EMERGING FROM COVID-19:
AN ACTION PLAN FOR A HEALTHIER STATE

Recommendations for New Jersey from the COVID-19 Work Group

April 2021
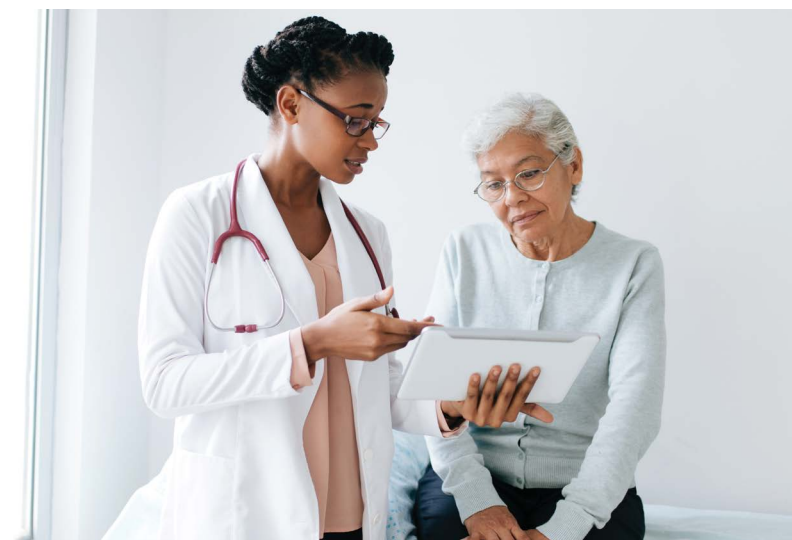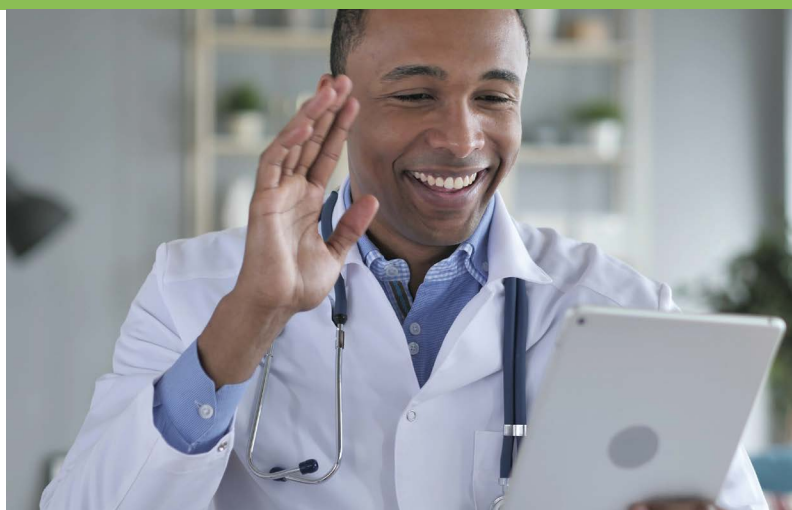
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NEW JERSEY HEALTH CARE **QUALITY INSTITUTE**

Emerging from COVID-19: An Action Plan for a Healthier State

	Data & Public Report	Funding/ Contracting	Innovation	Legis/ Policy	Technology	Access	Savings	Equity
		Methods				Benefits		
Create and Support a Resilient and Diverse Health Care Workforce for the Future								
1. Collect, analyze, publish health care workforce supply data to inform state strategy for development and retention.	✓	✓		✓	✓	✓		✓
2. Create Workforce Council to analyze data and develop 10-year strategic plan.				✓		✓	✓	✓
3. Improve health care licensing and credentialing systems to better deploy workforce.		✓	✓	✓	✓	✓	✓	
4. Evaluate outcomes of expanded licensure and scope of practice during pandemic to guide further regulatory change.	✓	✓	✓	✓		✓		
5. Improve utilization of Medical Reserve Corps to support public health.		✓			✓	✓	✓	
6. Develop and expand behavioral health programs for health care workforce.		✓				✓	✓	
7. Expand Medication-Assisted Treatment prescribing ability for providers treating people with Opioid Use Disorder.				✓		✓	✓	
Increase Support for Alternative Delivery of Care and Payment Models								
8. Convene the Telehealth Review Commission and adopt regulations to support growth.				✓				✓
9. Test state and industry supplied telehealth and remote monitoring equipment to increase access.		✓	✓	✓	✓	✓	✓	✓
10. Continue telehealth and remote monitoring in clinical trials.	✓		✓	✓	✓	✓	✓	✓
11. Implement the Manatt Report recommendations.		✓		✓			✓	
12. Support home-based medical care models.		✓	✓	✓	✓	✓	✓	✓
13. Adopt statewide plan for healthy aging.		✓		✓		✓	✓	✓
14. Track and set spending goals for high quality primary care.	✓			✓			✓	
15. Expand use and align payment models for patient-centered primary care.	✓	✓		✓		✓	✓	
16. Facilitate and leverage connections between primary care and public health to improve population health and trust in public health.		✓	✓				✓	✓
17. Issue "Integrated Facility" licensing regulations.		✓	✓	✓		✓	✓	✓
18. Advance Medicaid integrated physical and mental health payment changes.		✓	✓	✓	✓	✓	✓	✓
Promote Public Policies that Address Social Determinants of Health (SDOH) and Lead to Greater Health Equity								
19. Use community engagement to identify the most critical SDOH needs surfaced during the pandemic.	✓	✓	✓	✓		✓		✓
20. Use Medicaid waiver and state funding to support evidence-based models of services that address SDOH.		✓	✓			✓	✓	✓
21. Increase public reporting of demographic data on health outcomes to address disparities.	✓	✓		✓				✓
Revitalize and Reorganize Our Public Health Infrastructure								
22. Assess the structure of public health and improve resource allocation.	✓	✓	✓	✓			✓	✓
23. Align public health with emergency management, health care system, and community-based organizations to build trust and efficiencies.	✓	✓	✓		✓		✓	✓
24. Create universal immunization registry for adults to improve public health data.	✓	✓	✓	✓	✓	✓	✓	

http://bit.ly/COVID19ActionPlan

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Executive Summary

In times of crisis, we often focus on the efforts needed to address impending threats and attempt to right the ship. When the crisis subsides and the threats are no longer imminent, those resources and collective actions tend to be pushed to the wayside, under the assumption that they are no longer needed. But, as we envision our post-pandemic lives, given the enormity and inequity of the pandemic's toll, it is more important than ever that we not return to the status quo when a sense of normalcy returns. Rather, we must build on the momentum of this time to create lasting change. The pandemic exacerbated many of the deeply rooted issues we knew existed: health care workforce shortages; lack of access to mental health care; underinvestment in primary and preventive care; underinvestment in technology and innovation; inequity and disparities across different populations; and underfunding and misalignment of our public health system. We have an opportunity now for policymakers, public and private stakeholders, and employers to strengthen our health care system and create lasting change.

This action plan lays out four key areas to focus our efforts:

- **Create and Support a Resilient and Diverse Health Care Workforce for the Future**
- **Increase Support for Alternative Delivery of Care and Payment Models**
- **Promote Public Policies that Address Social Determinants of Health (SDOH) and Can Lead to Greater Health Equity**
- **Revitalize and Reorganize Our Public Health Infrastructure**

The 24 recommendations from the COVID-19 Work Group were shaped through an intensive engagement and consensus building process. We hope that through collective action we can turn these recommendations into real-world change that improves health care in New Jersey and beyond.

Acknowledgements

COVID-19 Work Group Introduction and Goals

BioNJ and the Quality Institute are dedicated to advancing a health care system that is safe and high quality; accessible and affordable; equitable, respecting of individual dignity; and transparent to promote access and safety.

The pandemic pushed us to be resourceful, innovative, resilient, and collaborative. Industry, government, and non-profit partnerships emerged across the country to address the immediate challenges we have faced this year. The pandemic also exposed barriers and cracks in our health care system and in our society, highlighted deep inequities in access to safe, high quality essential health and social services, and revealed the under-investment in our public health infrastructure.

Strengthening our health care system will require both innovation and sustained commitment. During the pandemic, innovation and technology enabled us to quickly advance the use of telehealth and use of data sciences and analytics to bring vaccines to market in record speed. The speed of the change required funding, regulatory support, cooperation of competitors, and flexibility to do things differently to enable us to move past the pandemic and save lives.

Challenges and rapid changes throughout the pandemic provided many issues to consider as a work group.
To focus our efforts and ensure that our recommendations are actionable, we established the following criteria:

- **Did the pandemic further the need to address this issue?**
- **Can we suggest actionable recommendations?**
- **Can we learn from or apply lessons from other states or countries?**
- **Can BioNJ, the Quality Institute, our partners and members advance the recommendations?**
- **Are the recommended actions applicable to future public health needs and are they sustainable?**

The consensus recommendations in this plan aim to guide health policy leaders and drive best practices and solutions informed by the experiences of New Jersey health care leaders during the COVID-19 pandemic.

The work group included representatives from all levels of our health care delivery system, from patient advocacy, provider, health care facility, health plan, and biopharmaceutical sectors, with input from public health officials. The goal was to create an actionable plan that identifies and amplifies our strengths and examines our weaknesses while sharing best practices and solutions. The action plan will be instrumental as we take steps to create a health care system where all people receive equitable and affordable health care and can live their healthiest lives.

The work involved in the creation of this action plan was co-funded by BioNJ and the Quality Institute. The Quality Institute conducted the research, convening, and drafting of the action plan. As a co-funder and visionary on this project, BioNJ provided thought leadership, supported the work group process, and served in an advisory capacity.

We thank all those who freely and generously contributed their time, ideas, and expertise to this process. We applaud their willingness to consider a wide range of ideas, and compromise when needed, to develop recommendations that have the potential to strengthen New Jersey's health care system.

CREATE AND SUPPORT A RESILIENT AND DIVERSE HEALTH CARE WORKFORCE FOR THE FUTURE

? PROBLEM:

Labor economists, patient advocates, and industry organizations have long argued that New Jersey would experience a health care worker shortage and that steps should be taken to address the shortage. Now we are facing the deadliest health care crisis in generations. Our already too small health care workforce is shouldering the burden of a pandemic with little reprieve. Health care workers are working even more hours, experiencing emotional trauma regularly at work, and continuing to be caregivers when they go home. They need greater support to maintain their own physical and mental health and wellbeing. Health care workers on the frontlines of the pandemic are facing burnout at alarming rates and many have left the field, leaving those who remain in even more difficult situations. In a Fall 2020 poll by the American College of Emergency Physicians and Morning Consult,[1] of 862 emergency physicians nationwide, 87 percent of respondents felt more stressed since the onset of COVID-19 — with 72 percent experiencing a greater degree of professional burnout.[2] We must address the workforce shortage and protect the emotional wellbeing of all who provide care during the pandemic and beyond.

