Moving Telehealth Forward in New Jersey

Opportunities to improve access to care and ease of use while leveling the playing field for New Jerseyans through telehealth

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The Nicholson Foundation

Changing Systems, Changing Lives

This report is a collaboration between **Knight Consulting, LLC** and **The Nicholson Foundation**.

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Executive Summary

New Jersey has the opportunity to build on lessons learned during the COVID-19 pandemic and become a national leader in the use telehealth—a position it had been moving toward even before the start of the public health emergency. To continue this expanded use, however, will require changes that include: eliminating the digital divide; establishing a private-public entity to advocate for statewide adoption of pertinent telehealth laws; educating healthcare providers working with vulnerable populations about the latest regulations that apply to telehealth; and adequately reimbursing providers for telehealth services that replace or complement in-person visits.

Telehealth use had been building for decades. However, its use in the United States had been mostly seen in rural areas until the COVID-19 pandemic necessitated a safer alternative to in-person visits to doctors and other healthcare providers. During the pandemic, telehealth use increased exponentially among all economic groups, but its distribution was uneven. Populations with limited access to healthcare services before the pandemic also tended to benefit less from telehealth during the pandemic.

The rapid increase in telehealth use during the pandemic was largely facilitated by federal and state waivers that quickly relaxed telehealth regulations and made it possible to meet the growing demand for virtual visits. These waivers expanded both the types of providers eligible for telehealth reimbursement and the number of sites where services could be accessed, most notably from patient homes. Reimbursement rates also were increased to be comparable to in-person visits, and penalties for failing to comply with privacy and confidentiality rules were relaxed.

In addition to these pandemic-related policy changes, an infusion of funds in New Jersey from government agencies and private foundations helped support existing and create new telehealth programs. These programs supported the purchase of needed equipment to provide telehealth services more efficiently; increased access to child and adolescent psychiatrists; delivered remote patient monitoring directly into more homes; connected more primary care providers to specialists via a nationally proven, virtual model; and adapted a recovery program focused on treating substance use disorders, from in-home to virtual services.

The increased use of telehealth resulting from all of these changes contributed to more efficient healthcare delivery. As noted, not everyone benefited equally. The pandemic also exposed and exacerbated preexisting inequities in access to quality healthcare services. Vulnerable populations were more likely to feel the effects of the pandemic than other groups and were generally less likely to receive timely healthcare services, including through telehealth. Disparities in availability and affordability of, among others, equipment, high-speed internet, and adequate broadband services contributed to this gap in service delivery. Temporary policy changes need to become permanent, and strategic investments in telehealth infrastructure must be made in order to capitalize on the advances in telehealth experienced during the pandemic.

The purpose of this report is to encourage the **strategic use of telehealth in New Jersey.**

Now is the time for New Jersey to become a leader in telehealth by ensuring its seamless delivery and sustainability. Telehealth adoption was accelerated during the COVID-19 pandemic, providing the opportunity to learn how this technology can be effective in meeting patient and provider needs. A key lesson learned is that some communities are less likely to benefit because they lack ample and adequate Wi-Fi, cellular, and technical infrastructures. Efforts are needed to promote equitable access through infrastructure funding, particularly for vulnerable populations in the state, and to ensure sufficient reimbursement for telehealth services.

Definitions

In this report, **telehealth** refers to a broad use of information and communications technologies (telephones, remote patient monitoring devices, and other electronic means) that support clinical healthcare, provider consultation, patient and professional health-related education, public health, health administration, and other services.

Within the broad definition of telehealth, the following are included:

Live (synchronous) video conferencing
Real-time, two-way audiovisual link between a patient and a healthcare provider or between providers to consult about a patient.

Store-and-forward (asynchronous) video conferencing
Recorded transmission of healthcare information, such as lab reports, imaging studies, videos, **e-consults**, and others between healthcare providers or between a patient and a provider.

Remote patient monitoring (RPM)
Electronically recorded and transmitted vitals and other medical data of a patient to a provider.

Mobile health (mHealth)
Transmitted health data or information sent through mobile devices to communicate, educate, and notify patients about appointments, health screenings, and disease outbreaks.

Telemedicine refers more specifically to the delivery of healthcare services from a provider to a patient at a different geographic location. In accordance with the provisions of New Jersey's 2017 telehealth law, telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

Telepsychiatry is a specific form of telemedicine comprising of psychiatric service provided by a psychiatrist or psychiatric advanced practice nurse (APN) from a remote location over secure, two-way, interactive audiovisual equipment.

Broadband refers to the variety of technologies that provide high-speed connections to the internet. It is offered through different media, including cable, fiber, and satellite.

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

Introduction

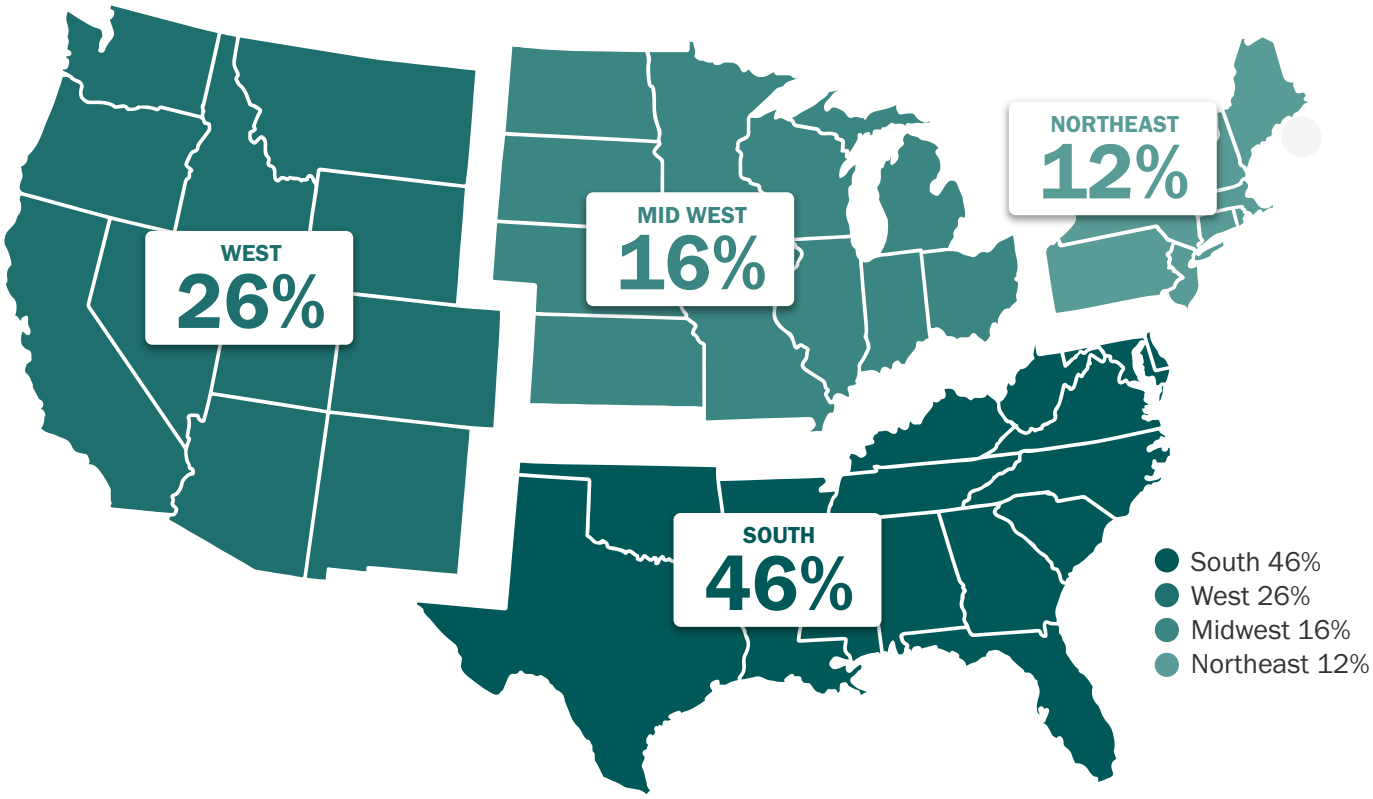
For decades, many rural and frontier areas of the United States have been using telehealth as a means of connecting healthcare providers with patients. This has occurred in spite of limited access to adequate communication networks and high equipment costs, particularly early on. The Northeast is the region of the country least likely to have adopted telehealth during the years before the COVID-19 pandemic (Figure 1). This in large part was due to the federal government historically prioritizing and funding rural areas of the country where distances to receive medical care, particularly specialty care, can be significant and prohibitive.

