



**2014 NEW JERSEY STATE
EXECUTIVE SUMMARY**

PATHS

Providing Access to Healthy Solutions

An Analysis of New Jersey's
Opportunities to Enhance Prevention
and Management of Type 2 Diabetes

WRITTEN BY
Amy Katzen and Allison Condra

PREPARED BY THE CENTER FOR HEALTH LAW AND POLICY
INNOVATION OF HARVARD LAW SCHOOL



ACKNOWLEDGMENTS

The authors thank the following individuals for their contributions to this report:

- | | |
|--|--|
| Nadia Ali, The Camden Coalition of Healthcare Providers | Kathy Grant-Davis, New Jersey Primary Care Association |
| Dr. Kemi Alli, The Trenton Health Team | Joan Gray, Virtua Hospital |
| Darrin Anderson, New Jersey Partnership for Healthy Kids, New Jersey State YMCA Alliance | Sandra Greci, Rutgers New Jersey Agricultural Experiment Station |
| Matthew Brener, Greensgrow Farms | Alison Hastings, Delaware Valley Regional Planning Commission |
| Charles Brown, Voorhees Transportation Center | Janet Heroux, New Jersey Department of Health |
| Erin Bunger, New Jersey Department of Health | Dr. Kathleen Jackson, Rutgers School of Nursing |
| Joel Cantor, Rutgers Center for State Health Policy | Melita Jordan, New Jersey Department of Health |
| Anthony Capece, Elijah's Promise | Peter Kasbach, New Jersey Future |
| Amanda Carter, The Camden Coalition of Healthcare Providers | Andrew Katz, The Camden Coalition of Healthcare Providers |
| Martha Chavis, Camden Area Health Education Center | Dr. Steven Kaufman, The Camden Coalition of Healthcare Providers |
| Mary Coogan, Advocates for Children | Katherine Kraft, America Walks |
| Peter Cormier, The Camden Coalition of Healthcare Providers | Ryan Kuck, Greensgrow Farms |
| Megan Cunningham, The Camden Coalition of Healthcare Providers | Michael Anne Kyle, The Greater Newark Healthcare Coalition |
| Victoria DeFiglio, The Camden Coalition of Healthcare Providers | Steve Landers, The Visiting Nurse Health Association |
| Sylvia Dellas, New Jersey Department of Health | Brian Lang, The Food Trust |
| Christene DeWitt-Parker, New Jersey Department of Education | Teresita Lawson, Zufall Health Center |
| Laurie Dickerson, Horizon Healthcare Innovations | Bill Lovett, New Jersey State YMCA Alliance |
| Joane DiNapoli, Riverview Medical Center | Patricia Lucarelli, Jersey Shore University Medical Center |
| Patrick Ervilus, River Primary Care Center | Mary Mickles, New Jersey Department of Health |
| Kim Fortunado, Campbell's Soup | Dr. Kathleen Morgan, Rutgers New Jersey Agricultural Experiment Station |
| Valeria Galarza, New Jersey Partnership for Healthy Kids | Michael Nanfara, Rutgers New Jersey Institute for Food, Nutrition and Health |
| Fran Gallagher, New Jersey Chapter, American Academy of Pediatrics | Peri Nearon, New Jersey Department of Health |
| Peter Gillies, Rutgers New Jersey Institute for Food, Nutrition and Health | Kay O'Keefe, Central Jersey Family Health Consortium |
| Francine Grabowski, The Camden Coalition of Healthcare Providers | Dr. Debra Palmer, New Jersey SNAP-Ed |



Janet Parker, The Camden Coalition of Healthcare Providers

Dr. Rupal Patel, Rutgers University School of Pharmacy

Dr. Rina Ramirez, Zufall Health Center
Elizabeth Reynoso, City of Newark

Diane Riley, Community Foodbank of New Jersey

Pam Scott, Partners for Health

Bill Shearer, AKA Health

Cyndi Steiner, New Jersey Bike and Walk Coalition

Dr. Alfred Tallia, Rutgers Robert Wood Johnson Medical School

Rose Tricario, New Jersey Department of Agriculture

Cindy Weiss-Fisher, New Jersey Department of Health

Linda Whitfield-Spinner, New Jersey Primary Care Association

Bernice Williams, Camden Area Health Education Center

Carol Wolff, Camden Area Health Education Center

Dr. Lucio Volino, Rutgers University School of Pharmacy

The authors thank the following students for their research, writing, and other contributions to this report:

Grant Barbosa

Katie Cohen

Mary Delsener

Julie Dickerson

Kathleen Eutsler

Laura Fishwick

Caitlin Foley

Kristie Gurley

Sohani Khan

Rachel Kurzweil

Timothy Lamoureux

Irene Libov

Carly Rush

Malik Touanssa



FOREWORD

About The Center for Health Law and Policy Innovation

The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) works to promote legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses and disabilities. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, food providers and producers, government officials, and others to expand access to high-quality health care and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable, and effective healthcare and food systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners

as well as leaders in health, public health, and food law and policy. CHLPI includes the Health Law and Policy Clinic (HLPC) and the Food Law and Policy Clinic (FLPC).

