



CHAPTER 1

Good Ideas at the Time: Learning from Programs that Did Not Work Out as Expected

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—w— **U**nwelcome as the news might sometimes be, there is as much to learn from foundation programs that fail to meet expectations as there is from programs that have met or exceeded them—perhaps more. The truth is that not every program can succeed as planned. “There have to be programs that don’t work out,” said Tracy Orleans, distinguished fellow and senior scientist at the Robert Wood Johnson Foundation. “If there aren’t, we are not doing our job—we are not taking enough risk.” Thus, it is not surprising that some Foundation-funded programs that seemed like good ideas at the time have not turned out to be so in practice.

The important thing is to learn from those programs that have not met expectations. A first step is trying to understand why programs did not work out as planned. Our review of



Foundation-funded programs that did not meet expectations* identified three primary reasons that they did not succeed:

The first is flawed strategy or design. Goals may be unrealistic or unreachable. Objectives may be unclear, or even conflicting. Various participants may have different ideas about what the goals are. Or the goal may be sound but the strategies to reach them problematic or unworkable.

The second is a difficult environmental context. Though the goals may be worthy, society is simply not ready for them or they may not be politically feasible. Or conditions at the planning stage are overtaken by economic, political, or social events, rendering even a well-conceived program ineffective in practice.

The third is faulty execution. There are myriad reasons that programs are not implemented effectively—lack of management ability, poor interpersonal relations skills, flawed leadership, bad judgment, and intra-organizational controversy, to name just a few.

In practice, it isn't easy to single out design flaws, execution flaws, or societal challenges as *the* factors that cause a program to disappoint; more than one of these are often present. Nor is it always possible to know when a program has not worked out: Muddy goals or strategies make it difficult to determine effectiveness. Moreover, program outcomes are rarely 100 percent positive or 100 percent negative. "It is not just a matter of success versus failure," said Nancy Barrand, the special adviser for program development at the Robert Wood Johnson Foundation. "You've got to account for the shades of gray."

As important as understanding why programs have not lived up to expectations is drawing lessons from them. This involves learning how to identify problems early and, where possible,

* These are programs that outside evaluators or Foundation staff members have found did not meet expectations, not just those that in the authors' opinion failed to reach their potential.

addressing them in a timely manner, as well as using the lessons from disappointing efforts in the design of new programs.

Programs that Did Not Meet Expectations Primarily Because of Strategic or Design Flaws

Strategic grant making of the sort that the Robert Wood Johnson Foundation and other large national foundations practice usually begins with setting goals and developing strategies to reach them. “I think the problems start with a lack of clarity about what you’re trying to accomplish,” Paul Brest, the president of The William and Flora Hewlett Foundation, said in a recent interview. “If you’re not clear about what the goals are, it’s really hard to know if you’ve succeeded. Beyond that, you need to have a plan to get there—a theory of change or logic model that links your philanthropic interventions to the goals you want to achieve. But it has to be realistic.”

Three Robert Wood Johnson Foundation-funded programs that did not meet expectations primarily because of flawed strategy or design are Community Programs for Affordable Health Care, Best Friends, and the Health Professions Partnership Initiative.

Community Programs for Affordable Health Care

In the early 1980s, many health policy experts looked to Rochester, New York, as a model for curbing spiraling health costs. In Rochester, employers, hospitals, and insurers had formed a voluntary coalition to cut health care costs by enrolling people in managed care. Staff members at the Robert Wood Johnson Foundation thought it worthwhile to try a similar voluntary, community-wide approach in other cities. So when the American Hospital Association and The Blue Cross Blue Shield Foundation proposed an idea to develop socially responsible cost containment programs in other American cities, the Foundation responded positively with Community Programs for Affordable

Health Care (CPAHC), a \$16.2 million initiative that began, in 1983, to test cost-containment strategies in eleven locations. The program embodied, as one commentator noted, “an idealistic, sunny notion . . . that community representatives holding very different vested interests would voluntarily put aside their own needs and aspirations to find a solution to a problem for the greater good.”¹

Almost as soon as it began, the program began to unravel. Foundation staff members became wary that the high-powered national advisory committee was taking the program in directions that the Foundation had not anticipated and did not approve of. “The national advisory committee thought that the Foundation had given it a blank check and that they were supposed to figure out how to spend it,” said Alan Cohen, a former Foundation vice president who had arrived after the program was under way but in time to oversee the evaluation. “We were sitting and watching and couldn’t believe what was happening.” The national program office also managed the program in ways that troubled the Foundation’s staff. “One potential grantee was so upset at the management style of the first national program director that it turned down the award,” Cohen recalled. Perhaps because the community partners were often joined in shotgun marriages, the programs they developed, in the judgment of Foundation officials, were pegged to the least common acceptable denominator and totally uninspired. So concerned was the Foundation’s board that in 1986 it rescinded \$3 million that had been authorized but not yet expended for the program.

