



Building a Culture of Health

A Policy Roadmap to Help All New Jerseyans
Live Their Healthiest Lives



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Finally, the report also was enriched by extensive engagement with individuals across all sectors of New Jersey including community members and leaders, business leaders, nonprofit organizations, philanthropies, academic experts, and current and past policymakers. Their feedback, whether collected through face-to-face conversations, survey responses, or review of the draft report, was integral to the development of this document (see Approach section for details on stakeholder engagement).

A Call to Collaborate

Dear Fellow New Jerseyans:

Like you, the Robert Wood Johnson Foundation—and most of our staff—proudly calls New Jersey home. And, also like you, we want our home state and the people who live here to be as healthy as possible. We hope you will work with us to achieve this—to create what we call a Culture of Health in New Jersey.

There is, however, an enormous, but not insurmountable, hurdle that must be overcome first: the wide, persistent, and, in some cases, growing gaps across the state in the opportunities for health. These gaps lead to the measurable differences in outcomes related to health and well-being experienced by New Jersey's residents—from county to county, town to town, and within neighborhoods. Residents' opportunities to make healthy choices vary tremendously when we look at factors such as race, income, and education level.

In fact, nearly 6,400 deaths among New Jersey residents could be avoided every year if we all—regardless of where we live, who we are, or how much money we make—had a fair and just opportunity to live our healthiest lives.¹ In Cumberland County alone, for example, 44 percent of premature deaths could be avoided if county residents had the same opportunities as residents of healthier counties. These differences in health are often the result of policies and decisions that shape a place: its neighborhoods, its schools, its streets and highways, its programs and services, its access to good-paying jobs—essentially, its opportunities for good health.

Closing these gaps and creating a Culture of Health requires more than expanding access to health care, though that is critical. It requires recognizing that health is a result of what happens where we live, work, learn, and play. It also leads to a focus on health equity—improving the underlying conditions in communities for everyone, while paying particular attention to closing opportunity gaps by place, race, income, and other factors.

This roadmap—which was developed with insights and expertise from New Jerseyans across the state—recommends a comprehensive set of policy options that cut across issue areas to close gaps and broaden opportunities so that everyone has a fair chance for health and well-being.

Let's work together to help build a Culture of Health in our state for everyone.



Dr. Richard Besser
PRESIDENT & CEO, RWJF



Executive Summary

New Jersey is a leader among states when it comes to the health and well-being of its residents, as evidenced by its eleventh place ranking in an annual state-by-state assessment of the nation's health. This performance reflects the state's demographic, social, and economic characteristics and its investments over the years in health-promoting policies. New Jersey, for example, has the third highest pre-kindergarten enrollment for 3-year-olds among all 50 states.

Despite these positive signals, health is not equitably distributed in New Jersey. Across a range of issues, New Jerseyans face significant and, in some cases, growing disparities in health opportunities and outcomes based on race, ethnicity, income, and county and neighborhood of residence. In downtown Trenton, for example, average life expectancy is 73 years, but it is 87 years only 13 miles away in Princeton. And babies born into black families in the state are more than twice as likely to die before their first birthdays than those born into white families. These outcomes often are the result of unjust and unfair policies and practices that have persisted for generations and created inequities and long-standing barriers to good health.

It is time to dismantle these barriers. It is time to build a New Jersey where good health and well-being are possible no matter who we are, where we live, or how much money we make. At the Robert Wood Johnson Foundation, we believe a

Culture of Health can be achieved if we all come together around equity-promoting public policies that eliminate obstacles to health, including poverty and discrimination, which make it difficult for many of us to access good jobs with fair pay; quality education and housing; safe streets and neighborhoods; and affordable, high-quality health care.

ABOUT THIS POLICY REPORT

This report—*Building a Culture of Health: A Policy Roadmap to Help All New Jerseyans Live Their Healthiest Lives*—identifies 13 health equity priorities and recommends specific policy options that will advance these priorities. Because our health is determined by where we live, learn, work, and play, the recommended options span many different sectors, including education, housing, nutrition, and income. In some cases, the options reflect policies that are new to our state, and in other cases, they focus on implementing or enhancing existing policies or improving their implementation. In all cases, the recommended options address pressing needs in the state, advance health equity, and are supported by evidence.

To develop this list of recommended policy options, the Foundation partnered with Rutgers University and consulted closely with a statewide advisory group. Together, we sought out the best ideas from diverse stakeholders across the state,



including community residents and leaders as well as representatives from business, academia, and the nonprofit sectors. Nearly 300 people participated in our engagement sessions, which included five community conversations in North, Central, and South Jersey. Participants provided input on their vision for a Culture of Health, opportunities and barriers to well-being, and priority issue areas. We also conducted targeted surveys and statewide polls to round out input. Key themes included the importance of addressing social, educational, and economic conditions along with health care access and affordability, developing ways to involve community residents in the state policymaking process, and considering the political and financial feasibility of various policy options.

Then, within each of 13 priority areas, we identified specific policy recommendations by answering the following questions: Does the policy

address conditions that are critical to health and well-being in New Jersey? Is the policy likely to be effective based on what we know from the best available science? Does the policy promote health equity by closing health gaps? Is there a plausible pathway, in the short- or long-term, for enacting, paying for, and implementing the policy? We relied on multiple sources to answer these questions, including evidence repositories, like the *What Works for Health* database, and consultation with our advisory group. The final recommendations comprise a broad, balanced portfolio of policy solutions to promote better health and well-being across the state.

Using this policy roadmap as a guide, we call on leaders and residents to work with us to build a Culture of Health in New Jersey.

Policy Priorities and Recommended Policy Options

HEALTHY CHILDREN AND FAMILIES

1

PRIORITY 1

Improve maternal and infant health outcomes by enhancing care, supports, and prevention.

While New Jersey's infant mortality rate is relatively low, the disparities are significant: black infants here are more than twice as likely as white infants to die before their first birthdays and black mothers are more than three times as likely as white mothers to die from pregnancy-related complications.

RECOMMENDED POLICY OPTIONS:

- Ensure that state strategic planning efforts are inclusive; address the health care, social, and community determinants of maternal and infant health; and fully incorporate the voices of women from marginalized communities.
- Address the full continuum of maternal and infant care and education, engaging all relevant types of providers.
- Reduce unplanned pregnancies by increasing availability and use of contraception, particularly long-acting reversible types.
- Increase the capacity and quality of home-visiting programs for new moms and their infants.

2

PRIORITY 2

Ensure maximum uptake of the recently expanded paid family leave benefit, particularly among low-income workers.

Evidence suggests that paid family leave policies benefit caregiver and infant health without causing employers undue financial or administrative burdens. New Jersey recently expanded its paid family leave benefit and should invest in the success of this program enhancement.

RECOMMENDED POLICY OPTIONS:

- Leverage funding to boost awareness and use of paid family leave benefits.
- Simplify application and benefits administration processes and shorten claims process times.
- Consider enhancements to the existing paid leave benefit.

3

PRIORITY 3

Increase access to high-quality early education for all of New Jersey's 3- and 4-year-olds, with a continued focus on children living in poverty.

High-quality early education programs improve health and well-being, reduce inequities in educational outcomes, and provide a positive return on investment. While New Jersey spends more on pre-kindergarten than all but one other state, funding for program expansion has not kept up with demand or with the intent of previous legislative efforts.

RECOMMENDED POLICY OPTIONS:

- Enhance the ability of the New Jersey Division of Early Childhood Education to assist, monitor, and hold accountable school districts in implementing high-quality, equitable, early education programs aligned with K-3 systems.
- Pursue opportunities to steadily increase access to and enrollment in high-quality preschool programs for low-income children.

4

PRIORITY 4

Boost the incomes of families supported by low- and moderate-wage workers to promote financial stability and economic opportunity.

Income and health are inextricably intertwined, with poverty and poor health often going hand-in-hand. In turn, policies that increase incomes can lead to improved early childhood health outcomes, health behaviors, and mental health.

RECOMMENDED POLICY OPTIONS:

- Increase uptake of the state and federal earned income tax credit (EITC).
- Consider enhancements to the state EITC.
- Evaluate the impacts of the state's phased-in minimum wage increases on economic and health outcomes.
- Develop a strong plan for enforcing the state's minimum wage increase.

HEALTHY COMMUNITIES

5

PRIORITY 5

Ensure New Jerseyans have equitable access to safe, affordable, and stable housing in the communities where they choose to live.

Our homes and communities are important factors in shaping our health and well-being. With high housing costs, a substantial deficit of affordable housing units, and high rates of residential segregation, New Jersey must take comprehensive actions to promote affordable, stable housing in thriving communities.

RECOMMENDED POLICY OPTIONS:

- Engage and empower community residents and organizations in housing and community development decision-making.
- Increase affordable housing production and preservation.
- Promote economic and racial diversity within communities.
- Continue to engage hospitals, health systems, and insurers in collaborative efforts to develop affordable housing for those most in need.

6

PRIORITY 6

Prevent childhood lead poisoning by maximizing state and federal funding and ensuring properties are lead-safe through inspection, remediation, and enforcement.

Despite increased awareness and public health interventions, lead exposure remains far too common in New Jersey—particularly among children of color and those living in low-income communities with old housing stock. Effective prevention strategies can improve health, educational, and social outcomes over the lifetimes of affected children.

RECOMMENDED POLICY OPTIONS:

- Maximize the use of the New Jersey Lead Hazard Control Assistance Fund for lead poisoning prevention efforts and target funding toward effective interventions.
- Seek additional federal support, including funding via the Children's Health Insurance Program, to target lead prevention efforts to low-income children.
- Require all rental and owner-occupied properties be certified as lead-safe prior to turnover or sale and/or on a periodic basis.

7

PRIORITY 7

Expand equitable access to healthy food in communities and schools.

Over 900,000 people in New Jersey—one-third of whom are children—have inconsistent, unreliable access to food and struggle with hunger. If promoted and implemented effectively, existing nutrition assistance programs and emerging private-sector partnerships can help more state residents access affordable, nutritious foods for their families.

RECOMMENDED POLICY OPTIONS:

- Increase enrollment in and use of federal food assistance programs.
- Increase participation in federal free and reduced-price meal programs in schools.
- Improve availability and accessibility of fresh produce and healthy foods in communities.

8

PRIORITY 8

Ensure all roads, sidewalks, and public transit systems are safe and accessible to all potential users.

Transportation systems connect people to economic, social, and learning opportunities. Making transportation systems accessible, safe, and equitable across all communities and modes of transit is only possible with adequate resources, and New Jersey has long struggled to ensure stable and sufficient funding streams for roads and public transit.

RECOMMENDED POLICY OPTIONS:

- Accelerate adoption and implementation of Complete Streets policies in localities, with a focus on health equity.
- Engage the metropolitan planning organizations in leveraging federal funds to support county and municipal transportation investments that promote health equity.



HEALTHY COMMUNITIES (CONTINUED)

9

PRIORITY 9

Reduce tobacco use disparities through price increases and cessation programs.

Tobacco use remains the leading cause of death and disability across the U.S., and is becoming increasingly concentrated among those who are more socially vulnerable. In New Jersey, smoking rates in lower-income communities, like Atlantic County (19%), are nearly double those of more affluent counties, like Somerset (11%), and the state has only one-tenth of the recommended amount of funding for tobacco prevention and cessation activities.

RECOMMENDED POLICY OPTIONS:

- Consider substantial increases to state tobacco taxes.
- Dedicate a substantial portion of tobacco tax revenue to: a) state tobacco control programs with a focus on prevention and cessation for populations with high smoking rates, and b) other policy recommendations in this report that require funding.

HIGH-QUALITY, EQUITABLE HEALTH AND SOCIAL SERVICE SYSTEMS

10

PRIORITY 10

Shift the health care system's focus toward delivering whole-person care, working with other systems to promote overall health and well-being.

New Jersey spends more per capita on health care than most other states, but a larger share of residents report their health status as fair or poor. Achieving better overall health requires effective partnerships among health care systems, public health, and social service systems to meet people's physical, mental, and social needs.

RECOMMENDED POLICY OPTIONS:

- Enhance Medicaid managed care contract incentives and requirements to address people's social needs.
- Support health systems and hospitals in addressing people's health and social needs in the context of community.
- Enable state health care, public health, and social service funding streams to be aligned or combined to achieve common health and well-being goals.
- Elevate people's voices in state health policy decisions.

11

PRIORITY 11

Ensure access to comprehensive, integrated mental health and addiction services.

Our mental health is a strong determinant of our physical health—and vice versa. Those living with mental illness and/or substance use disorders are also more likely to live with a chronic disease and a higher risk of death. The high costs and poor outcomes for people with mental health or substance use disorders are driven, in part, by inadequate access to coordinated care that meets their needs.

RECOMMENDED POLICY OPTIONS:

- Pursue integrated mental health, addiction, and physical health services for the entire Medicaid managed care population.
- Accelerate adoption of integrated health care models through stable funding streams.
- Further reform the New Jersey Department of Health's licensure process and policies to enable more seamless provision of coordinated mental health and addiction services.

HIGH-QUALITY, EQUITABLE HEALTH AND SOCIAL SERVICE SYSTEMS (CONT.)

12

PRIORITY 12

Improve access to health and social services throughout the state by leveraging technology.

New Jersey makes relatively generous benefits and services available to low-income residents, but connecting people to these programs and resources remains a challenge—with a sizable share of those eligible not applying for or enrolling in these benefits and programs. There is a need to both raise awareness of these programs and make them easier to navigate.

RECOMMENDED POLICY OPTIONS:

- Move toward a “mobile-first” strategy, making program information and applications accessible and seamless through mobile technologies.
- Continue to advance easy access to a single application for all major health and social service programs.
- Encourage more widespread adoption of tele-health and ride-sharing services to ensure timely access to care for hard-to-reach populations.

13

PRIORITY 13

Foster collaboration within and across state agencies to improve health equity.

The state must embrace a more integrated, comprehensive approach to policymaking—understanding how the decisions made today impact *everyone’s* health tomorrow. Diverse agencies—from agriculture to transportation to labor and workforce development—should be working together on analyzing problems, developing strategies, and implementing policies and programs.

RECOMMENDED POLICY OPTIONS:

- Create an inter-agency well-being working group to provide statewide leadership on cross-sector collaboration.
- Assess the impact of major new legislation and regulation on health and well-being.

Background

The Case for Building a Culture of Health in New Jersey

New Jersey is a leader among states when it comes to the overall health and well-being of its residents, but a new policy focus is needed to help give every New Jerseyan a fair and just chance to live their healthiest life. The state continues to show steady improvement on United Health Foundation's *America's Health Rankings*, for example, placing eleventh for overall health among all 50 states in 2018—up from thirteenth in 2016 and twenty-first in 1990.² Further, a recent national report from Trust for America's Health offered up a list of the most cost-effective, proven public policies that can help states improve the health and well-being of their residents, and New Jersey is one of the few jurisdictions that has enacted nearly all of the recommended policies.³ New Jerseyans can and should be proud of the state's many health-promoting public policies and the positive health trends that they have spurred—as evidenced across a spectrum of statewide health indicators.

Those policies include investments in early childhood education that has New Jersey, compared to other states, investing the second highest amount per child and achieving the third highest enrollment in pre-kindergarten for 3-year-olds.⁴ Similarly, New Jersey is one of only six states (plus the District of Columbia) to receive the highest grade for its efforts to provide paid leave for working families.⁵ And, as a result of a state-level health insurance mandate⁶ and a new reinsurance program, New Jersey has protected and built upon the coverage gains achieved through the Affordable Care Act, including the Medicaid

expansion.⁷ In terms of important health markers, New Jersey, in comparison to the U.S. average, has a lower rate of adult smoking;⁸ lower infant mortality rate;⁹ and substantially lower rate of teen births.¹⁰ It also has a higher rate of high school graduation¹¹ and a lower rate of premature death¹² than the national averages.