The HLPC was established in 1989. Its work includes federal and state health law and policy reform efforts to improve health care access and health outcomes for low-income people, with a focus on the needs of people living with chronic illnesses and disabilities.

The FLPC is the oldest food law clinical program in the United States, and was established in 2010 to address growing concern about the health, environmental, and economic consequences of the laws and policies that structure the U.S. food system. The FLPC aims to increase access to healthy foods, prevent diet-related diseases, and assist small and sustainable farmers in breaking into new commercial markets.



CENTER FOR HEALTH LAW & POLICY INNOVATION
Harvard Law School



FOOD LAW & POLICY CLINIC
Center For Health Law & Policy Innovation
Harvard Law School

History of the Report

The report is a product of CHLPI’s Providing Access to Healthy Solutions (PATHS) project. This executive summary provides an overview of the findings and recommendations detailed in the full PATHS report. PATHS is funded through Together on Diabetes™, the flagship philanthropic program of the Bristol-Myers Squibb Foundation. Together on Diabetes™ was launched in November 2010 with the goal to improve the health outcomes of people living with type 2 diabetes in the United States by strengthening patient self-management education, community-based supportive services and broad-based community mobilization. Consistent with the Bristol-Myers Squibb Foundation’s mission to promote health equity and improve health outcomes, this initiative targets adult populations disproportionately affected by type 2 diabetes.¹ Together on Diabetes™ partners include non-profits, universities, foundations,

and associations, many of which provide direct services to people living with type 2 diabetes.²

PATHS brings a broad policy focus to the Together on Diabetes™ Initiative. The project works to strengthen federal, state, and local efforts to improve type 2 diabetes treatment and prevention through the development and implementation of strategic law and policy reform initiatives that can bolster these efforts.

The report was funded by the Bristol-Myers Squibb Foundation, with no editorial control over the report’s content. All analysis and recommendations are based on the PATHS team’s own research and discussions with state-based stakeholders.

Overview of the PATHS Initiative

The first phase of CHLPI’s PATHS initiative began in the summer of 2012, with two state-level policy initiatives, in New Jersey and North Carolina. These two states were selected



because of their diversity from one another and the opportunity to create federal-level recommendations based on the findings from these states. These states were also selected because other Together on Diabetes™ grantees were already working in both New Jersey and North Carolina, and these organizations would be able to utilize our policy guidance. In future years, the PATHS team will conduct a federal-level policy analysis based on the state-level findings and identify common state best practices.

In order to gain a deep understanding of how the various policies in New Jersey and North Carolina impact the prevention and treatment of type 2 diabetes, the PATHS teams conducted online research and interviewed Together on Diabetes™ grantees and other stakeholders in the states. The goal of this work was to create comprehensive reports that provide (1) an overview of the impact of type 2 diabetes in each state as well as profiles of each state's demographics, economy, political structure, and existing state programs to address diabetes; (2) a discussion of the policies in New Jersey and North Carolina that impact type 2 diabetes; and (3) an analysis of how the states can improve their diabetes-related policies to reduce the prevalence and consequences of type 2 diabetes. The report on New Jersey is the product of this research and writing process.

How to Use the Report

The purpose of the report is to provide diabetes advocates in New Jersey with a resource to promote positive policy change within New Jersey. It is also intended to serve as a planning document for local and state government in their efforts to address the impact of type 2 diabetes in their communities.

Advocates and policymakers may strive to form comprehensive type 2 diabetes prevention and control plans. Such advocates and policymakers can use the report to identify many of the policy issues that affect type 2 diabetes, as well as to consider the report's recommendations as possible priorities within the overall plan.

Other advocates and policymakers may be focused on a particular policy arena, such as school nutrition or Medicaid case management reform. Such advocates and policymakers can use the table of contents to identify the sections of the report most relevant to their goals.



EXECUTIVE SUMMARY

As you read the report addressing the challenges of type 2 diabetes in New Jersey, remember two numbers and one family.

700,000: the approximate number of New Jerseyans living with diabetes.

3: New Jersey's rank in the nation for obesity among low-income children ages two to five, 16.6% of whom are obese.

