BACKGROUND AND VALUES

SI: You have written and spoken about the importance of social justice and the need for equity in health and health care. I imagine that these reflect values you developed when you were growing up. Would you talk a bit about your early years and upbringing?

RLM: I was born in Nashville, Tennessee, at the hospital affiliated with Meharry Medical College. My parents were in training there, my father in surgery and my mother in pediatrics. When I was two years old, they moved from Nashville to Seattle, partly because my father had a chance to be a surgical resident in the public health hospital and partly because they felt that life in the Northwest, without Jim Crow, would be a lot better than what they had experienced in the South. Plus my father loved the mountains and the water.
In a lot of ways, Seattle was a very progressive place. But there were still vestiges of the times—racism, and a real lack of social supports for people who were poor. My parents had a practice—as side-by-side solo practitioners, really—in the Central District, where most of the African Americans lived. It was a typical transition neighborhood; most new groups of people to Seattle lived there at one time or another. I spent a lot of time in my parents’ office, one because I liked it and also because both of my parents were physicians with no child-care supports in Seattle so at times there was no other option. I recall the excitement when they would be called to the emergency room at night and my brother and I would go along and hang out at the nurses’ station or in the waiting room while they saw their patients, and then we’d all go home.

As a result, I got a chance at a very early age to see how what we now call “social determinants”—issues of education and the economy and job security—affect health and people’s willingness to seek health care.

**SI:** Beyond the influence of your parents, what else helped shape your values?

**RLM:** One of them was being part of the civil rights movement. As distant as it was from the South, we still had our version in Seattle. My mother was from Atlanta and she grew up in Ebenezer Baptist Church. Martin Luther King, Sr. married my parents and buried my grandparents. When Martin Luther King, Jr. came to Seattle to speak, he came to our house, and I got a chance to meet him—to spend time with this iconic figure and to absorb his values. The importance of being engaged in the movement, of fighting for civil rights and social justice, were themes in our household.

Another was seeing the importance of people having access to health care. I can remember a conversation with my mother in about 1968, when there was a recession in Seattle, and Boeing, one of the two major employers at the time, was laying people off. I overheard my parents talking about the patients who weren’t coming in to get needed services because they had lost their
insurance, and I remember asking naïvely what having a job or health insurance had to do with a person’s decision to seek health care. And my mother breaking it down—how much people can afford to spend on things like health care and how much they had to reserve for other things. And how when people don’t have health insurance, they are forced to make real choices between rent and medicine. I grew up hearing that and being influenced by it.

About that same time there was a mother of four named Odessa Brown, who had leukemia and was not able to get health care because she wasn’t insured. When she died, the community rallied to build a community health center and named it after Odessa Brown. It’s a clinic for kids based on the community-oriented primary care model, and my mother was its first medical director.

Thus, the broader issues of health and health care, social justice, and the importance of public health were part of my upbringing.

SI: When did you decide to become a physician, and a public health physician at that?

RLM: I always knew I was going to be a doctor, from the time I was three years old. I talked about it all the time, but became serious about it in middle school.

My father died the summer before I was to start at Yale, so I stayed in Seattle for my first year and attended the University of Washington. Since I was registering late, I had to scurry to find courses. As luck would have it, I wandered into the introductory course in public health. I hadn’t thought about how influential that was on my thinking until recently when I was thumbing through the textbook, which I still have at home, and realized that the lectures in that course gave me a public health perspective—even before I had gotten a medical perspective.

A lot of my values came from my experiences as a Robert Wood Johnson Clinical Scholar, where after a long period of being focused on the traditional parts of medicine, I was reconnected with people who were thinking about health services research and broader issues of health and health care.
SI: How did you get to business school after receiving your medical degree?

RLM: My husband, Bob, and I had moved to Boston because I wanted to go to medical school at Harvard and then train at Brigham and Women’s Hospital. When we finished our seven-year stint in Boston, it was my husband’s turn to choose which city we lived in. (We had agreed that we were going to alternate choices of cities so that neither of us got a career advantage permanently.) He got a faculty job in Philadelphia so we moved to Philly. I had planned to get an MPH after my residency. It turned out, however, that Philadelphia did not have a school of public health. But there was a business school, Wharton, with an emphasis on health care administration and policy. Since I wanted to get a perspective on populations and analyzing the world in ways broader than the individual patient, I went to business school in health care administration. I began to see how my career could be broader than having a research career that focused upon an enzyme.

SI: Though you developed a broad interest in health policy, you specialized in geriatrics. What was behind that decision?

RLM: My main interest was in health policy, and I believed that Medicare was always going to drive health policy. Additionally, between finishing my residency at the University of Pennsylvania and starting the Clinical Scholars program, I had worked as a primary care physician at Temple in Philadelphia. I loved it but found it limiting in the sense that I had spent a lot of years learning how to take care of very sick and very complex patients, and most of the people I treated were young, relatively healthy women. The few geriatric patients that I had were both intellectually stimulating and very satisfying to treat. Following the academic medicine model, where your specialty should align with your research interest, I decided that aligning my interest in health policy with a research and clinical specialty in geriatrics made all the sense in the world for me.