However, New Jersey's impressive achievements mask important inequities and deficiencies across the state that must be addressed to give everyone the opportunity for good health. While low infant mortality is cited as one of New Jersey's strengths, a closer look reveals large disparities. For example, each year, Bergen, Morris, Monmouth, and Somerset counties see three infant deaths per thousand compared to eight deaths per thousand in Atlantic, Camden, and Cumberland counties.¹³ And black infants in the state are more than twice as likely as white infants to die before their first birthdays, while black mothers are more than three times as likely as white mothers to die from pregnancy-related complications.^{14 15}

These data prompted Commissioner Shereef Elnahal, MD, MBA, of the New Jersey Department of Health, to remark: "It's a tragic reality that race determines health outcomes for some New Jersey mothers and babies. Everyone, regardless of skin color, should be given an equal chance at a healthy, productive life."¹⁶ Commissioner Elnahal's words, though spoken in another context, make the case for building a Culture of Health in New Jersey.

HEALTH EQUITY IS KEY TO A CULTURE OF HEALTH

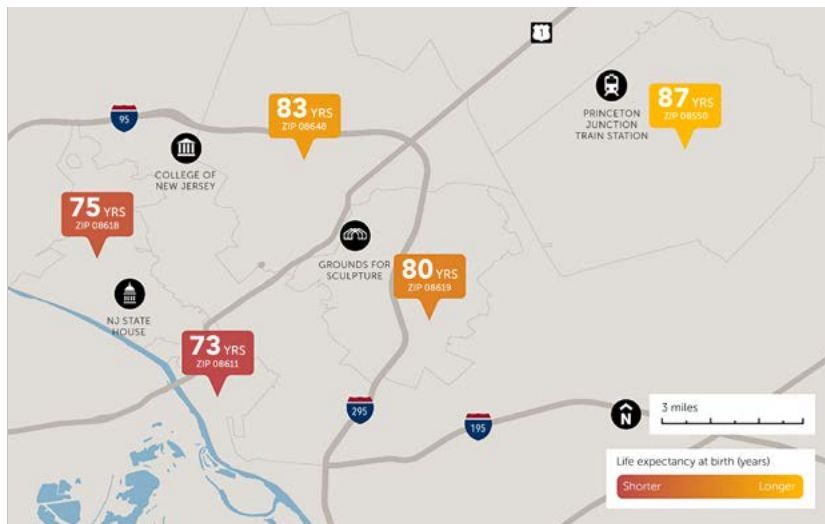
While our own health is partly a matter of our personal choices and behaviors, the choices we make generally depend on the opportunities that are available to us. And, within New Jersey, not everyone has the same opportunity to live their healthiest life. Children born into families residing in Cumberland County, for example, generally don't encounter the same health-promoting opportunities as children born into families residing in Morris County. Unjust and unfair policies and practices, many outside the traditional health care and public health sectors, have created long-standing barriers to good health that have persisted for generations. Examples include: bank lending practices that discriminate against people of color, school funding formulas that do not adequately account for the limited tax bases in poor communities, and labor protections that do not apply to—or are not

enforced within—industries that employ more women and people of color.

Research has shown that disparities—or health gaps—are common and can be place-based (i.e., based on where people live), population-based (i.e., based on race, ethnicity, age, income, education, or sexual orientation), or both. In downtown Trenton, for example, the life expectancy in zip codes 08611 and 08618 are 73 and 75 years, respectively.¹⁷ Move away from the river and downtown, and life expectancy in the more suburban 08619 and 08648 zip codes of Hamilton and Lawrence Townships jump to 80 and 83 years, respectively. In Princeton, average life expectancy in the affluent 08550 zip code—only 13 miles from downtown Trenton—is 87 years. All of these zip codes sit within Mercer County, but across the county, life expectancy varies by as much as 14 years.

Figure 1

SHORT DISTANCES TO LARGE GAPS IN HEALTH



Life expectancy across Mercer County

Source: Virginia Commonwealth University Center on Society and Health. *Mapping Life Expectancy: Trenton*. <https://societyhealth.vcu.edu/work/the-projects/mapstrenton.html>. Accessed February 6, 2019



A Culture of Health is built on the concept of equity rather than simple equality.

In a Culture of Health, good health and well-being flourish across geographic, demographic, and social sectors—fostering healthy, equitable communities; guiding public and private decision-making; and providing everyone the opportunity to live their healthiest life. Note, however, that a Culture of Health is built on the more fundamental concept of equity rather than simple equality. Health equity means that everyone—no matter who we are, how much money we make, or where we live—has a fair and just opportunity to be as healthy as possible. Health equity benefits all of us and, therefore, requires all of us to focus on removing obstacles to health such as poverty, discrimination, and their consequences, which include powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.¹⁸

A community stakeholder who provided input for this report referenced barriers to health equity, such as unfair school funding formulas, said: There is a lack of “trust” in institutions, with many people “scared” and “confused by a system that pushes them away.” And a business leader who also provided input echoed this sentiment, saying: We need to “break the cycle” of systemic discrimination that has created disparities over time.

THE POWER OF POLICY

While policy actions have sometimes created inequities in our state, they can also be leveraged to dismantle barriers to health equity. Policy is a powerful tool because it reaches everyone in a jurisdiction, is long-lasting when thoughtfully and consistently implemented, and may even change societal norms and expectations about health and well-being. In fact, policy changes—anchored in the best available science—account for some of the farthest-reaching improvements in public health in the 20th century, with many of these reforms affecting the social, economic, and built environments of communities.¹⁹

As such, this report is a policy guide to building systems that don’t push people away but, instead, bring people together from across all sectors to advance a Culture of Health in New Jersey. It lays out 13 overarching policy priorities, targeting some of the state’s most intractable health gaps, and recommends concomitant policy options to address each priority. Our goal is to inform state and local policymakers, community and nonprofit groups, and leaders in the private sector about which policies, if implemented in the coming years, would result in the most significant gains in health, particularly for those among us with the fewest opportunities to achieve optimal health and well-being.



Our Approach

Stakeholder Engagement and Policy Identification

To produce this policy roadmap, we partnered with the Center for State Health Policy (CSHP) and the John J. Heldrich Center for Workforce Development at Rutgers University. Together, we relied on a shared set of principles and values to guide our efforts.

GUIDING PRINCIPLES & VALUES

- Where we live, learn, work, and play impacts our well-being, particularly the social and economic conditions of our families and communities.
- Everyone should have a fair and just opportunity to live their healthiest life possible (health equity). Achieving health equity requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.
- Good health should flourish across geographic, demographic, and social sectors and everyone should have access to affordable, high-quality health care that meets their goals and needs for well-being.
- Everyone in New Jersey values attaining the best health possible; business, government, individuals, and organizations across the state should work together to build the conditions and opportunities for better health for all.
- Public policy is critical to improving health and achieving equity. Policies—like laws and regulations—affect entire populations, hold the promise of longevity with appropriate enforcement, can change societal norms and attitudes, and can reverse inequities born from previous policies.
- Policymaking should be driven by the needs and priorities of residents; robust public input is critical to equitable policy prioritization, development, and implementation.
- Science should guide policy design and be used to assess whether and how policies are effective. Evaluations of policies should include measures of community engagement and assessments of whether disparities grow or shrink.
- States play a key role in health policymaking: setting budgets and raising revenue, acting as a funder and implementer of key programs like Medicaid and K-12 education, serving as a major purchaser of services, fostering cross-sector/cross-agency collaboration, and enabling local innovation.

We also worked with Rutgers to establish an advisory group, which met with us regularly over a one-year period to guide our project strategy. Our advisors were selected for their knowledge of and experience in the policy domains relevant to building a Culture of Health in New Jersey, including education, transportation, community development, housing, and health care, and their understanding of the opportunities and challenges confronting the state. (See “Authors” page for a complete list of contributors to this report.)

OUR ENGAGEMENT EFFORTS

Within a Culture of Health, effective policies must reflect the needs and priorities of every community they touch. Thus, recognizing that we all have knowledge and expertise to share, we sought input for this report from a broad range of relevant stakeholders across the state, including community residents (both youth and adults) as well as representatives from academia, business, and the nonprofit sectors. A community resident who participated in the development of this report succinctly summed up why diverse input was so crucial: “Hearing all voices” and “being transparent” helps build a “base of credibility.”

Our engagement sessions were designed to elicit a wide range of answers to a set of key questions from participating stakeholders. Approximately 275 New Jerseyans participated in at least one of the events, which included: community conversations held in partnership with RWJF’s New Jersey Health Initiatives in Basking Ridge, Camden, Cape May, East Brunswick, and Trenton; a meeting of RWJF grantees in Princeton; a breakfast meeting

with statewide business leaders; and two meetings with nonprofits, academics, and researchers at Rutgers University (see Appendix for more details).

The key questions used to prompt conversations at these events included:

- What would a Culture of Health look like to you?
- What are the biggest challenges to achieving health and well-being in your community and across the state?
- Which of these issues are most important to address in the next several years?
- How can we come together to best move these efforts forward?

In addition to face-to-face conversations, we also solicited stakeholder input via surveys. CSHP conducted an online survey that reached more than 300 people over two different distribution waves in 2018. The survey, which asked respondents to identify their top health and well-being priorities from a comprehensive list of issue areas, enabled us to expand our reach to more groups, both across the state and across different disciplines, further enriching what we learned from the community conversations. CSHP also oversaw the “New Jersey Health and Well-being Poll,” which reached representative samples of New Jersey residents by phone about their perceptions of health and well-being in their communities. Both the 2016 poll, which surveyed more than 1,200 residents, and the 2017 poll, which surveyed more than 1,000 residents, informed this policy report, giving us deeper insights into the concerns of New Jersey residents.



WHAT WE HEARD

We listened intently during our many conversations and interactions with stakeholders across the state, generating substantive insights into their health-related priorities and their ideas for addressing these priorities. Our partners at Rutgers analyzed the comprehensive sets of notes generated at the various engagement sessions; synthesized the themes from each; and identified priority issues, key strategies, and core principles across all the various outreach efforts, including the surveys. While most stakeholders did not identify specific policy recommendations, they were very clear about the issues that they feel must be addressed to create health equity.

Among the concerns that stakeholders raised most often were:

- Economic opportunity, income, and poverty;
- Access to high-quality, affordable health care services;
- Maternal and child health, and supports for struggling families;
- Housing, education, and transportation; and
- Engaging residents and communities in state policy decisions.

The in-person conversations afforded rich opportunities for substantive and nuanced consideration of what it will take to improve health equity and well-being in New Jersey across all the issue areas. The cross-cutting strategies that were raised included: considering the health impacts of policies across state government; breaking down silos between state agencies and sharing data, funds, and strategic insights; considering the budgetary impacts of new policies and programs; and seeking new sources of revenue, including taxes on unhealthy products.

HOW WE SELECTED POLICIES

Based on the priority issues and key considerations generated through the stakeholder engagement process, CSHP and Heldrich researchers, in consultation with RWJF staff and advisors, used the following criteria to identify and evaluate a comprehensive list of policy actions for possible inclusion in this report.

- 1 Does the policy address social, economic, or other conditions that are critical to health and well-being in New Jersey?**
- 2 Is the policy likely to be effective based on the best available science and practice?**
- 3 Does this policy promote health equity and/or create an opportunity to close health gaps?**
- 4 Is there a feasible pathway for enacting, paying for, and implementing the policy?**

We relied on many trusted resources to help us identify policies for consideration and assess them based on the first three criteria above. These resources included the County Health Rankings & Roadmaps *What Works for Health* clearinghouse, the Community Preventive Services Task Force's *Community Guide*, the Centers for Disease Control and Prevention's *Health Impact in 5 Years Interventions*, and the Pew Charitable Trusts' *Results First Clearinghouse*. In addition, we considered

recommendations from New Jersey-focused policy documents, such as New Jersey Policy Perspectives' *Blueprint for Economic Justice and Shared Prosperity in New Jersey* and Fund for New Jersey's *Crossroads New Jersey*. We then consulted closely with our advisory group, along with other state and national content experts, on culling the policy options further, particularly as they relate to criterion #4 above. We aimed for a mix of policies: some that were feasible in the short-term with modest investments in advocacy, policy refinement, and new revenues; and others that were more aspirational, likely requiring intensive engagement, fine-tuning, and consideration of trade-offs, including budget commitments.

The final recommendations in this report comprise a carefully curated list of policy priorities and options that underwent rigorous vetting and scrutiny, but are not meant to be exhaustive. First, we recognize that building a Culture of Health is a *generational* pursuit, one that will require policies in 10 to 15 years that we can scarcely conceive of now. Second, we left some policies on the cutting room floor even when they were likely to meet the aforementioned criteria because we sought a final list that represented a mix of strategies across a wide variety of sectors that influence health and well-being. Ultimately, this report represents our best collaborative effort to engage diverse stakeholders across the state, listen carefully to what they had to say, and use their input and the best available science to generate a set of recommended policy options that promote health equity and can be implemented in the coming years.



Policy Priorities

Start Here to Build a Culture of Health

Building New Jersey's Culture of Health requires equity-promoting policies focused on children and families, healthy communities, and high-quality health and social service systems. In this section, we present 13 policy priorities for improving health and well-being in the state and recommend a series of specific evidence-based policy options to address these priorities.



Healthy Children and Families

POLICY PRIORITY 1

1

Improve maternal and infant health outcomes by enhancing care, supports, and prevention.

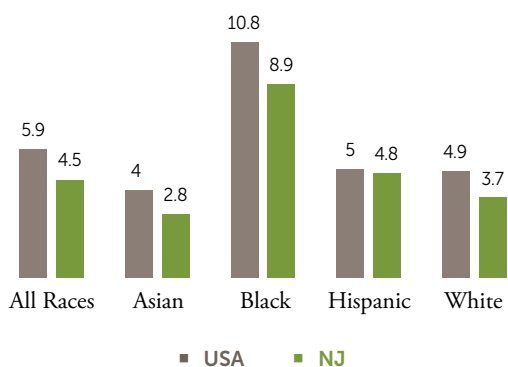
ABOUT THE CHALLENGE

Despite progress over the last half century, the United States still falls behind other industrialized countries with regard to maternal and infant health outcomes, and recently preterm births and maternal mortality rates have been rising.^{20,21} In New Jersey, while the infant mortality rate is lower than the national average, startlingly, the maternal death rate is almost twice the national average.^{22,23} New Jersey also has among the largest disparities in the nation for these outcomes: Black infants here are more than twice as likely to die before their first birthdays as white infants, and—especially striking—black mothers are more

than three times as likely as white mothers to die from pregnancy-related complications.^{24,25} These disturbing trends and inequities are likely the result of myriad factors,^{26,27} including fragmentation in care delivery for women and babies; racial discrimination in health care practice; growing levels of high blood pressure, obesity, and opioid addictions among pregnant women; inadequate responses to acute health issues arising in the perinatal period; and increasing social and economic stress faced by low-income women and women of color.

