it down and keep it simple so we that we can come up with some easy, effective strategies -- nobody asked me -- as simple as that.

So, when taking a looking at this, and I believe the statistics in those days were some 4-5 percent of the people who were actually eligible were donating blood. I am not sure what they are currently. I would think it might even have to go up in order to meet the needs.

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That meant that in terms of a community or a social norm, the norm was not to give blood. Out of that came the theme for the thesis for Miss Evans, and that was that the whole process was going to be a socialization to a deviant altruistic career, because you are a deviant if you do give blood because it is the norm to be in the 95 percent in a given time that don't.

So as a result of that we thought, well gee, she probably just answered one of the key questions that we have and we can probably jump on this and have a great recruitment strategy right away. We can use this in our recruitment efforts, our total recruitment efforts. So they developed this elaborate, predictive valiant program called Dial a Deviant -- that is a joke; we really didn't do it.

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As we went through and collected data and started talking to people, one of the first things that became evident was that effective donor retention and effective positive experiences were really through donation enhancement. We really started to zero in on this almost right from the beginning in terms of anyone that you talked to, whether it was at the beginning of the process in terms of their anticipation for what they were about to do to those who had just completed their donation, they really talked about what happened in the time that they were there. Actually, as you will notice as I go through the slides, waiting time is going to be a major issue. It is a way to overcome what is perceived as "it took too long to do this." Again, as I go through you will see similarities to what I discuss and they found to be positive, effective influences on retention and return rate, and they are the

same things that many of the centers are doing along with their successful stories. They have zeroed in on exactly the right aspects.

We also took a look at the collection setting along with that, as to whether or not that had much of an impact, and it does to some extent but, as you will see when we start talking about the donation career, that has less of an effect.

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So, that meant if effective retention is through donation enhancement, in order for that to be pulled off, it is really the collection staff, who is the public relations arm of every blood center, that has this responsibility. They have the primary responsibility.

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But, I have to say they are not alone and, again, I will bring it out as Brian Scully pointed out and I am sure others will, customer service really is everyone's responsibility. So, the collection staff can't be left out there alone. You do need to hire personalities and teach technical proficiency, but everybody that has any contact with a donor, and from my perspective in thinking about everything that we have learned, I would say that a blood center really should have a plan for everyone who walks through the door.

So, that means non-donors as well, and everyone should be prepared to help direct or redirect people into what it is they are there for because, just as the T-shirt or any advertising slogan is your walking billboard, what better billboard can you have than personal contact with somebody who has had a positive experience in one way or another with a blood center and they are going to talk to their friends, their family, co-workers and so on.

So, again I say the collection staff has the primary responsibility but it is one that actually should be built into, I think, everybody's job description in the blood center -- customer service being an obligation, that they need to try to do what they can to help people.

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So, as you study who is wrapped around that vein, what is involved in the process to commitment? Well, we came up with three basic categories. We first need to know about what motivates them -- why are they coming in; what goes on with them there? We have identified that there are career stages. Then, given that there are career stages, there are different cues that you can use and ways of treating people, depending on what stage they are in, and also by eliciting information you can determine what stage they are in and, therefore, tailor your treatment as they

go through the donation process and follow-up, I might add, which is also a key point.

So, in the decision-making process one of the issues that is particularly important -- actually, it is important for donors in all stages of their donation career, if you will, but it is the perceived expectations of others -- the community, people that they are close to, their family and their friends, and the whole notion, particularly now, that you can actually give blood and pass all those history questions. It is quite an accomplishment and people sort of look up to them in terms of you are a blood donor, and people react very positively to that whole notion of what others think about them as they go about their donation career.

In terms of the rest of the decision-making process, since you don't just all of a sudden decide out of the blue that you are going to give blood, it has to do with the information that you have been picking up over a long period of time, and that actually speaks to a lot of things that blood centers can do, particularly the marketing approaches that they are now taking and creating public awareness. So, the whole internalized impetus to give, because of the information that you have taken in before you actually make that educated decision and take some sort of action.

Also, going along with that, the whole notion of how important you feel it is that people should be out there donating and whether or not you see that as something that you should be doing yourself. You make evaluations in your mind in terms of pain; or am I nervous; is the staff going to be nice to me; how long is it going to take to do it; how long is the needle going to be in my arm. You might feel some sort of a moral obligation. You don't want to disappoint people. You might have some curiosity about the whole process. So, there are a number of things that come into play.

The questionnaires are very lengthy, I should point out, and people had to answer questions about all these various areas so that we could figure out were there a couple of key facts on which you could anchor a whole strategies, or was it just, you know, nothing really stood out and people are either going to donate or they are not. So, there was a very broad spectrum of aspects as to reasons, feelings, evaluations, kinds of judgments that data was collected for.

[Slide]

In the whole procedure of commitment you also have to deal with the negative aspects that can come up, and I will talk about those a little bit more afterwards, and the development of motives to reenforce self-concept.

The self-concept -- the way I phrased it is you get people to come in and donate blood, and we will talk a little bit more about the motivation, but when do they actually become a blood donor? And, that is what you are trying to achieve. If there is a bottom-line foundation to your recruitment strategies and the things that you want to do, it is the whole notion of getting somebody to go from giving blood to becoming a blood donor. When that happens they recruit themselves much more easily. All you need are cues and the people will start to come back, and that is when you start to zero in on donation frequency.

I have a separate section where I want to talk about the likely to continue perception, and a window of opportunity that oftentimes gets overlooked because it is almost so obvious in the whole process. Then, obviously, the actual behavioral commitment when somebody physically gets up, drives to the site or walks down to the site and gives blood.

[Slide]

So, factors affecting retention -- basically we are dealing with two types of motivation, extrinsic and intrinsic. Now, either one results in somebody donating blood. So, you can't say one is better than the other, but I look at it this way, it is kind of like the lite beer commercial -- extrinsic, tastes great; less filling.

Intrinsic -- intrinsically motivated people are the kinds of blood donors that become long-term regular, committed blood donors. Extrinsically motivated people are coming in either from social pressure; extraneous goals, because you are going to win a keg party or a pizza, and they are less likely to return, or certainly won't return as frequently or they are waiting for a better prize, or a better reward for the group or themselves to actually come back. So, your donation frequency, if you focus on these issues, is likely to go down. Intrinsically motivated people are ones who want to do good. They are caring people. They know it is good to help. They might be trying to help a relative initially but they have internalized their motives for donating blood and they educate themselves as to what we actually do with the blood after it comes in, how we test it, the products that it is separated into, how the components are used, which gets them hooked, if you will, into that long-term committed donation pattern.

[Slide]

So, the career stages that we have identified are, obviously, the first time extrinsically motivated donor. Again, a donation is a donation; get them there. As I pointed out earlier, it is the donation experience and it is, like, once we get them there what can you do with

them? So, you have got them. It is this person that you need to really focus in on because you want to move them as quickly as possible to an intrinsically motivated person. I will talk a little bit more about that when we get into the cues.

A second time donor or a first time intrinsic because we feel, as near as we can tell, if somebody was already internally motivated to come in to donate blood, they are already basically at the second stage. The only hurdle they had was actually the mastery of going through the process and donating but they almost kind of took it for granted and looked at it as just a mere formality because I am going on; I am going to be blood donor.

Then, the third and fourth time donor is a little bit different because we are now at a critical juncture. As you will see, at this point you have somebody right on the edge or whether or not they just give blood or are they becoming a blood donor. This is where the "close" if you are a sales person comes in, and this is where blood center strategies really need to kind of zero in.

Then, of course, the long-term committed blood donor is the last category. Assuming you provide opportunities that are convenient and you address some of the issues that I will talk about in a second, you have them and they are looking for opportunities, and they have

their own goals. It probably starts out as a gallon donor pin at that point. It could be a mug; it might be a T - shirt. They meet somebody like Brian who has given 45 gallons. I have given 8 gallons. They meet other people as they talk to them. They see what they are doing; what they are committed to. They have learned about how the products are being used. Maybe they have met patients. They certainly see them in advertising campaigns. That is what kind of drives them from there on out. So, that is ultimately where you want to go.

[Slide]

What stops you from getting there? The first things that you have to deal with are the negative physical reactions. In other words, if somebody comes in and, depending on where they are in their donation career, the negative physical reaction means a number of different things. If they are a first-time extrinsically motivated donor and somebody comes in and they faint, feel faint, convulse, you have probably lost them because a positive donation experience in the very beginning is your critical success period. So, this is about the worst thing that can happen. If it happens at a later date, after you are a regular committed donor, they probably already know they have done something wrong -- they didn't eat breakfast; they skipped lunch. They are an 8-gallon donor, just run

into the blood drive, "I'll be in and out in 20 minutes" -- right -- and they feel faint and, in a sense, they will end up blaming themselves.

Bruising -- that gets into another area but, again, the more donations somebody gets in eventually you are going to experience some sort of hematoma and it is not going to dissuade you. If it happens to you when you are a first- or second-time donor, the likelihood is you could lose them.

So, the follow-up programs, be it right the next day for a first-time donor, a follow-up program for people with reactions, with hematomas or anything like that, is really critical in terms of customer service and the likelihood of getting them to come back and the retention of that donor.

Of course, negative affective states -- I won't get into a lot of that but that is just basically being rude or ignored, not being thanked and you don't feel thanked, like anybody appreciated what you just did.

Then, waiting time. Waiting time is a killer, and waiting time gets worse the longer the career of the blood donor. They feel like, you know, they don't like all the questions; they already answered them. That is a huge issue now. They don't want to wait in any lines. They

want to just move through -- "I'm good; take my blood; let me go."

[Slide]

So, what are the cues for the first-time extrinsically motivated donor? Address their fears. You know they are going to be nervous. Answer basic questions, probably not in a whole lot of detail but you want to answer questions to sort of keep them calmed down. Keep them talking. Don't let them just sit there alone, thinking about that needle and the size of the hole in it. Help them through the process.

Again, this is really the collection staff and the volunteers or other people aiding the whole donation process so that they kind of know what to expect; they have a chance to ask some questions and you can kind of reassure them as they go through. Then, the main issue -- thank them; pay attention to them; and especially in the freshman era, as the quote said, "the last thing you want to hear is thank you." So they are appreciated it. And, you can't say it enough, particularly with the first-time donors a program such as where there is a follow up the next day as a reenforcement is an excellent way to go. You are really putting the hook in and it is going to be particularly important for that extrinsically motivated donor to help him start to cross over.

[Slide]

Cues for the first-time intrinsically motivated donor or a second-time donor -- well, if it is a first-time intrinsic, they are already curious about what it is you do with the blood. They know they want to help and they are good and caring people. So, you start to give them some information about what it is and what kind of people maybe use blood, the fact that you start to separate it into components, what the components are used for generally, and you start praising them for being such a good person when they come in, and this is where you can really start to zero in on them. You help them make the connection of their action and their self-image and you start working into your conversation the fact that it is great that you are becoming a blood donor. I think it is a key psychological issue, if you will, as opposed to just giving blood -- "I'll go down and I'll give blood." Giving blood, in my view after being around the social psychologists all this time, is kind of like a finite action, "that's it, I'll go in and I'll give blood." Whereas, becoming a blood donor is an ongoing, continuous process. So, that is the mind set that you are trying to create with any of the programs that you develop, the way you develop them and the way that you promote them. So, it is kind of like an

underlying foundation to what you should be trying to accomplish.

Obviously, minimizing the waiting time can't always be done but there might be some tricks that could be employed to change the perception of how you are spending your waiting time, and technology is great for that right now. There could be reading material -- I mean, there is any number of things which I won't get into, but if you use a little instinct and imagination you can come up with some creative ways for having them spend their waiting time so it doesn't have the impact of just sitting there, waiting for "next!" Again, thank them. Pay attention to them. You have to be doing something in the refreshment area -- they are about to leave. I can't say it enough.

[Slide]

Cues for the third- and fourth-time donors -- make them feel like they are one of the gang, like everybody kind of does this, and you need to discuss the potential of commitment to other programs. Now, during the course of all this study, as I said, my job in coming up with effective strategies -- I will point out a few things that became obvious to me, only after looking at them for so long because they were so obvious in front of me, and to most people, that you didn't understand the impact of what it was.

One of the things we know is that donors take a lot of pride in that accomplishment. We also know that they are looking for the nobility of purpose, if you will, for their donation. What are you going to do with that blood? Where is it going to go? Who is it going to benefit? That is why campaigns that make use of patients as a visual are very good because people can start to identify with the actual person that is going to receive that particular component, and the whole notion at this point that they might be helping three people with that one donation is something that really gets the hook in for these people.

So, at this point in the specialization that we have going on, as somebody moves through the donation process it is very easy to know that I am an O positive; I should be giving red cells because there is an O positive red cell shortage. So, you might want to create a club that zeros in on that. Whereas, the ABs that come through -- many centers already do have it and those that don't might consider starting some sort of plasma club. AB cells outdate -- you can reduce your outdate rate and you give an AB donor who is going to get this information sooner or later anyway, that ABs are the highest outdate rate of red cells, into a plasma club. You might want to convert you As to an apheresis club. Zero in on this. In other words,

you have to be able to give every single donor the nobility of purpose. You want them to become long-term committed donors, so you don't want them to hear the negative things like, "well, if we get one more A pos. we are just going to have to throw a bunch down the sink."

[Laughter]

Which has happened in years gone by, not so much any more, I am sure, but it has happened. So, now that the are well on their way to a career in donating blood, it is time to ask them to bring in a friend because they are the best ambassadors you have. At this point, if they are willing to do it, it is because they have had a good donation experience. They have met people. They probably even have some friends that they have developed, or if they go to the same site all the time they started to get to know the staff.

Again, minimize waiting time and I have to say it one more time, thank them. Pay attention to them as they go through the process. They are just as important as that first-time donor because this is the third or fourth time they have donated and you want them to come back, and especially in the refreshment area -- it is the last chance you get.

[Slide]

Then, the committed regular donor -- we want to always acknowledge the donation level. With the age of technology that we have, everybody really has the capability, and should spend the money if you haven't already, to recognize somebody at the point of contact. You walk through the door. I say, "hi, I'm Brian Koski." They ought to bring me up on the screen and you ought to have the whole scenario right there. You know where I am and everybody knows what to do, and you should have some sort of a system so that as they are passed on from person to person to the donation process they know exactly where they are and what it is that you want to do.

Now, with regular donors, you can use them particularly, I would say, in company blood drives and even in school blood drives where, of course, you are going to have tons of first-time donors -- if you have enough regular donors, team them up on kind of a buddy system because one of the biggest problems with fainting with first-time donors with pent up anxiety is because they don't have the information and they are just sitting there, waiting and, like I said, the needle is getting bigger, the hole is getting bigger. Get them to forget it. Get them engaged in some conversation. Get them with somebody who can talk about the process but, more importantly, they are with a friend. They are not just with somebody who is like

a staff person, so to speak. So, they are already at ease and they should get the correct information.

Use recognition for your reenforcement so that people will continue to be self-driven and look for opportunities on their own. I mean, there are plenty of blood centers. I am sure they have regular donors who call in and want to know where the next blood drive is, or they are just waiting for that cue and I will get into a little bit more of that in a few minutes.

So, what are the recognition factors? Well, you have the gallon donor pins. A lot of places do that. And, the mugs and the T-shirts. Senior name published is a big thing whether it is a company newsletter, whatever it is; any way you can do it. Of course, gallon donor boards if you have places that will do those, I mean, you have them hooked for life because their name is up there; they are kind of stuck and they have to keep going. They don't feel stuck though, we know that, but they become very self-motivated and they have made their conversion in terms of role identity where they really do view themselves as a blood donor. They have become, in fact, a blood donor.

DR. LEWIS: You have five minutes.

MR. KOSKI: Okay.

[Slide]

I need to bring up recognition versus rewards. I should just skip this one probably. I said non-tangible up here and I did the arrow both ways because you can get into a lot of debates with people. Non-tangible is to be taken sort of figuratively, not literally. So, the T-shirts and mugs, things of minor impact or value, if you will, are okay in our view. When it starts to become of monetary value -- trips, big things -- then donors are losing their focus. They are not donating for the right reasons, and you are not in the process of building a cadre of regular committed donors that want to donate on cue. Enough said about that.

[Slide]

So, what are the strategies? I will go through this quickly because I have a few other comments to make. Give personal thanks. Always stress the positive benefits. These things can be done by all people that represent the blood center and, again, this is not just for the collection staff although they are the primary people who accomplish this.

[Slide]

Focus on the donor self-attributions -- how good they are, how caring they are, what a great member of the community.

[Slide]

What I want to talk about before I wrap this up is the window of opportunity in the social psychological jargon, if you will. You have the role identity to begin with. You go to role behavior and the warm glow factor, which is something that we have talked about, and it is really just after somebody has successfully completed their donation. So, actually, this window of opportunity exists somewhere between holding onto your arm after you have completed the donation and going to the refreshment area. At that point in time, the positive feelings that a person has are most salient and they are most open to have the intention and perception that they are going to donate again, and they are most vulnerable to making that commitment. Then it is up to you to have a system in place to get them back. It is one of the things that gets overlooked because, sure, if someone has completed a donation you say, "hey, that's great!" and you thank them and out you go, and you have all the programs for follow up and to do other retention things. But there is something to be said for trying to gain a commitment almost immediately or as soon as possible right after that.

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Again, I have said it a number of times, the refreshment area -- it is the last time you see them.

[Slide]

Pre-donation education, whether that is in the schools, advertising, marketing -- anything you can do to get the word out to make it so that this is what we do around here, whether it is the community, the business, the school -- donating blood is a good thing and that is what we do, along with what is involved in the process obviously.

[Slide]

To summarize, I can't say enough about starting at the point of contact and the importance of customer service and this whole effective recruitment is everyone's responsibility, and retention. Once you have got them there, what you are trying to accomplish is long-term retention.

Deemphasize rewards so that you focus on recognition. Personalize your appeals. Again, patients as well as the people themselves are two ways to go with that. Reduce nervousness of the donor since that is one of the key factors in people not being able to successfully complete a donation or some problems that could lengthen the time between donation frequencies. Acknowledge regular donors verbally. It is a way of giving instant recognition in front of other people. Enlist the regular donors for support of first-timers.

[Slide]

Encourage involvement in the donation experience. Make the thanks person-centered. Encourage return donations or the donation programs because you can really zero in on this and give that person that extra sense of purpose as they go through "my donation is really going to be used." Then the notes of thanks. Reminders to give again. Use technology, e-mail, websites, cell phones, everything. Everything is at your disposal.

[Slide]

I want to go through real quickly, because of the importance of the findings, a high school study we did in terms of telerecruitment. What we were trying to find out is effective messages, and it was really geared to telerecruitment but it also has practical application to just sending recruiters out to do person-to-person recruitment. We tried three methods. We tried a reward, and then we tried a very long, heartfelt explanation about so-and-so is in the hospital, and they need this, and they are going to have this kind of surgery. Then we tried no reward; you are eligible, can you give, and we need you to come in Tuesday -- a very short, quick message.

The long intrinsic appeal was the first one, with also the promise of movie tickets, and this was done with college students in a small study; then the external appeal, again with the movie tickets and a long

explanation. Actually, this is the one that was with the movie tickets. The long intrinsic had no movie tickets but a long explanation about the patients that need your blood, and so on. Then, the short intrinsic appeal which is just a quick cue.

The overwhelming results for getting people to come back was the short intrinsic appeal, which tells you don't waste your time monkeying around. Just tell somebody you need them; they are eligible; we have a need for it. Can you make an appointment?

[Slide]

In the end, it tells you two things. Blood donors want to help. I just need to quickly explain the impact of that. In the blood center it is credible, and it tells you two things. In terms of the habit you create with blood drive sponsors, what you tell them to begin with is the habit you are creating from the beginning. So, it has scheduling implications. So, what it really means is if you go to a place and you ask them to go twice a year, they think that is how often they are needed. If you go there four times a year, they think that is how often they are needed. So, you are developing a habit with the companies. So, it is very important. The blood donors want to help and they are the people that should be your recruitment force to go around and help to recruit donors,

not have them arbitrarily selected because someone told you that you should have a 1 to 25 ratio of recruiters to the number of people of your sponsoring group.

I will end it with that. Sorry it went over.

[Applause]

DR. LEWIS: Thank you very much. We have really gotten off to a very good start this morning, hearing two excellent presentations. We are going to take a break and we are going to return here in about 20 minutes. Thank you.

[Brief recess]

DR. LEWIS: Our next speaker on the agenda is Bill Teague. He is president and CEO for the Gulf Coast Regional Blood Center, as he has been since 1975. In case you don't know, Bill is from Texas.

[Laughter]

He received his BS degree from Hardin Simmons University and graduated from the University of Texas School of Blood Banking, in Galveston. He served as director of the Community Blood Bank in St. Petersburg, Florida before returning to Texas and Travis County Medical Society Blood Bank in Austin Texas. His involvement with the blood banking community has included positions as president of the South Central Association of Blood Banks, president of the American Association of Blood Banks, and

treasurer of the American Blood Commission. Some of his blood banking honors include Medical Technologist of the Year for the Florida Division of the ASMT, Annual Lecturer for the South Central Association of Blood Banks, and Outstanding Administrator, now known as the Bernice Hemphill Award, for the American Association of Blood Banks, as well as a number of other career awards.

Bill is a 25-gallon donor and very active in this community in other regards. We are happy to have him present to us this morning a snapshot of success - focus groups and surveys.

Snapshot of Success - Focus Groups and Surveys

MR. TEAGUE: Well, thank you very much. It is always an honor to be invited to get with a group of winning blood bankers and certainly this morning is part of that. I do thank the FDA. I think this is a wonderful venture for the FDA. I know for many years all we heard was we are responsible for purity, potency, safety -- I think that was the order, and now that you are accentuating the supply, I have to tip my hat to you because I think it is well deserved attention, and I think you are going about it the right way. So, I congratulate you and it is appreciated very, very much.

There is a handout of my presentation. We brought it in this morning. If you haven't had a chance to

look at it, it has the front page and then it has the individual slides on the others, and I will be more than happy to respond to any questions that you have.

I do believe that the emphasis on recruitment is very justified, and I always loved recruiting, and as CEO of three blood centers in St. Petersburg, Austin and Houston, recruitment is very much a part of my responsibilities. I believe that we are all in recruitment, especially the collection staff as you heard earlier, but I also believe that recruitment is an under-supported program in many centers.

I am delighted to see the early presentations talk about more support, but if you really want to look at the commitment to recruitment in an organization, take the percentage of the budget that is related to recruitment compared to others and you will find really where the heart is. So, if it is not good in your center, then you need to take steps to get that corrected and there are several of us that would be more than happy to help.

I think the national organizations have done a good job of focusing on recruitment. America's Blood Centers has done a nice job of raising the awareness with national campaigns designed specifically to help local members of the ABC and, of course, it helps everybody in those areas. The ABB is moving toward that program and I

think that will help the American Red Cross that has done some good work there, and I think the FDA and the NHLBI followed that and I believe it is a very justified trend.

At home, take a hard look at what you are doing and how you are doing it. I have been asked to really focus on one or two items this morning and for those of you who know me well, you know that is hard because I like to talk about a lot of different things because I think they are all integral to the success of any recruitment program but I am going to focus on just two events.

But in preparation for that, I brought a little item that is enlisted "Boy, how time has changed!" And, for some of us who have been in blood banking a long time this is very true. Of course, it relates to the general population but spare just a minute with me -- "boy, how times have changed! A computer was something on TV from a science fiction show of note. A window was something you hated to clean, and ram was the cousin of a goat. MEG was the name of my girlfriend and GIG was a job for the night. Now they all mean different things and that really megabytes. An application was for employment. A program was a TV show. A cursor used profanity and a keyboard was a piano. Compress was something you did to the garbage, not something you did to a file, and if you unzipped anything in public you'd be in jail for a while. Log-on

was adding wood to the fire. A hard drive was a long trip on the road. A mouse pad was where a mouse lived, and a backup happened to your commode. Cut you did with a pocketknife. Paste you did with glue. A web was a spider's home and a virus was the flu. I guess I will stick to my pen and paper and the memory in my head. I hear no one has been killed in a computer crash but when it happens, they sure wish they were dead."

[Laughter]

I only relate that because I do believe that it is germane to the subject. If we stay in the old rut of trying recruitment tactics, we are probably going to fail. And, I will remind you that the only difference between a rut and a grave is the depth. So, as you go through your programs, please keep that in mind.

[Slide]

Just to give you a little bit of an idea about the Gulf Coast, we had about 211,000 actual procedures that produced about 220,000 units. We have an active double red cell program with our friends at Hemaneticks that provide the machinery. We have an active apheresis program, as many of you do, and they really do help. The components prepared obviously about 682,000. Because of the increased usage and change in our recruitment program, we are in an import mode. We think that will be temporary for another

year, about 32,000 units of red cells. We do serve 21 counties, which is about 21,000 square miles, and we serve 227 healthcare facilities.