The outside evaluators, Lawrence Brown, a Columbia University political scientist, and Catherine McLaughlin, a University of Michigan economist, skewered Community Programs for Affordable Health Care in an article in *Health Affairs*. “The basic reason why the CPAHC mission did not succeed is that it was always ‘mission impossible,’” they wrote. “The key policy lesson of CPAHC, and its major contribution to the national policy debate, is to demonstrate . . . the bankruptcy of [the notions] that

communities can and should be awarded a leadership role in containing health care costs, that progress is inevitable if only the leaders of powerful local health care institutions come to the bargaining table . . . and that government and the market must be held at bay.”² Senior Foundation staff members agreed that a flawed strategy had sunk the program. “The program’s central flaw, perhaps,” wrote Alan Cohen, Joel Cantor, and Steven Schroeder, “was its misguided assumption that cost containment could be achieved through intervention at the community or local level, when the true levers of power and control existed (and still exist) at the national level and state levels.”³

John Dunlop, the chairman of the national advisory committee, and George Stiles, executive director of the Council on Health Costs, which was the program’s grantee in Charlotte, North Carolina, disagreed. “CPAHC’s objectives were more modest and focused than the Brown and McLaughlin caricature,” they wrote. “It is ludicrous to believe . . . that the modest CPAHC resources could demonstrate major community-wide savings (especially in larger cities such as New York and Detroit) in four years or less.”⁴

Donald Cohodes, a high-ranking Blue Cross Blue Shield Association official who directed CPAHC for fourteen months in 1985 and 1986, added his two cents’ worth, calling the program a “design failure”⁵—one whose objectives were unrealistic and should not have been tried in the first place. This may be unduly harsh. At the time the program was being developed, health care costs were spinning out of control, Rochester seemed to have found a way of containing them, and nothing else seemed to be working. Why not try something new, even something that might be a long shot? The design flaw was both in trying to address a national problem at the local level and in assuming that an experiment in one city, Rochester, which had a unique environment (a few dominant corporations, a single major health insurer, and a limited number of hospitals), could be replicated in American cities with wholly different characteristics. Since the

program appeared to have been badly mismanaged, even though flaws in the design may be the primary reason it did not succeed, poor execution contributed as well.

Probably the main lesson is that foundations entering the rough-and-tumble world of local politics should do so with their eyes wide open and be aware that local politics can be venal. In the words of Brown and McLaughlin, foundation-funded programs aimed at containing costs “always threaten the earnings, mission, or autonomy (or all three) of major health care interests.”⁶ More broadly, CPAHC represents something of a loss of innocence about the potential of local coalitions to be the engines of policy change and of the capacity of foundations to contain the cost of medical care.

Best Friends

Even from the start, the Best Friends program was a stretch. A “character-building” program for sixth- through eighth-grade girls from low-income neighborhoods,⁷ Best Friends promotes an abstinence-only approach to sex and also to drugs and alcohol. In the words of Elayne Bennett, a Georgetown University educator, co-founder of the program, and wife of former Education Secretary William Bennett, Best Friends “promotes self-respect through the practice of self-control and provides participants [with] the skills, guidance, and support to choose abstinence from sex until marriage and reject illegal drug and alcohol use.”⁸

A controversial, unproven approach, abstinence only has been criticized as unworkable and out of touch with reality—even damaging, since it denies potentially sexually active girls access to information on ways other than abstaining to avoid becoming pregnant. Not that anybody is against abstinence before marriage. But there is, as Sarah Brown, executive director of the National Campaign to Prevent Teen Pregnancy, a Foundation grantee between 1997 and 2008, noted, “a profound difference between abstinence as a *message* and abstinence-only *interventions*.”⁹

Between 1990 and 2003, the Robert Wood Johnson Foundation awarded five grants totaling \$2.2 million to enable the Best Friends Foundation to carry out Best Friends programs in schools across the country. The programs followed the same general format in all the schools: an eight-session curriculum given throughout the school year; mentoring by a faculty member; participation in a weekly fitness or dance class; fulfillment of a community service requirement; various cultural enrichment activities; and scholarships to help program participants attend college or graduate school. By the end of the grant period in 2003, school systems were operating Best Friends programs in twenty-three cities in fourteen states, the District of Columbia, and the US Virgin Islands, with nearly 5,000 girls participating.¹⁰

In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (the law reforming welfare), which significantly increased funding for programs that teach “abstinence from sexual activity outside of marriage as the expected standard for school age children.” The following year, Congress authorized an evaluation of these abstinence-education programs. The evaluation was to be carried out by Mathematica Policy Research, a New Jersey-based research and evaluation firm. Wanting to add some Best Friends sites to the federal evaluation, the Robert Wood Johnson Foundation, in November 1999, awarded a \$750,000 six-year grant to Mathematica to evaluate Best Friends.

