

CHANGING SYSTEMS CHANGING LIVES

REFLECTING ON 20 YEARS

The Nicholson  Foundation

FOREWORD	1
ACKNOWLEDGMENTS	3
INTRODUCTION	5
CHAPTER 1	9
The Nicholson Foundation: A 20-Year Journey	
CHAPTER 2	23
Engaging with Government for Systems Change	
CHAPTER 3	33
Elevating Best Practices and Building Evidence for New Jersey	
CHAPTER 4	47
Finding and Nurturing Effective Partnerships	
CHAPTER 5	65
Investing in Organizational Nuts and Bolts	
CHAPTER 6	73
Tackling Complex Problems with Multiple and Complementary Solutions	
CHAPTER 7	95
Developing Future Leaders	
CHAPTER 8	105
A Steadfast Commitment to the Arts	
EPILOGUE	115
Reflecting on the Past and the Import of the Work	
THE CAST GLASS COMMEMORATIVE PROJECT	119



CHANGING SYSTEMS
CHANGING LIVES
REFLECTING ON 20 YEARS

Changing Systems, Changing Lives
describes the following projects and initiatives
supported by The Nicholson Foundation

IN-HOME RECOVERY PROGRAM FOR PARENTS WITH SUBSTANCE USE DISORDERS	25
YOUTH EMPLOYMENT AND EDUCATION SUCCESS (YE²S)	29
BEHAVIORAL HEALTH INTEGRATION	35
PROJECT ECHO AND TELEHEALTH	41
ACCOUNTABLE CARE ORGANIZATIONS	51
MEDICAID 2.0	52
MEDICAID POLICY CENTER	53
ADVERSE CHILDHOOD EXPERIENCES	55
HEALTHCARE INNOVATION PARTNERSHIPS	60
HEALTHCARE COALITIONS	67
QUALITY CARE AND EDUCATION FOR YOUNG CHILDREN	75
FAMILY SUCCESS CENTERS	81
MATERNAL AND CHILD HEALTH	86
MEDICAID ACADEMY	97
NEW JERSEY PEDIATRIC RESIDENCY ADVOCACY COLLABORATIVE	100

FOREWORD

BY JAN NICHOLSON, *President, The Nicholson Foundation*
AND BARBARA NICHOLSON McFADYEN, *Chair, The Nicholson Foundation*

In learning about an organization, we are all curious about its origin, and if there is an unlikely ending, we want to know the story there, too.

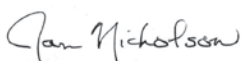
The Nicholson Foundation was born of a double blessing. The first was our maternal grandfather. He was a corporate man who, with a lifelong friend, kept trying entrepreneurial investments on the side. These fledgling industrialists purchased a toy balloon factory in Wooster, Ohio, in 1929. They converted the factory to making molded rubber items for the home, like dust pans. This became Rubbermaid, which went public in 1959. In 1993, Rubbermaid was voted America's Most Admired Company in *Fortune* magazine's annual survey.

The second blessing was that the family to whom this good fortune passed had help-thy-neighbor values. In our nuclear unit, our mother and father had complementary character traits. Mother was considerate and appreciative, never said an unkind thing, and always built the other person up. Dad was a man of his word no matter how small the commitment. He was generous, sympathetic to people for whom life was hard, and polite to everyone. Their marriage was a melding of beliefs about what is right, and they shared a desire that their earned and inherited resources go to helping people. Lacking pretention, they planned that the Foundation would commence when they were gone. Because they had lived in New Jersey for decades, it would begin with opportunities that presented themselves there. Our middle sister's death in 2002, and her bequest, set the Foundation in motion early. Dad died in 2006 and Mother in 2013, having seen contours of what the Foundation would become.

The Foundation's particular approach to helping people—systems change aimed at government—was inspired by another fortuitous occurrence. This was the introduction of Mark Hoover to Jan and his becoming the Foundation's public face initially, then its Executive Director. He had impressive records for systems change, first in Wisconsin state government and then New York City government. He agreed to try to bring about similar endeavors in New Jersey, this time from the outside.

The idea that the assets of the Foundation would be spent down emerged and solidified along the way. Our parents would not have objected. As the Foundation began to clock successes, there seemed to be more merit in achieving early what was possible than in holding back funds to sustain the Foundation itself. The Foundation's lifespan became the variable in the equation. The opportunities, and the capacity to seize them, were the determining factors. In the end, the money lasted 20 years.

Why tell the story? One reason is that we think that a rather singular and fruitful strategy unfolded and that others who share our goals might be influenced, if not emboldened, to continue its pursuit. In fact, as we looked back to put the story together, a coherence emerged that surprised even us. It intensified our more compelling reason to publish this book. This is to give credit—credit to the Foundation's team and leaders, to our grantees, and to our many mission-driven partners, including those in government itself. We are in awe of the resolve and caliber of the effort and the encouraging change that was the result. Our gratitude is immense. Read on, and you will learn what these contributors have done.



Jan Nicholson
President



Barbara Nicholson McFadyen
Chair



ACKNOWLEDGMENTS

As with all projects at The Nicholson Foundation, this book is the product of teamwork. Transforming an idea for telling the Foundation's story into a completed book would not have been possible without the combined efforts and dedication of many people.

We thank the writing team for their commitment to getting the story right, which was shown in the many drafts the book went through on its journey to a finished product: Anne Rodgers was the principal writer and led the day-to-day development process. Kevin McManemin, Arturo Brito, and Kimberly Boller also contributed substantially to the content. Wesley Wei and Madison McHugh, Foundation Fellows, provided essential support that kept the project on track. We also thank Carol Pickerine for her expert copy editing assistance.

We're especially grateful to Arturo and Kim for their strategic direction throughout the project's planning and development, their willingness to review multiple drafts, and their insightful comments.

A special thank you goes to the Foundation's Senior Program Officers—Maureen Deevey, Kay Hendon, Raquel Mazon Jeffers, Barbara Kang, Colette Lamothe-Galette, and Shannon Riley-Ayers—who graciously spent time with the writing team in many information-gathering and draft-reviewing conversations. We also are grateful to the Foundation's Chief Fiscal Officer, Michelle Fouks, for her substantial assistance in providing the fiscal information to support the content and financial graphs in the history chapter, and to all the other staff members for the information they provided and for their help and support along the way: Christina Chesnakov, Grace Munoz, Linda Refi, Fred Sambataro, and Bruce Trachtenberg.

Thank you to Linda Maher and her team of designers at Graphic Imagery, Inc. for their responsiveness and patience, and most importantly, for their beautiful design.

The heart of this book is, of course, our grantees and partners. We could include only a selection of projects, but we want to thank all our grantees and collaborators for their dedication to improving the health and well-being of vulnerable populations, their willingness to partner with us, and their excellent work.

Through the Foundation it describes, this book reflects the ambition of the Nicholson family for the Foundation's achievements and how that ambition was brought to life under the guidance of Jan Nicholson, The Nicholson Foundation's President, and Barbara Nicholson McFadyen, its Chair. We are grateful, as well, to Barbara McFadyen for her significant assistance on the arts chapter.

Above all, we express our appreciation to Jan Nicholson for her conviction that this was a story worth telling and for her constant encouragement and support throughout the development of this book.



INTRODUCTION

When we set out to tell the story of our 20 years of philanthropy in New Jersey and what we had learned from our efforts, we knew that The Nicholson Foundation had achieved some success: We had raised awareness about specific state needs in family well-being, health, early childhood, and other services. We had supported best practices and funded the implementation of evidence-based models. We had helped to change the systems designed to serve vulnerable populations.

What we didn't anticipate was that, at this very moment in our nation's history, a new awareness would well up and take the spotlight—an awareness of society's inequities and the failure to create a level playing field that would give all people the opportunity to provide for their families and achieve their aspirations. This made us realize that our work touched the very center of the social, economic, and health crises facing the United States. It turned out that now was the ideal time to tell our story.

Government's policies and safety net service systems are our society's front-line response to the inequity problem. On its own, the Foundation could not prompt dramatic changes to reduce poverty and racism. So our approach was to advance what we hoped would be meaningful change in safety net service systems so that they could, in some measure, redress the harm caused by these problems. Our goal was to help ensure that those systems provided accessible, effective, and equitable services.

This book describes The Nicholson Foundation's journey, from our beginnings in 2002 through our decision to spend down, to our consequent closing at the end of 2021. Initially, the Foundation focused on projects based in Newark. We supported programs to enhance family and child well-being, promote youth engagement in school and work, and help individuals successfully transition from incarceration back into the community.

Twenty years later, our mission was still the same, but we had evolved substantially. We had invested in communities throughout New Jersey, and our grantmaking priorities had changed in response to shifting state dynamics and new interests of the Foundation's board and staff. We also had adopted a more robust public presence.

As a small foundation, we could be nimble and responsive when looking for projects—from small, short-term projects all the way up to large multi-year, multi-faceted initiatives—that fit within our mission. But we also had to be purposeful and think

What Do We Mean by "Vulnerable Populations"?

The health and well-being of individuals, families, and communities depends on stable access to the essentials of life—nutritious food, adequate housing and transportation, quality education, sufficient and appropriate healthcare, and the assurance of safety. The Foundation defines "vulnerable populations" as those who face challenges in coping and reaching their goals because of systemic inequities that place barriers in the way of obtaining these basics.



broadly and strategically if we wanted to influence systems change, foster sustainable progress, and work across multiple administrations with individuals of all political viewpoints. These imperatives guided our approach to grantmaking.

Our mission was the driving force behind our hiring, partnering, and grantmaking decisions. We wanted to make a difference in people's lives now and for generations to come, and do it sooner rather than later. When hiring new staff and engaging with partners, we sought those whose values aligned with our mission and who shared our impatience to shift systems in ways that improved the likelihood of a better life for everyone.

We also were convinced that grantmaking was best done by staff with a wide variety of subject matter expertise, personal and professional experiences, and perspectives and opinions. We recruited from government agencies, service organizations, hospitals, educational institutions, and other groups.

We also applied this approach to partnerships by working with state agencies and departments, policy institutes, advocacy groups, field-building organizations, and research groups. They helped us build evidence, advance best practices, and create organizational "connective tissue" that linked government with local organizations to develop and provide better and more equitable health, education, and social services.

We put a premium on close collaboration with grantees. We carefully selected organizations with whom to work. We then collaborated with them every step of the way, from the very earliest conversations about a potential project, through the concept development and proposal phases, and throughout the project's implementation. Grantees had to think through and describe, in detail, the operational steps of their proposed project. We also provided fiscal guidance to help grantees create and implement improved accounting and financial reporting systems. We called all this "technical collaboration" rather than "technical assistance" because we wanted to engage in real partnerships with grantees.

We used performance-based grantmaking to foster grantee success. Beginning in 2011, we required that grantees define their goals, objectives, and outcome milestones. We then tied a certain percentage of the project's funding to achieving the milestones. These performance-based goals, along with careful planning, enhanced grantees' readiness to start the project and see it through efficiently and successfully. This approach also promoted opportunities for innovative thinking and helped grantees develop the organizational skills and capacity to thrive after our funding ended.

We funded more than projects. Like many other foundations, we supported conferences, publications, and other products that drove attention to issues and contributed to policy and regulatory change. We funded the development of policy briefs, deep-dive data and regulatory analyses, and blueprints for program transformation. We collaborated with others to sponsor conferences on big data and health and on pain management and the opioid epidemic. We funded journal supplements focused on community health collaboratives and on child development from conception through age 3. We provided direct help in the form of scholarships





*Youth participating in a race at a Nicholson-supported Family Festival, held to promote the state's Nurture NJ maternal health initiative (see our maternal health story in **Chapter 6**)*

for grantees to attend national conferences. We also used travel as a learning tool and lever for change by sponsoring immersive site visits for grantees and partners to multiple states and even abroad. These trips fostered long-lasting relationships and collaborations, and gave participants an opportunity to think about issues in new ways.

Amplifying the Work with a Robust Communications Strategy

In the early days, the Foundation was consciously low key. We wanted our projects to be carried forward by grantees who felt they owned the work. We thought they should get the credit for their accomplishments; our aim was to support and stay in the background.

That strategy changed dramatically when we began to invest in health. We realized we wouldn't be able to make a serious impact and achieve our objectives unless people knew about us, thought us credible, and talked to us on a regular basis.

Beginning in 2013, we took a number of steps to develop a vibrant, outward-facing communications effort. We:

- **Overhauled our website to create a modern and professional look**
- **Reached new audiences through focused media relations**
- **Got our name out by sponsoring events and accepting speaking opportunities**
- **Published op-eds, blog posts, and scholarly articles in leading New Jersey and national health publications**
- **Contributed to the conversation by joining social media**

Our communications strategy and our grant portfolio were intertwined—both grew in visibility, size, and complexity over time. Our goal was to use communications to advance the work of our partners and grantees and to bring to light issues facing vulnerable populations in New Jersey.



We pursued opportunities to work with others in ways that didn't involve writing

a check. Our staff provided consultation to state agencies, served on boards and advisory committees, and gave presentations on a range of topics. These activities cemented relationships with others, helped us get to know state and local stakeholders and understand their issues, and strengthened our reputation as a dependable thought leader and partner.



Over the years, government, philanthropy, communities, civic and service organizations, religious groups, and individuals have grappled with what they can—and should—do to address the disparities in our society and improve the health and well-being of those who face the greatest challenges. No road map exists, and groups have used many and various approaches to address these big problems. In describing the path we took, this book includes a chapter on the Foundation's history and evolution,

six theme-based chapters, a chapter on our support for arts projects in New Jersey and North Carolina, and a final reflection on our work and legacy.

The theme-based chapters are the heart of the book, for they describe the big ideas that lay behind our work and that were woven throughout all our projects. Each of these chapters begins with the rationale for why this theme was important to us, then illustrates with project examples, and closes with key takeaways about what our experiences might give others who are engaged in similar work. The six themes are:

- 1. Engaging with Government for Systems Change**
- 2. Elevating Best Practices and Building Evidence for New Jersey**
- 3. Finding and Nurturing Effective Partnerships**
- 4. Investing in Organizational Nuts and Bolts**
- 5. Tackling Complex Problems Through Multiple and Complementary Strategies**
- 6. Developing Future Leaders**

The United States is at an inflection point, with economic, social, and health disparities wider than ever. Renewed awareness of these forces creates new urgency and a greater resolve to change their trajectory. This has begun to happen, and New Jersey can point to some success. In 2021, the state stands poised to be a national leader in promoting health equity, improving access to quality and affordable early childhood care and education, and providing exemplary maternal and infant healthcare.

We believe that foundations, community organizations, and other changemakers in New Jersey and elsewhere can use our experiences and the lessons we learned as a springboard to generate their own real—even transformative—systems change. Helping all individuals, families, and communities attain the rewards of life will strengthen the nation as a whole.





THE NICHOLSON FOUNDATION

A 20-Year Journey



The Nicholson Foundation made its first program grants in 2002 and its final grants in 2021. Throughout this period, our mission stayed constant: To improve the health and well-being of vulnerable populations in New Jersey by augmenting, upgrading, or redesigning human services systems so they would better meet the needs of individuals, families, and communities.

Throughout its history, the Foundation intentionally remained a small organization focused on just one state. It was guided by a Board of Trustees that provided counsel on the overall vision and approach, but that gave Foundation leadership and staff the freedom to explore options, design tactics, and develop initiatives. The Board empowered; the team drove.

This chapter describes distinct eras of development in the arc of the Foundation's history, presented in four sections. Each section covers the Foundation's defining characteristics during that era, its primary focus areas and spending, and a timeline of important Foundation achievements and external shaping events. It also includes short profiles of five individuals whose leadership and deep experience inside and outside of government resulted in contributions that profoundly influenced the Foundation's progression, successes, and impact. The chapter concludes with a list of the Foundation's team members—the staff and consultants whose work, together, made it possible to fulfill the Foundation's mission.



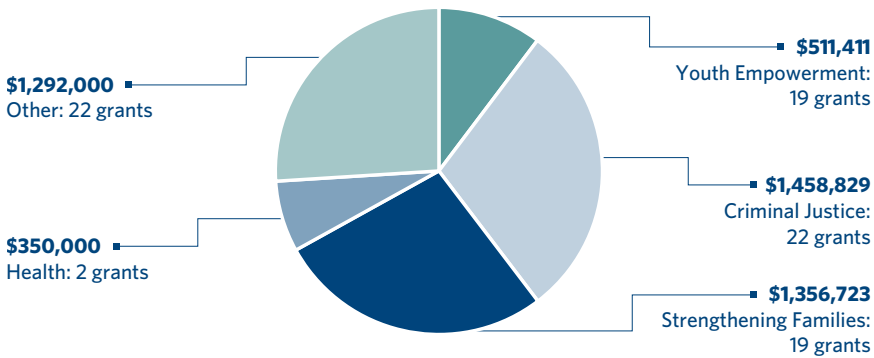


2002-2006: STARTING OUT

The Foundation’s early years were a time of exploration, of finding the “right fit,” where our funding could have an impact. Focusing on Newark and Essex County, we explored ways we could work with local government and community agencies. We spent considerable time and effort in talking to people to identify community needs and gaps in services. During these years, we made 84 grants, totaling \$5 million. The grants covered a wide variety of issues within the categories of grants shown in the pie chart. For example, about two-thirds of our grant funding supported projects in strengthening families, criminal justice, and youth empowerment. Projects in the Other category were as diverse as helping to create and renovate public parks in Newark and contributing to regional planning efforts. During this period, staff consisted of the Executive Director, consultants who managed projects, and a small number of administrative support staff.

2002-2006 Funding for Priority Areas

84 Grants: \$4,968,963



2002

- Mark Hoover hired, became first Executive Director (2002-2010)
- President Bush signs No Child Left Behind Act into law
- Foundation awards its first grants
- President Bush launches Health Center Growth Initiative; by 2007, 1,236 new or expanded community health centers were funded, for a total of more than 4,000 centers

THE NICHOLSON FOUNDATION
■ STATE/NATIONAL EVENTS





Mark Hoover: The Visionary Who Launched the Foundation's Work (2002–2010)

In his 34 years with the Wisconsin Departments of Workforce Development and Health & Social Services, Mark developed a singular capacity to bring about change. He had the skills with process and procedures to implement effective, large-scale programs. He understood the regulatory details governing federal and state spending, and he could see how to tap these funding streams to support his programs. Because of his strong record, New York City recruited him in 1996 to be the operating head of the \$15.5 billion Human Resources Administration.



In 2002, Foundation President Jan Nicholson invited Mark to work with Nicholson to explore whether he could spark change in New Jersey—from outside government. Could we start with local services and, over time, earn acceptance from higher-order systems and government?

One early success was to work with the courts to resolve severe overcrowding at Newark's youth detention center and to implement proper management systems. Then, as Mark continued to explore systems issues in New Jersey, he saw that people who needed social, health, and economic services were often not gaining access, or even reaching for it, for a variety of reasons: fear, lack of awareness, and confusion prompted by a system of multiple agencies with complex requirements. A promising best-practice solution was the one-stop center, where people could find connections to an array of community resources and support. Under Mark's leadership, the Foundation began one-stop centers for three populations: disengaged youth; families; and former inmates returning to the community. The youth empowerment and family stability programs continue to thrive today.

The combined force of Mark's abilities and the Foundation's resources set us on a path to create increasingly more consequential partnerships over the years with major institutions and government.



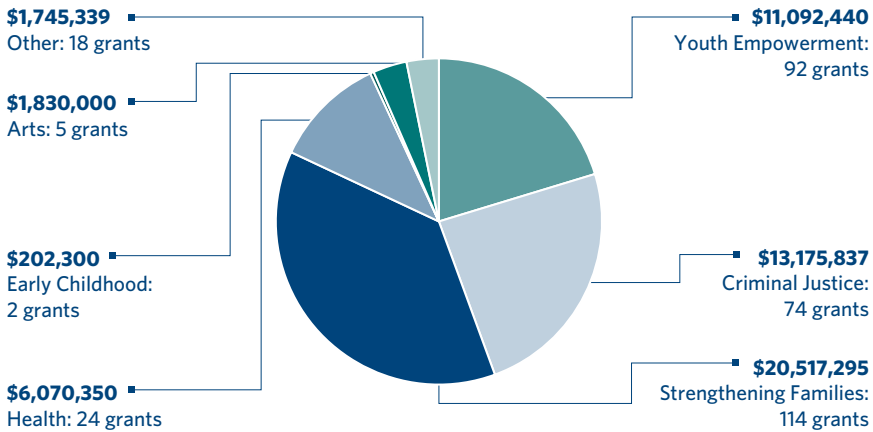


2007-2012: A SHIFT IN FOCUS

The years 2007 through 2012 were a period of growth and realignment at the Foundation, partly in response to national-level changes. Healthcare reform efforts were spreading, as was the understanding of the complex interrelationship among the well-being of individuals, family, and community and their health outcomes, according to various social measures. The Foundation decided to ride the wave of opportunity afforded by this public interest. We began a gradual shift in our grantmaking to a greater focus on health even though during this era, the great majority of grants remained in criminal justice, strengthening families, and youth empowerment. The Foundation also began to award a small number of grants for arts projects. The staff evolved, with a new Executive Director, as well as a Director of Health and Rehabilitation and additional staff, who were hired to develop and manage the growing health portfolio.

2007-2012 Funding for Priority Areas

329 Grants: \$54,633,561



<p>2007</p> <p>First Family Success Center grant awarded</p>	<p>2008</p> <p>First YE²S Center opens in Newark</p> <p>Joan Randell hired as Director of Health and Rehabilitation; later becomes Chief Operating Officer (2015-2017)</p> <p>Mental Health Parity and Addiction Equity Act passed, requiring parity between physical and behavioral healthcare</p>	<p>2009</p> <p>First performance-based grant awarded</p> <p>American Reinvestment and Recovery Act passed, with large investments in health IT, primary care</p> <p>Children's Health Insurance Program reauthorized</p> <p>Chris Christie elected Governor</p>
---	---	--





Charles Venti, MPA: The Catalyst Who Engaged Others to Improve and Expand Services (2004–2016)

Charlie came to the Foundation in 2004, as a retiree from the New Jersey Division of Youth and Family Services (DYFS). He began at DYFS as a protective services caseworker, eventually rising to become Division Director—the first caseworker ever to do so.

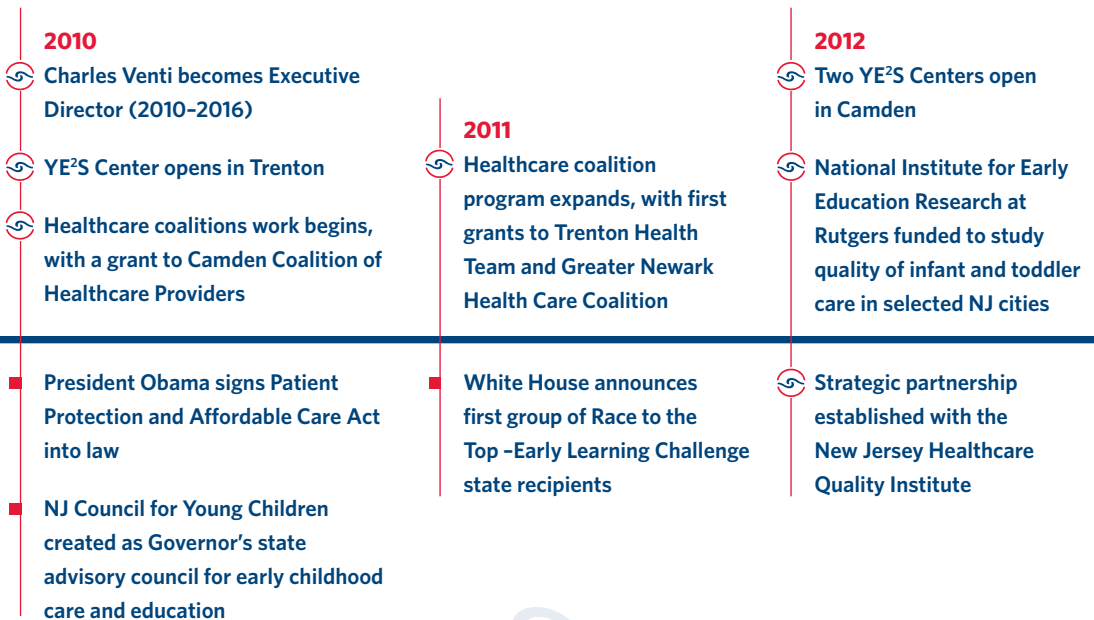


At the Foundation, Charlie was first a consultant and then Deputy Director, working closely with Mark Hoover to establish the Foundation’s early priorities and partnerships. In 2010, he became the Foundation’s Executive Director.

Charlie was a connector and a catalyst. His passion was improving social services so that they truly met the needs of the people they were intended to serve. Because of his years in state government, he had strong, longstanding connections with a wide variety of individuals and organizations in New Jersey. He saw the value of convening people from various parts of the community and combining their unique strengths to devise strategies for solving problems. He also understood that a good way to create durable change was to work with nonprofit and government systems that affected people’s daily lives. Charlie is especially likeable, an advantage for forming structured relationships and building trust.

Under Charlie’s leadership, the Foundation continued to build on initiatives begun in earlier years. With his background in child welfare and strengthening families, he also took a strong interest in cultivating early childhood initiatives. With his connections across the state, Charlie helped staff make new contacts and develop collaborations with public, private, and community agencies to create this portfolio of work.

Charlie’s steady leadership through the Foundation’s transition—from social services to health and early childhood services—was both supportive and meaningful for the successful maturation of the Foundation.



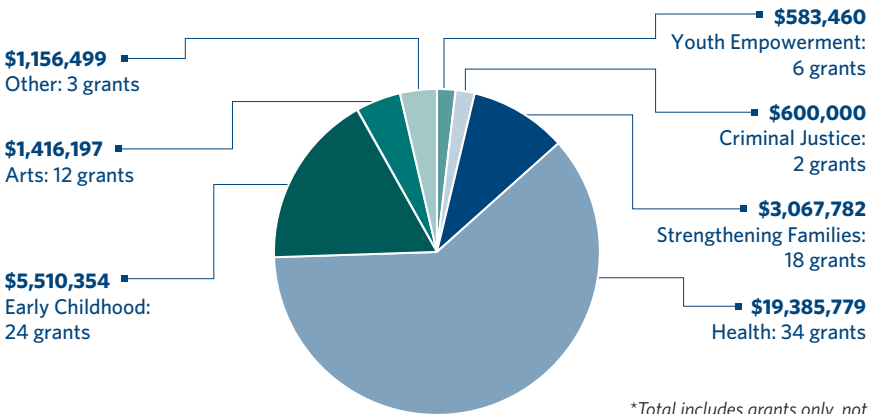


2013-2016: GROWING AND MATURING

The years 2013 through 2016 continued the shift away from earlier emphases, such as youth empowerment, to health and early childhood. In the health portfolio, the Foundation built program areas by funding planning grants that led to small pilot projects and then to larger-scale implementations supported by additional complementary projects. The early childhood portfolio also grew, gradually turning to an emphasis on infants and toddlers. The Foundation expanded in other ways as well, supporting projects across New Jersey and partnering with the state in substantial new initiatives. This era was marked by a smaller overall number of grants than in the previous era, but larger individual investments to develop initiatives over multiple years. The Foundation also began to use new funding mechanisms (mini-grants and Statements of Work) to support grant planning, conferences, publications, and expert consultants. The structure of the staff remained consistent, with an Executive Director, a small number of senior and administrative staff, and program officers.

