



President's Message

RISA LAVIZZO-MOUREY, M.D., M.B.A.

President and Chief Executive Officer

About 20 years ago, shortly after my husband and I relocated to Philadelphia, our daughter, who was about two years old, ran a fever for a couple of days. At first I wasn't too worried. I had recently finished my medical residency, which meant that my definition of "sick" had become pretty extreme. "Sick," to me, meant you were about to die. Not sick? Next patient, please. After being up with her most of one night, it became clear she wasn't getting better. When I woke my husband and said, "She's sick. I think we'd better go to the emergency room," he jumped out of bed and said, "OK, let's go," because he knew that I had to mean she was about to die. We headed to the emergency room, our anxiety mounting, trying not to fill our minds with a thousand "What ifs?" I had that dishevelled, frantic look you have when you've been up all night with a fussy kid. The physician looked at my daughter, looked at me, asked some quick questions, did a cursory exam, and said, "She's fine, go home."

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In formal health care-speak, this was “an absence of appropriate engagement.” And it immediately established a serious lack of trust between the doctor and this patient’s mother. In less formal language, I was steamed. I adopted a different approach with that emergency room doctor. I became more assertive, more intense, threw some medical terms back at her. Enough so that she called the attending physician, who ordered more tests, including a chest X-ray. What they found was that my daughter had pneumonia. Although we walked out of the hospital having gotten the appropriate tests and with the antibiotics we needed, it was not so easy to establish trust in that place and with that doctor. My husband and I talked about how another family—a family that couldn’t toss back the medical lingo, a family that didn’t have the confidence to question what was happening—might not have gained the attending physician’s attention, might not have received that vital X-ray. I still think about those families and those children. I know how frightened we were that night, but I knew in my heart that we would get help. I could make that happen. What’s exciting to me about becoming president of The Robert Wood Johnson Foundation is that, perhaps, I can help make “appropriate engagement” happen for other people, too.

ROOTS AND INFLUENCES

This is my own personal tale about the often abstract notion of access to high-quality health care, an issue in which this Foundation is deeply engaged. And having seen the system up close as a clinician, a teacher and a researcher, I’m personally committed to providing quality health care to all people equally. I am also an M.B.A., a parent and an African-American woman. I bring to this new challenge everything I’ve learned in these roles, plus the core value that has guided me in all of them—a strong passion for helping others. As a

geriatrician versed in chronic illness who made house calls most Mondays, I understand the fears and insecurities that individuals and families feel when the health care system fails them.

Significantly, I am a product of the Foundation. I’ve received much of my clinical training as the result of a fellowship—I was a Robert Wood Johnson Clinical Scholar from 1984 to 1986—so I feel a lot of loyalty, that I am carrying out the Foundation’s mission and have a strong personal connection to its work.

I also bring to the job a grounding and training in finance and management from my days as a Wharton graduate student and faculty member. The importance of measurement, of accountability, and of taking a disciplined approach to resource management and motivating people are all skills that I learned—and taught—in my business studies. They will guide me as I refine and recalibrate the goals, objectives and institutional brainpower of the Foundation, so ably developed over the past decade by my predecessor, Steve Schroeder. What I’ve found so extraordinary here is the passion and dedication of our entire staff to this Foundation’s core mission to improve health and health care, to make a tangible difference in the lives of all Americans. To a physician given an exceptional opportunity to lead, this spirit is infectious.