SI: How did that alignment work out in practice?
RLM: I spent my time as a Robert Wood Johnson Clinical Scholar trying to bring the three worlds together: clinical medicine, academic medicine, and health policy—all with a focus on geriatrics. Since medical school, I had aspired for a career in academic medicine, so I stayed on at the University of Pennsylvania as an assistant professor. At the same time, I began to develop a relationship with the health policy community in Washington.

But bringing it all together—the things I had learned in business school such as setting goals and using measurement to drive the advancement of those goals and the values I had learned in medical school about caring for patients and understanding their needs—was a challenge. In fact, a colleague of mine, Allan Hillman, and I taught a course at Wharton for several years trying to bring these two cultures together. Trying to be a bridge between the multiple venues was a theme for me at the time—and still is.

SI: Then you went to Washington?

RLM: Late in the first Bush administration, the Agency for Health Care Policy and Research, now known as the Agency for Healthcare Research and Quality (AHRQ), was established. The Secretary of Health and Human Services, Louis Sullivan, and the administrator, Jarrett Clinton, approached me about becoming the deputy administrator. At the time, pundits were saying that health care reform was going to be a big issue in the next election; it was something that the Democrats wanted and it was also on President Bush’s agenda. This agency was going to be involved in it, or so the word on the street said.

The position brought together all the things that I considered important. So against the advice of many of my academic colleagues, I went to Washington and commuted home to Philadelphia on the weekends for two years.

Within a year of my arriving at AHRQ, Bill Clinton was elected. When he started putting together work groups to lead his health care reform, he asked agencies for people who could go to the White House to work on it, and I was asked to go.
I spent a year and a half working at the White House, first with the quality work group and then as part of the communications team. Penn’s policy dictated that after two years, I had to either re-up for another two years or return to the faculty full time. At that point, I had been commuting for two years and the time away from home and our young kids was tough; so I returned to Penn and academia. I used the platform of academia to work on the same issues, just with a much different perspective.

**SI:** How did you get to the Robert Wood Johnson Foundation?

**RLM:** I was moving along a wonderful trajectory at Penn and was starting to think about the next stage of my career. I had considered a number of leadership positions within academic medicine. After turning several down, it became clear to me that that wasn’t what I wanted.

Out of the blue Steve Schroeder called me and said that the position of senior vice president for health care was open—would I be interested? Initially I said no, but fortunately Steve called me back a couple of days later and asked, “Are you sure you’re comfortable with your decision?” “I’ve been rethinking it since you called me,” I told him. “Why don’t you come and talk to me?” he said.

That’s how I got to the Foundation. Boy, am I glad that Steve called me back!

**SI:** As you look back, who would you say are the people who most influenced you?

**RLM:** I would put my mother first. She taught me the broader sense of how social determinants came into play and motivated me to be a doctor. Sam Martin and John Eisenberg at the University of Pennsylvania were important influences in how I thought about things like measurement in research and improving quality of care.

With exposure to leadership from a broader perspective, it was less the people I came into contact with and more the people whose leadership style I admired. For example, Nelson Mandela
has talked about “leading from behind.” This approach suits my temperament, and I think that it has served the Foundation extremely well. It is also a style suitable for an organization that, as Steve Schroeder used to say, “doesn’t deliver any health care services, doesn’t make any products, doesn’t regulate, and doesn’t pay for it.” So our role has to be very much an indirect one.

---

**Goals and Strategies as the President and CEO of the Robert Wood Johnson Foundation**

SI: When you became president in 2003, what did you hope to accomplish?

RLM: You’ll recall that in 1999, the Foundation had divided into two program groups: the health care group, which focused on the delivery of medical care, and the health group which concentrated on the nonmedical factors, such as smoking and diet, that influence people’s health. When I became president, the Foundation was still dealing with that reorganization. The people on the health side were concerned that they were never going to catch up to the health care side in terms of funding, and the people on the health care side questioned whether we needed to have this separation at all. I felt that we needed to develop a balanced yet integrated approach to health and health care. That was the stimulus for the Impact Framework.

Also, as a foundation, we were struggling with how we did our work and who we were. We still referred to ourselves as “grantmakers.” We spoke about the importance of strategy, and about the importance of communications. But we hadn’t put it together in a comprehensive way. By observing how the staff worked, I was able to develop “the five Cs” as a way of describing how we accomplished our objectives and created impact.

---

*Editors’ note: The complete quote from Mandela is, “It is better to lead from behind and to put others in front, especially when you celebrate victory when nice things occur. You take the front line when there is danger. Then people will appreciate your leadership.”
Third, I felt that we had been defined by major contributions in tobacco control and end-of-life care, and that we needed to have other areas that could similarly define us. So I began reading and talking to people about the big problems facing health and health care that others were not taking on in a major way.