2013-2016 Funding for Priority Areas

99 Grants: \$31,720,071*



*Total includes grants only, not mini-grants or Statements of Work

2013

- Three behavioral health integration pilot sites launched
- Pilot of the Quality Rating and Improvement System (QRIS) in infant and toddler classrooms begun in Newark early childhood centers

2014

- First Rutgers Project ECHO clinic launched in three primary care safety net practices

- Supplement to the Test Drive of the NJ QRIS, titled Grow NJ Kids, begun in 18 Newark centers with infant and toddler classrooms

- Gov. Christie signs NJ Medicaid expansion into law
- NJ included in third set of Race to the Top - Early Learning Challenge grants

- Steps to Quality begun—first quality improvement project in family care settings in low-income communities





Joan Randell, MA: The Innovator Who Established New Initiatives and New Approaches to Grantmaking (2008–2017)

Joan came to the Foundation from the New York City Human Resources Administration, where, as Assistant Deputy Commissioner, she led vocational rehabilitation programs for beneficiaries of public assistance services. Hired at the Foundation as the Director of Health and Rehabilitation, she became Chief Operating Officer in 2015.

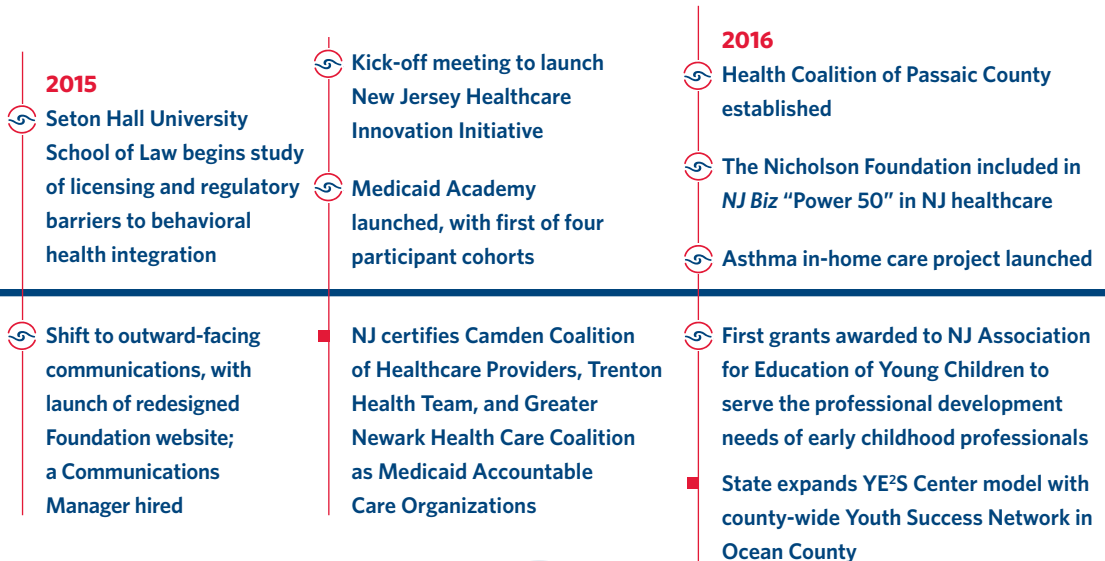


Joan led three major initiatives. First, she spearheaded the Foundation’s portfolio of health programs. This involved researching healthcare issues in New Jersey, hiring a team of program officers whom she guided in designing and implementing new initiatives, and establishing relationships with state healthcare leaders. Her vision was to develop a portfolio of complementary, innovative projects that could create durable systems change in New Jersey. This work resulted in projects that had a transformative impact on healthcare service delivery, such as the healthcare coalitions initiative, Medicaid 2.0, Project ECHO, and the Behavioral Health Integration initiative.

Second, she instituted performance-based grants (in which payment was attached to achieving specific, measurable objectives). This approach required grantees to develop detailed business plans and focus on sustainability. These changes necessitated close technical collaboration between program officers and grantees, resulting in strong projects and partnerships.

Third, she directed a realignment and expansion of the Foundation’s communications activities. This was carried out through a new website, contributions to leading New Jersey and national publications, participation in public forums, and enhanced media engagement.

Each of these achievements, and the strategic thinking and insistence on quality inherent in them, enhanced the Foundation’s visibility and its credibility as a thought leader and philanthropic force. Joan’s contributions were vital to the development of the Foundation’s programs and paved the way for the public-private partnerships that were a defining feature of the Foundation’s final era.





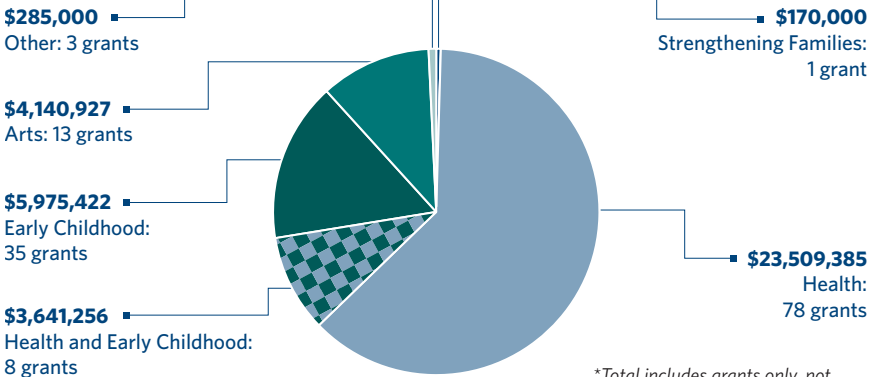
2017-2021: THE FINAL YEARS

A new Executive Director, Arturo Brito, arrived in 2017. He increased staff, established an Interns/Fellows program, and supported existing work while encouraging work in new directions. During 2020, he guided our responses to help grantees cope with the COVID-19 pandemic. The majority of grants continued to support work in health and early childhood, but with a fresh focus on the intersection of the two areas. In 2019, Arturo hired Kimberly Boller as Chief Strategy and Evaluation Officer.

The final years of this era were dominated by the Board's spend-down decision. A new priority emerged: Ensure that our work would be sustained. To this end, we seeded policy and research institutes and established new collaborations with other foundations and state leaders. We bolstered the capacity of grantees in management, public relations, data usage, training, and fundraising. We even helped 12 grantees participate in a Shark Tank-like event that gave them a chance to pitch their programs and attract new support.

2017-2020 Funding for Priority Areas

138 Grants: \$37,721,990*



*Total includes grants only, not mini-grants or Statements of Work

<p>2017</p> <ul style="list-style-type: none"> Arturo Brito becomes Executive Director (2017-2021) Medicaid 2.0: Blueprint for the Future released Behavioral health integration program expanded to six sites The Nicholson Foundation Interns/Fellows program established 	<ul style="list-style-type: none"> Statewide campaign to reduce sugar-sweetened beverage consumption begun Gov. Christie includes \$25 million in state budget to expand full-day pre-K programs Phil Murphy elected Governor 	<p>2018</p> <ul style="list-style-type: none"> Neighborhood Connections to Health Coalition, Greater Freehold, established Medicaid Policy Center launched Initiative begun to integrate behavioral health into all phases of Rutgers healthcare clinical training Adverse Childhood Experiences initiative launched, with event featuring Nadine Burke-Harris, MD, and state leaders
--	--	--





Arturo Brito, MD, MPH: The Leader Who Helped Ensure an Enduring Legacy for the Foundation (2017-2021)

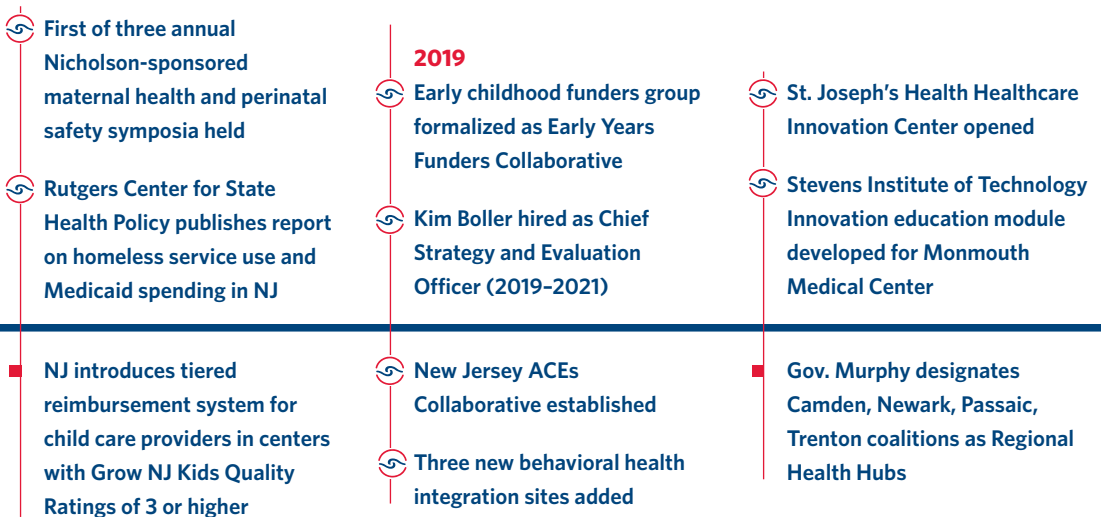
Arturo joined The Nicholson Foundation as its Executive Director in early 2017. He came to the Foundation from the New Jersey Department of Health, where he served as Deputy Commissioner of Public Health Services.



Early in his career, Arturo worked with underserved children and families as a community pediatrician focused on population health. Frustrated with barriers that prevented his patients from thriving, he became convinced that, although efforts to improve health and well-being had to be grounded in science, they also had to be person-centered and consider the realities of people’s lives. This conviction guided his work at the Department of Health, as he brought disparate state agencies and private-sector players together to address social factors thwarting healthy development.

Arturo was the perfect leader for embracing the Foundation’s work and capitalizing on the potential inherent in a meld of our health and early childhood efforts. He hired new program staff and promoted statewide efforts to address maternal and child health, adverse childhood experiences (ACEs), racial inequity, and limited access to quality child care and education—factors bearing on lifelong mental and physical illnesses. These efforts were pursued as collaborations between The Nicholson Foundation, other leading New Jersey foundations, and state agencies and departments.

During our final year, Arturo had the challenge of reinforcing the sustainability of the Foundation’s work while also bringing it to a conclusion. The Board considered it imperative to do both with care. As our grantmaking ceased, Arturo maintained a high level of engagement in webinars and communications. Under his leadership, rather than going gentle into that good night, we finished strong.






Kimberly Boller, PhD, MS: The Strategist Who Used Evidence to Advance Policy and Program Improvement (2019–2021)

Kim came to the Foundation from Mathematica Policy Research, where for more than 20 years she designed and led evaluations of early childhood and family support programs. A cognitive and developmental psychologist, Kim brought important skills to the Foundation. As the Chief Strategy and Evaluation Officer, she worked with program officers and partners to ground the Foundation’s work in the latest evidence and data. She guided the collection of new data and the incorporation of analyses to benchmark progress. Her ability to use and translate research for a wide range of audiences was helpful in working with institutional partners and individual service providers. She sought to find common ground with government, philanthropic, and community groups to facilitate partnerships.






Kim is good with people, as well as with numbers. She assumed management responsibility for the team, and this included supervising their project work and encouraging their post-Nicholson planning. With Board support, she developed an array of counseling, training, and publishing options for staff. For example, she led the hunt for job-search and life coaches and encouraged everyone to sign up for sessions. The aim of this support was to help staff find fulfillment in their next endeavors, and to help them identify and attain positions where they could make the greatest contribution.

Kim also led the team overseeing the wind-down of operations—the physical office, the website, the files, and the personnel operating systems. She did all this while being a full contributor to the mission, particularly in her areas of expertise—maternal and child health and early care and education. Her strategic thinking and collaborative style were well-suited to the breadth of the responsibilities she assumed.

2020
 **HealthySteps, an integrated behavioral health and pediatric primary care model, established at three Hackensack Meridian pediatric primary care practices**

 **First Lady Tammy Snyder Murphy announces at Maternal Health Awareness Day that the Governor had signed 24 maternal health bills passed by the legislature**

2021
 **New Jersey ACEs Statewide Action Plan released**
 **Nurture NJ Collaborative for maternal health established; Nurture NJ Strategic Plan released**

 **On January 20, the World Health Organization declares COVID-19 a global health emergency**






The Nicholson Foundation team, 2018, with Chair Barbara Nicholson McFadyen and President Jan Nicholson (4th and 5th from left, front row)




The Nicholson Foundation team, 2019, with President Jan Nicholson

 **Three Trimesters to Three Years: Promoting Early Development** supplement of *Future of Children* journal published by Princeton University - Brookings Institution

 **Population Health Institute planning begun** in collaboration with Robert Wood Johnson Foundation and NJ Department of Health

 **The Nicholson Foundation operations concluded**

 **Rutgers Infant Toddler Policy Center established** at National Institute for Early Education Research





THE NICHOLSON FOUNDATION STAFF AND CONSULTANTS

- **Nicole K. Butler, MA:** *Consultant, Education* (2007–2012)
- **Rachel Cahill, MPP:** *Consultant, Health* (2011–2014),
Senior Program Officer, Health (2015–2018)
- **Christina Chesnakov, MPH:** *Public Health Intern* (2018),
Public Health Fellow (2018–2021)
- **Maureen Deevey:** *Consultant, Health* (2009–2014),
Senior Program Officer, Health (2015–2021)
- **Michelle Fouks:** *Consultant, Program Integrity & Fiscal Planning* (2012–2014),
Chief Fiscal Officer (2015–2021)
- **Ed Fox:** *Consultant, Criminal Justice Reform* (2004–2008)
- **Michael Greene:** *Consultant, Evaluation, Youth Violence Prevention,
and Criminal Justice Reform* (2007–2012)
- **Cathryn C. Hendon, MSSW:** *Consultant, Early Childhood* (2009–2014),
Senior Program Officer, Early Childhood (2015–2021)
- **Kathleen Hoover:** *Consultant, Administration* (2002–2010)
- **Raquel Mazon Jeffers, MA, MPH:** *Consultant, Health* (2013–2014),
Senior Program Officer, Health (2015–2021)
- **Barbara Kang, MA, EdM:** *Consultant, Health* (2012–2014),
Senior Program Officer, Health (2015–2021)
- **Itai Karilik:** *Consultant, Workforce Development/Finance* (2005–2011)
- **Colette Lamothe-Galette, MPH:** *Senior Program Officer,
Health/Early Childhood* (2019–2020)
- **Chrishana Lloyd, PhD, MSW:** *Consultant, Early Childhood* (2014),
Program Officer, Early Childhood (2015–2016)
- **Keri Logosso-Misurell, JD:** *Consultant, Child and Family Services* (2012–2014)
- **Dyann Lonesome:** *Consultant, Criminal Justice Reform* (2006–2012)
- **Madison McHugh, MBA, MA:** *Communications Intern* (2018–2019),
Communications Fellow (2020)
- **Kevin McManemin, MS:** *Communications Manager* (2015–2020),
Communications Director and Program Officer (2020–2021)
- **Grace Munoz:** *Administrative Assistant* (2010–2021)
- **Brian O'Neill:** *Consultant, Information Technology* (2012–2018)
- **Kim Pengitore:** *Bookkeeper* (2009–2021)
- **Linda Refi:** *Consultant, Administration* (2011–2014),
Officer Manager (2015–2021)
- **Shannon Riley-Ayers, PhD, MS, MEd:** *Senior Program Officer,
Early Childhood/Health* (2017–2021)
- **Anne Brown Rodgers:** *Consultant, External Communications* (2011–2021)
- **Paul Saeman:** *Consultant, Education and Workforce Development* (2006–2015)
- **Fred Sambataro, MBA:** *Consultant, Administration* (2006–2014),
Fiscal & Administrative Director (2015–2021)
- **Bruce Trachtenberg:** *Communications Associate* (2020–2021)
- **Wesley Wei, MPH:** *Public Health Intern* (2018–2019),
Public Health Policy Fellow (2019–2021)
- **Anthony Welch, MBA:** *Consultant, Family Services* (2011–2012)
- **Liam Winters:** *Consultant, Information Technology* (2011–2021)





Engaging with Government for Systems Change



The Foundation viewed government as a critical player and partner in systems change—government at every level, from communities, to counties, to the state. The federal government, of course, is very important, but, as a small New Jersey focused organization, we lacked resources and standing for that ambition.

We approached our opportunity set in many ways: from the bottom up—one district’s high schools—or, from the top down—an entire state agency. We could go small with a single pilot, or go big with a collaborative redesign of a statewide program. We could partner with one organization or engage with multiple nonprofit and government entities.

In getting started, we found lower-hanging fruit at the local level. However, we recognized that states have considerable power over, and responsibility for, activities affecting the health and well-being of individuals, families, and communities. States also are a major provider of services for vulnerable populations. Thus, it was our ambition to move up over time and to earn opportunities to connect with more and larger divisions of state government.

We intentionally reached out to New Jersey’s agencies and departments during project development to solicit their ideas and involvement. This outreach helped us earn the state’s buy-in and collaboration. In some cases, we achieved ultimate success when state or local agencies or departments assumed responsibility for projects when Foundation support ended.

There is more to tell to paint the whole scene: In America, government does not stand alone. It is augmented by a rich stew of nonprofit organizations. These organizations take many forms—including philanthropies, universities, affinity groups, civic organizations, and mission-driven nonprofits—and have a variety of purposes—research, policy, grantmaking, advocacy, field-building, and service, to name just some. Government and this civil society constitute a vast symbiosis of mutual benefit. Government needs foundations and other non-governmental organizations to assist in advancing its policies and programs, particularly through providing services. This, in turn, creates opportunities for non-governmental partners to engage in the planning period and help build the evidence base that makes government action desirable and possible. Through contracts, government gives nonprofits the chance to fulfill their missions of service. It can build the momentum that spurs interest and creates a context where opportunities for investment can emerge. This can allow foundations and other non-governmental groups—and even, sometimes, private industry—to join in riding a wave of change. Our work with government was integrally linked to partnerships we formed with nonprofits and, ultimately, other foundations.

The following stories illustrate what’s possible with productive engagement with government. They describe how the Foundation:

- Partnered with state and local agencies and departments to implement a new model of treating and supporting families with young children when a parent has a substance use disorder
- Collaborated with local government agencies, school systems, and community groups to re-engage youth in education and career training





A NEW VISION OF CARE FOR PARENTS WITH SUBSTANCE USE DISORDERS

In 2017, the Foundation began looking for opportunities to invest in projects at the intersection of health and early childhood. As part of our research, staff and state agency and department leaders attended a conference on applying trauma-informed care in mental health and substance use disorder treatment. The conference was inspiring in many ways, and it spurred us to see whether this avenue could lead to potentially promising projects. Eventually, our research led us to the Yale Child Study Center. The Center aims to improve the mental health of children and families through research, clinical practice, and professional training.

We visited the Center with state decisionmakers, including Mollie Greene, the New Jersey Department of Children and Family's (DCF) Assistant Commissioner, Children's System of Care. We were especially interested in learning about evidence-based programs that serve families with young children and exploring opportunities for partnership. One Yale program—Family-Based Recovery—caught DCF's attention. As Shannon Riley-Ayers, the Foundation's Senior Program Officer who led this initiative, explained, "This was a turning point because we had found a program that meshed with the new direction in which the department was already moving to support children and families."

DCF's new approach embodied a healing-centered vision that aimed to help New Jersey residents be safe from harm or maltreatment; be physically, mentally, developmentally, and emotionally healthy;

The Family-Based Recovery Model

Family-Based Recovery is an in-home program for families with infants or toddlers who are at risk of abuse, neglect, poor developmental outcomes, or removal because of a parent's substance use.

Family-Based Recovery promotes stability, safety, and permanence for families through intensive psychotherapy, substance use disorder treatment, and attachment-based parent-child therapy. The program already had promising evidence to support it, and further testing in a randomized controlled trial began in 2016, with final results anticipated in late 2021 or early 2022.





and be bonded together through strong ties of kinship and community. Building on a robust body of research showing that these three factors—safety, health, and human connection—were closely linked, DCF was committed to re-orienting its programs to support this trio.

One area for action was helping families in which a parent had a substance use disorder. Over the past several decades, new and effective strategies and programs had emerged that emphasized sensitive and trauma-informed substance use disorder treatment while still protecting the child from harm or neglect. These new approaches

recognized that removing a child from the home because of the parent's substance misuse could have long-lasting traumatic effects for the child, the parent, and the whole family. Being removed from the home and placed in foster care could be psychologically and emotionally harmful for the child. Removal also could jeopardize the parent's recovery if it led to relapse as a way of coping with the loss of the child and with the sense of being judged as a less-than-competent parent.

Interventions that embraced the new approach were based on two fundamental principles: Parent-child attachment is critical to healthy child development, and substance use disorder treatment works. The hypothesis was that combining treatment with parenting support could be effective because the two approaches reinforced each other. Parenting well and bonding with a young child could strengthen abstinence, and recovery from substance misuse could strengthen the ability to parent well.

Family-Based Recovery's program embodied both these principles. It saw the parent-child relationship as an opportunity for recovery, maltreatment prevention, healthy attachment, and healing. The program's strategies were explicitly designed to honor the parents and to build on their innate strengths. In keeping with this principle, the clinicians and family support specialist who provided the treatment and parenting support tailored the sessions to the needs of each family. The sessions took place in the home, with the child, to help the parent feel comfortable in a familiar environment. Holding the sessions at home also meant that parents didn't need to find transportation or child care—removing an important barrier to treatment.

Adapting the Family-Based Recovery Model

During 2018 and 2019, we collaborated with several partners to adapt the Family-Based Recovery model to the New Jersey context. This pilot project, called the In-Home Recovery Program (IHRP), focused on families in Ocean County. The county had been particularly hard hit by the opioid epidemic and had a high need for IHRP's services. IHRP worked with families in three phases:

- **Assessment:** The IHRP team consisted of a family support specialist and two clinicians, cross-trained to provide individual substance use treatment and parent-child attachment-based therapy. The team met with the parent and child three times a week for four to six weeks to evaluate the family and develop an individualized treatment plan.

Substance Misuse is a Substantial Problem in New Jersey

In 2017, about 1 in 3 children involved with DCF had a caregiver with a substance use disorder, and about 1 in 7 had a caregiver with an alcohol use disorder, specifically.





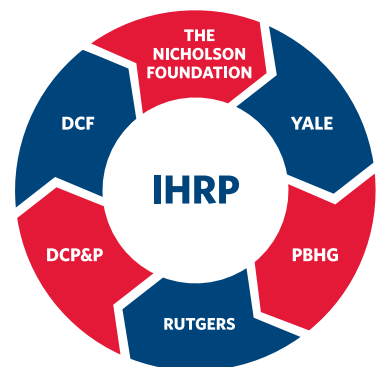
- **Treatment:** The team conducted three home visits a week for six months. After six months, visits could be continued for as long as six more months, though with less frequency. The sessions covered parenting support and child development education; promotion of positive parent-child interactions; support for increased parental reflective functioning; individualized trauma-informed substance use disorder treatment; psychiatric evaluation and medication (if needed); basic living and social service needs assessment; and financial and other support to meet those needs. Additionally, IHRP sponsored a Social Club, which provided a chance for participants, children, and staff to share a meal as well as clinical group time. Participants also were regularly tested for substance use and received a financial incentive for negative test results.
- **Discharge:** The team conducted one home visit a week for four to six weeks to prepare the parent and child to conclude the program. The team and family collaboratively made a plan to ensure continued success after discharge.

The COVID-19 pandemic presented a unique challenge because the core of the IHRP intervention rested on close, frequent, in-person communication between the family and the team. Beginning in March 2020, IHRP transitioned to a virtual environment for the home visits, the substance and alcohol screenings, and the Social Club. The team devised creative solutions to maintain the personal connection to the extent possible and to make the substance use testing easy and convenient. For example, Social Club meals were delivered to each participant simultaneously each week, and the participants chose the venue from which the meals would be ordered. In April, IHRP implemented an app-based toxicology and alcohol screening platform that preserved the integrity of the screening process and maintained the financial incentives that helped participants stay on track. Team members worked closely with participants to ensure they had the supplies and equipment they needed and to remove any technological barriers to participation.

Establishing a Successful Partnership

Our partners in this project included the Yale Child Study Center, DCF, local Department of Child Protection and Permanency (DCP&P) agencies, Preferred Behavioral Health Group (PBHG, a New Jersey organization that provides behavioral health counseling services), and the Rutgers University School of Social Work. Each member of the partnership made unique contributions to the project:

- The **Yale Center** team, led by Karen Hanson, created the original model with Johns Hopkins University and the Connecticut Department of Children and Families.
- **DCF** provided staff to manage the overall project and created teams that directed specific aspects of it.
- The **DCP&P** agencies were the local contacts who referred the parents for participation.
- **PBHG** clinicians and social workers delivered the intervention in conjunction with state case workers.





- Emily Bosk, an Assistant Professor at the **Rutgers University School of Social Work**, conducted a DCF-funded evaluation of the project.
- **The Nicholson Foundation** convened the partners, funded the program, and provided ongoing technical collaboration.

Within the overall partnership, individual collaborations flourished among the partners. For example, Foundation staff worked closely with the DCF team to conceptualize the adaptation of Family-Based Recovery in New Jersey. The Yale Child Study Center, DCP&P agencies, and PBHG worked together to ensure that the referral protocols meshed with New Jersey's systems. The overall partnership was further strengthened because, from the beginning, the partners intentionally chose to act as equals. They made decisions collectively and by consensus, not in a hierarchical or directive fashion.

Impact and Sustainability

As of December 2020, the project was able to report some promising results: Parents were engaged and actively participating in the intervention, substance misuse continued to decrease, all of the children remained at home with their parents, and none of the currently active families had new reports of child maltreatment. In addition, IHRP continued to serve as a key resource in meeting participants' basic living and social service needs.

Project partners spent substantial time refining the design and implementation of IHRP because it had the potential to transform how case workers and treatment clinicians support parents with substance use disorders. The project reinforced the state's conviction that this new approach could be a better way to not only serve, preserve, and strengthen families but to also reduce the prevalence of these disorders. DCF's commitment to the program was demonstrated by its financial and staff support and its decision to fully fund two teams from PBHG to continue the project in Ocean County for an additional year.

IHRP's principal aim was to demonstrate the critical importance of supporting parent-child attachment and to show that substance use disorder treatment works. This was amply illustrated in the feedback from two program participants. One mother commented on the practical benefits by saying, "I was able to care for my child and let her have a mostly normal life while I was going through the changes I needed to, to better myself for her. I was grateful for not having to pack her up three times a week and drag her to an office surrounded by strangers or, worse yet, look for a stranger to care for her while I was away. This would have been hard both on our relationship and on my bank account. This program gave me the flexibility and support I needed to prove I was in fact a good mother and could care for my child despite the poor choices I had made in the past."

Noting the transformational power of personal change, another mother noted, "This program really saved me, allowing me the chance to be the mother that I always wanted to be. It helped me to stay sober and focused on my recovery, as well as caring for my baby... I [had] started to believe that being an addict was my destiny. I thought that I would never be able to love myself and my daughter the way I am today. I don't always have amazing days. During the pandemic, this program really helped me get through the tough times."





YE²S: A RECIPE FOR YOUTH SUCCESS

Youth ages 16 to 24 are in a pivotal period. Time spent in school and in other activities, such as clubs, recreational experiences, internships, and work experiences, provide the building blocks for their futures. These experiences are developmental anchors, helping youth refine cognitive, social, and interpersonal skills; obtain certificates and diplomas; learn from mentors and explore leadership opportunities; and create social and professional networks. Positive school, community, and work experiences foster a sense of purpose and belonging and help youth define who they are and who they want to become.

However, many young people live in communities that provide relatively few opportunities for enriching educational and work experiences. That dearth can create long-lasting barriers to achieving future economic prosperity and social success. And when youth aren't able to succeed, their communities also suffer because of greater neighborhood instability, lower tax revenues, and higher healthcare and social services costs.