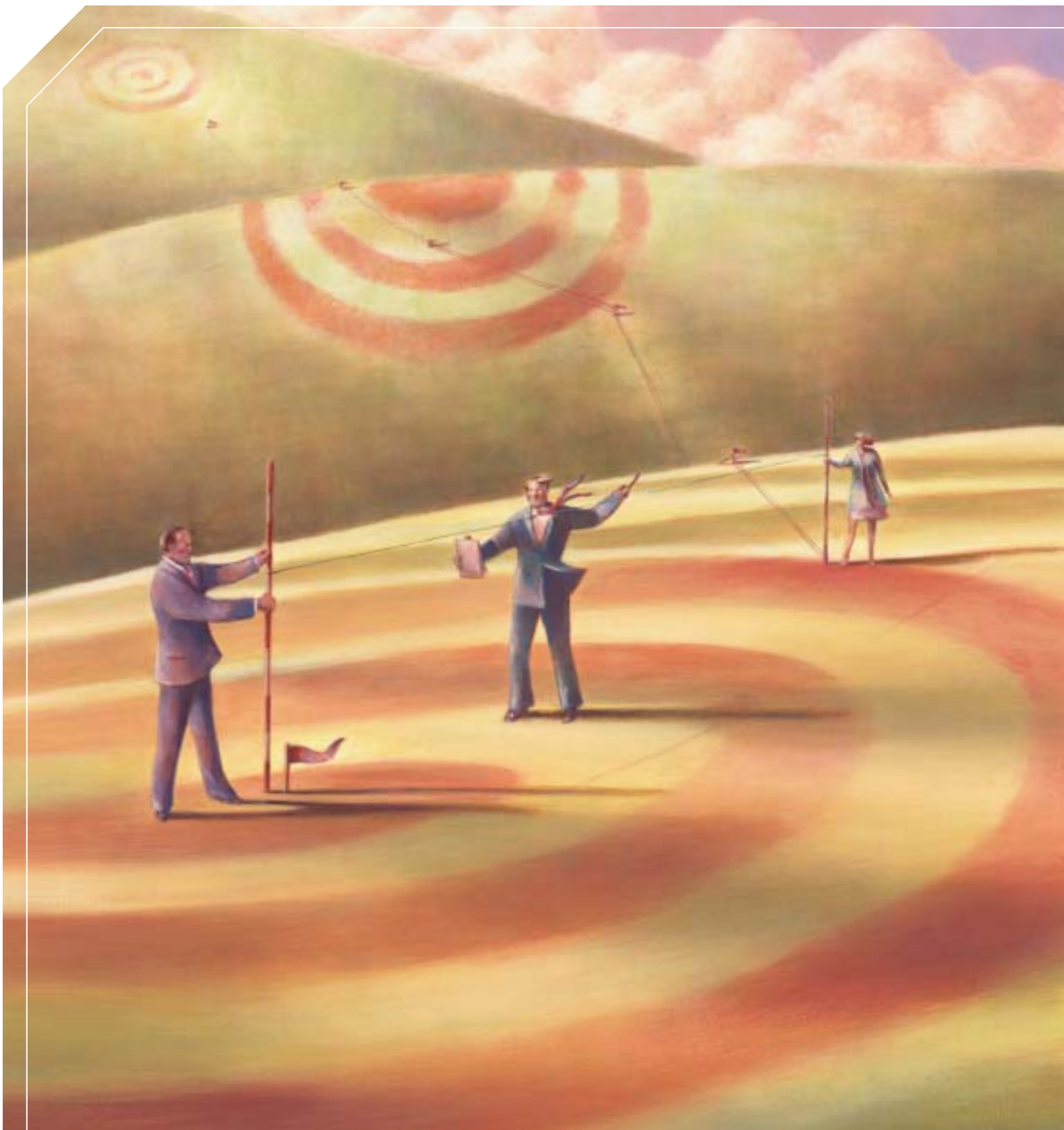
A TROUBLING REPORT CARD

If you asked people—both experts and rank-and-file Americans—to grade health care in this country, an overwhelming percentage would hand out a D. The system is not quite failing, but it is barely passing. This is particularly troublesome given our nation’s resources.

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gap is simply intolerable. Intolerable in the care they personally receive. Intolerable in the care their loved ones receive. Intolerable in terms of the growing number of uninsured. Intolerable in the rising cost of care. Intolerable in the occurrence of medical errors. Intolerable in the seeming inability of Medicare to provide for seniors. Intolerable when loved ones die in pain, alone, without the comfort and care they need.

And what about Americans' actual health? We are barraged by news stories—confirmed by our own personal observations—that Americans are increasingly and alarmingly reaping the undesirable rewards of sedentary and overindulgent lifestyles. We are overweight. Too many of us still smoke. We drink too much. We exercise too little or not at all. We indulge in a panoply of risky behaviors.