Figure 2

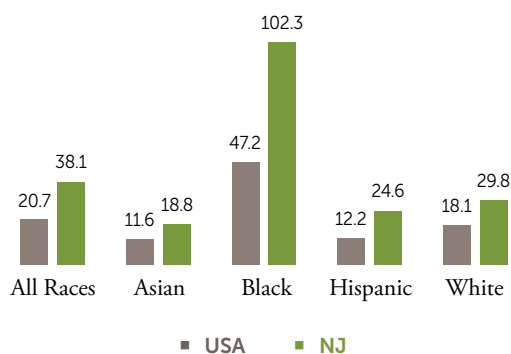
**INFANT MORTALITY RATES
PER 1,000 BIRTHS (2018)**



Source: America’s Health Rankings, Health of Women and Children, Infant Mortality. https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/IMR_MCH/state/NJ

Figure 3

**MATERNAL MORTALITY RATES
PER 100,000 BIRTHS (2018)**



Source: America’s Health Rankings, Health of Women and Children, Maternal Mortality. https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality/state/NJ

PROGRESS TO DATE IN NEW JERSEY

Under the leadership of Commissioner Elnahal, the New Jersey Department of Health (DOH) has invested \$4.7 million in new funds to support maternal health programs. Part of this funding included \$280,000 directed to the Statewide Parent Advocacy Network and \$280,000 to Children’s Futures to implement pilot doula programs in Newark and Trenton, respectively. The goal of these pilots is to reduce the likelihood of specific birth outcomes, including cesarean deliveries.^{28 29} Moreover, the state is dedicating funding to increase the number of sites providing CenteringPregnancy, a group prenatal care program shown to decrease maternal and infant morbidity and mortality, particularly among black women. Recently, the U.S. Department of Health and Human Services awarded nearly \$11 million to DOH and the Department of Children and Families to expand current home visiting programs that provide various supports to new mothers and infants.³⁰ Furthermore, the FY2019 budget boosted Medicaid funding to expand eligibility for family planning services to women with incomes

up to 200 percent of the federal poverty level, and to enhance coverage for postpartum, long-acting, reversible contraception (LARC).³¹

DOH also is developing a Maternal and Child Health Strategic Plan that will involve coordination across state agencies, tapping expertise within the health care, public health, and social service systems. In addition, First Lady Tammy Snyder Murphy has made this one of her signature policy issues and is spearheading Nurture NJ, a statewide awareness campaign committed to improving maternal and infant health and ensuring equity.³² Nurture NJ will adopt best practices from the perinatal quality collaborative proven effective in California and will include an annual “Black Maternal and Infant Health Leadership Summit,” a social media campaign to boost awareness, and a strategy to connect women and families to resources.^{33 34 35} There are currently 14 bills in the General Assembly and Senate to improve maternal health and obstetric care, illustrative of not only the broad legislative activity around this topic but also the urgency assigned by stakeholder groups advancing these issues around the state.³⁶

RECOMMENDED POLICY OPTIONS

1.1 **Ensure that state strategic planning efforts are inclusive; address the health care, social, and community determinants of maternal and infant health; and fully incorporate the voices of women from marginalized communities.**

The state should pursue a number of strategies to effectively engage with communities across the state and understand the heightened challenges faced by low-income women and women of color. This could include: hosting listening and learning sessions in places where women and families live, work, learn, and get care; engaging state agency leaders in these sessions along with front-line staff; using plain language and clear processes to involve residents in prioritizing issues, identifying solutions, and shaping all stages of policy and program design; and reporting back to communities on how their input was (or was not) used to inform decision-making.³⁷ This approach, which can be adapted for use with maternal and infant mortality review committees,³⁸ leads to more effective, practical, and tailored strategies for closing health gaps and enhancing trust in health systems. To further improve equity in its planning efforts, New Jersey should engage agencies beyond the health, human services, and child and family sectors to include education, transportation, community affairs, labor and workforce development, and corrections. Lastly, the state should continue to prioritize programs that effectively address interpersonal and institutional racism and reduce health disparities, such as CenteringPregnancy.³⁹

1.2 **Address the full continuum of maternal and infant care and education, engaging all relevant types of providers.**

This continuum includes pre-conception, prenatal, postnatal, and inter-conception care and education provided by pediatricians, internists, family physicians, obstetrician-gynecologists, specialty physicians, nurse practitioners, midwives, doulas, community health workers, and public health and social service workers. While often overlooked, pre-conception and inter-conception care can attend to health issues, health risk behaviors, and social challenges before pregnancy and can allow for informed pregnancy planning.^{40 41} Cross-disciplinary collaboration has been essential to the success of California's Maternal Quality Care Collaborative. Since its inception in 2006, the state has seen maternal mortality decline by 55 percent while the national rates have risen.

1.3 **Reduce unplanned pregnancies by increasing availability and use of contraception, particularly long-acting reversible types.**

Access to contraception can be achieved through enhanced insurance coverage and increased same-day, on-site access to the contraceptive of choice and through education and norms-changing campaigns. New Jersey policymakers need only look down the Turnpike to see the example in Delaware, a state that is working to reduce unplanned pregnancies by providing training and assistance to all health care providers, eliminating barriers to access for all forms of birth control, increasing

public knowledge, and evaluating programs.⁴² New Jersey has recently taken a significant step forward in this regard with the decision by the state’s Department of Human Services to provide coverage of LARC in all settings in the Medicaid program.⁴³ Now, it must promote the coverage change to patients and providers, track utilization, and make further policy changes as necessary. Overall, making LARC available at no cost can increase its use, reduce fertility rates (pregnancies), and decrease high-risk births among young women.⁴⁴

**“Prenatal care...
Early diagnosis...
Early intervention.”**

*Survey respondent
providing ideas
for advancing a
Culture of Health*

1.4

Increase the capacity and quality of home visiting programs for new moms and their infants.

These rich programs provide parenting supports, education about healthy development, and links to health and social services to families who can benefit the most from them. We know that there are several evidence-based home visiting models, such as Healthy Families America, Nurse-Family Partnership, and Parents as Teachers, which can improve family functioning and child development, reduce health-risk behaviors and child maltreatment, and even improve economic security.^{45 46 47 48}

In FY2017, across all New Jersey counties, 7,041 families participated in Healthy Families America, Nurse-Family Partnership, or Parents as Teachers. There are opportunities to expand capacity and quality of existing home visiting programs by:

- Developing a statewide integration and coordination strategy to ensure continuity across state and county public health and social service agencies, and the county centralized intake system. The goal of the centralized intake system is to process all referrals through a single entity to improve efficiency and connect families to appropriate services.⁴⁹
- Expanding the use and capacity of community health workers as trained home visitors. Community health workers can provide invaluable community-based peer support to mothers and infants through pregnancy and the critical postpartum period. Community health workers who come from participants’ own communities can create trusted, authentic relationships that enable mothers to navigate challenging social situations and the health care system.
- Creating and embedding program components into home visiting programs that build trust and respect between providers and patients; for example, implementing implicit bias training for all workers providing home visiting services.
- Improve outreach efforts to ensure that eligible families are aware of, and can enroll and participate in, home visiting programs.⁵⁰

Ensure maximum uptake of the recently expanded paid family leave benefit, particularly among low-income workers.

ABOUT THE CHALLENGE

A vast majority of parents with young children actively participate in the workforce,⁵¹ and face dilemmas about taking time away from their jobs to meet family responsibilities. The United States is one of the few industrialized nations that does not guarantee paid family or medical leave for employees, and nationally only 14 percent of all private-sector employees have access to paid family leave benefits.⁵² Illness, the birth of a child, or tending to the needs of aging or disabled family members all too often force individuals to choose between caregiving responsibilities and maintaining their incomes.

Evidence suggests that paid family leave policies result in a range of positive impacts, including increases in labor force participation among women (particularly when leave is less than one year); improvements in birth outcomes and breastfeeding rates; and, potentially, reductions in infant mortality.^{53 54} Research also demonstrates that paid family leave has little to no negative effects on businesses,⁵⁵ while demonstrating some positive effects on the morale and retention of female workers.⁵⁶ A study of New Jersey employers showed no decreases in employee productivity or increases in turnover; and a majority of businesses saw no significant additional administrative burdens while, in terms of financial impact, only two of 18 employers reported decreases in profits.⁵⁷ Currently, six states have paid family leave laws, including (in order of adoption): California, New Jersey, Rhode Island, New York,

Washington, and Massachusetts.⁵⁸ In New Jersey, use of paid leave benefits has been hampered by low-wage replacement rates, absence of job protection, and restrictive definitions of *family*, along with insufficient awareness of the benefit and a burdensome and untimely application and payment process.^{59 60} Experience indicates that these factors have had disproportionate impacts on lower-income workers who need the income support the most.⁶¹

PROGRESS TO DATE IN NEW JERSEY

In 2008, New Jersey became the second state in the nation to adopt a paid family leave law. Funded entirely by employee payroll contributions, the program provides wage replacements for workers when they go on leave to bond with a new child or care for a sick family member.^{62 63} On average, only 31,000 workers claim family leave benefits annually in New Jersey although many more are eligible to do so.⁶⁴ In recent years, New Jersey lawmakers and advocates have explored pathways to expand and optimize the benefit, but until recently, these efforts had stalled.^{65 66} A recent poll fielded by Rutgers CSHP showed that 92 percent of respondents favored funding programs to help people care for sick family members, and 76 percent supported increasing leave time to 12 weeks from the prior six weeks.⁶⁷ After years of legislative debate and stakeholder advocacy efforts, in January 2019, New Jersey passed paid family leave legislation that substantially expands and enhances the current program.⁶⁸

The new law increased the maximum leave time from six weeks to 12 weeks, expanded the definition of “family member” as it relates to eligible caregiving, boosted the wage replacement from two-thirds of one’s average weekly wage to 85 percent, with the maximum weekly payment increasing from \$650 to \$860. While the state’s original paid family leave legislation did not guarantee job protection, qualified workers were covered by the job protection provisions in the federal Family and Medical Leave Act or New Jersey Family Leave Act.⁶⁹ The new legislation included job protection for workers in companies

with 30 or more employees. The legislation also included \$1.2 million to expand awareness and outreach efforts to promote the availability of paid family leave, and charges the Department of Labor and Workforce Development to actively engage with businesses.⁷⁰ Previously, there were no allocated funds for awareness, although the state did complete some targeted outreach to employers and advocacy organizations in the early years of the program.⁷¹ In addition, the legislation set numerical goals for timely determination and prompt payment of benefits to address the issues with slow claim determination and payment processing.⁷²

RECOMMENDED POLICY OPTIONS

2.1 Leverage funding to boost awareness and use of paid family leave benefits.

Use dedicated awareness and outreach funds to implement a statewide campaign that informs and educates workers and employers about family leave benefits. Continue to build on the newly launched My Leave Benefits website to ensure applicants have easy-to-understand and updated information on various state and federal family leave programs for which they may be eligible. Special attention should be given to raising awareness among populations with historically low benefit uptake rates (e.g., men, low-wage workers, and non-English speakers). In addition, multiple partners and stakeholders should promote the program, including doctors, nurses, and hospital social workers, who are thought of as trusted sources of information, as well as through social assistance offices (e.g., Special Supplemental Nutrition Program for Women, Infants, and Children), home visiting programs, and Family Success Centers.⁷³ Finally, a training program for employers should be developed with specific resources for small businesses, those with low-wage workers, and those with many non-English speaking workers. Moreover, it is essential to recognize “champions” in the business community who are vigorously promoting increased access to paid family leave for their employees.

“Family-sustaining employment, child care and family leave.”

*Stakeholder
providing ideas for
moving toward a
Culture of Health*

2.2**Simplify application and benefits administration processes and shorten claims process times.**

The burden of completing the application process and the frequent delays in the review process and receipt of benefits can be a barrier to employee take-up.^{74 75} New Jersey could look to other states including California and Rhode Island for strategies to reduce or eliminate the wage and work history documentation required from employers, if already provided by employees, in order for applications to be deemed complete. Making detailed program data available on a quarterly and annual basis will provide the opportunity to address impediments to enrollment in a timely way, particularly if barriers are highlighted in specific populations or segments of workers. With enhanced capacity, the New Jersey Department of Labor and Workforce Development can field calls, respond to online inquiries and conduct enforcement, as needed.

2.3**Consider enhancements to the existing paid leave benefit.**

There are several ways to build on the existing law, including offering job protection for workers at companies with fewer than 30 employees, enabling self-employed individuals to opt in to the benefit, and allowing for leave in the case of a family member being on active duty. The absence of job protection is a significant factor when employees—particularly low-income workers and men—decide whether to take leave.⁷⁶ Rhode Island, New York and Massachusetts offer robust job protection, and analyses demonstrate that a larger proportion of men took leave in Rhode Island's first year of implementation than in California and New Jersey, neither of which included similar levels of job protection. New Jersey should assess the impact of its existing law and possible modifications while also carefully tracking emerging evidence from the public and private sectors on how paid leave benefits beyond 12 weeks affect infant and parental health outcomes, women's labor market outcomes, and economic outcomes for businesses.



POLICY PRIORITY 3

3

Increase access to high-quality early education for all New Jersey 3- and 4-year-olds, with a continued focus on children living in poverty.

ABOUT THE CHALLENGE

Research has shown that high-quality early education programs have positive effects on health and well-being, reduce inequities in educational outcomes, and provide a positive return on investment.^{77 78} However, nationally, only 42 percent of 3-year-olds and 66 percent of 4-year-olds were enrolled in early education programs in 2016.⁷⁹ Participation is lower for Hispanic (34%) and black (35%) children than white (42%) and Asian (45%) children, and racial and ethnic minorities are more likely to be enrolled in lower-quality programs.^{80 81} Notably, participation is also lower for children of parents with lower

educational attainment.⁸² Another challenge is that some children cannot sustain academic gains made in early education programs once they enter elementary school. In 2017, in New Jersey, 30 percent of 4-year-olds and 21 percent of 3-year-olds were enrolled in state-funded pre-kindergarten, ranking the state twenty-first and third, respectively, in the nation.⁸³ While New Jersey has shown its commitment to early education by spending more on pre-kindergarten than every other state with the exception of one, the reality is that funding for program expansion has not kept up with demand or intent of previous legislative efforts.⁸⁴

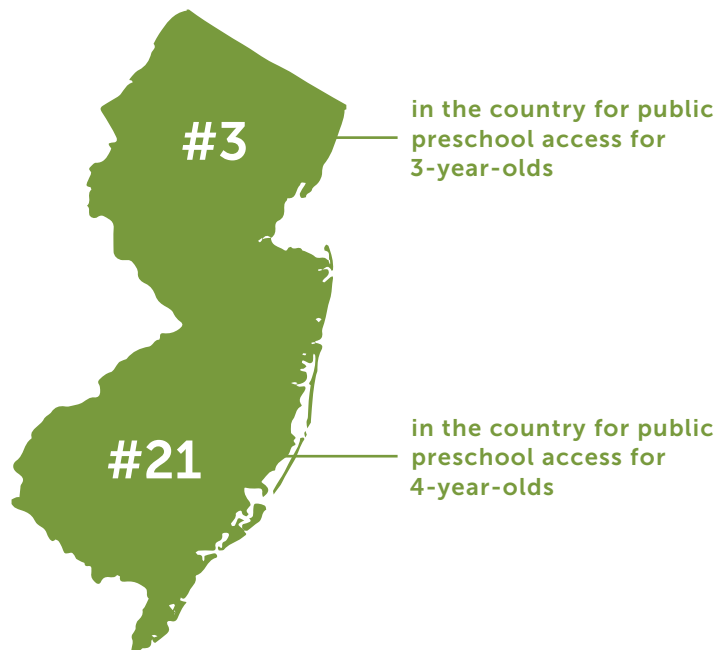
PROGRESS TO DATE IN NEW JERSEY

With the historic 1998 *Abbott vs. Burke* decision, the New Jersey Supreme Court ordered the state to provide “well-planned, high-quality” preschool for all children in the poorest communities—thereafter named “Abbott Districts.” Subsequent state funding expanded preschool access for 3- and 4-year-olds in 31 Abbott Districts (currently 35), and quality standards dictated by the decision resulted in significant improvements in educational outcomes, showing that students who received two years of high-quality preschool by 5th grade were performing better in reading, science, and math.^{85 86} By 2008, more than 40,000 children were enrolled in public preschool in New Jersey, and the state legislature passed the School Funding Reform Act to expand preschool to all low-income children in the state by leveraging policies already put in place by the Abbott preschool program.