During the Foundation's first decade, one of its main investment priorities was programs to bolster educational and work opportunities for youth. We looked at research on best practices for re-engaging youth who were not in school or working, and we learned about programs that matched services to students' needs, set high expectations, and encouraged positive environments and activities. We looked at alternative educational programs, small learning communities, and programs that partnered with community agencies.

We wanted to begin in Newark, so we reached out to the City of Newark, Newark Public Schools, and local community-based organizations, such as Rutgers University's Office of Continuing Professional Education's youth development division. The division, called Transitional Education and Employment Management (T.E.E.M.) Gateway, was dedicated to helping New Jersey's youth improve their quality of life and become productive community members.

With our support, this group of local leaders collaboratively built a bridge between youth and quality opportunities for lifelong learning and career development. That bridge was the Youth Employment and Education Success (YE²S) center, an integrated, one-stop center for counseling, training, and placement services.





Beginning with One YE²S Center

The first YE²S center opened in Newark in 2008, providing comprehensive, strengths-based, and individualized services to youth in a safe, supportive environment. Services included coordinated case management; referral to, and enrollment in, local school systems; academic tutoring; General Education Development (GED) high school diploma preparation; vocational and employment placement; career and life skills counseling; child care support; and connections to mentorships, community service, and internship opportunities.

Building on Success

Based on the success of the Newark approach, we talked with multiple city and county government agencies and community-based organizations about how to replicate the model in ways that responded to the unique needs of youth in other communities. In the subsequent four years, a YE²S center opened in Trenton (2010) and two centers opened in Camden (2012). Like Newark, these cities had high rates of poverty and social disadvantage and substantially lower high school graduation rates than did the state as a whole. Many of the participating youth also were involved with the local court system.

In Trenton, we worked with the City of Trenton, Trenton Public Schools, Mercer County Community College, and the Mercer County Workforce Investment Board. In Camden, we partnered with the City of Camden, Camden Public Schools, the Community Planning and Advocacy Council, and the Camden County Workforce Investment Board. All three centers had YE²S center advisory boards, with broad-based community membership.

Determining the locations of the centers turned out to be one of the most crucial decisions, for they needed to be in places where youth felt safe and comfortable. In Newark and Camden, we found neutral locations away from sites of gang violence. In Trenton, the center was located at the Daylight/Twilight High School, an alternative school that serves both youth and adults.

Each partner made important contributions to the centers. The Foundation provided funds for staff and operating expenses for the centers, and city governments provided office spaces and other in-kind support. The school systems offered space, facilities, and personnel to help with school enrollment for program participants. The Camden Workforce Investment Board supported a comprehensive GED program and provided support for a full-time GED instructor, counselors, and enhanced employment training opportunities.



Our relationship with The Nicholson Foundation was a true partnership. The Foundation's vision for collective impact, government/municipal leveraging, and flexible funding grants positively affected the lives of thousands of aspiring young adults.



— **KENNETH M. KARAMICHAEL, EDM,**
Founder, YE²S center and Rutgers T.E.E.M. Gateway program models





In the following years, the YE²S programs continued to thrive, developing a strong base of federal, state, local, and private resources that allowed the Foundation to end its grant support. For example, the U.S. Department of Health and Human Services funded a comprehensive, interdisciplinary four-year research study in Camden to explore effective case management strategies to support the needs of youth who were out of school or work. The Newark center secured a \$2.1 million, five-year Social Innovation Fund award, administered by the Corporation for National and Community Service (now known as AmeriCorps) to replicate an initiative focused on the specific needs of young men and to enhance their chances of completing the GED. The Trenton YE²S program became formally embedded within the school district's Daylight/Twilight program.

In 2016, the YE²S model expanded beyond the original three cities, when T.E.E.M. Gateway facilitated the development of the first countywide Youth Success Network, modeled after the initial YE²S center design. In partnership with Ocean County Community College, the program, known as the Ocean County Achievement Center, found a permanent home in the Community College and provided facilities, staff, and expanded wraparound services for all Ocean County youth.

Impact and Sustainability

Beginning in 2008, the YE²S programs brought local government agencies and community partners together in a shared vision of building productive futures for New Jersey's youth. Their success was recognized in various ways: Former Newark Mayor Cory Booker praised the program in multiple State of the City annual addresses, and the National Dropout Prevention Center named T.E.E.M. Gateway and the YE²S centers as a Model Program in 2011. In June 2011, the White House Council for Community Solutions hosted their National Youth Listening Tour at the Newark center, thus amplifying the impact and success of YE²S nationally. T.E.E.M. Gateway provided advice and support to youth development programs in a number of other countries, including South Africa, Morocco, Cuba, and Greece. This global cooperation, moreover, worked in both directions. Visitors from Northern Ireland, Brazil, Chad, and Denmark came to the Newark YE²S center to learn and to share their own strategies for supporting youth.



YE²S participants with Cory Booker and Ken Karamichael

The YE²S centers initiative began in 2006 with a conversation in a Newark coffee shop between Mark Hoover, the Foundation's Executive Director; Foundation staff; T.E.E.M. Gateway staff; and Stanford Brown, Chief Executive Officer of The Bridge, Inc., one of the community organizations that joined the YE²S effort. The conversation revolved around the idea of "collective impact investing"—how the Foundation could leverage its systems-centered thinking and its own and others' resources to bring together local school districts, school boards, mayors, and local and county government agencies in common purpose to measurably improve the futures of the youth they served. Over time, the blossoming of this idea helped more than 10,000 youth reconnect with education and work, ultimately changing the trajectory of their lives in ways that would profoundly benefit themselves and their communities.





CHAPTER TWO: KEY TAKEAWAYS

- **Recognize that government and the private sector play vital and complementary roles.** The private sector has the flexibility to respond quickly to opportunities as they arise, while government is restrained by budget cycles. Government, for its part, has the capacity to provide broad and long-term support to sustain programs.
- **Be sensitive to, and willing to align your work with, government's unique strengths and constraints.** If it is the goal of a project to be adopted by government, it is sensible to partner the development. That way, the service, funding, and political considerations government must contend with are naturally captured in the program design. Because of all these issues, government partners may need ample time to become actively engaged in, and to commit to, a project. This is especially important when the intervention involves a significant departure from established practice.
- **Be nimble when partnering with government.** You may need to quickly change and adapt if something unexpected happens, such as a major public health emergency, a change of political will, or a sudden change in funding.
- **Make formal and informal gatherings a central element of your partnership efforts.** These meetings can be a powerful way to bring together all stakeholders—government agencies, community organizations, and funders. Use them to gather information, highlight issues, encourage initial interest, gain commitments, and ensure continued buy-in and collaboration after programs are launched.





Elevating Best Practices and Building Evidence for New Jersey



All across the country, research, advocacy, and policy organizations are developing and promoting evidence-based and best-practice models to guide the work of service providers. The Nicholson Foundation actively sought out these models to inform its grantmaking, and borrowing the most successful and applicable of them made efficient use of our own resources.

Using models from outside as well as within New Jersey allowed us to benefit from the experience of a broad array of researchers and practitioners and gave our partners and grantees an opportunity to import inspiration and findings from elsewhere. Such replications provided proof-of-concept evidence for New Jersey, which was helpful in convincing payers to support the new efforts—ultimately facilitating systems change. One area in which we used this approach was health.

When the Foundation substantially increased its investments in health—beginning in 2010—a strategic priority quickly emerged: Strengthen the primary care component of the “safety net” healthcare system, which focuses on vulnerable populations. New Jersey, like other states, was experiencing high rates of poorly managed chronic disease—heart disease, diabetes, obesity, and asthma—and of mental health and substance misuse conditions. Primary care was the route through which most people entered the healthcare system to address these issues.

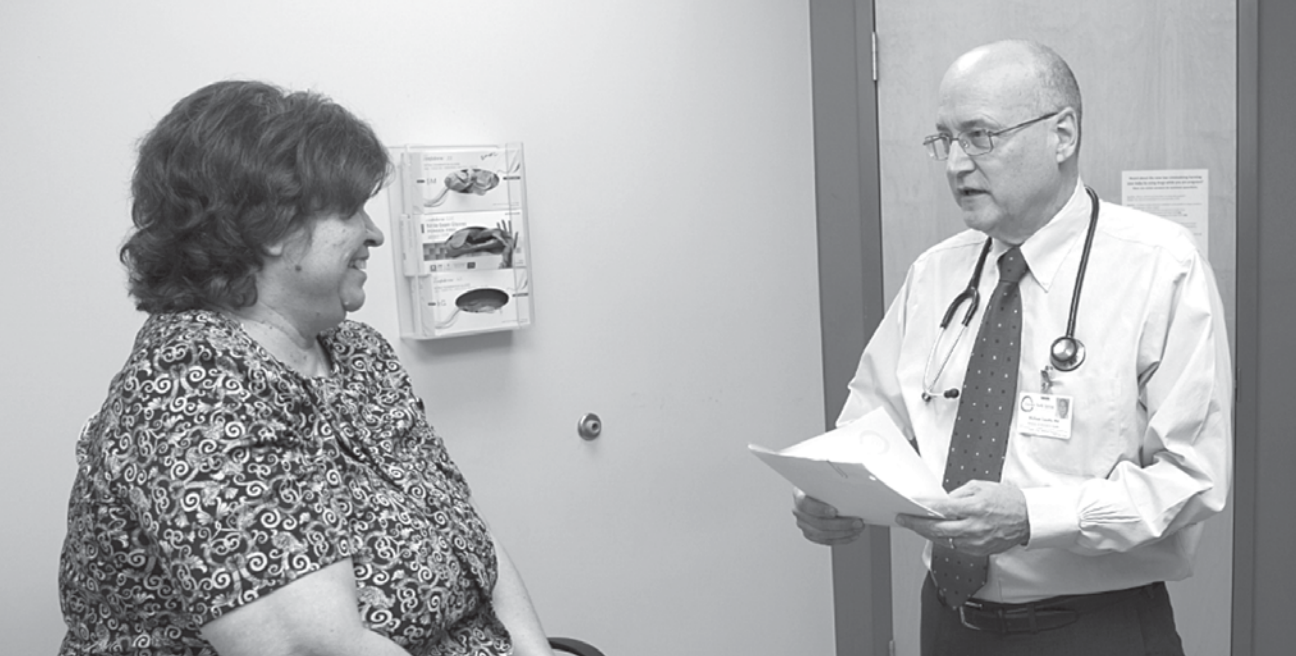
In New Jersey, primary care services for Medicaid and other vulnerable populations were delivered through community providers, Federally Qualified Health Centers (FQHCs), and hospital-based outpatient clinics. FQHCs were a critical component of the healthcare safety net because this national network of federally funded community-based organizations provided primary and preventive care to people of all ages, regardless of their ability to pay.

However, these safety net primary care systems, which were designed on a fee-for-service model to deliver acute episodic care, weren't well suited to provide the comprehensive, patient-centered, and team-based care that patients needed to address their interconnected physical and behavioral conditions and health-related social needs. We thought there might be better ways to give people stable access to appropriate and timely care while also reducing costly hospital-based care, improving outcomes, and reducing the burdens of chronic health conditions on society at large. Might it be possible to strengthen healthcare systems overall by changing protocols to institute team-based work flows, implement evidence-based practices, and use data to inform clinical activities, rather than by simply providing more funding? These goals echoed the core elements of the Triple Aim—enhance the experience of care, improve health outcomes, and reduce the cost of healthcare—which were the underlying force behind national efforts to reform healthcare.

The following stories illustrate what is possible by elevating best practices and building evidence in the field of primary care. They describe how the Foundation:

- Funded a multi-component initiative to integrate behavioral health into primary care for adults as well as children and to change the regulatory and licensing environment to make this service integration possible
- Supported Project ECHO, a national tele-mentoring model that connects primary care providers with specialists, as a strategy for improving care for complex health conditions





BEHAVIORAL HEALTH INTEGRATION: A BEST PRACTICE FOR NEW JERSEY

During the 2000s, efforts to provide needed behavioral healthcare in New Jersey were hampered by a shortage of care services. Not only was the supply of specialty providers limited, but few primary care providers had the capacity or expertise to provide this type of care. The result: Patients couldn't get treatment at all or didn't get treatment early, when it could have been less costly and more effective. It was a recipe for inefficient, expensive, and ineffective healthcare.

In exploring ways to address this issue, the Foundation found strong evidence to support "integrated care." In this approach, behavioral health and physical health issues are treated in the same setting and at the same time, in a coordinated way.

We were interested in seeing whether behavioral healthcare could be integrated into primary care settings that served people eligible for Medicaid and other safety net services.

Evidence showed that integrated care was good for primary care providers because it helped them understand and work with the "whole person." This mindset helped providers improve their diagnoses and design treatment to maximize compliance. It worked for patients because their behavioral health issues were addressed and their overall care was better and because working with their primary care provider was convenient, emotionally comfortable, and confidential. And it was good for the healthcare system because reducing stigma and barriers to treatment resulted in more people getting the behavioral healthcare they needed, when they needed it. Healthcare was improved overall.

In 2012, we launched a multi-pronged, multi-year effort in safety net primary care practices to alter their models of care by integrating behavioral health. By allowing our initiative to evolve over time and funding new grants as needs arose along the way, we enabled the adaption of best practices to the New Jersey context and built evidence about what worked.

What Is Behavioral Healthcare?

Care for mental health conditions, substance use disorders, and lifestyle changes related to chronic medical conditions.





Starting Small

We began with small-scale assessments to determine the feasibility of integrating behavioral health services into FQHCs and with a small pilot project in 2013. At the same time, we worked to find the right model of integrated care and the right partner to bring it to New Jersey. We found both in Cherokee Health Systems (Cherokee), a Tennessee-based FQHC and community mental health center. Cherokee operated more than 30 integrated care clinics in Knoxville and surrounding counties.

In 2014, we funded Cherokee to support the implementation of its model in a larger four-site pilot within two New Jersey FQHCs. Cherokee trained behavioral health consultants, licensed clinical social workers, and psychologists, and provided ongoing practical technical assistance to the sites. Cherokee also worked with the sites to develop new office policies and procedures, which helped institutionalize the practice changes, and helped them collect data to monitor and document progress.

The Cherokee Model

Cherokee's model of integrated care embeds within a primary care team a health professional who has expertise in behavioral health. This behavioral health consultant (BHC) provides brief behavioral health interventions to patients in real time, as needed. The BHC also works with the primary care provider and others on the team to ensure that all the patient's healthcare needs—both physical and behavioral—are addressed in a comprehensive and coordinated way.

Here's how it works: When a possible behavioral health issue emerges and the patient is willing to discuss it, the provider leaves, finds a BHC, and consults with the BHC on the patient's issue. The BHC then meets the patient in the exam room, checks in on how the patient is doing, and, as needed, provides a brief intervention and suggestions for additional help. When the intervention is complete, the provider returns and the visit resumes.

We chose Cherokee's model because of its many strengths:

- **It integrates behavioral health into primary care in such a way that the care, literally, comes to patients, when they are ready for it.**
- **It is supported by evidence showing improved patient outcomes and increased provider comfort with, and skills in, addressing behavioral health problems.**
- **It combines a powerful human touch with data-driven decisionmaking.**
- **It helps providers manage the vast majority of behavioral health issues within the primary care setting. This means that only the most severe issues are referred out to specialty care, freeing up higher-trained behavioral health specialists to focus on patients who require more intense services.**
- **It was developed within a practicing integrated-care clinic, not an academic or research setting. Cherokee staff were patient-centered practitioners first, and this experience provided the foundation for their later consulting and technical assistance work.**

Barbara Kang, the Foundation's Senior Program Officer who led this initiative, noted that implementing integrated healthcare was hard and took considerable time. "The sites had to change in small ways and in big," she said. "Changes included





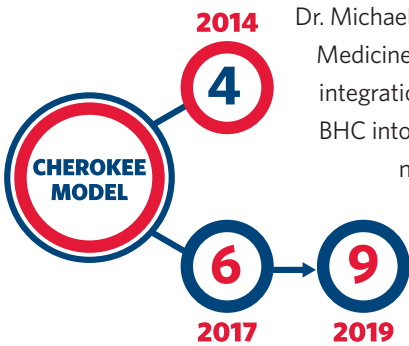
straightforward things like setting up new scheduling systems, changing clinic workflows, ensuring that medical and behavioral health electronic medical records could be shared, and revising consent forms. Even clinic layouts were sometimes changed to put the BHC offices in a central spot among the exam rooms. Other changes were less tangible but equally important. All the staff, together, had to transition to an entirely new, flexible, philosophy and practice of care.” Cherokee played a vital role in this transformation, for it provided intensive technical assistance, including initial training for all clinic leadership and staff to help them understand and accept this new approach. Cherokee also provided constant support to the staff as they changed their practice routines and culture of care. Ms. Kang continued, “The sites that thrived had leadership that fully embraced integrated care and provided the right support, encouragement, and staff training for the changes to succeed.”

Over the course of this pilot, the sites were able to increase the number of brief behavioral health interventions and began to bill payers for the patient encounters. However, it became increasingly clear that licensing and regulatory requirements made it difficult for the clinics to generate enough income to sustain the delivery of integrated healthcare. Realizing that this issue had to be addressed for integrated care in New Jersey to fully succeed, we approached a team at Seton Hall University School of Law, led by John Jacobi. Professor Jacobi’s background in health law, his expertise in licensing and regulatory issues, his years of experience working with the state—and the state’s reliance on his guidance on healthcare-related regulations—made him and his team the right partners for this task.

We asked the Seton Hall team to conduct an in-depth analysis of licensing and regulatory barriers to integrated care in New Jersey and to recommend ways to reduce them. The team worked closely with the state during the report’s development, with the result that the state was receptive to a number of its recommendations. The report, *Integration of Behavioral and Physical Health Care: Licensing and Reimbursement Barriers and Opportunities in New Jersey*, was released in March 2016.

Expanding the Model and Developing Home-Grown Expertise

Our success with the pilot and our collaboration with the state to address barriers to integrated care gave us the confidence to expand the initiative and build additional evidence. We funded the implementation of Cherokee’s model in six primary care sites in 2017 and funded three more in 2019. All of these sites primarily served those insured through Medicaid. Cherokee refined its technical assistance for these sites based on knowledge gained from the pilot.



Dr. Michael DeLisi, a primary care provider at St. Joseph’s Family Medicine at Clifton—one of the three 2019 sites—described what the integration of behavioral care looked like at his clinic. “Integrating our BHC into our care model increased our ability to meet our patients’ needs in-house. Patients who might not have gone elsewhere for additional needed care were able to get it here.

Doctors who might have had some hesitancy to address a need beyond their usual level of care began to reach out to their patients with that extra step, knowing that back-up and continued care were available at our clinic.”





During the six-site phase, it was clear that billing and coding issues were an ongoing impediment to financial viability. When we added the three final sites, we also funded a billing consultant with New Jersey expertise and asked Cherokee to help the sites improve these practices so that their integrated care services could become a fully sustainable source of income. We also reached out to Metropolitan Family Health Network, an FQHC in Jersey City and one of the six sites. Because they had been a leader when it came to billing practices, we asked them to work with Cherokee to give the sites additional billing-related clinical and administrative technical assistance. Involving Metropolitan also helped us move toward a long-standing priority for this initiative, which was to develop New Jersey-based expertise in integrated care that could be used to expand the model to other sites across the state.

Moving Upstream

Training active clinicians to provide integrated care was the first big step for the behavioral health initiative. The logical follow-on was to think about how to inculcate this holistic treatment approach at the beginning of a medical career. In other words, start the learning early, rather than later when it's harder to change established attitudes and approaches. That idea led us to Frank Ghinassi, President and Chief Executive Officer of Rutgers University Behavioral Health Care (UBHC).

Dr. Ghinassi is an academician and educator whose research has focused on the intersection of physical and behavioral health. He also was responsible for building quality integrated healthcare programs and training future healthcare professionals.

Beginning in 2018, with Foundation funding, Dr. Ghinassi worked with eight health-related professional schools at Rutgers University to lay the groundwork for new educational and clinical practice infrastructures and curricula that would integrate behavioral health into all phases of healthcare clinical training. This new training approach also would emphasize collaborative and team-based care.

In 2019, the schools established faculty and student steering committees to develop the new infrastructures and curricula. They also created an advisory council comprising Cherokee, Metropolitan, and Foundation staff, along with practitioners who could provide feedback from the field. The plan to introduce behavioral health integration in the eight schools included three tiers of training intensity:

- **Tier I.** All students in the eight schools receive an introduction to behavioral health integration through lectures, videos, and case studies. Planning for this component was completed in 2020, with content completed in early 2021. The next step is sharing this component with the schools' deans to develop a timeline for distribution to students.
- **Tier II.** Students from a subset of the eight schools receive more immersive training, which varies depending on the school and how far the students have progressed in their training. As of February 2021, the steering committee had begun to develop

Participating Health-Related Professional Schools

- **Robert Wood Johnson Medical School**
- **Rutgers New Jersey Medical School**
- **Rutgers Graduate School of Applied and Professional Psychology**
- **Rutgers School of Nursing**
- **Rutgers School of Dental Medicine**
- **Ernest Mario School of Pharmacy**
- **Rutgers School of Health Professions**
- **Rutgers School of Social Work**





the framework through which the students would receive this content. This included determining which schools and classes would be included in Tier II and the intensity and dosage of information provided.

- **Tier III.** Selected students who would be actively engaged with patients receive practicum experience (other students, such as future x-ray technicians, would not need this level of training). Development of this tier will be included in longer-term planning for this project.

The Foundation's grant funding supported UBHC's initial work to enlist the eight schools and complete the initial conceptual planning. Recognizing that this would be a complex and long-term effort, Dr. Ghinassi also pursued additional sources of funding to support this work after the Foundation's funding ended.

Considering New Populations

In the final stage of this initiative, we worked with others to bring integrated care to pediatrics. We funded the introduction of HealthySteps, an evidence-based, interdisciplinary pediatric care model, into three pediatric primary care practices within the New Jersey Hackensack Meridian Health system. In all the sites, two-thirds or more of the patients were insured by Medicaid. We co-funded this last phase of our integration journey with the Burke Foundation and the Turrell Fund, two New Jersey foundations with strong interest in early childhood issues.

This project also involved a collaboration among the Seton Hall law school team, ZERO TO THREE, and Manatt Health, a healthcare business strategy and consulting firm. The purpose of the collaboration was to develop a business case for the HealthySteps model. Because direct payments through traditional Medicaid reimbursement mechanisms are not always possible for HealthySteps visits, the team examined the potential of alternative Medicaid payment models as well as other types of funding streams. The approach used in this project was consistent with earlier phases of our integration initiative, in which we aimed to support an evidenced-based clinical model that would be financially sustainable over the long term. ZERO TO THREE was tasked with final development of the business case; its report will be completed by the end of 2021.

The HealthySteps Model

HealthySteps is a program of ZERO TO THREE, a national professional development and policy organization. HealthySteps promotes positive parenting and healthy development for infants and toddlers, with an emphasis on culturally diverse families living in low-income communities. HealthySteps specialists, who are behaviorists with expertise in child development, trauma, adverse childhood experiences, and other behavioral health issues, are integrated into the practice of pediatric primary care.

Impact and Sustainability

By fostering change at several levels of the healthcare system, the Behavioral Health Integration initiative had the potential to fundamentally strengthen adult and pediatric primary care in New Jersey.

At the individual practitioner level, the BHCs and HealthySteps specialists provided a focus on behavioral health and early childhood development issues that physicians might not have been able to address because of lack of knowledge, experience, or time. The initiative provided a way for these critical issues to be addressed more





comprehensively. Lee Ruszczuk, Director of Behavioral Health at Henry J. Austin Health Center, one of the participating adult healthcare sites, summarized the benefit by saying, “Integrated care at Henry J. Austin has allowed the whole person to be treated in one place with a team of skilled professionals all working together toward the same goal of getting patients to their healthiest.”

On the practice level, the initiative influenced primary care training, staffing, and workforce development issues and helped change practice cultures. It also improved billing and coding protocols and identified new payment streams, which helped sites become more financially stable and helped ensure the long-term viability of integrated care. By early 2021, the FQHCs that we began funding in 2017 were being reimbursed for three-quarters or more of their behavioral health claims, resulting in nearly enough income to fully support the model.

On the education and training level, this work demonstrated the potential to shift the way the healthcare workforce is developed in New Jersey and, in turn, other states. It did this by fostering the reprogramming of an academic environment to one in which healthcare would be conceived of, taught, and delivered from an integrated perspective.

On the policy level, the initiative led to a new examination of statewide regulations and licensing requirements for providers. Our work with the Seton Hall University School of Law enhanced the state’s emphasis on the importance of integrated care, and, at the state’s request, the Foundation funded Seton Hall’s continued collaboration with state agencies. Additionally, in 2018–2019, the New Jersey Department of Health established an Integrated Health Advisory Panel, which helped the state design a new, coordinated system of patient-centered care that encompassed prevention, wellness, treatment, and recovery. Professor Jacobi served on the panel, and his expertise was essential to its deliberations. The Nicholson Foundation played a substantial role, as Dr. Arturo Brito, the Foundation’s Executive Director, also was a member. In addition, the Foundation brought Cherokee leadership to the panel to describe their model of integrated care and their experiences working in New Jersey. The presentation influenced the panel’s thinking about policy and regulatory changes needed to facilitate the integration of behavioral health into primary care.

The Behavioral Health Integration Initiative—both the clinical implementation and the workforce development aspects—will continue after the Foundation’s funding ends because the organizations we worked with during more than eight years recognize that integrated care is a better approach to caring for patients than is the traditional form of separated care. They have invested time, resources, and leadership to change their practice cultures to reflect this new approach. Importantly, their work has been successful enough that they are now able to support integrated care without the need for grant funds.

In coming years, RWJ Barnabas Health plans to introduce the Cherokee model in their clinics and practices. Hackensack Meridian Health plans to take similar action with the HealthySteps model. The impact of these plans is potentially profound, for these institutions are the two largest healthcare systems in New Jersey. RWJ Barnabas treats more than 3 million patients a year in a range of settings, including hospitals and specialty and ambulatory care facilities, as well as through other services.

The Hackensack Meridian Health system comprises a diverse array of more than 500 patient care settings throughout the state.

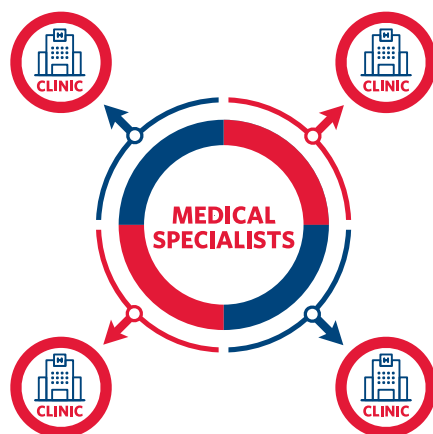




BUILDING EVIDENCE FOR AN INNOVATIVE HEALTHCARE SERVICE DELIVERY MODEL

An impetus for the Foundation’s interest in strengthening primary care was the expansion of Medicaid in New Jersey. The embrace of this opportunity under the federal Affordable Care Act of 2010 was announced by Governor Chris Christie in February 2013 and began in 2014. Healthcare experts and practitioners recognized that Medicaid expansion would result in a substantial increase in the number of patients. And, in fact, by July 2018, the number of Medicaid beneficiaries had increased in New Jersey by nearly 470,000. This rapid increase put pressure on the already overburdened supply of primary care providers serving patients insured by Medicaid, and highlighted the problems with specialty care for this population—few specialists, high costs, and low Medicaid reimbursement. Building expertise among providers so that they could safely and effectively manage complex health conditions—in effect, expanding their capacity to meet the the community’s specialty care needs and reducing care demand by making it more accessible early, before crises develop—was one way to address this overburden.