These numbers reveal the extent of the type 2 diabetes and obesity epidemics in New Jersey, and are inextricably tied to one another. Overweight and obese children are more likely to grow into overweight and inactive teens. Among New Jersey high school students, over one third report watching television for three or more hours and using a computer for non-school purposes or playing video games for three or more hours on an average school day. Moreover, despite its moniker as the Garden State, only 28% of New Jersey high school students eat vegetables or exercise for the recommended sixty minutes per day each week, while nearly one in five (19%) drink a can, bottle, or glass of soda at least once per day. These unhealthy trends often continue into adulthood. As of 2011, 61.5% of New Jersey adults—5,451,722.85 people—were overweight or obese. Almost 50% of those overweight or obese adults (2,718,443 people) had pre-diabetes—and about 25% of Americans with pre-diabetes are expected to develop diabetes within three to five years of diagnosis.

The Riveras: As documented in the film *A Generation at Risk*, the Riveras demonstrate the struggle of so many New Jersey families to stay healthy in difficult circumstances. Their story, which unfolds over the course of three generations and five decades, begins with Alicia Rivera's mother-in-law—a diabetic whose lower legs required amputation after ulcers formed and refused to heal. Alicia and her husband also have type 2 diabetes, and between the stresses of everyday domestic life; caring for three children—the youngest of whom has Down Syndrome; the difficulty of finding affordable, healthy foods within travelable distance; and the time, energy, and resources it takes to exercise, both Alicia and

her husband, despite their best attempts, remain overweight and struggle to manage their diabetes. As for their children, “[y]ou try to protect them,” says Alicia. “You tell them I don't want you to become me.” Yet, just two years ago, the Riveras learned that their 17-year-old daughter Becky also has type 2 diabetes.

For families like the Riveras with limited resources, type 2 diabetes is difficult to manage effectively, and mismanaged diabetes can lead to particularly debilitating physical effects: damaged blood vessels, heart attacks, strokes, blindness, liver disease, certain kinds of cancer, kidney failure, bone fractures, and amputations.

Diabetes affects more people and costs the state more money as each year passes. In 2010, there were 9.1 new cases per 1,000 people (age adjusted), up from 4.6 per 1,000 in 1996. By 2025, the number of people affected by diabetes in New Jersey is projected to double, and its cost to the state is projected to reach \$14.5 billion, including lost productivity.

New Jersey cannot afford to let these trends continue.

A range of societal conditions have brought New Jersey to this point. Conditions leading to a more overweight population include: food insecurity, high food prices in an already high cost-of-living state, lack of safe places to exercise, and lack of nutrition education. Conditions leading to poor disease management include: inadequate insurance coverage of diabetes prevention and management programs, inability to pay for expensive diabetes supplies and equipment, and insufficient coordination of care in a fragmented healthcare delivery system, among others. Just as these challenges range from environmental to medical to economic, their solutions lie in several distinct policy areas as well. Fighting type 2 diabetes will require an integrated approach that addresses the societal conditions that created this epidemic while also supporting medical and lifestyle interventions that can improve the health outcomes of those who already suffer from the disease.



The report begins with an overview of the medical profile of type 2 diabetes, and follows with an extensive profile of the state of New Jersey, including information on the state’s demographics, economy, and political structure. Next, the report reviews the state of type 2 diabetes in New Jersey, including incidence, prevalence, morbidity and mortality, and the direct and indirect costs of the disease. This section of the report concludes with background on the state’s food and healthcare delivery systems.

The core of the report, Moving New Jersey Forward, is a targeted analysis of how to improve state policies that affect diabetes prevention and management. These include recommendations for nutrition and physical activity policies the state can adopt to prevent obesity and type 2 diabetes, as well as recommendations to improve the healthcare delivery system for people living with type 2 diabetes. This executive summary provides a review of the report’s major findings and recommendations.

Recommendations

STATE GOVERNMENT INFRASTRUCTURE MAINTENANCE

The coordinated efforts of the New Jersey Departments of Health (DOH), Children and Families (DCF), and Human Services (DHS) will be critical to a successful type 2 diabetes

system of care. DOH, in addition to managing a broad range of public health functions, houses the state’s Chronic Disease Prevention and Control Unit (CDPC). DHS administers Medicaid/FamilyCare and the Supplemental Nutrition Assistance Program (SNAP)—which affect type 2 diabetics’ access to care, diabetes supplies, and healthy food—while DCF focuses on protecting young children from obesity and type 2 diabetes through regulations governing child care centers. On August 7, 2013, Governor Chris Christie signed *An Act Concerning Diabetes and Supplementing Title 26 of the Revised Statutes*. The law requires that DOH, in collaboration with DCF and DHS, create a “Diabetes Action Plan” for the Governor and legislature describing: (1) the financial impact of type 2 diabetes in the state; (2) the benefits of existing state programs to prevent or control the disease; and (3) the level of coordination among the three departments. DOH, and especially the CDPC within DOH, will likely take on the bulk of the responsibility for the action plan. DOH, however, has faced a steady decline in staffing levels since 2006—a reduction of approximately 30% over six years. DCF and DHS will also need sufficient personnel to collaborate with DOH, enforce new child care center regulations, and manage Medicaid, a program whose costs are in danger of skyrocketing if type 2 diabetes continues to increase in prevalence.