However, due to various fiscal and political realities, funding for this expansion was significantly limited until the state appropriated an additional \$25 million in 2017 and \$83 million in 2018.⁸⁷ The most recent boost makes funding available for new slots, improving the quality of the education, or extending the length of the school day.⁸⁸ However, many districts did not apply for the funding, most likely due to lack of awareness of the opportunity or confusion about the requirements, and the entire funding amount was not dispersed to districts.⁸⁹ New Jersey continues to operate the “Grow NJ Kids,” a multi-agency rating and quality improvement system that uses trainings, incentives, and other tools to enhance the effectiveness and quality of childcare and early education throughout New Jersey.⁹⁰ On average, the state’s major preschool programs meet eight of the 10 quality standards recommended by the National Institute of Early Education Research (NIEER).⁹¹

Figure 4

NEW JERSEY PRESCHOOL RANKINGS (2017)



Source: *The State of Preschool 2017*. National Institute for Early Education Research; 2018 <http://nieer.org/wp-content/uploads/2018/07/State-of-Preschool-2017-Full-7-16-18.pdf>. Accessed April 8, 2019.

RECOMMENDED POLICY OPTIONS

3.1

Enhance the ability of the New Jersey Division of Early Childhood Education (DECE) to assist, monitor, and hold accountable school districts in implementing high-quality, equitable early education programs aligned with K-3 systems.

DECE plays a critical role in ensuring preschool school funds are used effectively, efficiently, and consistently across districts. With the leverage of additional staff and resources, the program should be able to ensure that preschool programs are meeting quality benchmarks, including for class size, staff-child ratios, teacher qualifications, and cultural competency, and are making investments in curriculum development and schools' physical infrastructure. According to a NIEER assessment, New Jersey programs have the opportunity to advance in three areas: professional development, continuous quality improvement, and assistant teacher qualifications.⁹² With regard to implications for health, DECE could better assist preschools to provide vision and hearing screenings, referrals to health care and social service providers, healthy food and physical activity opportunities, and lead-safe environments.^{93 94} Alignment of preschool and K-3 systems is another important quality standard, as it helps to sustain academic gains made through early education programs. While the state currently requires school districts to have written preschool-to-kindergarten transition plans,⁹⁵ DECE, in partnership with other divisions and agencies, should develop clearer governance mechanisms to further align preschool and elementary school curricula, bolster data sharing across systems, and improve the effectiveness of teachers and administrators across both systems.⁹⁶

3.2

Pursue opportunities to steadily increase access to and enrollment in high-quality preschool programs for low-income children.

Currently, 53,000 New Jersey children are enrolled in state-funded preschool and another 12,000 are in Head Start, leaving tens of thousands of children from low-income families without equitable access to early education.⁹⁷ Over the last two years, the state has made incremental investments to reach more of these children, and continued progress is essential. Because the costs of expansion are sizable, the state should plan carefully, explore public and private funding options at the state and local levels, and consider trades-offs and compromises.⁹⁸ Even though preschool expansion has short-term costs, the returns on investment, in both the intermediate and long terms, are generally positive, with high-quality early childhood programs providing two to four dollars in return for every single dollar invested.⁹⁹ Along with increasing educational performance and reducing disparities,^{100 101 102 103} high-quality preschool can improve health behaviors and boost high school completion, creating potential state savings in criminal justice, social services, and health care sectors and improving children's economic outcomes in adulthood.¹⁰⁴ ^{105 106} With any new opportunities for preschool expansion, the state should set and communicate clear guidelines on program goals, eligibility, and application processes and timelines to enable the maximum number possible of districts to submit competitive proposals.

POLICY PRIORITY 4

4

Boost the incomes of families supported by low- and moderate-wage workers to promote financial stability and economic opportunity.

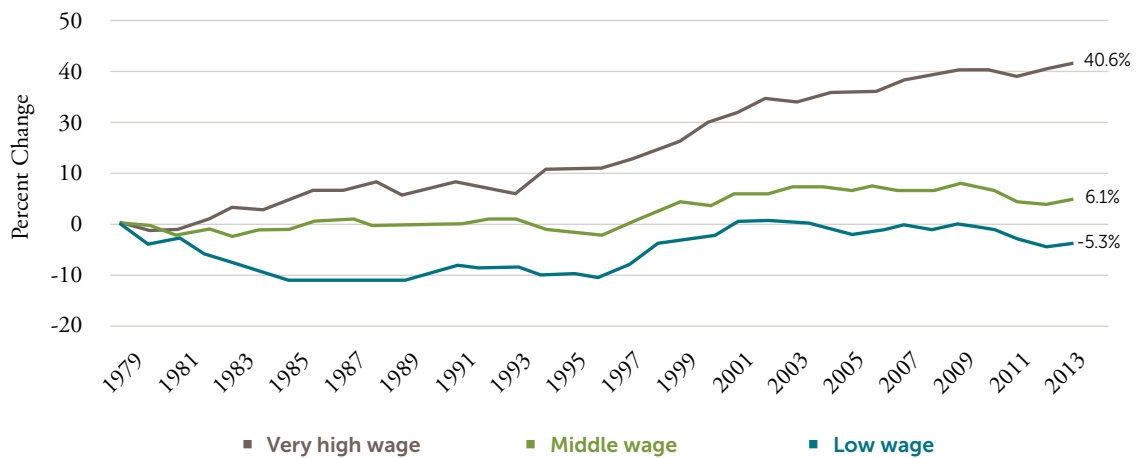
ABOUT THE CHALLENGE

Income affects health through many channels. It influences people’s abilities to purchase health-promoting goods, such as nutritious foods, and to build savings. It shapes the communities and homes people are able to live in, the schools that their children have access to, the quality and reliability of their health care, and the amount of stress and discrimination they face. In addition, poor health can also affect income by interrupting educational completion or making work difficult

or impossible. This is sometimes referred to as the “health-poverty trap.”¹⁰⁷ In the United States, the difference in life expectancy between those with the highest and lowest incomes is more than 10 years and is growing. This inequality in life expectancy mirrors patterns in inequality of income. While the nation and New Jersey are currently experiencing some of the lowest rates of unemployment in almost two decades,^{108 109} wage growth for low- and moderate-income earners remains stagnant.^{110 111} (See Figures 5 and 6)

Figure 5

CHANGES IN REAL WAGES IN THE UNITED STATES, BY WAGE PERCENTILE*



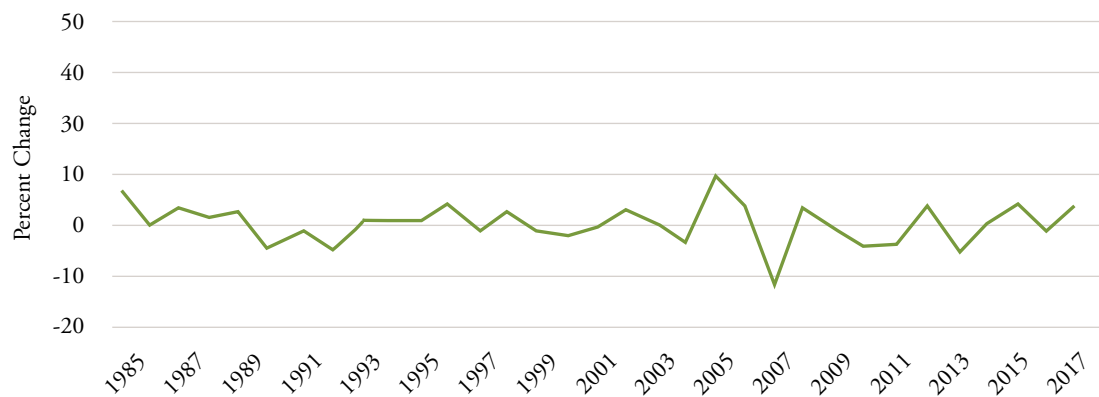
Source: Economic Policy Institute Analysis of Current Population Survey Outgoing Rotation Group microdata <https://www.epi.org/publication/charting-wage-stagnation/>

Reproduced from Figure F in Why America’s Workers Need Faster Wage Growth—And What We Can Do About It <https://www.epi.org/publication/why-americas-workers-need-faster-wage-growth/>

*Definitions of Wage Percentiles: Very high wage (95th percentile) means 95% of wage earners earn less and 5% earn more. Middle wage (50th percentile) means 50% of wage earners earn less and 50% earn more. Low wage (10th percentile) means 10% of wage earners earn less and 90% earn more.

Figure 6

REAL MEDIAN HOUSEHOLD INCOME CHANGES IN NEW JERSEY



Source: Federal Reserve Economic Data (FRED) Center, St. Louis Fed Analysis of U.S. Bureau of the Census data
<https://fred.stlouisfed.org/series/MEHOINUSNJA672N#0>

Flat income trends have resulted in growing numbers of Americans having trouble making ends meet; in 2017, almost 40 percent of adults reported that their families had difficulty meeting basic needs such as food, health care, housing, or utilities.¹¹² These challenges are more pronounced in New Jersey, which has among the highest cost of living in the nation, ranking fortieth for overall affordability and thirtieth for housing affordability.¹¹³

PROGRESS TO DATE IN NEW JERSEY

The state has addressed stagnant wages and economic opportunity through increases to the state Earned Income Tax Credit (EITC) and, most recently, the state minimum wage. The EITC is a tax credit for low- and moderate-income workers. The credit amount rises as the lowest wage levels rise, but at a certain income level, it plateaus and then gradually declines. The average annual credit is \$2,400 and 70 percent of recipients have incomes of \$25,000 or less.¹¹⁴ The EITC has been extensively studied, with evidence demonstrating that it promotes labor market entry, boosts incomes, reduces poverty, decreases

racial disparities in low-birthweight rates, and improves school performance and educational attainment among children.¹¹⁵⁻¹³⁰ The federal EITC was established in the 1970s and states began supplementing it with their own EITCs in the 1980s. Currently, 29 states, including New Jersey, have their own EITC, setting benefit levels as a percentage of the federal credit.¹³¹

New Jersey has increased its EITC three times since 2015; with an additional \$27.2 million investment in state fiscal year 2019, the state EITC will reach 39 percent of the federal credit amount this year and 40 percent next year in 2020.^{132 133 134} This translates to New Jersey having the third highest state EITC in the nation. However, in 2015, over 20 percent of qualified New Jersey workers did not receive the credit, likely due to lack of awareness, confusion about eligibility criteria, and complicated filing procedures.^{135 136} In addition, there has been no movement at the state level to increase the EITC benefits or lower age-related eligibility for childless workers.¹³⁷

New Jersey has also sought to improve incomes for low-wage workers through minimum wage

legislation. In February 2019, Governor Murphy signed legislation that will incrementally raise the minimum hourly wage from \$8.85 to \$15 by 2024,¹³⁸ making New Jersey the fourth state—alongside California, New York, and Massachusetts—to set a \$15 target through legislation. The minimum wage will increase to \$10 by July 2019 and \$11 by January 2020, followed by \$1 annual increases until it reaches

\$15 in 2024. Seasonal workers and workers at businesses with five or fewer employees will see a slower phase-in trajectory that will reach \$15 by 2026. Important particularly for the southern parts of the Garden State, farmworkers' wages will reach \$12.50 by 2024, and then a special committee will determine whether their wages will rise further.¹³⁹ Tipped workers will experience a smaller increase, from \$2.13 to \$5.13 by 2024.¹⁴⁰

RECOMMENDED POLICY OPTIONS

4.1 Increase uptake of the state and federal EITC.

Maximizing uptake is essential for obtaining the full health and social benefits of the EITC, but as noted above, certain populations who may be eligible do not claim it at high rates, including rural residents, the self-employed, and immigrants.¹⁴¹ In addition, many families with incomes below the threshold for filing a federal income tax return do not know they are eligible for the EITC.¹⁴² Of those who do file and claim the credit, many pay for tax preparation services even though free preparation is available to them,¹⁴³ as New Jersey has many free tax sites across the state.¹⁴⁴ A robust awareness campaign would ensure more eligible workers are aware of the credit and how to access free tax preparation such as the Volunteer Income Tax program offered by the United Way of Central Jersey to people with incomes below \$65,000 or persons with disability or limited English language skills. A recent study demonstrated that redesigning the Internal Revenue Service's annual tax claiming notice (to make it clearer and shorter and to highlight a worker's potential credit amount) substantially increased EITC uptake—an approach New Jersey could adopt.¹⁴⁵ Another strategy, adopted by Oregon, mandates inclusion of information about the EITC on state W-2 forms.¹⁴⁶ While a statewide awareness campaign would require financial support, New Jersey should explore a public-private partnership to secure resources, as increased EITC uptake results in positive community-wide economic impacts and is a cost-effective way of reducing poverty.¹⁴⁷

4.2 Consider enhancements to the state EITC.

There are several possible ways to increase the positive financial and health impacts of the state EITC, including offering a higher credit amount for all eligible workers, enabling childless workers under the age of 25 to claim the credit, and increasing the credit amount for childless workers. In New Jersey, childless workers under the age of 25 are not eligible for the EITC, and those ages 25 and older qualify for very modest credits. (The average federal credit for childless workers was \$280 in 2013.) Research suggests that EITC enhancements would have job-promoting and poverty-reducing effects, though New Jersey would need to weigh the costs and benefits of various expansion approaches.¹⁴⁸

4.3

Evaluate the impacts of the state’s phased-in minimum wage increases on economic and health outcomes.

Recent research suggests minimum wage increases have positive health impacts including improvements to birthweights, smoking rates, and days with health limitations (including work-related sick days).¹⁴⁹ Health effects are more mixed for teenagers and non-continuously employed adults.¹⁵⁰ These and other effects should be carefully studied with particular attention to sub-group effects by age, gender, race and ethnicity, job type, and by employer size and industry category. While minimum wage increases certainly boost pay for low- and moderate-wage workers who remain in the workforce, and likely reduce overall poverty, research regarding their impact on employment is mixed. Several studies show that increasing the minimum wage boosts income with little or no job loss, but other studies show negative impacts on employment, particularly among younger, less educated, and less-skilled workers.¹⁵¹ The size of the increase, cost of living, and labor market are all key factors that should be carefully considered. One potential, albeit unintended, consequence of a higher minimum wage is that some workers who see wage boosts may no longer qualify for some public benefits such as Medicaid or the Supplemental Nutrition Assistance Program, effectively leaving them with a net income loss (i.e., a “cliff effect”). New Jersey should study whether rules and benefit amounts should be adjusted in light of these concerns. Lastly, studies should also explore impacts on tipped workers, given the slower pace of increase in the New Jersey minimum wage for them.

4.4

Develop a strong plan for enforcing the state’s minimum wage increase.

States frequently face challenges with regard to having the resources and capacity to investigate claims of non-compliance with minimum wage rules and, even when non-compliance is established, workers are not always able to recover lost wages.¹⁵² New Jersey should design and implement a proactive strategy for assessing compliance with the law, focusing particularly on industries with poor labor records, and a fair but forceful enforcement regime including warnings, fines, and additional actions. The City of New Brunswick recently enhanced its 2014 ordinance, the first example of its kind in the state, banning wage theft.¹⁵³ However, careful consideration should be given to distinguishing between systematic violations and what those in the business community term as “honest mistakes.”¹⁵⁴

“More economic opportunities are the gateway to better health.”

Business Breakfast Participant



Healthy Communities

POLICY PRIORITY 5

5

Ensure New Jerseyans have equitable access to safe, affordable, and stable housing in the communities where they choose to live.