We looked for a model that could build this kind of expertise and found it in Project ECHO, a tele-mentoring strategy developed in 2003 at the University of New Mexico by Dr. Sanjeev Arora. Project ECHO uses telecommunications technology to connect an interdisciplinary team of medical specialists (a “hub”) with providers at various locations (the “spokes”). The strategy is to give primary care providers specialist expertise in a particular medical problem that occurs frequently in their patient community. The sessions include brief didactic presentations, case studies of patients, and interactive problem solving to enhance providers’ skills, knowledge, and ability to provide comprehensive, best-practice care for their patients. Project ECHO originally focused on hepatitis C, which was a recurring problem in New Mexico. Specialists necessary to address this disease were difficult to access in that state because the





population is so sparsely settled. In the years since, the model has been successfully applied to many other health conditions, including diabetes, hypertension, cancer, bone health, and ophthalmologic conditions.

We launched an effort in 2013 to use the Project ECHO model with primary care providers serving New Jersey patients insured by Medicaid. Among our partners were two agencies within the New Jersey Department of Human Services: the Division of Medical Assistance and Health Services (the agency that administers the state’s Medicaid program) and the Division of Mental Health and Addiction Services. Other state partners were the Department of Health (DOH) and the Department of Children and Families. An important element of our efforts to engage our state partners involved learning experiences, including several trips to New Mexico to experience Project ECHO firsthand and in-person seminars in New Jersey with Dr. Arora.

First Steps

One of the project’s first critical decisions was determining which health conditions would be the focus for a pilot Project ECHO clinic in New Jersey. We looked at data on complex diseases that were driving the majority of avoidable hospitalizations among those receiving Medicaid services. We also identified diseases for which access to specialists was scarce. We matched these findings to data on the interests of providers and health plans. Addiction, chronic pain, diabetes, and children’s behavioral health were at the top of the list.

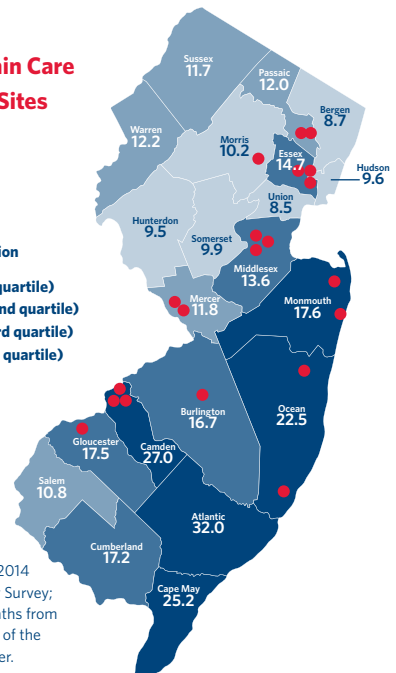
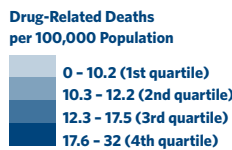
We decided to use the pilot Project ECHO clinic to address the treatment of chronic pain and opioid dependence because New Jersey, like many other states, was in the grip of the opioid epidemic. This crisis had resulted in part from primary care providers overprescribing or inappropriately prescribing opioids to treat chronic pain. Focusing on providers was a way to help them be part of the solution to the problem.

We also wanted to find a New Jersey institutional home for the hub. Because we wanted to move quickly, however, we initially partnered with the Connecticut-based Weitzman Clinic, a large FQHC that had an established Project ECHO opioid treatment clinic.

In 2014, we funded Weitzman to establish pain care clinics in three New Jersey primary care safety net practices. Following this successful pilot, we funded Weitzman in 2016–2017 to operate the New Jersey Pain Care Collaborative, a substantial expansion of the model to 29 providers in 20 safety net practices located in areas of the state with high numbers of drug-related deaths.

The experience with Weitzman proved to be an important building block: It identified local champions for the model

New Jersey Pain Care Collaborative Sites



Data Source: U.S. Census Bureau’s 2014 American Community Survey; 2014 drug-related deaths from the New Jersey Office of the State Medical Examiner.





and provided useful data and lessons that we could use in applying Project ECHO to other health conditions. Data collected by Weitzman throughout the project showed that providers found participation in the ECHO sessions valuable. These data also showed statistically significant increases in the providers' knowledge about complex chronic pain, their confidence in being able to appropriately treat chronic pain patients, and their use of guideline-recommended pain care methodologies. Finally, the data revealed a few not-surprising challenges: Staff turnover and conflicting organizational priorities hindered consistent participation in ECHO sessions. In addition, limited integration of clinical and workflow systems between the practices and their individual providers made it difficult to measure patient outcomes.

Finding a New Jersey Home for Project ECHO

Achieving our goal of finding the right home for Project ECHO in New Jersey took considerable time and effort. We wanted to find an academic medical center to serve as the hub for the new clinics. The hub would provide a steady supply of specialist faculty to guide providers in the primary care spokes. Serving as a Project ECHO hub also would benefit the academic medical center because it would give the center a new and innovative way to provide continuing medical education to its providers.

Ultimately, in 2016, the Robert Wood Johnson Medical System became our partner in this initiative, with the hub at the Robert Wood Johnson Medical School (RWJMS). In that year, RWJMS launched three Project ECHO clinics focusing on Complex Endocrinology and Diabetes, Chronic Pain and Pain Management, and Pediatric Behavioral Health. Through the clinic, providers all over the state could join in tutorials, collaborations, and consultations with the hub.

In 2019, the initiative broadened to include e-consults—a way to integrate specialist expertise into primary care using telehealth. From 2019 to 2021, the Project ECHO program also expanded the number of topics substantially, ultimately including 12 clinics covering a range of issues of critical current importance to providers.

E-consults: A New Frontier for Telehealth

In e-consults, a primary care provider communicates electronically with a specialist through secure, web-based email. The specialist replies with advice about whether a referral is needed. If not, the specialist works with the provider to determine the right course of treatment.

Between September 2019 and March 2020, the e-consult program:

- **Recruited 40 providers across 4 practices**
- **Recruited 14 subspecialty groups, including Infectious Disease, to address COVID-19**
- **Completed 107 e-consults**

ECHO Clinics in 2021

- **Adverse Childhood Experiences**
- **Agency for Healthcare Research and Quality Nursing Home COVID-19 Action Network**
- **Chronic Pain Management**
- **Community Health Workers**
- **Community Health Workers and Doula Competency Training**
- **COVID-19 Rapid Dissemination in Partnership with the State of New Jersey**
- **Complex Endocrinology**
- **Health Equity and Social Justice**
- **Maternal Child Health Opioid Use Disorder—Pre and Postpartum**
- **Neonatal Abstinence Syndrome and Substance Exposed Infants**
- **Postpartum Warning Signs**
- **Substance Use Disorder and Mental Health**





Similar to the Weitzman experience, a survey of RWJMS Project ECHO participants found increased content knowledge over time, enhanced sense of confidence in treating patients, and increased understanding and use of evidence-based guidelines. More than 9 out of 10 participants reported satisfaction with the sessions, noting that the sessions influenced their care plans and were an effective educational experience.

Evaluating the Model

New Jersey's Medicaid agency was interested in partnering on the Project ECHO initiative not only to enhance primary care services for patients, but also to try to reduce program costs. To build evidence of ECHO's impact beyond the data collected by Weitzman and RWJMS, we funded the Rutgers Center for State Health Policy to conduct an evaluation to test the impact of the Endocrinology ECHO clinic on patient outcomes and Medicaid spending. The analysis compared the patient outcomes and cost of care for ECHO-participating Medicaid primary care physicians to the experience of non-participating physicians, during and for more than a year following the intervention period. The analysis found statistically significant reduced Medicaid hospitalizations and hospital spending among the patients with diabetes seeing ECHO-participating physicians. It also found that other important patient outcome measures, including total Medicaid spending, while not achieving statistical significance, were consistent with a positive program effect. Publication of these results is anticipated in late 2021.

Project ECHO Shows its Value During a Crisis

In early 2020, the COVID-19 pandemic hit New Jersey hard, creating an unprecedented challenge to the state's healthcare system. New Jersey's DOH needed to convey information and guidelines about emerging practices for COVID-19 clinical care and personal safety to as many front-line providers as possible, as fast as possible. The Foundation reached out to DOH and suggested pausing the existing Project ECHO clinics so that the ECHO platform could be dedicated to COVID-19 uses. Project ECHO's expertise and easy-to-use infrastructure soon became essential to the state's efforts to quickly spread information about emerging best practices. In partnership with DOH, RWJMS launched four new Project ECHO clinics focused on improving the COVID-19 preparedness and response efforts of New Jersey providers and communities. The New Jersey Division of Consumer Affairs (DCA) also became involved because they license the state's healthcare providers. DCA's database of all licensed New Jersey providers was a critical resource that enabled the state to reach out to front-line providers comprehensively and quickly.

From March to July 2020, RWJMS completed 23 sessions in 4 topic areas relating to COVID-19: (1) epidemiology and infection prevention, testing essentials, telehealth regulation, and provider implementation; (2) maternal and child health; (3) mental health; and (4) long-term care. RWJMS and the state worked closely together to bring in the required clinical and communications experts to conduct the sessions. In all, more than 17,000 providers participated in the sessions, with an average attendance of 515 providers per session. In addition, the RWJMS Telehealth group was asked to deploy a new telemedicine effort to transition patients who didn't have COVID-19 from in-person visits to video medical visits. More than 600 providers took advantage of this new application, and RWJMS conducted 17 online training sessions with more than 570 staff members.





“Applying Project ECHO to the COVID-19 crisis was a transformative moment for this initiative,” explained Raquel Mazon Jeffers, the Foundation’s Senior Program Officer who led this initiative. “The model’s flexibility and utility suddenly became very clear to state government leaders, to providers, and to other interested groups, including the community-based and public health workforce.” As one indicator of this change, when the previous clinics resumed their sessions in September 2020, average attendance was more than 100 providers per session, a more than fourfold increase compared to pre-pandemic attendance. This rapid expansion of Project ECHO enrollment coincided with the rapid adoption of telehealth that was occurring simultaneously around the country in response to the pandemic.

Impact and Sustainability

The thousands of providers who participated in Project ECHO’s clinics benefited from two essential strengths of this initiative—the flexibility of the model and Project ECHO’s institutional home. As a simple video conferencing platform, Project ECHO required little or no adaptation to be used with a broad population of New Jersey providers, and it could be quickly repurposed to respond to unexpected events. Additionally, planting the initiative in a major New Jersey academic medical center provided long-term institutional stability and gave the initiative a base from which to grow and evolve.

One of Project ECHO’s main strengths is the diversity of both hub experts and spoke participants. The clinics strive to have multi-disciplinary teams of experts lead the sessions and an equally diverse group of participants join in and inform the discussion amid recommendations from the experts. Nearly 4 in 10 participants are medical professionals, including physicians, nurses, doulas and midwives, and pharmacists. Social services and behavioral health professionals represent another 4 in 10 participants. Indeed, “all teach, all learn,” in which all voices are equally important, is at the heart of the ECHO experience.

During the course of this project, we learned that it sometimes takes a long time for the right opportunity, the right partners, and the right idea to come together. It took more than five years for this initiative to find its ultimate institutional home in New Jersey and to become a viable and established approach for providing access to specialty care within primary care settings. Having these achievements in place was crucial to the success of the model’s application during the early days of the COVID-19 pandemic in the state.

The Foundation’s investment created an infrastructure that the state can continue to use to remove traditional barriers between primary care physicians, specialists, and community services providers; to foster new collaborative approaches to lowering costs and improving healthcare quality; and to build evidence for durable strategies that can strengthen primary care for populations in New Jersey who receive safety net health services. For Kathy Dodsworth-Rugani, Project ECHO’s Executive Director, the Foundation’s support for the program had a profound and long-lasting effect: “The Nicholson Foundation’s investment in Project ECHO inspired a host of partnerships with state government leaders, Rutgers University department leaders and faculty, other medical and academic health centers, hospital leaders, foundations, and community organizations. Project ECHO’s partnerships resulted in additional grants, enabling us to tap into subject-matter experts from across the state to lead the ECHOs and allowing participants to join ECHO from every county in New Jersey.”





CHAPTER THREE: KEY TAKEAWAYS

- **Adopt and adapt.** Find what works elsewhere and identify ways to use it or adapt it to specific contexts and circumstances. This is a smart way to improve services and build evidence.
- **Be willing to commit to providing resources over a long period.** Patience is necessary to ensure that the right people, opportunity, mechanism, and other elements come together to make a project succeed. It also helps in dealing with the inevitable complications that arise along the way.
- **Make sure that potential partners understand that the science behind an initiative is what makes it a priority.** Recognition by the partners that the project is a way to disseminate best practices and build evidence is important to generating equal enthusiasm and commitment by all.
- **Capitalize on experiences that grantees gain from funded projects.** Help them spread their good ideas and new expertise to other local organizations. This approach to building home-grown capacity can accelerate the dissemination of best practices and ensure systems change.
- **Understand that changing organizational culture takes time.** It can be done only with engaged leaders and champions who are invested in building a team that is committed to the initiative for the long haul.
- **Recognize that people who are closest to a problem often have the best ideas on how to address and even solve it.** Partnering with local groups, such as community-based health organizations, can help them highlight the role that health-related social needs play in health and other outcomes. These partnerships also can help them accelerate efforts to reduce inequities in care and services.
- **Remember that evidence evolves over time.** Research may bring unexpected results—positive or negative. Be open and transparent about the results and their impact. Remember that your goal is not to enact a specific model but to find out what really works to improve the lives of those you seek to help.





Finding and Nurturing Effective Partnerships



Foundations generally have the same goal—give money to support worthy initiatives—but they take different paths according to their missions and visions. From the very beginning, The Nicholson Foundation knew that forging partnerships as the centerpiece of our grantmaking investments was the best path for us to take.

Over the years, we carefully selected grantee organizations to fund, and we nurtured those relationships through ongoing technical collaboration and regular reviews of progress. We sought out a diverse array of nonprofit organizations, foundations, and state agencies and departments to join our work. In our later years, we intentionally started these partnerships on a small scale, sometimes with a planning grant. If the small projects were successful, we continued the funding with larger efforts. Sometimes, it took considerable time and trial-and-error effort to find the right partners and the right project on which to collaborate.

This partnership approach had several advantages. One was that banding together brought diverse skills and experience to bear on a problem. Collaborations also increased the likelihood that the funded organizations would be able to continue the work after the Foundation's support ended.

Another advantage was that partnering with others improved the Foundation's visibility in New Jersey and enhanced our reputation as a committed player in the focus area of the project. The work involved in developing an effective partnership also helped us hone our ideas and determine what was the best route for us to take in a particular issue.

The following stories illustrate what is possible with nurtured, productive partnerships. They describe how we:

- Worked with one partner to carry out multiple projects over a period of years
- Collaborated with multiple partners to tackle one priority issue
- Explored several types of partnerships before eventually finding the right fit for us in an emerging area of interest





THE NEW JERSEY HEALTH CARE QUALITY INSTITUTE: AN ENDURING PARTNER

During the first decade of the 2000s, a wave of healthcare reform efforts swept the country, with the national conversation focused on how to both improve quality and reduce cost. For the Foundation, the timing was fortuitous because, simultaneously, it was becoming increasingly clear to us that healthcare was intertwined with the social services arenas in which we were working. Factors such as poverty, structural racism, unstable housing, food insecurity, and economic and educational barriers all contributed to poor health outcomes. But people couldn't address their health problems because healthcare systems were overburdened, disconnected, and under-resourced. If we wanted to improve the overall well-being of vulnerable populations in New Jersey, we had to pay attention to healthcare as well as related social needs.

As a result, we started considering ways in which we could invest in healthcare directly. Our first step was to learn all we could about the healthcare safety net system in New Jersey. We scanned the New Jersey landscape and identified service providers; community leaders; non-governmental policy, education, and advocacy organizations; researchers; and other foundations working on this issue in the state. We got an essential boost in our understanding through multiple conversations with David Knowlton, a former Deputy Commissioner in the state Department of Health. He was the Founder and President of the New Jersey Health Care Quality Institute and a longtime leader in healthcare policy in New Jersey. Launched in 1997, the Quality Institute was a nonprofit policy and analysis organization that worked to ensure that safety, quality, accountability, and cost containment were all closely linked in the delivery of healthcare services in New Jersey.

The more we learned, the more we recognized that we needed a like-minded partner to help us think strategically about how to move forward in this area. We knew we had found that partner in the Quality Institute because it had four important characteristics:

- An established reputation as a respected leader and neutral advocate for all stakeholders
- A history of being an objective, data-driven organization
- A deep understanding of healthcare financing and payment systems
- A strong commitment to the value of primary care





Improving safety net primary care systems was the key thing we wanted to focus on. Medicaid would therefore be a major part of our efforts. The Quality Institute's extensive knowledge of New Jersey's Medicaid program and strong connections with the program's leadership were critical assets.

The Medicaid Program in New Jersey

Medicaid is a joint federal-state program that provides health insurance coverage for many low-income individuals, including adults, families with children, older people, those with disabilities, and pregnant women. Administered by New Jersey's Department of Human Services, Medicaid is critically important to the government and the people of the state.

- **Medicaid pays for health services for a large percentage of the state's population.**
 - **About 1 in 5 residents is enrolled. This translates to nearly 2 million people, including 1 in 8 adults and 1 in 3 children.**
 - **Nearly 3 in 10 births are covered by Medicaid.**
- **Medicaid represents a substantial financial investment for the state. In 2019:**
 - **Combined federal and state Medicaid spending in New Jersey was more than \$16 billion.**
 - **The state's contribution to Medicaid—\$6.6 billion—was nearly 17% of New Jersey's overall budget.**
- **Medicaid plays a significant role in the state's overall economy.**
 - **The healthcare industry is the state's second-largest employer.**
 - **On average, about one-quarter of the revenue of all New Jersey hospitals and half the revenue for safety net hospitals comes from Medicaid reimbursements. These payments are essential to the financial stability of New Jersey's hospitals.**

Medicaid enrollment goes up and down, depending on economic trends and policy actions. This has important implications for the number of people who are able to get healthcare and for the state's budget.

- **Enrollment increases in recessions and declines when economic conditions improve. For example, enrollment increased by nearly 217,000 over the course of the 2007–2009 Great Recession.**
- **Enrollment is affected by federal changes to the program. For example, the 2010 Affordable Care Act expanded the definition of Medicaid eligibility, which meant that more adults could enroll. Individual states were allowed to decide whether to apply this expanded eligibility to their Medicaid programs. New Jersey expanded Medicaid in 2014, and, by July 2018, enrollment had increased by nearly 470,000.**





Working Together

Over the years, our work with the Quality Institute encompassed an ongoing, collaborative conversation about strategies to streamline and improve the delivery of, and payment for, healthcare services for vulnerable populations. This joint work is illustrated by three shared initiatives carried out over a period of 10 years. Each was distinct and provided a firm foundation for the next.

Support for Medicaid Accountable Care Organizations (2010-2016)

In 2010, we began to invest in several fledgling community-based healthcare coalitions—in Newark, Camden, and Trenton (for more details, see *Healthcare Coalitions: A Strategy for Community Transformation* in **Chapter 5. Investing in Organizational Nuts and Bolts**). Informed by analyses of community- and neighborhood-level data, the coalitions were striving to ensure that quality, comprehensive services were delivered to local residents.

The following year, the New Jersey legislature enacted, and Governor Chris Christie signed, a three-year Medicaid Accountable Care Organization (ACO) Demonstration Project. With our collaboration and support, the Quality Institute strengthened the three coalitions' institutional capacity so that they could successfully apply to become Medicaid ACO sites. During 2012 and 2013, the Quality Institute worked with the coalitions to facilitate their participation in an ACO learning and support network. The Quality Institute convened meetings with the New Jersey Department of Human Services' Medicaid office and the Department of Health, organized conferences and webinars to help the

coalitions set up structures to collect and share data, and organized in-depth learning trips and other opportunities to share ideas, challenges, and best practices. In addition, the Quality Institute worked closely with the Medicaid office to resolve cost, legal, and many other issues related to the coalitions' participation in the ACO Demonstration Project.

Our partnership with the Quality Institute, along with our direct investments, helped the coalitions mature in their ability to work with the Medicaid system, provide direct care coordination and management services to individuals in their communities, and move toward a broader focus on improving population health. In 2015, the state selected the coalitions in Camden, Trenton, and Newark to be New Jersey Medicaid ACOs.

What is a Medicaid Accountable Care Organization?

An ACO is a network of doctors, hospitals, and other health-related professionals in a catchment area that share financial and medical responsibility for providing coordinated healthcare to patients with the aim of improving quality and reducing costs.

Originally designed for the Medicare program, the concept was applied to Medicaid programs in some states, such as New Jersey.



Linda Schwimmer, President and CEO of the New Jersey Health Care Quality Institute





Medicaid 2.0 (2016–2017)

The Medicaid ACO project provided many insights about New Jersey’s Medicaid program and its strengths and challenges. The next step was to apply these lessons to strengthen the program and make it more responsive to the needs of people insured by Medicaid.

Joan Randell, the Foundation’s Director of Health and Rehabilitation from 2008 to 2015 and Chief Operating Officer from 2015 to 2017, and who led the Foundation’s healthcare initiatives, conceived the idea of creating a blueprint that New Jersey Medicaid could use to redesign and modernize its program. The blueprint also would build on similar efforts other states were undertaking at the time. Such an initiative had the potential to transform the program and, ultimately, the lives of hundreds of thousands of those served by Medicaid. Realizing this potential, the Foundation worked with Linda Schwimmer—a healthcare policy expert who had succeeded David Knowlton as President and Chief Executive Officer of the Quality Institute—and her staff to conceptualize and plan the effort that turned this idea into reality.

In March 2016, the Quality Institute launched the Foundation-funded “Medicaid 2.0” initiative under Ms. Schwimmer’s leadership. The Quality Institute engaged Matt D’Oria, a Medicaid and health policy expert to provide strategic direction for the blueprint. The first activity was to learn from the many groups and agencies that designed, delivered, and paid for Medicaid services in New Jersey. This phase also included an examination of other states’ Medicaid programs and their innovations. The project’s participants then identified and examined issues in five key focus areas and developed consensus recommendations.

Medicaid 2.0: Blueprint for the Future was released in March 2017, with 24 major recommendations. Because state agencies and departments, organizations, and individuals across the healthcare spectrum were deeply involved in its development, the report was broadly accepted and used extensively by incoming Governor Phil Murphy’s healthcare transition team after he was elected in November 2017.

Following the *Blueprint’s* release, the Quality Institute—with another round of Foundation funding—worked closely with leaders across the state’s healthcare system to consider how the report’s recommendations could be carried out. As of February 2021, more than half of the recommendations had been implemented or were in the process of implementation.

Transforming Medicaid

The *Blueprint’s* 24 recommendations fell into 5 broad categories:

- **Modernization**
7 recommendations to modernize Medicaid infrastructure
- **Basic Medicaid Reforms**
3 recommendations on essential functions, such as quality measures and credentialing systems
- **Upgrades to the Medicaid Model**
3 recommendations to change the delivery of physical and behavioral health services
- **Financing Reform**
7 recommendations to address Medicaid’s fiscal problems and improve the return on investment for beneficiaries and taxpayers
- **Path to Population Health**
4 recommendations to address the long-term health of the Medicaid population in areas such as maternal and family health and advanced care planning





Medicaid Policy Center (2018 to Present)

As in other states, New Jersey's Medicaid program always has been important because of its size, budget, and responsibility to respond to federal and state policy action. The *Blueprint's* recommendations made it clear that the program had to look for ways to continually evolve and improve.

To address this need, the Foundation worked with and supported the Quality Institute to plan and establish a Medicaid Policy Center. The Center's role was to provide research and analysis to facilitate the Medicaid Director's and Department of Human Services Commissioner's policy recommendations and to help them be as objective and data-driven as possible. Beginning at its launch in 2018, the Center worked with the state and other healthcare players on additional *Blueprint* recommendations, such as developing improved payment mechanisms for maternity care and establishing a patient-centered medical home model for children with complex medical conditions. It also identified national best practices and leading-edge solutions to better serve those insured by Medicaid. Additionally, the Center monitored the health policy landscape to track emerging challenges in payment, service delivery, program administration, and beneficiary access, and provided other services, such as data reporting and federal and state budget analysis. Through this broad array of services and its close collaboration with the state, the Medicaid Policy Center gave the state, as well as other organizations that care about healthcare, added capacity to address issues that potentially have a broad and long-lasting impact on the health of people served by Medicaid.

Impact and Sustainability

The New Jersey Health Care Quality Institute was our first partner in building our healthcare portfolio, and it continued to be one of our most significant partners for the remainder of the Foundation's life. And, as is true with most successful partnerships, our years together benefited us both. We helped the Quality Institute grow and become a strong and self-sustaining organization. The steady support we provided over the years gave the Quality Institute room for deep and independent thinking about the needs of individuals, communities, and healthcare systems, and about ways that state programs could be strengthened to improve health outcomes. In turn, the Quality Institute helped us become a credible player in the healthcare arena in New Jersey.

Our 11-year partnership with the Quality Institute allowed both of us to deepen our understanding of the Medicaid system and to work closely with the state and other groups to transform and strengthen the program for the future. The work across

“**The Nicholson Foundation has been a catalyst for innovation, testing new approaches, and scaling best practices. Nonprofit organizations and the people they serve throughout the Garden State are lucky to have had such a generous and committed partner. The Foundation's lasting legacy will be the example that one small foundation can spark and foster generational change through rigorous analysis, support for evidence-based efforts, and an overarching commitment to mission.**”

— **LINDA SCHWIMMER**, *President and CEO, New Jersey Health Care Quality Institute*





these three initiatives—the Medicaid ACOs, the Medicaid 2.0 *Blueprint*, and the Medicaid Policy Center—came to fruition in recommendations that were accepted and implemented by the state and that have had a direct impact on the health and well-being of individuals, as the following examples show.

Strengthening the Coalitions

As a result of participating in the ACO learning and support network and the Medicaid ACO Demonstration Project, the community healthcare coalitions developed comprehensive case management systems that included multi-sector collaboration among local hospitals, primary care providers, social workers, and social services providers. This made a huge difference for patients with multiple chronic health conditions. Many had unstable housing situations, limited access to healthy food, and no consistent source of healthcare except for the emergency department. The care coordination teams were able to help these patients connect with primary care providers and create care plans. They also were able to help patients find stable housing and enroll in nutrition and social support programs. All of these actions, and others, helped patients build their own capacity to improve their health and well-being. The teams also laid the groundwork for the coalitions' expansion into population health programs, which are helping their communities create an equity-grounded vision of health and well-being for all.

Implementing Medicaid 2.0 Recommendations

In August 2018, the Department of Human Services announced that Medicaid would begin covering advanced care planning, one of the *Blueprint's* 24 recommendations. This was welcomed by older adults and disabled adults because it meant they could have meaningful conversations with their healthcare providers about their care. Now that these consultations would be reimbursed, providers, too, had an incentive to schedule adequate time to discuss their patients' priorities and create plans that reflected their wishes.



Improving Maternal Healthcare

Through its research and data analyses, the Medicaid Policy Center helped Medicaid advance one of its main priorities—improving maternal healthcare. In May 2019, the state legislature established a Medicaid perinatal care pilot program. This program changed how Medicaid paid for births in ways that rewarded providers who followed best practices and achieved good outcomes. This enabled high-risk maternity patients to receive quality care all through their pregnancies, including support from doulas and participation in CenteringPregnancy® group prenatal visits. Through perinatal risk assessments, care teams also were able to identify patients' social and behavioral needs and take action to address them. These components of comprehensive prenatal care gave patients a better chance for a safe and healthy pregnancy and a brighter start for their growing families. As Matt D'Oria noted, "When this program is fully implemented, more than 25,000 women overall will receive care in systems where the focus is on quality and good outcomes." And, in another boost to maternal health that was long advocated by the Quality Institute, as of January 1, 2021, the state no longer pays for early, elective deliveries (induced or surgical births before 39 weeks gestation for no medical reason). For decades, maternal health professionals have advised against these procedures because they carry extra risks for both baby and mother and deprive the baby of essential time to reach a healthy birth weight.