[Slide]

The program that we are really going to focus on is called Teens are People Savers. I believe we have some of our colleagues from San Antonio here. I think Sherry Miller was listed on the registration -- there she is. This program started, and you will see the founder of it in just a moment, but this program started and it did a very good job but it needed some help, and it is a nice joint venture because we had two contiguous service areas between our friends in San Antonio at South Texas Blood and Tissue Center and Gulf Coast in Houston, and since there is a little overlapping in this program they will be more than happy to tell you some of the success in their program as well. But I believe overall it has served very well.

TAPS, or Teens are People Savers, clearly was one of those programs that was developed with focus groups. We didn't do much survey; it was mostly focus groups but the result was absolutely superb.

[Slide]

The focus groups that we really worked hard on were school superintendents and teachers. We wove in students, but since the students rotated so much we felt

like the base of the program should be not only the administrators or the principals but the superintendents because we found that if the superintendent bought the program, the principals were likely to follow.

The teachers had the single biggest impact on the students. So, as we rode around to about nine counties and talked to these various high schools, we found a lot of reluctance to get involved, and the reluctance was based on several things. Number one, we have a Texas law that was publicly known as the no pass/no play rule. It really did hurt because a lot of people were in extracurricular activities that got cut out. Now, you know, every door that closes opens another one. So, we turned this around and said, well, that is fine; let's make it a part of the curriculum.

So, the blood drives began being a part of the curriculum. People who work in journalism efforts wrote news releases about it. They did publicity posters, etc. Biology classes taught about the biology of blood, what happens when you donate, etc. So, we wove it all in as part of the curriculum and, therefore, it was an extra curriculum item and it went over very, very well. But the focus groups were extremely helpful.

[Slide]

The school nurses were the ones that people looked to, especially the parents, for the safety factor. If it was okay with the school nurse it was okay with the parents. We worked in some PTOs or PTAs, depending on what it was called in that particular school, but the teachers and the school nurses all worked very well together in the focus group to be absolutely certain that we got all the bases touched.

The students came in and the students told us why they thought their peers were donating, and why they wouldn't. Ironically, fear was the number one issue. We thought it would be that way in some older folks, like some of us old grey-headed folks, but we didn't think it would be that way in the younger generation but it was. So, we addressed those through various items, and working with the superintendent, the nurses, the teachers, the students and the center -- and you will see how FDA played into it in just a minute -- it has been a very, very successful program.

[Slide]

We were proactive in that we went to our friends at the FDA and we said, here is what is being proposed. I think we have at least a couple of folks in the audience, Louis Simmons and Kathy Miller, whose name, address and everything is in your registration packet -- they were

very, very helpful. We sent them the proposal and we described the program. It was a proposed incentive for scholarship checks. A check would be given to the school. They looked at it and we asked them to review this, tell us if this will work. Will it be a paid donor; will it be a volunteer donor and, if not, can you give us some ideas on what might work?

[Slide]

Notice the date, April 14, 1998. It is very impressive that on July 2, 1998, very short turnaround time, we got a clear, concise, definitive report that told us exactly what we needed to know. They told us that checks would have been considered a paid donor, and the reason was the emphasis on 21 CFR 606 that said anything that is cash related can be a problem. However, they didn't just give us an opinion and then back of and say, well, lots of luck, Charlie, I hope you figure this thing out. They went so far as to say here are some acceptable alternatives, and that turned out to be gift certificates that were non-cash. For example, if you give a school a $1000 gift certificate, or card as we ended up using WalMart and Sams, you can't get a $900 computer and pick up $100 cash. You have to take that $100 credit and put it towards something else.

So, they were very, very helpful in doing that, and thanks to them and their quick response we implemented the program and I think you will find shortly that it was absolutely outstanding.

[Slide]

I think you can see in this, number one, Sylvan Miori who is the driving force behind this whole program. Sylvan is a retired eccentric millionaire who made his money in an automobile parts store, and he is one of those people you just love to be around. He has done such a good job in motivating and supporting the program that he is the primary reason the program is successful. You see the gift cards being handed out here. These are Sams and WalMarts. In just a moment I will tell you exactly how they relate to the school size; they do not relate to the donation. Consequently, he is the one that has generated the motivation. These are students and this is a teacher at the high school, and the students, the teachers and everyone involved said this program will work.

[Slide]

It is really a very simple formula. The school size is based on the scholastic level -- 1A or 2A, 3A, 4A, 5A, and the amount of the credit goes between $750 and $1500. At Gulf Coast it takes about $50,000 a year to fund this program. The funding is supported by foundation

grants and gifts -- relatively easy to raise once they know the benefits of the program, and we will get to the benefits in just a minute. But it is a good program. The students love it. The teachers love it, and everybody involved makes it work.

[Slide]

Here you see Sylvan in his Dracula outfit, complete with his name badge as Count Dracula. A couple of students and Stephanie on our staff at the blood center -- the nice thing about this is that, number one, it produces donors at very good times. It is amazing how they give pre-holiday because they are getting ready to go. They give blood before they leave and they also give on a regular basis throughout the year.

We have a follow-up program that says once they start giving, the vast majority of them stay. As was said earlier twice this morning by two speakers, if you don't start them early you may not get them at all, but once you start them and they get involved, then you have them until they become ineligible. And, this program does that. Without any -- any -- exception this program motivates these youngsters. They give because they are in a friendly atmosphere. They know everybody. They give because they know they need it. They do like the T-shirts, no question about that. They do like the benefit that goes to the

school in terms of the gift certificate because the school can use them for anything. But the main thing they get out of this is fun. There is not one of those blood drives that those kids produce that is not a fun event. I don't care how low you are feeling that day, you go to one of their blood drives and you will walk away feeling better than when you went in. It is just an infectious environment. They just love to have fun. The guys and the girls argue with each other about who is going to pass out, and very few of them do. The guys are hoping certain girls pass out. They don't so they are disappointed. But they work this program extremely well so they have a good time.

[Slide]

The program was outstanding on a local level. We felt it deserved better recognition and, fortunately, the Associated Press cam in and did a story on it. You may have seen it in your local USA Today. Here is Sylvan with a donor and staff and "I want your Blood." And, of course, all of us in blood banking love the Dracula story. It was on the Associated Press wires with USA Today. We counted 123 cities that called to inquire about the program. We know of ten programs that are already up and running in other cities as a result of this.

You also notice Sylvan with his six-gallon mug. That is a little old; he is at 8 gallons right now, but he

practices what he preaches. He is a very fine Italian fellow. He is really interesting. He tells the story, he says, you know, ships have famous things on them and you can tell the country of the ship by just lo-king at the ship. For example, the USS-whatever means a United States ship. HMS is Her Majesty's ship. He says, in Italy, ours have IMB on them and I said, Sylvan, what's that? He said, "it's a ma boat."

[Laughter]

So, consequently, Sylvan has his own way of doing things but he does it in a nice way.

[Slide]

Additionally, this program was so well recognized that CBS Evening News came down. Now, Sylvan Miori is in a small town called Horton, Texas which is southwest of Houston, and that is where Dan Rather grew up. But I don't know whether that was the reason that they came or not, but Dan did come down and a couple of reporters from CBS Evening News, and it did air in February of this year on the CBS Evening News as a way to help the national blood shortage programs. Locally, Sylvan was honored with a 1999 Jefferson Award. May of you are familiar with the Jefferson awards. It is for community volunteerism. It is a national recognition program, and the top three winners locally end up going to Washington.

Two years ago we had an individual donor win the Jefferson Award. He is one of six 100-gallon donors at the blood center. Obviously, it is an apheresis program-oriented project, but the Jefferson Award raises visibility in the community and it makes giving blood a good thing to do. It makes giving blood something that everybody appreciates and it makes giving blood something that you need to do because you know the need. Obviously, an award like this locally with high visibility in the media helped everything.

[Slide]

Here are the specifics -- and these are in your handout -- on where it started and where we are. It is in its infant stage. It is not running yet so the best is yet to come, but it is walking pretty fast. We are past getting up on our knees with our focus groups and understanding things. We are past the walking sage. We are trotting pretty good but we are not running yet but we will.

Obviously, to make a long story short and I know we need to get back on schedule, we started with about 2700 donations in 6 counties and this most recent school year, which ended in June, had 12 counties with 47 schools, about 96 drives and a little over 7500 units, or 177 percent increase. The system works.

We believe that the potential is yet to come on this. We are also taking a look at going to some of the colleges and Universities where these children to and try to follow this program there. Also, we would like to see it expanded.

[Slide]

Here is another example of Sylvan. You notice the KPRC TV Channel 2 recognizes him as the 1999 Jefferson Award program. Again, the spinoff, in addition to the actual blood that it puts on the shelf, is extremely favorable and very, very helpful.

[Slide]

The last item I want to talk about in this short time is our media program. You see listed here News-2-Houston, which is our NBC affiliate, ABC-13, Channel 11, the Spirit of Texas which is a CBS affiliate, and Houston's Warner Brothers 39 and Fox 26. We have multiple media drives throughout the year, each strategically positioned prior to a major holiday. These programs tie in with area shopping malls. It is amazing how people are interested in going to the malls. They go to the malls to walk so we get them. I spent five years in St. Petersburg and I enjoyed the presentation from Florida Blood Services. They have come a long way and I congratulate them. St. Petersburg is a wonderful place, and you have these donors that are so

committed, and it is astounding how the American Association of Retried People plays such a vital role in the blood program.

Now, the reason I bring AARP into this is that with the media drives, that is where we pick up a lot of the senior citizens. They are not all out working; they are back home cooling it or walking in the malls where it is cooler. Now, Houston is hot. If you can't clap your hands and get sprayed in the face you are not in Houston. It is hot and it is humid. So, the malls give a wonderful opportunity for people to come in, get their exercise, walk and come by and donate blood. And, we have several people that are very old but they are very good donors. So, we love them.

[Slide]

The radio is not to be left out. KQQK is our single best avenue into the Hispanic population. In the Houston area, the Hispanic population is exploding. As you know, about 60 percent of the Hispanics, at least in our area, are group O. God love you --

[Laughter]

-- they are the most difficult type to have. Anybody not have any trouble at all with keeping O negative and O positive on the shelf? I don't see one hand. So, the Hispanic population is a wonderful target group. With

our focus groups with the Hispanics we try to get the top leaders. We got the people who own the Tex-Mex restaurant. We got the people who own the two Hispanic television stations. We work those people in a focus group to the point where they said we don't know anything about this, nobody has ever asked us. What a shame! So, go ask. KQQK has been instrumental. They tie in with the television, based on the demographics, and after every one of our media drives we give each of the media involved a whole demographic printout on the zip code of the donors, the gender, the age and other demographic factors and they tie that and they say, okay, we see in the same market that we get blood donors out of that we get advertising results out of, and they are very, very helpful.

The Arrow, 93.7 -- it is sort of a soft rock group. I don't know about soft rock; that may be an oxymoron but they are a very good blood program. The Buzz, 107.5 is another one that we tie in with the television station. Young country -- we have a lot of country and western stuff in Houston. Many of you know I am very happy to be associated with the Houston Livestock Show and Rodeo. It is a wonderful organization -- 13,000 volunteers, 94 committees, 66 paid staff, and this last year we gave away 8.4 million dollars in scholarships to graduating Texas high school students. We have blood drives at the rodeo.

We have blood drives with the Astros or, God love them, as we call them now, the Lastros.

[Laughter]

Bless their heart, they are up the wall and they are just spinning but they will get out of this. They have a new stadium downtown. Bless their heart, it has not been good to them. It has a retractable roof and someone said when they opened the roof the hits all went out but I don't know.

KLOL, the running radio, has the "Rock 'n Roll up your Sleeve" blood drive in July, just before the July 4, and they have a "Happy Holiday Blood Drive" between Christmas and New Year. Outstanding. They were the first in our area to do this. They have now been doing it for 16 years and produce well over 90,000 donations.

The oldies -- God love the oldies. We have a bunch of people who listen to KLDE-FM, the oldies, 94.5. They are good donors though. Sunny, 991, KODA. They also work with independents as well as a television station, and Magic 102 is the most prominent African-American station in town. Funky Larry Jones, the primary motivator of the blood program at Magic 102 is a dynamic individual. He tells people, and I am quoting, before I gave blood I became white. I was so scared there was not one drop of blood in my body. And he said, you know, I gave blood and

it just irritated me so. I said, Larry, why? He said, because it was no big deal. I thought it was going to kill me. So now he tells his listeners every morning, on their traffic patterns, go give blood; it's easy to do. If I can do it, you can do it. And, they have a very, very strong program.

KSBJ-FM was the leader of our Christian radio blood drives. "God listens" is their motto. They have a dynamic program and they have two individual drives a year, one around Memorial Day and one earlier in the year. Then, they also have what they call "United for Life" where they bring three other area Christian radio stations into a joint venture. They all are very willing to give prime time coverage to the drives, and they are very willing to promote it in their news as well.

[Slide]

Well, how did we get all this done? We talked about focus groups. Now, if you want to try to get ABC, NBC and CBS to work together on a project, that is a challenge because they are all after ratings, but blood is one thing they all work together on. We were successful in getting the president and general manager of each of the television stations in the same room, at the same time, without armed guards and they sat down and they said we have to put our differences apart here and help the

community. So, now they have staggered blood programs so they don't overlap each other.

We are working on, but have not finished the details on a one-hour evening prime time hour in Houston where, for that one hour, all you will hear is about the blood program. We did it back in the mid-'70s but they are all new players now, and this would be an educational, informative program designed around patient testimonials and the ease of giving blood. We don't have all the details worked out but I think it will happen.

I work with the presidents and general managers. I think that is my role as CEO, to go out and tell that individual what we expect. Mary Richards, who is in our marketing department, works with the director of community affairs of the station. She does a magnificent job. Everybody knows Mary and loves Mary.

The general managers of the malls -- they are a little bit of an "ain in the pass" sometimes. The malls keep saying, well, we can't have blood drives because there is all this liability. Well, fine. Give them a "harmless" agreement. Not a problem, your attorney can work that out. We have about 22 malls. We just opened a new mall, called the Bass Pro Shop -- oh, I love that one; I love that one. We just finished a drive out there and had about 400 donors in a day and a half. So, it worked extremely well.

The CEO of the vendors -- the Gatoraid folks, the Crispy Cream Donut folks -- they love to get involved because they know the people that they are servicing are the doers in the community. They are not the sit back and let it run by type; they are the get out and do something about it type and the advertisers like that. We are also working with them on wrapping our donor coaches. We have about three of those sold already.

So, the CEO of the vendor, the general manager of the mall, the director of community affairs and the president and general manager of the station are your focus groups.

[Slide]

The bottom line on this particular issue is that in a short time we got about a 21 percent increase in donations. They fluctuate. It is really interesting. The TV will go up and the radio will go down. Well, in the next year or two the radio will to up and the TV will go down. The purpose for that comment is get it balanced. Don't put all your eggs in one basket because even one broken egg creates a mess. You know the definition of a mess, that is two gallons of paint in a one gallon bucket. So, you don't want a mess in any shape, form or fashion.

Consequently, work with them. Work with them, and if they don't give you everything you want right off

the bat, that is no problem. I learned a long time ago that halitosis is better than no breath at all --

[Laughter]

-- so take what you can get and build on it, but stay with them. Stay with them because they have a lot to offer and they need to offer that to the community. They are looking for ways to give back.

[Slide]

Finally, let's not ever forget why we are here. We get all wrapped up in CGMPs and OSHA and HCFA, and all this other kid of stuff, and internal stuff about, well, Nancy made Suzie mad and -- look, here is the reason for our existence. If this is not the primary focus you are in the wrong business and, believe me, every patient is worth it. Thank you very much and God bless you.

[Applause]

Questions and Comments

DR. CONLEY: While the speakers from this morning are coming down to the table, if anybody feels the need to stand up and stretch, you can do that while I am talking for a couple of minutes.

For those of you who are speakers, there is a little touch screen on the right that has all the house rules that I read earlier but also what is useful is that it has a little clock on the upper left-hand corner. So,

you can reach down there if you are a speaker and touch that touch screen.

Bill set the pace that I think we need to keep for this meeting. if any of you have written questions or comments because if you are a little bit mike-shy, if you pass them to the end of the aisle over here, Richard will pick them up and bring them down to me. This will be like the warm-up for this afternoon because we are going to have a huge group to answer your questions and listen to your comments later. It is intended to be more of a town hall session than anything else so you may comment as well as question. The information will be captured on our transcript and will be used to good purposes to document the meeting and get the word out about things that work.

Since I don't have the cards yet, I will open with a rather generic question. Most of you are talking about a goal of being independent in your own blood supply. Yet, I understand that sometimes there is a financial incentive to import blood because it may actually be cheaper. I just want to hear if that is balderdash or if you know of situations where that may be true.

MR. TEAGUE: At least in our experience, importing is not financially advantageous for multiple reasons. Number one, there is not a guarantee that it is going to be there. Number two, you pay a premium fee for

an individual component and don't have the opportunity to make multiple components out of your unit. Number three, or finally, I think it says that you are probably not doing as good a job as you should.

Now, I don't mean that we should ever stop exchanging blood components. If we are going to reduce the outdating in this country even further, we are going to have to exchange better. But to be dependent on it, in our opinion, is not a desirable trait, which is why we have a plan to get off of the dependency for our red cell importing.

MR. SCULLY: And I concur completely with what Bill just said, that it is inherently more expensive to import blood than it is to collect it on your own.

MR. CONLEY: Any comments from the audience?

[No response]

I have a question for Brian Scully, is the raffling of sporting event tickets or airline tickets an acceptable incentive to the FDA, being that they are offered to everyone and considering the value of their worth? I will let you comment first.

MR. SCULLY: We actually got together with the FDA before we proceeded with this program. As long as the baseball tickets or tickets to other sports venues are

vouchers that are good for any game and are not convertible to cash, they are an acceptable item.

MR. CONLEY: I think that sums up pretty much how our committee makes its judgments. Go ahead.

MR. TEAGUE: Let me emphasize the proactiveness of this thing. We got a lot of flak from our peers when we went to the FDA for this. You know, it is a lot easier to ask for forgiveness -- not from the FDA --

[Laughter]

-- just stop and think about what happens if you implement something and then you are advised that they should have been labeled a "paid donor." Number one, you are in deep trouble in general. Number two, you have automatically initiated recalls on all the components that have been generated from those units. Number three, you have a deviation from regulation of misbranding the product, etc., etc. Folks, it is just not worth it.

It would be one thing if the FDA was not responsive but the FDA has been very responsive in this area because it is a grey area. It is a tough area. But if you are proactive I assure you, at least in our experience, they have been nothing but anxious to help. They have been very helpful in terms of giving you alternatives. I encourage you to do it in advance and to get it squared away before you ever go public because once

you go public and then change it, it is very difficult to educate the population. Stop and think about it. We still have people who say, "oh, I can't give blood because I had malaria." "Well, when did you hear that?" "Well, I think it was 1951." People have a tendency to let stick what they are told, especially if it is a convenient excuse. So, it is best to get it squared away in advance and get it on the road. It is a lot easier. MR. CONLEY: Part of working at the FDA is sometimes taking flack and I know there has been a lot of consternation. As Bill said, it is a grey area when we try to consider the issues with donor incentives, and there are efforts under way right now to write some kind of a guidance that will spell that out.

But, listening this morning to Brian Koski's report, if you are using things that are generally considered inappropriate donor incentives what you are really ending up with is that you are doing yourself a disservice in long-term donor recruitment, based on the research that we have. So, I learned that this morning.

Questions from the audience? Yes, right here.

AUDIENCE: A question for Brian Scully or anyone else with similar experience, and it is also related to incentives. The statement was made several times that the T-shirts, food coupons etc. are made available to everyone, whether they donate or not. The question is, at what point

in the process does an individual become eligible for these items? Is it anyone who shows up at the door and waves and says I want my T-shirt? Do they have to register? Do they have to go through the screening process? Exactly what is the mechanism?

MR. SCULLY: Good question. They are given a T-shirt upon registration to donate blood. Obviously, during the history they can be kicked out, for lack of a better term. But anyone that shows up and registers to donate receives the item.

MR. TEAGUE: In our case, it is very similar. If you are deferred, however, we will mail your T-shirt because what we found was that they were deferred at one shopping mall during a major blood drive, and the next day they were at the next mall, and the next day they were at the next mall. So, we just have them sign up and we mail them one. That way, when we get back, if they have signed up in two or three different places, we can cross check and they get one shirt.

MR. CONLEY: Very good. Yes, right here?

AUDIENCE: Brian Scully, I am from Sarasota. I want to let the audience know how successful their program is because we are in the shadow of it, and there is not a week that goes by that I don't have somebody call me and say, "where is the Hooters where you're giving away --?"

[Laughter]

-- and it is not in my market. They do a great job up there. I wanted to ask you about the phone call back to the first-time donor. Who, in your organization, does that and how do you deal with that testing? We tried that at one point and we were trying to hold them until we got the reports back because we didn't want to call a first-time donor and encourage them and then have them end up getting a negative test report and that got to be very cumbersome.

MR. SCULLY: One of the reasons that we don't ask them at the time we call them to come back and donate again is because of that very reason. We simply want to thank them for making the effort to come in and donate. Down the road, if their blood was kicked out for one reason or another, obviously, we don't call them again.

The people who call are generally telerecruiters, although we do have administrative support services who calls. We have phlebotomists who call. Anybody can volunteer to call, and sometimes it is even better if we do have some of our collection staff call because these people can identify with them but we don't ask them, at that particular point in time, to come back to donate. We simply thank them for their current donation.

MR. CONLEY: Susan?

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AUDIENCE: My question is for Brian. Brian, you mentioned at one point that one percent of your budget goes for paid advertising. My question is how do you measure the efficacy of that advertising? Do you do focus groups or do you do donor surveys? And, if you do, is that part of the one percent budget?

MR. SCULLY: I will try to answer that as best I can. We have determined over a course of time that our paid advertising has worked just based on the fact that our donations have increased on a regular basis over the last five years. We do have focus groups. We do also do surveys but pretty basically we are just looking at hard numbers. When we do advertise, when we are on TV, our collections increase proportionately. Go ahead, Bill.

MR. TEAGUE: I have a similar question for you. First of all, I applaud the program. We deal with so many media groups, how do you equalize your expenditures so you don't irritate, aggravate and alienate some of the rest of them?

MR. SCULLY: Well, we employ a media buyer. We have an individual whose job it is to go out and spread the wealth. She deals with the radio stations and TV stations and the newspapers, and during the course of time she provides us with a budget, and that is generally based on the organizations, the TV stations and radio stations which

give us two for one, three for one or four for one. Each station has their own method of doing our commercials -- I guess you could call them commercials, and they will give us to, three or four more for whatever reason -- I don't know, but I think it makes them look good also. So, we have a buyer who does that for us.

MR. TEAGUE: Is that buyer on your staff or is that an outside entity?

MR. SCULLY: It is an outside entity.

MR. TEAGUE: An outside entity. Thank you. On that same issue, does FDA have any problem with us buying advertising like that?

MR. CONLEY: None that I am aware of.

MR. TEAGUE: I mean, as long as it is not false advertising, you don't make false claims like "our blood is NAT tested. It's safer --"

[Laughter]

MR. CONLEY: No problem with paid advertising. A reasonable follow up is one of the questions I have here, have you extended telemarketing to the Internet, for example banners? It seems that market targeting might be used here also, in other words, targeting segments of the market. I know there are a lot of NAT centers that collect information on cookies on our machines every time we dial in somewhere. Any telemarketing?

MR. TEAGUE: Ours is limited. We have at least one gentleman in the audience who probably has an awful lot more information than at least the three of us, Dr. Counts. If you are interested in talking about that, that is fine. But we certainly believe that that is not the wave of the future; it is now. The train has left, and we are doing everything we can to get on that rascal. It is still slow enough that we can catch it. So, it is not totally gone.

I was very proud of America's Blood Centers. They have established an e-donor committee, and they are seriously looking at this thing and it will have great ramifications for our recruitment and retention programs. But in our case, we have found that not only do we get the individual donors but we get companies involved in setting it up on the company, corporate Internet and they have internal programs where they advertise the blood drive, establish appointments, give out information. They answer questions. There is a direct link to our medical director so if they have a medical question that the corporate recruiter can't handle, then it comes straight to our medical director.

MR. CONLEY: Very good.