(See Table 1)

TABLE 1. Challenge	Recommendations
DOH, DCF, and DHS need additional resources to engage in the organized, collaborative efforts necessary to implement the Diabetes Action Plan.	<p>DOH and the New Jersey legislature should maintain investment in the ShapingNJ Partnership (which develops strong public-private relationships across state government, local government, and non-profit organizations to enhance primary prevention) and the Office of Nutrition and Fitness (which functions as the central coordinating body to work on obesity prevention).</p> <p>CDPC should maintain, integrate, and staff the coalitions it currently hosts.</p> <p>The legislature should allocate state resources to ensure that DOH, DCF, and DHS can perform their new and ongoing responsibilities.</p> <p>DOH and other state agencies should leverage the philanthropy and projects of private foundations, and involve these groups on the front lines of obesity prevention.</p>



ACCESS TO HEALTHY FOOD

A healthy food system is important for improving type 2 diabetes outcomes, as it not only helps prevent the incidence of type 2 diabetes and other chronic diseases, but also mitigates the consequences of type 2 diabetes once individuals are diagnosed with the disease. For many low-income individuals and families in New Jersey, access to healthy food is not guaranteed, due to the inability to afford healthy food (economic access); lack of geographic access to retail food establishments that sell healthy foods; and/or school nutrition challenges impacting the ability of a student to access healthy food at school.

Economic Access to Healthy Food

The federal government’s food assistance programs—such as SNAP and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)—provide food for many New Jersey residents struggling to put food on the table due to economic constraints. The federal government provides

the funding for these programs, but leaves the administration to the states. Notably, New Jersey has expanded its rules in order to allow individuals or households whose gross monthly income is less than 185% of the federal poverty level (FPL) to receive SNAP benefits, an eligibility threshold above the federal eligibility threshold of 130% FPL. Despite the existence of these federal assistance programs, New Jersey’s expanded SNAP eligibility, and New Jersey’s emergency food infrastructure, 13.5% of the state’s population was food insecure in 2010. In that same year, only 60% of all New Jersey SNAP-eligible individuals participated in the program; similarly, in 2009, only 60% of individuals eligible for WIC participated in the program. Moreover, while the amount of monthly benefits for both SNAP and WIC have generally been increasing over the past five years, in 2011 the amount of monthly SNAP benefits fell by \$5 for individuals and by \$10 for households, and WIC benefits also decreased slightly in 2012. (See Table 2)

Challenge	Recommendations
Too many New Jerseyans cannot afford to purchase healthy food.	<ul style="list-style-type: none"> Conduct a study to identify what barriers prevent low-income New Jersey residents from participating in SNAP, and implement policies that ensure eligible residents are aware of their SNAP eligibility. Expand SNAP eligibility criteria to include individuals and households at 200% FPL.
SNAP and WIC have low participation rates amongst eligible New Jerseyans.	<ul style="list-style-type: none"> Expand SNAP offices’ hours of operation to meet the needs of working families. Encourage DHS and the Division of Family Development to work with local welfare offices to improve the online services provided to SNAP beneficiaries. Conduct a study to identify what barriers prevent eligible New Jersey women from enrolling in WIC.
Enrollees in SNAP and WIC have trouble accessing the fruits and vegetables that are crucial for the healthy diets that prevent and mitigate type 2 diabetes.	<ul style="list-style-type: none"> Implement and increase SNAP incentive programs to encourage SNAP participants to purchase more fruits and vegetables. Provide state funding to New Jersey WIC’s fruit and vegetable programs in order to increase the number of participants by increasing the value of fruit and vegetable vouchers. Increase access to authorized vendors by, for example, encouraging local benefit offices to host farmers markets on voucher distribution days. Implement policies that facilitate the acceptance of SNAP benefits at farmers markets. Increase funding to food banks to ensure their accessibility to New Jersey residents, and support other efforts to reduce accessibility barriers to food banks.



Geographic Access to Healthy Food

Increasing access to healthy foods involves more than just providing financial assistance to those who cannot afford it; access to healthy food also means guaranteeing that all New Jersey residents have access to healthy food retailers either in their community or easily accessible by public transportation. Communities that lack access to healthy food retailers that provide “affordable fruits, vegetables, whole grains, low-fat milk, and other foods that make up the full range of a healthy diet” are classified as “food deserts.” According to the United States Department of Agriculture, in 2011, 340,000 New Jersey residents live in 134 federally-recognized “food deserts” across the state. However, the Reinvestment Fund, a non-profit organization based in Philadelphia, suggests that in actuality as many as 924,000 residents—10% of New Jersey’s population—lack access to affordable, healthy food, even if they do not live in a federally-recognized “food desert.”