ABOUT THE CHALLENGE

Our communities, neighborhoods, and homes play major roles in shaping our health and well-being.¹⁵⁵ As demonstrated by a Rutgers CSHP poll of New Jersey residents, perceptions of neighborhood and housing quality differed greatly depending on one's race, ethnicity, or income, with low- and middle-income New Jerseyans less likely to be satisfied with their housing.¹⁵⁶

New Jersey has long reigned as one of the most expensive places to live, with housing costs among the highest in the country. The state's average rental costs and median home values were ranked seventh and tenth, respectively, in 2018.¹⁵⁷ The affordability crisis is especially acute for very low-income families, nearly three-quarters of whom spend more than half of their incomes on housing.¹⁵⁸ Many families are eventually

forced out of their homes, as highlighted by New Jersey's foreclosure rate, which is more than twice the national average and the highest among all 50 states. The high cost of housing and lack of affordable housing are, in part, to blame for the recent rise in homelessness, with many households one paycheck away from losing their homes. The inadequate supply of affordable housing units in the state exacerbates affordability challenges.¹⁵⁹ Estimates suggest that New Jersey has 209,000 fewer affordable rental units than needed by low-income state residents. Moreover, New Jersey remains racially segregated despite decades of efforts to reverse this pattern. Among the 100 largest metropolitan areas, New York-Northern New Jersey and Philadelphia-Camden-Wilmington have the second and ninth highest, respectively, black-white residential segregation in the country.¹⁶⁰

PROGRESS TO DATE IN NEW JERSEY

New Jersey's judicial, legislative, and executive branches have sought to address housing affordability, stability, and inclusion for decades. Beginning with a series of court rulings (known as the Mount Laurel Doctrine) and legislative actions in the 1970s and 1980s, New Jersey was one of the first states in the country to require municipalities to provide a "fair share" of affordable housing opportunities within their jurisdictions to counteract exclusionary zoning policies that fueled segregation.¹⁶¹ Unfortunately, localities challenged these affordable housing targets, and regional contribution agreements allowed wealthier municipalities to pay and transfer their affordable housing quota to often less wealthy municipalities.¹⁶² According to many experts, this loophole fostered

continued segregation and widened disparities in economic opportunities across communities. While this practice was abolished through a 2008 amendment to the New Jersey Fair Housing Act, regulatory implementation and enforcement are still needed.^{163 164} As of early 2019, approximately 200 of New Jersey's 565 municipalities have agreed to settlements regarding their affordable housing production goals.¹⁶⁵ New Jersey has one of the largest state rental assistance programs in the country, providing support to nearly 4,000 households. However, funding for the program has been taken from the state Affordable Housing Trust Fund, which is supported through realty transfer fees and was originally intended for affordable housing production and preservation. This practice has continued for years and has hampered the state and municipalities from meeting their "fair share" housing goals. In the fiscal year 2019 state budget, \$15 million of the fund was set aside for affordable housing production and preservation purposes. In October 2018, Governor Murphy unveiled an economic development plan,^{166 167} which enumerated several strategies to address housing shortages and affordability, including promoting new and existing state and federal tax credits and leveraging the federal "Opportunity Zone" program to attract private long-term capital investments in low-income rural and urban areas.^{168 169} In addition, the New Jersey State Housing and Mortgage Finance Agency recently committed \$12 million to match investments made by hospitals for developing supportive housing.^{170 171} These partnerships are rooted in the recognition that housing stability is a driver of health outcomes and the private sector is an important partner in addressing the housing crisis.

RECOMMENDED POLICY OPTIONS

5.1 Engage and empower community residents and organizations in housing and community development decision-making.

While the state government has a key role to play in promoting affordable and stable housing, development decisions are intensely local, involving policy choices about land use, planning, zoning, and whether development will benefit residents across the socio-economic spectrum. A nationwide trend toward urban reinvestment and revitalization holds great promise but has also led to displacement of long-tenured residents who lose out on reaping the benefits of improved communities. This has had disproportionate impacts on communities of color. The state could maximize the equity-promoting effects of development through various means: for example, it could set community engagement standards and community benefit requirements for any development project receiving state tax credits or state financing. Another strategy growing in prominence is participatory budgeting,^{172 173} which allows residents greater influence over public spending, including, in theory, development financing.^{174 175} These approaches are still evolving, so careful consideration and local tailoring are needed. In addition, philanthropies, health systems, and socially minded businesses could invest in local community organizing groups focused on protecting the rights and elevating the voice of low-income tenants and homeowners.¹⁷⁶ Emerging research shows that community-organizing strategies can improve health equity by building power among marginalized groups and addressing the root causes of disparities.¹⁷⁷

5.2 Increase affordable housing production and preservation.

As noted above, the state's affordable housing supply does not meet growing demand, so a comprehensive multi-year strategy to increase supply is essential. Moreover, existing sources of funding are insufficient, and major new public and private investments at the federal, state, and local levels will be needed. We highlight here a few high-priority approaches. First, ensure the state Affordable Housing Trust Fund is dedicated, as designed under the original law, to affordable housing production and preservation, providing approximately \$75 million annually. Research suggests that trust funds can increase the supply of affordable, high-quality housing.¹⁷⁸ A recent expansion of the Neighborhood Revitalization Tax Credit could also help meet some housing needs.¹⁷⁹ Second, develop a clear regulatory and enforcement process regarding the requirement that affordable housing be produced when state-owned lands or state funds are used for development. This obligation was created under the state Fair Housing Act of 2008 and applies to state agencies such as the Department of Community Affairs, the Department of Transportation, including NJ Transit, the Economic Development Authority, and the Department of Environmental Protection.

5.3 Promote economic and racial diversity within communities.

First, build on the successes of the Mount Laurel Doctrine in tackling exclusionary zoning in New Jersey municipalities through continued monitoring and enforcement, state support for affordable housing production in “fair share” communities, and assisting communities with managing required growth in multi-unit affordable housing. Second, the state should encourage localities to adopt their own inclusionary zoning (IZ) policies, which can help mitigate gentrification-induced displacement of long-time residents, particularly when part of a comprehensive, multi-component affordable housing strategy.^{180 181} However, IZ policies vary in effectiveness based on local housing market conditions and can sometimes drive up development costs. Third, enforce an existing state law that prohibits discrimination against prospective renters who use Housing Choice Vouchers to pay a portion of their rent.¹⁸² Lastly, leverage the state’s authority in setting Qualified Allocation Plan criteria as part of the Low-Income Housing Tax Credit to increase the number of affordable housing units built in higher-opportunity areas with lower levels of poverty.^{183 184 185 186}

“Safe, affordable, healthy housing... with [too many] residents paying more than half of their incomes on housing...We are in a crisis.”

*Business Breakfast
Participant*

5.4 Continue to engage hospitals, health systems, and insurers in collaborative efforts to develop affordable housing for those most in need.

The state Housing and Mortgage Finance Agency should evaluate the impact of its recent commitment to match affordable housing funding from four health systems and, as appropriate, expand this approach. Recent research demonstrates that such partnerships are effective when they pool funds from public and private sources, engage communities in setting priorities, and share data across systems to target interventions and measure outcomes.¹⁸⁷ Some New Jersey health systems are seen as pioneers in this space: Cooper Health System, for example, has helped to revitalize a 10-block area around its campus in Camden.¹⁸⁸ Many states are also leveraging their Medicaid programs to pay for housing search and moving costs as well as supportive health and social services for patients with complex medical needs.^{189 190 191}

Prevent childhood lead poisoning by maximizing state and federal funding and ensuring properties are lead-safe through inspection, remediation and enforcement.

ABOUT THE CHALLENGE

Lead exposure, especially in infants and young children, affects brain development and functioning and can lead to impairment of executive functions, poor educational performance, and behavioral problems such as impulsivity, attention deficits, and aggression.¹⁹² Affected children have a higher risk of dropping out of school, becoming involved in the criminal justice system, and earning less throughout their lives.^{193 194} Despite the nationwide decline over the last half-century in the percentage of children with elevated blood lead levels (BLLs), currently defined as five micrograms or higher per deciliter, exposure remains all too common, particularly for children from low-income families and those who are non-white.¹⁹⁵

While there are many environmental sources of lead, lead-based paint, and dust, especially in older (pre-1978) homes, aging water distribution systems are among the most common sources of lead exposure.¹⁹⁶ In New Jersey, more than two-thirds of housing units are estimated to have been built prior to 1980,¹⁹⁷ and low-income neighborhoods with a high proportion of older rental units are most likely to have lead hazards. According to Jersey Water Works, the state has approximately 350,000 homes and businesses with lead service lines (LSLs), ranking fifth highest in the nation.¹⁹⁸ As recently as 2017, approximately 4,800 children in New Jersey were found to have elevated BLLs.^{199 200}

PROGRESS TO DATE IN NEW JERSEY

In 2004, the state legislature created the *Lead Hazard Control Assistance Fund*, which is financed by tax revenue from paint sales, to support property owners to safely remove or reduce lead risks. Over the subsequent decade, however, this proved to be an unreliable and unstable revenue source as funding was repeatedly redirected to other priorities.²⁰¹ During the 2017-2018 fiscal year, the state allocated \$20 million toward lead testing and lead paint abatement for older residential structures and enhanced testing for children.²⁰² In addition to this welcome reversal of a decade-long trend, New Jersey also put in place a number of policies to advance screening, prevention, and remediation of lead hazards. These include lowering of BLL threshold for action to 5 mcg/dL, tying this level to that recommended by the U.S. Centers for Disease Control and Prevention, and increasing public health prevention and case management services. More recently, Commissioner Elnahal of the New Jersey Department of Health has made lead exposure reduction a key priority for his agency during his tenure.²⁰³ Furthermore, nongovernmental organizations—with crucial support from the Fund for New Jersey—have developed plans, stakeholder engagement strategies, and advocacy efforts to eliminate New Jersey's lead threat within 10 years,²⁰⁴ including a special focus on LSLs.²⁰⁵ Finally, the Securing our Children's Future Act, which was approved by state voters in November 2018, makes \$100 million available to improve school drinking water infrastructure in the state.

RECOMMENDED POLICY OPTIONS

6.1 Maximize the use of the New Jersey Lead Hazard Control Assistance Fund (LHCAF) for lead poisoning prevention efforts and target funding toward effective interventions.

Lead poisoning is preventable, but correcting this pervasive environmental problem requires consistent resources and steadfast leadership.^{206 207} First, the LHCAF should be funded directly through the paint sale surcharge as outlined in the original law, rather than through annual appropriations, to create predictability and foster long-term planning. In addition, the state should seek out steady increases in funding for lead poisoning prevention from public and private sources. Second, the LHCAF and any other funds for lead poisoning prevention should be directed toward effective strategies, such as the Lead Safe Home Remediation Pilot Program, which addresses lead paint risks in older homes in high-risk communities;²⁰⁸ enforcement of the U.S. Environmental Protection Agency’s Renovation, Repair, and Painting (RRP) Rule, which requires renovation activities in pre-1978 properties to be carried out only by trained and certified professionals; full LSL replacement in homes and schools; and the lead-safe home certification program described below.²⁰⁹ All these strategies provide a positive return on investment when accounting for savings to the state’s health care, education, and criminal justice systems as well as higher lifetime earnings among children protected from lead exposure.²¹⁰ On RRP specifically, the state should work with localities to educate businesses and consumers about the rule and require training and certification before any work permits are issued and dust testing after work is completed. For LSL replacement, the state should also tap into the New Jersey Water Bank, which provides low-cost financing to support local governments with water and environmental infrastructure projects.²¹¹

6.2 Seek additional federal support, including funding via the Children’s Health Insurance Program (CHIP), to target lead prevention efforts to low-income children.

To supplement existing resources, New Jersey could take advantage of a CHIP provision—the Health Services Initiative, or HSI—to acquire federal funding support for its lead exposure assessment and remediation efforts. According to the Centers for Medicare & Medicaid Services (CMS), an HSI is a state initiative designed to “improve the health of low-income children,” and recent CMS guidance specifically affirms the feasibility of using the funds for lead screening, education, and abatement activities.²¹² Michigan and Maryland, with their recent HSI approvals, present good models of leveraging this underutilized and relatively generous federal matching payment.^{213 214} Michigan’s HSI-funded services are available to any person under 19 who is eligible for CHIP or Medicaid and include interventions related to lead paint and dust hazards, LSL replacement, lead hazards in soil, pre- and post-intervention environmental testing, and training for those doing remediation. To qualify, the HSI budget must be capped at 10 percent of the

“How many children are starting kindergarten with lead poisoning in our state?”

Stakeholder

state's CHIP-covered expenditures, and New Jersey must clearly establish the need, develop performance metrics, and demonstrate effectiveness of abatement activities. Beyond these tracking requirements, the state would benefit from more robust data on lead exposure risks from paint, water, and soil, as well as lead testing results for children at the local level and broken out by income, race, and ethnicity. Developing such data systems will be challenging but necessary to secure additional resources, allocate funds efficiently and equitably, and increase transparency and accountability.

6.3 Require all rental and owner-occupied properties be certified as lead-safe prior to turnover or sale and/or on a periodic basis.

Research shows that children living in federally assisted rental housing, which is covered by federal regulations requiring the identification and remediation of lead hazards, have lower BLLs than children in unsubsidized housing units.²¹⁵ This finding illustrates the positive impact of standardizing and systematically enforcing housing standards and holding property owners/managers accountable for lead remediation. Several states, such as Massachusetts, Maryland, New York, and Ohio, require all properties to be certified as lead-safe on a periodic basis and/or at the time of rental or sale.²¹⁶ If lead hazards are found, property owners must remediate them using their own resources and/or other funds, such as state tax credits or low-interest loans (as in MA). States often pair this strategy with proactive code enforcement to assess and address lead hazards before substantial exposure occurs. Inspection, certification, and enforcement regimes have contributed to sizable reductions in the number of children with elevated BLLs in states and cities that have adopted the approach. States and localities can leverage data to target high-risk neighborhoods, properties, and property owners for inspection. New Jersey does not have a uniform statewide lead-safe requirement (or property maintenance code), does not conduct inspections proactively, and does not have the capacity to reach all high-risk properties regularly, particularly single- or double-unit properties.²¹⁷ New Jersey should leverage the resources described above and partner with municipalities to put these approaches into place. Massachusetts has funded its inspection and remediation program, in part, through surcharges on annual licensing fees for real estate brokers, property and casualty insurance agents, and mortgage brokers, among others.

Expand equitable access to healthy food in communities and schools.

ABOUT THE CHALLENGE

Over 900,000 people in New Jersey—10 percent of all residents—suffer from food insecurity, and approximately one-third of these vulnerable New Jerseyans are children. Food insecurity is the lack of or uncertain access to affordable, nutritious, and safe food.^{218 219 220} New Jersey fares better on this metric than the United States as a whole, but there are still large and troubling disparities by county within the state.^{221 222} For example, food insecurity affects six percent of residents in Morris County and 17 percent in neighboring Essex County.²²³

Research indicates that food-insecure children are almost twice as likely to be in fair or poor health as food-secure children and are significantly more likely to be hospitalized.²²⁴ Food insecurity is also associated with obesity and type 2 diabetes,^{225 226 227} developmental risks,^{228 229} and poor academic performance.²³⁰ Nearly 300,000 New Jerseyans live in food deserts with limited access to healthy, affordable foods, and in many urban communities, food environments are saturated with corner stores and other retailers that typically stock and promote cheap, unhealthy packaged foods and sugary beverages.²³¹ Moreover, utilization of nutrition assistance programs in New Jersey is lagging: among those who are eligible, only 81 percent of residents receive Supplemental Nutrition Assistance Program (SNAP) benefits, and just 51 percent receive Special Supplemental Nutrition Program for Women Infants and Children (WIC) benefits.^{232 233}

PROGRESS TO DATE IN NEW JERSEY

SNAP participation in New Jersey has generally followed national trends and fluctuations in the overall economy, but, as mentioned earlier, participation as a proportion of all those who are eligible is lower in New Jersey (81%) than the country as a whole (85%).²³⁴ New Jersey sets eligibility at 185 percent of the federal poverty level, which is more generous than 35 other states. Approximately 400,000 schoolchildren benefit from free or reduced-price (FRP) lunch, with the highest participation in the northeastern part of the state and the lowest participation in the northwest.²³⁵ The 2011 New Jersey Food for Thought campaign led to substantial increases in participation in the federal breakfast program, but it still only serves half of all eligible children.²³⁶

In 2018, the state legislature passed a law requiring all schools with 70 percent of students eligible for FRP lunch to offer breakfast and participate in the Summer Food Service Program.^{237 238} Moreover, use of the Community Eligibility Provision (CEP) in New Jersey, which allows *all* children in high-poverty schools to access free breakfast and lunch without individual households having to apply, is lower than in 34 other states, including all of New Jersey's geographic neighbors. Since 2014, the state has, however, helped more than 80 school districts participate in CEP.