MR. SCULLY: This doesn't have anything to do with what you just spoke about but the young lady from Sarasota who mentioned that they were under our shadow, our

advertising on radio and TV covers a broad spectrum of the Florida area. So, people in Orlando and people in Sarasota and people up north all see the same radio and TV ads. So, they basically benefit all the blood centers surrounding us.

MR. CONLEY: Thank you. Right here?

AUDIENCE: I have a question for Bill. I have a question about the TAPS program. The scholarships that are awarded to the school districts, are they based on a certain percentage of donors, or does that come every time they agree to have a blood drive? I am a little confused on how they earn the scholarships.

MR. TEAGUE: The gift cards are based on the interscholastic league designation, i.e., a 1A or a 2A size school gets 750 and then the larger school, the 5A, gets 1500. So, it is based strictly on the inter-scholastic designation. You can't tie it to the number of donations.

AUDIENCE: So, if they sign up and are part of the program, then they get that for participating?

MR. TEAGUE: Correct. And, they are usable for anything. Some people buy computers. Some of them buy fertilizer -- there is a lot of that in Texas.

MR. CONLEY: Another question in the back?

AUDIENCE: A follow-up question about the Internet, for Brian Scully. You mentioned that you have

10,000 hits on the website a month. Have you analyzed that data? Is it interactive? Do you know what kind of traffic you are getting?

MR. SCULLY: At this point it is relatively new with us, and we haven't really done any investigation at this point in time. Some is interactive. We get a lot of e-mail through the Internet -- some really strange questions, most of which we send to our CEO and medical director, but even some weirder ones that I won't pursue presently.

MR. CONLEY: We have another question right here.

AUDIENCE: Yes, I am from Ft. Bragg, North Carolina, with the Army Medical Center there, and we have a very limited donor population but we also have a very limited incentive budget. What would be your recommendation, you know, for effectively spending what little money we do have for that?

MR. TEAGUE: We have very little experience with the military. We don't have much, the most military we see is when the President comes to town. There are some folks from San Antonio here that I know would have better guidance on that, but in our limited experience with the reserves, the incentives are not the turn-on for those folks. They have a very strong patriotic streak, and if you just let them know what is needed and make it easy for

them to give and treat them well, they will give, in our experience.

MR. SCULLY: We have the McNeil Air Force Base in the Tampa area, and we have four blood drives a year there that are very successful. Over the years we have given away running shorts, baseball caps, T-shirts that have the designation of whatever unit they are in, and we also have a competition between the different units and, obviously, give plaques or what have you. But it is generally the running shorts, the T-shirts and the caps that bring them in.

MR. CONLEY: Let me take one more question right here.

MR. COUNTS: Rich Counts, from Seattle. As Bill alluded to, we have had a fair bit of experience with the Internet so far. It has been interesting. We consider it still experimental. There are clearly people that you can reach that way that prefer to be contacted that way, both donors and other groups. There are people who get a lot of their information off the Internet.

When we started our web page a few years ago, we had an interesting experience. We had a lot of interest. The interest fluctuates from time to time. A web page is something you have to keep maintaining and you have to keep changing because a lot of people will look at it and then

if they don't see something new, they will go on to something else.

Different people use it different ways. Some have questions. We have a number of people who want to be contacted that way to remind them to donate but not everybody does. And, I think it is going to turn out like any other area, any other marketing area, that is, to find the most useful way to utilize that and to find the people that is an effective way to reach. It is not necessarily going to be a panacea. It certainly is a rapidly developing area and there are lots of experiments to be tried with that.

The question I have for the group is you have each talked about various things, certain things that are particularly effective or seem to be particularly effective in your center and the way it operates. One of the problems we have in fitting all of these things into our overall recruitment strategy so that we maintain a stable blood supply day in and day out is the appropriate mix of these things. Could you comment on how you decide the relative value of these things, such as T-shirt incentives, telemarketing and other things. That is a more global question I suppose than we have time for, but rather than just focus on one thing or another thing, how do you

evaluate the relative value of the various things that get included in your mix of packets?

MR. CONLEY: I can give you 60 seconds to answer that question.

MR. TEAGUE: Well, I will take 15. We look at two things. Number one, what worked with that group before and, number two, when we talk to them we give them the options and say, in your opinion, what do you think will turn these people on most?

MR. SCULLY: We, at FBS, use the SOTP method, which is seat of the pants, and what we have seen over the course of time with people coming in for certain incentives. We use the T-shirts because we determined years ago in selected drives that our participation increased by about 40 percent when we gave a T-shirt, and for the number of T-shirts that we buy we pay $2.15 for four-color T-shirts, good quality T-shirts, and in our mind that makes a whole lot of sense and if we don't give them out we are going to lose a whole bunch of donors.

MR. KOSKI: I guess in prioritizing I would put your money into anything that is directly interactive with the people in any way, shape or form, like telerecruitment, if you are on a limited budget, and work your way down to where you can afford to spend some money on your marketing items, if you will. So, I would go that way first. Of

course, using technology, you know, there are ever-evolving segments that will take advantage of that so that is a good place to spend money now too.

MR. CONLEY: I think that is a wonderful question to wrap up the morning session, to continue to think about how you prorate all these things that we are learning today, and it is a worthy question for the panel this afternoon when we convene again.

Let me tell you briefly a little bit about tomorrow. There are five breakout discussion groups. This is where you will give us your most input. They are facilitated discussions. There will be somebody in charge of each group. We have had to make some changes in those and I can tell you later in the day exactly who is doing what. But, as a facilitated discussion, that is to keep you on track, and there are objectives and goals of what is to be derived out of each group session and reported back here at the close of the day tomorrow before we all go home.

Each of you will have an opportunity to go to two of those sessions, one in the morning from 8:30 to 9:50 and then a second from 10:10 to 11:30. Because we want as evenly distributed groups as we can get, there are sign-up sheets for the sessions. They will be available out front, at the registration desk, beginning now so you can sign up

during the lunch break, during the afternoon break or before you leave here today. Those sign-up lists will be at the front table now.

The cafeteria is downstairs. We have eaten a little bit into the one-hour lunch time but because it is nearby I think we can make it. I would like to reconvene at 12:45. This afternoon we have lots of snapshots. Those are 30 minutes to tell you everything they know about donor recruiting on a focused topic. So, we are pressed for time. It is designed that way. So, go have a good lunch. See you at 12:45.

[Whereupon, at 11:50 a.m., the Workshop was recessed for lunch, to reconvene at 12:50 p.m.]

AFTERNOON PROCEEDINGS

DR. LEWIS: I would like to begin our afternoon session with Willard Nielson. Bill is corporate vice president of Johnson & Johnson and is responsible for public relations and corporate communications for the worldwide health products company. He joined Johnson & Johnson in 1988, after an 18-year career as a public relations agency consultant, and after his graduation from Oregon State University he served for five years in the military as a public information officer with U.S. Air Force both here, in Washington, DC, and in Japan.

During his career, Mr. Nielsen led an 8-year public relations advertising image improvement program for the pharmaceutical industry. He led a 10-year nationwide child injury prevention campaign. He served two terms as president of the Arthur W. Page Public Relations Society, and is past chairman of the Public Relations Seminar. He has chaired the Board of the Institute for Public Relations Research and Education, and serves on the Board of Directors and Executive Committee of the Global Public Affairs Institute. Mr. Nielsen is a member of a number of national and international public relations and media organizations, and has been recognized many times for his efforts in these groups.

Today, Mr. Nielsen will give us a snapshot of success in recruiting corporate campaigns. Welcome, Mr. Nielsen.

Snapshot of Success in Recruiting Corporate Campaigns

MR. NIELSEN: Thank you very much. It is a pleasure to be here. I know I am the only thing standing in the way of a good afternoon nap, so I am going to ask that the house lights remain up.

[Slide]

It is a pleasure to be with you. I am excited to tell you about a program that we are doing up in New Jersey that has produced some interesting results in terms of increasing the number of blood donors. I will talk to you about how we are organized, something bout budgeting and some of the critical success factors.

I must tell you that I have to observe that being with you today, here at NIH and in the company of the FDA, I feel safe --

[Laughter]

-- the pharmaceutical industry is bleeding a lot as we speak, and a lot of us are involved in that and trying to tell the truth. If I have any time left over we can talk about pharmaceutical pricing and Medicare drug benefit, but that is probably another meeting.

To get into this discussion, I want to give you top lines. This is a fairly logical and obvious approach to organizing a corporate effort, but I do think it is a bit unique in that we are dealing with the pharmaceutical industry and you would probably, as an average person on the street, think it would be quite natural for the pharmaceutical industry to be involved in supporting a good, healthy national blood supply. In the case of many companies and certainly my own, Johnson & Johnson, this has been true. But when we took a look at it a few years ago at the behest of Jim McPherson and Susan Parkinson at ABC, we were a little disconcerted that the record of an industry that is so embedded in the healthcare care system had kind of spotty results, and we were determined to see if we could do something about that, and also perhaps provide some kind of a model that might work in other industries and across the country.

[Slide]

So, let me move into this. Our program is called Rx Partners for Life. It is an annual donation program, and it was developed by an organization called the Healthcare Institute of New Jersey and America's Blood Centers. As I said, this was first talked about four or five years ago and came into being. We have had two drives and we are working on the third one. So, we have a bit of

history, but the history is also pretty short and if we have learned one thing it is that there is lots of room for improvement and, we think, the extension of this idea.

[Slide]

The goals of the campaign are really to help try to put an end to the perennial shortages by increasing donations within the corporate employer base within the State of New Jersey and, hopefully, across the country throughout the United States. Also, in this project, to try to look at Rx Partners for Life to see whether or not it could represent something of a gold standard which other industries might emulate and come to use as a benchmark against which to measure and evaluate their own campaigns.

[Slide]

A few years ago, how this program got started was that we were having a conversation about the nation's blood supply and, in all honesty and the spirit of openness, I have to tell you that Johnson & Johnson has a business in producing some of the test agents that are used on evaluating the quality of blood supplies. So, we have that interest but we also have an employee base that has been very committed for quite a number of years to donating blood. It was out of that kind of pooling of interest that we became acquainted with ABC and looked at ways that we could be helpful to try to improve the donor base.

The first target was the pharmaceutical industry where I happened to be involved in a very long effort to try to put a human face on that industry, and also to show that the companies that represent this industry are involved in a great deal of community support. Jim, you will remember that we went to PHARMA in Washington and tried to make the case, and it really fell on deaf ears because there wasn't something around which the industry could rally and pick up on very quickly.

I think this is an important factor as you look at approaching other industry groups. You have to sort of get them where they are gettable, and doing it on a nationwide basis initially just seemed too overwhelming and kind of off point. So, we turned, instead, to the State of New Jersey where we knew that there was a concentration of pharmaceutical companies, and it happened that at the same time there was an organization forming, prompted by the companies and other healthcare products companies, called the Healthcare Institute of New Jersey, which provided a perfect vehicle through which to launch a coordinated effort.

The New York-New Jersey area was also important for a couple of reasons. It is through the New Jersey and New York blood centers that hospitals in that great region, a very populous region, have to import more than 300,000

units of blood per year from other areas of the country and abroad to meet the tremendous number of procedures that are performed by hospitals in that area.

As I said, the other factor in our selection was the very prominent presence of quite a number of pharmaceuticals. There must be at least a dozen major companies that have located in New Jersey and have large employer bases. At Johnson & Johnson we have probably 13,000 employees, and it just represented a great way to begin to approach this very large industry. So bringing those interests together, ABC, our company and Shering Plough, a number of the other companies, and recognizing that our individual companies do a good job already, some of them, in running these blood drives, we wanted to capitalize on that.

I think the other point to make about this industry is that there is sort of a culture within healthcare companies that tends to be supportive of these kinds of efforts, and if you can get a program going with competitive companies and establish some competitive benchmarks, you also have a culture that wants to succeed, that wants to win, and Susan picked this up very quickly, that if you give the companies incentives so that they have a chance to win you have another important engine working for this campaign.

[Slide]

This slide shows something of the organization of this effort. In addition to the ABC and the Healthcare Institute of New Jersey, we had a steering committee made up of four companies. We had four individuals participating from each company to act as this kind of steering committee, and then each of those team captains were assigned other companies to approach and recruit for this effort.

A little lesson we learned -- keeping the steering committee small was also important. I think when we first started out we had too many players around the table and it was very difficult to get things going, but in the second year, with some streamlining and picking the right people, we had a vehicle that could really bring it together and achieve action in a very short period of time.

We had quite a range -- Johnson & Johnson employees give a tremendous amount of blood, and then other companies -- really only modest efforts and we were trying to raise the level across the board and there was a matter of trying to pull these companies into a coordinated campaign. Our initial proposition to them was let's pick a time period. We won't do this all in one Saturday, for example, because logistically that would be very difficult to do, but let's take a time period and if you would

initially put a regularly scheduled drive that you have into this program, then we would kind of coopt it so that we could get some critical mass around it. I think we had 17 companies the first time who did that, and others who were doing drives at other points of the year scheduled a new drive for that time period. So, over a three-month period, from November through February, all of them conducted drives around this common concept.

Having the steering committee obviously allowed us to do achieve some efficiencies in this. We were able to create a budget that could be discussed with the companies. The steering committee also provides ongoing monitoring and support and evaluation that is a very effective planning and implementation vehicle. That committee also has the ability to develop common materials that could be used in the companies so that they had a way of identifying with this larger effort.

The program, as I mentioned, is held from November through February each year. It is complete, with a formal launch. We do at a breakfast at one of the member companies. We invite representatives, not only the people who work on these drives in the companies but members of management, to come and join with us so that they can see one another and understand that they are all in this kind of common cause commitment. In fact, invitations are going

out within the next week or so for the launch of next year's program.

[Slide]

I wanted to begin to show you some of the results of this effort. The first bar on your left is a baseline record of units donated by the companies that were involved and you can see the results for 1999, and for the drive just completed, this last February for the year '99-2000, quite an interesting increase, 14 percent in the year '98 and anther 11 percent in '99, for a total of 28 [sic] percent increase in these companies over their historical giving rates.

We are pleased with this kind of improvement but when you look at the total employee base you kind of get weak in the knees about how much more improvement you could get with increased efforts. But we think it is off to a good start. The employee participation rates at the companies also increased from 17 to 19 percent.

The program is already being used as something of a model for other industries. The Nuclear Energy Institute launched a pilot program for its members called Energy for Life, which I think is a great name, in June of this year and are picking up on some of the same ideas and principles that we started with this Rx Partners for Life.

[Slide]

Just to give you an idea about some of the materials and budget implications of this, it is really not a lot of money when you can get a pooling of interest and get some basic materials explaining what it is you are trying to do and why together. We initially produced all the materials from one site in the first year of the campaign. In the second year of the campaign we were able to make templates available electronically so that they could be reproduced by participating companies. You can see a total of about $16,000 for materials. I believe this was the first year costs. The second year costs would come down very, very substantially because we were able to reuse a lot of the materials in subsequent programs.

[Slide]

Just to review some of the critical success factors, there are five involved. I think one of the most important in this effort was that forming the kind of coalition of companies gave us a very active and visible vehicle through which to approach these companies, all based in New Jersey, and to appeal to their public service and community instincts. We also had great support from leadership of these companies, and we think that is extremely important, to show executives involved in this because it helps win over the support of employees down the line when they see that everyone is included. As Susan

points out, some of these top executives even donated blood in the process --

[Laughter]

So I think this visible management support and kind of incorporating this idea into the culture of these companies is a very important success factor.

Another one is budget and being able to be very efficient. You need seed money. Several of us provided that seed money initially to get this going, but now we have an investment in art and graphics that will last for quite a while. So, the hit on the individual companies in repeating years is not all that significant and it is hard for them to say no.

Another critical success factor is having motivated and efficient blood drive captains, and also the active support from blood centers, and we have had tremendous support from ABC and also from the New York Blood Center working with the steering committee, and the people in the companies have just been phenomenal. I know the one at Johnson & Johnson who handles this, Theresa Ragazine, really ought to be here today because she has done so much work on this, but she is in fleet management. She buys cars for our sales reps. But she was infected by this and has really donated a great deal of time. No matter where you go -- I am sure it is true in your

experience -- you find people who are champions and who really want to get involved, and it is important to look for those people whenever you are trying to build a coalition of companies such as we were doing.

Another success factor was doing this over a defined period of time so you don't get the sense that this is ongoing and it has to be tended to on an ongoing basis. I think that is a factor that leads to failure, quite frankly. If you can organize a time where there is a start and a finish, and you are able to measure your accomplishment in terms of participation rates and units donated, that is something that people can then stop and look at, reflect upon and celebrate. In our case, with the help of ABC, we have tried to gain some publicity within the state about the effectiveness of this campaign.

The other critical success factor was the use of common materials and a common theme. In our State of New Jersey, with pharmaceutical company employees, many of whom have worked at other companies, they saw themselves in a wider community and we think that that helped the initial response to this campaign and will certainly help us build this into the future.

[Slide]

Speaking of the future, as I indicated, the invitations are going out shortly for our third drive which

will start in November. Again, it is sponsored by the Healthcare Institute of New Jersey and America's Blood Centers. It will start in November and run through February, and the next time you see that chart you won't be able to see the top of the next bar chart.

Also, with the Healthcare Institute of New Jersey and ABC we are looking at ways that we can extend this program nationally. Johnson & Johnson and all of our companies have large employee bases in New Jersey but we also have facilities all across the country. Many of you probably work with some of our affiliated organizations. We have 30-some odd locations just in my company, and we think that we can tap into all those locations and really have quite a substantial critical mass of support behind us.

We are also looking at ways now of getting back into PHARMA, the large international trade organization, and the possibility of expanding this to other companies that are located in other parts of the country, and also taking this idea into other elements of the healthcare manufacturing industry, such as BIO, which represents biotechnology companies and HIMA which represents the medical device manufacturers.

We are really pleased by the success of this effort. As I said, it is a pretty logical, straightforward

common approach. I can tell you though that it has been a lot of hard work on the part of a few people, and I give Susan and Jim at ABC and the New York Blood Center enormous amount of credit for being so supportive and also being so patient with these companies, many of whom get distracted by other things, not the least of which being the current political climate, but they are good at bringing us back to what is important and that is growing an effective donor base across the United States to support this very urgent need in our community.

So, that is my snapshot. I am not going to be able to stay for the panel but I have asked Susan to sit in. She knows more about this than anybody, and also what it takes to push companies along. I do think that there is a very interesting model here, and would be happy if you want to furnish some leads. For example, the petroleum industry -- we talked to Bill Teague about activating the automobile manufacturers. You could go down a list and probably come up with twenty different industries that have some of the same aspects to them as we find in the pharmaceutical industry. Having been a part of a corporate setting, I continue to believe that as employees spend more and more time devoted and committed to that workplace it represents a wonderful communications vehicle and a great kind of rallying point that we need to figure out, you

know, even better ways to tap into on behalf of the nation's blood supply. So, thank you very much.

[Applause]

DR. LEWIS: Thank you very much, Bill. Our next presenter is Keith Warnack. Keith is a public relations manager for the Puget Sound Blood Center. After graduation from Michigan State University School of Journalism, he has been involved in a career of over 20 years in journalism, marketing and public relations. Mr. Warnack is a member of the American Marketing Association, and is chair of the marketing committee of one of the nation's largest AIDS service organizations. He is going to give us a snapshot of success of donor education in the school system.

Snapshot of Success - Donor Education in the School System

MR. WARNACK: Well, thank you. First, I want to say how honored I was when Gil Conley first called me to invite me to come and speak regarding education in the Puget Sound Blood Center.

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The blood center was founded in 1944 and education and research has always been an important element of the blood program, and for more than twenty years now we have actually been going into the schools and providing blood science education. So, I was proud of the programs that we have always had in place. But then, after I hung

up the phone, I was trying to remember that this was a recruitment presentation and I was trying to think how am I going to tie our education programs into recruitment and, actually, after doing some research I am glad to say that I found some research that back that up.

[Slide]

Well, social capital is probably one of the newest buzz words that is really used to simply describe the behavior that we are all here to discuss and learn how we can foster and grow in our communities.

[Slide]

There are two primary ingredients to altruism. One is knowledge and the other is involvement.

[Slide]

I am glad to say that there are also some other people out there with a lot more than a B.A. in journalism who agree with me. Those people are James Youniss and Miranda Yates, and she also has Ph.D. but you can't tell there.

One of the studies that I looked at was their study. Actually, I should mention that Youniss is a professor of psychology at Catholic University here, in DC, and Miranda is our researcher at Brown University. What the study was, which was published in the Journal of Research on Adolescents, it tracked a number of students,

urban high school students here, in Washington DC, through a social justice's court. The students were required to work in soup kitchens at least four times during a semester. Afterwards the students would write essays on that experience. What these two researchers found after doing the final analysis was that as the semester went on with the students, the moral issues that were discussed increased in sophistication. The questions went from just discussing homelessness to eventually wealth distribution in society. And, by the end of the course work, and this was important, the behavior of the students had changed. The students actually averaged seven times volunteering in the soup kitchen when only four were required, and some volunteered even more than that.

What the researchers believe is that the students, throughout this process, were developing their identities and that part of their identity is seeing themselves as a political or moral agent in society, which is contrary to the belief that identity is really an inward search. The experience of these students in studying social justice and being involved in a program contributing to society pushed the students to take ideological positions and develop a context for finding a position for themselves in society. And, I believe that the results are

similar with the education project related to blood donation.

[Slide]

In the 1970s, late 1970s, the National Institutes of Health funded a program with the Puget Sound Blood Center to produce a blood education program. Probably many of you are familiar with certain elements of it. The program was actually comprised of four different modules, one for primary students, intermediate, junior high and senior high. The people involved in producing this, one of them being our executive director, Dr. Richard Counts -- there were a number of public school teachers from the area and social scientists and curriculum specialists from the University of Washington. The modules had titles like senior high module, but the primary level one was called, "My Blood, Your Blood," and the whole program eventually seemed to take on that name.

[Slide]

What it included was a teacher's guide, a lesson planner, posters, a film strip -- that gives you a sense of how old it was. There was an audio cassette that could be used along with the film strip, and photo cards that were used during class discussions. That is what the lesson guide looked like. Schools could borrow it. The blood centers would actually go to the school and they could

borrow it, or they could purchase it through the University of Washington.

[Slide]

The desired outcomes of the project were to raise awareness about blood's function, to increase the students' interest in blood science -- hopefully, they would have some future employees there, build a bridge between the blood centers and the schools. I think one important element of this whole program is that for once blood centers were not just going to schools to ask for blood donations but it was actually information that we could provide and part of a curriculum that the schools felt was important. So, it gave us an entrance into a number of the schools that we might not have had unless they were having blood drives. Finally, what we wanted to do was to create a new generation of blood donors.

[Slide]

The success of this -- there are a number of elements but, first of all, it had to be a solid science project. We had to have teachers wanting to order the products. It had to be entertaining so there were some pretty good illustrations throughout there. It had to be a flexible plan which would allow the teachers to pick and choose certain elements depending on the class structure or the amount of time they had. And, it had to be a very

turnkey product. Teachers didn't have a lot of time, and they still don't have and they probably have even less time, to learn everything there is to know about blood science that they are going to teach and then develop lesson plans. They needed to be able to pick up the package, pick and choose the parts they wanted to use and run with it.

[Slide]

Well, today the product is showing its age. The film strip is on video now but it still is very static images. Maybe many of you are familiar with "Bill Nye, the Sciences Guy" episode that he did on blood and circulation. Actually, it was filmed at the Puget Sound Blood Center. So, at times now when I get requests for the video I may send it out but sometimes I will send a bootleg copy of "Bill Nye, the Science Guy" along with it.

For the high schools, much of the education that we are providing -- there is still science education that we can provide but a lot of the AV that we have available is really a motivational video and it is using patient testimonials, and also providing walk-in students through what a blood drive looks like, exactly what the process is going to be. It is a good video and we certainly use it a lot, and we would be glad to offer it to any of the other blood centers who are interested in using it.

Regarding the motivational video, to get a little research in we did do a lot of focus group work on our public service announcements. What we wanted to do is look over the years at the different approaches we had to public service advertising and the different messages we were using to figure out which ones resonate most with the target audience. We actually brought in people. Some of the people in the audience were teenagers, up to in their mid-50s. Probably the most important finding related to that motivational video is that, regardless of the demographics, it was really the emotional appeal that resonated the most with people regardless of age.

Some of our PSAs were clever, a little hipper. Some were really focused on the science and the quality of our organization, but really it was the patient testimonials that, regardless of a patient's age, is what made the difference in people at least responding during the focus groups that that would motivate them to give blood.

[Slide]

As far as the results, this is looking over the last three school years, and you can see that there have been some significant jumps in blood donation. Probably the most important thing when you are looking at this is to realize that the school populations have not risen very

dramatically so the increase that we saw, especially in the '98-'99 year, was a 16 percent increase over the previous year and last year we saw a 12 percent increase.