SUPPORTING HEALTHY CHILDREN: A MULTI-SECTOR PARTNERSHIP MEETS A CRITICAL CHALLENGE FOR NEW JERSEY

In the spring of 2018, Arturo Brito, Executive Director of The Nicholson Foundation, attended a meeting of a group of New Jersey funders who would later become the Early Years Funders Collaborative. Dr. Brito had just read *The Deepest Well: Healing the Long-Term Effects of Childhood Adversity*, by the nationally renowned expert Nadine Burke-Harris.

In the book, Dr. Burke-Harris described what had been well established within the research community for 20 years, though rarely applied to make a meaningful difference—that adverse childhood experiences (ACEs) were at the root of lifelong mental health and physical problems and socioeconomic difficulties experienced by all too many people. Dr. Burke-Harris also provided comprehensive solutions for addressing ACEs through policy and systems change. “I was profoundly affected by the book,” recalled Dr. Brito. “I urged everyone at the meeting to read it and consider ways that our funders group could address ACEs in New Jersey.”

Understanding ACEs and Why They Are Important in New Jersey

ACEs are stressful or traumatic events that occur to a child before the age of 18. Without the caring and competent support of adults to help a child

The Early Years Funders Collaborative

In late 2012, several New Jersey foundations with investments in issues relating to young children and their families began to meet regularly to discuss their common interests.

In 2019, the members formalized their partnership as the Early Years Funders Collaborative (EYFC). This gave the group enhanced visibility and credibility, and provided a structure for collective action on issues of mutual interest. On several occasions, such as the ACEs initiative, a smaller group of EYFC members joined forces to pursue a particular issue.

As of March 2021, the funders included:

- Burke Foundation
- Overdeck Family Foundation
- PNC Foundation
- The Henry & Marilyn Taub Foundation
- The Maher Charitable Foundation
- The Nicholson Foundation
- The Schumann Fund for New Jersey
- Turrell Fund





manage and recover from these events, ACEs can result in toxic stress. Toxic stress is a situation in which the body’s normal responses to stress (such as increases in heart rate and blood pressure) remain higher than normal. When that stress response system remains “on” for extended periods, it can negatively affect a child’s developing brain and body, resulting in the potential for lifelong harm to neurological, physical, and emotional health.

Both Family and Community Factors Contribute to ACEs

Adverse family experiences provide the triggers that result in the toxic stress that disrupts healthy child development. Examples:

- **Physical and emotional neglect**
- **Emotional and sexual abuse, bullying**
- **Substance misuse**
- **Domestic violence**
- **Divorce**
- **Mental illness, including maternal depression**
- **Incarceration**
- **Homelessness**

Difficult community environments contribute when they undermine a child’s sense of safety, stability, and security. Examples:

- **Poverty**
- **Discrimination**
- **Violence**
- **Food insecurity**
- **Community disruption**
- **Lack of opportunity, economic mobility, and social capital**
- **Homelessness or poor housing quality and availability**

ACEs are a substantial problem in New Jersey. National Survey of Children’s Health data from 2018–2019 show that more than 1 out of every 3 children in the state—nearly 660,000—experienced at least one ACE, and more than 250,000 children experienced two or more ACEs. Racial, ethnic, and income inequities do not automatically cause ACEs, but they can exacerbate the situations that result in ACEs. For example, children living in poverty (a family of four earning about or less than \$25,000 a year) were three times as likely to have experienced two or more ACEs as were children in families making more than \$100,000 a year.

Forming an ACEs Partnership

That 2018 funders meeting was a turning point because it led several members to form a distinct new partnership to address the impact of ACEs throughout New Jersey. This alliance was composed of the Burke Foundation, based in Princeton, which is focused on healthy pregnancies and births, positive parent–child relationships, and quality early childhood care and education; the Turrell Fund, which funds quality services and initiatives that serve children, especially the youngest, and their families; and The Nicholson Foundation.



Founding members of the New Jersey ACEs Collaborative, l to r: Arturo Brito, Executive Director, The Nicholson Foundation; Atiya Weiss, Executive Director, Burke Foundation; Curtland Fields, President/CEO, Turrell Fund; James Burke, President, Burke Foundation



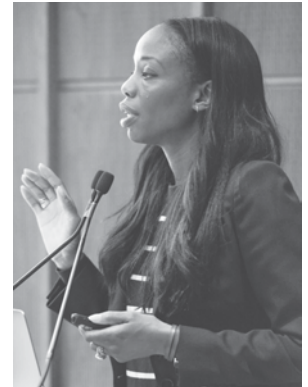


Raising Awareness

Given the urgency of New Jersey's ACEs problem, the funders moved quickly. One of the partnership's first actions was to hold an event to draw attention to the issue and launch efforts to address their impact in New Jersey. In preparation, the three Foundations met frequently with Christine Beyer, Commissioner of the New Jersey Department of Children and Families (DCF), who became an especially valuable partner in the collaborative because of her leadership role in the state and her previous experience developing policy around ACEs in Wisconsin. Together, the three funders and DCF became known as the New Jersey ACEs Collaborative.

The launch event took place in November 2018. It was attended by more than 100 leaders from across the state, who represented a wide range of sectors, including education, health, business, law enforcement, philanthropy, government, and the community. The event provided an opportunity for the Collaborative to describe a newly defined goal: Develop an action plan to guide statewide efforts to address the impact of ACEs.

At the event, New Jersey First Lady Tammy Snyder Murphy provided welcoming remarks, and Dr. Burke-Harris gave the keynote address. The Nicholson Foundation and the Burke Foundation announced their commitment of \$1 million each to a pooled fund for ACEs programs in New Jersey. The Turrell Fund and the PNC Foundation also made statements of financial and professional support. The event drew much media attention, propelling the initiative into the public eye.



Dr. Nadine Burke-Harris delivering the keynote address at the ACEs initiative launch event on November 13, 2018

Laying the Groundwork for Action

The Collaborative also commissioned a scan of the New Jersey ACEs landscape, including interviews with community leaders, nonprofit professionals, academic researchers, and policymakers. The findings were used to develop *Adverse Childhood Experiences: Opportunities to Prevent, Protect Against, and Heal from the Effects of ACEs in New Jersey*. Published in July 2019, this report described how ACEs were affecting the state and detailed five promising areas of opportunity for action.

The *Opportunities* report provided an important starting point for the next steps in the initiative, because in developing it, the Collaborative recognized the need to encourage groups around the state to contribute to the statewide action plan. The Collaborative also identified recruiting and supporting expert leadership totally dedicated to this effort as another major objective.





Building Connections to Inform the Statewide Action Plan

To achieve its first objective, the Collaborative funded the Center for Health Care Strategies (CHCS, a nonprofit health policy center) and Looking Glass Solutions (LGS, a human-centered design firm) to engage key stakeholders in creating the Action Plan. First, CHCS and LGS conducted 18 focus groups and individual interviews to solicit information and ideas from a wide variety of groups, especially from local communities. Insights from the focus groups and interviews, along with the areas of opportunity identified in the ACEs report were used to plan two ACEs Lab Sessions, held in January 2020—one in the northern part of the state, the other in the southern. The 60 participants in the Lab Sessions represented eight sectors interested in, and affected by, ACEs: research and academia, judiciary and law enforcement, philanthropy, community organizations, child and family services, policymakers, healthcare, and education. The presentations and small group brainstorming fostered connections across sectors and helped groups already working on this issue learn what others were doing. Participants also generated concrete, actionable ideas to inform the Statewide Action Plan.

What Is Human-Centered Design?

Human-centered design is a problem-solving approach grounded in understanding the perspective of the people who experience a problem, their needs, and whether a solution that has been designed for them truly meets their needs.

When possible, the people who experience the problem are part of the team that delineates the problem and designs the solution. Human-centered design also uses the practice of brainstorming solutions and then quickly testing and retesting them on a small scale to determine what might actually work.



Recruiting a Leader to Put Ideas into Action

The Collaborative's second main objective—supporting dedicated leadership for ACEs initiatives—was realized in June 2020 when the Department of Children and Families established an Office of Resilience and, after an extensive national search, hired Dave Ellis as its Executive Director. Mr. Ellis, a well-known expert in toxic stress and the lasting impact of ACEs and generational trauma, had extensive experience working with families and organizations to prevent ACEs, fostering research and survey efforts, and facilitating community dialogues and public-private partnerships. His charge was to complete the development of the Statewide Action Plan in partnership with DCF Commissioner Beyer, lead state efforts to support the development of ACEs-related policy and other public initiatives, and present New Jersey's ACEs-related initiatives at meetings, conferences, and public events around the state and nationally.

Mr. Ellis's responsibilities also included co-leading an interagency team (IAT) comprising leaders from the Offices of the Governor and the First Lady and nine state agencies and departments, including the Attorney General's office, the State Police,





the Office of the Secretary of Higher Education, and the Departments of Children and Families, Health, Human Services, Education, Labor, and Corrections. The IAT was tasked with identifying ways for their agencies to contribute to and coordinate state-level ACEs activities. Since its establishment, the Office of Resilience has continued to grow, and the addition of new staff has improved its ability to carry out its mandate.

Impact and Sustainability

In 2018, several foundations and the state's Department of Children and Families created the New Jersey ACEs Collaborative with this vision for child well-being: ACEs are not inevitable, and they do not have to determine a child's destiny; ACEs can be prevented and children can be protected from them; and children and families can get help to heal from their effects.

In February 2021, that vision got a significant boost when Governor Murphy announced the release of the *New Jersey ACEs Statewide Action Plan*. Reflecting research findings, extensive interviews, on-the-ground experience, and the voices of communities most affected by ACEs, the Plan called for a coordinated and multi-sector statewide response. It aimed to neutralize childhood trauma and build strong families by:

- Enhancing public awareness about ACEs
- Learning from communities directly affected by ACEs and including them in policy, practice, and funding decisionmaking processes
- Training parents, educators, law enforcement, healthcare providers, and others in ACEs and ways to reduce their impacts
- Promoting trauma-informed, healing-centered organizational capacity, policy, and budgets
- Fostering trauma-informed, healing-centered services and supports

A centerpiece of this effort was the NJ Resiliency Coalition, a new online platform that aimed to provide resources and information, foster opportunities for collaboration between trauma-informed and healing-centered organizations in the state, and serve as a repository of best practices in ACEs from New Jersey and other states. The platform also featured blog posts from community members who had experienced ACEs, allowing a safe forum for their voices to be heard and giving others a chance to use these experiences as a motivator for action to reduce ACEs. Because the *Statewide Action Plan* was envisioned as a living document that will continue to evolve to meet the changing needs of the community, the voices heard through the Resiliency Coalition will be an important factor in informing that evolution.

Lab Session Ideas Used in the Statewide Plan:

- **Build a comprehensive, sustainable care coordination system**
- **Enhance education for parents and caregivers**
- **Increase screenings for ACEs**
- **Address community determinants, like poverty and poor housing**
- **Create home visitation programs**
- **Increase drug prevention and treatment programs**
- **Fill gaps in trauma-informed care**





A LONG AND WINDING ROAD TO INNOVATION PARTNERSHIPS

Innovation in healthcare has been a popular concept for some time. It's been applied to the development of better devices, enhanced software solutions, and improved systems to deliver healthcare. In the early 2010s, the Foundation became intrigued by how innovation might be used to improve healthcare services in New Jersey. We started small, took a circuitous route, learned some important lessons along the way, and ended with a substantial investment in two institutions that have used innovation as a strategy for delivering quality healthcare to patients served by the safety net.

What Does Innovation Mean?

The dictionary defines innovation as “a new idea, method, or device.” Writers on innovation also describe it as a process that results in better solutions—something original and effective—to meet an existing need.

Starting Out

We began in 2014 by exploring the potential of innovation competitions, a big trend at the time. We thought that supporting a competition might be a good way to promote promising multi-disciplinary approaches to improving healthcare delivery for vulnerable populations and reducing its costs. We didn't have the expertise to stage a competition ourselves, so we contracted with Health 2.0, a digital health media company, and partnered with Rutgers University, which provided the participants, to create two events. To promote diverse ideas and backgrounds, we required that participating teams be interdisciplinary, representing various Rutgers schools and departments. The competition was well received, and the teams presented exciting and potentially useful ideas. However, we ultimately decided not to pursue this strategy because the competition format was not sustainable without continued Foundation funding.

Our second foray into innovation piggybacked on another big trend—start-up companies that were developing innovative healthcare solutions. We found several start-ups that focused on the safety net, and we funded several small projects. We also worked with several start-up companies and other entrepreneurial groups that were trying to bring innovations to commercial scale. However, we eventually realized that this avenue wasn't for us either. The start-ups and groups were good partners and the





technologies were appealing, but the solutions weren't a priority for the sites where they were implemented. More importantly, it was too difficult to insert the innovations into the safety net sites and settings we wanted to support. We also felt that it would take too long to bring the innovations to scale. We wanted to create more immediate, systems-wide impact.

Honing In

At the same time, we began to learn about the Center for Care Innovations (CCI), a California-based nonprofit that focuses on healthcare innovation for the safety net. We asked CCI to interview New Jersey organizations of various kinds to discern their interest in innovation in healthcare delivery services.

CCI found that the organizations were indeed interested, and their receptivity was the springboard for the notion of helping New Jersey organizations create innovation capabilities and eventually build an innovation center. Such a center would function as a laboratory for developing and testing new ideas and strategies. It was a better fit for us and appealing for two reasons:

- An innovation center would have significant potential for systems change because it would be located within a healthcare organization.
- An institutional home also would give the center greater stability and potential for long-term sustainability.

Our goal in creating an innovation center differed from the goals motivating the work of many other groups, however. In contrast to the common focus on developing new healthcare technologies or devices, we wanted to foster innovative thinking to improve the delivery of services to populations served by the safety net. In May 2015, we held a kickoff meeting with New Jersey stakeholders to introduce the idea of building human-centered design skills as a pathway to developing an innovation center. (For an explanation of human-centered design, see the story on ACEs, earlier in this chapter.)

We then issued a Request for Applications (RFA) asking for organizations to participate in a 12-month program, called the New Jersey Innovation Catalyst Initiative. During the program, CCI taught human-centered design to small teams within the nine participating healthcare organizations. The teams then used their new skills to identify a compelling problem for their organization, generate possible innovation solutions, and test the solutions to identify one that could be spread throughout the organization. Our aim was to generate interest and excitement for building human-centered design capabilities. Examples of projects that the health systems worked on during the program included strengthening patient engagement around heart disease, developing new systems for breast cancer care, and building community capacity to address social needs.

From this RFA, we selected two organizations to participate in an innovation center planning process. As part of this process, we funded visits by top-level staff of the two organizations to Columbus Regional Health, a health system serving 10 counties in southeastern Indiana. The goal was to learn about their innovation center and their





strategy for building innovation capabilities within their organization. The trip was an important step in cementing enthusiasm and buy-in from the organizations' leaders by helping them see that an innovation center was a truly feasible avenue to systems change.

At the end of this grant, one of the two organizations, St. Joseph's Health, chose to continue working with us to develop an innovation center within its institution.

Ending Up in the Right Place

The right opportunity at the right time with the right partner helps ensure success. That idea was borne out by the fact that at the time we issued our RFA, St. Joseph's Health was already thinking about innovation. They had formed an innovation committee comprising high-level management and clinical staff, including the President and the Chief Operating Officer. They knew they wanted to do something but they didn't know quite what. The CCI grant to learn human-centered design and try innovations was a great opportunity for them—CCI gave them the structure and guidance to build on their early thinking and commit to a formal innovation center. It's likely that St. Joseph's would have eventually developed an innovation center, but our support enabled them to get there faster.

Feeling comfortable with the innovation center concept, we pursued a second project with Stevens Institute for Technology, a technology-focused research university. We had gotten to know Stevens earlier in our innovation journey, when we were working with entrepreneurial groups who were trying to bring their innovations to commercial scale. Stevens had a substantial healthcare innovation arm but because their focus had been on for-profit hospitals, they had limited experience with the Medicaid program. We approached them to see whether they could take a project that already had been successful in a for-profit hospital setting and replicate it in a safety net hospital.

Stevens interviewed the leadership of several safety net hospitals and identified three potential ideas for an innovation project. It presented these ideas to members of the Hospital Alliance of New Jersey, the state association for safety net hospitals. This led to the selection of one idea—creating a technology-based educational program for staff to increase patient engagement and operational efficiencies—that would be implemented in one hospital. Monmouth Medical Center was selected. This idea was a win for both partners: Monmouth benefited from Stevens' expertise. And, if the solution was successful, Stevens could cultivate future business opportunities by pitching the innovation technology to other hospitals.

St. Joseph's Health is a multi-center healthcare system in Paterson, New Jersey, sponsored by the Catholic Sisters of Charity of St. Elizabeth. St. Joseph's provides quality care, with a special focus on those who are poor and underserved.

Stevens Institute of Technology is a private research university located in Hoboken, New Jersey. It supports academic and research programs in business, the arts, computing, engineering, and other science and technology fields.

Monmouth Medical Center, in Long Branch, is one of New Jersey's largest community academic medical centers and is an academic affiliate of Robert Wood Johnson Medical School of Rutgers University.





Impact and Sustainability

Our innovation journey was long and included many twists and turns. However, it taught us valuable lessons about the elements of successful partnerships, about the application of innovation to the safety net healthcare environment, and about the role of human-centered design in successful innovation efforts. We were able to explore an array of ideas to determine which innovation approaches might work for vulnerable populations, and we were able to inspire new thinking that might not have happened without our funding and support.

The result was two successful partnerships involving two innovation projects that went in somewhat different directions. We funded Stevens to develop 11 educational modules based on suggestions from Monmouth Medical Center's leadership and Human Resources Department. The modules were developed and delivered to Monmouth for testing, piloting, and future implementation. Stevens hopes its experience with the project will help it market this technology innovation to other safety net hospitals.

In contrast, our partnership with St. Joseph's resulted in an innovation center firmly established within that hospital. The center was supported by our funding in addition to St. Joseph's own in-kind and financial commitments and the direct involvement of top leadership. The center's primary space was located within St. Joseph's University Medical Center but it was operationalized throughout the St. Joseph's system. St. Joseph's moved quickly to put the center in place—it hired an innovation center director, found a human-centered design trainer, and identified initial projects for consideration. The center's tools and strategies had to change somewhat because of the COVID-19 pandemic, but St. Joseph's used what it learned to help its hospital system adapt to the realities of the pandemic and to build and refine the center.



The Nicholson Foundation has not only been a trusted partner for St. Joseph's Health, it has contributed vitally to our future success. We are grateful to the Foundation for sharing the same vision, passion, and dedication to helping our communities, particularly those who need it the most. While The Nicholson Foundation is sunsetting, its legacy will live on.



— **KEVIN SLAVIN**, *President and CEO, St. Joseph's Health, and*
LISA BRADY, *COO, St. Joseph's Health*





CHAPTER FOUR: KEY TAKEAWAYS

- **Spend time and effort to find the right partner.** It's a wise investment. The right partner is one whose values are aligned with yours and who also sees the project as a priority. Use various strategies, such as recruiting a specific partner or issuing an open request for proposals.
- **Talk to as many people as possible when starting new work.** Learn about priority needs, local resources, and opportunities for action. This will help identify potential partners—both within and beyond the groups with whom you usually work—who are ready to collaborate and generate real impact.
- **Understand that potential partners may have various reasons for wanting to change policy or pursue programs.** Take time to learn about these motivations, and build them into your planning. This will increase the chances of being able to enact the change you desire.
- **Create a partnership that's just the right size.** Make it big enough to be inclusive but small enough to act efficiently.
- **Acknowledge and respect the unique strengths and qualities of each partner.** Having the same goals and being willing to work collaboratively is essential to effective, trust-based partnerships and enhances the likelihood of long-term success.
- **Consider starting small with a partner.** A modest initial project can provide time to determine whether the collaboration works, if modifications are needed, and whether it might be better to “go it alone.”





Investing in Organizational Nuts and Bolts



To execute great ideas and realize their potential, organizations need enough of the basics—staff, data analysis capability, equipment, policies and procedures, and management-information infrastructure. The Nicholson Foundation has always recognized that supporting these nuts-and-bolts elements on behalf of collaborating organizations can be a significant element of its overall systems-change strategy.

Outright funding for the basics is a good approach, both as line items within a project grant or as a stand-alone capacity-building grant. This funding can allow grantees to hire staff to carry out specific activities funded by the grant, such as data analyses or care coordination. It also can support hiring staff for essential everyday functions, such as accounting, grants management, administration, advisory board activities, and strategic planning. This latter kind of support gives organizations breathing space so they can manage their work, develop and expand the services they were founded to conduct, and seek out new funding opportunities that can improve the prospect of stable growth over the long term. Infrastructure support, moreover, can enable organizations or agencies to make the best use of their space and resources so they can respond to emerging or urgent needs in the community. No matter whether it is large or small, this funding for the basics can provide a critical boost that helps grantees succeed.

The following story illustrates what's possible with nuts-and-bolts grantmaking. It describes how we:

- Helped community-based healthcare coalitions become engines for population-wide systems change and health improvement





HEALTHCARE COALITIONS: A STRATEGY FOR COMMUNITY TRANSFORMATION

In 2008, the Foundation began to seriously research healthcare in New Jersey as a new area of investment. We began by looking for potential partners and ideas for how we could use our resources to best effect.

We looked at data on healthcare services, costs, and outcomes and we talked with people who had extensive knowledge about, and experience in, safety net healthcare in the state. We learned that New Jersey's safety net healthcare system was characterized by:

- Inefficiencies and lack of coordination within and between healthcare and social service delivery systems
- Overreliance on avoidable, expensive emergency department and hospital care
- A lack of access to health insurance, which led people to rely on charity care, placing a heavy burden on already financially stressed healthcare systems

We also learned about the complicated health-related challenges affecting communities. They grappled with high rates of chronic, behavioral, and preventable health conditions that were exacerbated by undue burdens of systemic economic and racial disadvantage and social inequity. The safety net systems that provided and paid for healthcare services had difficulties in meeting these challenges because they were not designed to address broad health-related social factors.

Fortunately, a new, population-based vision for care was beginning to emerge. In 2002, a small group of Camden clinicians began to meet informally but regularly. They talked about how they wanted to create a better healthcare system for their city, one that treated the physical and mental health conditions of their patients and also paid attention to the social and logistical barriers that prevented people from accessing quality, integrated services. They theorized that a new, coordinated approach to care—a community-based healthcare coalition grounded in multi-sector partnerships—could address both the medical and the social needs of residents. In doing so, this approach could improve outcomes, enhance the population's overall





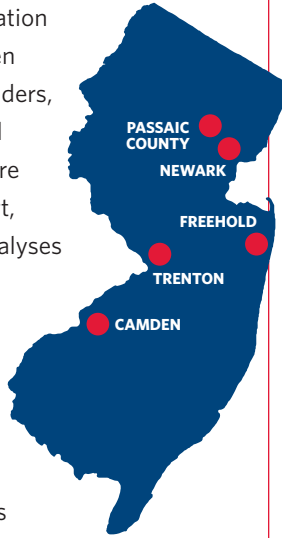
health and well-being, and reduce healthcare costs. In the years that followed, groups in both Newark and Trenton established similar community-based healthcare coalitions.

The concept was promising, but the coalitions struggled to realize their vision because their organizational structures were weak and their capacity (both funding and the people-power to make required changes and lead the work) was limited. Strengthening these elements could give the coalitions a fighting chance to have a major positive impact on the health and well-being of their communities.

Beginning in 2010, the Foundation awarded grants to the Camden Coalition of Health Care Providers, the Trenton Health Team, and the Greater Newark Healthcare Coalition. As part of this effort, we funded a series of data analyses of Camden, Newark, Trenton, and 10 other low-income, high-need communities. These analyses, conducted by the Rutgers Center for State Health Policy (an organization that provides research, policy analysis, training, and consultation services), examined avoidable hospital inpatient and emergency department use in each of the communities. Using comparisons among this sample of 13, Rutgers was able to project potential savings for Medicaid from strategies to improve access to primary care and to effectively manage chronic health conditions. These analyses provided vital data that the coalitions used to develop their programs.

In later years, we supported the development of two entirely new coalitions—the Health Coalition of Passaic County in Paterson (2016) and the Neighborhood Connections to Health Coalition in Greater Freehold (2018).

Initially, the coalitions tried to improve the quality and reduce the costs of services by focusing on individuals whose healthcare was especially costly. The lack of a regular source of care meant they often used hospitals for care. The coalitions



The Coalitions Began with Individually-Focused Care Management...

A patient has multiple health conditions and a difficult living situation that limits his ability to eat healthy meals at home, get proper medical attention, and follow doctor's orders. Based on a referral from community partners, the care coordination team members work with him to address his needs comprehensively. The nurse makes sure he gets an appointment with a doctor, who prescribes insulin for his diabetes. The social worker makes sure he has a working refrigerator in his apartment to safely store his insulin and helps him get fresh food to improve his diet.

...then Expanded to Population-Based Health Initiatives

Working with individual patients was just the start. The coalitions soon broadened their efforts to focus on the health of the community as a whole. For example, the Trenton Health Team became actively involved in efforts to improve the community's access to healthy food by hosting a weekly farmers market along with nutrition education sessions. To make the most of this opportunity to reach community residents, it also offered free health screenings each week at the market.





instituted team-based, coordinated care management to provide physical and behavioral primary care, and they helped patients obtain needed social services.

Over time, the coalitions recognized that health-related social factors had an outsized impact on the health of entire communities, not just on individuals. As a result, the coalitions expanded their work to encompass population health initiatives.

Nuts-and-Bolts Support

Multiple grants helped the coalitions grow from small collaborations to well-organized, thriving entities that were able to successfully compete for major state and federal initiatives and to carry out programs that benefited individual residents and the community as a whole. With our support, the coalitions were able to build institutional capacity through:

- **Hiring staff**, including those responsible for grant-funded programs, such as care coordination or data analysis, as well as those responsible for basic infrastructure activities, such as administration and management. The funds for program staff allowed the coalitions to provide expanded clinical services, collect and analyze community health data, and carry out community engagement efforts. The funds for infrastructure activities gave the coalitions greater capacity to conduct strategic planning, apply for grants, and carry out communications activities. These functions, which enhanced the likelihood that they could successfully pursue other funding opportunities and become self-sustaining entities, were especially important in the coalitions' early days.
- **Creating Health Information Exchanges (HIEs)**, which are an electronic data system that allows doctors, nurses, and other healthcare providers to appropriately access and securely share a patient's medical information. HIEs gave the coalitions an important mechanism by which to gather—and share—data about their communities, thereby helping them offer responsive services and plan strategically and efficiently. Camden and Trenton, especially, recognized the value of shared data, and they put significant effort into developing their HIEs and expanding their use of, and expertise in, data analytics. This was a major accomplishment of these two coalitions, putting them in a strong position to carry out new initiatives in a number of areas.
- **Conducting program planning and implementation** initiatives. These efforts helped the coalitions chart a course to long-lasting self-sufficiency.
- **Creating advisory boards** to guide coalition activities. The boards included a wide range of community leaders, residents, and organizations representing various sectors (such as housing, education, criminal justice, food, and transportation), so that the coalitions' programs and services truly reflected the needs and character of the community.
- **Supporting branding and communications plans.** These plans helped the coalitions build a visible and credible presence in the community.
- **Purchasing office equipment and supplies.** This mundane, but essential, activity allowed the coalitions to keep pace with their developing capacity.