SOLUTION:

Deploy a plan to support the health and wellbeing of health care workers; create a workforce sufficient in size and training to meet our projected health care needs, one that represents the diverse communities which it will be serving. The foundation of any plan must be predictive modeling based on current workforce supply and gaps; projections of future population growth, including age and health status; and consideration of other potential factors. If revisited regularly, a plan of this nature would guide the State on where to invest in education and job development to meet our ongoing needs as well as any future crises. The plan should be published and include widespread input. An investment strategy, now and during non-emergent periods, to support health care workforce development should be included. Longer-term investments in workforce development should be directed to the roles and communities of greatest need.

To successfully implement a health care workforce development plan, we also need to reform some of our regulatory processes to more expeditiously license and credential providers in New Jersey, without sacrificing training and quality. To achieve that goal, we will need to invest resources to upgrade technology and hire staff to properly analyze the data. We must also effectively utilize medical volunteers to expand our health care workforce.

Finally, we should increase access to mental health care services both in and out of the workplace and expand clinicians' ability to prescribe and provide medication-assisted treatment to patients with opioid use disorder.

1. **The State should collect, analyze, and publish health care workforce supply data to inform strategies for workforce development and retention.**

The New Jersey Physician Workforce Task Force Report,[3] released in 2011 by the New Jersey Council of Teaching Hospitals, predicted that New Jersey would be short nearly 3,000 physicians by 2020 if the State did not act.

The Association of American Medical Colleges releases an annual workforce profile that examines current physician supply, undergraduate medical education (UME) students, and graduate medical education (GME) residents and fellows by state. The 2019 report ranks New Jersey 12th in the country for active physicians, 19th in the country for active primary care physicians, and 28th in the country for active general surgeons. The statistics on primary care may be even worse than stated due to a common practice of some internal medicine physicians being miscounted as primary care. A closer look reveals that we are 3rd in the country for active physicians who are age 60 or older, meaning we are at risk of retiring more than a third (36 percent) of our active physician population. Both reports cite statistics relating to physicians only.

The New Jersey Department of Labor & Workforce Development Office of Research & Information recently released the New Jersey's Health Care Industry Cluster report.[4] This report provides a general outlook for health care employment in the State, while identifying important factors like the types of care that are in demand, the age of our health care workforce, and the gender, racial, and ethnic profile of New Jersey residents within the health care workforce.

Each of these reports covers a fragment of what we know about our health care workforce today. To create a pipeline for the health care workforce of tomorrow, we need more detailed and consistent information to know where to invest our efforts and resources and to determine if our workforce development and retention strategies are working. Fortunately, data in other states has been collated into reports which New Jersey may consider modeling.

Oregon's Health Care Workforce Reporting Program (HWRP), created in 2009, collects and tabulates information from licensees of 17 health licensing boards upon renewal. The Oregon Health Authority used the information collected by the HWRP to publish the Oregon's Licensed Health Care Workforce Supply report in 2020.[5] This report includes data on all types of health care providers such as primary care, behavioral health, and oral health.

> The Oregon Health Authority also maintains public data dashboards that include provider supply, provider to population ratios, and heat maps by county.[6] These quantitative resources are critical to creating a health care workforce strategic plan.

Another important aspect of the report includes qualitative information provided by the health licensing boards about other factors that may affect supply.

New Jersey needs comprehensive health care workforce data, from its health care licensing boards within the Division of Consumer Affairs, to be collected, analyzed, and published to inform a statewide strategy around development and retention to meet our current and future health care needs. We should model this effort after Oregon's HWRP and ensure that the Division of Consumer Affairs has the appropriate software and staff to successfully create and maintain public data dashboards.

2. **The State should create a multi-disciplinary "Workforce Council" to analyze health care workforce data and develop a strategic plan for the health care workforce for the next 10 years.**

To ensure that we can provide access to care for our growing and aging population, we must have well informed strategies, rooted in data, to educate, train, and most importantly, retain a robust health care workforce.

Strategies to retain the medical students we train and provide incentives for new clinicians to work here permanently include, but are not limited to:

- **Adjust the cap on the number of graduate medical students in hospitals.[7]**
- **Expand access to the State's Primary Care Practitioner Loan Redemption Program for more providers.[8]**
- **Reform the State's Conrad 30 J-1 Visa Waiver to allow more foreign-born locally trained providers to remain here.**
- **Provide tax incentives to in-demand health care professionals who stay in New Jersey.**

In 2010, the New Jersey Department of Labor convened the New Jersey State Employment and Training Commission's Health Care Workforce Council[9] to determine the most successful strategies to fast-track, cross-train, and up-skill workers to create a viable pipeline of health care workers who are educated and trained at levels required by health care employers. The Council published recommendations in 2012 and its last known public meeting date was in 2015. There is no additional public record of adoption of the Council's recommendations.

The Oregon Health Authority successfully used the data and information provided by its Health Care Workforce Reporting Program and published in Oregon's Licensed Health Care Workforce Supply to create a comprehensive Health Care Workforce Needs Assessment,[10] released in 2021. Oregon law requires a biennial needs assessment to inform proposals for using the Health Care Provider Incentive Fund to improve the diversity and capacity of Oregon's health care workforce. The report places great emphasis on equity and creating a diverse workforce that can deliver culturally appropriate health care.

> The report concluded with an analysis of the impact of COVID-19 on Oregon's health care workforce and provided several recommendations around diversity, shortages in underserved areas, use of care delivery models, needed provider types, and data collection.

A multi-disciplinary group, such as the Health Care Workforce Council, is needed to analyze health care workforce supply data to create a strategic plan for workforce development, education, and planning that includes specific goals, activities, and implementation targets. In addition to having all types of health care professionals represented, this group should also include the various state agencies that are involved in educating, training, licensing, and regulating our health care workforce. The Council should also reflect the diversity of our communities in age, race, ethnicity, and geography.

In response to the pandemic, a new law was enacted establishing minimum certified nurse aide-to-resident ratios in nursing homes in New Jersey,[11] and requiring the creation of a Special Task Force on Direct Care Workforce Retention and Recruitment in the Department of Labor and Workforce Development. The purpose of the task force is to evaluate current direct care staffing levels; examine policies and procedures used to track data on direct care staffing; examine the effectiveness of staff retention and recruitment strategies; identify any existing circumstances that allow for a shortage or surplus of direct care staff; develop recommendations for legislation, policies, and short-term and long-term strategies for the retention and recruitment of direct care staff to ensure an adequate workforce is in place to provide high-quality, cost-effective health care; and develop recommendations for a waiver process. As this task force proceeds with its work, it may be a model for the Health Care Workforce Council which would more broadly consider the health care workforce.

3. Improve existing licensing and credentialing systems to recruit and deploy health care workers more expediently.

Members of this work group have cited significant delays in processing health care provider licenses and accurately credentialing providers as barriers to deploying health care providers in New Jersey.

A law passed in 2017 has improved our ability to license providers more expediently. This law[12] required each professional or occupational board within the Division of Consumer Affairs to provide a secure online process to obtain an initial license or renewal of an existing license. Moving from a paper system that relied on the postal service to an online system has reduced the number of applicant errors and shortened the approval time for licensure, but there is more work to be done. All the boards need to be fully operational online and the efficiency of this process should be measured.

In addition to important technological upgrades, the State must commit resources to the Division of Consumer Affairs to ensure sufficient staffing to address the volume of applications it receives. As we work toward building a more robust health care workforce, we must expand the workforce responsible for processing those applications to avoid delays.

Once providers are licensed in New Jersey, they must also be credentialed by payers and health insurance carriers to participate in their networks. The process requires a review to ensure they have the required licenses, certifications, admitting privileges, and skills to properly care for patients. This process is cumbersome for both providers as well as carriers, as the information changes frequently. In addition, it is unnecessarily inefficient because, unless all of the carriers use one clearinghouse for the credentialing process, providers who are in multiple networks must undergo similar credentialing processes multiple times. The credentialing information is also used by carriers to create their network directories. Unfortunately, because the information changes frequently and is submitted for credentialing purposes rather than for collecting information specific to consumers searching for a provider, the process leads to inaccurate information in network directories, which harms consumers.

This issue was addressed by the 2016 Medicaid Managed Care Online Network Directories Workgroup and its recommendations should be adopted, including the designation of a third-party clearinghouse for universal credentialing, in the Medicaid program, of providers and maintenance of provider data. This change would reduce the burden on providers and each of the carriers, streamline the process by allowing single source verification, and result in more accurate information for consumers.[13] Commercial plans currently use a third-party clearinghouse to mitigate these issues and we believe the Medicaid program would also benefit from this change.

4. Evaluate the outcomes of expanded licensure and scope of work used during the pandemic to determine whether these approaches can be used to increase the health care workforce moving forward.

Governor Murphy signed Executive Order 103 on March 9, 2020, that allowed for pharmacists to participate in COVID-19 testing and administer vaccines; provided temporary licensure for out-of-state providers: temporary reactivation of retiree licenses; temporary licensure for foreign-licensed physicians; temporary suspension of the Advance Practice Nurse joint protocol and physician assistant delegation agreement; and temporary emergency graduate licenses for certain professionals. Each of these actions, issued by the Division of Consumer Affairs, served to expand our health care workforce capacity during the pandemic.

New Jersey became part of the Enhanced Nurse Licensure Compact (NLC) in 2019 along with 33 other states. Under the NLC, nurses can practice in other NLC states without having to obtain additional licenses. New Jersey has only partially implemented the compact to allow nurses who hold active, unencumbered, multi-state licenses issued by members of the NLC to practice in New Jersey under their multi-state licenses. Due to issues related to the pandemic, the State Board of Nursing has not yet issued multi-state licenses to New Jersey nurses.

There are currently bills introduced by the Legislature to join the Interstate Medical Licensure Compact for physicians and the Psychology Interjurisdictional Compact for psychologists.

Resources should be dedicated to evaluating the use of expanded licensure, increased scopes of practice, and interstate compacts to determine whether these efforts were successful, and if they should continue to be utilized during non-emergent periods to increase the health care workforce and thereby increase access to care.