Shortly thereafter, the evaluation plan started to come apart. The Best Friends Foundation, on the one side, and the Robert Wood Johnson Foundation and Mathematica, on the other, were unable to agree upon a plan to evaluate the program. A series of meetings of the leaders of the three organizations revealed disagreement on such fundamental issues as the evaluation methodology and the outcomes that should be measured. James Knickman, who was the Robert Wood Johnson Foundation vice president for research and evaluation at the time, recalled, “We wanted to take a random survey of students who had enrolled in the program;

Best Friends said no. Best Friends wanted to discard any girl from the survey who had had sex; we felt this was unworkable.” A stalemate ensued; the Best Friends Foundation refused to participate in the Foundation-funded evaluation. In January 2000, the Robert Wood Johnson Foundation cancelled the evaluation, and shortly thereafter Mathematica returned its initial payment for the study. The Foundation continued funding the Best Friends program through 2003, the end of the grant period.

Seven years after the Best Friends’ evaluation was terminated, Mathematica published its evaluation of four abstinence-only programs funded by the federal government. The results showed the abstinence-only approach to be ineffective.¹¹

In hindsight, it would not be unreasonable to question the decision to fund Best Friends, since the Foundation does not usually support programs employing approaches that have no evidence whatsoever of being effective. At the time the program was developed, however, there was great concern about the high rate of adolescent pregnancy and a desire to try a variety of approaches, including abstinence-only ones, to reduce it. Since Best Friends appeared to be the most promising of the abstinence-only programs and appealed to political conservatives, it was considered the sort of long shot worth placing a small bet on.

A number of lessons emerge from the Best Friends’ experience. One is the importance of investigating whether a strategy has *some* chance of working; that is, of assessing upfront the potential of the strategy to succeed. Equally important is the need to synchronize evaluation and program development at an early stage, where possible. Seven years elapsed before the Foundation decided to evaluate Best Friends. If the Best Friends program had been viewed as a test of an experimental approach to prevent teenage pregnancy—one that would be carefully evaluated—then there could have been an agreed-upon evaluation plan at the outset. Or it would have been clear that agreement on an evaluation could not be reached, and the decision whether to fund the program would have been considered in that light.

The Health Professions Partnership Initiative

Having funded programs throughout the 1970s and 1980s to prepare minority college students to be stronger candidates for medical school, the Foundation reached further down the pipeline in the 1990s to attract and prepare minority elementary and high school students for careers as physicians and other health professionals. In 1991, The Association of American Medical Colleges (AAMC) had initiated Project 3000 by 2000 with the goal of roughly doubling the number of underrepresented minorities (defined as blacks, Mexican Americans, mainland Puerto Ricans, and Native Americans) enrolled in medical schools. In 1994, the Foundation developed the Health Professions Partnership Initiative to support the AAMC in its Project 3000 by 2000. The idea behind the Health Professions Partnership Initiative was to increase the number of students from underrepresented minorities entering careers in both medicine and other health professions by creating a pre-medical pipeline below the college level. The program was designed to help medical and other health professions' schools build partnerships with secondary schools, colleges, and communities that would improve the quality of math and science teaching and increase, through enrichment activities, student interest in health careers.

The means adopted were ones that the Foundation had traditionally employed. It funded a number of different sites to come up with projects to attract and assist minority students, and it relied on local coalitions to carry out the projects. Initially, the coalitions were to revolve around medical schools, which were the grantees, and colleges, local schools, and school districts. Shortly after the initial ten grants were awarded, in 1996, the W.K. Kellogg Foundation agreed to co-fund the program. Since the Kellogg Foundation gave high priority to community-based initiatives, the two foundations stipulated that community organizations would be part of any coalitions formed for a second round of funding, in 1998. At the time of the third round of funding, schools of public health were added to the partnership mix.

All told, a total of twenty-six partnership programs were funded between 1996 and 2005, including five targeted to schools of public health. The lead agency was either a medical or other health professions school; partners were the public schools, community agencies, and in some cases the larger university. Each site received \$70,000 per year for five years, and all the partners were expected to contribute resources toward the program.

The program, which ended in 2005, was evaluated by a team from the University of Washington School of Medicine. The evaluation team and informed observers from the AAMC found that, on the whole, the program did not meet expectations. The authors of the evaluation wrote that they were “unable to identify outcomes in terms of numbers of children influenced by programs or instances in which lasting changes in health professions schools had occurred.”¹²

Some of the reasons that the program did not work out as expected had to do with its design, especially the strategies adopted to increase the number of minority high school students who would become doctors or other health professionals.

According to Jan Carline, the evaluator, and Davis Patterson, a research assistant associated with the evaluation, the foundations had unrealistic expectations about what small local interventions could accomplish in large complex public education systems working with seriously disadvantaged children. “The most effective methods for increasing the number of students academically capable of entering health careers appear to be based in general and systemic reform of education from the earliest levels of primary school through high school,” they wrote. “A single intervention in one grade or school level or a series of unconnected interventions will not result in a sustainable increase in academic performance.”¹³

Nor did the Robert Wood Johnson Foundation and the Kellogg Foundation understand public education very well. “Many of the failed programs did not take into account the difficult issues facing public schools today,” Ella Cleveland, the program’s

deputy director at the AAMC, wrote in a 2006 supplement of *Academic Medicine* devoted to the Health Professions Partnership Initiative.¹⁴

The foundations also had unrealistic expectations about the ease of forming community partnerships and their effectiveness. In practice, forming effective coalitions turned out to be very difficult.¹⁵

The goals of the two foundations underwriting the program were never wholly compatible. The Robert Wood Johnson Foundation's goal sought to support coalitions built around academic health centers. The Kellogg Foundation emphasized the importance of community organizations.