SI: After you assumed office, the words “social change” were used frequently in describing the work of the Robert Wood Johnson Foundation. What do you mean by social change and why is it important?

RLM: The concept of social change goes back to our mission—“to improve health and health care for all Americans.” The most important word to me is “improve.” That’s an action verb, and for us to improve health and health care, we have to look at social structures and the norms that our country abides by—and to change them. I look at social change as a transformative change that results in the lives of people being measurably better. I put the kinds of things that need to happen to improve health and health care on a par with other major social advances in this country, like civil rights and education reform.

SI: You mentioned earlier “the five Cs” as tools the Foundation uses to bring about social change. Could you describe the five Cs and why they are important for the Foundation?

RLM: In 2001, when I came to the Foundation, we were transitioning from thinking about ourselves primarily as grantmakers to thinking of ourselves as agents of social change. But although there was a lot of discussion about creating social change, we still talked mainly about our grantmaking and our grantees and getting money into the field. We didn’t describe the other activities that we engaged in. For me, the five Cs were a way of summarizing what I heard the staff say they were doing here, about how we can use all of the tools available to philanthropy to create social change.

* The five Cs are discussed in detail in chapter 4 of this volume.
It was clear that we spent a fair amount of time and resources on communicating results and doing it in a strategic way to get the information in the hands of the people who could make decisions. As part of everything we did we were always convening. We saw ourselves as a neutral convener. We were often the bridge connecting ideas and people. We also played a role in coordinating a lot of the different work, something we talked about frequently. And since I wanted to make it alliterative, I struggled with how to characterize evaluation and our commitment to measuring, and I came up with counting. Those five are all parts of the work that characterizes the Robert Wood Johnson Foundation. But because we were spending so much of our time talking about the cash (which could count as a sixth C), we weren’t conscious of them.

SI: You also developed the Foundation’s “Promise” shortly after you became president and CEO. Where did it come from and what is its significance?

RLM: The Promise was our way of talking about what we saw our brand to be—what distinguished us from others.* But the resistance from a lot of the staff led us to avoid the word “brand,” which was seen as something that industry does. I remember some staff members saying, “We’re not soap; we don’t need a brand.” So we developed another way to describe the concept of a brand, to tell our audience what differentiated us from others and what it is that we promise to do. We then went about a process to understand how others saw us and how we saw ourselves. Through that process, we came to understand that the field had a much better sense of what our promise was than we had internally. It was folks outside who said, “You take on the big, important things.” “You have a rigorous approach to producing evidence that can be used for policy change.” “You want to make a difference.” We said, “That’s what we try to do. We just never talk about it like that.” And that’s how we came up with the Promise.

* The Promise is included as Appendix A.
SI: There is another, shorter document, the Foundation’s “Guiding Principles.” Why and how was this developed?

RLM: Early in his presidency, Steve Schroeder had developed a document that was called the Foundation’s “Core Values”—patterned after the credo of Johnson & Johnson—that described our responsibilities to various constituencies. He developed it at the prompting of Jim Burke, a Board member and former CEO of J&J. As part of the interview process and of my study of the Foundation and J&J, I learned that when Burke became the chairman of J&J, he asked everybody to reexamine the company’s credo. After a great deal of analysis and discussion, the J&J leadership recommitted to it. It’s been written that the values expressed in the credo made it easy for J&J to do the right thing when the poisoning of Tylenol came along.

When I stepped into Steve’s shoes, we were in a period of redefining ourselves. We had the Core Values document, but it was not as accessible as it should have been. So we engaged in a similar kind of exercise as J&J had. We had small groups examine the language, and then we had an active discussion throughout the Foundation. The result was our Guiding Principles, a document that represented what we aspired to do and how we aspired to conduct ourselves.* We put it on the wall and on everyone’s desks, and we use it as our touchstone.

SI: At about the same time, you were developing an Impact Framework. How did this come about and what did you see as its purpose?

RLM: The Impact Framework is the way we conceptualize our programmatic work; it articulates our priorities. The concept of multiple portfolios, each with a set of characteristics that it tries to stay true to and which contribute to the overall mission, came out of our understanding of mutual funds. Just as mutual

* The Guiding Principles are included as Appendix B.
funds have different portfolios of funds for low-, medium-, and high-risk investments, the Foundation could also diversify its portfolios, though along program lines. The idea was that once you have these defined, you could dial them up or dial them down, depending on your assets, the external environment, and the probability of success.

The Foundation’s Portfolios and Priorities

Childhood Obesity

SI: Let’s turn to the Foundation’s different portfolios and the different priorities. Perhaps we should start with childhood obesity—the one that is most public and most identified with your legacy.