5. **Assess how the Medical Reserve Corps can be better supported and deployed to address the State's ongoing public health needs.**

The Medical Reserve Corps (MRC) was created in 2002 by the Office of the Surgeon General in response to the 9/11 terrorist attacks to create the mechanisms to identify, train, and track volunteers who could strengthen local public health and serve if another human-made or natural disaster occurred.[14] The success of the program led to a nationwide expansion and was codified into law.

In New Jersey, the MRC is a network of community-based, locally organized units comprised of volunteers who are pre-identified, pre-registered, trained, and exercised. The program launched here in 2005. There are 24 local reserve corps in New Jersey – one for each county and one each in Manalapan, Newark, and Paterson. There are about 5,000 total registered volunteers in the state. MRC health professional volunteers include nurses, pharmacists, EMTs, physicians, counselors, social workers, and veterinarians. MRC community health volunteers provide services such as language translation/interpretation, education and outreach, hospitality, food services, reception, logistics, security, and assistance to individuals with disabilities, access, and functional needs.[15] MRC volunteer liability coverage is provided at the local/county level.

MRC volunteers can be especially vital during emergencies and disasters when paid public health and emergency response assets are overwhelmed as they have been during this pandemic. Many states, including New Jersey, have called on MRC volunteers to aid in the vaccination process. But some public health experts close to the MRC say the program has suffered from neglect in recent years, and that it has sometimes been underutilized during the COVID-19 crisis, amid a disjointed federal government response to the pandemic.[16]

The MRC program needs accurate and timely data to safely and efficiently recruit, interview, train, and deploy volunteers. Outdated technology prevents the MRC from quickly deploying the many volunteers that have indicated their interest in helping during the pandemic. A more sophisticated online volunteer registry is needed to track volunteers from the application process to deployment in the field. Further, the MRC needs seamless connection to the health care boards in the Division of Consumer Affairs (DCA) to aid in the vetting process for health care professionals. Currently, the MRC must manually receive confirmation from DCA that a health care professional is in good standing.

One example of a new technology tool that the State should explore is Provider Bridge,[17] a platform to mobilize volunteer health care professionals, has been developed to support medical license portability and connect volunteer health professionals with health care entities to increase access to care.

The MRC in New Jersey should be supported and expanded during non-emergent periods to ensure that a strong medical volunteer base can be easily identified, educated, trained, and quickly recruited to support our health care workforce in a future emergency.

6. Develop and support evidence-based behavioral health programs to target the growing need to provide mental health services to health care workers.

Some of the greatest barriers to mental health care for health care workers are lack of access, stigma, and time.

Programs to help manage stress and address mental health issues should meet people where they are in the workplace or in their homes. Employers should voluntarily lead by example by cultivating a safe space for self-care and treatment and develop a worksite mental health program. These may include, but are not limited to, an anonymous behavioral health hotline, group peer-led discussions to reduce stigma, tips for mindfulness and meditation, providing coverage for telemedicine, and training management in mental health first aid to provide the skills to respond to the signs of mental illness and substance use.

Many employers are piloting new and innovative ways to provide mental health support at work. The NYC Health + Hospitals Helping Healers Heal program uses wellness rounds to look for and address signs of anxiety, burnout, compassion fatigue, and other symptoms for busy clinical staffers who were less able to take mental health breaks.[18]

Once internal resources have been exhausted, or when they are not the right fit for employees who elect out of internal solutions, employers should look to external programs and tools for added support. The American Psychiatric Association Foundation Center for Workplace Mental Health[19] includes a host of resources for employers looking to do more to support the mental health of their workforce.

Some health care workers will choose not to seek out care at work due to perceived stigma. The State of New Jersey runs the Crisis Counseling Program (CCP)[20] funded by Federal Emergency Management Agency (FEMA) and in coordination with the Substance Abuse and Mental Health Services Administration (SAMHSA) in disaster declared communities.

The CCP New Jersey Hope and Healing model provides psychoeducation, individual and group crisis counseling and assessment, referral, and resources linkage. Services are free of charge and open to the public, but many are geared specifically to health care workers and under-resourced populations.

These programs provide critical opportunities for health care workers to anonymously participate in activities to support their mental health and should be continued permanently beyond the declared state of emergency.

7. **Expand prescribing ability for medication-assisted treatment (MAT) for people with opioid use disorder (OUD) to increase the health care workforce able to provide access to this care.**

Existing health care emergencies did not disappear with the onset of COVID-19. The convergence of this pandemic with an existing opioid epidemic has had profound impacts on people with substance use disorders. There is less access to treatment, increased isolation, and people are experiencing more stress. These factors can be even more challenging for people in recovery. Newly released information shows that New Jersey had 3,046 suspected overdose deaths in 2020, a reversal of the downward trend and slight increase from the year prior.[21] The opioid epidemic shows no signs of abating.

One of the best strategies in the fight against OUD is medication-assisted treatment, the use of medication, along with other therapies, to help sustain recovery from substance use disorders, and to prevent and reduce opioid overdoses.[22] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), research shows that a combination of medication and therapy can successfully treat these [substance use] disorders, and for some people struggling with addiction, MAT can help sustain recovery. MAT is also used to prevent or reduce opioid overdose.[23] One medication utilized in MAT is buprenorphine. Experts, including the National Institute on Drug Abuse, agree that buprenorphine is a safe, effective treatment for opioid use disorder.

An X-waiver is required by the Drug Addiction Treatment Act (DATA 2000)[24] for the outpatient use of buprenorphine for the treatment of opioid use disorder. Treatment with buprenorphine reduces the risk of death among people with OUD by as much as 50 percent. Although buprenorphine treatment has increased over the past decade, it is often not available when and where it is most needed. Federal laws that make buprenorphine for OUD difficult to access for many patients, including those most at-risk for overdose death, are a key driver of the persistent gap between treatment need and availability.[25] Furthermore, the capacity of the buprenorphine prescriber system is currently insufficient—the number of X-waivered prescribers does not match clinical need, and, among providers who do have an X-waiver, the number actually prescribing buprenorphine is even lower.[26] Providers are required to complete between eight to 24 hours of specialized training before they can apply for the X-waiver and are restricted in the number of patients they can treat.

To combat an epidemic within a pandemic, we must increase the health care workforce to create more avenues for patients to access the treatments that will help them maintain their recovery efforts such as suspending onerous X-waiver requirements to allow non-X waiver prescribers to prescribe buprenorphine.

During the COVID-19 public health emergency, the Drug Enforcement Administration (DEA) did reduce some of the barriers to providing medication for opioid use disorder (MOUD) by allowing qualifying practitioners (with X-waivers) to prescribe buprenorphine to new and existing patients with opioid use disorder based on a telephone evaluation. Prior to the pandemic, an in-person evaluation was required to prescribe buprenorphine to new patients. The safety of expanded access to prescribe buprenorphine telephonically should be evaluated, and, if outcomes improved, should continue beyond the pandemic to increase access to life saving treatment.

INCREASE SUPPORT FOR ALTERNATIVE DELIVERY OF CARE AND PAYMENT MODELS

A. Telehealth

? PROBLEM:

Before the pandemic, regulatory requirements, including limitations on the allowed type of software and equipment as well as disincentives within the existing reimbursement systems, discouraged many providers from investing in and widely adopting telehealth as part of their practice. The pandemic, at least temporarily, swept away those barriers. Telehealth has become an important strategy to provide a wide variety of care to patients in many settings. Additionally, the technology has been used to enable Telemonitoring (or remote monitoring) for home-based care and remote participation in clinical trials. Telemonitoring involves the use of telehealth to remotely monitor health status, including capturing and sharing data, such as weight, blood pressure, or glucose level via medical devices.

Telehealth served a critical public health function by protecting patients and providers, eliminating direct contact for those visits, and thereby preserving personal protective equipment when it was in short supply. According to the Fair Health Tracker, from November 2019 to November 2020, billing for telehealth services based on volume of claims increased by 8,472.96 percent in the Northeast region.[27] The top three reasons for visits were mental health conditions (by a wide margin); exposure to communicable diseases; and joint or soft tissue injuries.[28]

Telehealth has obvious value, such as convenience. A ten-minute consultation to look at a rash, for example, is much easier than the hour or more ordeal of traveling and waiting under the traditional in-person model. Clinicians also report further benefits such as being able to see a patient's home setting and the opportunity to engage with a patient's caregivers at the visit, as well as fewer "no-show visits." Telehealth is useful for routine services that do not require in-person care, but are time sensitive, such as follow up consults to refill a prescription for certain contraceptives. But not everything can be done over a screen. For some, telehealth is not a full replacement for annual well visits (including immunizations) or emergencies involving chest pains or respiratory issues. There are also accessibility gaps that hinder telehealth for many patients.

Despite its value and success during the pandemic, the adoption of telehealth has been uneven by provider type, patient age, socio-economic factors, and by patient language, ethnicity, and race. A quarter of Medicare beneficiaries lack a device with the capability to conduct a video visit.[29] This percentage is higher for those who are Black, Latinx, and those with disabilities.[30] Moreover, due to lack of equipment or comfort level using the technology, from mid-March to mid-June 2020, nearly a third of Medicare beneficiaries who received telehealth care did so by telephone audio only.[31]

As telehealth continues as a mode of care, it will be important to align on how to define and measure what is good quality care and which types of care are appropriate to deliver via telehealth. Several groups, including the National Quality Forum (NQF)[32], the World Health Organization (WHO)[33], and the Agency for Health Research and Quality (AHRQ)[34] have already proposed frameworks for evaluating and measuring telehealth to answer these questions. This guidance should be considered, and stakeholders should move forward quickly to align on measures and principles to include in reimbursement contracts and care delivery models to promote appropriate telehealth use. Such principles should focus on quality of care; patient satisfaction; whether the care can be provided virtually; protecting patient privacy; accessing patient's medical records for the visit; and efficiency. Recently, the American Academy of Pediatrics (AAP) synthesized the quality metrics proposed by the above listed organizations into a single framework for measure developers and researchers to use to study telehealth's impact on patients and to develop quality measures that fall into one or more measurement domains: (1) Health Outcomes; (2) Health Delivery — Quality and Cost; (3) Experience; and (4) Performance Indicators. The AAP's framework is intended to support measures that will communicate telehealth's value to four key stakeholder groups: patients, providers, health systems, and payers.[35] This framework is a strong start for New Jersey stakeholders to use to design telehealth regulations, as well as reimbursement and care delivery models that include telehealth.