Other reasons for the initiative's lack of success had to do with the changing perceptions of race and education. "During the project, institutions of higher learning were buffeted by a series of legal, legislative, and ballot-based setbacks to affirmative action," Charles Terrell, who directed the program at the AAMC between 2002 and 2005, wrote. "The tragic impact of these imposed barriers was that *Project 3000 by 2000* did not meet its goal."¹⁶ Moreover, the initiative was underfunded. "One of the most important factors," Jane Lowe, who currently directs the Foundation's vulnerable populations team, said, "was the lack of funds to get the job done. Seventy-thousand dollars a year barely paid for a staff person." Finally, the execution of the program did not proceed smoothly. At the national program office, the key person at the AAMC died early in the program, and it took a long time to replace him. At project sites, leadership within some of the communities proved elusive. At the foundations, it was not until the middle of the program that its co-funders were able to agree upon a collaborative oversight arrangement.

Although the initiative did not bring about the hoped-for results, it did leave some long-lasting benefits behind in the participating communities. More than half of the sites were considered either exemplary in preparing students for the health professions or having developed excellent components, such as

teacher training programs, quality after-school, weekend, and summer enrichment programs, and strong partnerships between community organization and schools.¹⁷ Even programs that do not achieve their overall goals can have positive effects on the people they touch.

—❧— **Programs that Did Not Meet Expectations
Because of a Challenging or Changing
Environment**

It is ironic that the areas of highest priority for the Foundation—areas such as expanding health insurance coverage, improving quality, and reducing childhood obesity—are precisely those that are most difficult to affect because they face the greatest societal challenges. SUPPORT, the Generalist Physician Initiative, and Strengthening Hospital Nursing are programs that were designed to bring about change in areas that the Foundation considered as priorities. All three ran into social, political, or economic barriers that led to disappointing results.

SUPPORT

SUPPORT, the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment, a \$31 million research project that the Robert Wood Johnson Foundation funded between 1988 and 1996, did not achieve the result that the Foundation had hoped for: improving the care of dying hospitalized patients. The program trained teams of nurses whose job it was to communicate patients' wishes for treatment (or withholding of treatment) to physicians and then to work with family members and physicians to see that those wishes were carried out. A rigorous evaluation found that the program led to absolutely no improvement.¹⁸

Neither doctors nor hospitals nor nurses nor patients nor their families were able to overcome the inertia of the system.

Despite the attention to end-of-life care from high-profile legal cases, the publicity given to living wills, and SUPPORT itself, end-of-life care did not improve. As SUPPORT's co-principal investigator, Joanne Lynn, wrote, "Physicians did not know what patients wanted with regard to resuscitation, even though these patients were at high risk of cardiac arrest. . . . Most patients who died in the hospital spent most of their last days on ventilators in intensive care." Except for the comatose, Lynn noted, more than half of the patients were reported to have substantial pain.¹⁹

What makes SUPPORT so instructive is the Robert Wood Johnson Foundation's reaction to these discouraging results. Faced with an intervention that achieved so little, the Foundation developed a whole new end-of-life program area out of SUPPORT's ashes. Steven Schroeder, the president of the Robert Wood Johnson Foundation at the time, recalled, "One of the program officers behind SUPPORT came into my office, practically in tears that the program had not worked. My reaction was, 'Let's take this lemon and make the most delicious lemonade out of it that anybody has tasted.'"

The Foundation developed its recipe for lemonade by embarking on an ambitious \$170 million effort between 1996 and 2005 to improve the care given to dying patients—one that, in combination with the work of the Open Society Institute, knowledgeable observers credit with building a field of palliative care in the United States, even though it is still not known whether the care of dying patients has in fact improved.

The Generalist Physician Initiative

Since its very first days, the Robert Wood Johnson Foundation has been trying to restructure the medical care system from one built around specialists to one built around primary care practitioners. The Foundation's interest in primary care—or generalist medicine, as it is sometimes called—has continued through the decades. Nonetheless, interest among medical students in careers

as generalists had declined throughout the 1980s, reaching its nadir in 1992, when fewer than 15 percent of medical school graduates planned careers in primary care (down from 36 percent in 1982).