RLM: When I became the Foundation’s president, I was looking for an issue where the Foundation could have a significant impact on improving the nation’s health, much as we have had in tobacco. Based on my research, two rose to the top—quality of care and childhood obesity. Another possibility was health insurance coverage, but at the time, an expansion of coverage seemed almost impossible. And we were still reeling from the defeat of health reform during the Clinton years.

Around the time I first joined the Foundation, the Surgeon General’s report on obesity came out. It said that childhood obesity was a largely underappreciated problem, one that had been accelerating for nearly a decade and a half and that no one was taking on directly. As I was preparing my first president’s message, I remembered that report and thinking, “Tackling obesity would be perfect as an issue for the Robert Wood Johnson Foundation. It’s a big challenge. It’s hard. It’s messy. And success would really improve the nation’s health.”

We had a series of meetings with the staff and with the Board about what it would mean to take on childhood obesity.
A lot of people were daunted by it. They questioned whether it wasn’t mostly about personal responsibility for adults and whether beleaguered schools would be able to change and, say, add more physical activity and serve healthy food. In the end we agreed that we should explore what could be done about childhood obesity, which was rising to alarming levels. This is similar to the approach we’d adopted in tobacco: focus on children. And it built on things we were already doing, such as promoting physical activity and improving the built environment.

Next we discussed whether we should take a clinical approach or a prevention approach to the problem. Jim Marks, the senior vice president for health, insisted that we take a preventive approach. Then the childhood obesity team honed the strategy. We agreed to concentrate on an age group—schoolchildren—where we had a significant number of policy levers; to concentrate on the energy-in and energy-burned equation; and to attempt to influence that from a policy perspective. Our trustees reminded us of our obligation to focus our efforts on the most vulnerable populations.

SI: You declared that not only was the Foundation’s goal to halt childhood obesity, it was to reverse it. And you committed a large sum, $500 million, to the effort. What prompted you to do this?

RLM: I said we needed to have a goal, by a specific date. The childhood obesity team wrestled with this and concluded that the first thing we could do is to halt the rise. But Jim Marks said, “No, that’s not good enough. We’ve got to reverse it.” I then stuck our collective neck out by making it public. My reasoning went like this: I knew roughly how much money we were likely to spend on various large childhood obesity efforts. So rather than retrospectively saying, “We spent $500 million to combat childhood obesity,” why not say in advance, “We are going to spend $500 million on childhood obesity.” If the Foundation said that, others would sit up and think, “This is clearly a big problem, one deserving of the nation’s attention.”
So we announced a commitment of $500 million to reverse childhood obesity.

SI: How do you think things have been going and what big challenges are left?

RLM: I feel very good about how much progress the nation has made. With a problem like this, the first thing you have to do is to raise awareness and get a common agreement on the nature of the problem and an approach to solutions. It would be hard to find very many circles in which people don’t see this as important. No matter whom you talk to—people in the military, business leaders, school administrators, cab drivers—everyone understands the importance of the issue. There’s also a great appreciation about how the solutions require work across sectors. People acknowledge the important role of parents, but they also understand that business, urban planning, transportation, schools, and communities have to be involved. Today, there is an appreciation that just wasn’t there in 2001 or even in 2003.

There are now pockets of real hope, in the sense of communities seeing a downturn in, or even reversals of, childhood obesity rates. Childhood obesity in Arkansas has gone down. California has documented a reversal of childhood obesity in some places. New York City; Philadelphia; El Paso, Texas; West Virginia; and Mississippi have seen successes as well. The Healthy Schools program, which takes a comprehensive approach, is demonstrating a decrease in body mass index (BMI).

A lot still needs to be done. First, we’ve got to get beyond isolated pockets of hope. Second, we have to address clinical needs in addition to preventive needs. Otherwise, we’ll lose a whole cohort of kids who are already overweight or obese. Then the business case needs to be continually made to the food manufacturers. These, along with structural changes in our environment and incentives in how we spend our days, will sustain the reductions in childhood obesity we’re beginning to see.

Even though there remains a lot to do, the fact that change is taking place in some areas—in a relatively short period of
time—is enormously positive. In comparison to the length of time it took the tobacco-control community to start showing change, this is a much more accelerated time frame. I feel very good about that.

**Coverage and Access to Care**

**SI:** Expanding health insurance coverage and increasing access to care have been Foundation priorities since day one. The Foundation was active in the efforts to enact health care reform in the early 1990s, and received some criticism for its activism. What did the Foundation learn from that period and what did it do differently in 2009–2010?

**RLM:** Recognizing that a major policy change such as health care reform is a long-term proposition and that there is always going to be opposition, we maintained a strictly nonpartisan approach. We knew we were going to be in it for the long haul and that we would have to work across the aisle. So we developed principles of coverage but did not endorse any one approach to achieving them. We supported research that spoke to both sides. The consciously nonpartisan approach that we took, the principles for coverage that we developed, and the relationships formed with people across sectors—such as business and labor, insurance companies, and consumer advocacy groups (what we called the “strange bedfellows”)—came out of our having been perceived as being aligned with groups that had a particular agenda in the 1990s.