As I mentioned before, the video or the product that we are sending out to schools now is primarily a motivational tool, and it is used by our recruiters that are going in before a blood drive. But I think it is important that we have an education program that can be used by schools, that would be desired by schools, especially the schools that as of yet are not having blood drives.

[Slide]

Well, guess what -- we are reinventing "My Blood, Your Blood." I probably shouldn't be using this to sell a product but actually "My Blood, Your Blood" -- I am very proud of it. It is not completed yet but it is a product that has been produced through the America's Blood Centers Foundation and a number of the independent blood centers have contributed funds to get it going, and also Roche, Ortho and Baxter are all major contributors to this. Wheat the new program will look like -- there will be a lot of animation. There will be live action characters working alongside some animation. There is a lot of great photo microscopy, and a lot of the technology that was not available in the '70s has been used in this new piece.

In addition to the science video, there will be a website, mybloodyourblood.org. There will be a teacher's guide, which was produced, again, by a team of physicians, science teachers from the Seattle area, and also there will be a community implementation plan which I think will be one of the critical elements of this new package, and what we will actually do is provide some information for blood centers for how to get this program into their local schools. There will be templates of letters that people can write to school officials; newsletter ads that can be dropped in; and just a number of other ideas for blood centers to help them get it out.

I guess I invite you all to the premiere which will be July 16th at the Science Museum of Minnesota during the ABC meeting. Again, that is Sunday, July 16th. Hopefully, it will all be ready. That is my snapshot.

[Applause]

DR. LEWIS: Our next snapshot is our first tag team presentation. It is Mike Nichol and Rob Evans. Both are part of the Canadian Blood Services. Michael Nichol has been in the Canadian blood program for over 21 years, rising to his current position as director of donor and volunteer management for the Canadian Blood Services. Following seven years as an administrator with the federal government, Mike began his career in blood serving as

center administrator for the Ottawa Blood Center from '78 to '87. In '87, he moved to the head office where he served as director of the blood donor recruitment and director of manufacturing and development. Mike has also served as director of plasma operations and business development, including responsibilities for CBS's fractionation program and the development of its two stand-alone plasma collection centers. Mike has been a member of AABB since 1980 and is also a member of the ADRP.

Mike is joined today by Rob Evans, who is presently Canadian Blood Services' director or marketing. He joined the blood system in 1993, first as the blood donor recruitment manager at the Calgary Blood Center and then as marketing, communications and supply manager for Western Canada. Rob took on this current national position last year. He has had 18 years of marketing and communications experience in diverse businesses, such as publishing, tourism, radio, advertising and insurance, and he claims he was never a life insurance sales person. In the interest of full disclosure, I have to say the organizing committee tried to verify that but we couldn't gather any information one way or the other. Rob is an accredited member of the International Association of Business Communicators and is a guest lecturer and

instructor for the public relations program at a local college near his home.

Michael and Rob will speak on maintaining supply while implementing new donor restrictions.

Snapshot of Success in Recruiting

Maintaining Supply While Implementing New Donor Restrictions

MR. NICHOL: Thanks very much. My name is Mike Nichol, and I am pleased to be here with my colleague, Rob Evans. We are going to be telling you a little bit about two very significant donor recruitment/marketing programs that we have introduced in Canadian Blood Services over the last ten or eleven months.

I guess one of the things that you may be wondering, particularly those of you who were at ADRP and heard the same presentation and wondered how it is that we would ever get down from 50 minutes to 30. Rob decided to take out all of his jokes, his bad jokes --

[Laughter]

[Slide]

Anyway, as I said, we are delighted to be here today to talk to you about two programs that we have introduced in Canada. As you are going to find out, the original intent of these two programs, while they were somewhat different initially, we are pleased to be able to

say that the net results of these programs have not only allowed us to replace lost donations as a result of the introduction of a U.K. travel policy last September but, in fact, we are going to tell you a little bit later on, at the end of our presentation, that we have actually increased collections over the same time period of a year ago. So, we are particularly delighted about that.

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Before we begin, before we get into the specifics of the two programs, we would like to give you a bit of an overview and background to Canada and Canadian Blood Services. Canadian Blood Services is the sole supplier of blood and blood products in Canada, with the exception of the Province of Quebec, right here in the orange-yellow area, which is served by Hema Quebec. Through our 16 regional blood centers located across the country, we collect, test, process and distribute blood and blood products to Canadians through some 650 hospitals located in the nine remaining provinces and three territories that are served by Canadian Blood Services. Just to give you some idea of the size of our program and scope, in the 12-month period ending March 31st of this year we collected 722,844 units of whole blood.

Now, I would like to actually ask Rob to get up and give you a little bit of a history lesson in terms of

Canadian Blood Services and how we got to where we are today. Rob?

[Slide]

MR. EVANS: We thought it was a good idea to not only give you a bit of a geography lesson but also some history because the background of the Canadian blood system is important for you to understand where we are coming from. Canadian Blood Services, CBS -- and, as I said in Memphis, that is not your national television network; that is CBS in Canada -- took over Canada's blood system on September 28th, 1998. So, we are just coming up to our second anniversary.

We took over our system that was fragile, to say the least. In fact, blood collections in Canada had declined for every year of the previous ten years. Truly, our goal when we took over the program was simply to stabilize the supply during the transition period to make sure that there was enough blood there for those people who needed it. We weren't focused on branding. We weren't focused on necessarily increasing the donor base; we wanted to stabilize and make sure the blood was there for those people who needed it.

I am going to hand it back to Mike. I will be back here a little bit later but just to sort of follow up on what Mike said about our two different roles. Yes,

there were two different campaigns for two different reasons and, in fact, the ad campaign that I will be talking about actually started before the CJD policy came out, and for marketers it was a wonderful opportunity for us in that through the ad campaign we were developing increased awareness for the need for blood, and for Mike's operations they were offering increased opportunity to act upon that, and that is why we are here today as a tag team, because it is the combination of both those efforts that we think contribute to the bottom line. So, I will see you shortly.

MR. NICHOL: Thanks, Rob. We have lots of time and we are going to try and limit ourselves to our 30 minutes. But if we do start to speak quickly because we are trying to squeeze everything in, it is partially because of that but also because, as you well know, coming from Canada we have a somewhat cold weather climate in the winter and at a very young age we learn to do everything very quickly.

[Laughter]

[Slide]

I am going to begin by telling you a little bit about our donor management program, which is one of the two programs that Rob and I are here to talk about. The donor management program was essentially born out of the need

that Canadian Blood Services identified to develop a program so that we could replace lost donations that we anticipate we would see as a result of the introduction of a VCJD deferral policy.

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So, let me begin first of all by telling you a little bit about that policy itself. Canadian Blood Services became aware early on in 1999 that our regulator Health Canada, which is the equivalent of your U.S. FDA here in the U.S., would be requiring us to implement a deferral policy for anybody who had traveled to the U.K. for a certain period of time. We weren't really specifically aware of the exact requirements or details of that policy but through different conversations and information that we gathered we learned that this would be coming out and introduced sometime in the middle of 1999.

We certainly very much supported the introduction of this policy based on some of the information that we also had. So, what basically came about was that in August of last year, August 17, 1999 to be exact, just about a year ago, Health Canada officially announced its policy that any individual who had traveled to the U.K. for six months or more cumulatively would be deferred from donating blood. The other requirement that they outlined was that

this policy would have to be mandated for implementation no later than February of this year.

Well, of course, we had some heads up on this. We had begun the planning process, and we were actually able and wanted to introduce this sooner than that. So, we implemented that policy on September 30th of last year, about 45-odd days after the official announcement of the policy.

We had done some work in terms of what we expected the anticipated loss to be, and in total, with respect to the planning for this particular donor management program, we were working on the presumption that we would lose a total of 38,500 units per year or in the first year. That was made up based up on some epidemiological work that we had done of actual deferrals of 18,500 to 19,000 donations and then, again for the purposes of this program, we assumed that we would lose an equal number of people who would self-defer. So, that is how we came up with something in the neighborhood of 38,500 donations that we would lose.

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We knew in planning this donor management program that there would be a varying impact on our centers because, obviously, the impact on some centers with

different types of populations would vary and, depending on where that was, we would see a different impact.

So, based again on this epidemiological work, we new that the range was from a minimum of 0.31 percent or 74 donors in our smallest centers to as many as 4.14 percent or almost 6000 donors in our largest center.

Now, I can tell you that as of a couple of weeks ago, on June 17th of this year, we have actually lost 7800 donors as a result of this deferral policy and, of course, many of these donors, as you can appreciate, were long-time, ongoing donors who gave more frequently than just once a year. We don't know the exact numbers but we know that were many that were in that category and, of course, the other thing that this doesn't tell us is that we don't know how many people have actually self-deferred because, of course, this is the number of people who have actually attended a clinic and been deferred.

[Slide]

We began the process, as I said, prior to the official announcement by Health Canada, and we essentially had four separate approaches. I am going to give you a little bit of information on each one of those approaches in a few minutes, but just to kind of give you the high level, the first of those approaches was what we called the bridge-funding approach or the short-term approach. That

would be followed by a donor recruitment strategy and also a complementary donor retention strategy and then, of course, we also wanted to provide some program support. We knew that would be necessary to our 16 centers across the country as they introduced the variety of programs that we were going to be offering them.

That was certainly the key, the variety of programs, because what we wanted to do was to offer our centers the option of picking and choosing whichever of the options we were going to offer them based on what they best felt would meet their needs in their local community. So, we essentially developed what we referred to as a shopping cart of options under these various categories. Then we met with the centers very early in September and we basically walked through all of these strategies, and they picked which ones would meet their needs specifically.

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So, let me tell you a little bit about the bridge-funding strategy. As I said, we only had about 45 days from the day of the announcement to the day we were implementing the policy. So, any kind of longer-term recruitment strategies whereby we might be having to hire staff or train staff, we obviously couldn't do that in the short period of time. So, we needed something to give to centers so they could have some quick hits, some early

successes and offset the immediate short-term effects of the loss of donors as a result of the deferral policy.

So, essentially the purpose of the bridge-funding was to introduce local initiatives to supplement the shortfalls that the centers would see. The only conditions around this were that the centers had to almost immediately implement whatever options they wanted. In other words, we would provide them with some limited funding and they would decide to either expand clinics on short notice by paying staff overtime, or perhaps do some other initiatives that they thought would work best. It had to happen very quickly. They had to be one-time costs. We didn't want these carrying on over a long period of time. Again, we wanted to have one-time quick-hit early successes.

[Slide]

I will tell you a little bit about the donor recruitment strategies that we introduced, and there were many of them that we offered to centers as part of the shopping cart of options. These were going to be directed at new donors and lapsed donors. We also felt that we could reach out and get the attention of many established donors and convince them to donate more frequently than they were. Then, we also felt that a key to any donor recruitment strategy was that it would have to be linked to a complementary retention strategy. In other words, if a

center picked a certain recruitment strategy they had to identify a complementary retention strategy to ensure that the efforts they were putting into recruiting wouldn't be lost, and that was one of the conditions of the so-called agreements that we had with each of our centers.

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So, what were some of those recruitment strategies? Well, the first one I am going to tell you about is our "what's your type campaign?" This has been a very successful campaign that we have launched across the country. Essentially, it revolves around this particular display booth and a blood typing session that we conduct in various locations through each of our cities across the country. We take this booth out to shopping malls or schools and we basically look at attracting the attention of people who aren't already blood donors, and we basically get the information about them in terms of their name and their telephone number, and we ask them a very simple non-threatening question, and that is, if we run short in your blood type over the next few weeks, would you mind if we gave you a call to see if you would like to come in? Of course, as I said, that is a non-threatening question. Most people say yes to that. We give them their blood type. We do the blood typing and then, of course, we don't just wait to see what happens in terms of the blood supply;

we follow up very quickly an we call those folks, and we convince them to come in and give it a try. We have found that about 17 percent of everybody that we have blood typed ends up giving at least one donation. So this program has been very successful for us.

[Slide]

One of the key elements of our recruitment strategies was to offer centers the option of increasing or supplementing the kinds and numbers of clinics that they were running. So, whether it be going to new clinics -- mobile site locations I guess you would call them, expanding the existing clinics that they operated in terms of hours or days of the week, perhaps introducing new mini clinics of two beds where they would go into small locations and try and get a few donors here and there -- these were all options that we offered centers and many of the centers picked and chose different kinds of options within that category.

As you have heard earlier today, in the U.S. here, of course, telerecruitment is a very important recruitment tool and that is no exception in Canada. It is one of the cornerstones of our donor recruitment program. So, we offer centers a number of different options to increase or supplement their telerecruitment campaigns, whether that be through adding staff to do cold calling,

going back and looking at our lapsed donor list to try to get those folks to come in one more time or return to the blood donor program -- a variety of different options were offered that centers took advantage of.

We also introduce the option of a direct mail campaign, and this was similar to the telerecruitment program but, again, it was geared to specific mail groups that we had on our computer lists that we might not otherwise see at a clinic.

Revised donor deferral policies is something we had looked at, and we continue to look at in Canada. An example of that is that we have recently been advised by Health Canada that we will be allowed to collect units from folks that are on antihypertensive medications and, in fact, Rob is working on a marketing and recruitment campaign directed specifically at those people. And, we have a number of other deferral policies that we are examining that would allow us to collect units from otherwise healthy individuals and, in fact, some of these policies are only in place in Canada, for whatever reason, and aren't particularly required in other parts of the world.

[Slide]

Some of the other initiatives that we used in terms of recruitment -- friends and family campaign. We

have been working closely with a number of hospitals across the country to try and spread the word and reach out to friends and family members of anybody who has had surgery or been treated in the hospital. We think there are hundreds of thousands of people that would fall into this category and we have just initiated some major campaigns around this whole initiative.

You folks, in the U.S., are using blood mobiles or self-contained blood collection vehicles prominently throughout the United States, and we don't have any at Canadian Blood Services yet. In fact, hopefully, within the next couple of days we will be issuing our first RFP to purchase our first vehicle, our first pilot vehicle. Again, this came about as a result of this program. Our ultimate goal is to reach out to donors in those areas where we wouldn't normally be able to get to people, whether they be small industrial parks or what-have-you, and we hope to be able to introduce a full-scale blood mobile program within the next couple of years.

Stakeholder outreach involves us working with groups like the Canadian Hemophilia Society, the Canadian Cancer Foundation, the Heart and Stroke Foundation and, similar to the friends and family campaign, we are looking at getting our message out to groups associated with those organizations and convincing them that not only do they

have a need to understand the importance of donating blood as it may well affect their family members or friends but, in fact, we would like to get them convinced to come on in to one of our centers and make a donation and become a blood donor.

[Slide]

I mentioned donor retention strategies that would have to be linked to any of our donor recruitment programs and I will tell you a little bit about those right now. The first thing I am going to tell you about is a donor passport. You each were given one of those passports this morning. The purpose of the donor passport was essentially to try and condense all of the information that donors need when they come to any one of our blood donor clinics in one place so that they don't have to be reaching through pockets, purses, wallets, what-have-you, running back out to the car or calling home to Auntie Millie to get information. We wanted to basically try and give the donors a sense of (a), streamlining the process a little bit and then (b), to give them a sense of joining a bit of a club, a membership in a club.

[Slide]

This is what the passport looks like. Just quickly to go through the elements, this is the passport cover, the red vinyl piece, with our logo on it and our tag

line, "blood, it's in you to give." You will see that on pretty well everything that we produce at Canadian Blood Services.

The four cards or pieces in the element -- this is a thank you for your donation card. The red blood drop will peal off and can be put on a calendar so that it will remind the donor of the date of the next donation. Then, they can write in the date of their next donation and put it in the passport to keep as a handy reference. At Canadian Blood Services we issue every donor a donor identification card, and those are centrally produced. It takes about five or six weeks so that on the occasion of that donor's first donation they will get this temporary card which they can keep in their passport until they get their regular card, which will also fit in the passport.

Then, the other two pieces -- it takes about an hour to donate blood, as you can read when you look at this. It just basically gives some general information about blood donations and general criteria that is handy information, again, for the donor. Then, the top information is a card that we give to the donor to write down any important information that they might need on the date of their next donation, such as medications they may be on; if they have given at more than one center, what center that was and when it might have been. So, that is

the donor passport. This has been very well received by all of our donors across the country.

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The second piece I am going to tell you about is called the first-time donor kit. We were not doing an awful lot in Canada to acknowledge and recognize our first-time donors and we thought that this was a very good starting point. What we wanted to do was to give first-time donors some special attention and acknowledgement for their efforts and their, in essence, joining and becoming a blood donor -- joining our club.

[Slide]

This is what the first-time donor kit looks like. Again, I will quickly walk you through this. This is the container, the vinyl pack that the materials are kept in. Again, you can see it is the first-time donor kit.

This is a letter that is signed by our CEO, Linda Cranston. It is included in the package and it is basically a thank you letter and a welcome letter to the donor.

This is a special first-time donor pin that we have designed specifically for that first-time donor and, obviously, they are the only people that are the recipients of these particular pins.

This is a give away item. It is a band-aid dispenser, again with our logo on it. "Where does my blood go" pamphlet is a little information brochure that we thought had a lot of interesting facts and information about the uses of blood and blood donation in general.

Then, the fridge magnet or office filing cabinet magnet is the piece at the top. It is for the year 2000. We are in the process of getting additions made or, I guess, they would be stick-on pieces that will go over the top of this for the year 2001 but, essentially, they can be written on and the donor can put that magnet on the fridge at home or in the office on a metal surface and mark on there the date of their next donation.

This kit has been extremely well received by first-time donors. They are very warmly receiving these kits and feel that it has been something that makes them feel very important and part of a very important team.

[Slide]

The donor ambassador program is a program that we have also introduced and geared specifically to first-time donors. The purpose of this is to kind of give the first-time donor that helping hand and guidance to that first-time donation. Any of you that are blood donors will know that that can sometimes be a very intimidating process. It can certainly be a confusing process in the hustle and

bustle of a clinic. So, what we wanted to do is put in place some individuals, either experienced blood donor volunteers or experienced donors who can no longer donate, who are all very well aware of the process; strategically locate them in the clinics and kind of be available to kind of walk those first-time donors through the process, kind of alleviate any fears they might have; just keep them occupied if they are waiting to talk to one of our nurses or clinic staff.

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The pieces that we have developed for the donor ambassador program are basically these three posters. They are put up at clinics and we basically encourage anyone to ask our ambassadors any question they might have. Then, of course, the ambassadors themselves wear these name tags or ID badges that identify them as a donor ambassador.

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Donor information services options -- we identified the need to put in place, whether it be in clinics or back in our centers or wherever, information for nursing staff, or clinic or collection staff that would be available to answer any kinds of questions whether they be specifically about the VCJD issue, which was very important at the time, or just general questions, whether it be about an individual's next appointment date or any other kinds of

information. That, again, has been very well received and implemented in different ways in our blood centers.

[Slide]

I mentioned program support briefly. This was basically a lot of the backup administrative and technical support that we gave all our centers. New information technologies -- we introduced a variety of new software packages, the most prominent one being data warehouse software package, which has essentially given our centers the tools they need to know everything they ever wanted to know about their donors, their clinics and their collections.

Market research and surveys, as Rob is going to tell you in a minute, is one of our credos at Canadian Blood Services. Anything we do, we want to know how successful it is and whether it is worth doing again or for the first time, for that matter. So, market research and surveys are extremely important.

[Slide]

Collateral material development -- you have seen some of the materials and there were a number of other pieces that we have either developed or are in the process of developing right now that we are providing to centers.

[Slide]

Well, if you thought that was it, you are in for more so I would like to bring back Rob to tell you a little bit about our "if you knew" campaign.

MR. EVANS: I have about ten minutes so I will blast through this.

[Slide]

I am going to talk to you a little bit about the "if you knew" campaign, the largest blood donor recruitment or advertising campaign in Canadian history.

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I am going to take you back to history class just for a moment to give you some more perspective on where we are coming from. As I said, there was limited branding at the time of the launch of CBS. We really focused on donor retention and just making sure blood was there for those people who needed it right away. Subsequent polling served to improve that. There was very limited use of CBS as an organization. In fact, there was confusion. The majority of Canadians thought that the Canadian Red Cross was still the major blood program in Canada. So we knew we had a problem there.

We looked at the needs and opportunities and the campaign was born out of two identified needs. The first one was centered around branding a new organization and really rebuilding trust and confidence in the system. You

have to realize that in Canada we had had a national inquiry into tainted blood in the mid-1980s and every night it seemed, at least for those of us in the blood program, that we were nailed on the evening news. We do a lot of polling and surveys and it certainly showed us that public confidence and trust in the system as a whole was down, down, down and before we could actually motivate people to donate blood we had to gain some sort of confidence and trust in the system. So, part of the branding objective was to also rebuild confidence and trust, and we have been monitoring that, again, with more polling.

The second need really centered around increasing blood donations. We had inconsistency in providing regular supply to some of our major urban hospitals, particularly Vancouver and Toronto. So, we needed to increase the number of donors coming through the door and increase the frequency the people who were currently donating.

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Our objectives -- number one, increase awareness among Canadians that Canadian Blood Services was the organization responsible for Canada's blood system. We were going to basically evaluate that by looking at the polling prior to the campaign and then polling after the campaign to see if there was a difference there.

On the collection side it was simply measuring the amount of blood collected during the campaign window in a number of targeted areas, and we will show you that at the end, as compared to the previous. So, that is how we were evaluating the program.

[Slide]

Some of the statistical that we put in place -- well, as you have heard, a lot of people do this in focus groups. It was the way we took this campaign forward. We went right across the country and we included donors, lapsed donors and non-donors in those focus groups and we asked them what it would take to motivate you to donate blood for the first time, for you to come back into the system and become a blood donor again, or to donate more frequently.

And, they gave us some very clear and candid messaging. They told us that it is not about empty shelves. The story that, you know, the shelves are empty going into this long weekend doesn't cut it. Nobody cares about that. They told us that it is all about the impact a blood donation can have on someone's life, and you have heard that from a couple of other presenters today. They really said it is about the impact on someone's life.

[Slide]

They said we had to make the message provocative and bold. We had to make it about people, not empty shelves, and we had to make it real. The bottom line was this is important and don't soft sell it.

[Slide]

So, we took that feedback from those groups. Our advertising agency was actually part of the focus group sessions, and we asked them to come back with some creative mockups that we then tried out on further focus groups sessions. We wanted to get the reaction. Were we hitting the mark that the previous focus groups had told us? Clearly, if was the "if you knew" that drew the strongest endorsement from these groups. We had about four or five creative mockups done but "if you knew" was certainly the winner.

[Slide]

The campaign key messages -- pretty simple, "if you knew you could save a life, would you?" And everything ends with "blood, it's in you to give." Now, for our three product lines, plasma, bone marrow and blood, we changed that tag line for the specific program so "plasma, it's in you to give," and "bone marrow, it's in you to give" as well.

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Some additional strategies -- well, our media mix and Brian talked a little bit about PSAs. In the Red Cross world we weren't allowed to buy advertising. So, this is the first time in Canadian history we actually paid for advertising. We bought it heavily. We bought a very significant program of television advertising, both nationally and regionally 50 percent of prime time. We also bought specialty channels. We bought things like the Academy Awards and Super Bowl, and Super Bowl in Canada is a lot less expensive than it is in the U.S. --

[Laughter]

-- our pockets aren't quite that deep, just in case you were wondering! We also bought radio. We bought that locally and regionally. However, every spot was center driven so we had 24 separate tag lines for every spot. Our goal is always to do the national materials to make sure people can close the sale locally. It doesn't really help to give the national contact -- for TV we have to do that but for anything we are doing locally in the marketplace, we put a local contact number there.

Finally, we are on every theater screen basically in Canada for the month of December and January. We have two major chains in Canada so we are on one chain for the month of December and another chain for the month of January. You will see the spot here in a moment. That was

very effective, and we tied in our volunteer effort that seemed to be very effective. For the month of December, for three nights a week we had volunteers show up at the theaters, and after the people saw the spot at the beginning of the trailers, when the movie was over these volunteers were there in CBS Santa hats and they were handing out candy canes with a holiday donate blood message, with the local phone number on there for people to act -- again, very positive. A lot of the volunteers were our staff members. It became a real morale thing for people to be there, and they got a free movie pass for going there as a volunteer, but great feedback from that and we believe we got a lot of donors through that program.

Now, if we can have the video here, we will run through the spots. There are two television spots.

[Video presentation]

And the second spot -- we ran these in rotation just to keep them fresh.

[Video presentation]

The next spot is a youth spot that we had done previously to the "if you knew" campaign and we customized it to meet the "if you knew" campaign.