To attract more medical students to careers in primary care, the Foundation launched a \$100 million cluster of programs in the early 1990s. The centerpiece was the Generalist Physician Initiative, a seven-year, \$33 million program. It was designed to influence four points considered critical to attracting medical students to careers as generalist physicians (that is, as general internists, general pediatricians, and family practitioners). The four points were admissions, undergraduate medical curriculum, residency programs, and setting up practice. The fifteen medical schools that administered the Generalist Physician Initiative did, in fact, address each of these points by, for example, marketing themselves as generalist schools, changing the admissions process to target more students with generalist potential, adding generalists to admissions committees, introducing primary care into the curriculum at an early stage, creating more primary care residency slots, and forgiving loans to students choosing primary care practice.

Enrollment in generalist tracks at the participating schools did increase somewhat, but no more than in the nonparticipating medical schools. In the mid- and late-1990s, there was a brief surge in interest in generalist careers as medical school students responded to managed care companies' need for primary care physicians as entry points in the system and gatekeepers.²⁰ So enrollment in generalist tracks increased across the board.

After the backlash against managed care led to reducing the role of generalist physicians and strengthening that of specialists, the percentages of medical students seeking primary care slots sank again. Between 1997 and 2002, for example, the number of American medical school graduates in family practice residencies declined by 19 percent. Joel Klompus, a San Francisco-based physician and president of the board

of directors of Brown & Toland, a large physicians' group in California, commented, "It has become almost impossible to attract medical students to careers in primary care. There are so many incentives driving them into specialties."

In retrospect, the Generalist Physician Initiative was a worthy but unsuccessful endeavor. It bestowed the Foundation's imprimatur on an issue that the Foundation considered important, much as the Foundation's work to expand health insurance coverage and increase the percentage of minority health practitioners—equally challenging assignments—give a certain credibility to these issues. It did not, however, change either the culture of medical schools, the aspirations of medical students, or the number of primary care physicians. Foundations do not have the power to change the economic climate in which career decisions are made. Given a reimbursement system favoring specialty care and the high prestige of specialists (compared with the heavy workload and comparatively low income of primary care physicians), it is little wonder that medical students are not clamoring to become generalist physicians. As the deputy director of the Generalist Physician Initiative, Gerald Perkoff, a physician and, at the time, professor at the University of Missouri Medical School, wrote, "Market forces have more to do with career choice than do the needs of the system, and certainly more than philosophies."²¹

Strengthening Hospital Nursing

The Strengthening Hospital Nursing Program did not meet expectations, but for somewhat different reasons than the examples discussed above; the circumstances under which the program was planned changed markedly as the program was being implemented, rendering the original objectives difficult to reach.

In the late 1980s, as the Strengthening Hospital Nursing Program was being conceived, the country was in the midst of a nursing shortage. Among the reasons cited for the nursing

shortage was a high level of job dissatisfaction. To address this, the Robert Wood Johnson Foundation, in collaboration with The Pew Charitable Trusts, developed a program to make hospital nursing a more attractive profession. The program had a second goal, improving patient care. Thus the full title of the program—Strengthening Hospital Nursing: A Program to Improve Patient Care.

The two goals were not necessarily compatible. As the program developed, the second goal was interpreted quite broadly to mean a restructuring of the way hospitals were run. “The Strengthening Hospital Nursing Program seeks to bring about a fundamental change in the US hospital,” Barbara Donaho and Mary Kay Kohles, the program’s director and deputy director, wrote.²² Mitchell Rabkin, at the time the president of Beth Israel Hospital, a grantee of the program, viewed the kind of change envisioned by the program as one recognizing “that the hospital is fundamentally a nursing institution.”²³

Between 1990 and 1995, twelve hospitals and eight hospital consortia participated in the Strengthening Hospital Nursing Program. Each grantee had considerable flexibility about how to structure its \$1 million implementation grant, and each took a somewhat different route.

Despite improvements in some of the participating hospitals, characterized by the evaluation team from the University of California, Berkeley, as running “deep and wide,” the program was overtaken by the changing health care workforce.²⁴ Even as the program was ramping up, the nursing shortage was disappearing. Managed care companies, which came to dominate health care in the 1990s, were laying off nurses and looking for less well-trained personnel to fill their roles. With nurses fearing for their jobs, they were hardly in a position to demand that hospital care be organized around them.

Strengthening Hospital Nursing appears to have had positive results in some of the hospitals in the program.²⁵ Viewed from a broad perspective, however, the program neither succeeded

in restructuring hospital care around nursing nor in improving patient care. Making this kind of systemic change is difficult in any environment, and even more so in one in which managed care made the position of hospital nurses so tenuous. As the program's evaluators concluded, "The importance of larger economic forces on hospital decision making cannot be ignored."²⁶

Both the Strengthening Hospital Nursing Program and the Generalist Physician Initiative underscore the need to keep track of the social, political, and economic environment in which programs operate, and to make programmatic revisions that may be required by changing circumstances.