The field of telemedicine matured during the early 2000s and the framework for telehealth laws and regulations at both the federal and state levels was fairly well established by 2008. One study showed that there were already 382 statues and regulations specific to telehealth in 2008. The state of New Jersey, on the other hand, did not pass telehealth legislation until 2017, being one of the last states to do so.

A 2019 national survey by telehealth provider American Well showed that even before COVID-19, interest in telehealth services had increased across the country. Although only 8% of patients had used telehealth at the time of the survey, more than 60% were willing to use the technology, including for an initial consult. Individuals ages 18 to 34 years were the most open to using telehealth. However, all age groups were interested in using telehealth to meet various healthcare needs, including mental health issues, prescription refills, and urgent care. This included more than half of seniors (ages 65 years and older) willing to use telehealth.

FIGURE 1

Consumers who have used telehealth by region (2019)



When the COVID-19 pandemic hit, the use of telehealth accelerated nationwide. In one review of private healthcare claims data, from October 2019 to October 2020, telehealth claims skyrocketed nationwide by more than 3,000%. Not only was telehealth safer than in-person visits, but the technology also made it easier for patients to access medical services without compromising work, study, or child and elder care responsibilities. Telehealth use during the pandemic increased not just for safety reasons, but also because it was often the only option for patients.

The rapid increase in telehealth visits was seen across all age groups and patient conditions. In one analysis of data from January to June 2020 of approximately 17 million commercially insured and Medicare enrollees, visits increased by nearly 24% for those 65 years and older; and by 39% for those 30 to 39 years old. Across patient conditions, the percentage of visits provided through telemedicine ranged from 3% for glaucoma to 53% for depression. Telehealth was used at least once by the majority of specialists, including endocrinologists (67.7%), gastroenterologists (57%), neurologists (56.3%), pain management physicians (50.6%), psychiatrists (50.2%), and cardiologists (50.0%). Telehealth facilitated continuity of care when in-person visits were suspended during the COVID-19 pandemic, allowing for remote behavioral health visits, including across state lines. In one study, primary care providers indicated that telemedicine improved patient access through greater convenience, offered more time for counseling, allowed for better medication management, and increased the ability to connect with patients and families because they could see and evaluate their home environments. However, primary care physicians expressed concern that there were some patients with limited digital literacy, meaning that they were challenged in using technology. Physicians also expressed concern about the loss of personal physical connections, potentially weakening physician-patient relationships.

The Evolution of Telehealth in New Jersey

Understanding Federal and State Regulations

The federal Centers for Medicare and Medicaid Services (CMS) sets regulations for Medicare, a federal insurance program for people ages 65 years and older, and those with certain disabilities or end-stage renal disease, regardless of age. Medicaid, on the other hand, is co-regulated by CMS and individual states, with variable eligibility across states. Generally, Medicaid provides health coverage for children living in low-income households, people with disabilities, and, in some states, low-income adults below specific thresholds. Some people qualify for both programs. In 2020, there were 1,635,892 Medicare beneficiaries in New Jersey and, as of June 2021, there were 2,004,955 receiving Medicaid services.

For decades, Medicare has regulated and paid for telehealth services (largely in rural areas, pre-pandemic) as an alternative to traditional, in-person healthcare visits. Because of increased need during the COVID-19 pandemic, significant regulatory and policy changes at both the federal and state level took place, which allowed accelerated adoption of telehealth nationally, including in New Jersey.

The federal Medicaid statute does not recognize telehealth as a distinct service, but views telehealth as a delivery system. New Jersey, like other states, can therefore determine which specific telehealth services qualify for Medicaid reimbursement, their geographic reach, how they are provided, and the categorical types of providers who may provide them. States can also make changes to telehealth coverage without CMS approval, as long as covered providers are "recognized" and qualified according to Medicaid statutes and regulations, and reimbursements for services do not exceed upper limits set by CMS. A separate state plan amendment (SPA) for coverage or reimbursement is not required if a state Medicaid office elects to reimburse for telehealth services the same way and at the same rate as it does for face-to-face services, visits, and consultations. Otherwise, an SPA is required.

Telehealth Use in New Jersey Before 2017 Legislation

In response to concerns about the growing shortage of psychiatrists and psychiatric advanced practice nurses (APNs) in the state, New Jersey Medicaid created a program in December 2013, as permitted by CMS. The program allowed for the use of telepsychiatry at private practices and outpatient hospital settings, as long as 14 specific requirements were met. Few providers, however, embraced the program because the requirements were felt to be too cumbersome, and Medicaid did not reimburse for purchase of telecommunication equipment or "directly" for the service.

In spite of these challenges, Henry J. Austin Health Center (HJAHC), a Federally Qualified Health Center (FQHC), established telepsychiatry services in March 2014. HJAHC adapted an evidence-based model initially developed by Cherokee Health Systems (Knoxville, Tennessee). In this model, an in-person behavioral health consultant (BHC) is embedded within the primary care team. With funding from The Nicholson Foundation, HJAHC added a Florida-based, New Jersey-licensed psychiatric APN to the BHC to conduct telehealth visits with patients and provide consults directly to primary care providers located at multiple HJAHC sites.

Another organization that adopted the use of telehealth for mental health services was Catholic Charities, Diocese of Trenton (CCDoT), one of seven agencies in New Jersey chosen by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to expand services at their Certified Community Behavioral Health Clinics (CCBHCs). The CCBHC program started on July 1, 2017, just a few weeks before New Jersey enacted its telehealth law. CCDoT used the grant funding from SAMHSA to pilot an ambulatory detoxification program through the use of telehealth. This gave clients access to an after-hours behavioral health clinician, mitigating the risk of relapse when they left the physical setting. CCDoT was able to continue its telehealth services during the COVID-19 pandemic, eventually implementing a virtual exam room model. In this model, a community nurse uses computer tablets and technologically adapted medical tools (e.g., stethoscopes)

to transmit health information from a patient's home to a prescriber located elsewhere. This structure supports equitable access to healthcare services.

Beyond mental health services, Hackensack Meridian Health, the largest healthcare system in New Jersey, launched Convenient Care NOW in January 2016. This is a mobile application where patients with the financial means could access around-the-clock urgent care through their mobile devices, tablets, or computers. In December 2018, after passage of the 2017 telehealth law, Robert Wood Johnson Barnabas Health, the second largest healthcare system in New Jersey, launched a similar program, RWJBarnabas Health TeleMed®.