[Video presentation]

So, you can obviously tell that was geared more to youth. The last one is the adaptation we used in the cinemas and you will see how we changed that.

[Video presentation]

So, those are the four spots that we have been running.

[Applause]

Thank you. I will talk a little bit more about awareness on those spots but, interestingly enough, for our summer radio campaign that we are doing right now, our polling has shown that the awareness of that "if you knew" message and the "blood, it's in you to give" has allowed us to buy ten-second tags to beef up our frequency levels going into the long weekends. So, now all we have to do is have somebody come in and say "if you knew only three percent of Canadians donated blood, would you give?" I am blowing it here but, anyway, there is a ten-second tag with an "if you knew" message and the "blood, it's in you to give" and we boost our frequency up around those long weekends very economically because there is recognition of that. We do road reports, the weather is brought to you by Canadian Blood Services. So, by building awareness of those key phrases we have really been able to access a lot more media.

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So, more strategy -- we created three targeted websites for this campaign. The first one was geared for media. The second was geared for the healthcare community, and the third one was for the general public Each of these sites had targeted information for the particular audience. So, we really wanted to drive those key groups to sites that had relevant information for them.

We also did the teaser campaign on outdoor billboards throughout the country. Basically, for two weeks before the campaign the billboards looked like this -- "if you knew, would you" -- with those messages. It created a little bit of a buzz and when we actually launched the campaign, the words "you could save a life" popped on and actually our logo, up here.

We also tied this into a media teaser campaign. What happened was media received a white coffee mug that had the words "if you knew, would you want it?" There was a tag on it that was anonymous and it just drove them to the www.ifyouknew media website. When they went there, all it said was "all will be revealed in two days." So, they didn't know who this was from.

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However, when they poured the hot coffee or hot beverage into the cup something happened. The cup turned white. "You could save a life" came on it and our logo

popped on the back. So, we created a lot of excitement that way. In fact, they became a collector's item. We only gave them sort of to our core media people who had been supporting us and the key people in media right across the country. We were flooded for calls for more of these mugs. We didn't have them. There was about a six-week production time line. We ordered them, but what that allowed us to do was go six weeks after the launch and say, "here's the mug that you wanted. Let me give you an update on how the campaign's going." So, we really got some legs out of that hole program. Media love give-aways. I used to be one so I know that.

[Slide]

We had a national media strategy, public relations strategy tied into this campaign and it was certainly successful. We had excellent coverage both locally, regionally and nationally. In fact, within 72 hours we had over 180 stories and that included our largest national news program.

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A little bit of branding because, again, that was one of our objectives. We produced a whole range of collateral items that had the "if you knew" message. We actually took images from the TV spots and tied them in. So, we had posters, signs that were about this high, coffee

mugs, T-shirts, the whole gamut. Really, the plan there was to take the campaign to the streets and link the local campaigns to the national campaign.

Of course, if you are familiar with real estate, it is location, location, location and in advertising it is frequency, frequency, frequency. So, when we are investing the kind of dollars we are doing at a national level for these messages, we really want to make sure that the centers take advantage of that by making their local materials match that. So, again, the recognition of "if you knew" and "blood, it's in you to give" when you are doing it at a local level you are capitalizing on all that investment that we put in nationally. So we really trying to keep it consistent.

[Slide]

So, was it a success or a failure? Well, national general public polling -- and, as Mike has alluded to and I have certainly talked about, we do tons of polling and surveys; we are very much focused on that -- Canadians' awareness of CBS and our role increased by four percent. Not huge, but when you realize that we are not even two years old yet and the previous operator ran the blood program for fifty years and, basically, for the first year of our operation we weren't focused on branding but were simply focused on stabilizing the blood program, we are

happy with that and we think that is going to go, especially with the consistency of the materials that we have developed and 47 percent of the Canadians polled said they had recently seen or heard CBS advertising regarding the need to donate blood. So, almost 50 percent of the population had some recall of it, and 76 percent of those people who had the recall of the ads said they had made them think seriously about donating blood. So, very positive from our point of view.

[Slide]

Now, we did in-clinic donor surveys for the months of January, February and March. We had 48,000 people respond to those. They were just fill-out surveys so it was a very high return rate. We didn't expect that we were going to get that high, and the news there was very good -- 78 percent of the people, donors in a clinic, said they were aware of the ad campaign, unaided recall because there was really nobody to ask anything. Of those 78 percent, 53 percent said the ads had encouraged them to make their donation that day. So, very positive from our point of view. The ads were making some sort of impact out there for sure.

[Slide]

To give you some idea on the collection side of things, envelopes please, Mr. Nichol --

MR. NICHOL: Nine percent for overall collections.

MR. EVANS: So increase in collections during the time period is nine percent. The increase in new donors?

MR. NICHOL: Ten percent.

MR. EVANS: Number of youth donors?

MR. NICHOL: Eighteen percent.

MR. EVANS: And, finally, the number of returning donors coming back to the system?

MR. NICHOL: Sixteen percent.

MR. EVANS: So, that is where we wrap up. I have always been told you end a presentation on good news. We think that is good news. I know we have kind of blasted through this and we took a 50-minute presentation down to a little bit over 30. So, if you have questions for Mike and me, that is fine. We are going to be here all day today and we are here tomorrow so, please, feel free to approach us and ask any questions. Thank you for your time.

[Applause]

DR. LEWIS: Thank you. Before our break, we have one additional speaker. We are happy to have Suzanne McCombs with us. Suzanne is a director of communications and donor recruitment at the Oklahoma Blood Institute. She is responsible for volunteer services and public relations, as well as recruitment of approximately 170,000 blood

donations each years. Suzanne has 16 years of experience in the area of donor recruitment and has served as president of the Association of Donor Recruitment Professionals, the ADRP, and Suzanne is also the recipient of the Ron Franzmeier Lifetime Achievement Award in the year 2000. She currently serves on the AABB donor recruitment/public relations committee and is on America's Blood Centers' donor recruitment committee. Suzanne received a bachelor's degree in journalism from the University of Oklahoma, and today will tell us about matching collections to inventory need.

Snapshot of Success - Matching Collections to Inventory Need

MS. MCCOMBS: Thank you.

[Slide]

First of all, I would like to just thank the FDA for inviting me. It really is quite an honor, and it is very exciting to me to see concern and interest about donor recruitment finally hit the national level like it seems to be hitting. So, I think that is good news for all of us. Considering the shortages that we are seeing, I think this meeting couldn't have happened any faster. So, I think it is a good thing.

I will also let you know, just like Brian Scully, this is my first time to use a Power Point presentation

but, unlike Brian Scully, nothing is going to move and if you want music we are all going to have to hum.

[Laughter]

[Slide]

Matching collections with inventory needs is critical to a blood center's ability to have an adequate supply of all blood types at all times. Even under the best circumstances this is a delicate balance in a fragile system. One model for matching collections to inventory needs is determined by looking at four different elements.

[Slide]

First of all, the blood center philosophy, the hospital needs, the demographics of your population and the geography of your service area. The model for matching collections to inventory must be customized to each individual blood center. The Oklahoma Blood Institute has developed a model over the past 23 years that works well in Oklahoma. I would like to walk through the four elements and talk about the impact that they have on us and give you a chance to think about how they might work for you as well.

[Slide]

Before I do that, I would like to tell you a little bit about the Oklahoma Blood Institute. First of all, Oklahoma is a little bit smaller than Canada --

[Laughter]

-- but a lot bigger than Rhode Island. The Oklahoma Blood Institute is a regional, not-for-profit blood center. We are responsible for providing the blood supply to 71 hospitals and 45 counties throughout the state. That is about two-thirds of our state. We were established in 1977 by the physicians of the Oklahoma County Medical Society and OBI has always been considered a medical organization rather than a blood bank. OBI is an export center and has not imported any blood into its system since it reached self-sufficiency in 1981.

[Slide]

Here is Oklahoma. In case you are not familiar, Texas is underneath, Kansas is above. OBI is really a series of blood systems. Our headquarters are located right in the center of the state, in Oklahoma City. That is also where our laboratories are. Additionally, we have four donor rooms located throughout the city and six sub-centers that are located strategically throughout the state.

[Slide]

This just gives you some idea about what we do draw-wise. Given the relatively small population and the large geographical service area, OBI collects about 70 percent of its red cells on mobiles. As you can see, we

are doing a fair number of plasma and apheresis red blood cells plus plasma on mobiles, and we have really just gotten off the ground with our platelet mobile program but it is growing steadily.

[Slide]

Now that you have some perspective on who we are and from whence I come, we will talk a little bit about the strategies that coming up with a model that will enable you to meet your inventory needs with your collections.

[Slide]

First of all, you have to look at your blood center philosophy. A blood center's philosophy regarding importing and exporting, among other things, will determine the options that are available for matching collections with inventory needs.

[Slide]

Our philosophy at OBI is not to import. Since importing blood is simply not an option for us, OBI relies completely upon its donor recruitment department to ensure that the supply for all blood types and for all components is sufficient at all times. In fact, at OBI we have a special recruitment mission which I like to share with people.

[Slide]

That is, to recruit the right number of the right type of the right donors at the right time, to donate the right procedure on the right technology to meet patient needs 24/7.

[Slide]

Our plan is always to draw 120 percent of what we anticipate that we are going to use, and that really is the only way that we can be sure that we will never have to import blood.

[Slide]

So, how does OBI's recruitment department ensure that the draw will be at 120 percent of anticipated use? Normally this is simply handled by planning ahead. However, as we have seen this summer, when the draw is a little bit down and usage is way, way up and importing is not an option, the pressure on donor recruitment can really be felt. Up until last week, I will tell you that we were really good at preventing any kind of shortage. However, this summer we have experienced the worst blood shortage that we have seen in twenty years. The draw is really what we planned for it to be but our usage is going up, up, up. We are not sure why, but it has not been much fun.

Some important OBI recruitment philosophies include the following: First of all, I have to reiterate what Brian Scully said. I think every blood center that I

am familiar with that really does a good job does the basics well. They are out there, asking the donors. Their recruiters are good at projecting. They are making those 24-hour calls ahead. They are planning efficient mobiles. They are doing the basics very well, and I believe we do that.

One thing we do is a lot of advanced planning for mobiles. Like all centers, we try to schedule as far in advance as possible. We currently have the majority of next year scheduled and some of our groups on the calendar for 2002. We utilize incentive promotions and public blood draws at the malls for every holiday. Our mall drives are scheduled for the next year with specific malls and specific media tied into specific holidays. Ordinarily, this is sufficient to maintain the inventory that we need.

However, we also have backups just in case the bottom should fall out, and our backups include going internally and looking at our donor groups and having them lined up to help us if we need them. Rather than being able to turn to imports when we are short, we must focus internally. Let me give you two examples of that.

This past January we experienced a snow storm that literally shut down the state for most of three days. We turned to Ft. Sill, which is an army post which is located in the southwest part of the state, and because the

soldiers were already there, they came through and donated hundreds of units of blood and literally were our blood supply for several days.

Another example of that is the first liver transplant that took place in Oklahoma City. They really don't like us to talk about this but that patient went through 1200 blood products, and at four o'clock in the morning I got a call saying that we were literally running out of blood trying to support one patient. The sergeant was adamant that we not go public with the reason for needing blood.

[Laughter]

So, what I did was to place a call to my drive coordinator at home of what was then AT&T, which was about a 5000 person plant in Oklahoma City, and in 20 minutes she was back to me with approval that, yes, we could bring all of our equipment and all of staff and come out and start drawing donors. Well, in the meantime the patient died, stopped using blood and we decided that we didn't have to go to extremes, that we could recover without them. But it is good to know they are there.

Any number of things can throw out the delicate balance between collections and inventory, whether it is the sudden loss of 400 units of blood because GM went on strike or simply the weather. As we all know, a few well

place aneurysms in surgeries gone south can use a lot of blood very quickly. When the reason for increased usage is public people will come out of the woodwork, as we personally experienced with the Oklahoma City bombing and the F5 tornado that hit Oklahoma City last year. However, when the increased usage is not public we must turn to our donors and to our donor groups.

As with most blood centers, we are constantly balancing our mobile and telerecruitment. Our mobiles bring in the volume and our telerecruiters fine-tune by calling in specific types. We have a great deal of flexibility with our recruitment resources. For example, during the days leading into a holiday weekend we can shift all plasma recruiters to red cells and apheresis platelets. If a mobile has to suddenly cancel and cannot be replaced, again, we can switch telerecruitment to the component that we are going to be short on.

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It is really ironic that I am standing here telling you that we don't do media appeals because we did one last week. We did our first one last week. Actually, in 16 years at OBI, I can count on one hand the times that we have really gone to the media and said "help" but last week was one of those and, while we saw an extra about 1500 donors in about 3 days, it was at great cost. The reason

we don't like to go to the media is pretty obvious. When we do go to the media, because it is such a rarity, it is a big event. We had front page coverage for two days, as well as all the television and radio stations talking about the blood shortage.

But we really do try to avoid it for the following reasons: First of all, we are very big into control. We like to control our recruitment. We like to control our testing which is why we would never consider importing. We like to control our inventory and we even like to control blood usage. Obviously, when you go to the media you lose all control. You say the blood supply is low, we are trying to prevent a shortage and the media reports that people are dying because there is no blood in the hospital. The words dire, dangerous and emergency just jump out of your TV sets and your radios.

Of course, the last thing you want is for all of your donors to come in and donate at the same time. The other thing that happens is that we max out our resources. We are simply not equipped to handle 1000 extra donors in a day. We are not set up for it.

The biggest expenses that we see include overtime for our phlebotomy staff, for our laboratory staff, special ordering and supplies and equipment. And, when the masses respond to a media appeal and resources are maxed out,

obviously, your customer service goes right down the toilette. We have found that when people come in as the result of a disaster they are very forgiving, but when they come in because you asked them to they don't understand why you don't seem to be prepared to handle 1000 donors.

Another thing that happens is just the incredible expense that you incur when you suddenly have 1000 additional donors. Again, overtime and, as we experienced last week, the inability to make platelets from whole blood on all of our donations.

Another reason that we want to avoid it at all cost is because we know that the public, as well as the media, becomes very immune if you overdo it.

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Another important recruitment philosophy at OBI is, again, the significance of building relationships at all levels, and we really try to work on keeping our CEO involved with other CEOs so that when we need to turn to them we can. Again, this is something that happened last week. We had a big drive going at the FAA Aeronautical Center, which is about 3000 people, and our CEO was able to pick up the phone and call the director of the FDA and ask for a push from the top, and that made a big difference -- about 100 additional units of blood. So, those are good things.

So, OBI's philosophy of not importing places a great deal of pressure on our recruitment department, and it also makes monitoring the blood supply absolutely critical.

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The next component of the model is looking at the hospital needs in your service area because this determines the inventory that you will keep in your hospitals as well as your center.

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Hospital inventory is determined by the amount of blood used by the hospitals, the types of procedures performed, the proximity of the hospitals to the center and medical direction from the blood center. Determining inventory has to be a partnership between the blood center and the hospital.

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At OBI we maintain an inventory at our main center; we maintain inventories at our six sub-centers; and we maintain inventories at each of our hospitals. Some things that make us maybe a little bit unique are that we customize our models, so to speak. We did begin universal leukoreduction on July 1st and, while this is a wonderful thing for patients, it throws out two new challenges for recruitment. Namely, we must now get our sickle cell trait

sgg

positive donors and our ABs to stop donating red cells. First of all, the sickle cells won't filter and the ABs -- it is just too expensive, especially since we have such a high rate of outdate. So, we are going to try very carefully to get those people to be non-red cell donors and, of course, we have to use great care in doing that so that the message they hear is not that we don't need them.

We use only apheresis platelets and apheresis plasma in our system. We stock apheresis cryo, and our hospitals are scattered over 39,000 square feet.

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As you all know, there are two types of inventory --

[Laughter]

-- the first one being normal and the second one being what we saw last week, and that would be when all hell did break loose.

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So, when importing is not an option, monitoring is critical.

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At OBI we have to monitor inventory carefully and constantly. One thing that I believe is a little bit different and important to our ability to match collections and inventory is our structure at OBI. As the recruitment

director, I answer directly to the CEO. I am also part of what we call our operations team, which consists of myself, the laboratory director, the collections director, patient service director, chief financial officer and CEO. This team essentially makes all of the decisions regarding blood center operations so recruitment is always involved.

I understand that in many cases there are multiple levels between the recruitment department and the CEO, and I believe when that happens it lessens the voice that recruitment carries at a blood center.

Some of the tools we use to monitor our blood supply are our fist call communications, which is simply that one of our physicians is always on call and gets very involved. They handle all urgent issues, as well as monitoring the supply and as soon as the supply drops significantly or usage increases significantly, the first call person calls me. I am able to shift telerecruitment and mobile recruitment to accommodate what we are going to need. This communication is absolutely critical to preventing shortages. We also maintain minimum stock levels on all products and all components. As soon as any of those minimum levels drop, I also get paged on that. I also get paged for any liver transplant that takes place. We have one liver transplant team in Oklahoma City but they will not go into surgery without having 20 units red cells,

20 units of apheresis plasma and 2 units of apheresis platelets ready. So, we have to keep on top of that.

Another important tool are inventory reports which I just live and die by, just as much as I do our projection reports. That is what we look at first thing in the morning so we really need to be doing for the day. One little trick that we use for maintaining the single donor platelet inventory throughout the weekend is that on Saturday morning, at 9:00 a.m., we have to have the 70 rule in place. That means that between what we got scheduled and projected and what is sitting in inventory, the number has to equal 70. I was told right before I left that the 70 rule is now the 90 rule.

We also have set standards for every holiday weekend for single donor platelets. We shift all of our telerecruiters to platelets and to red cells, and we go in with a very set number for what we have to do leading into any holiday.

Another critical component to monitoring the inventory is medical intervention by OBI physicians. When a large amount of a particular type of blood is ordered our physicians always get involved by calling the ordering physician. This enables us to know what we need to prepare for and, when appropriate, it gets O negative patients switched to O positive. We had a case recently where a

great deal of O negative blood was given to a man, and if those things go unchecked we would simply run out. So, that is an important part of our plan.

When a center is not importing blood, the recruitment department must always be aware of the inventory levels in order to prevent shortages of any particular type.

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One other important part of putting together a model is the consideration of demographics of a blood center's population. This determines how we will collect. We have to take a look at who are our donors, where are our donors and what do our donors need. Clearly, if we do not all start doing this and putting more resources towards this on a national level we are not going to be able to keep up with inventory needs in the future.

Fortunately for us, we are still small town enough in Oklahoma that people feel a real sense of community and they donate at higher than the national levels. We are a mix of urban and rural donors. We are 82 percent Caucasian. Our service area population is about two million. We have three air force bases which has contributed considerably to the 550 donors we have lost so far to the U.K. deferral. We have one large army post and we have a lot of churches. We have a tremendous draw on

Friday from our military donors and Sunday is one of our biggest mobile days. Our average donor is college educated. He is a white male and he is between 35 and 45 years old. All of these elements play a role when we decide how we are going to collect blood, and they play a role for you and how you are going to collect blood.

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Our donors, like everybody else's donors, want too service. If there is one thing that we could change, I think probably at all of our blood centers it would be if we could provide outstanding customer service and get everybody else bought into that idea. That definitely is number one. Our donors, also like your donors, appreciate recognition. They like events. They like letters. They like cards. They like thank yous. They like to hear from patients. They like to hear from Dr. Gilcher.

Just quickly on patients, I agree with everything that has been said about them today, that we have to bring them back into the picture. If you think about it, we are really far removed from the patient at the blood center. You go into a nice, clean, sterile environment and there is no patient around. So, I think it is very important that we let the patients be our recruiters, and I think people are doing a really nice job with that.

One thing we focus on a great deal at OBI are donor benefits. We are very concerned about health benefits. We think we were the first blood center in the United States to put in cholesterol testing, in 1986. We think we are the only blood center so far to put in PSA testing, prostate specific antigen testing. We do have to charge for that because it is expensive but it is $15 if you are a donor and $20 if you are not, and our donors love that.

The next thing that we are going to do in the area of health is to put the donor's test results on the net so that they will go to our website and they actually will use their own pin and go right in and they can look at their test results. They can print them. They can have them wherever they are in the world.

We do insurance plans. We have done them since we opened our doors. I think their biggest value is perception. Our churches love the idea that they can help cover church members, although the total amount of money we spend on insurance plans has never been more than $20,000 in one year.

And doodads. Our donors love T-shirts. I was glad to hear Brian Scully admit that they are giving out T-shirts with all donations. So are we.

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The last element to really consider when putting together the model is the geographic of your service area. It is very simple but it is very important. This also determines how you will collect. You have to consider the proximity of your hospitals to your centers and the proximity of your donors to your centers.

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At OBI we have a main facility in the center of the state. Each of our six sub-centers is located approximately 100 miles from the main center, and our service area, again, is about 39,000 square feet. We have two cities and we have 43 rural counties.

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The impact on geography to us is that we have huge mobile operations. That may not be the way for everybody to go but when you are spread out as we are, you cannot expect people to get in their cars and drive an hour and a half just to get to a donor center. Our sub-centers all have their own recruitment staffs and they have their own mobile operations and they have their own blood supply. So, they service the outlying hospitals as well as the donor groups. We do see a very increased cost as far as travel goes, but on the flip side of that, there is a great advantage to being spread out strategically across the state. At any normal given time, one center can carry

another center. For example, when the farmers in the north part of the state are harvesting their wheat we don't look to them for blood but we look at our other centers around the state to carry them at that time. Also, last year when we had the tornado that came through, we really saw the significance and we had a hard time moving blood in some parts of the state but we had other parts that we could get to and get blood back and forth. So, we really felt fortunate, when we realized how close we could have come to actually losing one of our centers, that we do have a system in place that we have.

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So, I think that we can all agree that the delicate balance of matching collections to inventory needs is critical to every blood center's ability to maintain the right number of the right products at all times.

We have achieved a fair amount of success at the Oklahoma Blood Institute but what we do obviously won't work everywhere. Every blood center must develop its own model for balancing collections and inventory. I would encourage you to consider the four elements that will shape your model. Your blood center philosophy will determine your options. Your hospital needs will determine your inventory levels, and your demographics and your geography will determine how you collect blood.

As Brian Scully said earlier this morning, recruitment and marketing have to be moved to the front burner at every blood center, and all blood centers must become focused on the donor if we are going to be able in the future to continue to match collections with inventory needs. Thank you.

[Applause]

DR. LEWIS: Thank you very much Suzanne. We are a couple of minutes ahead of time. We are not going to get the 40-minute break that I wanted this morning but Gil will allow us a 20-minute break, and I will ask you to maybe use some of that time if you haven't already signed up for some of our sessions tomorrow. Now would be a good time to do that and get your name down on the list. We will be back here in 20 minutes. By my watch, that will be a couple of minutes until three.

[Brief recess]

DR. LEWIS: We are ready to start our second afternoon session. Our next speaker this afternoon is Jacky Kocz. Jacky is the executive director of the Community Blood Bank of Northwest Pennsylvania, as she has been since 1986. During her career she has been a captain in the U.S. Air Force, serving as chief of laboratory services at Wurtsmith Air Force Base in Michigan. She serves on the executive committee of America's Blood

Centers, and also with ABC she serves on the market research committee, the strategic planning committee, and chairs the resource sharing committee and the membership committee. She is a member of the American Association of Blood Banks and the Pennsylvania Association of Blood Banks. Jackie is an MT, ASCP and her formal education includes bachelors degrees in medicinal chemistry from the State University of New York at Buffalo, and microbiology from Penn State University, and a masters degree in management from the Central Michigan University. We are glad to have you here today, Jacky, to discuss donor retention and treating donors right.

Donor Retention - Treating Donors Right

MS. KOCZ: We want to talk fast ... in conclusion --

[Laughter]

With the problem that I had with this thing a little earlier -- you guys all saw the thing went into standby. I wasn't quite sure how I felt about a three o'clock presentation because that is half way between lunch and happy hour, and I am thinking that, you know, either guys are falling asleep or you are making plans for later!

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I am here to talk about donor retention, and pretty much what I am going to say is going to reenforce

what Brian Koski said this morning in terms of his market research.

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Let me first start out by providing you with a disclaimer. This isn't going to be a presentation merely on customer service issues. We have all been to a number of seminar on customer service, and most notably the ones by the Disney Institute especially, and I think we have to go beyond customer service. The reason for that is that when you think of the customer you think in terms of a transaction. If I frequent a restaurant or if I go to a retail store or if I go to a movie theater or Disney Land to be entertained, I am getting something for what I am paying for that. The question, in terms of our donors, is what are we really giving them? So, that is why I think we need to go beyond the customer service issues and get beyond that.