Through public-private partnerships involving the New Jersey Department of Health (DOH), the New Jersey Economic Development Authority (NJEDA), The Food Trust, New Jersey Partnership for Healthy Kids, and the Reinvestment Fund, the state has developed a network of 150 healthy corner stores in 23 cities that stock and promote healthy foods and a \$20 million fund to assist supermarkets and other food retailers to open in food deserts across the state.²³⁹ As of early February 2019, 16 bills were passed by the General Assembly

aiming to eliminate food insecurity, tackle food waste, address hunger on college campuses, streamline enrollment in nutrition assistance programs, engage farmers, and support food retailers.^{240 241} One bill provides four years of property tax credits for supermarkets and grocery stores that open in designated food deserts,²⁴² and another bill offers up to \$5,100 per corner store to assist them in stocking, marketing, and selling fruits, vegetables, and other healthy foods.²⁴³

RECOMMENDED POLICY OPTIONS:

7.1 Increase enrollment in and use of federal food assistance programs.

State agencies should continue to advance their close and productive collaboration with community and advocacy organizations to increase participation in SNAP (through the New Jersey Department of Human Services), WIC (through DOH), and the Child and Adult Care Food Program (CACFP), which reimburses day care providers for offering snacks and meals through the New Jersey Department of Agriculture (DOA). The state should: maximize existing interagency efforts and cross sector initiatives to bolster outreach to high-need populations, particularly non-English speakers and rural residents; streamline the application process by leveraging data from other public benefit programs for eligibility verification; utilize online, in-person, and phone-based certification processes; maintain waivers from SNAP work requirements in high-unemployment areas; and ease the process for small food stores to accept SNAP and WIC.²⁴⁴ (See Policy Priority 12 for recommendations about improving online public benefits enrollment.) To bring more child care sites into CACFP, the DOA should strengthen program administration, support food buying hubs that smaller providers can join, engage school districts as meal vendors or sponsors, adopt universal menus, and offer more training and technical assistance.²⁴⁵

7.2 Increase participation in federal FRP meal programs in schools.

The DOA should leverage its existing partnerships with community groups to expand training and technical assistance to schools, districts, and meal providers to fully implement the requirement that schools with 70 percent of students eligible for FRP lunch offer breakfast after the bell.²⁴⁶ The state should also bolster its efforts to encourage greater participation in CEP in order to reduce redundant paperwork, ensure that low-income children don't fall through the cracks, and eliminate stigma. Given that CEP participation rates have not changed from 2014-15 to 2015-16, the DOA could assess outreach and training strategies of other states and determine whether there are policy barriers to program adoption.²⁴⁷

7.3

Improve availability and accessibility of fresh produce and healthy foods in communities.

The state should leverage any new funding to build on the existing healthy corner store and supermarket development programs. The DOH should lead the effort in helping corner stores procure and market healthy foods and develop partnerships with health organizations, while NJEDA could conduct market analyses and help supermarket developers access public and private sector financing. The DOH, in partnership with academic researchers, should continue to study the health and economic impacts of these strategies. Early evidence shows that healthy corner stores and new supermarkets increase the availability of healthy foods^{248 249} but changes in food purchasing behaviors have been more elusive.^{250 251}

“A box of cereal is \$6-\$7...it has to be affordable to the point where it’s attainable.”

Community Participant

POLICY PRIORITY 8

8

Ensure all roads, sidewalks, and public transit systems are safe and accessible to all potential users.

ABOUT THE CHALLENGE

Equitable, safe transportation systems connect people to economic, social, and learning opportunities. They shape the contours of our neighborhoods, influence our everyday decisions, and are an essential ingredient in the well-being of individuals and the vitality of communities.²⁵² For decades, New Jersey’s transportation projects were built primarily to accommodate vehicular traffic.²⁵³ Historically, New Jersey has among the most densely traveled roads, and this density combined with suburban sprawl results in ubiquitous traffic congestion, heightened personal stress, loss of productivity, and decreased quality of life for motorists.²⁵⁴ In addition, motor vehicle crashes—which include crashes involving automobiles, bicycles, and pedestrians—remain the leading cause of death among young people ages 8-24.²⁵⁵ While New Jersey has the fourth lowest rate of such crashes in the nation, there are

significant disparities as rates among blacks are 25 percent higher than among whites, and the state’s pedestrian fatality rate is higher than the national average.^{256 257 258 259} Making transportation systems accessible, safe, and equitable across all communities and modes of transit is only possible with adequate resources, and New Jersey has long struggled to ensure stable and sufficient funding streams for roads and public transit. The Transportation Trust Fund (TTF), created to pay for New Jersey’s surface transportation infrastructure, was depleted in 2016 after decades of insufficient funding.^{260 261 262} While the Fund received a boost through recent gas tax increases, it continues to fall far short of meeting the state’s massive maintenance, repair, and capital needs for all users—pedestrians, bicyclists, motorists, and transit vehicle users.

PROGRESS TO DATE IN NEW JERSEY

As early as 2009, the New Jersey Department of Transportation (DOT) approved a Complete Streets policy for federally and state-funded projects,²⁶³ making the state a leader in the nation.²⁶⁴ (Complete Streets is an approach to transportation design and operation that enables safe access for users of all ages, modes, and abilities.) Since then, the DOT has provided guidance and technical assistance for local adoption of this strategy, as counties and municipalities own and maintain more than 90 percent of New Jersey's roadways. As of February 2019, eight (of 21) counties and 149 (of 565) municipalities have adopted some form of a Complete Streets policy.²⁶⁵ An upcoming (spring 2019) Complete Streets model policy and guide by the New Jersey Complete Streets Working Group—a partnership of advocates, not-for-profit organizations, and local and state government representatives—should be a helpful resource for all remaining localities. It outlines an approach to policy adoption that prioritizes health, equity, and fairness in transportation expenditures, incorporates green storm water management practices, and includes

ready-to-adopt implementation standards to ensure policy objectives are met. This document will describe concrete steps to move from policy adoption to implementation.

In 2015, New Jersey adopted a national vision of halving traffic deaths by 2030 (Toward Zero Deaths),^{266 267} and Jersey City became the first municipality in the state to commit to eradicate all traffic deaths through Vision Zero, an international campaign for safe, healthy, equitable mobility for all.^{268 269} Other progress from the last year includes: legislative actions to speed up capital projects funded by TTF;²⁷⁰ reforms to the operations of NJ Transit along with a boost to its financial health through a potential new non-transit revenue stream (developing—or selling for development—its sizable real estate holdings into transit-oriented communities);^{271 272} the establishment of a new statewide Office of Transit-Oriented Development;^{273 274 275} and the creation of a Transportation Infrastructure Bank to offer low-cost financing for local transportation projects.²⁷⁶ These changes encourage many New Jerseyans' emerging preference for mixed-use, walkable communities with easy access to public transit.^{277 278 279}

RECOMMENDED POLICY OPTIONS:

8.1

Accelerate adoption and implementation of Complete Streets policies in localities, with a focus on health equity.

Strong evidence demonstrates that Complete Streets approaches improve pedestrian and cyclist safety, increase physical activity levels, and can lead to enhanced individual, social, and economic well-being in the adopting community in part through reduced vehicular travel and improved air quality.^{280 281 282} The state should adopt a broader Complete Streets vision focusing on health equity coupled with robust guidance for localities and sufficient resources for implementation and evaluation.^{283 284 285} Specific strategies should include: targeting adoption and implementation resources to communities with the highest rates of crashes and deaths; requiring—and providing funding to—municipalities to engage community

members in prioritizing local transit projects; assisting localities in leveraging other state transportation resources to integrate Complete Streets policies into larger transportation and community development strategies; and evaluating impacts of these policies on motor vehicle crash disparities. As Massachusetts has done, New Jersey should consider ways to dedicate a meaningful portion of Complete Streets and other transit funds to localities where average household income falls below the state median.²⁸⁶ Cost, the complexity of policies that cross municipal boundaries, and turnover of county and municipal officials and staff can impede progress with Complete Streets.²⁸⁷ The state can address such challenges by helping to align or harmonize policies regionally and locally. In addition, New Jersey should promote collaboration among state agencies and departments to maximize the integration of health equity considerations in transportation decision-making.

8.2

Engage the metropolitan planning organizations (MPOs) in leveraging federal funds to support county and municipal transportation investments that promote health equity.

MPOs are federally mandated policymaking boards responsible for creating short- and long-term transportation plans for their respective metropolitan regions and for prioritizing and coordinating federally funded transportation projects.²⁸⁸ As the entire state of New Jersey is covered by three MPOs, they are important partners in defining a shared vision and shaping state as well as local transportation policy priorities.²⁸⁹ These MPOs should focus efforts on a) dedicating funding for active transportation, b) using performance measures that include health outcomes to analyze and score proposed transportation projects, and c) measuring the impacts of transportation investments on health equity.

“There needs to be zoning laws that focus on the walkability of the built environment.”

Community Participant

POLICY PRIORITY 9

9

Reduce tobacco use disparities through price increases and cessation programs.

ABOUT THE CHALLENGE

Despite substantial public health progress over the last several decades, tobacco use remains the leading cause of death and disability in the United States. The U.S. Centers for Disease Control and Prevention (CDC) estimates that smoking-related diseases accounted for approximately 12,000

deaths and \$4 billion in health care spending annually in New Jersey in the late 2000s. While New Jersey has the seventh lowest adult smoking rate in the United States (13.7%),²⁹⁰ glaring disparities still exist across the state, with smoking rates in lower-income communities, such as Atlantic County (19%), nearly double those of

more affluent counties, such as Somerset (11%).²⁹¹ The prevalence of tobacco use among New Jersey youth is close to the national average of 16.8 percent, with e-cigarette, hookah, and cigar use being higher than cigarette use and Hispanic and black teens having higher use of certain products than white teens.²⁹²

Tobacco use has become increasingly concentrated among socially vulnerable groups, including people with lower incomes and educational attainment; lesbian, gay, bisexual, or transgender people; those without insurance or covered by Medicaid; and people with mental illness.^{293 294} In addition, blacks have a greater risk of dying from smoking-related diseases than whites even though they generally smoke fewer cigarettes and begin smoking at later ages.²⁹⁵ While disadvantaged groups report wanting to quit at equal or greater rates than more advantaged groups, they are less likely to quit successfully, possibly due to the underutilization of, and lack of access to, effective smoking cessation treatments.²⁹⁶ Effective tobacco control policies also have not been equally adopted and enforced in communities with large proportions of low-income residents and people of color.²⁹⁷ In addition, New Jersey has only invested 10.5 percent of the CDC-recommended amount of funding in tobacco prevention and cessation activities.²⁹⁸

PROGRESS TO DATE IN NEW JERSEY

In 2006, New Jersey enacted the Smokefree Air Act, which prohibited smoking in bars, restaurants, and workplaces, and near schools. Three years later, New Jersey became the first state to address electronic cigarette use by including them under its smoke-free law.²⁹⁹ In 2017, New Jersey was the third state to raise the minimum legal age for the purchase of tobacco products to 21.³⁰⁰ The momentum continued the following year as the smoke-free law was extended to public parks and beaches³⁰¹ and a new tax on liquid nicotine was implemented.³⁰² By 2018, New Jersey had the tenth highest cigarette tax rate (\$2.70 per pack) in the country, slightly more than Pennsylvania (\$2.60/pack) and Delaware (\$2.10/pack) but falling well below the rate of \$4.35 per pack in New York and Connecticut.³⁰³ In 2018, with an eye toward enhancing treatment and reducing disparities in tobacco use, the state removed prior authorization requirements for tobacco cessation medications in the Medicaid program and has plans to include group counseling for tobacco cessation as a covered service in 2019.³⁰⁴ Recently, the New Jersey Department of Health (DOH) also announced a \$6.7 million investment to combat smoking and e-cigarette use among youth, including resources for treatment, public awareness and youth engagement, and policy change, enabled through 2017 legislation mandating that one percent of revenue from taxes on tobacco products be directed to such DOH programs.³⁰⁵

RECOMMENDED POLICY OPTIONS

9.1 Consider substantial increases to state tobacco taxes.

Research shows that tobacco taxes reduce smoking, particularly among young people, low-income smokers, and racial and ethnic minorities.³⁰⁶ As a point of reference, a 20 percent increase in the price of tobacco products results in a 10 percent decline in overall consumption, a four percent decline in adult use, and a nine percent decline in youth initiation.³⁰⁷ Lower smoking rates are associated with reductions in health care costs,³⁰⁸ with the promise of some savings to the Medicaid program,³⁰⁹ both directly for smokers and for those affected by smoking, including babies born prematurely to mothers who smoke.³¹⁰ If the cigarette tax were increased, the state should consider raising taxes proportionately on cigars, little cigars, smokeless tobacco, and e-cigarettes to prevent switching to other tobacco products. To mitigate the tax's impact on low-income smokers who may still have trouble quitting despite the price increase, the state should dedicate tax revenue to targeted cessation efforts as described below. While higher tobacco taxes do create greater enforcement challenges, New Jersey can leverage effective strategies used by other states to prevent or reduce tax evasion,³¹¹ such as high-tech tax stamps on tobacco products, which the state has authorized but not yet implemented.³¹²

9.2 Dedicate a substantial portion of tobacco tax revenue to: a) state tobacco control programs with a focus on prevention and cessation for populations with high smoking rates, and b) other policy recommendations in this report that require funding.

All neighboring states are closer than New Jersey to meeting CDC recommendations for tobacco control spending (13% in Pennsylvania, 21% in New York, and 54% in Delaware versus 10.5% in New Jersey).³¹³ The state should double down on its support for prevention and cessation activities through revenue from the tobacco tax increase. This is particularly important for moderating the regressive impacts of the tax on low-income smokers. In addition to having less access to effective cessation treatments, socially disadvantaged smokers are exposed to more tobacco advertising, live in homes and communities with more smokers, and are more likely to smoke mentholated cigarettes that can make quitting more difficult.^{314 315 316} New Jersey could leverage its recent investments in 11 regional “quit centers” located in counties with the highest incidence of tobacco-related diseases to meet the needs of these groups. Several studies demonstrate that state tobacco control programs are effective in preventing initiation, promoting quitting, and reducing consumption.^{317 318} A study of California's tobacco control program found that a \$2.4 billion investment from 1989 to 2008 led to cumulative health care expenditure savings of \$134 billion (\$56 in savings for each \$1).³¹⁹ Evidence from Massachusetts shows that tobacco control efforts focused on Medicaid enrollees³²⁰ led to a return on investment of \$2.12 for every \$1 spent.³²¹ While New Jersey has taken important steps to increase access to tobacco cessation services for Medicaid beneficiaries, it should invest in raising awareness of these benefits and closely monitor treatment utilization and quit rates.

“All prices of all products reflective of all costs—taxing what we don't want.”