At the same time, we know that expanded health insurance coverage is something that Democrats advocate more than Republicans. Cost reduction and quality improvement, on the other hand, are issues that often get bipartisan support. Our work on quality, particularly outside the Beltway, has been enormously helpful to our reputation as an organization looking to find solutions. And our support of activities both on the ground and at the federal level has added to our credibility.
SI: Now that the Affordable Care Act has passed, how is the Foundation positioning itself?

RLM: We’ve set a goal of having 95 percent of the people enrolled in insurance by 2020. The other big issue for us is cost. As a country, we are going to have to come to grips with the need to provide higher value care: better outcomes for the amount of money we’re spending. We are building into our work an increasing emphasis on cost and value.

Similarly, we’ve started looking within our human capital portfolio at the policy questions vis-à-vis the workforce that must be addressed. This isn’t saying that we’re going to develop more fellowship or scholarship programs. Rather, we want to be engaged in helping develop policy solutions that will allow us to address the need for additional health care workers, especially primary care professionals, required to care for so many newly insured Americans.

Quality/Equality

SI: Why did you create a team that links quality and equality?

RLM: We have a long history of attempting to eliminate or decrease disparities, going back to the days of our first president, David Rogers. We funded programs to train minority faculty members and to help minority students, and we saw increasing access as a way of reducing disparities. I was on an Institute of Medicine committee that looked specifically at how to reduce disparities in the health care system. One of the conclusions of that committee was that quality improvement might be a way to reduce disparities. As president of the Foundation, I wanted to act on this IOM report. As we were going through the process of honing in on fewer strategic objectives, the idea that we could create a bridge between the two communities by linking quality improvement and disparities was a natural for us.

SI: What have been the priorities of the quality/equality team and how do you feel about the progress in achieving them?
RLM: Quality is another of those areas that has been on the Foundation’s radar screen for a long time—and where success has proven elusive. In the 1990s, we gave a great deal of attention to developing the tools to measure quality and the organizations to set and uphold quality standards: The Joint Commission, the National Committee for Quality Assurance, and the National Quality Forum. I think that these, plus our support of The Dartmouth Atlas and the quality team at Dartmouth, have paid dividends. Now, we are mainly focused on improving quality on the ground through our Aligning Forces for Quality program, which is working with providers, payers, and consumers in sixteen locations. It’s still too early to tell what impact the program will have, but the early reports are encouraging. And with the exception of the last eighteen months, health care costs have continued to rise, making it more important than ever to find ways of providing, and paying for, care based on its value.

Public Health

SI: How would you assess the Foundation’s work to improve public health?

RLM: Public health was one of the teams that came about as the result of several different areas merging: our ongoing tobacco-control work and the incipient work shoring up the public health infrastructure. Bringing the two areas of work together was a struggle at first. We are now looking broadly at what we need to do to put prevention more firmly on the national agenda and to build an infrastructure to support that effort. The rewarding part of this is that people in the fields of public health and prevention have appreciated the fact that the Robert Wood Johnson Foundation has highlighted the importance of what they are doing and is getting more people to pay attention to their work. So I think that’s been successful.

What’s different about our priorities in public health compared with some of the other portfolios is their breadth. Therefore,
it’s a little harder to define success. We’ve defined it as modernizing the public health system, but as we’ve heard in the midcourse review of our public health programs, it’s not clear to the field exactly what success will look like.

**Human Capital**

**SI:** As you look back on the Foundation’s work to develop human capital, which dates back to 1972, what is your feeling about its impact and where do you see it going?

**RLM:** I think that it is one of our most successful areas, if not the most successful one. When you look at how external groups rate us, human capital always comes out at the top. When we talk to former fellows, they often tell us that the fellowship transformed their career. Another measure that we look at is the percentage of the top positions in American medicine filled by former Robert Wood Johnson Foundation fellows. The percentage is very high, something like 37 percent.

The strength of the human capital team is the three thousand fellows and other alumni. I would like our network of former fellows to become as valuable to us as alumni are to universities—a pool of people who really are our reputational capital. Internally, we are still trying to figure out the best ways to draw on that enormous resource, and I want us to focus on that over the next few years.

I should also signal our work in nursing, which is a priority of the human capital team, as it has been for the Foundation since its earliest days and was for our founder, Robert Wood Johnson. Over the years, we’ve sought to strengthen the profession from a wide range of angles—training nursing leaders, strengthening care at the hospital bedside, and supporting research, among others. Most recently, we funded the report of the Institute of Medicine on *The Future of Nursing*. The report emphasizes the critical role that nurses play in improving the quality of patient care and provides a comprehensive platform for the full participation of
nurses. We recognize that this will take time, and we are in it for the long haul.

**Vulnerable Populations**

**SI:** Turning to vulnerable populations, how would you describe the work of the vulnerable populations team and how has it evolved?