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One of the things I always like to remember, especially after I hear a Disney presentation is "there ain't no needle at the end of the line in Disney Land."

[Laughter]

I have never been one for catch phrases and maxims like failing to plan is like planning to fail. But that is mine so you can write that down.

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So, what am I here for? I am going to give you a broad-brush perspective on what we think about the donor in terms of donor recruitment, and offer our experience at CBB of Northwest Pennsylvania as an illustration.

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Well, let's talk about the donor. I think there are a number of elements that go into and determine whether an individual will donate blood and whether they will continue to donate on a regular basis. There are the motivators, and I further divide these into overall and short-term. There are the facilitators of the donation process, and finally there are the maintainers or reenforces that directly influence whether a donor will return.

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Well, what is it that motivates our donors? Well, we have the overall or general motivators. This is the general inclination that brought the donor to your doorstep in the first place. These are very individual and they can include personal experience with blood transfusions, knowing somebody who received a blood transfusion, family history of donation -- we all see and should encourage the families that bring their children into our donor centers and they make it a family event, and

these kids see that donating blood is a positive, good thing to do. There is also group encouragement, most often seen in our mobile programs. Or, there could be a general sense of community or altruism.

Additionally, there are the short-term motivators or what I call the "mo du jour." These are the things that bring the donor in that particular day. For example, to draw the analogy, I regularly try to keep fit and I do exercise and I have a general motivation that I think that is a positive, good thing to do, but on any given day I may or may not have the inclination to actually put feet behind my motives. So, it could be that I just happen to have more time that day, or it could be that it is an absolutely gorgeous day and I want to go for a brisk walk, or I might have just had a fat attack that morning --

[Laughter]

-- and the skirt was a little tight, and that is an immediate reminder. So, in the cases of our donors there might be something that brings them into our donor centers that particular day. It could be an appeal. I think that it gives them a sense of urgency, and when we are thinking about competing about the donor's time, in many instances we are facing, in this day and age, the tyranny of the urgent. We all have so many important things that we need to get done in the same 24 hours that

have always existed in what we call a day, and sometimes that appeal moves donating at the blood center up to the top of the list. It could also be a promotion that the donor wants to take advantage of. Or, it could just be enough reminders from the telerecruiters, they have received enough phone calls or messages left on their answering machines.

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Of the motivators, blood centers can certainly influence the short-term motivators and possibly even some of the general motivators, but another area that we can definitely influence is in the area of the donation facilitators. These can include convenient locations of our donor centers and blood drives; convenient hours of operation; promptness of service; cleanliness and comfort of the surroundings; and a capable and professional staff that inspire confidence.

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Beyond the facilitators and what is key to retaining blood donors are the maintainers or the reinforcers -- how the donor is treated; how the donor feels before, during and after the collection process; how the donor is appreciated and recognized. All of these to make that donor feel like he or she is the most important person in the world and that the time that they have spent

in that donation process was well spent time and worth their while. Each of these will influence whether the donor will subsequently return to you facility or continue to donate anywhere, for that matter.

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So, each of these elements -- motivators, facilitators and the maintainers and the reinforcers should shape our philosophy and our approach to our donors. And, the last one, the maintainers and the reinforcers is one that I think is key.

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Well, in order to relate our experience at CBB, let me tell you something about our center. We are located in northwest Pennsylvania. "You are here." Actually, you are not there because if you were there you wouldn't be listening to me right now. But we are located in the northwest corner of the state, in Erie, on the lake. We are equidistant from Cleveland, Buffalo and Pittsburgh so we have our choice of NFL teams to root for -- by the way, go, Bills!

Erie's population is approximately 280,000 and although it is the largest city in the state you certainly couldn't tell that by looking at it, nor does it act like a city. It behaves more like a big small town, which is wonderful from a donor recruitment perspective but it can

be very frustrating if you pay attention to progress and politics.

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More about CBB -- we were founded in 1967, initially as a donor recruitment agency. We obtained the FDA license in 1986 when we took over all of not only blood recruitment but collection, processing and distribution. We are the sole supplier of blood and blood components to all eight hospitals in Erie County, Pennsylvania, and I do stress Pennsylvania because I have not changed counties and I was born in Erie County, New York and I am now living in Erie, Pennsylvania, which is in Erie County and if I go across state on the other side, to Ohio, I can also find an Erie County there.

We now supply Bradford Regional Medical Center, which is in nearby McKean County, hence the name change. We used to be called the Community Blood Bank of Erie County. We collect approximately 20,000 whole blood and apheresis products per year.

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We have one fixed site in Erie County, responsible for 75 percent of our whole blood collections. Our mobiles comprise about 25 percent of our whole blood collections. Annually, we see about 78 percent return of our whole blood donors at our fixed site and 76 percent on

our mobiles. I should also state that overall we collect about the average, 5 percent of our eligible population.

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Our overall whole blood donation frequency per donor is 2.2 donations per year. At our fixed site, 20 percent of our whole blood donors donate 4 or more times per year, 30 percent donate 3 or more times per year. On mobiles the percentages are less, 10 percent donate 4 or more times per year and 20 percent 3 or more times. That is somewhat self-limiting by the number of times we visit each site. We have a number of sites where we only go once or twice a year.

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So what is our approach? Our approach for our recruitment efforts is defined by altruism, we encourage it; emphasis on the sense of community. To provide a consistency of message in terms of need and who we are, we like to offer what we call the personal touch to our donors, not only in the way we recruit them but also the personal touch that the nurses give them when they collect the blood. We like to provide reinforcement through education and thank yous and recognition and reward for frequent donors.

[Slide]

That philosophy also provides us with an idea of what we want to set up as the goals. Watch this, I love this -- bulls eye. I am a firm believer that if you aim at nothing, you will hit it. So goals are necessary.

Well, what are our goals? We want to be self-sufficient and we have pretty much achieved that. We would like to have a consistent supply. We haven't achieved that yet. We have a lot of ups and downs in our inventory. Repeat donors -- after all, these are the safest donors. And, we want to attract new donors who will become repeat donors.

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What about considerations? There are a number of things that we will consider in improving any recruitment effort or initiative: achievability, is it doable? Sustainability, can it be carried over from year to year? Financial impact is always a consideration, especially in this era where the emphasis is on safety and new testing requirements -- it is often the donor recruitment department that suffers. Accountability, who on the staff will be responsible for the details of any effort? That was brought up earlier I think by the lady from Sarasota when she asked the question who does this on your staff in terms of the first-time donor phone calls. And, donor

feedback, either formally through focus groups and surveys or informally, i.e., they will let you know.

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So, what comprises our recruitment efforts at CBB? Well, we have our telerecruiters. We have five part-time telerecruiters. We call off of a real time database so nobody is being called too soon. Everything is computer driven.

Phone calls with a message -- our recruitment efforts tend to be a little bit scripted and the reason for that is that twice each day we take the inventory, both morning and afternoon, of the blood that is on the shelf at the hospitals. So, we know on any given morning what blood types we need so the morning recruiters know what they need to call, and in the afternoon we take the inventory again so the evening recruiters know what they need to call.

We provide new donor postcards. Again, there is the idea of the detail. Rather than the phone calls, we want to send postcards and it is our telerecruitment staff that said we can take this on; we have time for it.

Reminder postcards -- these are sent to donors whom we just can't seem to reach by phone or we are leaving a lot of phone messages. In other cases we have donors who prefer that. So, when they come in to donate they fill out a postcard that is put in a box and 56 days later that

postcard will be sent out and mailed to that donor reminding them it is their tie to donate again.

We do mailings for special reasons; special types might be needed. Right now we are getting ready to do one to recruit apheresis donors.

We do surveys through our telemarketers. When we changed our location about five years ago, the telerecruiters, when they finally reached somebody by the telephone, asked the west side donors if we moved more east, would you donate? The east side donors, if we moved more west, would you continue to donate? The southern donors, if we moved more north, would you donate? We didn't care about the northern donors because those are the fish in the lake.

We also have the milestone certificates. When they achieve the one, two or three gallons, it is the telerecruiters that send out those certificates.

And, we offer thank yous. This is something that we have just now added to the script so that when the recruiters are calling the donors and they are looking at the last time they donated, they are acknowledging that they notice that the donor has been in, thanking them for that donation and then asking them to donate again.

[Slide]

Well, what about mobiles? Well, to have a mobile you need a drive coordinator. We have one. Her name is Lisa. As I told you, she is responsible for 25 percent of our blood supply, and we have a mobile. We have one self-contained blood mobile as indoor setups for mass drives or, as the staff now refers to them as field trips.

Groups are encouraged to schedule well in advance so donor groups, particularly those who host two to five drives per year, are asked to schedule in the last quarter of the current fiscal year, and groups that host one drive per year are encouraged to schedule at the beginning of the year. So, Lisa's calendar is generally filled at least six months in advance.

The drives are tailored to each site with personalized fliers, posters, payroll stuffers, schedules sent to each donor chair four weeks prior to the drive. Two weeks later Lisa will call to confirm the packet receipt. We sent reminder postcards to the past donors of those drives, to their homes, about two weeks before the drive date.

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On the day of the drive the nursing staff arrive on time to be ready for the first appointment. Lisa provides them a trip sheet of the nursing staff to tell

them what to expect. For mass drives to high schools and colleges, Lisa actually works those drives.

The staff stay on time with the appointment schedule as closely as possible because we have to respect the business, that they are taking time to allow their people to come and donate. This can sometimes get off kilter due to reactions or people showing up too early or too late for their appointments, but I just tell the staff to muddle through and do the best they can.

Communication is key. So, they are constantly contacting the donor chair at the fixed site as well that donor chair can contact the nurses at the drive. And, throughout the day the staff greets and thanks every donor. I am sure my nursing staff would love how I have pictorialized them in the slide --

[Laughter]

[Slide]

After the drive, the very next business day the donor chair receives a phone call fax or e-mail with the drive statistics and the highlights. Statistics include the donors screened, total units donated and total new donors. Within one to three business days thank you letters are sent to the donor chairs and the appropriate company personnel. At this time, thank you posters and fliers are sent with the drive statistics and all first-

time donors receive a personalized thank you letter, asking them to donate again at the next scheduled drive or at our fixed site, whichever is appropriate.

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It helps when you have an energetic and enthusiastic mobile coordinator who does consider it part of her job to play the cheerleader, and Lisa does just that. The donor chair receives a statistical summary of that year. At least one positive feature is highlighted. So, even if their donation collections might be down for that year, Lisa will find something positive to emphasize to reenforce with them the importance of the contribution that they made. And, all donor chairs are invited to and recognized at our annual donor dinner.

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We also have a public relations staff. We have one PR director on staff. His name is Michael. He is here today. Wave to the people, Michael. Michael, you have just become a visual aid. Thank you.

By the way, somebody asked a question earlier about if you have a limited budget. Well, Michael is an expert in operating on a shoestring budget. So, if you have any questions as to how he spends his very, very meager PR budget, he is the guy to ask.

We rely on PR to tell the story of our center. We do advertising. We do work with a public relations firm, although I will say that Michael is such an excellent writer, he writes a lot of the copy for our PSAs, radio spots, etc. We do use radio, usually in conjunction with promotions, as some of our previous speakers have discussed. We have some TV spots.

We offer a blood watch wherein two TV stations broadcast the particular inventory needs on Mondays and Tuesdays. So, at the beginnings of the week, donors who watch the noontime news can see what particular blood inventory needs we have.

Michael is also responsible in great part for education. We have a "pulse" section of our newspaper, that comes out on Friday, that is health related. They now put in a weekly feature that puts in the total of weekly blood usage of our two largest hospitals. Michael also does a lot of health fairs and school visits, and he is a natural because he is a ham and he likes to do that.

We do promotions. There is no way to get around not doing them. We do them usually in conjunction with the local business or radio station, somebody who is trying to assist us in our collection efforts in reaching donors.

One of our most successful promotions has been the 4-life program. This is a T-shirt giveaway but it is

associated with one of the four seasons. So, after your fourth donation that year you get the seasonal T-shirt. Basically, the promotion will run for four years. So, the first year you might get the spring T-shirt, and then the second year the summer, or whatever, and it becomes collectable. We have just started a new cycle of T-shirts. We have a couple of mascots. Between the advertising firm and Michael, we came up with Buzz and Pinkie who are two cute little mosquitoes that we have been featuring in some advertisement and they are now featured on the T-shirt for the 4-life program.

We also have our annual donor dinner, which is our largest event. It recognizes those who have achieved the 5, 10 and 15 gallon marks. We have donors that come to this year in and year out who aren't even being honored, but they just want to be a part of it because it is such a wonderful event. It recognizes the donors, and the donors really like to cheer each other on.

[Slide]

Well, I have just presented an overview of our recruitment efforts at CBB, but none of them would enable us to retain our donors if the donor is not reenforced on every visit, and that is by your front-line employees. They will make or break your ability to retain donors. Your receptionist gives the first impression of your

operations. Courtesy, respectfulness, making the donor feel welcome are as much a part of his or her job as answering the phone and registering donors.

When we do happen to have an appeal or do have a promotion and we are very, very busy, and there is an extended waiting time it is the receptionist who will go back, check on things and report to the donors waiting in the waiting room that the nurses are working as hard as they can. We know you are waiting patiently; we will handle you as quickly as we can. If you can't wait, we understand fully. Most of the donors will wait. They just are appreciative that you have acknowledged that they have been waiting.

[Slide]

You also have your collection staff. They are in the best position to reenforce your message of need and to reflect your gratitude. This implies seriously looking at the person that you are hiring for these all-important positions, not just their skills but their ability to relate to your donors in a positive way. I like to consider it a "likability" factor. It also means doing your best at retaining good staff and sometimes that is very, very difficult to do as the healthcare field is changing.

[Slide]

So, recruitment and retention of staff is very important to recruitment and retention of donors. Ultimately, it is about cultivating a relationship with your donors, a positive one. One of my nursing staff characterized it the other day as saying you have to treat the donors like a guest in your home. That includes thanking them profusely. I cannot emphasize enough how much gratitude goes a long way, as I think all of our speakers have said. I mean, how many days do we go in our existence where we are just feeling pretty flip and unappreciated, and then someone extends that simple thank you, that simple word of kindness that just makes you feel darned good. I mean, some days you just have to settle for the thank you for shopping at our K-Mart.

[Laughter]

But our donors need to know that we care as much about them as we do about the pint of blood that they have just donated, and they must know that we appreciate them. That means overcoming those obstacles that we can do something about.

[Slide]

So, what are the obstacles? Focus on numbers -- we can easily get numbers driven within this industry. We need to focus on the dollars we spend and the inventory we hold. However, in doing so we sometimes sacrifice the long

term for the short term. The question is, is it more important to get that pint from that kid at the high school or college, or make his or her donation experience so positive that you have created a life-long donor, one who will give many pints and save many lives?

That means that that benefit may not inure directly to your center because our young people are moving. They graduate from high school; they move on to college. They go from college, they change locations. But, hopefully, if their donation experience at your center or your mobile drive has been a positive one, they will become regular donors and donate blood on a lifetime basis in the communities that they reside in.

We have alienators that are obstacles. That can be the inopportune remark by the staff member who has had a very long day, or someone within earshot commenting on how the blood type of the donor isn't the one we happen to need at the moment. You can also have an overly attentive staff member. If the donor brings a book and opens it, don't talk to him. They want to read.

Poor customer service -- that obviously cannot be minimized. The donors need to know that we respect their time. Deferrals are an obstacle. It needs to be stated that we have deferred too many perfectly good donors for things that do not impact directly on the safety of the

blood supply. As an example, in 1999 we deferred 211 regular repeat blood donors permanently. Those 211 donors represented 2077 donations to my center prior to their deferrals and now we have lost them. And, 27 of those we had to defer for core. They represented 501 whole blood donations.

[Slide]

In addition to obstacles there are also pitfalls. There is the giveaway syndrome. This is relying on giveaways to attract donors. In our case, we find it to be expensive. It is tricky if you think about the FDA focus on inducements, etc. If you have the budget and you can sustain it, wonderful; more power to you. But in many of our cases, particularly those of us who operate smaller centers and have limited budgets, they are just not sustainable.

We did step into this one a few years back with our milestone program. I will tell you, we were able to use focus groups where we talked to regular donors and we talked to infrequent donors, and we found that they really didn't care so much about the milestone program. What they really wanted more was public recognition. So, we were able to extricate ourselves from that and we did not see an appreciable difference in donations.

The second pitfall is trying to please everyone. You will always have folks who don't like your location; they don't like your hours; they don't like the cookies; they don't like the coffee. All I have to say to this is I cannot give you a sure formula for success but I can give you a sure formula for failure, and that is to try to please everybody.

[Slide]

Now in conclusion, forgive me if I have stated the obvious but sometimes what may seem obvious to us is often overlooked and that is the crux of the message today. Let us not overlook our donors. Think of your relationship with them as just that, a relationship. Treat them with civility. Treat them with courtesy and respect. And, if I have learned anything in my lifetime it is to remember to say thank you. Thank you very much.

[Applause]

DR. LEWIS: We started off with a story of success and we have had a series of snapshots, and our last presentation today is another story. Jill Scolamiero and Mark Thornhill are going to present their story. Jill is the director of allogeneic product for the New York-Pennsylvania region of the American Red Cross, and has risen to this position within the Red Cross Blood Services over the last 26 years. This has included 15 years with

the North Atlantic region and 6 with the New York-Pennsylvania region. In her current capacity Jill is responsible for directing recruitment, marketing, scheduling, telerecruitment and collection operations. She is obviously very successful in that she ensures the collection of 312,000 whole blood units a year.

Jill is joined in this function, as well as in speaking to us today, by Mark Thornhill who is the director or donor services for the New York-Pennsylvania region of Bio-Medical Services of the American Red Cross. Mark is responsible for the recruitment and collection of the large number of whole blood units just mentioned, as well as 17,000 apheresis units. Mark has been with the Red Cross for 16 years in various capacities, including director of manufacturing and director and assistant director of donor resources development. He has served in the regions of the Gulf Coast in Mobile, Alabama, Alabama and the New York-Pennsylvania region. And, this story of success is in donor recruiting in a blood center.

Story of Success - Donor Recruiting in a Blood Center

MR. THORNHILL: I am Jill Scolamiero --

[Laughter]

We are very respectful of the time of the day for you as well as us, so we are trying to do it a little bit different. We will try a little humor through this

presentation, a little interaction and ask you to be engaged with us.

[Slide]

First of all, very specifically what we would like to do is kind of interview each other a little bit to share a little more about us as people. None of this has been rehearsed. I haven't told Jill the questions I asked her; she hasn't told me what to ask. We decided we won't embarrass each other so we will go ahead and ask questions.

Jill, all of us, our regional staff are moving to Rochester, except for me but most of the regional staff is because we have a new building that we are moving into. Jill, you just had a significant event happen last week, you bought a house.

MS. SCOLAMIERO: I bought a house.

MR. THORNHILL: And what do you like about it?

MS. SCOLAMIERO: I like it because it is big; lots of things we can fix up and I will be closer to work. I won't have to commute two hours each way.

MR. THORNHILL: Ten minutes?

MS. SCOLAMIERO: Ten minutes.

MR. THORNHILL: Okay. Jill is our Tiffany Award winner for this year for our region. It is the highest award in the Red Cross. She is the award winner for management. Jill, the Tiffany Award, it is something that

is prestigious in our organization. How do you feel about having it?

MS. SCOLAMIERO: I am excited that after 26 years I will receive it. So, thank you for nominating me. He was my nominator. He is also my boss.

MR. THORNHILL: Jill also is notorious in our region because every Halloween, on the specific day, Jill dresses up in another character. So, Jill, you have dressed up in many different ones. Which one did you enjoy the most?

MS. SCOLAMIERO: Being a tea bag.

MR. THORNHILL: Okay. Jill is from Boston. Go ahead, top it.

MS. SCOLAMIERO: So, tell everybody something personal that they probably don't know about you, about dancing.

MR. THORNHILL: Oh, yes. Sure. Thanks, Jill. I am from a small town in Ohio, called Warren, Ohio. There is a small music center there called Packard Musical Center. One time I was there, and I was about -- I don't know, I was much younger and I got a call on my phone, and I had a hobby. I have to tell you, I used to teach disco dance. I got a call and it was from our local Packard Music Hall and they said that they had an actress in town called Barbara Streisand and she needed a lesson on how to

disco dance. So, that is my claim to fame. That is about as big as I will get. All right?

MS. SCOLAMIERO: Mark and I have something else in common. He has a son who is going into fifth grade and I have a daughter that is going into fifth grade. So we commiserate about that and give each other advice on occasion. One of the standing jokes we have had -- we have worked together six years -- is Mark claims there are concept people and there are detail people. So, we decided a long time ago that Mark, being the largest concept person and me, being a detail control freak, we should form a partnership and together our skills would be able to move the New York-Penn where it needed to go to support the patients in our area.

MR. THORNHILL: Thank you. Is that the last one?

MS. SCOLAMIERO: That is it.

MR. THORNHILL: All right.

[Slide]

We have a story to tell, and our story is about increasing collections at a significant rate, or the number that you see, in three years. Are you interested in hearing about it?

[Affirmative responses from the audience]

Okay. Before we give you any arrogant postulates about how to do that, I would like to ask some questions of

you. First of all, how many people are from the western part of the Continent? Raise your hands. Ma'am, I am pointing to you. Who are you? What do you do, and what would you like to hear about that?

AUDIENCE PARTICIPANT: I am with United Blood Services. I am from Phoenix, Arizona, and I would like to know how you did that and how much money you had to spend to make it happen.

MR. THORNHILL: We will tell you how. I am not sure we will tell you how much we spent but I will tell you it wasn't that great. Thank you very much.

So, the northern part of the Continent, how many people are from there? Raise your hands, please. Young lady who just put her finger up, who are you? What do you do and what do you want to hear?

MS. BERNIER: I am Brigitte Bernier, from Quebec. So, I think I am the "northest" one.

MR. THORNHILL: Yes, I think so.

AUDIENCE PARTICIPANT: I had this year an objective of increasing my donors of 24,000. So, I am anxious to hear what you have to say about it.

MR. THORNHILL: Thank you for being open to that. All right, we are going to move to the east. Who is from the east? Hands, please. Come on. Young lady in the back row. Please?

AUDIENCE PARTICIPANT: [Not at microphone; inaudible]

MR. THORNHILL: Good. Thanks for being here. We are going to finish with one of the most wonderful parts of this country, the south. Who is from the south? Ma'am, how about you?

MS. DARIOTIS: I am Jeanne Dariotis, from Tallahassee, Florida. This amazes me; it is a great addition. So I guess I am kind of interested in whether you increased the number of donations per donor or whether this is all new donors to you.

MR. THORNHILL: Thanks. We can share that too. I have to tell my southern story. As was indicated, I started with the Red Cross in Mobile, Alabama and that is about as close to the water as you get. When I came there from Ohio I was greeted by the ambiance and graciousness of southern individuals, and there was a smirky smile as they greeted me and one of the questions that was asked me in the beginning was, "do you know what a dam' Yankee is?" And I said, "no, I'm very confused; I don't." They said, "well, it's a Yankee that comes south and stays. So, we look forward to you going back north." And I have gone back north to New York. No longer am I a dam' Yankee. So, thanks for letting me share that.

We have a story to tell. First of all, a premise. Our information that we will share is not specifically just about the discipline of recruitment. It is about the issue of systems within a blood center and focusing at total systems because they all support each other. They are all dependent on each other, and when they all work together ultimately the donor and the patient are served.

[Slide]

What we will touch on is an overview of the region. We are one of 36 regions within the Red Cross that supplies approximately 50 percent of the nation's blood supply.

Secondly, we will talk about primary measures, and our primary measures is a misnomer for measures of success. We will limit that to five measures, measures that we measure every day, we communicate every day to our staff and we focus on regarding success.

Thirdly, structure, and structure is two elements for us. There is organizational structure. We will talk about how we limit that, how we flatten that but mostly we will deal with systems, and systems are the activities that bind people for results.

We will also talk about the future because the future is important relative to keep growth moving so that

there is not status quo. We will tell you what our intention is both in production as well as how we will move to the future. Questions and answers we will defer until the panel.

[Slide]

MS. SCOLAMIERO: A few facts about our region -- we cover upstate New York and parts of Northwestern Pennsylvania. We employ 800 employees and 400 of those are from the donor services department. Donor services, which Mark is the director of, is really recruitment and collection staff under one department who truly work together in a team environment, which Mark will touch on in a minute. We have about 425 mobiles every month. We also conduct regular fixed site operations. We have 13 fixed sites.

[Slide]

We serve a population of 6.8 million. This year that just ended we collected 312,000 units. We distribute about 489,000 component red cell products a year, and we distribute about 1200 red cells ever day.