Programs that Did Not Meet Expectations Primarily Because of Faulty Execution

Programs sometimes do not work out because they are poorly managed, because the leadership is flawed, because they unnecessarily deviate from the original plan, or for the many reasons that implementation suffers. In any given case, flawed execution can trump even the best-planned strategy. "After observing many organizations, including the Robert Wood Johnson Foundation, I think that foundations tend to overemphasize strategy at the expense of execution," wrote Steven Schroeder.²⁷ The Clinical Nurse Scholars Program and the Center for Child Well-being offer examples of programs whose lack of success was attributable primarily to flawed execution.

The Clinical Nurse Scholars Program

At the time of the nursing shortage of the early 1980s, staff members at the Robert Wood Johnson Foundation identified a problem: nursing schools were graduating nurses who had strong academic backgrounds but were unprepared for the real world of hospital nursing. "Nurses started their careers in a sort of culture shock because they weren't prepared," noted

Carolyn Newbergh, a health writer.²⁸ To address this problem, the Foundation developed the Clinical Nurse Scholars Program to train a core of nursing professors and leaders who would reorient academic nursing around clinical skills. Modeled on what was considered the Foundation's signature program, the Clinical Scholars Program for physicians, the Clinical Nurse Scholars Program began in 1982 and, with extensions, was expected to run through 1994. Carried out in three of the nation's leading nursing schools—the University of California, San Francisco, the University of Pennsylvania, and the University of Rochester—the program was to provide two years of training to nine nursing faculty members a year.

A Foundation review of the program completed in 1987 concluded that the program had deviated from its objective. Rather than emphasizing clinical teaching skills, it had become a vehicle to finance the doctoral studies of clinical nurse scholars and, in addition, was no longer focused on hospital nursing. The Foundation's leadership was so upset with the direction the program had taken that it ended the program early, funding seven classes instead of the ten that had been originally planned.

In succeeding years, a consensus has developed that this decision was an overly drastic response to a genuine problem of program execution. The former president and executive vice-president of the Foundation (along with one of the co-authors of this chapter, Stephen Isaacs), concluded in 1997, "The Clinical Nurse Scholars Program probably was terminated prematurely; although it had veered from its original objectives, it might have been redesigned to overcome some of its problems." Nor did the Foundation act in partnership with its grantees, or even listen to them. According to Newbergh, those involved in the program, who have since become leaders of academic nursing, felt that "[the Foundation] didn't understand that for nurses to gain prominence as leaders, they needed to follow the same path as the nation's most noted doctors—by developing expertise in research."²⁹

The Clinical Nurse Scholars Program illustrates the need for regular program monitoring so that deviations from original objectives can be identified early, as well as the need to carefully consider drastic steps, such as premature closure of a program, before taking them. Ironically, in the face of a more recent nursing shortage, in 2008, the Foundation issued a call for proposals for a new program called the Robert Wood Johnson Foundation Nurse Faculty Scholars whose objective, “to help talented junior nursing faculty advance in their careers by giving them the opportunity to develop a research program and participate in other scholarly activities,”³⁰ is almost identical to the one that had led to the Clinical Nurse Scholars Program’s termination nearly twenty years earlier.

The Center for Child Well-being

In response to a board directive, in mid-1996 the Foundation created an internal task force to explore what more it could do to improve children’s health. One recommendation to emerge from the task force was the establishment of a new center that would, among its other roles, be a major force in disseminating objective, scientifically sound information on child health and development and play a leading role in advancing children’s health nationally. The Foundation invited William Foege, a physician and one of the giants in public health, to develop and head the center, an invitation he accepted only after considerable arm-twisting, according to former Foundation senior vice-president Ruby Hearn.

Foege submitted an ambitious proposal, a scaled-down version of which the Foundation funded in February 1999. Under the \$9 million grant, the Atlanta-based Task Force for Child Survival and Development, headed by Foege, would set up a new Center for Child Well-being whose work would include using a scientific approach to identify each of the critical elements of healthy development for children, adopting sophisticated communications strategies to translate what had been learned

from research into practice, and strengthening leadership within the child health and development community. Foege became director of the center on a half-time basis.³¹

Roughly seven months after the proposal was funded, Foege accepted a position as a senior adviser to the emerging Bill & Melinda Gates Foundation, allowing him to return to his first passion, global health. A few months later, his deputy resigned for unrelated personal reasons. Although Foege remained the Center's executive director at the agreed-upon 50 percent level and the deputy was replaced, Foundation staff members felt that there was a leadership vacuum at the top.

Partly because of this, and partly because the center had not met some of the benchmarks that had been established (for example, developing a Web site, establishing a virtual network of collaborators, and forging relations with other children's health groups), a proposal for expanding the Center, submitted in late 2000, ran into tough sledding at the Foundation. Staff members pointed out that the Center had made limited progress on some of its key benchmarks. As Paul Jellinek, a Foundation vice president at the time and currently a private consultant, observed, "We never had a clear understanding of what it added up to." The result: instead of supporting the Center at an increased level for three years, as requested, the Foundation agreed to only eighteen months' funding, after which the Center would be on its own. Currently, the Center is still connected with the Task Force for Child Survival and Development, and has a Web site.