**RLM:** When I first came to the Foundation, we talked about areas that were strategic and other areas that were opened up by people who were good at prospecting—people such as Terry Keenan, who were able to find those really great programs, the nuggets that needed to be developed, and who would then foster them. But because this kind of programming wasn’t seen as strategic, a lot of people at the Foundation did not consider it to be valuable.

At the same time, we were always talking about how to take projects to scale. What the vulnerable populations team has defined as its niche is the perfect blend of the two—finding the nuggets and providing the additional resources to take them to a bigger scale. Programs like Playworks\(^2\) and Green House\(^3\) are well on their way. There are going to be others that won’t get that far but which, with our help, will grow and serve many more people. Thus, we are using our skills to identify innovative programs that address the social determinants of health, and we are nurturing those programs and taking them to scale, in the ultimate hope of finding other partners that will continue supporting them. I think the vulnerable populations portfolio has been a great success.

**Pioneer**

**SI:** Last, but not least, how do you view the work of the pioneer portfolio?

**RLM:** Pioneer is the newest of all of our concepts. It has defined what it means to invest in something that is truly innovative—something that brings an approach from a different
industry to health or health care and has the potential to change dramatically how we do our work—ideas such as Project ECHO or the OpenNotes program or, a few years ago, Games for Health.

Where we’ve struggled is in connecting the ideas that emerge from the pioneer portfolio with some of the other things we’re doing. For example, we have a strategy in childhood obesity, but there is a lot going on related to childhood obesity that doesn’t fit within that strategy, some of which could be real game changers—like some of the Games for Health, for example. If you were to get some of those games in schools, it could revolutionize the way kids get physical activity.

Project ECHO is another.\(^4\) I remember ten years ago, we were struggling with the problem that poor people were not getting specialty care. One of the things that struck me in the Project ECHO video is that Sanjeev Arora, who developed the idea, said that there are shortages of specialists everywhere in the world. And when I heard Dr. Arora lead with that, I thought, “Here’s something that has been a problem for a long time, and he has a very innovative way of dealing with it.” We didn’t come at it by saying to the pioneer team, “Here’s the problem we’re trying to fix—lack of specialty services in underserved areas. What can you do to solve that?” It just happened that way. I’d like to see it happen more frequently.

I’d like to see the pioneer team identify areas that might become important priorities for the Foundation in the future. It would be a great story if ten years from now we are moving in a new direction because of a little tiny something that we explored in the pioneer portfolio.

**Enterprise-Level Programming**

**SI:** Let’s talk about enterprise-level programming. What is the “enterprise level” and what is its purpose?

**RLM:** It gets back to some of the early concerns expressed after we divided the Foundation into health and health care
groups: that we were never going to take on big areas that don’t fall neatly into one or another team. That we were not going to be a single foundation any longer. The enterprise-level programs address those concerns.

A lot of the work we think is important doesn’t fall neatly within one team or another. This kind of work, which cuts across teams, we have termed our enterprise-level work because it involves the enterprise—the Foundation—as a whole. There are many examples. Take, for example, reducing health care costs. It has implications for our work in quality, coverage, prevention, and vulnerable populations, and yet none of those teams can concentrate on it, so it becomes an enterprise effort. We envisioned enterprise as an opportunity for someone who has a really great idea that addresses the enterprise as a whole to write it up and present it to senior management. If it’s approved, that person can oversee the program.

We’ve always had enterprise-level work, like *Health Affairs*, Grantmakers In Health, The Center for Effective Philanthropy, and the National Health Policy Forum—even the *Anthology*. We have simply identified it and given it a name.

**Impact Capital**

**SI:** Related to these points, there has been much talk in philanthropy about the use of “impact capital,” that is, nontraditional ways of funding programs. How has the Foundation used this and what do you see as its future?

**RLM:** One of the things I’ve noticed is that some philanthropies working in other social areas employ their capital more adventurously than we in health and health care do. If you look at education or the environment, foundation leaders are talking about using mission-related investments and double- or triple-bottom-line investing. In health and health care, we have been relatively limited to grants. The Robert Wood Johnson Foundation has done some program-related investments, but not very
many. One of our challenges is to use these diverse financing mechanisms more effectively.

---

**Evaluation and Communications**

**SI:** The Foundation has always given great importance to evaluation. Would you describe how you view its role currently and in the future?

**RLM:** I think evaluation has evolved in interesting ways, and the research and evaluation unit is in the process of defining a different role for itself as the Foundation has become more focused. We’ve done program-by-program evaluations, and we’ve examined clusters of programs as the *Anthology* does. We’re now working with two innovations. First, we are doing midcourse reviews of some of our strategies. Based on what we find, we can make adjustments in the programs or the balance among programs. Second, we are looking at how we’ve done in a body of work that has largely closed—what we call “retrospectives.” We’ve done retrospectives on chronic illness, tobacco, end-of-life care, and substance abuse. When we start to integrate what we’ve found from all of the retrospectives, there are going to be some very interesting lessons for the Foundation and for philanthropy in general.