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MR. THORNHILL: One of the issues that we use as our filter system is the mission statement of donor services. The emphasis on this mission statement will be three-fold, as you see: Production, and production is

meeting patient needs consistently, not just part of the year, not just during holidays, not just during high school season but every day.

Secondly, you will see what comes out of there is an issue of education of recruitment, and that is partnership, partnership with our communities. We are not the individuals responsible; our communities are and engaging them in education and information forms that partnership and forms that commitment to stability.

The third element that you will see in there is innovation, and innovation is as much for our donors, our patients and really mostly for our staff because through innovation, whether that is in programming and technology or in people, it keeps the system alive.

Those are the three elements of our mission that you will see reflected in the programs and the systems that we share with you.

[Slide]

Philosophically behind the development of this department -- this department was initiated six years ago -- are three elements: A united focus, and focus for us is bringing together primarily employees into focus of mission, values, strategy, tactics, and bringing all individuals into that within a measurement system that allows them to know at any time in the day, in the week, in

the month or the year are they successful, and making sure that we recognize that at all times.

The second issue is structure. We believe in a structure which has a little bit of overhead and a lot of service. As an example, we don't have system directors. As an example, we don't have directors of recruitment; we don't have directors of collections. We have general managers that pull everybody together. We do not have just collection groups; we have production teams that are interdisciplinary together that focus on results. So, structure or the relationship people have with each other is an important element.

Results oriented systems -- one of the clichés is we do not believe in building unless it is in a system and, as you know, a system begins with measurements. Results oriented is really the issue of initiative, ambition and tenaciousness. Some example -- I do not, again, mean to be overly arrogant -- in the last three years we have increased collections within the Red Cross the highest volume and the highest percentage, but also attached to that is our collection staff. They have the lowest QNS rate in the country in the Red Cross. Thirdly is the issue of stewardship of money. We have the highest production per unit, per hour, per collection staff in the Red Cross.

All of those elements are very, very important to the total systems of donor services.

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Just a reference, this graphically displays the growth. As you see, three years ago we were at collections of 252,000. We ended our fiscal year, which was last week as Jill indicated, at 312,000. That is allogeneic blood. That does not include auto and directed. Really, the reference point there is in the beginning of time, which was four years ago, it was a struggling region that imported approximately 25,000 units a unit, struggling economically. We closed this year with exporting approximately 30,000 units of a very fiscally sound organization, one focused at quality, one focused at recognition, one focused at providing a high quality employment life for all employees.

[Slide]

MS. SCOLAMIERO: Average productive units collected for operation -- we drool every time we hear of a region which goes out for a blood mobile and collects 100 to 200 units for a drive. Both of us came to the New York-Penn region from another region where we really inherited a whole proliferation of small blood drives. As you can see, four years ago our average productive units per drive, fixed sites and mobiles together, was 30. This year our

goal was 36 and we will actually come out around 40. So, we really have a very long way to go.

One of the things that we have eliminated, because of the small size of our drives, is the mobile bus. Again, we inherited three almost dying busses -- and, a show of hands if any of you have ever towed these to blood drives --

[Laughter]

We really got tired of that, and really felt that wince there was so much potential, which we will touch on, in our region that this was really something that we had to put aside for now and perhaps some day in the future that will be something we want to look at again. But that did have an immediate impact on our average production.

[Slide]

MR. THORNHILL: It is our responsibility to make sure that we attract healthy donors, but it is also our responsibility to make sure that we don't defer healthy donors. Our responsibility has been to educate donors before they arrive at our site so that they are healthy individuals coming in. It has been our responsibility to make sure that we use objective medical criteria in evaluating donors -- not subjective but objective. So, the impact of that is as you see. The impact of that has been

approximately 7000 opportunities for other individuals to come to our blood drives.

[Slide]

MS. SCOLAMIERO: We have also had significant reductions in our QNS rate, which four years ago was 3.5 percent and this year was just a little bit over 2 percent. Being from a recruitment background, I was fascinated how the collection staff really addressed this problem, and it really is very similar to deferrals. Every day they pay tedious attention to every collection that the staff perform and they actually do a count on every individual. So, at the end of the day they know how many deferrals every individual had and what those deferrals were and if there is a QNS problem, which is more often than not technique of the phlebotomist.

They started a little concept they called vein clinics. Again, the purpose of identifying people who are struggling with certain kinds of problems is not to have a punitive measure. it is really to single out those people who need retraining. So, for example, if somebody is having difficulty, we would send them to their vein clinic. They would work with one of the supervisors or one of the managers until they perfected their technique and ultimately drove down their QNS rate. So, that has been very successful.

Again, we typically talk about increases of collections coming from the recruitment staff efforts, but in our environment it is truly that the collection staff have participated in this effort because all the gains that we make by focusing on training for our staff to drive down QNS and deferral rates has a direct impact on the bottom line. So their contribution, the collection staff contribution to the total 60,000 additional units has been very significant, and they are well aware of that and, because of that, they really feel a partnership in this whole growth process.

[Slide]

MR. THORNHILL: Another word we use organizationally is deviations. This is really any error that has to do with following through a process. In the collections department you will find that about 98 percent of those are CGMP problems relative to the blood donor record and can range from a misspelled last name to a wrong social security number, etc.

What we have focused on is issues of quality also and quality is the same thing. Measure. Find out what your outliers are. Develop critical actions, communicate and recognize. When you bring the whole issue of quality in, it makes the same statement as if you were attracting

more donors. It is the full responsibility for focus on results.

[Slide]

This is our cost per unit, and this is an outcome. This is not a focus; this is an outcome. This is an outcome of increasing collections per drive. I will tell you this, over the last two years we have not increased any staff. We have not increased any quantity of drives. What we have increased is the productivity of what we have. So, the end result is that you naturally will decrease your cost down. It is very important because as you decrease that it provides you opportunity to invest in the organization as it goes forward.

[Slide]

MS. SCOLAMIERO: We are going to touch briefly on the highlighted areas of this slide. First of all, under systems we are going to talk a little bit about how critical developing a collection plan is for our organization, which truly is what are all the numbers that will drive what we need to collect every day, every week, every month, and so forth.

We are going to touch on D.A.I.S.Y. which stands for Donor Automated Information System. Management reporting is also a critical aspect of what we do, which we are not going to highlight today but, as Mark said earlier,

whatever we do we need to establish baseline and we need to be able to measure it. So, God knows, I think we have a report for just about anything, and are actually looking to streamline some of that activity shortly. Finally, under systems we are going to touch on Life Share, which is our marketing campaign.

MR. THORNHILL: We won't go in depth today, but we have what we call our customer quality initiative. It is a fancy term for basic surveying on a daily basis service delivery from sponsors as well as our operational supervisors. Our sponsors are asked to fill out a survey daily. Our return is about 60 percent. They answer the bottom-line question which is the most important, how was their experience that day regarding the collection experience. Our results are that 90-98 percent of our sponsors are fully satisfied. That goes into an automated system in the evening. It spits out a report the next day to all of our collection staff on how they were perceived by their sponsor. Our supervisors also fill out a survey that answers the question -- your partner, your recruiter, your account manager, how did they do in setting up that drive, going through the critical planning actions to make sure that the room was adequate; to make sure that there was running water there; to make sure the door was unlocked -- all of those small things that can either make a drive

or create a tragedy. They evaluate that. They fill that in, and that recruiter gets a report the next day on how their partner perceived their service.

Incentives, to us, has only to do with our recruitment staff. We provide no incentives no donors in any way, no trinkets, not anything. Incentives is a stage system for our sales staff that rewards them on two elements, yes, elements of volume and production but also elements of quality planning for blood drives, and they cannot receive a bonus unless they have done the job first in quality planning regarding the environment of a blood drive.

S.O.S. is significant opportunities for success. It is a national role model. It is a program that involves our collection staff in the actual production and feedback every day regarding how they are doing. We will go into detail on that.

Staff development is the issue of taking our staff and providing them professional opportunities for growth, not just for making sure that they perform all regulatory processes correctly but how are they progressing in their development on a career ladder upward.

Communications is both internally and externally. Internally, we use our voice mail system extensively. We know on an hourly basis every day as managers how we are

doing on that day in meeting our quotas. The staff know that also.

Communications is also external with our public. It has been a rough month, hasn't it, with regard to collections? The ability to involve your newspaper, your television and your media in becoming partners is a critical element for us.

MS. SCOLAMIERO: Again, all of these statisticals we believe have led to our ability to become more efficient and to become more successful in all of the areas that we have touched on already, except for MACSimum Success. Briefly, MACSimum Success was a work group, a multi-level work group where people came together because, as we went into MACs, we wanted to try to prevent our deviation rate from going sky high and basically a work group was pulled together and they set a goal for themselves that the efforts of that group would result in a 50 percent decrease in the deviations rate.

Well, of course, that seemed ludicrous but far be it for management to discourage their high goals. Mark, I am trying to remember what the actual results were.

MR. THORNHILL: Thirty percent.

MS. SCOLAMIERO: But they actually achieved through a whole process of daily communications and tips to the collection staff, and so forth -- they reduced it by 30

percent. So, again, I think for us it exemplifies the culture of bringing people together at various levels of the organization, including those who have to go out there and do these jobs every day, to be part of that process to buy in, to participate, and them to communicate.

[Slide]

MR. THORNHILL: Jill mentioned that she is the detail person and I am the concept person, but the one thing that we share is that we are both obsessive math people. We believe that behavior can be measured, can be collected, can be trended, can be affected. With our planning process for our collection plan on, again, a goal of 320,000 for this year, we are obsessive on the mathematical perspective.

[Slide]

But first, when we start, is what drives it, which is transfusions, and that is the need, and that is the definition, and that is where we start. We start with that on a monthly, a weekly, a daily perspective based on past history. The plan comes from there. It goes to what we call share rate. Share rate is actually how many productive units did you gain for how many you went out with. We, again, measure that. It is all an automated system, and we forecast that based on a mathematical formula. I will tell you that over our experience of six

years it is amazing how accurate it can be in a forecasting process.

The other thing which was mentioned today that we measure in product is APO, average product per operation, and this is where we are at as an organization. We will not have any more drives. We will not have any more staff but our APO will grow and then the solvency of our organization will also grow.

On business unit differences, within our department we have 18 different business units. What we do is treat each differently, not differently but individually regarding expectations of growth because they are different points. We do not give them boilerplate performance expectations for all. We measure where they are at, where they are moving, and assist them in doing that so that we have incremental growth by all and total growth also, as you have seen.

Resource capacity analysis comes down to really truck, supervisors, time, miles. All of that, we have in our D.A.I.S.Y. system, and automated system that tells us at all times how our capacity is for planning the future or how our capacity is tomorrow relative to flexing for drives, relative to staffing regarding resources. it is all analyzed by an hourly perspective of time.

[Slide]

D.A.I.S.Y., again, stands for donor services automated information system which we developed in the New York-Penn region. I am going to give you just a quick story, that when I first came to the New York-Penn region from the North Atlantic region I asked the secretary, could I please have a list of all of our sponsoring organizations, what month they collect blood in, how many people they have, how that adds up horizontally and vertically, how that compares to the work plan so I know if there are any gaps on any particular months. She laughed loudly and pointed her finger at the paper files. I think that was just an eye opener for us because we truly believed that if we were going to move the organization ahead quickly in collections, which we needed to, to even begin coming close to being self-sufficient, we had to get some systems in place right away.

[Slide]

Our current theory on all of this for D.A.I.S.Y. and the impact our organization has been a half day truly becomes a minute. I am sure all of you have account managers or field representatives, or whatever the particular title you may have, who will drone on for a long time because there is always too much paperwork and our region was no exception. We really went into designing D.A.I.S.Y. with the concept of really turning what was

half-day tasks that were fairly mundane and basic into a minute.

The first part of this system is an automated sponsor database, and for every sponsor we have about 250 fields. You can imagine what they all are, all the logical kinds of fields that you would imagine. But, by having a sponsor database, it allows us to look at particular sponsors, what their potential is, what their donation patterns are, and it allows, first and foremost, for us to follow what is really one of our national policies -- territory management. It is very hard to try to manage a territory if you don't have any blueprint to look at.

D.A.I.S.Y. also has an automated calendar on it, and what that means is, as Mark indicated one of the problems that I have certainly seen in my tenure is recruitment will go along and they will develop a schedule then send it to collections and they will say, oh, no, can't do this, that, this that," and it goes back and forth and maybe six months later you have a calendar that both departments can truly live with. The beauty about D.A.I.S.Y. is that it already has capacity limits in it. It won't allow you to over-book without certain approval processes because there are only so many trucks and there is only so many staff.

Also, in our region we very often share staff among districts, and that is one of the roles I play, sort of being a traffic cop. You know, if one district has a real big media drive, of course, we all act as a family and we try to pitch in. But the calendar tells us, on any given day, what we are projected at six to ten months in advance; where we are right now; what the capacity is remaining for staff; are there any trucks available; who has confirmed what by the state; what are the booking levels.

The other thing it really provides, and all the recruiters here I think will appreciate it, is a personal calendar for all the account managers or for product services, various things. In the old days the account manager would sit there, and they would take the big calendar and highlight all their drives for the month. Now we can just say here is just your individual schedule for the month so that they don't have to waste that kind of time.

Last, and certainly not least, is that our national organization also came out with an account management training program, and it was wonderful. It was very timely for us. It is a concept that has been around for a long time that is very tried and true, and we call it a 12-week plan. Really what the 12-week plan is, it is a

series of tasks and communication activities that an account manager does for each and every drive, and we fully believe that if they do all of those steps in a quality way and a timely way, their chance of having a successful blood drive is dramatically improved. That includes having a very comprehensive sponsor meeting.

One of the favorite tools truly for account managers is called an account management summary because one of the biggest problems in recruitment that I have always been aware of but never really, truly found a system that worked for it was how do you tell an account manager who runs 20 drives a month to follow the 12-week plan when, on any given month, they are dealing with 60 different sponsors at various parts of that 12-week process. So, for them D.A.I.S.Y. provides them with a calendar, if you will, of all of their drives and what those critical due dates are so that they can put it all together and figure out, okay, I might not be able to do this task on this very day but within reasonable boundaries. At least I am not sitting there, trying to figure out what am I trying to be doing. That alone has saved our account managers an enormous amount of time. They are my biggest fans of D.A.I.S.Y. I mean, they truly don't know how they could move on without this. It has allowed them from being in the office two days minimally a week to being in there only

one day a week at best. So, again, I think this has helped us enormously to put some foundational systems in place that allow us to do account management and territory management correctly.

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We also developed what we call the life share campaign. Life share is really about fair share values, which is not a new concept, of course. It started with tithing. Life share really means that once we reached a point where we knew all of our sponsors' potential in terms of how many employees they had, or how many people in a community, or how many juniors and seniors in the schools, or how many non-commuting students at a college -- and, believe me, it took us two years to get all that information but once we got that information we could finally answer the old question that always bothered me, and that was, I would ask an account manager, "well, why did you decide that goal was 50?" And, they would say, "well, I don't know; we always did that."

Well, wait a minute, there is another way to do this, so we did establish fair share values, and I think they are very well known in most regions -- certainly Rolf Kovenenski, Penn-Jersey who, in my experience, invented, if you will, and started the whole fair share values system, but businesses, for example, if you have 1000 employees,

for the annual goal we would ask them to contribute at least 250 donations a year.

Just the ability to have a fair share value system allows us to do a number of things. We finally have something real that we can talk about in terms of what we believe anybody's fair share contribution is to support patient needs.

We also provided the 25 account managers with messages about how this all comes together. At the time we started life share we were not self-sufficient as a region, and so that was obviously a big opportunity because we had to become self-sufficient and we also had to grow collections. So, we did develop a campaign where, you know, I didn't need 25 people trying to figure out how to talk about life share. So, they have a flip chart presentation and various tools that allow them to go out and feel very confident and very good about the fact that what they are asking is only fair share. And, 47 percent of all of our mobile sponsors today are what we call premiere sponsors, and those are sponsors who have exceeded their fair share value.

The other thing that life share told us, which sort of answers one of the questions brought up earlier, is until we went through the whole data analysis of finding out what is our potential based on the population, and

based on the fair share values, we never knew what our potential was. When we found out it was almost double what we were collecting, number one, we breathed a big sigh of relief because we weren't sure we really had potential. But it allowed us to define what our greatest opportunities were, how we could get the furthest the fastest, and so forth. So, I would have to say that knowing where you are and knowing where your potential is by sponsor has just been the backbone of our ability to move forward.

Last but not least, before the whole fair share value system we were not able to recognize sponsors. Somebody would say I want to go out and buy a plaque. Well, what is it for? Well, they had this great drive. Well, you know, that is nice but... . Once you have fair share values we have a premise where we can equitably recognize and encourage our sponsors for either exceeding their goals or for striving to meet those goals.

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MR. THORNHILL: Just a comment about cost. When we have made these presentations in the past, one of the objections to our presentation is, well, you are a large region; you must have a big budget. D.A.I.S.Y. was the baseline and now life share is incorporated in that. The expense for us was $30,000 of outside programming. Of course, there was a lot of internal expense based on our

personal time but very little expense to be able to create these systems.

S.O.S. is our system that really, again, brings people focused and together. It is a significant opportunity for success and it is focused on bringing our collection staff into share product responsibilities and they do. They are very responsible. They have an impact every day on how many units we have. We help them with that by giving them metrics that they are responsible for, presenting donors, QNS and deferral rate. They have, and it comes again from D.A.I.S.Y., a forecast on every drive, on what the anticipated level of presenting and loss should be.

What they then do, they measure it on an hourly basis on how they are doing. When they are exceeding that level, they then have a defined decision tree that they go through to attempt to effect and bring down that performance to an expectation. On the third hour of that process, if they haven't brought it within expectation, they then have a system where they review that process, decision tree, and they request help. They have a help-line system back to their manager that allows them to brainstorm and also patch in their counterpart, the recruitment individual because the help may be from the sponsor. The help may be to focus on individuals who are

outliers on that day regarding needle sticks. Their focus may be on requesting other collection resources from other drives that are not doing well to triage support there. But without knowing what the expectation is, without having a system to measure it, to communicate and ask for help, the impact would not be -- a significant system that has affected product but also, more so, links everybody together in the results.

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This is where we are at; this is where we will be. This is our defined business plan for the next two to three years. There is a need there. There is a significant need for product. We have significant potential. We must then be responsible for responding to that. Our organization, both our national organization, our area organization, and internally expect that others will respond to that.

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How will we do that? From the strategic planning process we have engaged in over the last years has been very interesting because it has been motivated not out of crisis; it has not been motivated out of a problem; it has not been motivated out of not meeting hospital needs; it is motivated out of getting better. Our focus in that is relative to savings and, again, a savings not in the sense

of managing and counting paper clips but savings relative to evaluating processes to make the small changes such as for plasma -- how do you package it so that your breakage is affected? Such as, when you are interviewing donors, the syntax of your questions, what effect does it have? All of those small incremental things, when you are looking at 320,000 units, have a large effect and allows you to invest.

Jill has mentioned the sponsor and donor base. We feel that the opportunity is huge. In an arrogant way, we believe the opportunity is that we could supply all the blood for the Eastern Seaboard. We probably won't get there but the opportunity is there. Excuse the arrogance.

Technology, very important for us. If we can reduce our collection experience by five minutes; if we can take a unit and we can prepare the components at bedside; if we can create a system that is overwhelmed with paper and create no paper -- if we can do that, then we must, and we must be leaders and partners with our national organization of technology.

Regulatory issues should be regulatory opportunities. It is not a negative area. It is a wonderful area that allows us to develop staff and provide them with opportunities for professional growth. That has to be a focus for us at all times. Really, it is an add-

on, staff development, much more than minimum expectations but, again, equipping staff so that they have a career ladder within the Red Cross.

We have a theme statement within our strategic planning: We want to become an organization where individuals make the statement, "it is my Red Cross," not, "I go to work. It's mine." We must move from an organization in blood banking that historically has had individuals that have been disenfranchised and people who went to work to an organization of empowerment, of ownership, of involvement so that people can say "this is my business."

MS. SCOLAMIERO: That is it.

MR. THORNHILL: Thanks.

MS. SCOLAMIERO: Thank you.

[Applause]

Questions and Comments

MR. CONLEY: Anyone who has been a speaker this afternoon, if you would come down and join us at the front table so that you can answer questions, I would appreciate it. I also have to say when the opportunity came up for me to chair the planning committee for this, and you always get a little bit nervous, but the speakers today have been excellent. The presentations --

[Applause]

Thank you very much. As you heard earlier, we have one fresh face on the panel, Susan Parkinson is sitting in for Bill Nielson since he could not stay.

One things I looked for -- you know, I always get to ask the first question -- one of the things I looked for in speakers was, I wanted to find and was unable to in my limited search -- I was looking for donor centers that could be competing for donors but that had found a way to cooperate in donor recruitment. Audience and panel, does such an animal exist anywhere? I mean, I found some large companies that themselves, for their employee population, alternated donations between two competing groups in their area, but is anyone doing a cooperative effort of which I am unaware? Maybe this is something we could talk about in one of the breakout sessions.

When you come to the mikes, please identify yourselves for the record.

MS. CARNAHAN: My name is Ginya Carnahan. I am director of donor recruitment at Suncoast Communities Blood Bank in Sarasota. On occasion we will work with the blood banks south of us and north of us on a regional outreach. We do in August an event called the O-Party, right prior to Labor Day, and we share art work, T-shirts. We pay for media and share the costs. It has been effective for several years.

The atmosphere of competition though is getting stricter and we are thinking a little bit about maybe just doing it ourselves this year.

MR. CONLEY: So, it is something you have done in the past but it is increasingly difficult to do.

MS. CARNAHAN: Yes, it certainly is.

MR. CONLEY: Some of the examples we heard this morning were paid advertising on television that obviously goes out of your own zone. I know Brian was saying you were doing that, and I guess the spill-over effect is whatever happens but not that anybody has come to you and said, well, can we help and get our name on it too?

MS. CARNAHAN: Florida Blood Services, in fact, for several years in the summertime had a program with the NBC affiliate that listed blood drives throughout their entire broadcast area, and it was spearheaded by Florida Blood Services. It took into consideration our blood bank and several others, and we were certainly appreciative of that. Thanks, Brian.

MR. CONLEY: So, there is some going on. January? MS. SIGMON: Jan Sigmon with the military blood program office, here in Washington. I think that there are quite a few combined drives within the military and community blood banks throughout the United States. I know that the Navy has quite a few with

different community blood banks. A community blood bank will often provide much more of the advertisement. We provide the donors. We actually do splits in that the two different groups will draw the donors differently because we are dealing with different licenses so that the donors will come in. We will actually say one to you; one to us and the military has usually a small quota, and once we get our quota we just leave and the donors are there for the rest of the community. So, we do that through the United States at different locations. I know particularly in the Navy, we share donors when there is a drive, something you might consider in your MOUs if you are looking to do that. The military does need significantly less donors than what you are looking for most of the time in your community. So, it might be an idea.

MR. CONLEY: Thank you, Jan. Bill?

MR. TEAGUE: Bill Teague, from Houston. We have a hospital blood bank program in Houston, the St. Luke's Episcopal Hospital, and the blood center and St. Luke's have a joint blood drive with our ABC affiliate each year. It works very well. Basically, what we do is have a single advertising effort but we divide the area of collection. One group will be at the station, another group will be at a mall and donors go wherever they want to. It works very, very well.

MR. CONLEY: Very good. So, there is some cooperation going on out here. I should say again if anyone has written questions, if you will pass them to the end someone will pick them up. I see a hand raised in the back.

MR. SUMMERS: Yes, my name is Kendal Summers. I am probably wearing two or three hats when I say what I am about to say. I am a vendor. I work with blood centers across the country producing a publication for ADRP. And, it is interesting to me that I see that most of our blood centers have been large and successful of the people who have spoken. I think I see out there a lot of the small blood centers which have to work well with each other, especially because they don't have the resources that many of the larger blood centers do.

Secondly, perhaps as maybe something that we can see prophetically for the future, I see that people who have come to have relationships with other people through organizations like ADRP, even when they move around can have relationships that can actually soothe wounds that were maybe there before through competitive environments because they know each other personally. So, I think it is great when you can get people together in forums like this where they can put a face with a name of people who

otherwise have been in competition because that really makes it better.

Wearing one more hat, I am a former Blood Systems United Blood Services employee, and in the south we had a very good relationship with Life Blood of Memphis, but once again our company had the philosophy that, I think, as much as possible we would take the high road, and they had the same philosophy and we were able to work very well together, especially because, like Brian and some of the other folks, we shared media and we found that it worked best when some of the folks in Memphis and our organization would speak with the same voice. We accomplished far more when we could do that.