New Jersey was also one of the earliest adopters of remote patient monitoring (RPM). For example, the Visiting Nurses Association Health Group (VNAHG) of New Jersey had an RPM program as early as 2013, and the Hackensack Accountable Care Organization implemented a program in 2014.

Enacting New Jersey's Telehealth Law

The collective work around telepsychiatry, RPM, mobile applications and others ultimately led to the establishment of the New Jersey Telemedicine and Telehealth Law (P.L.2017, c.117), effective July 21, 2017.

Before 2017, HJAHC and CCDoT were among the few in the state to use telepsychiatry for Medicaid patients because of challenges with obtaining reimbursement and purchasing equipment, and strict technical and regulatory requirements set forth in the 2013 telepsychiatry program. The 2017 telehealth law eased some of the restrictive regulatory requirements. For example, it included a coverage parity portion, requiring payment for telehealth for covered services when medically appropriate, and requiring private payers to reimburse telehealth services "no more than" in-person rates. The law, however, also required that providers be licensed in New Jersey, that patients be located at the provider site when using telehealth, and that an initial in-person visit take place before the provider prescribe certain controlled dangerous substances. Of the nine Northeastern states, only New Jersey, Connecticut, and Maine included coverage parity in their telehealth laws.

Accelerating Telehealth Adoption Due to the COVID-19 Pandemic

In an effort to help the healthcare community prepare its response to COVID-19, Trump Administration Health and Human Services (HHS) Secretary Alex M. Azar II, declared a public health emergency for the United States, effective January 27, 2020. In March of the same year, Secretary Azar used section 1135 of the Social Security Act (SSA) several times to pass a number of blanket waivers for Medicare and Medicaid rules, and facilitate access to telehealth services. On March 6, 2020, CMS temporarily expanded access to telehealth for Medicare beneficiaries under the 1135 waiver authority and through the Coronavirus Preparedness and Response Supplemental Appropriations Act. Reimbursement for telehealth was now allowed for a greater number of provider types and more than twice as many services. Locations from where telehealth could originate from were also expanded beyond medical facilities to include patient homes. Reimbursement had parity with in-person visits, and penalties were no longer imposed for noncompliance with Health Insurance Portability and Accountability Act (HIPAA) rules. The expansion obviated the need for providers to apply for individual waivers.

Before the public health emergency, approximately 13,000 beneficiaries in fee-for-service (FFS) Medicare received telemedicine services, weekly. An internal CMS analysis of Medicare FFS claims data from March 12, 2020, through June 13, 2020, revealed that during the last week of April 2020, that number jumped to nearly 1.7 million. It was also found that 22% of rural beneficiaries used telemedicine services, compared to 30% of urban beneficiaries. This was significant in that pre-pandemic telehealth use was more common in rural areas.

In an analysis of data from a Medicare beneficiary survey administered from June 10, 2020, through July 15, 2020, disparities in telehealth use were identified by region, race, income, internet access, and number of chronic conditions, among others. For example, beneficiaries from the West and Midwest were more likely to report that their usual providers offered telehealth more often than those from the South. Beneficiaries who reported an income level below $25,000 were less likely to report that their usual providers offered telehealth than those whose income was higher. Non-Hispanic White beneficiaries were one and one-half times more likely than non-Hispanic Black beneficiaries to have their usual providers offer telehealth in lieu of regularly scheduled appointments. Having more than one chronic condition was also associated with a greater likelihood of having usual providers who offered telehealth to replace a regularly scheduled appointment.

HHS must officially renew the public health emergency, a status that allows many of the waivers and expansions for telehealth that have occurred since the COVID-19 pandemic began in March 2020 to remain active. Each renewal extends the public health emergency an additional 90 days. It has been extended at least five times, most recently by President Biden's HHS Secretary Xavier Becerra, on July 19, 2021, extending it another 90 days.

Following the national declaration, states, including New Jersey, followed suit. On March 9, 2020, New Jersey Governor Phil Murphy declared a public health emergency for the state. On March 19, 2020, he signed the time-limited Telemedicine and Telehealth Bill A3860, waiving pre-pandemic restrictions around Medicaid reimbursement for telehealth for the duration of the state's public health emergency. This even included allowing out-of-state healthcare providers to offer telehealth services. Services could also be provided from any location, and patients could receive them from their homes. Providers could now be reimbursed at the same rate as for in-person visits. Verbal patient consent could be used in place of written consent. On March 20, 2020, the New Jersey Division of Consumer Affairs, Office of the Attorney General, and Department of Banking and Insurance together released a bulletin announcing relaxation of HIPAA rules, regulations, and patient consent requirements for telehealth within the state, and applying the same standard of care as for in-person visits. Prior review of a medical record would not be required during a telehealth visit. New legal protections and immunity for providers were established.

A number of the state's healthcare professional boards also issued licensing waivers that facilitated greater telehealth access during the pandemic. The New Jersey Medicaid Office temporarily relaxed telehealth rules on March 21, 2020, including waiving site-of-service requirements, removing restrictions for the use of alternative technologies for telehealth, and not imposing penalties for noncompliance with HIPAA rules. The New Jersey State Board of Medical Examiners (BME), adopted regulations implementing the 2017 telehealth law during the pandemic, specifically on April 20, 2020. BME oversees physicians, podiatrists, certified nurse midwives, acupuncturists, athletic trainers, bioanalytical lab directors, physician assistants, electrologists, hearing aid dispensers, and perfusionists. Other professional boards or committees within those boards oversee social workers, veterinarians, psychologists, art therapists, nurses, audiologists, orthotic and prosthetic professionals, physical therapists, and psychoanalysts. They, too, have adopted regulations implementing the 2017 telehealth law. As of March 15, 2021, the State Board of Dentistry; State Board of Marriage and Family Therapy Examiners, Alcohol and Drug Counselor Committee; State Board of Respiratory Care; and Occupational Therapy Advisory Council were reviewing public comments submitted in response to their respective proposed telehealth regulations. As of August 31, 2021, a Telehealth Review Commission, mandated by the 2017 telehealth law, had yet to be appointed.

Governor Murphy terminated the public health emergency in New Jersey on June 4, 2021, when he signed into law P.L.2021, c.103 and through Executive Order 244. However, P.L.2021, c. 103 also extended administrative orders, directives, or waivers that relied on the existence of the public health emergency until January 11, 2022. This means that agencies can continue or modify such orders, directives, or waivers around telemedicine until then, unless they are explicitly revoked. In addition, the legislation further authorized the Governor to seek an additional 90-day extension of such orders, directives, or waivers, which request may be granted by a concurrent resolution passed by the legislature. As of August 31, 2021, the state telehealth waivers were still in place, as permitted by P.L.2021, c. 103. The federal waivers instituted by CMS will continue with regard to Medicare and Medicaid beneficiaries until the federal government withdraws the national public health emergency.

Even with the national and state waivers, a challenge for wide adoption of telehealth persisted early in the pandemic. Many providers interested in incorporating telehealth into their practice could not afford to buy the necessary equipment, did not have technical expertise or support, or lacked clarity about reimbursement policies. The congressional Coronavirus Aid, Relief, and Economic Security (CARES) Act, passed on March 25, 2020, included $200 million for the purchase of telecommunication and information services, and necessary equipment by non-profit Medicaid providers to connect healthcare providers with patients at their homes or through mobile devices. The Federal Communications Commission (FCC) began accepting applications for the program on April 10, 2020.

New Jersey providers took advantage of the opportunity with 27 organizations receiving a total of more than $8.5 million (Table).