These system problems and these personal behavior choices are like two massive freight trains speeding toward each other, and we may not be able to deal in any kind of just and humane way with the aftermath of their seemingly inevitable crash. Our challenge is to try to prevent that train wreck.

THE FOUR PORTFOLIOS

Our four goals focus on access to care, chronic conditions, community health, and substance abuse. All of them include elements that address both system change and personal behavior. They can be pursued in various ways. Most recently, we have implemented a new defining framework through which our grantmaking will operate. It is a formal construct that acknowledges the different grantmaking techniques and styles employed at the Foundation, and helps us harness these varied approaches more effectively and hold ourselves even more accountable for the private funds of which we are stewards for the public's benefit. That construct

clusters our investments into portfolios. Going forward, the Foundation's grantmaking will fall into the following portfolios:

Targeted—Achieving specific improvements, in specified time frames, in nine issue areas: health care coverage, quality care, disparities in care, end-of-life care, nursing, tobacco control, addiction prevention and treatment, childhood obesity, and public health. A majority of our grantmaking is in this portfolio.

Vulnerable Populations—Identifying and fostering new and effective ways to deliver services at the community level to our most vulnerable populations, in efforts such as *Faith in Action* and our *Local Initiative Funding Partners Program*.

Human Capital—Improving the quality of the workforce and developing the leadership essential to improving health and health care. Many long-standing training programs—such as *Robert Wood Johnson Clinical Scholars*, *Robert Wood Johnson Health & Society Scholars*, and *Robert Wood Johnson Health Policy Fellowships*—are in this portfolio.

Pioneer—Seeking innovative, breakthrough ideas and approaches that may change the fields of health and health care.

The problems we face are national in scope, so even with our significant financial and human resources, we need to become more astute in identifying problems, defining time horizons and levels of investment, and holding ourselves accountable for accomplishing the objectives that we and our grantees set out to achieve. Our goal is to make a difference in your lifetime, and this framework will help us do that.

WHAT WILL CHANGE—AND WHAT WON'T

Under my presidency, I expect no radical departures from the past—in other words, evolutionary, not revolutionary change. We will focus on fewer issues, bringing more integrated strategies to a highly targeted set of program priorities. We will be looking two steps down the line in order to increase the chances that our grant dollars are paying off. We will put great emphasis on achieving and measuring concrete results. Grantees will find a much greater concentration on outcomes that signal systemic improvements, effect real social change, and bring discernible improvements to people's lives.

Over the past 30 years, this Foundation has touched the lives—and careers—of millions of Americans. But our nation continues to need large-scale momentum to bring about demonstrable improvements in our weakened health care and public health systems. The Foundation needs to harness and focus our enormous potential to garner public support to broaden and deepen our impact.

The Robert Wood Johnson Foundation has been an innovator and leader in the way we communicate our goals, our programs and, of course, our grantees' myriad accomplishments. I want our communications to become even better. We need to be more transparent about how we do our work, what we expect from grantees (and of ourselves), and how we evaluate our grant results. I want to make our key initiatives a constant part of the national debate and to find new venues to talk about the core issues that will determine the future health of all Americans.

What will *not* change is our Board's vision, compassion and dedication—the legacy of our founder, Robert Wood Johnson—and the energy and resourcefulness of our staff and grantees in implementing that vision. While we are proud of what has been accomplished and look forward to the successes that we believe lie

ahead, we are humbled by the magnitude of the task. We will continue to “work smart,” but we are neither omniscient nor omnipotent. The sea we seek to navigate is wide and deep and, even with the considerable financial and intellectual assets at our command, our boat is still quite small.