*Business Breakfast
Participant*



High-Quality, Equitable Health and Social Service Systems

POLICY PRIORITY 10

10

Shift the health care system’s focus toward delivering whole-person care, working with other systems to promote overall health and well-being.

ABOUT THE CHALLENGE:

New Jersey spends more per capita on health care than most other states, ranking fifth and fourteenth highest among states on Medicare and employer-sponsored insurance spending, respectively.³²² Yet even with these expenditures, it has a larger share of residents reporting their health status as fair or poor, ranking twenty-ninth among states on this marker.³²³ Research

demonstrates that factors outside of the health care system—such as housing, food security, education, employment, and experiences of trauma—account for approximately 80 percent of the variation in health outcomes.³²⁴ To achieve true health—what the World Health Organization describes as “complete physical, mental, and social well-being and not merely the absence of disease or infirmity”³²⁵—health care systems, including

providers, insurers, and hospitals, need to develop better strategies for aligning with public health and social service systems to meet people’s physical, mental, and social needs.³²⁶ Such a “whole-person” approach also includes providing care that is timely, affordable, and engendering of mutual trust.

Despite the increased awareness of the need for aligned systems that address social and community factors, the U.S. health care system still faces barriers to actualizing these changes, including separate financing streams and delivery systems, insufficient data sharing within and across sectors, and payment models that still reward the volume of services delivered rather than improved health outcomes.^{327 328}

PROGRESS TO DATE IN NEW JERSEY

New Jersey has made gains in adopting policies and pursuing investments focused on “whole-person” care. As was noted previously in this report, New Jersey has been very active in shoring-up protections of its health insurance market by enacting a state-level individual mandate and reinsurance program, which translates into residents being able to secure more affordable, stable coverage. In addition, the Medicaid program recently expanded access to treatment for opioid use disorders, autism spectrum disorders, and family planning.³²⁹ In its Medicaid managed care program, New Jersey has adopted various provisions to address beneficiaries’ social needs, including covering non-traditional services, requiring partnerships with community-based organizations, and adopting care coordination strategies.³³⁰ And, the recently announced “Medicaid Innovation Office” holds great promise for additional reforms focused on value, quality, and whole-person care.³³¹ Several health systems have implemented integrated care models and focused on upstream determinants of health, including RWJBarnabas Health which is investing locally and supporting initiatives around healthy homes, workforce development, and urban

Figure 7

MANY FACTORS BEYOND HEALTH CARE INFLUENCE OUR HEALTH AND WELL-BEING



Source: County Health Rankings: What and Why We Rank: Model--Health Factors

greenhouses.³³² As noted earlier, in Policy Priority 5 regarding housing policy, the state Housing and Mortgage Finance Agency also recently partnered with the New Jersey Hospital Association to match investments made by four health systems in affordable housing. Another New Jersey organization, the Camden Coalition of Healthcare Providers, has developed a care model for people with complex health and social needs and shared its vision and expertise with partners across the country through the National Center for Complex Health and Social Needs.

RECOMMENDED POLICY OPTIONS

10.1 Enhance Medicaid managed care contract incentives and requirements to address people's social needs.

While many state Medicaid managed care systems are beginning to address social needs through case management and partnerships with community agencies, payment incentives linked to social determinants of health are by no means commonplace among states.³³³ New Jersey, for example, requires Medicaid managed care organizations (MCOs) to establish a community advisory committee representing various sectors. However, 13 states take a step further by integrating measures related to addressing social needs into MCO quality assessment and performance improvement requirements. Oregon, for example, monitors whether MCOs use community health workers to promote individual and population health in certain geographies. Five states incorporate addressing social needs into value-based purchasing strategies, and two states (Arizona and North Carolina) have mandates or incentives for MCOs to invest in community health needs.³³⁴ Evidence for such strategies is still emerging, so in pursuing such reforms, New Jersey should carefully evaluate costs and benefits, as well as necessary tradeoffs and potential unintended consequences.

10.2 Support health systems and hospitals in addressing people's health and social needs in the context of community.

State actions can increase health system investments in whole-person care and community health, create sustainable financing mechanisms, and spur evaluations of returns on investment.³³⁵ ³³⁶ The New Jersey Department of Human Services should build on lessons from its first experience certifying Medicaid Accountable Care Organizations (ACOs) by providing continued support to ACOs, including assisting with strategy and governance, building community partnerships, enhancing data sharing and systems, and encouraging MCO participation.³³⁷ In addition, the state should create an enabling environment for health systems to invest in community development, whether through housing, small business development, or urban green space. Health systems with missions focused on community health, a shared fate with their surrounding neighborhoods, and an eye on the future of health care payment and delivery are more inclined to make investments in social and community conditions. States can help by incentivizing such approaches through value-based payment models, Medicaid managed care contracting, and community development grants and tax credits. Cooper University Hospital in Camden, for example, leveraged the state's Neighborhood Revitalization Tax Credit to renovate more than 100 properties in its surrounding neighborhoods.³³⁸

10.3

Enable state health care, public health, and social service funding streams to be aligned or combined to achieve common health and well-being goals.

People’s health needs go well beyond capacities of a single state agency, so creatively combining funds within and across agencies can foster multi-sector strategic planning, efficiency in resource use, and improved individual and community well-being. While New Jersey has experimented with such models, some states are going much further.³³⁹ Rhode Island, for example, has blended maternal health, chronic disease, substance abuse, and other funding streams to create 10 “Health Equity Zones” throughout the state.³⁴⁰ Teams of health care, social service, and advocacy organizations have led data-driven efforts to tackle their communities’ most pressing issues, including diverting people with opioid use disorder away from the criminal justice system, reducing social isolation, and helping to eliminate childhood lead poisoning.³⁴¹ State investments in robust data systems and practical, flexible data sharing processes are crucial to such funding strategies.

10.4

Elevate people’s voices in state health policy decisions.

Power—the ability to shape and make decisions—can be considered a fundamental determinant of health,³⁴² and policy engagement can be an opportunity for empowerment. To ensure that health systems are responsive to the needs of their communities, they must actively, openly, and consistently engage local residents in identifying problems and assets and developing and prioritizing solutions. The state, including through Medicaid and other programs, should pursue strategies to engage program participants and other stakeholders in decision-making. This can be achieved by working with trusted local stakeholders to conduct listening and learning sessions in communities with diverse health assets and challenges, using lay language to involve people in the early stages of policy design and then through the implementation and assessment phases, reporting back to those who were engaged about how their input shaped the program, and involving leaders of state agencies—along with frontline staff—in such conversations.³⁴³ One such example is Massachusetts Medicaid’s One Care Implementation Council, which has been focused on improving care for those dually eligible for Medicaid and Medicare.³⁴⁴ The Council includes patients, caregivers, community groups, advocates, and providers, along with program leaders—all integrally involved in program design and implementation.

“Doctors [need to be] more responsive to what’s happening in your life.”

Community Participant

Ensure access to comprehensive, integrated mental health and addiction services.

ABOUT THE CHALLENGE

Nationally, approximately one in five people suffer from mental illness or addictive disorders—affecting families and communities across every geography, race and ethnicity, and income level.³⁴⁵ In 2018, over 3,000 New Jersey residents are believed to have died from drug overdoses, and suicides among 10-to-18-year-olds in the state have increased by more than 50 percent over the past decade.^{346 347} Evidence has shown that a person’s mental health is a strong determinant of their physical health—and vice versa. Over two-thirds of those with mental illness also have one or more chronic physical illnesses, and, not surprisingly, shorter life expectancies.³⁴⁸ Substance use disorders (SUDs) are likewise associated with higher chronic disease burden and mortality risk,³⁴⁹ and people with mental health problems or SUDs use more health care services.³⁵⁰ In fact, over 90 percent of New Jersey Medicaid patients in the highest utilization cost bracket have mental health or substance misuse diagnoses,³⁵¹ and the New Jersey Hospital Association reports that 65 percent of the increase in emergency department use between 2011 and 2015 was among people who had a mental health or substance use disorder diagnosis.³⁵²

The high costs and poor outcomes for people with mental health or substance use diagnoses are driven, in part, by inadequate access to coordinated care that meets their needs. Physical and behavioral health services are often siloed—housed in separate locations and paid for by unaligned funding streams with disconnected

medical records and clinical care plans. This “perfect storm” of care delivery factors means that vulnerable patients are not served in a coordinated, seamless way that can help them achieve their best health outcomes. These gaps in care do not affect everyone equally. People of color often seek care for behavioral health concerns from their primary care physicians, but these patients are often left untreated or undertreated.³⁵³ In a 2015 survey of New Jersey primary care physicians, most reported no behavioral health resources within their practices, and three-fourths disagreed that “it is easy to secure mental health services” for their patients who need them.³⁵⁴ Concerns about access to mental health services echoed throughout conversations with stakeholders, not only in development of this report but also in other recent policy discussions focused on drivers of health and well-being throughout the state.

PROGRESS TO DATE IN NEW JERSEY

New Jersey has taken a number of important steps toward behavioral health integration. State officials have focused on enhancing integration within the Medicaid program, which provides benefits to 1.7 million individuals, including some of the state’s most vulnerable residents who require clinically complex care. Beginning with the state’s 2012 Medicaid comprehensive demonstration waiver and continuing with the waiver renewal that began in 2018, New Jersey has improved management and integration of behavioral health. Most recently, state Medicaid managed care contracts “carved in” certain behavioral health services for selected populations, including those receiving long-term



care, many of those dually eligible for Medicaid and Medicare, and those receiving developmental disability services. They also are offering a broader suite of benefits to these same groups for treatment of SUDs, including opioid addiction. All Medicaid managed care organizations in the state now also bear risk for *all* inpatient psychiatric admissions just as they do for medical admissions.

The private sector is also taking big strides on the path toward better integration. Through the recent merger of Hackensack Meridian Health (with networks reaching some two-thirds of the state) and Carrier Clinic behavioral health services, multi-disciplinary behavioral health teams will be deployed throughout Meridian's hospitals, and behavioral services will be offered on-site in urgent care centers.^{355 356} Likewise, the recent affiliation agreement between RWJBarnabas Health and Rutgers Health, with its University Behavioral Health Care unit, signals significant opportunities for deeply rooted care integration. Finally, private insurers, such as Horizon Blue Cross Blue Shield, have been experimenting with online systems that allow primary care providers to spotlight concerns

and speed connections with available mental health providers.

Other efforts underway in New Jersey include pilot programs funded by The Nicholson Foundation to adapt the Cherokee Health integrated care model in primary care practices.³⁵⁷ New Jersey is also one of just eight states participating in the Certified Community Behavioral Health Clinics Demonstration, which has enabled providers to extend a broader range of integrated services to their patients.³⁵⁸ In January 2019, the New Jersey Department of Health announced that a "Family-Centered Mental Health Access Program" (supported by the Health Resources and Services Administration and Nicholson Foundation) will build on the work of pediatric psychiatry collaboratives to integrate screening and telehealth into primary care pediatric practices. Lastly, with an advocacy group giving New Jersey an "F" grade on ensuring that mental health coverage mirrors physical health coverage, the state legislature is considering ways to hold insurers accountable for adhering to Affordable Care Act parity requirements.^{359 360}

RECOMMENDED POLICY OPTIONS

11.1

Pursue integrated mental health, addiction, and physical health services for the entire Medicaid managed care population.

While certain behavioral health services are currently included in Medicaid’s managed care contracts for higher-risk groups of beneficiaries, behavioral health service delivery remains largely outside of the managed care system. Other states, like Kansas, have made the shift to “carve in” behavioral health for their entire Medicaid managed care population.³⁶¹ There is strong evidence that interventions supporting the integration of behavioral health and primary care, such as deploying multi-disciplinary care teams, using systematic approaches to implement evidence-based practices, and leveraging health information technology,³⁶² are linked to improved mental health; increased adherence to treatment; improved quality of life; increased patient engagement, satisfaction, and care coordination; and reduced drug and alcohol use, while also likely decreasing disparities.^{363 364} Continuing on the path of improving integration and management of behavioral health for all New Jerseyans covered through Medicaid holds potential to substantially improve care and lower costs.

11.2

Accelerate adoption of integrated health care models through stable funding streams.

While some initiatives launched in New Jersey have made inroads into providing coordinated care, including the Cherokee Health model and other pilots mentioned above, ensuring ongoing funding for these efforts remains a challenge. Consistent and long-term support is required to build and sustain these initiatives. The state should leverage its Medicaid delivery system reforms and emerging value-based payment initiatives to promote and regularize adoption of integrated care models. If successful, the state’s recently launched Medicaid strategy to encourage expanded, office-based SUD medication-assisted treatment could be built upon to expand mental health services offerings in primary care as well.³⁶⁵ New Jersey should advance additional “bi-directional” models that encourage the delivery of behavioral health services within primary care settings *and* primary care services within behavioral health settings through existing managed care contracts. Arizona has leveraged such bi-directional integration through managed care contract requirements.³⁶⁶ Maine’s strategy for integrated care resulted in nearly half of primary care practices in that state providing some level of integrated care.³⁶⁷ As the state looks toward improving care integration, policies to attract and retain a robust behavioral healthcare provider workforce need to be pursued in tandem.

11.3

Further reform the New Jersey Department of Health’s licensure process and policies to enable more seamless provision of coordinated mental health and addiction services.

According to one integrated care provider from Washington State, “Integrated care requires a regulatory and data system environment that *expects* integration.”³⁶⁸ New Jersey has indeed made progress on developing an integrated license strategy and this effort should be prioritized for implementation in the field. Additional administrative, regulatory and payment reforms can also be pursued to “harmonize” these systems to support more and seamless integrated services.³⁶⁹

Improve access to health and social services throughout the state by leveraging technology.

ABOUT THE CHALLENGE

While New Jersey has relatively generous benefits and services available to help low-income residents, connecting people to these programs and resources remains a challenge. As shown in the figure, although many New Jerseyans are eligible for programs such as Medicaid, the Earned Income Tax Credit (EITC), and the Supplemental Nutrition Assistance Program (SNAP), a sizeable share of those eligible are not applying for or enrolling in these benefits and programs.^{370 371 372} Unfortunately, our state’s under-enrollment rates are sometimes worse than the nation as a whole, but this presents an opportunity for action and improvement.

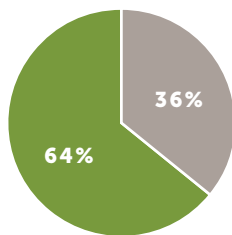
While these programs could enhance health and well-being for thousands of New Jersey residents, many factors contribute to less-than-optimal participation, including lack of awareness and sometimes cumbersome or difficult-to-navigate application processes. Across the state, stakeholders engaged in developing this report highlighted the need for services to be easier to access and navigate, with many suggesting their own phones could facilitate easier access and navigation.