—❧— **Learning from Programs that Haven't Met Expectations**

Increasingly, foundations are attempting to establish clear goals and measurable strategies, assess progress against them, and, most important, learn from their successes and failures. Every program is different, however, and provides lessons that may be applicable

only to its own situation. It is hard to compare a tobacco-control program, for example, with one to improve the care of chronically ill patients. Even so, some general lessons emerge from this review of programs that have not met expectations.

Managing Expectations

In a two-trillion-dollar-plus health economy with political, social, and economic factors that often seem beyond anyone's control, one cannot realistically expect a single program—or even a cluster of programs—to bring about major social change. The political, social, and economic barriers faced by social-change programs—such as those to expand generalist medicine, increase health insurance coverage, reduce obesity, and improve quality of care—are enormous. But fostering social change is exactly what big foundations such as Robert Wood Johnson often aim to do.

A first lesson to emerge from the analysis of programs that did not meet expectations is that major foundations ought to address important issues and enunciate ambitious goals of changing social policy but that expectations for success should be tempered. In the words of Joel Fleishman, currently a Duke University professor and one of the leading thinkers on foundation accountability, foundations should “recognize that a bit of humility is appropriate when grappling with major social change.”³² Unfortunately, many foundation staff members are tempted to oversell a program to get its approval.

How much humility? There is no simple formula to guide how much risk of failure a foundation should be prepared to accept. Fleishman observed, “For-profit venture capitalists...expect eight or nine of every ten investments to fail, and one or two to succeed mightily.”³³ While such a low success rate may be hard to swallow in philanthropy, a tolerance for lack of success must be built into programs that attempt to bring about social change. As The Hewlett Foundation's Paul Brest observed, “If nothing seems to be working, then one must

reconsider the goal and the strategies of reaching it. And it makes sense to set intermediate targets that get measured along the way. If short-term and intermediate-term targets are not being met, it is unlikely that the long-term goals will be.”

Moreover, programs may gradually chip away at the problem in ways that cannot be easily seen until something happens outside the control of the foundation, such as a new law or policy. To take an example from another foundation, The California Endowment worked for years to promote policies that would ban the sale of junk food and soda in the state’s public schools, without visible success. Almost overnight the political situation changed. A new governor interested in halting childhood obesity was elected, and the state legislature passed laws banning junk food and soda from being sold in the state’s public schools.³⁴

The staff and the board of the Robert Wood Johnson Foundation have grappled with questions of risk and expectations. Risa Lavizzo-Mourey, the president and CEO of the Robert Wood Johnson Foundation, noted that “the trustees have given the staff a lot of leeway to tackle big problems such as childhood obesity and quality of care, to adopt bold approaches, and even to fail if they don’t work out. There are no constraints placed on us because a program might fail or even embarrass us.”

Clarifying Objectives and Strategies

In a recent study of business failure, Paul Carroll and Chunka Mui concluded that most avoidable failures are due to flawed strategies.³⁵ Although foundations don’t have to meet the same bottom line as businesses do, they have a bottom line to meet nonetheless. According to Phil Buchanan, the president of The Center for Effective Philanthropy, “People don’t define goals and strategies well enough. So they can’t know what works and what doesn’t.”

This is the case in some of the programs examined above. In the Strengthening Hospital Nursing Program, it was unclear

whether the objective was to strengthen the practice of nursing in hospitals or to restructure the way hospitals were administered. In the Health Professions Partnership Initiative, the intervention was not robust enough to lead to the desired result. In the National Health Care Purchasing Institute, discussed in chapter 3, it was not clear whether the program was aimed at the public sector, the private sector, or both.

Since 2003, the Robert Wood Johnson Foundation has been using an “impact framework” that sets out and guides the board, the staff, and the grantees in short-, medium-, and long-term objectives.³⁶ “Laying out a framework for people in the field—the ones doing the work—that gives them the ability to know how they are doing is critical,” Lavizzo-Mourey said. “It also gives them the ability to know where they are and to know that no program is likely to be 100 percent successful or 100 percent failure.”

Focusing on Goals but Remaining Strategically Flexible

Pierre Omidyar, the founder of eBay, in a speech to the 2002 graduating class at Tufts University, said, “Prepare for the unexpected . . . Sometimes ideas have ideas of their own . . . In the deepest sense, eBay wasn’t a hobby. And it wasn’t a business. It was—and is—a community: an organic, evolving, self-organizing web of individual relationships, formed around shared interests.”³⁷

“Prepare for the unexpected!” For philanthropy, the lesson is: remain flexible enough to alter tactics while not losing sight of the overall goal. As Tony Proscio observes in chapter 2 of this volume, several Foundation-funded programs went through midcourse corrections after it became clear that the original plans were not working.

A related point is not to be wedded to strategies that aren’t effective in practice. Former president Steven Schroeder, looking back at the Foundation’s efforts to build community coalitions,

observed, “I am not sure that our logic model was correct. I don’t think there was evidence that you could mobilize communities absent already existing coalitions, which often start with a group of committed advocates, such as breast cancer advocates. . . . After a while, the formation of coalitions itself became the goal rather than a strategy to reach the intended goal.”