NEW CORE ISSUES

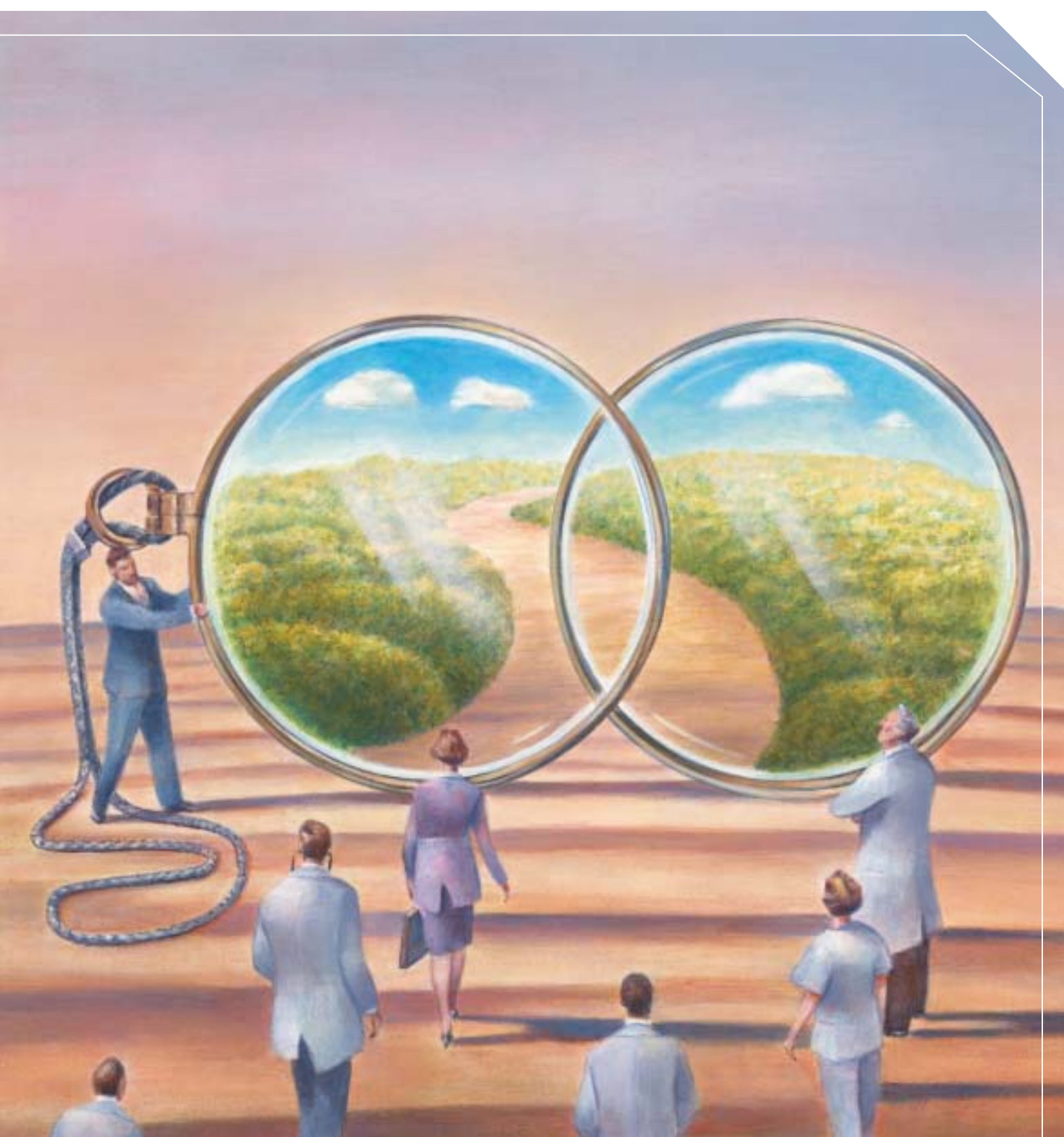
Many items in the portfolios will seem familiar issues for RWJF. Here's my thinking about some of the newer issues that will be at the top of our agenda in the next few years.

Nursing: When we think about the future of health care, it will be the nurses and other front-line workers who will be on the leading edge of change. Over the next decade, we are committed to a thorough re-examination of the ways in which nurses interact with other health care providers. In the hospital setting, particularly, these relationships have to be retooled to adapt to shifting circumstances that include:

- An aging population with many complex chronic conditions.
- A hospital nursing workforce whose average age is 45.
- A disconnect between the existing workforce and an increasingly diverse patient base.
- A lack of professional autonomy coupled with institutional cultures that inhibit nurses from pressing for needed changes.

The nursing profession is in extremis, and our nursing initiatives, which will focus on improving the hospital work environment, will be at the core of our increased emphasis on health care quality.