💡 SOLUTION:

The federal government widely loosened payment and privacy restrictions for telehealth use amid the pandemic. The State also issued orders that provided greater flexibility and payments for telehealth. Many of these changes will end when the public health emergency ends. Now that telehealth use has expanded so rapidly, we have a good opportunity to assess its value and adopt regulations and test models of care and payment that further telehealth as one part of the health care continuum while recognizing its advantages and limitations. Telehealth use and payment rules will have to be addressed at both the state and federal level. New Jersey's Telehealth law created a multi-stakeholder Telemedicine and Telehealth Review Commission ("Review Commission"), which is the ideal forum to address these issues.[36]

One incredible lesson from the pandemic is how quickly a mode of care, such as telehealth, can be adopted and widely used by so many people in very innovative ways. As we move forward, we should assess those innovations and outcomes and adopt regulations that support this mode of care delivery.

Recommended Actions:

8. **Convene the Telemedicine and Telehealth Review Commission and adopt comprehensive regulations to guide telehealth's growth.**

The Review Commission should be appointed and convened expeditiously. It should evaluate (using electronic medical records, encounter data, clinical trial data, patient/caregiver reported outcome data, etc.) how telehealth has affected the quality, cost, and equity of care for patients with specific conditions. A particular focus should be on how telehealth use may have varied by age, insurance type, race, ethnicity, and language.

The Review Commission could be staffed by state and health care policy researchers, with the goals of identifying quality measures and drafting a robust, quality informed set of regulations that enables telehealth to flourish equitably and efficiently. Ideally, the regulations would be published for adoption prior to the lifting of the public health emergency. The Review Commission should consider and include in its work all known federal changes regarding privacy requirements, equipment and software standards, and federal reimbursement policies.

The Review Commission's findings should identify populations that struggle with the equipment use, obtaining equipment, or lack broadband and propose policy solutions to address these barriers. This information will inform investments that the State or private entities may decide to make to address such digital inequities.

Finally, the Review Commission should consider the specific changes that were made during the public health emergency and whether and to what extent it would recommend retaining such changes. The specific changes that enabled and encouraged greater telehealth use by both providers and patients include: reimbursement for audio only services; payment parity for in-person and virtual services; changes to consumer cost sharing; relaxation of privacy laws and allowing additional technology platforms; allowing for remote monitoring and visits for certain clinical trials; easing limitations on patient or provider location for virtual visits; and increased allowance for out-of-state licensees to deliver care. These changes and issues are governed by various state and federal entities. Which entity would be responsible for adopting any recommendations and by what mechanism must be spelled out by the Review Commission. The recommendations should be evidence-based and formed through an open, transparent process.

9. **Support testing State funded and voluntary programs that include the provision of remote monitoring devices and digital equipment to increase health care access and improve outcomes.**

The State and other stakeholders in the health care system should create and test programs that provide equipment (smart phones, tablets, remote monitoring devices) to enable the use of telehealth by various populations within various settings to improve health care access and outcomes. Many such programs exist throughout the country, with three highlighted in this action plan.[37] [38] While some studies have shown improved outcomes and savings, most studies have been smaller scale or of shorter duration and more insights are needed to widely scale these innovations.[38]

WellCare Health Plans of NJ identified a "connectivity gap" in multiple communities and found ways to enable people to stay connected to their families, employment opportunities, as well as to their health care providers. WellCare's Community Connections program donated cell phones with three months of service to: The Partnership, which assists pregnant individuals and new parents; NJ Re-entry, which assists with employment searches and job readiness; and Women's Centers in Passaic and Camden, which assists those involved in inter-personal violence. WellCare also donated tablets to nursing homes throughout the state to enable residents to communicate with their families to combat social isolation and to participate in telehealth services.

Clover Health identified members with chronic conditions who were without technology to stay connected with their provider and therefore at risk of poor outcomes and preventable hospitalizations. Clover Health provided 1,803 members with tablets to connect them to nurse practitioners to better manage their chronic illnesses through the insurer's Video on Wheels program.

Lifeline Medical Associates conducted virtual visits with patients who reported their own blood pressure and weight. The initiative builds on the organization's pre-pandemic work that was accelerated because of COVID-19. The effort provides patients with a "Mommy Box" that contains a blood pressure monitor, scale, and fetal doppler for prenatal monitoring. Patients are enrolled in a patient engagement application to integrate the information with their medical records.

In some models, provision of a smart phone or tablet, or enabling a certified nurse assistant at a skilled nursing facility, or a caregiver or assistant to help a patient with devices and telehealth at home, has enhanced care and has been shown to be cost-efficient.[40] These innovations should be further tested by the State and other purchasers as strategies to address the social determinants of health. For providers, models such as Accountable Care Organizations or Patient-Centered Medical Homes, where providers are paid based on shared savings and quality outcomes, are well poised to support these types of investments. For purchasers and managed care organizations, if these interventions work, they have financial incentives to provide this equipment to better manage members with chronic illnesses and thereby reduce hospitalizations, associated complications, and costs.

10. **Continue telehealth and remote monitoring in clinical trials to advance research and equity in trials and study its impact.**

Just as patients and providers benefitted from greater access to telehealth during the pandemic, researchers and clinical trial participants were able to use telehealth to continue to conduct clinical trials remotely. This flexibility saved money and made life easier for some very ill and older patients as well as those who live considerable distances from their caregivers. Pursuant to FDA guidance, researchers could mail certain medications, perform examinations via telehealth visits, and home monitor patients' vitals. Some clinical trials, however, still required in-person visits to draw blood or review certain vital signs and symptoms. For the duration of the public health emergency, the FDA should continue its guidance that allows for changes to ongoing clinical trials, including allowing certain observations to be done via telehealth.[41] The safety and efficacy of these changes should be reviewed, and the benefits of these changes should be considered for continuation beyond the pandemic, with study accuracy and patient safety always of paramount importance. Additionally, the evaluation should include data on the impact of telehealth on the diversity of trial participants by age, race, ethnicity, and language. The evaluation should include a qualitative component with input from a diverse group of trial participants.

B. Long-term care and home-based care for older adults.

? PROBLEM:

The staggering number of COVID-19 cases and deaths in long-term care (LTC) facilities in New Jersey and nationally highlighted how ill equipped we were for the pandemic. A New Jersey Department of Health commissioned report ("Manatt Report"), released in June 2020, provided guidance for strengthening the State's long-term care system.[42] The recommendations became part of a legislative package, most of which was enacted with the support of both the LTC industry and consumer advocacy groups. The New Jersey Department of Health (DOH) has begun implementation of several of these laws including creating a consolidated webpage for LTC data, which provides access to inspection reports, some facility ownership information, data on current outbreaks, and ongoing guidance for residents and LTC operators.[43]

As noted in the Manatt Report, many of New Jersey's LTC facilities are older and have multiple residents per room. Many lack infection control expertise — and a large percentage had documented deficiencies and citations. As LTC facilities typically stock PPE for the purposes of short-term infection outbreak and for staff use only, they did not have enough PPE to protect their staff and residents in the way that COVID-19 required. This was further complicated by the global shortage of PPE during the peak of the pandemic, a lack of information initially available about how the virus spread, and limited testing availability and protocols for residents, visitors, and staff. The report further explained that these facilities were staffed by workers, particularly certified nurse assistants, who provide 90 percent of the direct patient care. These employees often do not have health insurance — which may decrease the likelihood that they would seek medical care if they began showing symptoms of COVID-19 and thus risk spreading it within the facility. Many live in areas which had high rates of community spread of the virus. They are caring for our frailest residents. During the height of the pandemic, these factors, collectively, led to the high rates of infection and death from COVID-19 in these facilities.

The Manatt report sets forth recommendations for increased financial and quality reporting and transparency, better aligned and staffed government oversight, increasing LTC direct staff salaries and benefits, clinical quality and infrastructure improvements, and reforming reimbursement policies to pay for value and quality. The report also highlights opportunities to increase residents' social connectedness when visitation is limited, such as the purchasing and

utilization of communication technology. Legislation has passed on some of these recommendations and must now be implemented.[44] Additional capacity within the Department of Health will be needed to support the additional oversight required in these legislative changes as well as to carry out already existing core oversight functions. These needs include resources to conduct more frequent inspections and following up on corrective action plans.

While these critical improvements to LTC are needed, a growing number of aging adults prefer to remain at home. It is time to redesign our health care financing and delivery system, as well as our communities and public health system, to better support home and community-based care.[45] Both Medicare and Medicaid are moving in this direction.

Medicaid pays for two-thirds of all LTC residents. The State's Medicaid Managed Long-Term Services and Supports (MLTSS) system, since launching in July 2014, has facilitated the growth in home and community-based care while nursing home occupancy has been flat or decreased. This trend is likely to continue post-pandemic. Through MLTSS, individuals can receive a range of home and community-based services including these relatively higher cost services:

- **Supplemental payments towards remaining in Assisted Living (Medicaid pays towards the medical costs at a fixed daily rate);**
- **Adult Day Care (for assistance for acts of daily living and socializing);**
- **Personal Care (including family paid as caregiver).**

While New Jersey actively encourages residents to use these benefits if they are eligible and thereby stay at home, many will not meet the eligibility requirements.[46] Individuals with income above the Medicaid eligibility limits, but who cannot afford these services, have fewer options to support them at home. One other option for some such individuals is enrolling through a Qualified Income Trust[47] mechanism.

💡 SOLUTION:

Although Medicare and Medicaid are the largest purchasers of LTC, to date, steps toward value-based payments to encourage improved quality have been relatively modest. More action towards value-based payments was recommended in the Manatt Report and is expected nationally.

The Medicare Value-Based Program rewards and penalizes nursing facilities with incentive payments based on the quality of care as measured by a hospital readmissions measure. New Jersey Medicaid began linking quality to payment in 2019 by paying a small performance bonus for achieving certain metrics. The Manatt Report, and patient advocates, acknowledged this first step and encouraged additional work on value-based payment.

Health plans, health care systems, and entrepreneurs are deploying caregiver and technology-based programs, telehealth, remote monitoring activities, Hospital at Home models, as well as Medical Care at Home Models, to support people who prefer to remain in their homes for on-going, episodic, or post-acute care.[48]

AARP, as well as certain foundations, are advocating for sweeping systemic changes to policy and payment systems to create plans for healthy aging. One such example is California's Master Plan for Aging.[49] The plan was launched through an executive order by Governor Gavin Newsom. Since its launch, private industry, corporations, health systems, foundations, and local leaders have supported and engaged in what is a massive effort to reinvent care across all ages by pursuing and investing in social policies, from housing and transportation to work force and health care financing, that enable people to grow old in their communities.