Second, we are adopting new methods, such as network analysis, in ways that are still to be played out but that I find very encouraging. We are continuing to ask ourselves if we can develop methods that will allow us to quantify the value of our work in more efficient, more rigorous ways than we’ve done before. Those are new approaches to evaluation that could be interesting and exciting for the field.

**SI:** And communications?

**RLM:** I believe that we have defined the field of strategic communications within the nonprofit and philanthropic areas. Tobacco was the success story. Close behind is coverage; we did a lot in coverage that others didn’t have the wherewithal to do.
Now, we’re defining how we can be strategic with a much larger audience.

We have always felt that because our resources were limited, we couldn’t afford to reach out to many people beyond the policymaking and stakeholder elites. But with the concept of Web 2.0 and social media, we are revisiting that. I’m not sure how it’s going to play out, but I believe we now have the opportunity to reach many more people in a very strategic way than we had, say, fifteen years ago. For me, that is the great challenge for communications.

---

**Assessing the Impact Framework and Team Programming**

**SI:** In retrospect, how do you think the Impact Framework and team programming have worked?

**RLM:** I don’t think we’re going to be able to say how well it’s worked until we’ve been through a complete cycle of a set of strategic objectives. But on the whole, I think it has worked pretty well. An issue for us has been that the teams managing the three nontargeted portfolios—human capital, vulnerable populations, and pioneer—have struggled with what their real purpose is. They wanted to be like the targeted portfolios.

The vulnerable populations team has gotten beyond that and has defined who it is and how it’s going to operate. The team is clear about what it does, and this is gratifying. The pioneer portfolio has given us a window into a great many interesting things. I don’t think we would be as far along on our Web 2.0 philanthropy thinking if it weren’t for the pioneer team. Nor would we have gotten into some really innovative projects like Games for Health and the OpenNotes project. The pioneer portfolio is still young. Its history is yet to be written.

Human capital offers an example of our ability to dial up and dial down, depending on the circumstances. Between 2000 and 2003, we had a huge budget for our coverage portfolio,
but when it looked like we weren’t going to get anywhere with expanding coverage, we started reducing that budget and putting more into human capital programs. Now we’re increasing coverage again and reducing human capital, which is painful. It’s not easy to dial things up and down. That’s a lesson we’ve learned.

Another lesson we’ve learned is that in the targeted portfolios, we’ve got to be really targeted. Four targeted priorities are probably about all you can handle.

---

**Management and Governance**

**SI:** Related to these points, I would like to get your views on managing the Foundation. Would you talk about the pros and cons of the team approach and how it’s evolved over time?

**RLM:** The concept evolved from being a group of people who did their individual programming while *calling themselves* a team to one where there really *is* a team. The change had to do with two things. The first was requiring teams to develop an objective with some measurements related to it. We had a couple of periods when we had to cut back on resources and when the objective and the team’s willingness to stick with it really had to be tested. Second, we gave real authority to the team director. Giving team directors the authority to make funding decisions and having people report to them brought decision making a lot closer to where strategic discussions were taking place.

The pros, I think, are that we have more programs that are on-strategy and the teams are very productive. The cons are, first of all, the risk of the Foundation becoming fragmented by teams; that’s part of the reason we began to concentrate on the enterprise as a whole. Second, it doesn’t reward those really creative, gifted program officers who are kind of Lone Rangers and who you don’t want to stifle. I’m not sure that the likes of Terry Keenan would have done well on a team.

**SI:** How are you avoiding, or minimizing, the downsides of a team approach?
RLM: The answer to the first danger, fragmentation, is our enterprise-level programming. We have deliberately kept enterprise-level funding small because we don’t want it to be a big part of what we do. At the same time, we want to provide an opportunity for those people who’ve got that creative spirit and see things in a broad perspective.

With regard to the second, nurturing innovative thinkers, we try to foster creativity in two ways. The first is through our pioneer portfolio. Pioneer is really a team made up of individuals who are good at prospecting. The other way, as I mentioned, is through our enterprise-level activities.

SI: Turning to governance, what do you see as the appropriate role for Board and staff, and how has it evolved over the years?

RLM: When I became the Foundation’s president, one trustee described the role of the trustees as that of being a super program officer. The trustees made it clear to me after a retreat that they wanted the Board to be more focused on strategy and policy and less on individual programs.

We’ve largely achieved that. Most of the time, the Board talks about our overall strategy, our program strategies, and our progress in meeting our objectives. We only occasionally highlight individual programs. I believe that this is the appropriate role for the Board.

At the staff level, we tend to cluster things a lot more, by team and by strategic area. The downside is that people want to do more things by team and don’t want to bring ideas to the entire program staff. There is a tension between, on the one hand, wanting to share information so that we function as a single foundation and, on the other hand, keeping decision making close enough to the people who know the material best. That tension will always exist.