TABLE

New Jersey Organizations Who Received FCC Telehealth Program Round One Relief Funds

RECIPIENT ORGANIZATION	LOCATION	AMOUNT AWARDED	AWARD DATE
Parker Health Group	Piscataway	$ 28,838	5/6/2020
Adult Services (Preferred Behavioral Health Group)	Lakewood	$ 420,675	5/20/2020
Cooper University Health	Camden	$ 506,284	5/20/2020
Hunterdon Drug Awareness Program	Flemington	$ 37,571	5/20/2020
Irvington Counseling Center	Irvington	$ 17,124	5/20/2020
Rutgers Community Health (Suzanne Salamanca)	Newark	$ 21,434	5/20/2020
St Joseph's Hospital and Medical Center, Inc.	Paterson	$ 472,059	5/20/2020
Ocean Health Initiatives (Lakewood Health Center)	Neptune	$ 782,629	5/28/2020
Resource Center for the Chemically Dependent Inc.	Denville	$ 19,750	5/28/2020
United Methodist Communities at the Shores	Neptune	$ 909,560	5/28/2020
Vantage Health System, Inc.	Dumont	$ 34,856	6/3/2020
Mental Health Association of Essex and Morris, Inc.	Montclair	$ 39,959	6/3/2020
Berkeley Center	Bayville	$ 58,336	6/10/2020
Care Plus NJ	Paramus	$ 442,361	6/17/2020
Morristown Medical Center	Morristown	$ 827,637	6/17/2020
SERV Behavioral Health Center	Clifton	$ 37,193	6/17/2020
Henry J. Austin Health Center	Trenton	$ 223,485	6/17/2020
Family and Children's Services	Elizabeth	$ 14,253	6/17/2020
Family Connections	East Orange	$ 347,358	6/24/2020
Lawrence County Health Department - Behavior	Parsippany	$ 37,308	6/24/2020
Salem Home	Parsippany	$ 16,079	6/24/2020
Atlantic Health System, Inc.	Morristown	$ 499,800	6/24/2020
Hackensack University Medical Center	Neptune	$ 973,055	6/24/2020
The Osborn Family Health Center	Camden	$ 204,603	6/24/2020
Youth Development Clinic of Newark	Newark	$ 9,250	6/24/2020
Barnabas Health Medical Group	West Orange	$ 784,200	7/1/2020
Southern Jersey Family Medical Centers	Burlington	$ 937,755	7/1/2020

An additional $250 million from the federal government for rural and underserved areas was made available for COVID-19-related telehealth services as part of the Consolidated Appropriations Act, 2021, passed on December 27, 2020. The FCC issued an Order and Report on February 2, 2021, stating that this appropriation was the next step toward committing funding through the existing COVID-19 Telehealth Program, further emphasizing that the ongoing COVID-19 pandemic had caused unprecedented stress on the nation's healthcare system. On August 26, 2021, the FCC awarded an initial $42 million of the $250 million for its COVID-19 Telehealth Program. Neighborhood Health Services Corporation, an FQHC located in Plainfield, New Jersey, was one of the 62 applicants awarded funding. Neighborhood Health Services Corporation will use its $491,308 to purchase remote patient monitoring devices that are Bluetooth enabled.

To support broadband connectivity, network equipment, and information services, another $100 million was made available by the FCC through its Connected Care Pilot Program. Funds came from the Universal Service Fund. The program covers up to 85% of costs and does not fund end-user devices or medical equipment. As of June 17, 2021, more than $57 million had been awarded to 59 telehealth projects in 30 states and Washington, D.C. New Jersey was not one of the states.

Foundations have also supported the use of telehealth in New Jersey during the pandemic. For example, on April 30, 2020, Novartis US Foundation committed $2 million to the New Jersey Primary Care Association (NJPCA) to provide primary and specialty care, including mental health services, to uninsured and underinsured residents through a novel digital care model. NJPCA selected five FQHCs with pre-existing programs and plans to expand those capabilities—CAMcare Health Corporation (Camden County), Henry J. Austin Health Center (Mercer County), Metropolitan Family Health Network (Hudson County), Monmouth Family Health Center (Monmouth County), and Zufall Health Center (Dover County). The grant expedited the development of this digital care model.

Examples of New Jersey Telehealth Programs

The following programs are examples of **four different telehealth models** currently making a difference in New Jersey.

The COVID-19 pandemic accelerated their use while also demonstrating the value of telehealth during non-pandemic times. They were chosen to illustrate the broad range of ways in which telehealth can be incorporated and tailored to best address the specific needs of different patient populations.

1 Increasing Access to Pediatric Mental Healthcare Through Telepsychiatry

NEW JERSEY PEDIATRIC MENTAL HEALTH CARE ACCESS PROGRAM, THE NEW JERSEY CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

Approximately one in five U.S. children, ages 3 to 17, has a mental health disorder. Fifty percent of all psychiatric illness occurs before the age of 14, and 75% present by the age of 24. Yet, there are still only 9.75 child psychiatrists per 100,000 children (ages 0 to 19 years), a woefully inadequate number. The ratio (12.5) in New Jersey is higher than the national average, but, like the rest of the country, child psychiatrists are more likely to practice in high-income communities, counties with higher levels of post-secondary education, and metropolitan counties compared to other areas. Of the 21 counties in New Jersey, 14 are designated Mental Health Professional Shortage Areas by the federal Health Resources Services Administration (HRSA).

With funding from the New Jersey Department of Children and Families, the New Jersey Pediatric Psychiatry Collaborative (NJPPC) was established as a pilot program in 2014 by Hackensack Meridian Health (HMH) to address the shortage and uneven distribution of child and adolescent psychiatrists (CAPs) in New Jersey. Through NJPPC, pediatric primary care providers (PCPs) conduct behavioral health screenings and refer at-risk patients to CAPs located at one of nine regional hubs, managed by four health systems (Atlantic Health System, Cooper University Health Care, HMH, and Rutgers Health). CAPs provide free, in-person evaluations, diagnostic clarification, and medication consultation, and work with licensed social workers and counselors who facilitate referrals to appropriate community programs when, for instance, long-term mental healthcare is needed. Despite the collaborative expanding from the original two hubs (covering four counties) to nine hubs (covering all 21 counties) in its first three years, access to CAPs remained a challenge for at least two reasons: inconsistent staffing by CAPs because of a national shortage; and lack of transportation by many patients and families.

In 2018, the New Jersey Department of Health applied for and was awarded a five-year grant from HRSA to layer telepsychiatry on top of the in-person CAP services. The New Jersey Chapter, American Academy of Pediatrics (NJAAP) administers the grant, called the New Jersey Pediatric Mental Health Care Access Program (NJPMHCAP). The Nicholson Foundation provided matching funds during the first two years of the grant, with NJAAP using in-kind dollars in subsequent years.

In the initial year of the HRSA grant, the program began to pilot telehealth where patients located at their pediatric PCP's office were connected to CAPs through live video conferencing at three of the nine hubs. Beginning in March 2020, as closure of offices began because of the COVID-19 pandemic and as allowed by federal and state waivers, patients were able to receive CAP telehealth services directly from their homes. By April 2020, all nine hubs were providing telehealth services as the NJPMHCAP team worked with each hub to implement videoconferencing software and by providing additional equipment to the CAPs, when necessary. Between April and August 2020, almost all CAP services were conducted through telehealth. During the fourth quarter

1 Increasing Access to Pediatric Mental Healthcare Through Telepsychiatry (cont.)

of 2020, as offices began to reopen, the NJPMHCAP team resumed providing the required equipment to pediatric PCPs. The additional equipment allowed PCPs to increase the number of virtual services they received from CAPs, including on-call consults (presentation of specific patient cases by pediatric PCPs), patient-specific treatment plans, and didactic learning sessions.