An improved network of LTC home-based care for aging adults will need to include a move to quality-based payments; the use of technology as well as in-home care; and fundamental shifts in our public health and broader community infrastructure and payment systems as outlined in the California Master Plan. Governor Murphy signed Executive Order 227 to catalyze change like the California effort.[50]

Recommended Actions:

11. Implement the Manatt report recommendations.

The Manatt report recommendations, as enacted, should be implemented as quickly as possible. Funds from the federal government can be used to support these efforts and should be invested in modernizing facilities (including converting multi-patient rooms to private rooms), ensuring adequate staffing levels overall and by skill level, ensuring a supply of PPE, staff training and retention programs including opportunities for professional development, enhanced wages and benefits to reduce turnover, and making sure that each facility has staff with infection control expertise to address the issues that contributed to higher death and infection rates. The implementation must be done in partnership with the LTC industry recognizing that this industry has many good actors and dedicated staff members who put their lives at risk for their residents.

12. Support home-based medical care models.

Through Medicare, Medicaid, and other payers, support and reimburse home-based medical care, which includes a variety of care models that serve the most medically complex and socially vulnerable people. Medical management, co-management, and oversight by nurse practitioners, physician assistants, and physicians — often as part of an interprofessional care team — and the execution of a medical care plan are core components in the care of these patients. Essential care also requires addressing issues related to patients' functional status, cognitive and behavioral concerns, and SDOH. There are many examples of these models and their use should be expanded in New Jersey.[51]

13. Adopt a statewide plan for healthy aging.

Such a plan would create incentives and funding for the State and local government to focus on being "Age Friendly" when making zoning, transportation, tax, and health care delivery, policy, and funding decisions. Executive Order 227,[52] which creates the Age-Friendly State Advisory Council to identify opportunities for creating livable communities for people of all ages in New Jersey is a good first step. Local public health can play an important role in this effort. During the pandemic, local public health departments worked closely with housing authorities, senior resource centers, local first responder agencies, and others to identify residents with greater needs, who were living alone, or who did not have access to technology. These partnerships enabled residents to connect with volunteers to receive food, social visits, transportation, and help with getting vaccinated. The bonds they built during the pandemic must be preserved and enhanced.

C. Strengthen patient access and connection to high quality primary care.

? PROBLEM:

A strong primary care system is essential to moving away from fee-for-service and toward value-based care. This was true prior to the pandemic and remains true today. A trusted primary care practice helps patients navigate the health care system, access necessary preventive care and screenings, and manage their chronic conditions. The pandemic's toll on primary care practices has made the call to increase support of primary care even more urgent. According to Asaf Bitton, MD, executive director of Ariadne Labs, during the pandemic "up to five percent of practices have closed, and 20 percent are at risk of closure."[53] Dr. Bitton argues that "[t]hese closures will lead to many consequences, including huge barriers to access, and then the downstream effects of [patients receiving] less necessary or preventive care and experiencing more delays in care." His point is consistent with the many studies showing evidence of the benefits of a health system with a strong primary care base.[54] These benefits are across the board and include reducing the major causes of death and disorders and reducing racial and ethnic disparities.

In a pandemic, a trusted and accessible source for health information is even more critical. Primary care of all types, from family physicians to pediatricians to community health centers, stayed open within the public health restrictions to serve their patients. They redesigned their physical settings, protocols, and utilized telehealth. Those practices that were in alternative payment arrangements, such as Patient-Centered Medical Homes (PCMH) or Direct Primary Care, had some economic protections and advantages over those that were entirely reliant on fee-for-service payments. Overall, primary care practices have served as essential sources of information for patients for identifying COVID-19 symptoms, explaining testing and infectious disease prevention, keeping patients out of the emergency room when appropriate, and providing vaccine information and delivery.

As we rebuild from the pandemic and assess its financial and emotional toll on various segments of the health care system, we have a rare opportunity and responsibility to publicly discuss what type of care we want to preserve, support, and expand. The evidence supports increased investment in primary care and strengthening it in New Jersey.[55] Unfortunately, as a country, we are going in the wrong direction, as primary care spending in 2019 across commercial payers was only 4.67 percent of total national commercial health care spending, falling from 4.88 percent in 2017.[56] As we consider what a stronger post-pandemic health care system looks like, we must analyze the value of primary care in our communities during this pandemic and in future public health crises. We should explore the bridge between primary care and public health — and the role of primary care providers in driving healthy habits and preventive care, increasing basic health literacy, teaching infection prevention, driving immunizations and addressing vaccine hesitancy.

Invest in primary care to build up a vibrant network of high-quality primary care practices that offer comprehensive, team-based care, such as practices organized as a PCMH. PCMH payment models adequately reimburse practices to actively manage patients' care using data, direct outreach, and technology to expand patient access and engagement. These models would increase the total utilization and spending on primary care, but over the long-term should improve overall patient and population health outcomes, increase patients' connection to primary and preventive health, improve trust in public health and create an important bridge between the public health system and the health care delivery system. When done effectively, these models of care may also reduce spending related to hospital admissions and chronic conditions.

In New Jersey's commercial market, some insurers have made significant investments in the PCMH model and New Jersey was one of seven regions to participate in the Comprehensive Primary Care Initiative, a demonstration project implemented by the Center for Medicare and Medicaid Innovation in collaboration with private health plans to evaluate the impact of a specific change in the way primary care practices are paid. The primary care practices received a per member per month (PMPM) payment in addition to standard fee-for-service payments and were eligible to receive an additional shared savings payment if the total spending on all the patients in all of the participating practices in their geographic region was lower than the spending in a comparison group of patients. The Comprehensive Primary Care Initiative ended in 2016 and was replaced by Comprehensive Primary Care Plus (CPC+).

Recommended Actions:

14. **Track and set goals for spending on high quality primary care.**

Track how much of New Jersey's health care spending is for primary care in comparison to other health care services. As part of the effort, the State should align with stakeholders on the right balance to increase the percentage invested in primary care without increasing total health care spending. One example is Massachusetts.[57] In late 2019, Governor Charlie Baker proposed comprehensive legislation to improve outcomes, increase access, and "bring down costs" by promoting access to behavioral health and primary care services and setting a target to increase spending on primary care and behavioral health services by 30 percent over three years "within the construct of the state's health care benchmark." The Massachusetts Health Policy Commission (HPC) joined Governor Baker in calling for increased investment in primary care. Specifically, the HPC recommended that "payers and providers should increase spending devoted to primary care and behavioral health while adhering to the cost growth benchmark." Governor Murphy recently established a similar group to address health care spending.[58] The timing is right to review the State's spending in primary care as compared to other health care services, especially by region, age, type of insurance coverage, race, ethnicity, and spoken language. The newly appointed group is well positioned to recommend steps to ensure that New Jersey appropriately invests in strengthening primary care.

15. Expand use of aligned payment models for primary care that are more patient-centered and less reliant on fee-for-service.

A Patient-Centered Payment Model has the following characteristics:

- It enables patients to have their specific health care need addressed by a team of providers who have agreed to work together to achieve specific, feasible outcomes for that need.

- It enables patients to select which provider team to use based on the quality standards and outcomes that each provider team commits to achieve for that patient and based on the total amount that the patient and their insurer will pay for all the services the patient will receive with respect to the need that is being addressed.

- It gives the team of providers adequate resources and sufficient flexibility to deliver the most appropriate combination of high-quality services to achieve the best outcomes based on the nature and severity of the patient's need.

- It holds the team of providers accountable for achieving the expected results for each patient in return for the adequate, flexible payment.

As part of any call for greater investment in primary care, the State and other purchasers should continue to expand models that support quality and shared savings based on outcomes. In addition, purchasers, such as Medicaid and the insurance carriers on the government subsidized marketplace, should align their quality measures and increase their investments in these models to accelerate the health system's move away from fee for service. While the evidence for one particular primary care model over another is still developing and growing, some models and programs have demonstrated improved quality and modest cost reduction.[59] As mentioned above, and found in studies, practices with per-member per-month payments to support their ongoing care coordination of patients were in a stronger financial position during the pandemic and shelter-in-place orders.

16. Facilitate and leverage relationships between primary care and public health to support trust in public health and better population health.

Establish formalized, closer ties between local public health departments and community-based primary care providers to facilitate on-going cooperation on immunization programs, anti-smoking, and other public health campaigns. One of the lessons learned in the pandemic is that local public health and local health care providers often did not know one another and did not work together. The pandemic and collective work on contract tracing, communicating about long term care facilities and associated regulatory changes, testing sites, vaccination sites and availability, created opportunities for local public health to work more closely with area providers. These relationships, if kept up, will serve communities well in future public health emergencies or natural disasters. But they can also be leveraged in support of much needed public health campaigns where there is a lack of funding. Every stakeholder can contribute something to get public health messages out. Strategies should include appointing area primary care practices to serve on local boards of health, regularly inviting local providers and public health officials to present at each other's meetings, sharing board of health newsletters and minutes with practices, and holding regular forums either in person or virtually to continue these new relationships.

D. Increase accessibility of integrated behavioral health care.

? PROBLEM:

The COVID-19 pandemic exacerbated our country's behavioral health problems. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2018, an estimated 47.6 million adults in the U.S. had experienced mental illness in the past year, which represents 19.1 percent of the adult population.[60] According to a recent Centers for Disease Control and Prevention (CDC) survey,[61] more than 40 percent of U.S. adults surveyed in June 2020 reported struggling with pandemic-related behavioral health issues and over one in ten adults seriously considered suicide. These numbers represent a drastic increase in the percentage of American adults experiencing behavioral health issues. The pandemic also created a new class of worker deemed "essential." Employees in the public and private sectors were deemed "essential workers" during the pandemic if their duties and responsibilities were essential to the public's health, safety, and welfare. This included workers like lab workers, gas station attendants, grocery store personnel, and employees of other retail stores and warehouses. Concerns about being exposed to the virus at work along with uncertainty about employment have created fear and anxiety in essential workers that threaten the wellbeing of our workforce. Lack of access to appropriate treatment, stigma associated with seeking out treatment, and an inability to carve out time for self-care and treatment are all significant barriers to treating and supporting the mental health of our essential workforce. Moreover, patients who received fragmented care or who are treated separately for their physical and emotional ailments have poorer outcomes over time and their care ends up costing more.[62]

💡 SOLUTION:

Any attempt to alleviate the behavioral health impact of the pandemic must examine structural deficits that prevent people from seeking or receiving treatment. The CDC has recommended that the public health response to the COVID-19 pandemic should include increased intervention and prevention efforts to address associated mental health conditions and that community-level efforts, including health communication strategies, should prioritize young adults, as well as underserved populations and communities, essential workers, and unpaid adult caregivers.[63] In order to increase intervention and prevention efforts for these populations, we must increase access to care and break down existing barriers to providing care by eliminating regulatory and payment barriers to integrated care (whole person care that includes both physical and mental health services).