This geographic access problem exists, at least in part, because the state has 25% fewer supermarkets per capita than the national average and needs 269 new supermarkets in order to meet that average. In an effort to bring healthy food to New Jersey’s food deserts, the New Jersey legislature passed the New Jersey Fresh Mobiles Pilot Program Act in 2011, which authorized the New Jersey Department of Agriculture (NJDA) to develop and assist in the creation of a mobile farmers market program throughout the state. This legislation marks an innovative approach to the geographic access problem but by itself will be not be a sufficient solution. **(See Table 3)**

Access to Healthy Food at School

Given New Jersey’s obesity rates among low-income children, influencing the way children access food and learn about wellness and healthy living is an increasingly important aspect of preventing and treating chronic diseases like type 2 diabetes. Most children eat lunch at school, many eat breakfast, and perhaps just as many children eat snacks at some point during the day. Children’s ability to access healthy food at school grows in importance as the economic picture for children and families across New Jersey worsens; in 2010, nearly one third of the state’s children lived in low-income households.

Federal school meal programs—the National School Lunch Program (NSLP) and the National School Breakfast Program (NSBP)—allow low-income children to receive either free or reduced-price meals (F/RP meals) at school. Under federal law, schools that participate in the NSLP are required to establish a school wellness policy. Additionally, in 2003, New Jersey enacted a law requiring the establishment of school breakfast programs in public schools where 20% or more of the students enrolled in the school are eligible for F/RP meals. Despite an increase in the number of New Jersey students participating in the NSBP during the 2011-2012 school year, New Jersey ranked forty-sixth in NSBP participation levels amongst the states in 2011. The low student participation rate can be partly attributed to low rates of school participation in the NSBP across the state.

At school, children also have access to “competitive foods”—those sold outside of the NSLP and NSBP. States have the ability to

TABLE 3. Challenge	Recommendations
340,000 New Jerseyans live in federally-recognized food deserts and struggle to access healthy foods.	Provide funding or other support to programs like the New Jersey Food Access Initiative that increase the number of permanent retail food establishments offering healthy food in New Jersey. Offer grants or tax incentives to corner stores that stock healthy foods to improve consumer access to those healthy foods. Provide state funding to develop and expand farmers markets and improve access to them by encouraging their development in new areas and by providing public transportation. Complete additional pilot mobile vending programs.



create higher standards for school meals and competitive foods than the federal standards and can set nutrition standards for food sold in vending machines. Beyond the NSLP and NSBP and outside of the school year, the federal government offers two summer feeding programs that provide free, nutritious meals and snacks to help children in low-income areas access proper nutrition throughout the summer months. (See Table 4)

FOOD AND PHYSICAL ACTIVITY INFRASTRUCTURE

How local and state governments decide to use their land—for example, to encourage the production of healthy food and to encourage increased physical activity—are important issues to address when discussing the prevention and treatment of chronic diseases.

The federal government provides support to agricultural production in a number of ways, especially in the form of financial assistance. The Specialty Crop Block Grant program, which finances production of fruits, vegetables, and nuts, is funded by the federal government and administered by state governments.

While New Jersey does not have any tax breaks or incentives for specialty crop producers, the state does have a law that reduces the amount of property taxes landowners pay on farmland. The state has also implemented two programs to preserve farmland, through which New Jersey preserved 2,183 farms, and a total of 204,452 acres. Moreover, the New Jersey legislature passed a law in 2011 to encourage and facilitate the development of urban farming within New Jersey’s municipalities. While the state has made strides to preserve and increase agricultural production, and although there has been an increase in the number of farms in vegetable production in New Jersey, the number of acres of vegetable production fell between 2002 and 2007 by about 5,000 acres.

With regards to physical activity, governments and communities are increasingly working to ensure that all residents have the opportunity to live healthy lives *where they are*. Complete Streets is a national movement to convert existing neighborhood infrastructure into pedestrian and bike-friendly roadways.

Challenge	Recommendations
Children in New Jersey schools are not receiving adequate access to healthy food.	<p>Increase participation of eligible children in school lunch programs by utilizing the direct certification process.</p> <p>Encourage individual New Jersey schools to take advantage of the new community eligibility option created by the Healthy, Hunger-Free Kids Act of 2010 to offer universal free meals in high-poverty schools.</p> <p>Encourage New Jersey local governments to provide students with an adequate time to eat lunch.</p> <p>Restore state allocation of funding toward the school breakfast program to increase participation, provide universal free breakfast, and improve the quality of school breakfast.</p> <p>Keep the stricter standards established in New Jersey law when applying the federal competitive food standards.</p> <p>Limit what can be sold in school vending machines.</p> <p>Require the NJDA to conduct a study identifying what barriers exist that cause low participation in summer nutrition programs.</p> <p>Streamline the application processes for school lunch, breakfast, summer feeding, and after-school programs.</p>
Children in New Jersey schools are not receiving adequate wellness guidance and screening.	<p>The NJDA and Department of Education (DOE) should publish all of the school districts’ wellness policies on their websites.</p> <p>Pass legislation requiring public schools to conduct body mass index screening.</p>