Results from the HMH Telehealth Year Two Evaluation (Kelley Analytics, October 2020) indicated that more than 50% of CAP assessments were conducted by telehealth from October 1, 2019, to September 30, 2020. The three most common consults were for anxiety (53.1%), depression (36.5%), and attention issues (24.0%). Pediatric PCPs who were "high" users of telepsychiatry assessments were more likely than "low" users to receive results from the CAP in a timely manner, manage medication appropriately, and discuss the results with CAPs. Both pediatricians and CAPs rated the telepsychiatry component highly on a number of outcomes, including increased and timelier access to mental health services, and improvements in the appropriateness of referrals. They urged that expediting access to CAP evaluations, through the scheduling of telepsychiatry appointments between patients and CAPs from either their PCP offices or patient homes, continue after the waivers were lifted.

In addition to the positive reports, some users also noted problems in using this telepsychiatry service. Some families, for instance, had limited or inadequate Wi-Fi access, poor cellular service, insufficient plan minutes on their mobile devices, or technical challenges connecting. Patients living in underserved or vulnerable communities and those with high Medicaid populations tended to experience these challenges more often than others. Providers, for their part, expressed concern that pediatric exam rooms being used for telepsychiatry reduced space availability and thereby limited the number of patients they could see in-person.

In spite of these and other challenges, the addition of telepsychiatry provided a safe alternative for mental health services during the COVID-19 pandemic and increased access to CAPs, particularly those living in communities with limited transportation options. In the midst of the pandemic, families generally found that telepsychiatry was less constraining than in-person visits and met their needs to balance work, their children's education, and visits to pediatrician offices. Telehealth was reported to strengthen trust between families and providers because it improved continuity of care.

> *"The COVID-19 pandemic caused psychological effects on children, such as an increased likelihood to experience worry and anxiety, as well as a fear of dying, a fear of relatives dying, and a fear of what it means to receive medical treatment. Additionally, with the immediate closure of New Jersey schools in mid-March 2020, many children experienced a traumatic loss of academic and social structure and stimulation provided by an in-person educational environment. They also had fewer opportunities to spend time with their friends and receive social support essential for good mental well-being. NJPMHCAP has become more than just a supplemental part of the hub program; it has become an essential part to ensure that all children have the same access to care across the entire state. Without the telehealth network, the hub's ability to conduct evaluations would have been severely hampered at a time when it was needed most."*
>
> *—Steven Kairys, MD, MPH, Founding Chair of Pediatrics, Hackensack Meridian School of Medicine, K. Hovnanian Children's Hospital, Jersey Shore University Medical Center, Hackensack Meridian Health. Dr. Kairys also serves as NJAAP Medical Director and Co-Principal Investigator, NJPPC.*

2 Bringing Healthcare into Homes Through Remote Patient Monitoring

THE CONNECTED HEALTH INSTITUTE, VISITING NURSE ASSOCIATION HEALTH GROUP

Patients in need of transitional care when leaving the hospital are typically taken care of by a home health agency. Patients and families usually select the agency based on prior experience, geography, or other value-added factors. Home healthcare typically lasts between 30 to 60 days, depending on the patient's health plan coverage. The standard home health agency's reimbursement for the duration of care is generally limited to the cost of patient visits over an episode of care, usually administered by a nurse or therapist (e.g., physical, occupational) making one or two in-home visits weekly, with additional follow up by phone. Although this care model provides a good transition for the patient when they return to their home after hospitalization, weekly monitoring is often insufficient.

To bridge this gap, remote patient monitoring (RPM) is used throughout the country by home health agencies on high-risk patients. RPM allows for accurate, round-the-clock recording and tracking of vital signs and other measurements. However, public and private payers usually do not cover the costs of home-based equipment.

In spite of not receiving financial reimbursement from insurers, the Visiting Nurse Association Health Group (VNAHG), a leading New Jersey home health agency, formed the Connected Health Institute (CHI) in 2015. CHI develops, tests, and uses RPM technologies, such as Bluetooth-connected peripheral devices that record patient health and medical data at home and transmit them to VNAHG staff at remote locations. The RPM platform includes a user-friendly dashboard, which integrates real-time data with electronic medical record systems (EMRs) and alerts providers when data are outside of expected values or when patients do not use telehealth equipment appropriately or as scheduled. Through this model, one nurse can manage up to 200 patients remotely, complementing scheduled in-person visits and notifying field staff when additional visits are necessary.

VNAHG absorbs the costs internally with the belief that, over time, demonstrating improved outcomes with fewer resources will eventually motivate insurers to reimburse for both equipment costs and the remote visits themselves. Nonetheless, despite the substantial number of patients who could potentially be served by RPM, the costs of the equipment has limited how many VNAHG patients can receive a telehealth "kit" that includes a digital scale, blood pressure monitoring devices, and a pulse oximeter (to measure blood oxygen level). Once the kit is set up in the patient's home and tested, RPM is used to do the following: monitor for chronic disease exacerbation and educate patients to improve chronic disease management (e.g., congestive heart failure, pneumonia, hypertension, and chronic obstructive pulmonary disease); assess medication adherence, daily weights, physical activity, and signs and symptoms; prevent avoidable hospitalizations and unnecessary emergency department visits; and maintain compliance with professional, regulatory, and accrediting standards of practice.

> *"I supported this initiative as a telehealth project manager for the deployment of the prior generation of telehealth kits used by the VNAHG for this project. During this time, I was able to have hands-on access to the patient home setting to observe any barriers and obstacles in the home, including dead zones for cell service, delivery and set up of equipment, the difficulty for some patients to use the vitals monitoring devices, etc. On a positive note, I was able to observe the differences in quality of care between patients lucky enough to be placed in the telehealth program compared to those that were not."*
>
> *—Michael Relli, Principal, Knight Consulting, LLC*

2 Bringing Healthcare into Homes Through Remote Patient Monitoring (cont.)

A six-month pilot program in 2017 evaluated the effectiveness of the telehealth kits among patients (Figures 2 and 3). Half of the participants received the kits, the other half did not. Of those patients given the kits, 84% used the included devices, as intended. Hospital readmission rates were 30% lower for the group with the kits. Improvements in activities of daily living (ADLs) were significantly higher for those receiving the kits in three of six categories: ambulation; bathing; and adherence to oral medications.