Recommended Actions:

17. Issue "integrated facility" licensing regulations.

New Jersey has been working toward integrating physical and behavioral health care, but still needs to amend its regulations to allow for a single integrated facility license. The New Jersey Health Care Quality Institute Medicaid 2.0 Blueprint for the Future,[64] which laid out a plan to redesign and modernize New Jersey's Medicaid program, outlined in recommendation number 11 (in the Blueprint) the major issues caused by the lack of a fully integrated care system. These issues include system fragmentation, misaligned service priorities, health disparities, and lack of prevention and evidence. The State, to its credit, has recognized these issues and has taken preliminary steps in the right direction. However, given the current mental health crisis, those actions must accelerate. To increase access

to care, the New Jersey Department of Health should publish the integrated facility licensing regulations that were developed with guidance from the State Integrated Health Advisory Panel,[65] a group of experts convened by the Department to create a unified system of care to address these stated shortcomings in our current system.

18. Advance integrated physical and mental health services payment changes in Medicaid.

The State's Medicaid program and contract should finalize its plan to fully integrate its managed care model for physical and mental health care. Despite years of incremental steps towards integrated care, and acknowledgement of its importance to patient outcomes, most outpatient mental health is not included under the State's contracts with the five Medicaid Managed Care Organizations (MCOs) and instead is run through a separate fee-for-service payment model. It is time to move forward with Medicaid's plans to amend the program and MCO contract to emphasize integrated care and to include behavioral health services for all adults in the contract. Under this change, the MCOs would be responsible for ensuring that when a provider is completing a patient assessment (at an annual exam, for instance), that they utilize a standardized evidence-based assessment to appropriately evaluate a person's presenting medical, psychiatric, and social determinants needs. The individual's plan of care should address the behavioral health and primary care needs, as well as include integrated service planning and treatment, appropriate to the level of care required.[66] These changes would shift the payment and delivery philosophy of the State to a more whole person approach. The coordination of health, behavioral health, and social services in a patient-centered manner would improve health and wellbeing through more efficient and effective use of resources.

PROMOTE PUBLIC POLICIES THAT ADDRESS SOCIAL DETERMINANTS OF HEALTH (SDOH) AND CAN LEAD TO GREATER HEALTH EQUITY.

? PROBLEM:

COVID-19 highlighted existing patterns in our health care landscape in which factors such as an individual's race, ethnicity or their socioeconomic status increased their likelihood of facing poor health outcomes. These factors are often referred to as social determinants of health (SDOH). Adverse SDOH, such as living in an area where it is not safe to spend time outdoors, prolonged increased stress levels, or limited access to healthy food, can directly influence an individual's health, and are often the result of the effects of inequity or discrimination, such as systemic racism. COVID-19 is a prime example of this. Specifically, the Black and Latinx communities face increased risks of contracting, getting severely ill, or dying from COVID-19.[67] New Jersey data mirrors national trends, with Black and Latinx individuals being three times more likely than white individuals to contract COVID-19 and almost twice as likely to die from the virus.[68] A study from the Rutgers New Jersey Medical School has shown that Black individuals are more likely to experience adverse SDOH than white counterparts, and that these factors contribute to worse outcomes for COVID-19 infection and severity. In addition to disparities based on race, socioeconomic factors also contribute to worse health outcomes. Educational and income disparities can make an individual more likely to face health concerns, such as diabetes and hypertension, which increase their likelihood of getting severely ill or dying from COVID-19.[69] Policy makers must fully appreciate that the disparities we are seeing in COVID-19 cases are the result of societal forces, and not personal decision-making or failures of an individual or their community.

Policy solutions to address SDOH must directly connect at-risk populations with a comprehensive range of health and social support services while also making systemic changes to the way we invest in such services. Any proposed policy action or intervention must recognize how discrimination can impact every aspect of an individual's life — as well as the impact that decades of inequities and mistrust of these systems can have on the success of proposed interventions. Additionally, it is essential that programs incorporate the voices of the community they are designed to serve in every stage of development and are informed by accurate and useful data. While some of this work will be incremental, we cannot lose sight of the immediate needs of many populations, especially during these unprecedented times, and should actively implement evidence-based solutions to barriers to care to improve health outcomes as soon as possible. For example, we should both immediately expand care management programs that can connect individuals with necessary health and social services programs, while also investing in areas that influence health over a long period of time, such as access to affordable housing.

The calls to action below present a strategic approach to move toward policy change, rather than more granular suggestions. This was intentional; we felt it was important to not boil down solutions to very complex systemic problems into a few bullet points. We want to guide and support our state leaders in actively and directly engaging local leaders and subject matter experts in this effort. Additionally, while this section is dedicated to improvements in SDOH, the themes of improving access and health equity across the state can be found throughout this action plan.

Recommended Actions:

19. **Meaningfully engage stakeholders and subject matter experts in relevant fields to identify key issues and impactful interventions to the most pressing health-related social needs highlighted during the pandemic.**

SDOH interventions should stem from existing community-based efforts, peer-reviewed studies, and data. The Urban Institute recently highlighted three strategies for community engagement during COVID-19 and beyond which we recommend be utilized as New Jersey explores effective ways to address SDOH:[70]

Crowdsourcing: Crowdsourcing, which can be done on accessible virtual platforms or in person, provides a more open opportunity for the public to submit input and ideas on an issue. Events like open public meetings and town halls can solicit feedback from groups or individuals that may be otherwise left out of important discussions. Responses can range significantly during this type of information gathering and can help funders or government officials ensure that their initial scope of work aligns with priorities of those most closely affected by an issue.

Ecosystem Mapping: This exercise builds an understanding of social connections, relationship dynamics, subject matter expertise, and power within a community or ecosystem and allows for the utilization, and support, of existing resources to meet mutual goals. A thorough ecosystem map can help ensure that all relevant parties are included at each step of work and that the right relationships and power structures are engaged during key stages of implementation.

Data Walks: Data walks bring together research and community members to share research, data, and other forms of evidence to get both a complete picture of available data and to agree upon areas for additional research. Data walks can also be helpful in addressing inconsistencies or flaws in existing data to ensure that there is a mutual agreement on core data sets that are used for major decision points of a project.

20. Identify both long-term interventions to create systemic change while also prioritizing immediate steps that can be taken to alleviate the impact that COVID-19 has on underserved populations in the short-term.

The State should identify and prioritize opportunities that can create much needed access to quality health care in the immediate future, while also investing in longer term changes to revise our current models of care delivery that perpetuate existing inequities. Some of the short- and long-term steps that can be taken to address these issues include:

The Center for Medicare and Medicaid Services (CMS) recently released guidance regarding opportunities for state Medicaid programs to address SDOH under current authorities or to apply for waivers to do so for their beneficiaries.[71] As New Jersey Medicaid prepares to submit its Section 1115 Waiver renewal this year, it should include innovative SDOH strategy proposals with the goal of creating sustainable and reimbursable pathways to evidenced-based services that address health-related social needs for underserved populations.

We should expand models like the Delivery System Reform Incentive Payment[72] (DSRIP) Program clinic at Robert Wood Johnson University Hospital.

> To address emerging trends across the country that indicated limited bed capacity at the beginning of the pandemic, Robert Wood Johnson University Hospital wanted to ensure they had enough beds for those with severe COVID-19 infections — while also providing patients who presented to the ED with moderate COVID-19 symptoms with appropriate follow-up care. Individuals with and without insurance were eligible for care at the DSRIP clinic, which had the primary goal of engaging patients who would have a difficult time adhering to discharge instructions, such as getting a follow-up outpatient appointment and filling any necessary prescriptions. They also provided supplies like pulse oximeters to some patients and used medical students to do phone outreach after discharge to provide additional care management.

These initiatives can create better health outcomes for patients with limited resources.

To address SDOH, in Governor Murphy's 2021 budget address, the Governor proposed that $2 million be allocated to a pilot program to provide rental assistance for pregnant women to improve maternal and infant health outcomes. The Governor also plans to use federal funds to support renters facing eviction through the Emergency Rental Assistance Program.[73]

21. Increase the tracking and reporting of health outcomes and public health information by race, ethnicity, occupation, and language to allow for informed decision making at all levels of intervention.

By increasing the data that is collected, tracked, and reported on for health and public health services, future funding decisions and investments in new or ongoing initiatives will be more responsive to what is happening on the ground. States are most likely to see the type of collaboration necessary to make this successful if they own

and operate their own public health database, as competing platforms and vendors working with individual organizations would create multiple siloed data sources rather than a single integrated system.

The New Jersey State Department of Health currently operates the New Jersey State Health Assessment Data (NJSHAD), a website that allows for the public to access deidentified data, statistics, and other information about health and wellbeing of residents. In addition to already created reports and summaries of key health issues, individuals can also get the unique data they may be looking for by doing their own dataset queries on the site.[74] If a valuable resource such as this were expanded to allow relevant entities to enter their own collected data, it could collect much more information, be updated more frequently to better reflect current demographics and health statuses, and be used more broadly to make informed decisions about future policy changes and program investments. Additionally, ensuring that health care data is provided in conjunction with important demographic information is essential to better tailoring interventions to appropriate populations. These measures would make us more effective in addressing SDOH.

REVITALIZE AND REORGANIZE OUR PUBLIC HEALTH INFRASTRUCTURE

? PROBLEM:

Public health initiatives protect and improve the health of individuals and communities. That can be achieved by promoting healthy lifestyles, researching disease and injury prevention, and detecting, preventing, and responding to infectious diseases. This role has never been more tested than in the face of the pandemic. There is consensus among public health officials that all health is local in terms of immediate response. Yet the public is largely unclear on what public health is and has a limited understanding of what local health departments accomplish.

Public health funding has been on the decline and should become a priority, especially in non-emergent periods, to maintain a strong infrastructure capable of responding to major health crises. Public health spending as a proportion of total health spending has been decreasing since 2000 and falling in inflation-adjusted terms since the Great Recession. Health departments across the country are battling 21st Century health threats with 20th Century resources. The COVID-19 crisis demonstrates this reality in the starkest of terms.[75] In New Jersey, we fare worse than most of the country in terms of public health investment. When compared to national averages, New Jersey health departments are under-resourced, ranking last out of 50 states in public health expenditures.[76]

Beyond our current health care emergency, our nation's need to address critical public health challenges is only increasing with disease outbreaks, vaping, the opioid epidemic, extreme weather events and other crises. Understaffed public health departments cannot take on these crises alone. There is a great need to create stronger alliances among public health departments, the network of agencies charged with responding in an emergency, and other community organizations.