Quality: We must redefine what “quality health care” means to Americans. All too often, the term “quality” defaults to simplistic notions of more-is-better,



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get-it-when-you-want-it, and having-the-latest-and-best-amenities. People almost never define quality care as timely, efficient, cost-effective or patient-centered. When I think back to that night in the emergency room with my daughter, what we wanted was timely care, not fancy waiting rooms or the newest, most expensive antibiotics. Current thinking seems to have locked providers into a permanent growth cycle, adding new services, new wings, whole new specialty hospitals. Inevitably costs go up. But challenge administrators on the *quality* of these new services, and you learn that they perceive quality initiatives as an expensive “add-on.” My fervent wish is that 10 years from now people will understand we can't afford *anything other than* quality care. It's the only kind of care that we should accept, that should be delivered, and that should be reimbursed. And what does quality care look like? It's centered on the patient and family, based on the best clinical evidence, cost-effective and systems-minded—meaning that all disciplines and institutions work cooperatively. This paradigm is almost infuriatingly logical, but it requires nothing short of a revolutionary change in mind-set, which we hope to help bring about.

Childhood Obesity: America's social and cultural environment should make it easier for kids to eat right and be active. In our programming, we will focus on children because, in terms of this problem, they are the most vulnerable group in our society—the least autonomous, yet the target of a continuous barrage of unhealthy temptations. Recently, the *New York Times* reported that if the present trajectory in kids' eating habits holds, their generation is destined to have a shorter life span than adults have today. Such a regression is unconscionable.

Even people who believe that addressing children's obesity is primarily their parents' responsibility acknowledge how hard a job that is in the current

environment. I look back and realize how fortunate I was in raising my son and daughter. I was blessed with financial resources that many parents don't have, and my children attended a school that emphasized healthy foods and physical activity as a regular part of the day. How unusual that is becoming! Exposed to high-calorie non-nutritious foods, television, video games and neighborhoods that are not walkable, our children's bodies are like strangers in a strange land. The world has changed but their physiology has not. The challenge for the Foundation is to help communities create environments that are healthier for kids and to help parents encourage the right choices.

Vulnerable Populations: Too many people fall through the cracks of today's health care system. Sometimes because of age. Sometimes the problem is poverty. Sometimes it's culture or ethnicity. Sometimes it's race. “Vulnerable populations” cannot be simply defined. But what links vulnerable people together is the difficulty they have in navigating our nation's health care system or in protecting their own health. Typically, they need services from a number of providers and, because these component parts of our “system” often are uncoordinated, the likelihood of both redundant services and overlooked needs is high. A key challenge here for the Foundation is to locate the gaps in care, and develop new service delivery models—something we have considerable experience in doing. We need to find effective models that can be adapted to work at the community level, rather than waiting for a probably less effective, less flexible one-size-fits-all national solution.

Disparities: Various racial and ethnic groups experience the United States health care system differently, regardless of income, education levels, or location, as my opening tale helps illustrate. We can define and approach this problem in several ways. One that I believe will be particularly effective is to support

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efforts to develop evidence-based protocols for specific procedures, recognizing that care will never be completely uniform because it has to account for individual differences and preferences. Quick progress may be possible in some specific disease areas—cardiovascular conditions, for example—because the evidence of poor outcomes due to disparities in care is compelling.

PROGRAM CHANGES

One of the great lessons my predecessor Steve Schroeder passed on to me and our foundation colleagues can be found in his 2001 Annual Report message. It's the line from the Kenny Rogers tune, *The Gambler*: "Know when to hold 'em; know when to fold 'em." Foundations rarely support enterprises, or even fields, in perpetuity. There are always new fields to plow, new ideas to reach for, new players with new objectives and visions. The hard part, as Steve so aptly noted, is determining when to exit a field. We don't always get it right—it's hard to know when you've reached the tipping point, except in hindsight. In recent years, we've had some notable successes—in groundbreaking work on helping patients, families and providers deal with decision-making and care near the end of life, and in reducing the harm caused by substance abuse, particularly tobacco use.