FIGURE 2

Impact of Telehealth on 30-day All Cause Hospitalization Rates

% of Patients hospitalized in first 30 days of Start of Care

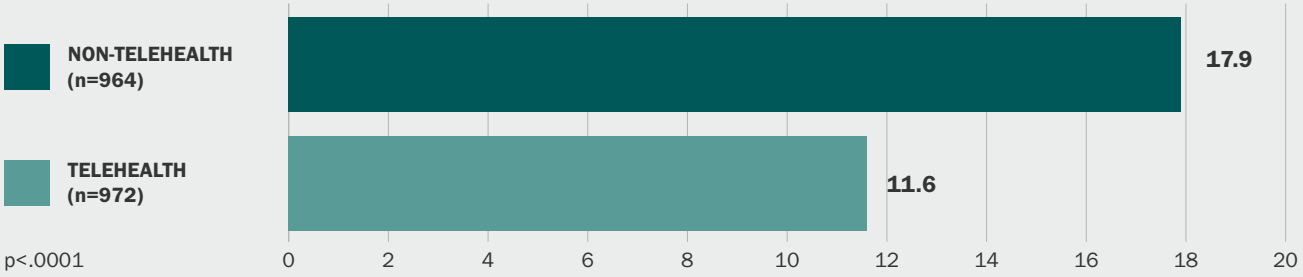
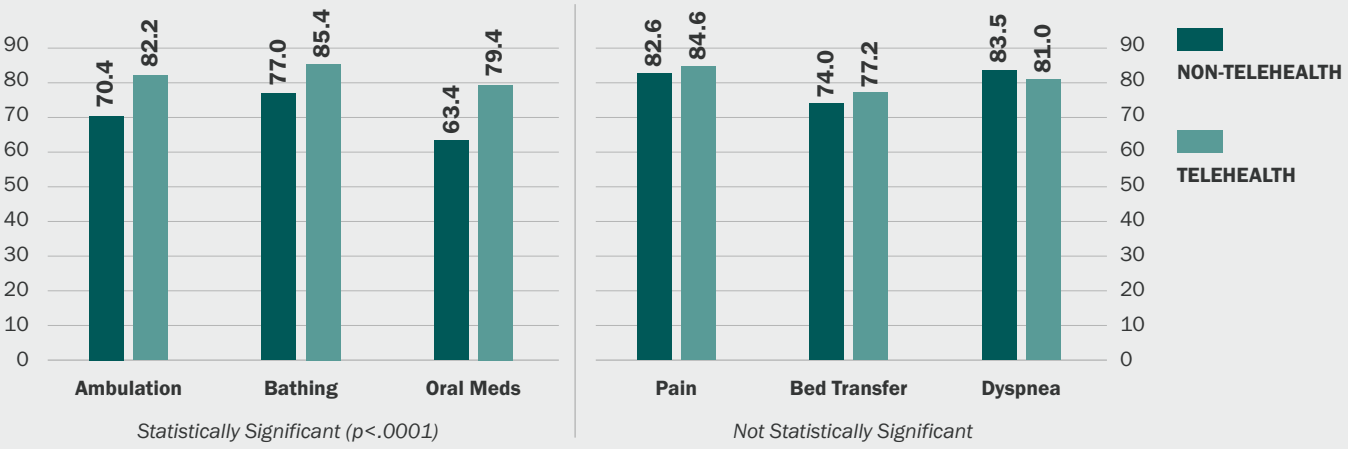


FIGURE 3

Impact of Telehealth on Change in ADLs from Start of Care to Discharge

% of Patients with Improvement in ADL



Figures 2 and 3 represent data from: Robert J. Rosati, Tami M. Videon and Stephanie Kozakowski. The Impact of Remote Patient Monitoring of Home Health Care Patients with Heart Failure: Pilot Study, *International Conference on Home Health, Hospice and Information Technology (H3IT), October 6, 2018, Grapevine, Texas.*

2 Bringing Healthcare into Homes Through Remote Patient Monitoring (cont.)

In part, driven by these outcomes and similar programs nationwide, CMS began allowing home health agencies to include RPM expenses on their cost reports for their Medicare patients in 2019. Although this did not provide a direct payment for services, it did help offset some of the telehealth-related expenses.

At the onset of the COVID-19 pandemic in early 2020, CMS and private insurance plans approved the use of virtual home visits for reimbursement when they were part of a patient's care plan and if physician-authorized. Virtual visits do not typically include RPM but may use some of the same technology and software platforms for communication with the patient—for example, a tablet supplied to the patient and back-end software for clinicians to schedule and conduct the visits. The change was made permanent by the end of 2020. For Medicare patients, this meant that virtual home visits were considered equivalent to in-home visits and could therefore be counted toward the overall number of required visits during a 60-day period. However, the virtual visits had to be on the plan of care and could not count as part of the minimum number of visits necessary to avoid a Low Utilization Payment Adjustment.

While CMS allows home health agencies to report telehealth equipment expenses on their cost reports, the agencies are not directly reimbursed for RPM services. During the pandemic, some reimbursement was provided for virtual home visits, but not RPM. Other practitioners (physicians, nurse practitioners and physician assistants) who are eligible to furnish evaluation and management services can bill for RPM services for Medicare patients who have chronic and acute conditions (pre-pandemic, this was limited to established patients).

3 Connecting Primary Care Providers to Specialists Through Telemedicine

RUTGERS PROJECT ECHO, RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL

In 2003, Sanjeev Arora, MD—a liver disease specialist at the University of New Mexico (UNM) Health Sciences Center in Albuquerque, New Mexico—launched the first Extension for Community Health Outcomes (ECHO) clinic, connecting with rural primary care providers (PCPs) in the state to provide care for patients with complex health problems, such as infection with the hepatitis C virus (HCV). Through videoconferencing, PCPs presented specific cases to Dr. Arora and other specialists who would, in turn, provide case-based education and training on the management of this curable disease. It proved effective: A study published in the *New England Journal of Medicine* in 2011 demonstrated that treatment by PCPs at 21 ECHO rural and prison sites throughout the state was as good as that provided by specialists at the UNM clinic, as measured by blood HCV levels.

Since its inception, Project ECHO has grown to 920 programs run out of 423 global hubs in 44 countries. Although they include programs like the one developed out of UNM, many go beyond individual case presentations and are lecture-based sessions. Examples of current sessions include those focused on chronic pain management, substance use disorders, behavioral health, dermatology, and, more recently, COVID-19.

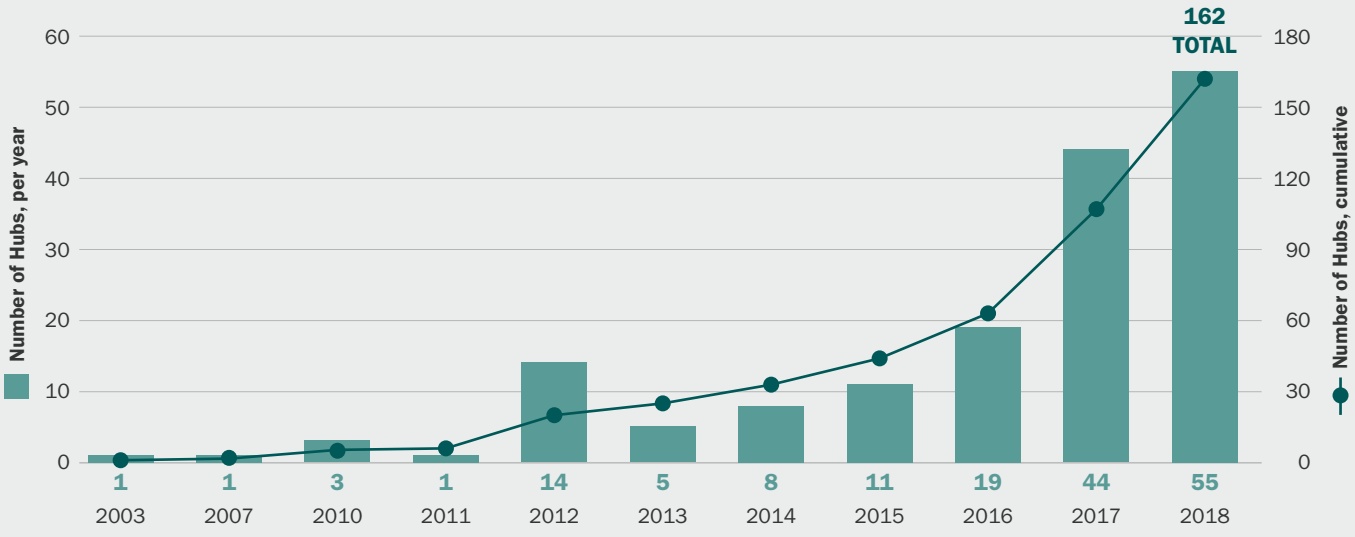
Forty-eight U.S. states participate in Project ECHO, and the number of hubs launched each year nationwide has steadily increased between 2003 and 2018, with a cumulative total of 162 programs in 2018 (Figure 4).