New Jersey established a Complete Streets policy in 2009 that requires curb extensions, bike lanes, crosswalks, pedestrian scale lighting, and other bicycle and pedestrian accommodations in every new infrastructure project. Safe Routes to School (SRTS) is another nationwide initiative that seeks to increase physical activity by encouraging children to walk or bike to school. The New Jersey Department of Transportation (DOT) has actively promoted and worked to expand the SRTS program throughout the state.

(See Table 5)

NUTRITION AND PHYSICAL EDUCATION

Increasing the number of opportunities for individuals to receive education about

nutrition, health, and physical activity will help in the prevention and management of type 2 diabetes and other chronic diseases.

The Nutrition Education and Obesity Prevention Grant Program, also called SNAP-Ed, provides funding to states to create nutritional education programs and activities that increase healthy eating habits and promote a physically active lifestyle for SNAP participants. New Jersey’s SNAP-Ed Program is run through a partnership with Rutgers University Extension Service. For WIC participants, New Jersey offers nutrition education opportunities through individual counseling, group classes, interactive displays, and health fairs.

TABLE 5. Challenge	Recommendations
<p>New Jersey has not fully developed its capacity to produce healthy food.</p>	<p>Provide state funding to supplement support received through the federal Specialty Crop Block Grant program, initiate a state-level specialty crop block grant program, or provide state funding to encourage the development of the agricultural sector in the state.</p> <p>Educate New Jersey specialty crop farmers about various sources of financial support such as the federal Specialty Crop Block Grant program, and help farmers navigate the grant application process.</p> <p>Ensure tax laws do not disadvantage small specialty crop producers.</p> <p>Increase farm to institution market opportunities for farmers by passing new legislation requiring state purchasing preference for in-state products or a resolution showing support for local food procurement.</p> <p>Provide supplemental financial support to help aggregators and food hubs start and develop.</p> <p>Continue to reduce the barriers to entry for urban agriculture through access to low-interest loans.</p> <p>Provide funding for the development of urban agriculture operations.</p>
<p>New Jersey communities need additional support to create and preserve healthy communities and a built environment that encourages walking, biking, and other active forms of transportation and exercise.</p>	<p>Require the New Jersey DOT to conduct a study to discern to what extent the New Jersey Complete Streets policy is being implemented, identify any barriers to implementation, and work to reduce these barriers. Meanwhile, New Jersey should conduct a study to fully understand the link between Complete Streets and obesity prevention, identify strengths, and identify areas for improvement.</p> <p>Allocate state funding, once the original federal funding is spent, to support New Jersey DOT’s SRTS Program.</p> <p>Provide state funding for physical activity infrastructure improvements like joint use, Complete Streets, SRTS, and local efforts in municipalities seeking to increase healthy living by improving their environments. In addition to or instead of providing funding, DOT and/or NJDA could provide technical assistance to municipalities seeking to improve their built environments.</p>



In the school context, the New Jersey DOE developed the New Jersey Core Curriculum Content Standards (CCCS) for Comprehensive Health and Physical Education. The CCCS describes what all New Jersey public school students should know and be able to do by the end of their time in public school.

Consumer education, through cooking classes, food labeling, and community physical activity courses, are helpful in empowering residents to make healthy choices. Some progress has been made in these areas. For example, in 1999, the New Jersey legislature created the New Jersey Council on Physical Fitness and Sports to support programs related to recreation and physical activity. The Patient Protection and Affordable Care Act of 2010 (ACA) now requires restaurants across the country with more than twenty locations to provide consumers with nutritional information for the foods listed on menus and display boards. New Jersey has the option to expand menu labeling requirements to apply to smaller-chain restaurants or non-chain restaurants within the state. (See Table 6)

ACCESS TO INSURANCE

The availability and affordability of health insurance is an essential part of a successful type 2 diabetes system of care. In the absence of coverage for these services, people at risk for and living with type 2 diabetes are more likely to forgo the care they need, increasing their risk of developing serious complications. From 2010 to 2011, 16% of New Jerseyans lacked insurance. New Jerseyans with lower incomes were far more likely to be uninsured; 46% of adults with income below 100% FPL lacked insurance, and 44% of adults with income under 139% FPL also went without.