One of the things that is a challenge and that I didn’t fully appreciate going into this—or even until fairly recently—is that we now have a Board with term limits, and we’re almost to
the point where we’ve replaced the Board completely. We are no longer going to have long-serving trustees who are on the Board for fifteen, sixteen, or seventeen years and have a great deal of institutional memory. It’s not happening anymore. But it’s important that the Board, even though limited by terms, feels a deep connection to the Foundation.

SI: How do you get that connection? And how do you get a Board with such political diversity to agree on controversial topics, such as health care reform?

RLM: First of all, you seek Board members with a commitment to the Foundation’s mission and work. I’ve learned that it is very important to choose people who have a history with the Foundation. Have they been a fellow? Do they know us through J&J and a commitment to Robert Wood Johnson? Have we funded them in the past? Have they had a connection as one of our collaborators? Are they from an organization that knows our work and shares our values? It’s hard to come into an organization like ours as a trustee if you don’t have something that connects you in that way. And, of course, we look for Board members who value our nonpartisan approach that seeks to find common ground.

Also, I spend a lot of time talking with the trustees, one on one, over the phone or in person. I try to visit them at least once every couple of years, in their own communities. When something arises that has the potential to be divisive or set a new policy, we set up a working group where we lay out and adopt general principles. Then, when it comes to the specifics of a project, the Board and staff have something to refer to for guidance. A good example is coverage. While our trustees had different views about how to achieve expanded insurance coverage, they all agreed with our principles that provided us with a framework for looking at health care reform—principles stating, for example, that everybody ought to have coverage and that care should be accessible and affordable.
The Role of Philanthropy

SI: As you look back over ten years, what have you learned about the potential for and limitations of philanthropy in bringing about social change?

RLM: Foundations have a serious limitation, of course: we cannot lobby. As a result, we can’t be as aggressive on particular issues as we might want to be. We get outspent and outmaneuvered in those kinds of situations all the time. Throughout the health care reform debates, which were pretty intense, we had to be quiet. That is the way Congress designed it, but it is enormously frustrating, when you have a good sense of the literature and you know the issues, to have to sit on your hands.

It is interesting how, over the past forty years, philanthropy has become increasingly transparent. We’ve helped make it like that. For example, publicly announcing our program goals and targets for 2015 is going to be a first for us and I think for any foundation. Once we’ve announced these, we will have to share publicly our assessment of how well we’ve done against them. In the past, when we changed directions, we were not quite as open as we are going to have to be in the future. It has forced me to think about how to do it, in a way that will serve both us and the field well.

The great potential of foundations is that they can choose difficult problems, stick with them for a long time, bring people to the table who wouldn’t ordinarily come to it, and eventually, get things done that other sectors won’t or can’t. That’s a real upside.
Appendix A: The Robert Wood Johnson Foundation Promise

We believe that good health and health care are essential to the well-being and stability of our society, the vitality of our families and communities, and the productivity of our economy—indeed, they are fundamental measures of our success as a nation.

Helping all Americans lead healthier lives and get the care they need is the mission of our Philanthropy. Our strategy is to identify major health challenges, seek bold, transformative solutions, and sustain our commitments until success is achieved. Our guiding principles flow from a sense of responsibility to all our constituents. In particular:

- To the nation, we pledge to tackle the greatest challenges to good health and health care for as long as it takes to achieve lasting results.
- To the most vulnerable among us, we pledge to pursue solutions that are effective, affordable, and equitable.
- To our grantees and collaborators, we pledge to set clear goals, forge strong and creative partnerships, and measure our work by transparent, evidence-based criteria that meet the highest standards of performance and integrity.

Through our actions we pledge an unyielding commitment to the philanthropic vision of our founder, General Robert Wood Johnson, whose remarkable business career and passion for improved health and health care made this work possible.

This promise is made by the trustees and staff of the Robert Wood Johnson Foundation.
Appendix B: Guiding Principles

Our mission is to improve the health and health care of all Americans. Thus, our fundamental responsibility is to help improve the conditions, policies and practices that protect and promote health and to improve the care people receive. Our philanthropy represents a public trust:

- We are stewards of private resources that must be used in the public’s interest and particularly to help the most vulnerable in our society.

As investors in and partners with other organizations, we depend for our success on our grantees and our colleagues in the fields of health and health care and related disciplines. We must promote new ideas by encouraging innovation:

- We must select grantees fairly.
- We must be responsive to our grantees and to the field.
- We must be objective, rigorous, and transparent in assessing grantees’ progress and the results of their work.
- We must communicate clearly and openly to the field and to the public.

Improving health and health care for all Americans depends on the performance of our staff at all levels:

- We must meet the highest professional and ethical standards.
- We must share a passionate dedication to our mission.
- We must commit ourselves to lifelong learning and continual improvement.
- We must represent different perspectives and experiences.
- We must respect the views of others.
Notes