At least three Project ECHO hubs are based in New Jersey, including Rutgers Project ECHO, Trinitas Regional Medical Center, and the New Jersey Chapter, American Academy of Pediatrics. Healthcare providers in the state can participate in these hubs or others worldwide, depending on availability and costs. Among out-of-state hubs used by providers in New Jersey is the Connecticut-based, Weitzman Institute ECHO, operated by Community Health Centers, Inc., the first Federally Qualified Health Center (FQHC) to run its Project ECHO clinics under the Institute.

The Nicholson Foundation initially funded the Weitzman Institute in 2014 to bring a Project ECHO program to FQHCs and other primary care providers in New Jersey, specifically to address pain management and opioid

FIGURE 4

ECHO Hub Launches in the United States by Year



Counts of hubs launched by year, 2003-2018. Bars capture the number of new hubs launching in a year and the line captures the cumulative total of launched hubs.

3 Connecting Primary Care Providers to Specialists Through Telemedicine (cont.)

addiction. The Weitzman ECHO has been supported over the years by two state agencies and other private foundations, including The Mayday Fund, The Wallace Foundation, The Pfizer Foundation, and Vertex.

In the fall of 2016, The Nicholson Foundation funded the start of Rutgers Project ECHO with three initial clinics on complex endocrinology, pediatric behavioral health, and chronic pain. These clinics supported efforts to improve care within New Jersey's Medicaid and underserved populations. Since then, with additional funding from the The Nicholson Foundation, the United Healthcare Foundation, the New Jersey Department of Health (NJDOH), the New Jersey Department of Human Services (NJDHS), Rutgers New Jersey Medical School, and a grant from the University of New Mexico (which was awarded a national grant from the Agency for Healthcare Research and Quality to support nursing homes during COVID-19), Rutgers Project ECHO has been able to expand beyond its three original programs. Added programs focus on the following: maternal child health and opioid use; postpartum response and care; substance exposed infants; adverse childhood experiences; community health worker and doula training; substance use disorders; nursing home COVID-19 protocols; and health equity and social justice. From 2020 to 2021, more than 12,000 participants have attended one or more of these ECHOs. The programs have consistently maintained high satisfaction scores (above 95%) and demonstrated significant increases in learning and use of evidence-based guidelines. In addition, 300 nursing homes with over 1,100 participants have attended the Rutgers Project ECHO nursing home program and 64% have attended 13 or more of the 16 sessions.

In response to the pandemic, a special series was developed for NJDOH, NJDHS and the New Jersey Office of the Attorney General's Division of Consumer Affairs to provide rapid dissemination of information on COVID-19. The case-based COVID-19 learning sessions updated key stakeholders statewide about policy, rules, and regulations around the virus and infectious disease control in near real-time. In 2020, a total of 27 COVID-19 sessions were held with approximately 15,000 unique participants attending an average of three sessions each.

The Nicholson Foundation also funded an e-consults pilot program. This program enabled PCPs to conduct secure HIPAA compliant electronic consultations directly from electronic medical records (EMRs) to specific Rutgers Robert Wood Johnson Medical School subspecialty groups.

Developing and sustaining programs has been challenging, in large part because insurance payers rarely reimburse them. Most hubs in the United States rely on time-limited philanthropic or government grants. Some charge PCPs for their use. In some instances, programs, or entire hubs, have closed at the end of grant funding. However, Rutgers Project ECHO has been able to develop meaningful partnerships across the state and maintain ongoing funding of its program.

Recent federal legislation, however, supports further evaluation of Project ECHO and considerations for reimbursement. For example, in December 2016, the ECHO Act was passed by Congress with strong bipartisan support and was signed into law. The ECHO Act directs the Secretary of Health and Human Services (HHS) to examine the ECHO model and identify methods for reducing barriers to further adoption, particularly in medically underserved and rural areas. Topical areas of interest include mental and substance use disorders, chronic diseases and conditions, prenatal and maternal health, pediatric care, pain management, and palliative care. On May 22, 2019, three Democratic senators introduced the ECHO 2019 Act, which, had it passed, would have provided grants and technical assistance to develop and evaluate technology-enabled collaborative learning and capacity building models—like the Project ECHO model—across the United States. The grants would have been used for the purchase of equipment, curriculum development, evaluation, and direct support to healthcare providers. On September 25, 2019, two dozen senators sent a letter asking HHS to explore ways to support the Project ECHO model within existing means of authority. The letter made two specific requests: issue guidance to states on financing strategies currently available through Medicaid that could be used to support technology-enabled collaborative learning and capacity building models like Project ECHO; and explore opportunities available under Medicare.

4

Supporting Substance Abuse Recovery Through Live Video Conferencing

THE IN-HOME RECOVERY PROGRAM, PREFERRED BEHAVIORAL HEALTH GROUP

In January 2020, Preferred Behavioral Health Group (PBHG) launched the In-Home Recovery Program (IHRP) in Ocean County, New Jersey, building on the success of a treatment model developed at Yale University and implemented in Connecticut and Pennsylvania. IHRP is a multipronged, two-generation, trauma-informed program that supports parental substance use disorder (SUD) recovery, healthy attachment, family stability, and positive child development. The objective is to keep children in their homes while their parents receive treatment. Families are referred through the Division of Child Protection and Permanency, New Jersey Department of Children and Families. IHRP provides enrolled individuals and families SUD treatment, child/parent counseling, and therapy through teams of licensed clinicians, family support specialists, and psychiatrists. Families are also connected to community resources, can participate in weekly social support groups (Social Club), and have around-the-clock access to counselors for crisis and emergency management. In-home visits by the teams are conducted three times per week. Enrolled individuals are tested for drug use at regular intervals. Clients can participate with IHRP for up to one year. The average length of participation is seven months.

Due to the COVID-19 pandemic and declaration of the public health emergency, on March 18, 2020, PBHG replaced in-person home visits with virtual ones, connecting program participants with providers through live video conferencing. To preserve the integrity of the program, PBHG adapted the virtual visits to emulate the in-person ones, to the extent possible. For example, they integrated an automated management tool into their electronic medical record system, allowing for remote collection of signed consent forms. Regular toxicology screening also continued with urine samples collected at clients' homes, before and after weekly telehealth sessions. Although it was not possible to supervise sample collection, PBHG developed a protocol that ensured compliance and accuracy. And families participating in Social Club joined through Skype to meet and share a delivered meal, just as they had done during in-person gatherings.

Between January 1, 2020, and May 1, 2021, IHRP had enrolled 36 families, with 80% successfully completing the program. Three-quarters of original enrollees were able to continue in the program through the virtual format. One-quarter were challenged by not having the necessary telehealth equipment or had inadequate internet/Wi-Fi access. PBHG provided those families with smartphones, high-speed internet services, and other equipment to ensure their continued participation.

As the first wave of the pandemic slowed down, some families returned to in-person visits, while others continued to use the virtual option. The program eventually evolved to one where families could choose all in-home, all telehealth, or a combination for their weekly visits.

The IHRP virtual format was not covered under the original grant, but The Nicholson Foundation provided a bridge grant to PBHG to be able to pivot to telehealth, quickly. The bridge fund was also used to procure services from DynamiCare Health, which now sends saliva swab testing kits directly to family homes in lieu of the urine samples. PBHG is working to further modify the workflow by leveraging a mobile health offering from DynamiCare Health, in which the saliva test can be video recorded using app-based technology.