The ACA allows states to expand Medicaid eligibility to most adults with income at or below 138% FPL and provides subsidies for people to buy insurance in new Health Insurance Marketplaces. New Jersey has agreed to expand Medicaid eligibility under this new option, potentially adding an estimated 104,000 new Medicaid enrollees, on top of the 610,000 New Jerseyans expected to benefit from private insurance subsidies. Even so, many eligible New Jerseyans do not know about or understand these new opportunities. (See Table 7)

TABLE 6. Challenge	Recommendations
Individuals and families need to be educated about healthy eating and physical activity.	<ul style="list-style-type: none"> Increase SNAP-Ed funding by increasing SNAP participation, thereby increasing federal funding provided to the state. Ensure all local agencies providing WIC education have internet access.
New Jersey communities need increased access to useful nutrition, health, and physical education.	<ul style="list-style-type: none"> Pass a law extending the reach of menu labeling requirements to more retail food establishments. Continue to provide grants to municipalities through the New Jersey Council on Physical Fitness and Sports, and provide funding for physical activity initiatives in various communities.

TABLE 7. Challenge	Recommendations
Too many New Jerseyans eligible for new insurance plans are either not aware of the plans or do not know how to enroll in them.	<ul style="list-style-type: none"> Increase allocation of state resources for both media outreach and community enrollment activities to help consumers learn about and access new insurance options. Provide small grants to community groups helping with enrollment. Re-purpose the Centers for Medicare and Medicaid Services (CMS) funds for Marketplace planning for outreach work. Leverage existing state resources to educate people about new insurance enrollment options through Medicaid and the Marketplace.



MEDICARE, MEDICAID, AND PRIVATE INSURANCE COVERAGE FOR KEY HEALTHCARE SERVICES

Diabetes management is complex and nearly always requires major lifestyle changes, including adherence to medication and blood glucose testing regimens. Unfortunately, cost-sharing and quantity limitations can make accessing diabetes education and supplies a challenge for patients. While Medicare, New Jersey Medicaid, and private health plans in New Jersey's individual and small group insurance markets cover diabetes supplies and medication, each insurance program falls short when it comes to coverage for prevention and management services.

One major example of a coverage failure is the Diabetes Prevention Program (DPP). Although it is associated with a 58% reduction in the risk of pre-diabetes advancing to type 2 diabetes, neither Medicare nor New Jersey Medicaid covers the DPP.

In addition, neither Medicare nor New Jersey Medicaid provides adequate coverage for diabetes management services. Medicare only covers a very limited number of Diabetes Self-Management Education (DSME) and Medical Nutrition Therapy (MNT) visits and requires patients with diabetes to cover roughly 20% of the costs for these services, which can be a major barrier. New Jersey Medicaid, in turn, does not require its contracted managed care organizations (MCOs) to cover DSME or MNT at all. Neither Medicare or New Jersey Medicaid covers

DSME or MNT for people diagnosed with pre-diabetes. In addition, while both Medicare and Medicaid cover diabetes supplies such as glucose testing strips and monitors, Medicaid MCOs frequently change the covered brand of these supplies, introducing substantial confusion for beneficiaries.

New Jersey's Diabetes Cost Control Act requires that insurance plans regulated by the state cover a variety of diabetes-related medications, equipment, supplies, and education. While private insurance providers cover DSME, they may still limit access (i.e., by covering a small number of training sessions), and they are not required to provide MNT services. Further, private insurance plans, like Medicaid MCOs, change test strip and monitor brands frequently, risking confusion and problems with management adherence.

A final challenge for diabetes management is that New Jersey's Medicaid program has allowed contracted MCOs to rely on telephonic case management programs that, based on research in other states and in Medicare, are unlikely to yield either better health outcomes or lower costs. Thus, while New Jersey Medicaid beneficiaries living with type 2 diabetes have access to case management services, the design is less likely to improve diabetes outcomes than more high-touch case management programs. More intensive case management is also more likely to reduce costs through avoiding unnecessary hospitalizations. **(See Table 8)**



Challenge	Recommendations
Medicare and Medicaid patients have limited access to lifestyle intervention programs and diabetes education.	<p>Advocate for Senator Al Franken’s Medicare Diabetes Prevention Act of 2013.</p> <p>Advocate with CMS to (1) provide DSME and MNT coverage for people with pre-diabetes and (2) cover an increased number of allowed hours for DSME.</p> <p>Require Medicaid MCOs to cover DSME and MNT, both for people with diabetes and pre-diabetes.</p> <p>Nominate DSME to be considered a United States Preventive Services Task Force preventative service eligible for the A or B rating that would make it available to consumers free of cost-sharing.</p> <p>Collaborate with non-profit organizations and foundations to enhance self-management support.</p>
Changes in test strips, glucose monitors, and insulin brands can be confusing and expensive.	<p>Limit brand changes in test strips and glucose monitors and ensure adequate access to strips and monitors in Medicaid MCOs.</p> <p>Use influence or regulatory authority to limit private insurance plans test strip and monitor changes to once per year.</p>
New Jersey’s Medicaid case management system is not designed either to optimize health outcomes for beneficiaries with type 2 diabetes or to minimize costs.	<p>Conduct an analysis of the existing case management system.</p> <p>For complex patients, shift the focus to in-person visits; increase case manager contact with providers; and enhance information-sharing systems.</p>