Little public information exists about the organization of our public health infrastructure and the flow of resources from the federal government to states and then to local public health departments. This is in large part because the federal government provides funding and support, but it delegates authority to the states to organize and deliver public health services, which can vary greatly by state. A statewide assessment is needed to fully understand how New Jersey uses funding and support from the federal government to create a strong local public health infrastructure — and to determine potential areas for improvement and efficiency.

A clear area for improvement now is enhancing the relationships between local public health departments and the various agencies and organizations that also play a role in emergency management, the delivery of health care services, and work in the community. There should be greater alignment between these organizations at the state and local level to create an environment of open communication and collaboration. A stronger and more inclusive public health system will translate to greater public trust and will improve our collective ability to respond to a crisis.

Recommended Actions:

22. **Assess the structure, roles, and funding of state, county and local public health offices and evaluate whether these organizations have adequate resources and how their respective roles can be improved to support public health.**

A comprehensive review of the public health infrastructure in New Jersey is needed to determine whether the current organization of state and local agencies meets the needs of our population and effectively achieves the core aims of public health. Updated in 2020, the 10 Essential Public Health Services[77] provides an important framework to guide public health to protect and promote the health of all people in all communities. These essential services should be used as benchmarks to assess the overall performance of our public health system across the State.

In addition to more than 90 local health agencies,[78] New Jersey also has 22 Local Information Network and Communications System (NJLINCS) agencies. NJLINCS is a system of public health professionals and electronic public health information that enhances the identification and containment of diseases and hazardous conditions that threaten the public's health.[79] New Jersey has long been a home rule state, but may benefit from increased collaboration, shared resources, and greater alignment across its many public health departments.

External research should also be conducted to consider whether New Jersey would benefit from a regionalized approach, rather than a patchwork of county and local offices that receive varying levels of funding from the CDC and the State. A 2006 study by the RAND Health Center for Domestic and International Health Security prepared for the U.S. Department of Health and Human Services called "Organizing State and Local Health Departments for Public Health Preparedness," said "researchers have proposed that public health services might be more effectively and efficiently delivered on a regional basis, merging counties or states into geographic regions linked by similar health status, economic, or geographic characteristics."[80]

The New Jersey Department of Health convenes a three-member Public Health Council to ensure the reasonable protection of the health of the public-at-large; review and consult with the Commissioner regarding the regulations for the State Sanitary Code; and review the administration of funds under the Public Health Priority Funding Act of 1977.[81] This Council provides an existing and formal connection between the State and local public health agencies where a comprehensive review and analysis of the state's public health infrastructure could be discussed and analyzed. The Council should meet regularly and publish its meeting minutes to ensure that a consistent and transparent connection between the State and public health exists.

23. **Align the public health infrastructure with the emergency management system, health care system, employers, and community-based organizations to build greater trust in public health to address future issues.**

Subchapter 9 of the Public Health Practice Standards of Performance for Local Boards of Health in New Jersey requires local boards of health to develop community health partnerships. Entities that impact the public health and have access to populations and/or resources in performing defined prevention, screening, rehabilitation, or support activities will convene, build coalitions, and identify and organize community resources to support the goals and activities of the local public health system.[82] Emergency management organizations, health care providers, employers, and community organizations should support these efforts by partnering with local public health departments to align their respective goals. The Johns Hopkins Bloomberg School of Public Health Institute for Health and Productivity Studies and the de Beaumont Foundation recently released a report on the "Seven Ways Businesses Can Align with Public Health for Bold Action and Innovation." As set forth in the report, "the business sector can play a vital role in amplifying efforts to rebuild a robust and resilient public health infrastructure that attends to the needs of workers, customers, and communities."[83] Each of these organizations has a vested interest in the public health of their communities and greater efforts should be made to coordinate a multi-sector public health response.

As a result of the pandemic, local health departments have already begun to foster stronger clinical and community partnerships. The Quality Institute's Mayors Wellness Campaign,[84] a statewide community health initiative that works with mayors and community leaders to help improve overall health and wellness in their communities, invites New Jersey municipalities to apply for Healthy Town Designations each year. Through that process, towns provide detailed examples of how they work with community partners to achieve better health for their residents.

> This past year, we saw countless examples of towns working with agencies throughout their communities to provide additional services, such as transportation to medical appointments, hosting exercise classes, collecting data on important issues like mental health and substance abuse, offering education about advance care planning, distributing healthy food, and opening COVID-19 testing sites and vaccine clinics.

Promotion of ongoing partnerships like these will help build trust and open lines of communication for greater coordination during future public health emergencies.

24. Establish a universal immunization registry to support more robust public health data.

Currently, health care providers are required to utilize the New Jersey Immunization Information System[85] (NJIIS) for children under age 7 and their , to monitor school entry requirements, and to maintain Vaccines for Children[86] (VFC) program eligibility. The NJIIS should also include immunization records for all New Jerseyans, including all children and adults, to build more robust public health data sets.

One of the core functions of a public health system is to prevent the spread of infectious diseases. And one of the best strategies in the fight against that spread is vaccination. Public health officials need to be armed with the right data to implement vaccination strategies in communities where the spread of infectious diseases needs to be better contained. Having access to current adult immunization records will help lawmakers and public health officials identify and address areas and populations with lower immunization rates.

Governor Murphy signed Executive Order 207[87] on March 9, 2020. This order automatically enrolls New Jersey residents who choose to receive a COVID-19 vaccine into the State's existing vaccine registry. The Governor's Executive Order changes inclusion into the NJIIS from an opt-in to an opt-out program for residents who elect to receive a COVID-19 vaccine. We recommend using Executive Order 207 as a model to expand the opt-out provision to include all children and adult vaccination records, and not just those who choose to receive a COVID-19 vaccine.

Conclusion

The months and years ahead will test our collective commitment to emerge from the challenges of the pandemic better prepared for any future crises — and with a stronger health care system for all. We will need to turn recommendations into real-world policies that make a difference in the lives of all people in our State. We included all sectors of our health care system and government in this action plan because all elements must work together. **"Emerging From COVID-19: An Action Plan for a Healthier State"** includes specific policy changes as well as long-term interventions to create systemic change. We hope the recommendations will serve as a guiding light taking us forward from the darkest days of the pandemic.

Emerging from COVID-19: An Action Plan for a Healthier State

Appendix A – Scorecard	Data & Public Report	Funding/ Contracting	Innovation	Legis/ Policy	Technology	Access	Savings	Equity
	Methods					Benefits		
Create and Support a Resilient and Diverse Health Care Workforce for the Future								
1. Collect, analyze, publish health care workforce supply data to inform state strategy for development and retention.	✔	✔		✔	✔	✔		✔
2. Create Workforce Council to analyze data and develop 10-year strategic plan.				✔		✔	✔	✔
3. Improve health care licensing and credentialing systems to better deploy workforce.		✔	✔	✔	✔	✔	✔	
4. Evaluate outcomes of expanded licensure and scope of practice during pandemic to guide further regulatory change.	✔	✔	✔	✔		✔		
5. Improve utilization of Medical Reserve Corps to support public health.		✔			✔	✔	✔	
6. Develop and expand behavioral health programs for health care workforce.		✔				✔	✔	
7. Expand Medication-Assisted Treatment prescribing ability for providers treating people with Opioid Use Disorder.				✔		✔	✔	
Increase Support for Alternative Delivery of Care and Payment Models								
8. Convene the Telehealth Review Commission and adopt regulations to support growth.				✔				✔
9. Test state and industry supplied telehealth and remote monitoring equipment to increase access.		✔	✔	✔	✔	✔	✔	✔
10. Continue telehealth and remote monitoring in clinical trials.	✔		✔	✔	✔	✔	✔	✔
11. Implement the Manatt Report recommendations.		✔		✔			✔	
12. Support home-based medical care models.		✔	✔	✔	✔	✔	✔	✔
13. Adopt statewide plan for healthy aging.		✔		✔		✔	✔	✔
14. Track and set spending goals for high quality primary care.	✔			✔			✔	
15. Expand use and align payment models for patient-centered primary care.	✔	✔		✔		✔	✔	
16. Facilitate and leverage connections between primary care and public health to improve population health and trust in public health.		✔	✔				✔	✔
17. Issue "Integrated Facility" licensing regulations.		✔	✔	✔		✔	✔	✔
18. Advance Medicaid integrated physical and mental health payment changes.		✔	✔	✔	✔	✔	✔	✔
Promote Public Policies that Address Social Determinants of Health (SDOH) and Lead to Greater Health Equity								
19. Use community engagement to identify the most critical SDOH needs surfaced during the pandemic.	✔	✔	✔	✔		✔		✔
20. Use Medicaid waiver and state funding to support evidence-based models of services that address SDOH.		✔	✔			✔	✔	✔
21. Increase public reporting of demographic data on health outcomes to address disparities.	✔	✔		✔				✔
Revitalize and Reorganize Our Public Health Infrastructure								
22. Assess the structure of public health and improve resource allocation.	✔	✔	✔	✔			✔	✔
23. Align public health with emergency management, health care system, and community-based organizations to build trust and efficiencies.	✔	✔		✔	✔		✔	✔
24. Create universal immunization registry for adults to improve public health data.	✔	✔	✔	✔	✔	✔	✔	

AAP – American Academy of Pediatrics

APN – Advanced Practice Nurse

AHRQ – Agency for Health Research and Quality

CDC – Centers for Disease Control and Prevention

CMS – Centers for Medicare and Medicaid Services

CCP – Crisis Counseling Program

DATA – Drug Addiction Treatment Act

DEA – Drug Enforcement Agency

DSRIP – Delivery System Reform Incentive Payment

DOH – Department of Health

DCA – Division of Consumer Affairs

ED – Emergency Department

EMR – Electronic Medical Records

FEMA – Federal Emergency Management Agency

FDA – Food and Drug Administration

GME – Graduate Medical Education

HIPAA – Health Information Portability and Accountability Act

HCW – Health Care Workforce

HWRP – Health Care Workforce Reporting Program

HPC – Health Policy Commission

KPI – Key Performance Indicator

LINCS – Local Information Network and Communications System

MAT – Medication-Assisted Treatment

MCO – Managed Care Organization

MRC – Medical Reserve Corps

NJOEM – New Jersey Office of Emergency Management

NQF – National Quality Forum

NJSHAD – New Jersey State Health Assessment Data

NLC – Nurse Licensure Compact

OUD – Opioid Use Disorder

SAMHSA – Substance Abuse and Mental Health Services Administration

SDOH – Social Determinants of Health

UME – Undergraduate Medical Education

WHO – World Health Organization

Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services is the federal agency responsible for administering the Medicare and Medicaid programs and carrying out other functions with respect to health care and health insurance.