Recommendations

The COVID-19 pandemic accelerated the already increasing use of telehealth in New Jersey and nationwide. During this public health emergency, federal and state government moved swiftly to relax regulations regarding telehealth and licensing and to reimburse for telehealth services at the same rates as for in-person visits. Relaxed regulations allowed for the use of alternative communications platforms, eliminated prior authorizations, removed preexisting restrictions for establishing doctor-patient relationships, and **in some cases reduced or even abolished cost-sharing requirements**. Simultaneously, building on decades of advancements in the telecommunications field, increasingly reliable, more affordable, and user-friendly software became more readily available. The result was an exponential increase in the overall use of telehealth and a more efficient healthcare system. Certainly, some clinical circumstances demand in-person visits, but the pandemic highlighted that patient outcomes, and provider and patient satisfaction can be improved when telehealth is incorporated strategically into healthcare delivery.

However, the pandemic also exposed and exacerbated preexisting inequities in access to quality healthcare services. Vulnerable populations were more likely to feel the effects of the pandemic than other groups, and less likely to receive timely healthcare services, including through telehealth. Contributors to unequal access to telehealth included disparities in availability and affordability of the following: high-speed internet; adequate broadband services; sufficient minutes for data, audio, and voice services; and smartphones, tablets, computers, and other equipment. Limited digital literacy, often an issue for people ages 65 years and older, but also for lower income individuals regardless of age, was another contributing factor.

Implementing the following recommendations can lead to a healthier New Jersey:

Eliminate the digital divide.

Eliminating the digital divide in New Jersey will entail strategic investments in broadband infrastructure, which allows for access to and affordability of up-to-date technology for all residents. The state of New Jersey therefore should do the following to eliminate the digital divide:

Develop a heat map to identify communities in New Jersey lacking adequate connectivity to high-speed internet, including senior and public housing.

Look to national models to develop and implement innovative programs to bring reliable, high-speed internet access to those currently lacking it. For example, the state of Delaware is currently evaluating the use of telehealth kiosks within public libraries to help low-income residents access health and social services.

Identify and secure available federal dollars designated for increasing telehealth access in underserved suburban and urban areas in addition to rural areas and connecting patients to healthcare services through equipment purchases. Recent examples include funds made available through the Consolidated Appropriations Act of 2021, the Federal Communications Commission COVID Telehealth Program, and the Connected Care Pilot Program.

Give healthcare providers, particularly those working with vulnerable populations, the technical assistance they need to succeed when using technology.

Partner with private telecommunications companies to connect communities to existing programs that address technological infrastructure, data collection and analysis, and disparate socioeconomic issues. Examples include Verizon's Citizen Verizon and Connected Smart Cities and Communities, and Comcast's "Lift Zones."

Establish a private-public telehealth collaborative entity to advocate for statewide adoption of pertinent telehealth laws.

In recent years, some states have established and funded telehealth entities to advocate for its use and educate about its benefits. Although the state's 2017 telehealth law required the New Jersey Department of Health to establish a Telemedicine and Telehealth Review Commission, it does not yet exist. A private-public collaborative should therefore be formed and include representation from a diverse group of stakeholders, such as various state agencies, local healthcare organizations, non-profit groups, commercial technology organizations, and members of the community. (In July 2020, members of the New Jersey General Assembly took a step toward such an entity by introducing Bill A4403. The authors of this report do not take a position on this bill, but agree with its general intent.) The collaborative entity should serve the following functions:

Review, interpret, and make recommendations about communications to the general public on the meaning of existing laws and amendments, as they occur.

Advocate for the adoption of pertinent laws, promulgation by regulatory agencies of robust rules and guidance on those laws, and adjustment of licensing requirements so as to allow for more effective telehealth use.

Provide information and advice to those charged with enforcing compliance with fraud and abuse laws to ensure that confusion or lack of clarity with respect to regulations does not impede the proper implementation of telehealth services.

Educate healthcare providers working with vulnerable populations about privacy and confidentiality laws and how best to abide by HIPAA laws when using telehealth.

Even when providers understand and value the benefits of incorporating telehealth into their practice, they may not know how to maintain HIPAA compliance at all times and in all circumstances. During the pandemic, some of these requirements were relaxed by federal and state governments. Post-pandemic, however, it is expected that HIPAA compliance will once again be required. The New Jersey Departments of Human Services and Health, along with corresponding Professional Boards, should therefore do the following:

Clarify HIPAA-compliance and state regulatory requirements for telehealth platforms, patient consent, documentation, and use of telehealth from various locations.

Hold continuing education sessions on regulatory compliance for providers.

Fund providers to purchase secure, cost-effective, user-friendly, and reliable telehealth platforms that are capable of connecting with multiple devices.

Commission studies to evaluate existing and promising telehealth programs and widely disseminate findings.

Telehealth programs have variable results—some have demonstrated improved health outcomes and cost-effectiveness; others may improve outcomes, though may be too costly; and some may not improve outcomes or be cost-effective. Many telehealth programs have yet to be evaluated. The state should therefore do the following:

Conduct a national scan to identify and detail best practices in telehealth.

Evaluate emergent and promising telehealth programs to determine effectiveness and cost.

Establish an entity to assist practice evaluation of specific telehealth use, both from a process improvement and outcomes evaluation perspective.

Reimburse evidence-based telehealth services to replace or complement in-person visits, where clinically appropriate.

As the state learns about which telehealth programs are clinically appropriate and cost-effective, it should reimburse providers through Medicaid for qualifying patients at the same rate as in-person visits. Commercial plans should do similarly.

Promote the value of telehealth to providers and patients.

The COVID-19 pandemic accelerated a pre-existing interest in the use of telehealth services among providers and patients alike. The pandemic helped normalize the use of telehealth, and the state should take advantage of this momentum by doing the following:

Develop a statewide public awareness campaign using data-driven results to highlight the benefits of incorporating telehealth into healthcare. Relevant state agencies and departments, such as the Office of the Attorney General and the Departments of Health, Human Services, Children and Families, and Banking and Insurance, should work together and in partnership with providers and patients to develop the campaign.

Provide grants to Federally Qualified Health Centers, safety net hospitals, and private practices to use and evaluate telehealth best practices.

Educate public and private insurance programs about telehealth best practices.

Summary Statement

New Jersey has an opportunity to build on lessons learned during the COVID-19 pandemic. As federal and state public health emergencies are lifted, consideration should be given to continuation, or making permanent, at least some of the waivers enacted during the pandemic. Each allowance should be carefully scrutinized, and a determination made about its contribution to a more effective healthcare delivery system, particularly for historically underserved populations. The private, public, and community sectors should work together, strategically, to ensure that all New Jersey residents have access to proven telehealth services.

If there is one lesson to remember as a result of the pandemic, it is that telehealth adoption went from being an option of convenience to a necessity, frequently unrecognized before the pandemic. To become a national leader in telehealth though, requires New Jersey to begin its efforts by addressing the needs of populations that have historically been marginalized from the healthcare system. To do otherwise would only perpetuate existing disparities in the state.

Acknowledgments

To complete this report, research was conducted through a variety of methods, including reviews of current and historical laws, industry standards, and white papers; interviews with key stakeholders in the health ecosystem, such as industry technology vendors, state government departments, and federally funded telehealth resource centers; and analyses of examples designed to leverage telehealth technologies.

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Changing Systems, Changing Lives