Health Coalition of Passaic County Community Action Board meeting





Making a Difference in Their Communities

Over the years, the coalitions evolved substantially, with the Camden, Newark, and Trenton coalitions becoming strong enough to be selected for New Jersey's Medicaid Accountable Care Organization (ACO) Demonstration Project in 2015. Though not a formally designated Medicaid ACO, the Health Coalition of Passaic County functioned in a similar way. (For an explanation of Medicaid ACOs, see *The New Jersey Health Care Quality Institute: An Enduring Partner* in **Chapter 4. Finding and Nurturing Effective Partnerships.**)

The coalitions learned important lessons from the Medicaid ACO experience, and when the Demonstration Project ended in 2018, they were able to continue providing community care and successfully evolve to a next phase. In January 2020, Governor Phil Murphy signed a new program into law, which designated the Camden, Trenton, Passaic, and Newark coalitions as Regional Health Hubs. The Hub designation allowed the coalitions to continue—and build on—their ongoing work by:

- Providing care coordination and care management services
- Serving as the focal point for local nonprofits, healthcare and social services providers, and local government to come together in partnerships to assess and address community needs
- Supporting the state's health initiatives by collecting and analyzing regional health data through their HIEs
- Carrying out population health initiatives, which led to the four coalitions becoming a key resource for health services and outreach to their communities during the COVID-19 pandemic

The Hub designation gave the coalitions a stable source of infrastructure funding and support, which reduced their reliance on grant funding. As Regional Health Hubs, the coalitions also were in a stronger position to serve their communities through population-based health and wellness programs as well as by providing services on an individual level. Importantly, the designation allowed the state Medicaid administration to share its data with the coalitions, which helped the state and the coalitions coordinate their approaches to improving the health of communities. The Trenton and Passaic coalitions used their Regional Health Hub funding to hire data analysts. These staff enhanced the coalitions' ability to link separate data sets and conduct more sophisticated analytics than they were able to do previously, putting the coalitions in a stronger position to carry out population health programs.

Regional Health Hubs benefited the state's Medicaid program also because they provided a way for the program to understand local communities more fully and to respond to them more effectively. For example, the Trenton Health Team conducted a community needs assessment, which provided valuable data on local health and health-related needs and gaps in services.

Impact and Sustainability

Maureen Deevey, the Foundation's Senior Program Officer who led the coalitions initiative, described its multi-layered impact this way: "Individually, the coalitions worked to improve the health of their communities, and, in the process, became strong anchor institutions that improved the ability of those communities to respond to the





needs of their residents. Collaboratively, the four coalitions formed a powerful network that worked together to improve the health and well-being of people and communities throughout the state.”

The experience of the Trenton Health Team is a prime example of how the Foundation’s nuts-and-bolts support was critical to the coalition’s evolution from an ad hoc committee of municipal officials and healthcare providers to a nationally recognized, innovative nonprofit organization engaging healthcare professionals as well as state agencies and departments, community service organizations, and grassroots advocates.



The Trenton Health Team would not exist if Nicholson had not invested in us early on.



— **MARTHA DAVIDSON**, *Trenton Health Team Development Director*

Initially, the Foundation’s support enabled the Trenton Health Team to hire staff needed to improve healthcare and outcomes for Trenton residents. Early funding focused on improving access to care, which dramatically reduced wait time for medical appointments from weeks to several days.

Improved access and coordinated care management also helped the Trenton Health Team and its partners achieve a major goal: Reduce the community’s reliance on expensive hospital emergency room care for non-emergency health issues. From 2010 to 2012, emergency department visits among those with especially high healthcare costs dropped by about one-third at St. Francis Medical Center and by more than half at Capital Health. These two hospitals, both members of the Trenton Health Team, were the city’s safety net hospitals. Inpatient stays also fell substantially, resulting in major decreases in hospital charges for this group of patients.

One of the most significant innovations made possible by the Foundation’s support was the investment in health-data management and analysis. Development of the coalition’s HIE allowed healthcare providers to share medical information about patients, resulting in more coordinated healthcare, better informed clinical decisions, fewer repeated services, and, ultimately, improved patient care. As of the end of 2020, more than 1,250 clinical professionals had used the HIE to access health records for almost 700,000 patients.

As the coalition’s vision for a healthy Trenton expanded to focus on population health, it worked with clinical and social services providers to explore new structures, practices, and policies to integrate, coordinate, and align disconnected programs to make the community healthier. In January 2021, Merck for Mothers selected Trenton as one of its Safer Childbirth Cities sites. The Trenton Health Team is partnering with other local organizations, including Children’s Home Society of New Jersey, Children’s Futures, Capital Health, and Central Jersey Family Health Consortium to coordinate services to improve outcomes for pregnant women, new mothers, and infants. It also is working to expand available doula services in the community.

Since 2010, the Trenton Health Team has become a regional nexus for health-related data and community-clinical linkages. By adopting an integrated, multi-sector approach to healthcare delivery that also addresses health-related social factors, this coalition has facilitated the exploration and implementation of innovative concepts to address the Triple Aim of healthcare reform: improved patient experience, better outcomes, and reduced healthcare costs.





CHAPTER FIVE: KEY TAKEAWAYS

- **Help grantees build their organizational capacity.** Providing funding for activities such as grant writing, development, and strategic planning strengthens organizations so they can continue their work after funding ends.
- **Invest creatively.** Even a small infusion of funds may provide an essential boost to an organization that already has a stable funding stream and needs just a little extra help to allow a new idea to blossom.
- **Look for opportunities to ensure full implementation of proven models by providing sufficient and directed resources.** Under-resourced initiatives may struggle to robustly implement best practices or maintain fidelity to evidence-based models. Sufficient funding can help organizations—from state Medicaid agencies to small service providers—carry out these initiatives successfully.
- **Prioritize the use of information technology hardware and software and organizations' data-analytics capability.** This includes the ability to collect, analyze, and use data specific to a place and a population as well as to create integrated data sets that cover multiple aspects of health, well-being, and health-related social factors. Local and integrated data have immense value for informing practice because they highlight and explain critical issues affecting communities. They also can point to the multi-sector efforts that are required to successfully address these issues.
- **Engage many community groups and government agencies in collecting data and applying their findings.** This information can be invaluable for making decisions and creating programs with durable impact.





Tackling Complex Problems with Multiple and Complementary Solutions



Healthcare, early childhood care and education, and social services are complicated, disconnected, and all too often not available or affordable. This makes it difficult for people, families, and communities to get what they need to succeed. To address this problem, The Nicholson Foundation invested in flexible and complementary systems-change strategies to raise awareness of the importance of these issues, make the services easier to access, and improve their quality, affordability, and equity.

Investing in multiple and complementary strategies makes sense because it engages a variety of players who have the necessary skills, expertise, and experiences to adequately address the problem. In addition, using several different approaches to explore what works creates bodies of evidence to support future initiatives and partnerships. Using public-private collaborations to pursue these approaches allows grantmakers to share ideas with government and helps government attend to priority needs that it may not be able to address on its own.

The following stories illustrate what's possible with multiple approaches to solving problems. They describe how we:

- Engaged in parallel efforts to improve the availability of, and access to, quality early childhood care and education
- Supported a one-stop solution to help families easily and efficiently connect to multiple social services and other helpful resources
- Funded six complementary projects, all of which focused on enhancing the equity of maternal healthcare and reducing maternal and infant deaths and injuries during childbirth and the first year of life





OFF TO A GOOD START: ENSURING QUALITY CARE AND EDUCATION FOR YOUNG CHILDREN

For decades, a growing body of scientific evidence has shown that the brain develops faster during the first three years of life than at any other time. This evidence also has demonstrated that early-life experiences have a profound impact on physical, mental, and emotional health, in both the short and the long term. Positive environments and nurturing relationships with caregivers are essential to setting a child on a healthy developmental trajectory.

Building on our early interest in supporting educational engagement for youth and fostering family stability and well-being, in 2011 the Foundation began a multi-year program of investments in projects to substantially improve the care and education experiences of young children in New Jersey. We funded work that addressed both preschool care and infant and toddler care. Because of the historical lack of attention to infant and toddler care, however, we and our partners eventually decided to give priority to these issues. Over time, a two-pronged approach for interdependent action emerged: Strive to improve the quality, availability, and affordability of infant and toddler care and education, and promote an early childhood policy and advocacy agenda.

Strengthening Programs and Providers

Beginning in the late 1990s and gaining momentum in the mid-2010s, a number of states recognized the importance of the infant and toddler years and focused on improving the availability and quality of child care choices for parents. To encourage child care programs to invest in quality, the federal government supported states in adopting the Quality Rating and Improvement System (QRIS). This framework set forth quality standards aligned with established early learning and practitioner best practices. For families, QRIS was an easy-to-use and meaningful tool for assessing the quality of early care and education settings in their community. For child care and early learning programs, the associated QRIS administration provided resources that helped them continue their quality improvement efforts.





New Jersey began to develop its statewide QRIS in 2011 through work with the BUILD Initiative (a coalition of states and organizations that helped state leaders develop early childhood program, service, and policy systems tailored to each state’s unique young child population). We supported this work by funding Advocates for Children of New Jersey (ACNJ, an education and advocacy organization), and Programs for Parents (the Essex County child care resource and referral agency), to conduct a QRIS pilot test in several early learning centers that also served infants and toddlers.

This effort was informed by several reports that defined and highlighted continuing issues related to the quality, availability, and cost of care and education for very young children. For example, a 2013 report by the National Institute for Early Education Research (NIEER) at Rutgers University pointed to the need for early childhood care by estimating that New Jersey was home to about 320,000 infants and toddlers and that about 67,000 children were cared for by non-relatives. Other reports demonstrated that care for infants and toddlers was hard to find and harder to afford. A 2013 report from ACNJ found that child care was, on average, a family’s second-highest expense, after housing. A typical New Jersey family spent about one quarter of its gross income on child care; a single working mother with one infant could expect to spend about one-third of her income on child care. The report summarized the importance of ensuring quality early childhood care and education in stark terms: “Children who experience high-quality child care have a better chance of arriving at kindergarten with the foundation they need for school success, research shows. That means that getting all children off to the right start benefits children, families, and our state as a whole.”

The experience of the pilots generated valuable insights about the specific needs and challenges of families, staff, and programs based in child care centers. These insights informed the state’s QRIS, which was called Grow NJ Kids.

In 2013, New Jersey was one of six states that won a Race to the Top - Early Learning Challenge grant from the U.S. Department of Education,



Grow NJ Kids, New Jersey’s QRIS

Grow NJ Kids is a collaboration of four New Jersey Departments: Children and Families, Education, Health, and Human Services.

Here’s how Grow NJ Kids works:

- **Early childhood care and education providers enroll in Grow NJ Kids and complete a self-assessment.**
- **Trained professionals funded by the state then work with the care providers to strengthen specific aspects of quality by offering training, technical support, and classroom materials.**
- **Throughout the process, providers document their progress until they demonstrate “rating readiness” and request a formal rating visit from Grow NJ Kids.**
- **Providers are formally rated by a trained rater and can earn up to five stars. Programs with higher ratings receive higher subsidy rates for care provided to eligible children.**
- **Ratings are posted on the Grow NJ Kids website (www.GrowNJKids.com).**





and the state used this funding to develop Grow NJ Kids. As part of this quality improvement effort, the state adopted several of the program enhancements that had been included in the ACNJ/Programs for Parents pilot tests.

In 2014, New Jersey began what it called a “test drive” of Grow NJ Kids in three counties. The Foundation encouraged the state to include a fourth county, Essex, in the effort. In Newark, Essex County’s largest city, we funded Programs for Parents to carry out Grow NJ Kids in 16 early childhood centers in the South Ward and Fairmount, the city’s lowest-income neighborhoods. We were particularly interested in testing the basic Grow NJ Kids program in centers that included infant and toddler classrooms. This project also tested improvements, such as developing a professional learning community and providing scholarships for teachers, establishing community advisory boards, and encouraging family engagement in the program. One of the participating centers that served toddlers became the very first center to receive a Grow NJ Kids rating.

Developing the rating system for center-based child care was only part of the picture, though. Because many families rely on family-based care for their young children, in 2014 we funded Child Care Connection, Inc., Mercer County’s child care resource and referral agency, to launch Steps to Quality. This child care quality improvement project focused on family-based settings serving young children, including infants and toddlers. Over the next three years, Steps to Quality became the prototype for the family child care component of Grow NJ Kids. Child Care Connection collaborated with Programs for Parents and Community Child Care Solutions (the child care referral agency for Middlesex and Somerset Counties) to recruit family providers in Trenton, Newark, and Perth Amboy to participate in Steps to Quality. The agencies used a variety of strategies to strengthen the skills and knowledge of these providers so that they could provide better learning opportunities for young children and prepare for the formal Grow NJ Kids rating process.

Another Approach to Filling the Need for Quality Infant and Toddler Care

New Jersey’s school-based Pre-K expansion during the 2000s meant that local Head Start agencies began to have unused capacity for their Pre-K programs. This created an opportunity to augment the supply of care and education settings for infants and toddlers.

We worked with two Head Start agencies—Greater Bergen Community Action Inc. and Gateway Community Action Partnership—to provide funding so they could convert Head Start classrooms into ones for Early Head Start (the companion federal program serving infants, toddlers, and pregnant women). We funded renovations to make the classrooms age-appropriate and partnered with The Henry and Marilyn Taub Foundation (a New Jersey foundation with interests in early childhood issues and maternal healthcare), which provided funding for evidence-based infant and toddler teacher training.

Our support helped the agencies create new Early Head Start classrooms and expand and improve existing Early Head Start classrooms, for a total of 17 classrooms in Paterson and in Atlantic and Cape May Counties, communities with an urgent need for this care.





Increasing Awareness and Pushing for Change

While the efforts to launch the QRIS were happening on the front lines of child care, we also began efforts to encourage policy change. In 2013, in conjunction with the Turrell Fund, a New Jersey foundation that supports quality services and initiatives for young children and their families, we funded a new ACNJ effort, Right From the Start NJ. This initiative first focused on informing state government leaders about the importance of the infant and toddler life stages, building a network of champions among early education organizations, and conducting policy analyses to make the case for greater funding and policy attention to infants and toddlers.

In 2017, Right From the Start NJ entered a new phase with the launch of a public-facing communications campaign through Caucus Educational Corporation. Caucus produced New Jersey public television content on the importance of the early years and launched social media feeds and a website that provided information for families, community leaders, and policymakers. The Right From the Start NJ work was instrumental in helping ACNJ receive a Think Babies designation and grant in March 2018 from ZERO TO THREE. ACNJ used this grant to create the Think Babies Coalition, a partnership of more than 60 public- and private-sector groups in New Jersey interested in early childhood issues.

Right From the Start NJ and the Think Babies Coalition also sponsored Strolling Thunder, an annual event in which advocates, parents, and babies gathered in front of the New Jersey State House and visited lawmakers to tell them why infants and toddlers were an important state priority.

In 2020, the Turrell Fund, ACNJ, Caucus, and the Foundation convened to reassess the activities and impact of the Right From the Start NJ campaign. This collaboration grew to include other groups involved in early childhood issues, including the Infant and Toddler Policy Research Center at NIEER and the New Jersey Association for the Education of Young Children (both of which had also received individual grants from the Foundation).

Following a Nicholson-funded rebranding by a strategic communications firm, a new awareness and advocacy-focused campaign called Reimagine Child Care brought all the groups together in a unique effort dedicated to building public and private support for a robust and durable child care policy agenda. Launched in August 2020, Reimagine Child Care's goal was to secure \$76 million in new state and federal funding by 2023 to improve the affordability, accessibility, and quality of early childhood care and education for all infants and toddlers in New Jersey. The campaign consisted of a new website, an enhanced social media presence, and efforts to widely disseminate information about relevant events and opportunities for action.

What are Think Babies and ZERO TO THREE?

Think Babies is a national campaign spearheaded by ZERO TO THREE, the premier national organization that works to ensure that babies and toddlers benefit from the early connections that are critical to their well-being and development. ZERO TO THREE selected ACNJ to lead Think Babies in New Jersey. The campaign focuses on five key policy areas: paid leave, child care, maternal and infant health, home visiting, and infant and early childhood mental health.





To inform the campaign, the Foundation funded surveys conducted by Fairleigh Dickinson University. The surveys aimed to quantify the public’s views around early childhood care and education and understand the specific challenges parents face. The first survey indicated that the vast majority of New Jersey residents viewed infant and toddler care as an important issue for the state to address. The second survey explored how families were adjusting their child care arrangements during the COVID-19 pandemic. The survey found that the pandemic had forced some New Jersey parents of young children out of the workforce entirely or caused them to reduce their work hours. Six times more women than men were affected. Nearly half of respondents also said that the pandemic had made affordable child care harder to find, with more Hispanic and Black parents than White parents reporting increased costs.

Summing up the work on these campaigns, Kevin McManemin, the Foundation’s Communications Director, who led much of the rebranding effort, recounted, “Whether it was called Right From the Start NJ or Reimagine Child Care, collaboration was the key to these multi-faceted campaigns. Externally, we partnered closely with our co-funders at the Turrell Fund every step of the way. Internally, within the Foundation, five of our staff members worked together to provide technical collaboration and support for different campaign partners through multiple, distinct grants.”

Impact and Sustainability

Thanks in part to our support for the Grow NJ Kids pilot tests and the Steps to Quality initiative, Grow NJ Kids is a strong and growing program, with nearly one-quarter of all regulated child care centers and family child care providers participating as of July 2019.

By early 2020, the Foundation and its partners could also point to some meaningful changes in the environment for the care and education of young children, including infants and toddlers:

- An increase in the infant child care subsidy rate by 40%, the first increase in 10 years



#REIMAGINEchildcare

Main Findings from the Surveys

The two Fairleigh Dickinson University surveys found that:

- **New Jersey residents view infant and toddler care as an important issue for the state**
- **COVID-19 forced some New Jersey parents out of the workforce or caused them to reduce their work hours**





- Creation of a tiered reimbursement system in Grow NJ Kids to reward quality early childhood care and education centers that serve families who receive state subsidies; efforts to extend tiered reimbursement to family child care providers continue
- The ability for families with annual earnings of less than \$60,000 to qualify for a Child and Dependent Care Tax Credit
- Inclusion of \$6.2 million in the state's 2021 budget to help cover an increased minimum wage for child care staff
- The announcement by Gov. Murphy in January 2020 of a reduction by 50% in the co-payments that parents who receive state help paying for child care must pay, saving 32,000 New Jersey families \$23 million per year
- National recognition in the form of a \$100,000 planning grant to ACNJ in 2019 from the Pritzker Children's Initiative and a follow-up, three-year \$1.2 million implementation grant. The awards supported the convening of a partnership of government, service providers, advocates, and others concerned about care and education for young children. The partnership was tasked with creating a vision and strategies for expanding services to support the healthy growth and development of infants and toddlers from New Jersey families who need help with finding and paying for quality early care and education. These grants were awarded in acknowledgment of work already underway in New Jersey. The Pritzker Children's Initiative's plan, *Unlocking Potential*, was released in June 2020.

The availability, accessibility, and quality of care and education for young children is a continuing concern, and was only heightened by the COVID-19 pandemic. "Even so," notes Kay Hendon, the Senior Program Officer who led the Foundation's Early Childhood strategic focus area, "higher subsidy rates, a mature QRIS, tiered reimbursement, and other engines of quality improvement are now features of the care and education landscape for young children in New Jersey. These successes address the needs of families and are helping to put young children, especially infants and toddlers, on a powerful and positive trajectory for the future."





NEW DESTINY
FAMILY SUCCESS CENTERS, INC.
A Family Gathering Place
www.patersonfsc.org
(973)278-0220

FAMILY SUCCESS CENTERS: A ONE-STOP STRATEGY FOR STRENGTHENING FAMILIES AND COMMUNITIES

A healthy family can be defined in various ways—good physical and emotional health; strong, stable, and supportive relationships with loved ones and friends; resilience in the face of challenges; and sufficient access to education, work, play, and other opportunities. Healthy families are essential to healthy communities. Recognizing these realities, one of the Foundation’s earliest priorities was to pursue evidence-based strategies and promising practices and programs that improved families’ access to needed social services.

We started in Newark. In 2006, we reached out to community leaders, government agencies, and service providers in the city to learn about potential approaches for achieving this goal. We discovered that one of the biggest problems facing families was that in order to get services, they had to deal with a confusing and fragmented system of multiple agencies with multiple rules and requirements. The agencies were not set up to help people succeed. Not only was this burdensome and difficult for families, it was inefficient for the city.

That year, Foundation staff traveled to Pittsburgh and learned about a promising solution: one-stop centers to connect families to services and resources. Surprisingly, it turned out that the Pittsburgh centers were modeled on a family resource center established in the 1980s in a public housing project in Elizabeth, New Jersey. Two aspects of the Pittsburgh centers appealed to the Foundation—families could visit one place to learn about all available resources, and community members were actively involved in the centers’ work through their participation in strong advisory boards.





Staff returned to New Jersey inspired to revive this approach, optimistic that it could help the Foundation achieve the goal of making a difference for struggling families. “We started out in Newark with an interest in helping to lift people out of poverty and we looked for opportunities to support local leadership,” explained Charles Venti, Executive Director of The Nicholson Foundation from 2010 to 2016. “We wanted to find champions for causes that could advance the prospects for people in those communities, with an eye not just toward a one-time investment but where the investment would result in systemic reforms that would have a broad and lasting impact on people.”

Our interest was timely because change was happening on the local as well as the state level. Cory Booker had recently been elected Mayor of Newark, and he wanted to address the root causes of poverty and crime in the city. He was convinced that a prevention-based approach, including projects like one-stop centers, would be more effective than merely reacting to crises as they emerged. The state, too, was thinking along the same lines as it began to shift the focus of its child protective services from intervention to prevention. Governor Jon Corzine, elected in November 2005, created a new Department of Children and Families, the first cabinet-level department devoted to serving at-risk families. The new department provided an avenue for prevention- and support-oriented activities and funding.

Beginning in 2007, we funded the development of 11 one-stop centers, later called Family Success Centers (FSCs), to connect families to services and resources. The centers were located in several Newark neighborhoods and the surrounding urban communities of Essex and Union Counties. In addition, we funded two GrandFamily Centers, which focused on the unique needs of grandparents who were primary caregivers for their grandchildren.

At the same time we were building out our complement of centers, the state Department of Children and Families was establishing a network across the entire state. Our centers were taken over by the state in 2013, when the Foundation moved on to other services ripe for systems change. Our interest in the model, however, didn’t dim. In 2018, we welcomed the opportunity to turn to the FSCs again to help us in a project involving pediatricians in training. (For more on this project, see *Developing Pediatric Leaders Through Community Partnerships* in **Chapter 7. Developing Future Leaders.**) But this is getting ahead of the story of what FSCs grew to be.

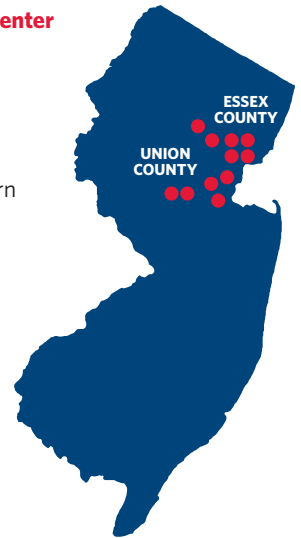
Initial Family Success Center Locations

Essex County

- Newark Now
 - Newark (4)
- United Way of Northern New Jersey
 - Montclair (1)
- Family Connections
 - Orange (1)

Union County

- United Way of Greater Union County
 - Elizabeth (1)
 - Plainfield (2)
 - Roselle (1)
 - Linden (1)





The One-Stop Solution

FSCs connect people to a wide range of coordinated services designed to promote family stability and child well-being. The centers serve all families living in the local neighborhood and offer both on-site services and connections to community resources. They are intentionally located in neighborhoods that are easily accessible by foot or public transportation.

The FSC one-stop concept serves an important systems function for the state: Capturing client data and pre-qualifying clients for multiple family support programs at one time and in one place reduces red tape and increases efficiency. It also serves a critical service function for clients: When parents are connected to multiple services simultaneously, they don't need to take time away from work and family to travel to multiple agencies to repeat similar enrollment processes. The one-stop center was conceived, moreover, as a way to help families manage conflicting responsibilities (e.g., court appearances during working hours).

FSCs have evolved further to play a central role in the community by providing a venue where residents, leaders, and agencies can come together to address the problems facing their community. Each FSC is overseen by a parent advisory committee, which provides overall direction and guidance to staff as they develop programs. In addition to facilitating access to child, maternal, and family health and social services, FSCs provide parenting, finance, cooking, and yoga classes; credit counseling and tax help; workforce development and training assistance; mentoring; and healthy living and stress management support. An essential aspect of the services FSCs provide is to partner with families and individuals to support the development of skills that help them advocate on their own behalf.

Coming to an FSC is a radically different experience from visiting a social services agency. A visitor is warmly greeted by a staff member, and the centers are furnished with comfortable chairs and sofas. While parents are talking with staff, children can be occupied with books and toys in play areas. A kitchen provides coffee, tea, and water. Staff give new visitors a tour of the center and tell them about all the resources, activities, and volunteer opportunities available. If they choose, visitors can register with the center, but this is not required to receive services. The services, activities, and classes provided at the FSCs provide an important source of community connection and support that clients might not experience otherwise.

As initially conceived, the FSC approach was unique because it was the only comprehensive way into government services that families could access on their own, without a referral. Without the FSC, families would have had to wait until they faced a crisis, such as eviction, running out of food, or some other emergency, before being able to get help for a problem. This proactive, rather than reactive, approach was a distinguishing feature of the FSC program.





Staff members working together at the New Destiny Family Success Center, in Paterson

To provide all this support, the FSCs have traditionally partnered with a wide range of agencies and organizations. For example, Newark Now, which managed several Nicholson-funded FSCs, collaborated with Essex County Welfare; the Newark OneStop Career Center; Essex County College; Opportunity Reconnect; United Way; local health, economic empowerment, and family welfare groups; and private partners, including banks and prospective employers.

Including Grandparents

Data from the U.S. Census Bureau's American Community Survey estimated that during 2008–2010 about 113,000 children in the state (or about 1 in every 18 children) were living in grandparent-headed households. Living with grandparents happens for a variety of reasons and can provide children with a stable environment they would not otherwise have. Yet, many grandparents face the same struggles in providing for their grandchildren as parent-led families. Moreover, many face complicating factors. Grandfamily children, for instance, often have moved from school to school, without the records that should have accompanied them. Grandfamilies are eligible for support payments for the children they are caring for, but in New Jersey these payments are at three different levels, with the highest payments applying to children officially designated as foster children.

From 2009 to 2015, we funded two FSCs focused on these important caregivers—the Essex County GrandFamily Success Center, which we founded with the Salvation Army in Newark, and the Mercer County GrandFamily Success Center, run by the Children's Home Society of New Jersey. Their services and support enabled caregiver relatives to do the best they could for their young family members, either permanently or temporarily until the children could be reunited with a parent. The GrandFamily centers taught grandparents how to advocate for their young charges in the school system and helped grandfamilies qualify for higher levels of support.





Impact and Sustainability

From 2007 to 2012, we funded a total of 11 FSCs and 2 GrandFamily Success Centers, complementing the network of FSCs that the state had begun to build. In 2013, the state assumed responsibility for the entire FSC program and, as of 2021, manages a vibrant network of 57 centers located in all of New Jersey's 21 counties. In 2019, this statewide network served nearly 32,000 registered families comprising 50,000 registered individuals.