Monitoring and Assessing Programs

For the most part, program officers at foundations are motivated largely by the development of new and exciting programs. Once a program is conceived and approved, it is easy to forget it and move on to the next. Evaluation is often left for the very end, and in too many cases is an afterthought. One lesson from this review is the importance of routine monitoring of programs, including the social-economic-political context in which they are developing, and acting upon reports of changed circumstances. The recession of 2008–2009 offers a telling example. “When state budgets went south with the deteriorating economy, our programs struggled,” Lavizzo-Mourey said. “We have to be prepared to react quickly to external circumstances like those.”

Related to that is the importance of incorporating evaluation very early in the life of a program. Supporting Families After Welfare Reform, discussed in chapter 2, is an example of a program where monitoring and listening early to the problems expressed by grantees led to a restructuring that probably saved it. The Health Professions Partnership Initiative and Best Friends are examples of programs where an evaluation (or in the case of Best Friends, the prospect of an evaluation) came too late to address fundamental flaws that, had they been disclosed earlier, might have been remedied.

The development of formal logic models specifying the theory of change for an individual program or a cluster of programs and the identification of indicators of major events or outcomes are useful tools to monitor developments, and the Foundation has

utilized them since the late 1990s.³⁸ Yet even they do not provide a full understanding of strategies undertaken by the Foundation. A third point relating to monitoring and assessment to emerge from this review is the importance of reviewing entire strategies, not just programs or clusters of programs, at a mid-way point.

—∞— Dealing with Programs that Don't Meet Expectations

There are a number of ways of dealing with programs that do not work out as planned. The most dramatic example of turning around a disappointment is SUPPORT, where the failure of the intervention led to a major new effort to improve end-of-life care. In other cases, such as the SmokeLess States program and the Supporting Families After Welfare Reform (discussed in chapter 2), programs underwent a midcourse correction after it became clear that the planned approaches were not working. For the most part, however, ineffective programs simply continue until the grant period is over.

There does come a time, however, when a program has such troubles that it cannot be saved, even if modified, and the Foundation should pull the plug. This happened with Community Programs for Affordable Health Care, the Center for Child Well-being, and the National Institute for Health Care Purchasing Institute (discussed in chapter 3). The Clinical Nurse Scholars Program was also terminated early, though in retrospect, the termination appears to have been premature.

Since every program is different, each will require a decision appropriate to the particular circumstances. As a rule, unless a program goes completely off in a wrong direction, the wise course is for the Foundation and grantees to work together to try to correct it. The Foundation considers that it is in a collaborative relationship with its grantees and that both are working for the common good. As such, problems that arise are considered to be common ones that both the grantee and the Foundation

should try to resolve in partnership. “Ideally, the Foundation and its grantees will have developed a relationship as partners and will have the openness and flexibility to fix problems, even major ones, as they develop,” Risa Lavizzo-Mourey said in a recent interview.

—❧— Conclusion

The Robert Wood Johnson Foundation is widely considered as being in the forefront of learning from its programmatic experiences and, through vehicles such as published program evaluations, its Grant Results Reports, which are posted on the Foundation’s Web site, and this *Anthology* series, sharing what it has learned. The Foundation is striving to develop a culture whereby the staff and the board learn from the results of its programs, both positive and negative, though Foundation staff members candidly confess that there is a long way to go.

We have chosen to avoid the word “failure,” since even programs that do not work as expected can provide valuable lessons and directions for the future. SUPPORT led to a twenty-year effort to address problems in end-of-life care. Health Link, a prisoner re-entry program, had no significant effects on recidivism, but influenced the field’s approach to re-entry.³⁹ Failure occurs when lessons are not learned or communicated to others.

More foundations are attempting to be strategic in their grant making, scrutinizing the results of their programs more carefully, and even making their successes and failures public. The James Irvine Foundation, for example, posted a case study of a program that underwent a midcourse correction on its Web site. For the past twelve years, The Wallace Foundation has posted all of its program evaluations—positive and negative—on its Web site. “Though we encounter sensitivities and concerns, the effects have been positive,” said Ed Pauly, the director of evaluation at The Wallace Foundation. “The program staff, in particular, finds the posted evaluations very useful and uses evidence about programs

that have not worked out as a way of improving future programs.” And The Hewlett Foundation posts the results of The Center for Effective Philanthropy’s surveys about the foundation.

Yet, at this point, there is more talk than action. “There is a great rhetorical embrace of being strategic, adopting performance indicators, and measuring results,” The Center for Effective Philanthropy’s Phil Buchanan said. “However, there is still a big gap between the rhetoric and what people actually do.”

Even though action lags behind words, there is clearly some momentum in philanthropy toward understanding impact, reporting on results (even negative results), and sharing them with the field when appropriate. Who knows, maybe in the not-too-distant future, it will become the norm.

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