MR. CONLEY: Very good. I do have some written questions but are there any from the audience? Let's start here, in the back.

MS. LOPEZ: Lisa Lopez, from Humanatics. I have a question for Jill. You mentioned that the fair share metric for company-sponsored drives was 250 donations per year per 1000 employees. I just wanted to know how did you come up with that calculation, and do you have a similar calculation for school system blood drives?

MS. SCOLAMIERO: Basically, in the Red Cross system most of the large regions -- we set system standards just historically. I don't even actually know where they

started, but it has been my experience that the whole concept of 25 percent annual participation by business -- that has certainly been the platform of Rolf Kovenenski in the New York blood program, Rosemary Leland in Penn-Jersey, the North Atlantic region, the Carolinas, and that is the business value. For high schools we use a goal of 25 percent of the juniors and seniors, 15 percent of non-commuting college students and 7 percent of the age eligible population in a community. So, again, it has really evolved over time based on best practices that I am familiar with in the Red Cross system.

MR. CONLEY: Right here?

MS. BERNIER: Brigitte Bernier, from Hema, Quebec. My question is either to Bob or Michael. Very good presentation, I was really impressed with what you did with U.K. We didn't have the same impact because our population is mostly French but we might have it soon. I was wondering, the booth that you make, what is your type of job? What would you do with it? When the people are coming into the booth, what would you tell them?

MR. NICHOL: Basically, we take the booth out to any kind of an area where we can set it up as a display. So, say for example, we take it to a shopping mall, we find a place where we can set it up. The booth itself is basically designed to catch people's attention, bring them

over to the booth, and then we have some staff that are there to answer any questions that the people may have either about blood donations but specifically about getting their blood typed. They will go through that process. We will type their blood for them if they like, and we will capture their name and their phone number and keep that for later references when we go back to the centers and we are in a position to be able to call them up.

So, it is really kind of an attention getter, almost like you would see at a conference, sort of in an exhibit area. That is basically how we use it, just to get people's attention and get them over there. It has some interesting facts and information, but it is really an attention grabber more than anything.

MR. EVANS: I will just add to that. The original concept came from our Edmonton blood center. They really used that as an education tool just to get out to the community. They really didn't look at it as a recruitment tool. What they found was that when they were doing this -- there is a natural curiosity about your blood type, and what they found was everybody saying, "well, where can I go donate?" once they had the finger poked. So, they added this element.

What we did when we took it up regionally and then nationally -- some of you may be aware of the Japanese

theory that your blood types determines your occupation. So, the material they get is the characters that were on the display that you saw, and it is a CD size pamphlet that rolls out, and really there is no message about donating blood until about the fourth panel. The hook is your occupation or your blood type may determine your occupation. We go on that so it is very non-threatening. You are at a trade show or at a health festival. People aren't afraid that they will walk up and be recruited to donate blood. So we get the curiosity thing. They go through it and they find out they are supposed to be a gambler or a witch. You create dialogue and by the end of it you have been able to talk -- as the panel unfolds, I think it is about a 7 CD size folder, as it unfolds it talks about did you know that every minute of every day someone in Canada needs blood or blood products? Did you know that only 3 percent of adult Canadians donate blood, yet, virtually all of us will need blood or blood products in our lifetime? There is a message about the size your wallet doesn't matter. By the end of it, it gets into some pretty strong messaging about donating and, of course, that is at the close point when the nursing staff or the clinical assistant says can we call you if we are short in your blood group? As Mike said, you know, 80-some odd

percent of the people say yes to that and we are seeing about 17 percent of those people showing up at our clinics.

MS. BERNIER: Thank you.

MR. CONLEY: One of the few places where I have really heard some disagreement on the facts and what is supported and what isn't is on the issue of donor incentives. I have a question here that is really a two-partner and it kind of hits upon that, but if it opens up a little bit of exchange about donor incentives, that would be good.

The first part, has anyone traced viral marker rates to incentives? Or, along that line, is there an increase in donor deferral when you are offering different incentives? The second part, have you noticed an increase in viral marker rates with certain incentives?

I know Dr. Williams is in the audience and he has been looking at this some but, I don't know, his research may still be very preliminary. Comments, please?

MR. EVANS: I can talk a little bit from the Canadian perspective. We have actually just presented a donor incentives policy to our executive management team and are at the point of ratifying it. So we gathered a lot of information. I can tell you that the information, and we searched internationally, was pretty inconclusive. It seemed that for every study that said that there was no

difference in TD rates there was another study that said there was. A lot of it was qualified with not scientific survey information.

I can't remember, there was a doctor at ADRP this year, I believe from Dallas, who talked about when they did concert ticket giveaways, they could actually track the deferral rate by the band --

[Laughter]

-- and he certainly said that there was a higher deferral rate, higher TD rate as a result of incentives. The recommendation we are making in Canada, we are going to drop the term donor incentive because our philosophy is that there should be no other incentive to donate blood but the altruistic motivation. So, it is now donor appreciation. We have set a limit for draws. It has to be $100 or less, and draws cannot be promoted externally. So, it is simply an appreciation. When you show up at a clinic you can enter a draw and you can win down the road.

We have two categories, draws and general incentives. General incentives are something that has to be under $10 in value given to everybody at a clinic, and we are just having a debate right now whether those can be promoted internally an externally or just internally. So, we are very much limiting that and trying to keep the focus on altruism.

DR. WILLIAMS: Alan Williams, Red Cross, Holland Lab. Through the Red Study and its survey program we have been trying to measure the impact of incentives both in terms of what donors are attracted by them, which are discouraged by them, and any impact that it might have on safety.

There are anecdotes out there. They are very difficult to evaluate because if the data is not corrected for first-time versus repeat donor status, demographics of the donors, etc. it is very difficult to take a prevalence figure and say what it means scientifically.

In New York it has been done so far and there is one paper which, hopefully, will be published in the next couple of months. We have been looking at this measure of deferrable risk which, by surveying a donor for risk factors that they admit to by anonymous mail survey following donation that they did not admit at the time of donation, we get this measurement of deferrable risk which runs on the order of 2-3 percent reproducibly.

Preliminary data to date, and this is unpublished data subject to change, in the repeat donor population there is a slightly higher level of deferrable risk in donors who say they would be encouraged by a future incentive to come and donate blood, and this covers a number of the incentives that are commonly used. However,

the medical importance of this also is difficult to evaluate because between first time and repeat donors you see a magnitude of two-three fold deferrable risk increase as well. So, yes, it is measurable. It is not there apparently in first-time donors.

I think probably the more important thing that we are starting to realize is measurement of a discouragement factor, particularly the monetary equivalent incentive. There is a discouragement factor of up to 12 percent and even higher in repeat donors. So, what might not be recognized is that while you are bringing a lot of kids and new donors to the door, you may well be turning off some of your older altruistic donors, and that is something that I think is important to keep in mind and perhaps measure.

That is really the state of the data so far. We are conducting analysis on a large data set and trying to pull our additional information. I think that will be forthcoming over the next year.

MR. CONLEY: Very interesting. In the back?

MS. REARDON: My name is Susan Reardon. I am with Ortho-Clinical Diagnostics. I am curious about the extent to which there are corporate tax incentives available for corporations that organize blood drives to the extent, for instance, if you wanted to give away a

couple of days off or some other kind of thing. Are those kinds of benefits deductible for corporations?

MR. CONLEY: So, when a corporate drive is sponsored and there are expenses associated with that corporate drive, I assume they write that off as a contribution deduction. Who knows for sure because I am guessing?

MS. REARDON: I can go back and ask Bill.

MS. PARKINSON: The answer is no, it is not tax deductible.

MS. REARDON: It is not?

MS. PARKINSON: No.

MS. REARDON: Would there be any value to exploring the notion of there being some tax deductibility?

MS. PARKINSON: Over the years, we have actually had different people try to get tax incentives of personal tax exemption for, you know, the time that it takes to drive to the blood center to give a donation and that has never actually worked. Jim, do you have any more to say about that? No? No, it has just never worked.

MS. REARDON: I have one other question for Rob or Michael. Is the Canadian Blood Services an arm of the Canadian government, and are you funded by the Canadian government?

MR. NICHOL: We are funded by the nine provinces and three territories of Canada through the provincial governments, other than Quebec which is funding Hema Quebec. We are a not-for-profit organization, completely independent of government.

MS. REARDON: And, how is the level of contributions from the provinces established?

MR. NICHOL: It would be based on per capita population. So, obviously, the smaller provinces make a smaller contribution to the overall budget.

MR. CONLEY: But that is not a tax. Are they obligated to pay?

MR. NICHOL: That is a good question. Well, we go through this series of negotiations with the provincial ministries of health every year to essentially determine our budget. So, it really is a negotiation process each year. They decide as a group how much they are going to fund us and then the amount of divided on a per capita basis by provinces and the three territories.

MR. CONLEY: We are going to do Bill and then we are going to go to the back.

MR. TEAGUE: Thank you. We were talking about incentives to donors. My question related to the last presenters in relation to their incentives to staff. You mentioned, if I understood correctly, that there was

incentive pay for recruiters or account managers, as I heard them called, and there was some implication that there might be incentives for collection staff as they participated in the S.O.S. program etc.

My question, one, are there incentive payments for those two categories of staff? Two, what are they and how were they decided?

MR. THORNHILL: The quick answer is they are not an incentive process for collection staff. It is directly to our sales staff, which is our account managers and our telerecruitment staff. It is based on values and it is based on two values primarily. First of all, the value of a certain percentage of blood drives that must reach what we call an efficiency rate, a show rate which is 87-110 percent of goal. So, 60 percent of their drives must reach that range. That efficiency level is defined on staffing capacity. Those are resources to be able to support that. Anything over 110 percent is not a good experience probably for that sponsor or donors. So, it is 60 percent. Again, that is a value.

The other value I mentioned is effective planning, quality planning of the blood drive. As I mentioned, in our process they are evaluated daily by supervisors. So, they must reach 95 percent of all their

blood drives, defined as high quality plan by their collection supervisors.

So, when they reach both those values of production as well as quality planning, then they are eligible for the bonus. It is a step system. It builds on itself and has three levels -- one month, second month, third month. They raise accordingly on that. If they don't keep that consistency up after a second month or a third month, then they return to the beginning which is a lower amount than the building process. So, it encourages consistency rather than just shooting for high production on one month.

MS. SCOLAMIERO: But they don't get paid per unit.

MR. CONLEY: Right there, in the back row?

DR. ALVING: Barbara Alving, NHLBI, NIH. I thought it was very interesting that OB is beginning to mix in a little healthcare with the blood donations by measuring cholesterol levels and PSA testing. But it would seem that a major issue would be that of looking at iron deficiency and providing the opportunity perhaps for iron supplementation in women donors. A fair percent seem to be lost because of this problem. Have you addressed, of have any of the other persons there addressed any systematic way of looking at iron deficiency, doing ferritin levels and

supplementing with carbonyl iron and trying to maintain the female donor base? Is that out of the question? Too difficult to do?

MS. MCCOMBS: Actually, no. We are in the process of putting together a program that will come out next year that will be aimed at healthy heart, and talk about the iron overload issues, and we will be seeing if we can add some additional testing.

MR. EVANS: One of our blood centers has done a program for iron-deferred people, and they have a little kit and they have information on what types of foods they should eat. In fact, they did a deal with General Mills and Cheerios, and they had a little Cheerios packet that went along with that, and they talked about making changes in your diet and coming back to donate.

MR. CONLEY: I am going to read a question, then Dr. Williams, then January and one in the back. Suzanne McCombs mentioned that there is increased usage of blood. In fact, she also mentioned during her talk that their physicians get quickly involved when there is a large order of a single type to talk with the ordering physician.

The question really is do blood centers participate in education campaigns to encourage healthcare providers to use blood conservatively, or are other blood centers getting involved the way OBI does, or did I

misinterpret what OBI is doing? Really, this is almost beyond the ken of this group because we are talking about trying to reduce usage instead of increase supply.

MS. MCCOMBS: No, that is correct. Our physicians are very involved in trying to educate physicians about utilization. In fact, it is something that has been presented to our hospitals as a way to actually lower their cost. So, they are very interested in having that happen. And, I don't know about other places.

MS. PARKINSON: There are blood centers all over the country who do this. In fact, some people even have employees of the blood center right in the hospital transfusion service so that they can monitor the blood supply. It is one of the biggest issues we have. Utilization is going up all over the country. So, this is going to become more important as we have a deeper chasm between supply and demand.

MR. CONLEY: Bill, do you have a comment on that issue?

MR. TEAGUE: Yes, on that same issue, there are a lot of initiatives but most of them are related to the Group O issue, trying to be sure that the Group O units are used appropriately, and that is a strong combination between the provider of the actual transfusion and the provider of the supply. It has been very effective in

changing practices. Now, I think that could be built upon nationwide.

MR. CONLEY: Go right ahead.

MS. MCCOMBS: My question is does anybody know why the usage seems to be going up? Susan, do you know why?

MS. PARKINSON: We do surveys that you have to answer all the time, and anecdotally what it sounds like is that physicians are more comfortable with the safety of the blood supply so they are not as judicious about using blood. They just use it at random.

MR. CONLEY: January, do you have a comment on that issue?

MS. SIGMON: I just have a question. Is that red cell usage that is going up or platelet usage that is going up that you are seeing?

MS. PARKINSON: Both.

MR. CONLEY: And some of it is being tracked in an ongoing project that Jan mentioned this morning. So, it takes a few months before you have data that you feel you can begin to trust what is happening. So, that information is being followed a little bit more than it ever has in the past. Hopefully, we will have better data as time goes on.

MS. SIGMON: I have one comment on that, just out of curiosity and a comment for the record, is there a

possibility that platelet usage could be going up because you are using platelets from donors who have aspirin within 36 hours rather than 72 and they are needing more platelet transfusions because they are less effective? Just a comment.

MR. CONLEY: A comment. Dr. Williams?

DR. WILLIAMS: A question for Mark, you showed one bar graph that showed a reduction in donor deferrals over a period of years of a couple of percent. You attribute it to elimination of subjective deferral. Could you explain that a little bit?

MR. THORNHILL: I want to reduce it to the simplest statement. In looking at the deferral rate we found in evaluating it, really evaluating it more in the sense of percentage of deferrals, tracking it back to employees, and what we found is that when you do any type of measurement that really outliers, a few individuals, were deferring a high percentage of individuals, up to 30 percent. In doing some interviewing process of those employees we found that there were some interviewing techniques that really were not objective, such as, "you don't look like you're feeling well today." Well, that really sends a message, doesn't it, to the donor that they don't feel well today. So, really the whole issue of

objectivity relative to interviewing process and definition of facts was a significant issue.

MR. CONLEY: Very good. Yes, please?

MS. CARNAHAN: I was just going to make a comment about the discussion of educating women about low iron. In our blood center, our medical director prohibits us from giving any information whatsoever because he feels like it is practicing medicine without a license. So there!

[Laughter]

MR. CONLEY: So there! I believe there was a question back here. Yes, please?

MS. BOONE: I just have a couple of comments. My name is Melissa Boone and I am from the Mississippi Valley Regional Blood Center in Davenport, Iowa. The first thing is that this morning a lot of people were talking about e-donor and Internet scheduling. We are doing this. It is working wonderfully. We scheduled 492 donors last month. The show rate is 100 percent. I can track that every single day. I can send a thank you note to each one of those donors for coming into the blood center via the Internet. I can also give them a reminder message 7 days prior to their appointment. It takes all of about 15 minutes per day to look at these appointments and do this scheduling. It is working wonderfully. I love it.

The other comment was on the cereal. Margaret Lewis contacted General Mills. General Mills sent us about 2500 sample boxes of two different types of cereal to pass out to donors with iron information. So, that is just something for feedback. She did it via the Internet. So, just basically some information. But if anybody wants information on e-donor, I would be happy to let you know about it.

MR. CONLEY: Maybe General Mills is practicing medicine.

[Laughter]

Did you want to make a comment? Go right ahead.

MR. MARKHAM: Is that real time or is it actually in e-mail that the donor is sending in some suggested times or can they actually see what the schedule is?

MS. BOONE: What I do is, I went in all the way until December of 2000, put my schedule in. Blocked out those appointments off of our regular Life Tech system, blocked those appointments out, and I gave one appointment every hour to donors so they could go in and say I want this appointment; I want this appointment; this appointment. They can pick in a 3-day period. So, they can choose their period from July 3 through July 6 and they will see every availability on those dates for whatever location they are requesting. So, it is in real time

basically because I have blocked those appointments out of the system so we don't put anything in there until we see those. The night before we will try to schedule those appointments if they have anything scheduled over the Internet.

MR. CONLEY: Very good. In the back?

AUDIENCE PARTICIPANT: A quick question for Mark and Jill. I really admire what you have done because it seems to me that what you are doing is taking the resources who are walking in your door and you are getting more product from the same people who are walking in by, one, decreasing your deferrals and, two, decreasing your shorts. My question is, you can only do that so far. Of the 60,000 units that you are collecting more per year, how many of those came from new donors or increasing donor frequency or whatever versus doing business more efficiently and qualifying the qualified donors and decreasing the short rate?

MS. SCOLAMIERO: I will answer part of the question. New donors was not our focus because it was our belief that if we wanted a fast rate of return we needed to look at our current sponsors and that would prove to be the most beneficial. That really worked out extremely well. Our first-time donor rate is only 11, 12 percent right now and it needs to be much higher. So, like everyone else

here, we are listening to some other regions and how they are dealing with that. So, that is the new donor part. We really looked to increasing frequency primarily from our existing donors.

AUDIENCE PARTICIPANT: So you are saying the bulk of that 60,000 came from just doing business more economically, reducing waste.

MR. THORNHILL: Yes, really. You said it better than we can. Really the potential is there. It is just focusing on doing it better. Again, as Jill mentioned, we would like to increase our first-time donor rate but the potential there regarding frequency is so high that just focusing on that will be very productive.

MR. CONLEY: Yes, right here?

MS. CONLEY: Kathy Conley, from Rhode Island Blood Center. First of all, I would like to thank everybody for their presentations this afternoon. I think they did an excellent job. Suzanne, you mentioned something about a doctor beeping or you being beeped when they are going to be doing a liver transplant to make sure there is enough blood. Do the hospitals share with you weekly what operations they may have that will be using large amounts of blood, or is it just on a one-time basis here or there?

MS. MCCOMBS: It is just the livers.

[Laughter]

MR. CONLEY: A written question. The FDA frequently has calls from individuals or groups concerned about being deferred on FDA policy. Obviously, the answer when they complain is, "well, I can't help it; it's an FDA rule." I was just wondering if folks have found a way to redirect that initiative, in other words, to find other roles for people who have been deferred but are interested in supporting the donation process? Any successes there?

MS. MCCOMBS: We have turned a lot of those people into research donors and they seem to feel pretty good about that.

MR. CONLEY: So there is one option. Anyone else?

AUDIENCE PARTICIPANT: We have a volunteer program and a lot of our donors that end up being permanently deferred that have been long-term donors come on board and help us with picking up blood at drives, and calling, and putting labels on envelopes, etc.

MR. CONLEY: Wonderful! Yes, go ahead, Bill.

MR. TEAGUE: We have found a very appropriate role for permanently deferred donors, and we always tell them that is temporary based on future changes in the regulations, but we have a speakers bureau and many of them make very good speakers to go out and talk to groups about

I would if I could. I can't give blood anymore but one way I can support the program is to come out and tell you how badly it is needed and how easy it is, etc. So, I think Suzanne is right, I think if we look for a place those people can be made to be very happy while they are in the parking lot, waiting for the regulations to change.

MR. NICHOL: Just to add to that, Gil, as I mentioned earlier, we have a donor ambassador program which has been able to use a lot of deferred donors who are just looking for some way to continue to participate. That is an ideal setting for the right kind of individual who likes to talk to folks and stay involved in the donor program. We have found that to be quite successful too.

MR. CONLEY: Are there any other questions from the floor before I read one last one?

[No response]

Hopefully, this one won't keep us here all night. Donor incentives are on everybody's mind. In your opinion, what is and is not acceptable? Is anything that has a monetary value bad? That would knock out a lot of blood center programs -- free movie tickets, baseball tickets, etc. What is the viewpoint of the FDA -- clearly?

[Laughter]

We said earlier that there is a guidance document under development, and I know there is a group working on

it and I am not part of that team. Basically, it is anything that can be easily convertible to cash. I know that is something we object to. Anything of significant value we object to -- and what significant value is, I think that is trying to be defined. Is that it in a nutshell, Les?

MR. HOLNESS: Les Holness. Yes, that is basically it, Gil. I just want to say that the group that is working on it works on individual case by case basis on a lot of these cases. So, although that is the test that is used, what you mentioned, many of the incentive programs are looked at on an individual case by case basis.

MR. CONLEY: And, as Bill mentioned earlier today, that group, if you contact them in advance, they sit down as a committee and discuss it and do try to come to a prompt decisions about issues. It is always a problem when we get a call on a Friday afternoon at three o'clock that says that a radio station just called us and they want to offer thus-and-so for the Saturday blood draw. We really can't turn it around that quickly.

Any other comments on what is a good incentive/bad incentive? And, you all said you don't offer any.

MR. THORNHILL: Well, first of all, we have the luxury of having also state law that is actually even more

conservative than FDA with the New York State licensure. I want to emphasize for our region and I think also the Red Cross the benefit of having that law because our belief, which I think has been shared by all colleagues here, is that the motivation should be altruistic for giving blood, and it is our belief that a dependency on material incentive is short-lived and also it is very expensive and will probably be a long-term proposition. So, it is our belief that to sustain the habit of altruistic giving is really our challenge and we are fairly firm on it.

MR. CONLEY: Any other comments on incentives?

MR. WARNACK: Well, I guess the only advantage I could see for incentives, and it was mentioned before, if you are giving out T-shirts or something, it should be used as promotion or advertising or marketing the organization. So, if it is some sort of giveaway that is just going to end up in someone's drawer, then I wouldn't really see the point. We have a warehouse full of license plate frames but we are starting to see those out and about a bit more.

MS. SCOLAMIERO: The only incentive that we have to have -- my belief, obviously we need employers to allow employees time off to donate. I mean, that is just sort of a black and white need. But in some ways, for us, we don't have a lot of competition in our region but it really

levels the playing field and everybody is really good with no incentive because they know nobody else is getting any.

MR. CONLEY: I think that has been driven home for me today. I mean, we have heard about the successful program, RX Partners, and in calling around to try to set this program up, I heard from people in Atlanta and from people in Delaware that they had positive spinoffs and donations for that program. I talked to the people in Delaware who have done a corporate-sponsored program with Discover card that is growing into other credit card groups in Delaware, and I am amazed and pleased at the success of those corporate programs, especially knowing because I presumed -- this was questioned earlier -- that people could realize a tax deduction for the expenses that they were putting into that. So, obviously, that is another hard sell for our recruiters to go in and get the corporate programs set up.

Before I recap for tomorrow morning, I think again our speakers deserve a hand for the entire day.

[Applause]

Tomorrow morning we will begin the actual session at 8:30. We will be in Natcher, which is across the road and has many small meeting rooms. One session will start at 8:30. There will be a break between sessions, and the second will start at 10:10. I looked at the list earlier

today and they look pretty well evenly divided so we probably will not have to do any reassignments of folks. So, you should be attending the session you want to. Joe will be looking tonight at the numbers so he can assign the groups to the most appropriate room over at Natcher. Those lists will be posted here tomorrow morning. They will also be posted prominently in the front lobby area of Natcher as you come in so that you can find your place. If you would like to come here first, there will be another Continental breakfast in the lobby here, as there was this morning. They were set up by 7:30 when I cam in this morning so they should be here that early again, and you are welcome and encouraged to join us for that Continental breakfast.

We will break for lunch after our meetings tomorrow. Again, there is a cafeteria here and there is also a cafeteria in the Natcher Building. You can use either one of those. Then, we will reconvene here and the facilitators will give the reports for the two sessions that were held in the morning.

There are two substitutions for the facilitators. We have people who cannot make it to the meeting. Elizabeth Callaghan will be facilitating the session on incentives and I will be facilitating the session on donor retention/donor satisfaction. So, we will see you there in

the morning. If you have not signed up for a group tomorrow, the sing-up lists are still outside.

MR. EVANS: I have a question, Gil. Is there a place to store luggage if we are going to be leaving directly from here?

MR. CONLEY: Joe will make those arrangements in the morning and you can check at the registration desk in the morning to see how to handle that.

Thank you, all, for your attention and I will see you in the morning.

[Whereupon, at 5:00 p.m., the proceedings were recessed, to resume on Friday, July 7, 2000 at 12:30 p.m.]

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