To help ensure that the FSCs would last, the Foundation's grants and the state's funding encompassed several additional components to bolster the centers themselves. These included:

- Quarterly meetings and an annual conference, which allowed the FSCs to develop connections with each other, share learnings, and discuss best practices
- Training and support for staff members and advisory board members; in 2018, the state developed a Family Success Center training, coaching, and leadership program
- Collaborations among FSCs and with other organizations to spread the FSC philosophy and encourage others to adopt the model

Family Success Centers are an important element in the structures intended to support families in ways that improve their overall health and well-being and enhance their opportunities to fully participate in their communities. And, the model is spreading. State officials have provided technical assistance to other communities, including Gainesville, Florida; New York City; and the District of Columbia.

FSCs also have provided a means by which state and local agencies can connect directly to communities. This connection can help agencies better understand their communities and be in a stronger position to address their needs. An ancillary initiative, the nonprofit Family Success Institute, has provided policy and practice research to support the development and expansion of the FSC model and its emphasis on prevention as the preferred approach to working with families.

Lastly, an understanding of an intangible but very meaningful aspect of the FSC has emerged. The FSC is a safe place for families to get to know others in their neighborhood. Connecting can go a long way toward strengthening families, preventing child maltreatment, and enhancing community well-being. Cari Burke, program director for Acenda, which oversees several FSCs, explained the power of socialization this way: "Social connection is a protective factor. It is a support system that can cushion the impact of unemployment, substance abuse, and events arising from the everyday stress of poverty—all of those things that can happen when people don't have life skills or resources to get them out of a bind that they might face. If people are isolated and disconnected from others in their community, the stresses increase, which can lead to child maltreatment and neglect. If we bring in that social connection, the protective factors increase."





A MULTI-FACETED APPROACH TO MAKING NEW JERSEY THE SAFEST PLACE TO HAVE A BABY ... FOR EVERYONE

Of all the goals related to the health and well-being of individuals, families, and communities, perhaps none is more compelling than ensuring that everyone has a safe and healthy start to life. That means making sure that every woman* can have a healthy pregnancy and safely deliver a healthy baby. Yet, New Jersey has far to go to reach this goal.

The most recent state data show that, tragically, from 2014 through 2016, 151 mothers died during pregnancy or delivery, or within one year of giving birth. This translates into a pregnancy-related mortality ratio of 15.0 per every 100,000 live births for New Jersey. For women of color in New Jersey, the experience of childbirth is especially hazardous. During that same period, non-Hispanic Black women had about seven times more pregnancy-related deaths (44.5 deaths per 100,000 live births) than did non-Hispanic White women (5.8 deaths per 100,000 live births).

Serious injuries during childbirth, such as cardiac issues and hemorrhage, tell a similar story. In 2018, the rate of serious maternal injuries during childbirth and after giving birth was nearly three times greater for non-Hispanic Black women than for non-Hispanic White women.

Most Maternal Deaths and Injuries are Preventable

However, this is true only when women have equitable access to quality maternal healthcare before, during, and after they give birth.

Women of color describe common negative healthcare experiences during pregnancy and delivery:

- **Trouble obtaining care and appointments during the first, critical, trimester of pregnancy**
- **Difficulties in getting healthcare professionals to listen to their concerns and take them seriously**
- **Lack of access to helpful information on available resources and services**

*Throughout this story, we use the term “woman,” but in a desire to be universal and inclusive, we acknowledge that the word covers all pregnant and birthing people.





The burden of unequal healthcare falls not only on the mothers, of course, but on their babies as well. Although New Jersey has one of the lowest overall infant mortality rates in the country, the disparities across racial and ethnic groups are substantial. In 2017, the non-Hispanic Black infant mortality rate was more than three times higher than the rate among non-Hispanic White infants.

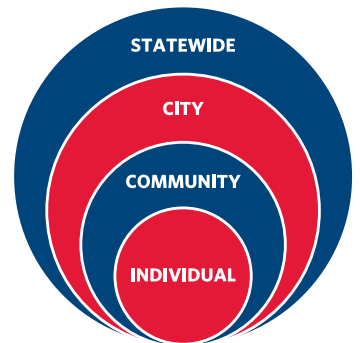
New Jersey’s racial disparities in the rates of maternal and infant deaths and injuries are deeply rooted in a web of multi-layered and intersecting inequities and systemic racism that play out both implicitly and explicitly in culture, institutional traditions, and generational and personal trauma. All women of color, regardless of income level, experience disparities across various aspects of their lives, including employment, education, finance, and law and justice. Their negative experiences with the healthcare system are no different, and mortality and morbidity among women and infants of color are leading indicators of these healthcare disparities.

Fortunately, many maternal and infant deaths can be prevented by improving women’s health before, during and after pregnancy. Currently, New Jersey has the fourth-highest rate of overall maternal mortality among all the states. If the goal is to change that ranking and improve maternal healthcare quality in the state, then the route to that goal must be through an unwavering focus on equity. This means taking the actions necessary to ensure that ALL women have access to, and receive, caring, excellent, and culturally appropriate healthcare.

A Complex Problem in Need of New Solutions

In 2017, the Foundation began actively looking for opportunities to invest in areas at the intersection of health and early childhood—our two primary focus areas during the second half of our history. Maternal health was a logical investment. It was an important public health problem that disproportionately affected populations of color in New Jersey, and the causes were inextricably tied to health-related social needs and systems of care. We believed that strategies addressing systems of care could have substantial and durable effects on the health and well-being of women of color and, potentially, of all women in New Jersey.

We began to talk with the state, other foundations, and other partners about collaborations to reach groups of women who had not previously received concerted, culturally relevant attention. The result was a multi-pronged initiative consisting of six distinct yet complementary projects, operating at different levels—the state, city, community, and individual level—and guided by multiple partnerships with a variety of agencies and groups. The driving force behind all these efforts was a desire to improve the equity—and importantly, the quality—of maternal healthcare and to reduce maternal morbidity and mortality. And, we recognized that including women of color as central partners in devising and executing strategies for action had to be an essential component of these efforts.





STATEWIDE:

Supporting the First Lady's Statewide Nurture NJ Initiative

At the **state level**, we found a willing partner in Governor Phil Murphy's administration. Inaugurated in January 2018, the Governor made it clear that improving maternal health and eliminating racial disparities in maternal deaths and injuries would be a key priority for the state. New Jersey recognized that existing approaches were not improving health outcomes sufficiently, particularly when it came to health disparities. The state wanted to think strategically and holistically about this issue and dedicate resources to those most affected—Black and Brown women.

First Lady Tammy Snyder Murphy made maternal health her signature issue and reached out to a variety of partners and funders, including The Nicholson Foundation, to help her design and implement Nurture NJ, a major multi-sector statewide campaign to improve maternal and infant health. In her many speeches and writings on this issue, she made her passion and commitment clear: "I am the mother of four beautiful children, who are the joy of my life. I carry the knowledge of our Black maternal and infant health crisis in my heart every day, as well as the understanding that but for the color of my skin, I, too, may have been lost or suffered during childbirth. But with that knowledge comes the determination to not only solve this crisis but to make New Jersey a leader and model for equitable maternal care for our entire nation."

Nurture NJ's goal was to reduce the maternal mortality rate by 50% and ensure equity in care and in perinatal outcomes for mothers and infants of all races and ethnicities—in sum, to make New Jersey the safest and most equitable place in the country to deliver and raise a baby. The campaign involved 18 state agencies and departments in a cross-sector approach to improve collaboration and programming.

We supported Nurture NJ in three ways:

1. We engaged a team of nationally recognized perinatal experts to work with state and community leaders to develop a Nurture NJ strategic plan. The experts connected with almost 100 people across the state to discuss the maternal and infant systems of care and learn about the experience of women across New Jersey. Co-funded by the Foundation and the Community Health Acceleration Partnership (CHAP), the *Nurture NJ Maternal and Infant Health Strategic Plan* was released in January 2021. As the plan makes clear, "the disparities in maternal and infant outcomes are not the result of differences in genes or behavior, but the result of the different historic, social, economic, and health environments experienced by Black and Brown women."

The plan provides a road map to fundamentally change how New Jersey approaches maternal healthcare by: (1) ensuring that all women are healthy and have access to care before pregnancy, (2) building a safe, quality, equitable system of prenatal, labor and delivery, and postpartum care, and (3) encouraging supportive community environments so that

What is CHAP?

The Community Health Acceleration Partnership (CHAP) is a project of Rockefeller Philanthropy Advisors (RPA). CHAP works to build stronger, more effective community health systems through investments that spark change and engage strategically.





the conditions for health are available. The three routes to achieving these goals are to build racial equity infrastructure and capacity, make community engagement a central component for action, and engage multiple sectors.

2. We created and implemented a strategic communications campaign focused on reaching healthcare providers and women who are pregnant, with a specific focus on communities of color. The Foundation funded two communications firms to address information needs identified in the Nurture NJ strategic plan.
3. We supported Family Festivals, which are neighborhood events with a block-party-like atmosphere. They feature state, county, and local social services providers who can connect families with resources, such as prenatal care, mental health and addiction services, child care and education, and food and housing assistance. By January 2021, Family Festivals had been held in Atlantic City, Camden, Jersey City, Newark, Paterson, and Trenton, connecting more than 5,500 families with nearly 600 providers.



In a second **state-level** project, we began to collaborate with the Department of Health (DOH) in 2019 to develop a blueprint that identified evidence-based strategies for how the healthcare system could reduce maternal mortality. A critical element of that effort involved improving the state's maternal morbidity and mortality data infrastructure, and we funded a national expert to help DOH substantially reorganize and update their ability to gather and report data. This technical assistance was instrumental in helping the state apply for, and win, a five-year, \$10.5 million grant from the federal Health Resources and Services Administration (HRSA) to support a new Maternal Care Quality Collaborative. The Collaborative, which functions under the umbrella of Nurture NJ, is a multi-disciplinary team of experts charged with establishing a vision and statewide goals for health services focused on decreasing maternal deaths, injuries, and racial and ethnic disparities.

CITY: **Engaging Healthcare Coalitions in Initiatives to Reduce Pregnancy-Related Complications and Mortality**

At the **city level**, we partnered with CHAP and the Burke Foundation (a New Jersey foundation focused on healthy pregnancies and births, positive parent-child relationships, and early childhood care and education) to supplement funding from Merck for two Safer Childbirth Cities projects in New Jersey. We also joined a national funder collaborative supporting the work. The Merck for Mothers Safer Childbirth Cities Initiative is a global effort aimed at ending preventable deaths of women, especially Black women, from pregnancy-related complications. An important goal is to reduce disparities in the quality of care and in the use of community resources. After a national competition, Merck selected 10 U.S. cities to participate in and receive technical assistance for quality improvement efforts and use of data to track progress and guide improvement. Applicants were required to have secured committed





companion funding, and the award prescriptions were individualized. Two of the 10 first-round winners were New Jersey cities, a gratifying recognition for the service providers, advocates, policy experts, and funders working to improve the New Jersey healthcare system. The awards were won by the Camden Coalition of Healthcare Providers and the Greater Newark Healthcare Coalition—both of which were previous grantees of the Foundation. Interestingly, their projects were quite different:

- **The Camden Coalition of Healthcare Providers'** project aimed to strengthen citywide data infrastructures to connect women to pregnancy-related services and improve healthcare and social services coordination. The project relied on Central Intake, a state referral system that helps people obtain state-funded services.

- **The Greater Newark Healthcare Coalition's** project used the public health system to educate healthcare providers on best practices for maternity care, provide services to women at risk of adverse birth outcomes, and develop a public information campaign to increase women's awareness of serious complications associated with pregnancy and the postnatal period.

In January 2021, Merck announced a second cohort of nine Safer Childbirth Cities; this time, the **Trenton Health Team** was included. The Trenton Health Team, also a Foundation-funded healthcare coalition, was funded to create a data analytics system to expand knowledge of maternal health challenges and to enhance doula services for women with high-risk pregnancies.

Supporting Community-Based Healthcare Coalitions

The New Jersey Safer Childbirth Cities Initiative sites are all community-based healthcare coalitions. The Foundation has been a longtime funder of health coalitions in multiple cities, including Camden, Freehold, Newark, Paterson, and Trenton.

The Foundation's support for infrastructure, staffing, and other basics have helped the coalitions evolve and flourish—and successfully apply for systems change projects like Safer Childbirth Cities.

To learn more about our support for these coalitions, see *Healthcare Coalitions: A Strategy for Community Transformation* in Chapter 5. Investing in Organizational Nuts and Bolts.

COMMUNITY and INDIVIDUAL: Improving the Pregnancy, Delivery, and Postpartum Experience

"We can't forget that the most important focus of efforts to improve care and reduce mortality and morbidity is, of course, the person going through the birthing experience," explained Kimberly Boller, the Foundation's Chief Strategy and Evaluation Officer, who spearheaded coordination of the overarching and final strategy push for our maternal health work. "The goal is to make every pregnancy, delivery, and postpartum experience as safe, healthy, and satisfying as possible. There was no doubt that state-level, systems-focused efforts were absolutely necessary to create lasting change. But engaging women directly was equally important, and we developed additional partnerships and projects to do so."





At the **community level**, we supported implementation of the Centering® group healthcare visit model within New Jersey’s Healthy Women Healthy Families initiative. This project aims to reduce the rate of preterm births and low birthweight among participating women and to address racial disparities in outcomes. A second goal was to strengthen the long-term use of this model in other areas of New Jersey.

We funded this project jointly with the Burke Foundation and The Henry and Marilyn Taub Foundation. Project grantees used the CenteringPregnancy group-visit model at sites in Jersey City, Paterson, Trenton, and Newark. The Centering Healthcare Institute, which developed the model, provided technical assistance to the sites.

At the **individual level**, we supported an effort to increase the number of trained doulas in New Jersey. Doulas are professionals who provide physical, emotional, and informational support to women before, during, and after birth to help them achieve a healthy and fulfilling experience. This project, a collaboration with DOH, was also a component of the state’s Healthy Women Healthy Families Initiative. Bringing the Uzazi Village Perinatal Doula curriculum from Kansas City, Missouri, to New Jersey in 2019, the project trained community doulas to reach out and engage pregnant women of color and offer them culturally appropriate care. The Uzazi Village curriculum, considered to be a best-practice model, specifically builds upon the strengths and resilience inherent in Black communities. The Foundation funded three community-based organizations located in Camden, Essex, and Mercer Counties to recruit and train 79 doulas. The Foundation also supported health equity training sessions specifically for new doulas to help them provide culturally appropriate and responsive care.



Doula participants at a training session

What Is the Centering® Model?

The Centering healthcare visit model is a paradigm shift away from the traditional one-on-one provider-patient experience.

The Centering model brings patients into a group setting (held at a clinic or other community-based organization), where they can learn from provider facilitators and from each other. The two-hour visits provide plenty of time for health assessments, interactive learning, and community building.



A Centering® session for mothers-to-be

What is Healthy Women Healthy Families?

New Jersey’s Healthy Women Healthy Families Initiative uses a collaborative, community-driven approach of community health workers and referral hubs to improve maternal and infant health outcomes for women of childbearing age and their families, while reducing racial, ethnic, and economic disparities in those outcomes.





Impact and Sustainability

It can take time for the results of projects to manifest themselves in measurable systems change and improved health outcomes. However, a few milestones illustrate how the seeds for systems improvement have been sown and have created the potential for better and more equitable maternal healthcare and better outcomes for mothers and their babies:

- New Jersey DOH's maternal data system is now recognized as a national model. DOH officials deliver presentations around the country describing its features and how it has improved the state's ability to conduct maternal health surveillance and track progress on reducing preventable mortality and morbidity.
- As of February 2021, New Jersey's Medicaid program has begun to cover doula services. This new feature of the program is essential to long-term support of doulas as they transition from grant funding to sustainable reimbursement.
- Since 2018, the New Jersey legislature has passed, and Governor Murphy has signed, 36 bills—both in packages of multiple bills and in single bills—related to infant and maternal health. These include measures creating a pilot program that changes how Medicaid pays for births in ways that reward providers who follow best practices and achieve good outcomes (the program was developed by the Medicaid Policy Center, a program managed by the New Jersey Healthcare Quality Institute, a Nicholson Foundation grantee; for more on the Medicaid Policy Center, see *The New Jersey Health Care Quality Institute: An Enduring Partner* in **Chapter 4. Finding and Nurturing Effective Partnerships**). Medicaid now also prohibits the state's health benefit plans and Medicaid from covering early, elective deliveries (surgical or induced deliveries before 39 weeks that are not medically necessary). These deliveries carry risks for both mother and baby. The national Healthy People 2020 goal for unnecessary surgical deliveries among low-risk, first-time mothers is 23.9% of all births; overall, New Jersey's rate is 30.3%.
- New guidelines to advise clinicians and healthcare systems on perinatal healthcare for women during the COVID-19 pandemic were released in May 2020 by the New Jersey Perinatal Care During COVID-19 Work Group. The Work Group was led by the New Jersey Health Care Quality Institute, and the development of the guidelines was funded by the Foundation.
- A new maternal and child health Project ECHO clinic, funded by the Foundation, was created in collaboration with DOH to address perinatal issues and support the development of a stronger, more equitable system of care for women. (For more on the Foundation's investment in Project ECHO, see *Building Evidence for an Innovative Healthcare Service Delivery Model* in **Chapter 3. Elevating Best Practices and Building Evidence for New Jersey**.)





- Grounded in specific recommendations included in the Nurture NJ Strategic Plan, Governor Murphy's 2022 budget includes funding for a number of programs and policies. These include expanding Medicaid coverage from 60 to 365 days postpartum, an increase in funding for pregnancy and reproductive health services for undocumented mothers, a pilot to provide housing support and additional services for eligible pregnant women, a doula registry to support development of the workforce, and an analysis of the areas with the highest rates of maternal and infant morbidity and mortality to raise awareness and increase outreach, services, and supports in those locations.

Even with these accomplishments, much more work can still be done. Using the Nurture NJ Strategic Plan and the growing infrastructure for improved and equitable maternal care as a springboard, four funders came together to establish a New Jersey Funders Birth Equity Alliance in 2021. The funders included the Burke Foundation, CHAP, and the Robert Wood Johnson Foundation, with The Nicholson Foundation in an advisory role during its wind-down in 2021. The Alliance's purpose was to address racial disparities in maternal and infant health in New Jersey by strengthening "the ecosystem of actors" who are critical to promoting equitable maternal and infant health outcomes. The Alliance will continue to work closely with state government, support capacity-building for local organizations, and encourage efforts to elevate the voices of affected communities.

Efforts over the past several years have put building blocks into place for effective, statewide systems change. These building blocks—the Nurture NJ Strategic Plan and campaign, the Department of Health data system, the Merck Safer Cities Initiative, numerous local efforts, and the New Jersey Funders Birth Equity Alliance—show what can happen when government, philanthropy, and community come together in common purpose.

We believe that New Jersey is now on track to lead the nation in both raising awareness of racial inequities in maternal and infant health and implementing multiple, complementary strategies to guide state and local action. With a state budget focused on increasing access to, and quality of, healthcare; with multi-sector partnerships creating durable initiatives; and with newly mobilized communities, New Jersey is on course to truly fulfill its goal of making the state the safest and most equitable place to deliver and raise a baby.





CHAPTER 6. KEY TAKEAWAYS

- **Recognize the inherent complexity of some problems.** Don't be daunted by what seems like a huge or intractable problem. Multiple organizations or complex approaches may be needed to successfully tackle these types of issues. It's okay to accept the reality of slow change over time while still being impatient about getting to that change. Recruit others—especially those directly affected by the issue—who can bring big thinking and diverse skills, experience, and perspectives to devising solutions. These collaborations can spark fresh ideas, bring in new viewpoints, identify common goals, and enhance the focus on areas where combined action may lead to great impact.
- **Be aware that complex problems evolve over time in response to external events.** Work with collaborators within and across partner organizations to devise flexible and realistic short- and long-term goals and objectives that can accommodate these changes. Philanthropy can provide consistent leadership and stability even if other partners come and go.
- **Take advantage of the role that philanthropy can play as a neutral convener.** Foundations can bring together agencies and organizations that have different perspectives and priorities and that may not regularly communicate. This can create opportunities for joint action on problems of common interest.
- **Prioritize clear and persistent communications with policy makers and influencers about gaps in services.** Highlight potential opportunities for filling those gaps. Keeping these issues visible is necessary to motivate action that enhances access to affordable, quality services. This is especially true when a new public health or policy issue becomes the dominant focus of attention, pushing other issues aside.
- **Start with a strengths-based approach when planning social services interventions.** Supporting programs that give families and communities the power to address their own needs is a positive approach with long-term potential.
- **Do the homework.** Study closely the history of what has been done and what approaches have been taken in the area of concern. Before enacting a proposed solution, know what specifically has been done in this area, and how those reforms have fared.
- **Catch a wave.** A swell of political or public interest can carry an initiative a long way.





Developing Future Leaders



Effective systems change cannot occur without flexible and strong leaders who are committed to the process. The Nicholson Foundation understood that leaders are the people in positions to influence funding, manage programs, set policy, develop regulations, and lead initiatives. Investing in the development of good leaders therefore increases the likelihood that projects and initiatives will be continued and succeed over time. The process of developing good leaders has auxiliary benefits. It provides opportunities to bring people together and build lasting relationships. Given the disconnected nature of many government, health, and human services agencies, emerging leaders might never interact without these opportunities. Bringing future leaders together also helps to identify common goals and enhance the potential for leveraging investments across multiple systems, creating opportunities for powerful, collaborative action.

The following stories illustrate what's possible when leadership development is viewed from this broad perspective. They describe how we:

- Supported a leadership training program for Medicaid staff and those of related agencies
- Invested in a program to improve the practice of pediatric care in New Jersey by helping medical residents engage with their local communities





BUILDING LEADERSHIP SKILLS AND CAPACITY TO ENHANCE THE FUTURE OF MEDICAID

For people who live on the economic margins of society, Medicaid is a critical lifeline that supports their ability to obtain affordable healthcare and, therefore, their ability to work and care for their families. In June 2013, Governor Chris Christie signed a state budget that included funds to cover expanded eligibility for Medicaid under the Affordable Care Act. Expansion began in 2014, and by July 2018, the program had added about 470,000 low-income adults and children. The sheer size, complexity, and cost of the Medicaid program (more than \$16 billion in 2018, with the state's contribution—about 40%—representing about 17% of the state's budget) created huge pressures to improve the quality of services and reduce costs.

(For a more detailed description of New Jersey's Medicaid program, see *The New Jersey Health Care Quality Institute: An Enduring Partner* in **Chapter 4. Finding and Nurturing Effective Partnerships.**)

Early in 2015, an intriguing idea arose that would strengthen the state's responses to this pressure. The Center for Health Care Strategies (CHCS), a nonprofit policy organization in New Jersey that advances innovative and cost-effective models for organizing, financing, and delivering healthcare, approached the Foundation and the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS), the state's Medicaid agency, with the idea of a Medicaid Academy. The Academy would focus on mid-level management staff (for example, a Deputy Director of Policy) because these people were the ones who managed Medicaid's day-to-day programmatic, policy, regulatory, and budgetary aspects. The Academy would help participants improve their knowledge of Medicaid and better understand the challenges facing the program. This training would help participants do their jobs better and, in turn, help Medicaid work more efficiently and effectively.

The Medicaid state plan, which covers a huge range of issues related to covered services and populations, reimbursement, program administration, and other topics, runs to more than 800 pages.





The Academy had a second aim as well: Build on the agency's ongoing efforts to cultivate staff's leadership and professional skills. These skills would be important assets as the staff rose from mid-level to senior leadership positions in the agency.

Our previous successful experiences partnering with CHCS on other projects, and their history of working with other states on similar projects, assured us that they had the experience and expertise to lead this new project. Another bonus was that CHCS was well-known to Medicaid leadership and staff.

A Commitment to Leadership Training

The Foundation funded four cohorts of the Medicaid Academy. Each cohort included about 30 staff from the state's Medicaid agency and other agencies with relevant public health, insurance regulation, and budget responsibilities. Over each eight-month session, CHCS helped participants understand the inner workings of Medicaid. It also taught them about new Medicaid program design possibilities, including approaches undertaken by other states. Participants were able to talk with each other about Medicaid issues of mutual concern and share implementation successes and challenges.

As the program evolved, it added two components. The first, Academy in Action, was launched in 2016. Academy in Action allowed participants to apply what they learned in the classroom to a policy problem important to state leadership. Medicaid leadership selected participants based on the program's own needs as well as the professional development needs of staff.

Through Academy in Action, participants from different agencies worked together on developing solutions to shared policy and programmatic problems, which helped cement cross-agency communication and collaboration. CHCS provided technical assistance, and senior staff at the participants' agencies supervised the collaborative effort to develop the solutions. At the end of the Medicaid Academy session, the participants presented their projects to Medicaid leadership, including to the Director.

The second component, the Executive Leadership Program, focused on a variety of topics designed to meet the needs of senior program managers, such as improving team functioning and enhancing executive communication. This component, which began in 2020, operated through a virtual format because of the COVID-19 pandemic. These participants also created projects similar to the Academy in Action projects. By the end of March 2021, five groups had planned and presented their projects to Medicaid leadership.





Impact and Sustainability

As of February 2021, 131 staff members had participated in the Medicaid Academy, and the Executive Leadership component had 25 participants. In addition, 36 participants had been selected for the Academy in Action. A clear signal of the program's impact was the continued enthusiasm of participants. Michelle Pawelczak, Director of the DMAHS Office of Customer Services and a Medicaid Academy participant, described the benefits of the program by saying, "The Medicaid Academy has served as a bridge between the academic knowledge and the job we are responsible for as public servants. Theoretical concepts only make sense when they can be used as a tool to make our reality a better one."

Medicaid's leadership team also was very supportive. It not only requested additional cohorts but also worked with CHCS to further develop and refine the curriculum. In addition, the Academy in Action projects helped the Academy achieve an important aim, which was to bring together staff from various state departments and agencies to collaborate on projects of mutual interest. Two projects show how the Medicaid Academy participants contributed to New Jersey's Medicaid program:

In the first project, two participants convened staff from Medicaid and the Department of Health to discuss health disparities in infant and maternal mortality. They analyzed policy options to address the problem and discussed how to sustain an existing pilot doula program. This collaborative effort not only fostered interagency collaboration but also helped to inform meaningful policy and funding changes. In March 2019, New Jersey announced \$1 million in the state budget to support doula care. In May 2019, Governor Phil Murphy signed Bill S1784 into law, which allowed the state to expand Medicaid to cover doula services. Coverage for these services began January 1, 2021.

In the second project, another Academy in Action team worked on information technology policy solutions. For example, one solution used state health information technology funding to help behavioral health providers connect their electronic health records to the state's Health Information Exchange (a mechanism for securely and electronically sharing health information across multiple providers). This was helpful to the state as it developed new and secure procedures for sharing data.





DEVELOPING PEDIATRIC LEADERS THROUGH COMMUNITY PARTNERSHIPS

The connections between health, early childhood development, social environments, and the well-being of children and families may seem clear today, but this wasn't always the case. Traditionally, doctors did not address patients' needs beyond the physical.

However, in recent years, the manifestations of poverty and racism have increasingly been recognized as creating ongoing stresses that contribute to physical and mental health issues and make it difficult for children and their families to thrive. Understanding this larger context of a family's life can give pediatricians important insights into how to provide care that holistically addresses patient needs, supports parent and child relationships, and builds a strong partnership between the family and pediatric health professionals. This understanding also helps pediatricians provide care that recognizes and builds on the innate strengths and resilience of families and communities.