We at The Robert Wood Johnson Foundation take pride in knowing that we've helped to build these fields and have contributed to the successes achieved by the many dedicated people with whom we're privileged to have been associated. Indeed, it is partly because of these successes that we feel prepared to move on to other critical health challenges—childhood obesity, disparities in care and hospital nursing. In the short run, we will continue to meet our past commitments to fund both prevention efforts related to tobacco and to other substances, like alcohol and illegal drugs, and end-of-life issues— for, to be sure, there are still considerable hills

to climb before unalloyed triumph in those fields can be declared. But we believe that the successes that have been achieved can be sustained with some additional support from The Robert Wood Johnson Foundation and with the continued robust efforts of our partners and other innovators in these fields.

GOOD PEOPLE, GOOD IDEAS

The prospects for The Robert Wood Johnson Foundation are bright. Building on the impressive legacies of my three predecessors, I am confident that our dedicated staff, grantees and funding partners truly can help to improve the health and health care of people in this country. We do this simply through investing in good people and good ideas. Throughout the various changes outlined in this message, this remains a constant. When you read the tribute to Terrance Keenan that follows, you will understand more fully what I mean and how I know that our staff, following Terry's example, will continue to find the good people and good ideas that the Foundation will be proud to support.



Risa Lavizzo-Mourey, M.D., M.B.A.

President and Chief Executive Officer



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Leadership Excellence Dedication

Sometimes, an organization gets lucky. Sometimes, an extraordinarily talented person emerges from its ranks and, simply by following his instincts, comes to personify what the organization is striving to be. Sometimes, that person contributes for a long time, cooking up a seemingly endless string of inventive ideas, leading by marvelous, inspiring example, and becoming beloved inside the organization and out. And sometimes, if it's lucky, the organization has a chance to offer a public thanks. The Robert Wood Johnson Foundation got lucky with Terrance Keenan.

In December, Terrance, or Terry as friends and colleagues know him, formally retired from RWJF after 31 years of service, but he remains a formidable intellectual presence, inspiration and contributor. He was with the Foundation from the beginning and, during his tenure, he helped expand the Foundation from a fledgling organization to an influential leader in improving the health and health care of all Americans.

"He was an ambassador at large for the world of philanthropy," said Edward Robbins, former director of RWJF's Office of Proposal Management. "Anyone who ever came into contact with Terry felt differently about philanthropy afterward. He cares about people, particularly those who are downtrodden, and that really came across."

Within RWJF, Terry's influence can be judged by the number of once-controversial ideas that he championed and eventually brought into the mainstream. His longtime friend and colleague Frank Karel, RWJF's former vice president for communications, offers a particularly Keenansian insight.

When RWJF first started making grants nationwide, Karel said, "We would parachute into a community, give some money to start something, and then when our three or four years of support were up, the people we had funded would start knocking on doors looking for more money.

Some of the small local foundations were getting upset." Terry's solution? A program that identified proposals from local and community foundations that meshed with RWJF guidelines and offered matching money up to \$500,000. The *Local Initiative Funding Partners Program* that Terry conceived is now properly recognized as one of RWJF's signature efforts. "It was an absolute stroke of genius," Karel said.

Similarly, Terry saw nurses as skilled medical professionals when most of the medical community viewed them as support staff. "He single-handedly encouraged the Foundation to become interested in nursing's contributions to primary care," said Rheba de Tornay, dean and professor emeritus at the University of Washington School of Nursing in Seattle and trustee emeritus of the Foundation.

Often a "love-hate feeling" simmers between grantees and the foundations that fund them—and there can be mutterings about arrogance and lack of sensitivity and responsiveness. Not so with Terry. Regarded as a consummate grantmaker, he has been especially appreciated by novice grant applicants because he worked hardest for them. If they had the germ of an idea, he was always willing to take the time and do the work to help them develop their thoughts and their plan.

In many ways, his *modus operandi* was an exact match with the Foundation's Guiding Principles: Always remembering that the organization represents a public trust; recognizing the primacy of new ideas and innovation; and demanding of himself and others the highest professional performance.

But Terry's greatest legacy may be the example he set for his peers and colleagues, said Steven Schroeder, former president of RWJF: "People have told me that he's their role model. They'd like to grow up to be like Terry Keenan."