In New Jersey, nearly 90 percent of residents have computers and almost 75 percent have smart phones.³⁷³ While low-income individuals and racial and ethnic minorities are not as likely to own

Figure 8

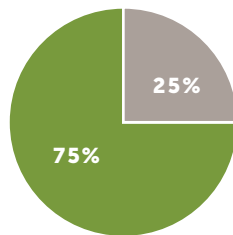
NOT ALL NEW JERSEYANS ARE BENEFITTING FROM PROGRAMS FOR WHICH THEY ARE ELIGIBLE

One in three uninsured eligible for Medicaid in NJ is not enrolled



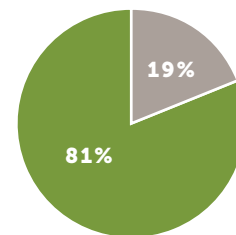
- Uninsured and Eligible, Not Enrolled
- Uninsured, Not Eligible

One in four eligible for EITC in NJ is not receiving it



- Eligible, Not Receiving
- Eligible, Receiving

One in five eligible for SNAP in NJ is not receiving it



- Eligible, Not Receiving
- Eligible, Receiving

Sources: Kaiser Family Foundation, New Jersey Division of Taxation, USDA Estimates of State Supplemental Nutrition Assistance Program Participation Rates

computers or have home access to internet services, a majority *do* own mobile devices: nationally, 72 percent of blacks and 75 percent of Hispanics report having smartphones (even among blacks and Hispanics earning less than \$30,000, over 60 percent are smartphone owners).³⁷⁴ In spite of the high level of access to technology across the state, New Jersey is not always maximizing opportunities to leverage this technology to optimize service delivery within the state. In a report card grading states on employing technology to “improve service delivery, increase capacity, streamline operations and reach policy goals,” the Center for Digital Government gave New Jersey a “C” grade for its efforts in 2018, placing it behind 47 other states.³⁷⁵

PROGRESS TO DATE IN NEW JERSEY

Despite earning only a mediocre grade, New Jersey has made gains in leveraging technology to create more accessible and user- and tech-friendly services. For example, in 2017, the state launched NJHelps, an online screening tool aimed at pointing residents toward available health and

social services.³⁷⁶ The NJOneApp aims to combine applications for several service programs (including General Assistance/Work First New Jersey, SNAP, and Temporary Assistance for Needy Families), and NJSave is designed to provide a single entry point for seniors and residents with disabilities to access a range of assistance programs. In November 2018, as part of its first coordinated coverage awareness campaign, the state also launched GetCovered.NJ.gov to galvanize health insurance enrollment.³⁷⁷ The New Jersey Department of Health is working with the New Jersey Innovation Institute on a tech challenge to find creative and user-friendly strategies to connect residents with services,³⁷⁸ and efforts are also underway in the state legislature to create a task force to help modernize state computer systems, “secure paperless record keeping,” and pull more programs into the OneApp.³⁷⁹ ³⁸⁰ To provide statewide leadership to these efforts, Governor Murphy also created a chief innovation officer position for New Jersey, and hired a leader with experience incorporating public views into information technology program development.³⁸¹ ³⁸²

RECOMMENDED POLICY OPTIONS

12.1 Move toward a “mobile-first” strategy, making program information and applications accessible and seamless through mobile technologies.

New Jersey should leverage the proliferation of mobile devices to more easily connect people to a range of information and services. While ensuring attention to privacy and security, ideally, mobile apps would enable residents to find needed services, enroll in programs, receive text notifications and reminders about program changes, identify actions needed to maintain eligibility, and receive health promotion recommendations. Utah, for example, based on a data-driven analysis of its “citizen needs,” has made information about its state and community services available on Amazon Echo and Google Assistant (which can also be accessed on mobile phones).³⁸³ As New Jersey considers advancing its mobile strategies, it could pursue a regional approach, working with local organizations to test and refine strategies for connecting residents with services near where they live. Local libraries and municipal centers could provide similar supports to ensure residents without

mobile phones or home high-speed internet can access such services as well. A key challenge is building systems and procurement and financing strategies that allow these mobile resident-centered strategies to evolve as technologies evolve. In addition, while many prefer mobile-first options, some populations with complex needs might still prefer a “high-touch” approach available through face-to-face interaction, maintaining a continued role for frontline staff in program administration and navigation.

12.2

Continue to advance easy access to a single application for all major health and social service programs.

While some recent efforts have focused on bringing more programs into NJOneApp, which could be an important interim step, the state should follow the lead of Utah and Michigan and shift to using a single public sign-on system, which works across the breadth of its state agencies and encompasses a full range of services, allowing residents to enter their information only once to access needed help across all state services.^{384 385 386}

12.3

Encourage more widespread adoption of tele-health and ride-sharing services to ensure timely access to care for hard-to-reach populations.

New Jersey’s 2017 tele-health law requires coverage of tele-health through Medicaid, Medicaid managed care, other state-sponsored insurance, and private insurance.³⁸⁷ While New Jersey was one of 20 states rated as “progressive” in its telemedicine coverage and reimbursement policies, the state needs to do more to encourage its use, especially for those in rural areas. This might include developing information campaigns to ensure that New Jerseyans know about the availability of these services and eliminating copays for its use for those in rural zip codes.³⁸⁸ There is strong evidence that tele-medicine increases access to care, especially for people with chronic illnesses and people living in underserved areas.³⁸⁹ Technology can also be leveraged to ease access through transportation (with some estimating that over three million medical appointments are missed each year due to transportation problems).³⁹⁰ While New Jersey health systems are increasingly employing ride-sharing services to provide free transportation for their patients (Hackensack Meridian Health with Lyft, RWJBarnabas Health with Uber, Cooper and Camden Coalition with Roundtrip), more should be done to extend these services on the same no-charge basis to rural areas within the state.^{391 392}

“How do we start to collaborate and connect people to services? Every single person has a cell phone—how can the state leverage that to connect them to services?”

Community Participant

13

Foster collaboration within and across state agencies to improve health equity.

ABOUT THE CHALLENGE

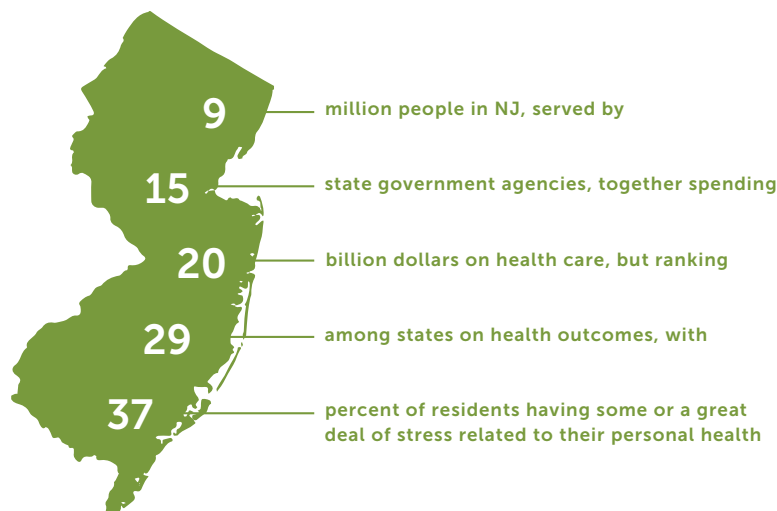
A healthy New Jersey means addressing all the drivers of our health in a way that no one is left behind. To realize this vision, the state must embrace a more integrated, comprehensive approach to policymaking—understanding how the decisions made today across all of state government impact *everyone’s* health tomorrow. This goes well-beyond decisions related to health care, which we know is only one factor influencing our health. Rather, diverse agencies, from agriculture to transportation, should be working together on analyzing problems, developing strategies, and implementing policies and programs—all with an eye toward improving health equity.³⁹³ Unfortunately, state decision-making is typically fragmented, and health equity

considerations are not regularly acknowledged, let alone elevated.

Improving health equity requires jettisoning the “business-as-usual” approach. It calls for leadership, changes in operating culture, data sharing, new models of governance (e.g., decision-making, budget allocations, project management), and dedicated resources.³⁹⁴ With state and federal budget pressures mounting and a premium placed on stretching every dollar as far as it can go, making these paradigm shifts is all the more essential. Fortunately, investments in health, well-being, and equity have been shown to yield significant returns, not just in population health, health care savings, and longevity, but also in overall economic productivity.^{395 396 397}

Figure 9

NEW JERSEY HEALTH & WELL-BEING BY THE NUMBERS



Sources: United States Census Bureau. Quick Facts: New Jersey: 2017 New Jersey Population Estimates. <https://www.census.gov/quickfacts/nj>

State of New Jersey: Departments and Agencies, 2019. <https://nj.gov/nj/gov/deptserv/>

State of New Jersey. Report of the Healthcare Transition Advisory Committee: 2018. <https://nj.gov/governor/news/reports/docs/Healthcare%20Transition%20Report.pdf>

Commonwealth Fund 2018 New Jersey Scorecard on Health System Performance, 2018. <http://datacenter.commonwealthfund.org/scorecard/state/32/new-jersey/>

Rutgers Center for State Health Policy Poll on Stress in New Jersey, October 2017



PROGRESS TO DATE IN NEW JERSEY

Commissioner Elnahal of the New Jersey Department of Health (DOH) has recognized that: “The public health and health care challenges we face are formidable, and overcoming those challenges is going to require new levels of collaboration between the DOH, the rest of state government, and all our partners and stakeholders working across New Jersey.”³⁹⁸ In fact, DOH has promoted a “Health in All Policies” approach targeting various statewide challenges (including lead poisoning and making healthy choices easy), working across state agencies and in various settings (e.g., schools, communities), utilizing a range of strategies (including education, policy change, and surveillance). The DOH has also catalyzed public-private health partnerships to develop community health assessments and improvement plans.³⁹⁹ In addition, DOH’s

Integrated Population Health Data project holds great promise in linking and leveraging a range of health and social data to inform decisions affecting the well-being of New Jerseyans. More broadly, the state has also made important strides looking across the individual mandates of various departments to employ multi-agency approaches to address critical problems, including combating the opioid epidemic; developing New Jersey’s Apprenticeship Network;⁴⁰⁰ and advancing, through a data-driven approach, bail reforms that help address some of the inequities in criminal justice throughout the state.⁴⁰¹ New Jersey is also one of only five states that now requires analyses of how changes to criminal justice laws impact racial and ethnic minorities.⁴⁰² Notably, New Jersey’s first chief innovation officer is spearheading efforts to move toward more agile and collaborative government services.⁴⁰³

RECOMMENDED POLICY OPTIONS

13.1

Create an inter-agency well-being working group to provide statewide leadership on cross-sector collaboration.

New Jersey should join other states across the nation that have adopted cross-agency collaborative efforts to promote well-being.⁴⁰⁴ An inter-agency workgroup, charged and led by the governor's office and co-led by DOH and the Department of Human Services, should be established, focusing on visioning, governance, and creating collaborative opportunities to promote well-being, including through data analysis and data sharing. The state should provide dedicated funding for operations and pilot projects. In creating the workgroup, the state should work to incorporate lessons from other states, including: assuring common understanding of concepts related to population health and health equity through level-setting and training; and ensuring the organizing principle or framing for the group resonates with departments throughout the state. For example, some state groups have focused on health equity while others have organized around a healthy workforce or vibrant, sustainable communities.^{405 406} The workgroup could identify promising areas for collaborative work (e.g., Maryland has worked to eliminate threats from lead and asthma through efforts across its health, environment, and housing and community development departments⁴⁰⁷) or allow ideas to bubble up more organically from agencies. Either way, the workgroup should develop performance metrics and accountability mechanisms and ensure its pilot projects or efforts are aligned with the work with other statewide initiatives.

"We can't solve these problems by budgeting the way we do. We need to think across departmental lines."

Stakeholder

13.2

Assess the impact of major new legislation and regulation on health and well-being.

Just as states regularly assess the fiscal and, in some cases, environmental impacts of proposed policies, they can also analyze the potential impacts on health equity. Case studies of states adopting such an approach—often through “Health in All Policies” strategies or health impact assessments—have shown their effectiveness in raising awareness of the social determinants of health and creating opportunities to embed such considerations in everyday policy decisions throughout state government.⁴⁰⁸ Washington State, for example, has instituted governor- or legislature-ordered “health impact reviews” of significant legislation and budget proposals—one-page research-driven summaries of the intended changes and their likely effects on health.⁴⁰⁹ New Jersey should adopt a similar approach for budget or legislative changes over a certain dollar threshold. It could begin by having the Office of Legislative Services extend the current racial and ethnic minority impact statements beyond laws related to criminal justice. Another option is to employ the Health Impact Project's (HIP's) Health Notes strategy—a program designed to support informed decision-making through the creation of brief, nonpartisan, timely summaries describing the health effects of proposed legislative changes. HIP is a collaboration of RWJF and The Pew Charitable Trusts, and Health Notes have been deployed in a handful of states over the last two years.⁴¹⁰

Conclusion

Next Steps Toward a Culture of Health in New Jersey

Now is the time to come together and build a Culture of Health in New Jersey. The steady progress that we, as a state, have been making—as demonstrated by improved health rankings and indicators—suggests that we are committed to the health and well-being of our residents. But we can do better on a crucial component: an accompanying commitment to health equity. New Jersey cannot be a true national leader on health until all of us, our leaders and residents, come together and commit to ensuring that every New Jerseyan has a fair and just opportunity to live their healthiest life.

Building a Culture of Health will require unprecedented collaboration across all sectors and all communities. It will require assuring that those who have been pushed to the margins are brought back into the circle and have what they need to make healthy choices. It will require the directing of resources to communities that have suffered from generations of under-investment. It will require implementing evidence-based, equity-producing policies like those recommended in this report. But how do we do these things and how do we know if we are making progress?

RWJF is committed to sharing these recommended policy options broadly and to bringing together diverse stakeholders, including policymakers, to explore how best to move forward. We also are exploring ways to support adoption and implementation of the recommended policy options, including through research, communications, advocacy, and technical assistance activities. Finally, we are committed to measuring progress made toward a Culture of Health in New Jersey. This will include observing the engagement levels of organizations and communities across the state in championing these policies, tracking which policies are adopted and how robustly they are implemented, and assessing the impact of these policies on health equity. As we noted earlier, improvements in the average health of a population are important and desirable, but closing health gaps is essential. Therefore, we will need to track both (a) changes in the selected outcomes among disadvantaged groups and (b) the size of disparities between disadvantaged and advantaged groups.

Every New Jerseyan will benefit as the state continues to make progress toward improved health and well-being, but the most significant progress will come when health gaps are eliminated and health equity is achieved. We urge policymakers and other leaders across the state to take up and advance the recommendations in this report with us. Together, let's work to build a Culture of Health across New Jersey—and serve as a model for the nation.

Appendix

Forums to Capture Priorities for Creating a Culture of Health in New Jersey

Together with RWJF partners, the project team convened a series of forums throughout the state to collect perspectives from the field on what a Culture of Health would look like inside New Jersey and what priorities rise to the top for starting to realize this vision.

CAMDEN RUTGERS UNIVERSITY	June 9, 2018	<i>New Jersey Health Initiatives Next Generation Community Leaders:</i> Focusing on lessons from young people engaged in projects designed to help build healthier communities throughout New Jersey
NEW BRUNSWICK RUTGERS CSHP	June 26, 2018	<i>Stakeholder Survey Follow-Up Forum:</i> Focusing on policy priorities for building a Culture of Health and lessons from the field
NEW BRUNSWICK RUTGERS CSHP	June 27, 2018	<i>Stakeholder Survey Follow-Up Forum:</i> Focusing on policy priorities for building a Culture of Health and lessons from the field
PRINCETON RWJF	June 28, 2018	<i>RWJF Partners Gathering:</i> Reviewing priorities for a Culture of Health and lessons from work of RWJF grantees and partners working throughout New Jersey
PRINCETON RWJF	July 11, 2018	<i>Business Breakfast:</i> Capturing business perspectives on steps for creating a Culture of Health within the state and the role of the private sector in helping to implement them
CAPE MAY TECHNICAL SCHOOL	July 17, 2018	<i>Southern Community Forum:</i> Capturing priorities for a Culture of Health from community leaders and members in the southern region of the state
BASKING RIDGE YMCA	July 18, 2018	<i>Northern Community Forum:</i> Capturing priorities for a Culture of Health from community leaders and members in the northern region of the state
EAST BRUNSWICK YMCA	July 19, 2018	<i>Central Community Forum:</i> Capturing priorities for a Culture of Health from community leaders and members in the central region of the state
TRENTON FRIENDSHIP BAPTIST CHURCH	August 23, 2018	<i>Trenton Community Forum:</i> Capturing priorities for a Culture of Health from community leaders and members in Trenton and the surrounding area

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