Coronavirus Disease 2019 (COVID-19)

The World Health Organization (WHO) has decided to name the disease caused by the novel coronavirus "COVID-19" and refers to the virus that causes it as the "COVID-19 virus." CO for corona, VI for virus, D for disease, and 19 for the year the outbreak was first recognized, late in 2019.

Cost-Sharing

Cost-sharing is the amount that a patient pays out-of-pocket to a health care provider in return for a service, with no reimbursement from a third-party payer. The four principle approaches to cost-sharing are co-payments, co-insurance, deductibles, and balance billing.

Delivery System Reform Incentive Payment (DSRIP) Program

A Delivery System Reform Incentive Payment Program is a special pool of funds that can be used by a state Medicaid program to encourage or support changes in care to Medicaid beneficiaries and other low-income individuals by hospitals and other providers. The programs are created on a state-by-state basis through Section 1115 Medicaid waivers approved by the Centers for Medicare and Medicaid Services.

Direct Primary Care

This is a term used to describe a payment model in which a primary care practice charges a monthly, quarterly, or annual fee to a patient that covers all or most of the services the primary care practice provides to the patient, including patient visits, laboratory testing, care management, etc., and there are no separate fees charged for individual services. Direct primary care is a bundled capitation payment, but with the payment coming from the patient rather than a health insurance plan. In contrast, "concierge medicine" is typically a structure where a patient pays a fee of some kind in addition to fees for individual services, with the additional fee assuring that the patient will receive services that would not otherwise be possible under current fee schedules, including longer visits, phone calls, 24-hour access, etc.

Encounter

An encounter is an interaction between a provider and a patient. In a capitation payment model or other payment model that does not tie payment to the specific number or types of services delivered, a purchaser or payer may still wish to know what services were delivered to patients, so instead of submitting a claim for each service (since a claim is generally associated with a payment), a provider may be asked to submit a form documenting an encounter. Encounters include services that would be eligible for payment under a fee-for-service payment model, but they may also include other services or interactions that are not typically paid for under fee-for-service, such as telephone calls or e-mails with patients.

Fee-for-Service Payment

A fee-for-service payment model is one in which a specific amount is paid when a particular service is delivered, and generally where the payment amount differs depending on which specific service is delivered.

Health Care Workforce

The WHO has defined health workforce as all people engaged in actions whose primary intent is to enhance health. These human resources include clinical staff, such as physicians, nurses, pharmacists, and dentists, as well as management and support staff, i.e., those who do not deliver services directly but are essential to the performance of health systems, such as managers, ambulance drivers and accountants.

Health Equity

Health equity is what is achieved when everyone reaches their full potential for health and wellness. With health equity, no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

Home-Based Medical Care

Home-based medical care encompasses a variety of care models that often serve the most medically complex and socially vulnerable people. Medical management, co-management, and oversight by nurse practitioners, physician assistants, and especially physicians — often in collaboration with an interprofessional care team — and the execution of a medical care plan are core components in the care of these patients. Essential care also requires addressing issues related to patients' functional status, cognitive and behavioral concerns, and social determinants of health.

Hospital at Home

Hospital at Home is a term that includes several specific models of treating patients at home who would normally be treated in an in-patient setting. Models include the Acute Hospital Care at Home program which is an expansion of the CMS Hospital Without Walls initiative launched in March 2020 as a part of a comprehensive effort to increase hospital capacity, maximize resources, and combat COVID-19 to keep patients safe. This program creates additional flexibility that allows for certain health care services to be provided outside of a traditional hospital setting and within a patient's home.

Infrastructure

"Infrastructure" is a generic term used to describe systems and services that a provider needs to have in order to deliver quality care to patients. The term is used to refer to fixed assets such as computer equipment, software systems such as electronic health records or data analysis software, or personnel such as nurse care managers.

Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact is an agreement among participating 29 U.S. states to work together to significantly streamline the licensing process for physicians who want to practice in multiple states. It offers a voluntary, expedited pathway to licensure for physicians who qualify. Recognizing that physicians will increasingly practice in multiple states because of telemedicine, U.S. state medical boards in 2013 began actively discussing the idea of creating the Compact to help streamline traditional medical-license application processes.

Managed Care Organization

A health insurance company or provider organization that contracts with a purchaser to provide all of the health care services needed by a specific set of individuals in return for a pre-defined amount of money, such as a capitation payment. The MCO is both permitted and expected to "manage" the care delivered to these individuals to hold the costs of services within the amount it is paid, such as through the use of care management, prior authorization, and other techniques that are designed to limit the utilization of services by patients.

Medical Home

A medical home is a generic term used to describe a physician practice which operates in ways consistent with one or more of the principles of the Patient-Centered Medical Home. Although a "medical home" was originally intended to apply to primary care practices, it has also been used to refer to specialty practices that provide care to patients with a particular health problem in ways that are consistent with one or more of the principles of the Patient-Centered Medical Home.

Medical Reserve Corps

A national network of local groups of volunteers engaging local communities to strengthen public health, reduce vulnerability, build resilience, and improve preparedness, response and recovery capabilities.

Network

In health care delivery and payment, a network consists of two or more providers who will deliver services in return for agreed-upon payment and cost-sharing amounts for patients who are covered under a particular health insurance plan or who are receiving services as part of a bundled or global payment.

New Jersey Division of Consumer Affairs

The Division of Consumer Affairs maintains 51 Professional and Occupational Boards and Committees that oversee and regulate more than 750,000 individuals and business in New Jersey.

Patient-Centered Medical Home

A Patient-Centered Medical Home is a primary care practice that is structured and operated consistent with a set of principles jointly developed by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA). The principles are:

- Personal physician – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.

- Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

- Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care, chronic care, preventive services, and end of life care.

- Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

- Quality and safety are hallmarks of the medical home: Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family; evidence-based medicine and clinical decision-support tools guide decision making; physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement; patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met; information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication; practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model; and patients and families participate in quality improvement activities at the practice level.

- Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework: It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit; it should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources; it should support adoption and use of health information technology for quality improvement; it should support provision of enhanced communication access such as secure e-mail and telephone consultation; it should recognize the value of physician work associated with remote monitoring of clinical data using technology; it should allow for separate fee-for-service payments for face-to-face visits (payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits); it should recognize case mix differences in the patient population being treated within the practice; it should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting; and it should allow for additional payments for achieving measurable and continuous quality improvements.

Patient-Centered Payment Model

The patient-centered medical home (PCMH) is a model of care in which patients are engaged in a direct relationship with a chosen provider who coordinates a cooperative team of healthcare professionals, takes collective responsibility for the comprehensive integrated care provided to the patient, and advocates and arranges appropriate care with other qualified providers and community resources as needed.

PCMH practices develop transdisciplinary care teams to improve care coordination and care management of patient populations aiming to improve safety, efficiency and quality in patient care. By becoming a recognized PCMH, practices can improve care delivery and take advantage of private or public incentive payments that reward patient-centered medical homes.

Payment Model

A "payment model" is a description of a method for paying providers for health care services. A payment model may define a methodology for determining the relative amounts that will be paid for different services or patients, rather than the exact dollar amounts that will be paid to a specific provider. A payment model is typically implemented through a contract between a payer and a provider that may include additional specifications regarding the patients who will receive services covered by the payment model, the parameters that will be used to convert the methodologies of the payment model into actual payment amounts, etc.

A payment model has four fundamental elements or building blocks:
- A definition of the services that will be covered by a single payment and the level of flexibility that the provider has in determining which services can be delivered.
- The mechanism(s), if any, for controlling utilization and spending.
- The mechanism(s), if any, for ensuring good quality and outcomes; and
- The mechanism(s) for ensuring adequacy of payment.

Primary Care

Primary care is the principal source of health care services for an individual, particularly preventive health care services.

Provider

The term "provider" means any individual or organization that furnishes, bills for, or is paid for health care services, including physicians, hospitals, skilled nursing facilities, home health agencies, etc.

Purchaser

Purchaser is a term used to describe an individual or organization that purchases health insurance or health care services on behalf of itself or individuals affiliated with it (e.g., its employees) using funds derived from its own business operations or deductions from the compensation paid to its employees, rather than health insurance premiums paid by others. A purchaser may pay providers for health care services directly or through a third-party payer, such as a health insurance company. For example, a self-insured employer is a purchaser, because the employer uses funds generated through its business operations to pay for health care services for its employees. The federal government's Medicare program is a purchaser because it uses general tax revenues to pay for a significant portion of services to Medicare beneficiaries.

Section 1115 Waiver

A Section 1115 waiver is a waiver granted by CMS to a state under Section 1115 of the Social Security Act to allow it to spend Medicaid funds in different ways than what would otherwise be required.

Social Determinants of Health (SDOH)

The World Health Organization (WHO) defines SDOH as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems.

Telehealth

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and landline and wireless communications.

Utilization

By patients: Utilization by a patient is the number of times the patient receives one or more services. For example, a patient who visits the emergency room frequently is said to have high utilization of emergency services.

By providers: Utilization by a provider is a measure of the number of times the provider delivers or orders a particular service for a group of patients. For example, a physician who orders imaging studies frequently is said to have high utilization of imaging studies.

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BioNJ is the life sciences trade association for New Jersey with nearly 400 Member companies representing research-based life sciences organizations and stakeholders across the ecosystem from the largest biopharmaceutical companies to early stage start-ups. BioNJ is dedicated to ensuring a vibrant ecosystem where Science is Supported, Companies are Created, Drugs are Developed and Patients are Paramount. Because Patients Can't Wait®, BioNJ supports its Members in the discovery, development and commercialization of therapies and cures that save and improve lives and lessen the burden of illness and disease to society by driving capital formation, fostering entrepreneurship, advocating for public policies that advance medical innovation, providing access to talent and education and offering a cost-saving array of critical commercial resources. For more information about BioNJ, please visit **www.BioNJ.org**.

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The New Jersey Health Care Quality Institute's (Quality Institute) mission is to improve the safety, quality, and affordability of health care for everyone. Our membership comes from all stakeholders in health care. Together with our 100 plus members, we are working towards a world where all people receive safe, equitable, and affordable health care and live their healthiest lives.