In December 2017, Foundation staff began supporting an initiative designed to help pediatricians care for children and families within this broad context. The underlying strategy was to help pediatricians know and become engaged with the communities in which their patients lived. Importantly, the initiative was designed to begin when pediatric professionals were still in training. By working with pediatricians during this critical period in their careers, the initiative aimed to cultivate future community leaders who could have a real impact on the health and well-being of the children and families in their care.

Supporting a Network for Community Engagement

The heart of this initiative was the 10 pediatric residency training programs in New Jersey. Theoretically, because the programs were spread throughout the state, they were well positioned to foster the pediatric residents' connections to the communities in each program's surrounding area. However, the residency programs





didn't have a formal network of support among the faculty and residents. The programs addressed community and advocacy on the surface only and rarely offered community-based experiences beyond the clinic walls. Moreover, they did not have well-developed relationships with community services providers and local leaders that could serve as trusted go-betweens to help them identify service gaps and connect with children and families in the community.

An opportunity to transform this dynamic emerged when the American Academy of Pediatrics (AAP) approached the Foundation with the idea of working with the residency programs through their Community Pediatrics Training Initiative (CPTI), a national program that AAP launched in 2005. CPTI aims to improve child health by strengthening community health and advocacy training. It educates and empowers pediatricians to build partnerships with community leaders, families, and other child health professionals. CPTI had lots of experience from their work with 120 pediatric residency programs through more than 200 grants, and, by 2020, it was partnering with programs in 42 states. CPTI was the right partner to work with to engage the New Jersey pediatric residency programs in community outreach. This new initiative was called the New Jersey Pediatric Residency Advocacy Collaborative (NJPRAC).

A Step-by-Step Approach

NJPRAC began with a six-month Foundation planning grant in 2018. During this time, CPTI engaged all 10 of the state's pediatric residency programs, and the programs collectively identified shared priorities and committed to community engagement projects. An important component of the project was that faculty members as well as residents would participate in the community engagement efforts. The Foundation and CPTI also worked closely with the New Jersey Department of Children and Families to conduct a scan to identify potential community partners.

This scan eventually highlighted the Family Success Centers program. This well-established, statewide, state-funded network of 57 neighborhood-based facilities connects people to a range of services designed to promote family stability and child well-being. In a way, this brought us full circle, for the Foundation had been a driving force in the origins of this network. Now, more than seven years after the hand-off to the state of the 11 centers we funded, we were pleased to have the opportunity to engage with the program again. (For more about this network, see *Family Success Centers: A One-Stop Strategy for Strengthening Families* in **Chapter 6. Tackling Complex Problems through Multiple and Complementary Strategies**.) By the end of the planning grant, each residency program had established its own partnership with a Family Success Center located in its surrounding community. Throughout, the state was strongly supportive and involved in project meetings and events.



Community members at a Family Success Center event





A full rollout by NJPRAC began in January 2019. Residents and faculty members first engaged with families through “Ask a Pediatrician” nights hosted by the Family Success Centers. These events helped establish trust and build relationships and led to additional programs, such as evidence-based parenting courses led by the pediatric faculty and residents.



As the pediatricians continued to be a part of the Family Success Center activities, ideas for more activities and joint projects bubbled up from the community, reflecting specific needs of local children and families. For example, one residency–community partnership emphasized obesity awareness and prevention, and carried out “Hip Hop with the Doc” dance events, healthy-eating seminars, and cooking demonstrations. NJPRAC and the Family Success Centers jointly led nearly 100 sessions, classes, and presentations, reaching more than 1,300 families. One pediatric residency program leader described the impact of the relationship this way: “We did not even know the Center existed before NJPRAC, and now we design and participate in events there regularly. We have a great working relationship with its Director and continue to develop closer ties to members of the Center, who are part of the community that we serve.”



Making healthy yogurt and fruit parfaits at a Family Success Center

When the COVID-19 pandemic occurred, the residency programs created a webinar to answer

community members’ questions about the virus. Over time, this webinar expanded into a weekly “house call” series with experts in social work, law, nutrition, and dentistry partnering with pediatricians from a variety of specialties to respond to the community’s questions and concerns.

The Family Success Center collaborations with the residency programs were an important avenue not only for building trusted relationships with communities but also for cultivating leadership skills among the pediatric residents. A further important focus was to make these strategies last by formally incorporating them into the residents’ training. NJPRAC’s residency programs launched a coordinated effort to rethink and retool their curricula to build in strong advocacy and community engagement content. They assessed their existing curricula and developed new components for use by all of the residents. For example, the programs developed two case studies to help the residents develop skills in planning, carrying out, and evaluating community pediatrics advocacy and engagement efforts. One case study focused on educational interventions and the other on public and private insurance systems, with emphasis on Medicaid eligibility and special populations, including immigrant children.





Residency program teams also implemented the positive parenting course *Keystones of Development Curriculum*, which was created by Mount Sinai and supported by the Burke Foundation, a New Jersey foundation that works to improve healthy pregnancies and births, positive parent-child relationships, and quality early childhood care and education. This curriculum provided an additional platform to help the residents understand the broad context of their families' lives and develop skills in providing preventive counseling to address adverse childhood experiences (ACEs) and related issues as well as to support families' innate strengths. All of the residency programs identified faculty champions for this work; most were also NJPRAC faculty leads. A training orientation was held in September 2020 to bring all of these leaders together to launch the *Keystones* curriculum.

Impact and Sustainability

Community and environmental factors are just as important to health and well-being as are individual factors. Successful and comprehensive care, therefore, involves a collaboration among healthcare professionals, the family, and the community. By engaging pediatric residents in this community-focused project, NJPRAC was able to have a potentially profound impact on the way that residents practice pediatric medicine. The faculty's active participation in all aspects of the project also helped change how they would teach future groups of residents, thereby reinforcing this fundamental shift in pediatric practice culture. The number of faculty engaged in community health and advocacy training at the residency programs grew from 15 in 2018 to 26 in 2020.

This project helped residents become more knowledgeable about the lives of community members and their local environments, strengthening their ability to care for patients in ways that encompassed all the factors that affect health and well-being. In addition, relationships that the pediatric residents developed with Family Success Centers staff and leaders of community-based organizations gave them a detailed understanding of the services those organizations offer. This made the residents more effective in connecting families to meaningful services. It also meant that both the pediatricians and the community service organizations could provide knowledgeable advice and mutual referrals—each knew that they had trusted and responsive providers to which they could send families.

Another important effect of the program was that NJPRAC created a strong network among the residency programs themselves. One program leader noted that “the opportunity to form important relationships with other physician leaders and advocates across the state has been invaluable. We now have strong ties with every pediatric residency program in New Jersey, and plan to use this interconnectedness to continue to further our work as pediatricians, teachers of future pediatricians, and advocates.”

Since its launch in 2018, NJPRAC has helped almost 400 future pediatricians develop into leaders who can work with the families in their care to maximum benefit, bringing to bear a mesh of supportive partnerships that contribute to the long-term health and well-being of children and their households.





CHAPTER SEVEN: KEY TAKEAWAYS

- **Invest in programs designed to develop future leaders.** Nurturing people and providing opportunities for them to become leaders is a powerful way to foster systems change.
- **Promote collective learning.** These experiences foster long-lasting connections and a sense of community, and they can generate more impact than one-on-one training.
- **Seek out people who have diverse professional and personal experiences and who play various roles in their organizations.** This approach creates a strong mix of participants who bring multiple perspectives that enhance the sharing and learning of specific content and strategies.
- **Invite participants who have not previously worked together.** This can lead to unexpectedly strong collaborative relationships and new initiatives that endure long after the leadership development project has ended. These relationships are especially important for staff who come from state agencies or departments that may not otherwise have the opportunity to collaborate. Building strong interagency relationships is important for the present and the future.
- **Cast a wide net.** It's hard to predict which individuals starting their careers will end up reaching the top rungs of power—and will remain working in a particular field of interest. Building large and inclusive training cohorts provides the best chance of influencing future leaders.





A Steadfast Commitment to the Arts



Beginning in 2009, The Nicholson Foundation funded a number of projects in New Jersey and North Carolina that supported the arts, a particular interest of Barbara Nicholson McFadyen, Chair of the Board of Trustees, who lives in North Carolina. The arts projects complemented the Foundation's other grants in a number of ways. They:

- Aimed to improve health and well-being by broadening educational horizons for children and adults, empowering youth, unleashing the creativity and resilience of correctional inmates, and strengthening families
- Were intentionally designed in collaboration with local communities, to ensure equitable access for residents of all ages and income levels
- Were planned as community hubs that would help knit people together by providing opportunities to share enjoyment, discovery, accomplishment, and solace from art

Through pictures and words, this chapter highlights these arts projects and their lasting influence on communities in New Jersey and North Carolina.





GLASSROOTS CRAFT FELLOWSHIP PROGRAMS FOR YOUNG ADULTS

Young adults ages 18 to 24 are at a vulnerable stage of life as their earlier support systems—teachers, coaches, school, and other childhood programs—end. They must find their own path to productive adulthood. To give young adults from Newark, New Jersey, the chance to forge a new trajectory, GlassRoots formed partnerships with two stellar craft schools—Penland School of Craft, in North Carolina, and the Peters Valley School of Crafts, in New Jersey. The GlassRoots-Penland Fellowship Program took place from 2016 to 2018. The initiative then transitioned to the GlassRoots-Peters Valley Fellowship Program, which began in the summer of 2021.

GlassRoots, founded in 2001 and located in Newark, seeks to transform young lives through glassmaking education. Students gain knowledge of chemistry, physics, math, and engineering, and develop practical business skills as they acquire glassmaking prowess and create and market their products. At the same time, they develop valuable life skills and learn to work with others.

Penland School of Craft, founded in 1929, is located in North Carolina's Blue Ridge Mountains. It provides experiential education in various media, including books and paper, clay, drawing and painting, glass, iron, metals, photography, printmaking and letterpress, textiles, and wood.

Peters Valley School of Crafts, founded in 1970, is located in a rural area of New Jersey's Delaware Valley. It brings artists from around the world to provide educational workshops for adults and youth. Workshops cover many media, including ceramics, drawing and painting, fine metals and jewelry, glass, paper and book arts, wood, fiber and textiles, and photography.

During the Fellowship Programs, students spend several weeks working with GlassRoots staff and artists preparing for their trips. Once at the craft schools, they participate in an in-depth residency, where they explore craft media and develop skills from the schools' diverse offerings. Each student also works with program staff to develop their life skills and investigate professional opportunities in the arts. The intensive support throughout the Fellowship Programs is designed to expose the participants to a range of new experiences and possibilities and set them on a successful path to future education or employment.



GlassRoots-Penland students



A Penland student with his work



GlassRoots-Peters Valley students



A Peters Valley student with her work





INSIDE OUT: PENLAND SCHOOL OF CRAFT PRISON ART PROJECT

For many people, studying the arts is a way to experience and learn about the wider world and, as a consequence, create a better version of themselves. Exploring one's own creative talent, moreover, can be deeply fulfilling and give new meaning to life.

People who are incarcerated have very limited opportunity to experience art, even though it could be particularly meaningful for them. In keeping with its mission to enrich lives by teaching skills and the value of the handmade, Penland began working with Avery-Mitchell Correctional Institution (AMCI) in 2017. This work continued in 2018 under a grant from the Foundation. AMCI is a medium-security correctional facility in Spruce Pine, North Carolina. It houses about 850 male inmates ages 22 to 73.

Three teaching artists visited AMCI each week to provide one-hour workshops for 15 inmates. The initial aim was to focus solely on drawing exercises. However, the workshops soon grew into a collaborative learning experience in which everyone taught each other and all grew as artists. In 2019, the Foundation funded the program's third year, which culminated in a formal exhibition of the inmates' work at a local venue open to the public. The exhibition featured works in several media, including pencil, pen, pastel, and watercolor, and families were invited to attend. Funding from other foundations continues to support this spirit-lifting program.

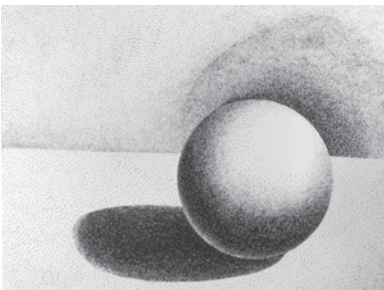
The quotes on this page illustrate the profound impact of the Prison Art Project on the inmates.



Art has completely changed my life, and with it came hope, purpose, goals, dreams, and a coping mechanism in times of stress, depression, and loneliness.



— A participating inmate



I couldn't draw a decent stick figure when I first came to prison. It's a skill that I've gained since I've been in here. If I am to have a message to the world out there, let it be: There are some of us, a good number of us, who strive to be better versions of ourselves, even from behind these walls. Don't forget about us.



— A participating inmate





ARTS EDUCATION

Many view the arts as fundamental to what makes people human. The arts foster creativity and understanding, and help people express their emotions and values and describe their interactions with others and their environments. The arts bring joy and meaning to millions, providing a bridge between people, communities, and cultures. The arts can also be important for making communities healthy—strengthening them socially, educationally, and economically.

Arts education—for children, in particular—has many benefits. It's associated with gains in math, reading, cognitive ability, critical thinking, and verbal skills, as well as improvements in motivation, concentration, confidence, and teamwork. School-based arts education helps level the playing field for children who don't have much opportunity to experience the arts.

The ArtsCenter, founded in 1974 and located in Carrboro, North Carolina, creates an educational environment that provides opportunities, inspiration, and tools for people of all ages and skill levels to participate in the arts through classes, performances, and exhibits all year round. The ArtsCenter is the largest employer of artists in Orange County, and serves more than 100,000 students and other residents throughout the area. Since 2011, the Foundation has supported the ArtsCenter's Arts Education for All Ages, which encompasses a dynamic set of programs for youth, from toddlers to teens, as well as adults.



An ArtsCenter goal is to ensure that all children have access to arts education. It does this through Afterschool Arts Immersion for K-5 students; Arts In Residency, a curriculum-integrated arts program in four high-need elementary schools; and ArtsCamp, which offers visual and performing arts sessions during the summer for K-6 students.



ArtSchool is Orange County's most comprehensive source for arts education for those ages 15 and older, with hundreds of classes at all levels across a diverse array of art forms. The ArtSchool also builds the local professional pool of artists and works with Orange County Schools to offer enhanced professional development for teachers.





VIBRANT HOMES FOR THE ARTS

For the arts to fulfill their potential and fully serve their communities, arts organizations need sufficient and appropriate space. In addition to supporting programmatic initiatives, the Foundation provided facilities grants to help GlassRoots, Penland School of Craft, The ArtsCenter, and Pocosin Arts School of Fine Craft renovate aging structures or build entirely new buildings to create vibrant new homes.

GlassRoots

Historic St. Michael's Hospital in downtown Newark has been extensively renovated to house a collection of activities that will be stimulating for city life, including a state-of-the-art glassworks for GlassRoots. The new glassworks enables this youth-focused arts organization to serve many more students; adds to the local economy with workforce training, manufacturing activity, and a sales enterprise; and anchors a thriving arts community. The new space includes three glass art studios; a glassblowing production and repair shop; maker spaces; kiln, mold, and sandblasting studios and finishing shop; a museum space; and a convening space.



Artist's rendering of the renovated St. Michael's building, with GlassRoots on the right



Artist's rendering of the new GlassRoots entrance





Penland School of Craft

Penland's new **Northlight Building**, serving a variety of vital purposes for the Penland community, is the heart of Penland's campus. As the main community gathering hall, Northlight holds workshop orientations, morning and afternoon yoga, student Show 'n Tell exhibitions, student scholarship and annual benefit auctions, and evening instructor presentations. Not only an important part of daily activities, Northlight accommodates new state-of-the-art studios in papermaking and traditional and digital photography. Completed in 2018, this building won a 2019 Design Merit Award from the North Carolina AIA Triangle chapter of the American Institute of Architects for its innovative architecture and use of materials.

Core House gives emerging artists a place to live, work, and build community with their artistic peers while they participate in Penland's two-year work-study CORE Fellowships. This building was completed in 2021.



Northlight Building



The front of Core House at night





The ArtsCenter



The ArtsCenter, located in the heart of downtown Carrboro

Moving to a newly-remodeled building, The ArtsCenter will create innovative new ways to inspire creativity and promote participation in the arts for learners of all ages and at all levels. The vision is to create an inviting community hub that will engage the entire local area and foster cultural and social equity. This building will allow the ArtsCenter to offer improved arts spaces, more classes, and enhanced programs using state-of-the-art technology. Furthermore, its central location, with proximity to shops, restaurants, and a new town library, will help enrich community engagement. Nearby trails, bike paths, and pocket parks will add to the experience by providing an inspirational natural surrounding. The ArtsCenter renovation will be completed in spring of 2023.



Artist's rendering of the northwest corner of the new ArtsCenter



Artist's rendering of the southeast corner of the new ArtsCenter

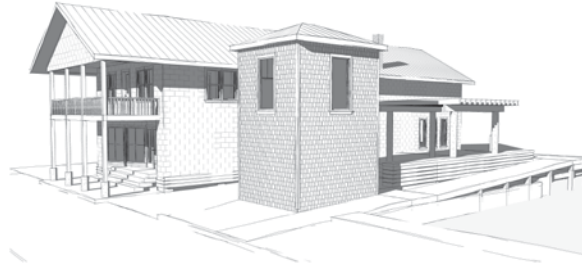




Pocosin Arts School of Fine Craft

Pocosin Arts is located in Columbia, on the east coast of North Carolina. Its “Crafting Community” project will bring the local population together for personal growth and career opportunities through a reimagining of its space and expanded craft education. The project’s first stage began with extensive renovations and improvements to the studios and special event building, **Riverview**. The second stage will introduce new community-building programs, including Yoga, Mother’s Night Out, and Ballroom Dancing.

The renovated and expanded building and the new programs will help Pocosin Arts provide quality, diverse craft education all year round with both day and evening offerings. Pocosin will partner with local schools during the day to provide studio and classroom space for career and technical education in woodworking, metalsmithing, and ceramics. Adult enrichment programs will use the studios during the evenings and weekends. In the summer months, Pocosin will host visiting artists and instructors as well as students from across the United States taking part in weeklong studio workshops. Pocosin’s expanded capacity will also bring much-needed economic vitality and opportunity to the region. A grand opening to celebrate the completed renovations and the new programs is scheduled for fall 2022.



Architectural rendering of the completed Riverview building



An artist at work in a Pocosin studio



A yoga class with a river view





Reflecting on the Past
and the Import of the Work



This is the moment to stand back and consider the essence and the arc of our work. To ask whether we succeeded at our goals. And to think whether this book has a message for the community of people and institutions striving to move society forward.

America's prosperity continues to grow, but only for some. Too many people are being left behind. The Nicholson Foundation yearned to see the essentials of a healthy and successful life be more equitably attainable and to see barriers reduced so opportunity could truly exist for everyone. Our approach was to try to improve the systems that are meant to help people have a chance—education, health, social services, early childhood care and education, and even criminal justice. Our goal was to augment or change these systems so that the services they provide individuals, families, and communities would be more accessible, more effective, and not work at cross-purposes.

To do this, we believed we had to engage with the primary forces of our human support system. This meant working with government because it has the responsibility to do the heavy lifting and because it has the reach and the resources to effect change at a scale that matters. We also partnered with nonprofit service providers and other non-governmental organizations that populate much of our civil society, because they were often our entrée to working with government. America's civil society is a remarkable force for augmenting the good that government does and for redressing its sins of omission and commission. But government itself is at the heart of our safety net. So, this is where we set our sights. We chose New Jersey because of the Nicholson family's interest in helping with problems near home. The state's population and relatively small geography made it a good match for the Foundation's resources.

The basic question we started with was whether a talented stranger from outside government could find a way in, to help. Whether, over time, we could build capability, credibility, interest in us, and trust. We began by making cold calls and reaching out to the few people we knew from prior, isolated, family giving. We started small, working at the local level on easily defined issues—by ourselves, or with just one partner.

We built a management information system for Newark Public Schools so administrators could track whether students were meeting all the course requirements to get a diploma. Too many times, students learned at the last minute that they could not graduate. We also created a system of online courses to help students catch up and fulfill their requirements. We worked with Essex County Courts to solve the overcrowding problem at the Newark Detention Center and to create a management manual that set out proper policies and procedures for the facility.

We then began to partner with nonprofits: Early initiatives were the one-stop support centers we set up with Newark Now that connected people to social services, our collaboration with the Salvation Army for a one-stop center to serve grandparents raising grandchildren, and our work with Rutgers University's T.E.E.M. Gateway to launch a youth program to create new opportunities for education and employment.

Over time, we worked with higher levels of government on issues with broader application, and with more partners. We generally sought partners whose experience and standing would strengthen the initiative and help us gain access to the right players. We intentionally hired people who had worked in New Jersey government to help us build credibility and trust.





One of our first partnerships on the state level was with the Department of Corrections (DOC) to design a program in which inmate transition planning began six months before release. The inmate's resources and needs were evaluated and help was identified for getting medical care, finding housing, restoring family relationships, and searching for a job. The help was to be available on the inmate's first day out.

We also began to work on strategies that had to unfold, and sometimes evolve, over time. One of these was the Grow NJ Kids rating system. It was the necessary first step that paved the way for New Jersey to give an incentive to child care centers, and also to family providers, to improve their quality. With the rating system in place, the state could pay higher reimbursement rates for children in higher-rated care. Another was the five community-based healthcare coalitions that we nurtured over more than a decade. Beginning as small multi-sector groups of providers, these coalitions are now important drivers of population health for their communities.

In our later years, we worked in broad collaborations involving multiple state agencies and non-governmental advocacy, policy, and research organizations—such as the New Jersey Health Care Quality Institute, the Center for Health Care Strategies, the Rutgers Center for State Health Policy, and the New Jersey chapter of the American Academy of Pediatrics—to address issues requiring complex fixes and deep culture change. The Medicaid 2.0 initiative was a formal collaboration of more than 100 government and nongovernment healthcare players in New Jersey, plus national consultations for extensive primary and secondary research on other state Medicaid systems. The initiative's redesign of the state's Medicaid program affected two million—one in five—of the state's residents.

At the beginning, 20 years ago, we did not find like-minded philanthropic interest in partnering with government, but we found it on a few occasions along the way. We joined the Council of New Jersey Grantmakers, and the Council engaged a liaison to the City of Newark, indicating awareness of the value of being attuned to government. We helped fund this position. In our final years, other New Jersey philanthropies joined with us in working with government on major initiatives. This was important to us, as it was one of our strategies for building endurance into the work. Other foundations have been full partners in Nurture NJ, an initiative that through its study of maternal mortality and morbidity outcomes data brought into focus systemic racism and inequity and revealed the need for an entirely fresh look at maternal health services in New Jersey. This campaign led to a plan for fundamental change through public-private partnerships, which the New Jersey Funders Birth Equity Alliance was formed to support.

The New Jersey ACEs Collaborative created a formalized partnership among three New Jersey philanthropies and the New Jersey Department of Children and Families to draw attention to, and address the impact of, adverse childhood experiences (ACEs). By funding efforts and developing a statewide action plan, the Collaborative helped to sensitize all the systems that touch young children and to foster teamwork across a wide range of services.

Since we began our work, the greater foundation community has garnered increasingly vast sums of money. This builds pressure for bigger thinking and larger initiatives, to comply with federal giving requirements. One would think this need would lead to more interest in working with government, for its scale, and for its funding capacity,





which would give the social-investment gains a better chance to endure. With some notable exceptions, however, there seems to be reticence to move in this direction. Some in the foundation community see the nonprofit community as a more dependable partner than government because they consider nonprofits more steadfast in their commitment to social equity and less vulnerable to sudden political change.

Indeed, a sudden political reversal happened to us during the era of our criminal justice work with the state DOC. A new governor was elected, and interest in our programs lapsed. We took a lesson from this experience. Henceforward, we watched for waves of public interest, a stabilizing factor for political will. The major groundswells of public interest in health and early childhood that occurred across the nation during our second decade were an impetus for our shift toward these areas. Today, national interest in criminal justice reform has emerged as a powerful new force, galvanized by George Floyd's very public and tragic murder. Interestingly, the John and Laura Arnold Foundation—now reorganized as an LLC called Arnold Ventures, which undertakes advocacy and social-purpose business investments as well as grantmaking—has partnered with New Jersey in a, so far, strikingly successful bail reform initiative.

It is impossible to assess—much less assert—whether our particular initiatives have made life better for people on a lasting basis. The Foundation has been but one, small, player in a sea of effort. We did prove to ourselves that it is possible to influence government from a position outside it, that it is possible to inspire a variety of partners to join in, and that these public-private collaborations can bring about fundamental change. Based on the stories we have told here and on other experiences we could not include, we believe that we have improved systems in New Jersey that serve people for whom life is difficult, people who do not equitably share in prosperity. The changes we helped bring about in these services, moreover, hold promise for continued higher quality and greater accessibility. We have started things in motion.

We are not alone in partnering with government, but it is a road less traveled. Government sets the table with its funding choices, regulations, operating infrastructure, and size. We suggest that to live with this domain as a given, without engaging with it, is to accept limitations and to paper over problems and insufficiencies. It is also to ignore need. It is hard for states to experiment because they lack flexible funding. Learning about the array of new approaches that have been tried and proven is also a time-consuming challenge for state officials. For its part, the federal government works to spread good ideas and incentivize their adoption—not only by states, but by our civil society at large. This effort is a modest seeding operation, however, not a blanketing one.

We leave this record of our work in the hope that more philanthropies and non-governmental organizations will be emboldened to follow a path similar to ours and summon the resolve to change the way things always have been done. We think that turning *toward* government rather than away from it, to address the systems that are our social safety net, is our best hope, today, for improving the health and well-being of all our families and communities.





THE
Cast Glass
COMMEMORATIVE PROJECT

THE
Cast Glass
COMMEMORATIVE PROJECT

For more than 60 years, New Jersey was home for Marion and William Nicholson. The work described in this book reflects their concern for the state, their belief in striving for a fairer society, and their commitment to youth and the arts. A particular interest was GlassRoots. Founded in 2001, GlassRoots was the vision of Pat Kettenring, whose dream was to engage underserved youth and young adults through the transformative power of the glass art experience. Early support from William Nicholson allowed Ms. Kettenring to move forward in building an organization dedicated to art and to youth who had few chances for learning, work, and personal growth. Since then, GlassRoots has engaged tens of thousands of Greater Newark-area youth in its services, including its core Youth Entrepreneurship programs, student field trips, and “art-for-art’s-sake” classes for the public.

To celebrate GlassRoots’ inspiring new home (described in **Chapter 8. A Steadfast Commitment to the Arts**) and to recognize the Nicholsons’ contributions, their daughters, Jan Nicholson and Barbara Nicholson McFadyen, commissioned the Cast Glass Commemorative Project. This sculpture, by glass artist Dean Allison, features two youths in the act of gathering molten glass in preparation for blowing. From concept and design to casting, firing, cooling, and devising the connections between sections, this sculpture has been more than two years in the making. Final assembly, surface finishing, and installation will be completed by the end of 2022.



The models, participants in the GlassRoots - Penland Fellowship, were Ya'zmine Graham and Joshua Toler



Creating the life cast with a plaster mold; beginning application and opening process



The wax models created from the plaster molds being refined in the artist's studio



The sculpture comes to life as the cast glass sections are assembled



The Nicholson Foundation

thenicholsonfoundation.org
419 East 50th Street
New York, NY 10022

The Nicholson Foundation Board of Trustees

Jan Nicholson
Barbara Nicholson McFadyen
Michael P. Vito

The Nicholson Foundation. *Changing Systems,
Changing Lives: Reflecting on 20 Years.*
Newark (NJ): The Nicholson Foundation, 2021.

This book also is available online at
www.thenicholsonfoundation.org/changinglives

We thank staff and grantees of
The Nicholson Foundation, Phil Leo,
and Andriyko Podilnyk for the
photographs used in this book.