HEALTHCARE DELIVERY SYSTEM: PROVIDER AVAILABILITY & COORDINATED CARE MODELS

Provider Availability

Prevention and management of type 2 diabetes require the delivery of appropriate treatment and supportive services. Unfortunately, New Jersey faces shortages of both primary care physicians and advanced practice nurses (APNs), which present significant challenges to the state’s ability to ensure access to key services. New Jersey has taken some steps to increase access to primary care physicians, the most important of which is the Primary Care Loan Redemption

Program, which allows monetary redemptions in exchange for a minimum of two years of full-time work in medically-underserved areas in New Jersey. Similarly, the state is working to address the nurse shortage challenge by passing the Nursing Faculty Loan Redemption Program Act, and the Robert Wood Johnson Foundation has launched the New Jersey Nursing Initiative to support scholarships for individuals pursuing masters and doctoral degrees. Despite these efforts, New Jersey will continue to face shortages due to uneven distribution of primary care physicians, low Medicaid reimbursement rates, lack of nursing faculty in nursing schools, and restrictions on APN practice. **(See Table 9)**


TABLE 9.
Challenge
Recommendations

Inadequate primary care physician workforce.

Enhance the role of primary care within state medical schools and encourage medical schools to invest in robust family medicine departments.

Maintain and enhance incentives to practice in underserved areas through loan repayment for physicians who practice in these areas.

Increase primary care reimbursement in Medicaid so it closes the gap with Medicare.

APNs do not have the full practice authority to practice and prescribe and are not fully utilized in the healthcare system.

Eliminate the joint protocol requirement for APNs to prescribe medicines or devices.

Require insurance plans, both within and outside the Medicaid program, to include APNs in their primary care provider panels.

New Jersey faces a severe nursing shortage, due in large part to a shortage of nursing faculty leading to an insufficient number of places in the states nursing schools.

Continue to invest in the Nurse Faculty Loan Redemption Program and collaborate closely with the Robert Wood Johnson Foundation's New Jersey Nursing Initiative to encourage nurses to pursue teaching careers.

Coordinated Care Models: Patient-Centered Medical Homes, Medicaid Health Home Program, Comprehensive Primary Care Initiative, Accountable Care Organizations

Coordination of care refers to a care delivery approach designed to help patients access appropriate healthcare services to stay healthier. The fragmentation of health care is a major barrier to providing coordinated, quality care for chronic conditions like diabetes. A significant reason for fragmentation is the fee-for-service payment model, in which the provider is paid for each service he or she provides. Both the federal government, through the CMS, and the state of New Jersey have a number of programs and projects designed to help move the healthcare system away from high-volume, fragmented, and expensive care. These programs are geared towards coordinated care that yields better outcomes, quality, and patient experience of care, and lower costs.

One exciting approach to enhancing care coordination is the promotion of health information technology (HIT). New Jersey is using its 2011 Operational HIT Plan to

guide adoption of HIT in the state, while the New Jersey Health Information Technology Extension Center (NJ-HITEC) and the New Jersey Primary Care Association offer provider training and education. These efforts are (1) helping to reduce the confusion associated with newly implemented healthcare information systems, (2) helping physicians adopt electronic health records (EHRs), and (3) developing and connecting Health Information Organizations (HIOs) across the state. Adoption is still slow, unfortunately; in New Jersey, only 53.8% of office-based physicians use an EHR system, compared with 71.8% nationally.

Patient-centered medical homes (PCMHs) are characterized by providing comprehensive, patient-centered, and coordinated care, as well as accessible services and enhanced quality and safety. In New Jersey, fourteen out of the state's twenty federally-qualified health centers are working towards PCMH certification, and five have already achieved this status.

In addition to PCMHs, there are several other programs, provided for by the ACA, that will increase and improve coordination of care:



2014 NEW JERSEY STATE EXECUTIVE SUMMARY

an optional Medicaid Health Home program targeting patients living with chronic illness, a CMS-operated Comprehensive Primary Care initiative (CPC), and an accountable care organization (ACO) program within Medicare.

In addition to these federal opportunities, in 2011 New Jersey passed An Act Establishing a Medicaid Accountable Care Organization Demonstration Project. The law creates an opportunity for ACOs to be accountable for

reducing costs across the whole Medicaid population in a given geographic area, incentivizing a focus on the most expensive patients, whose costs can be brought down the most through better case management and care coordination. However, the law does not require MCOs to agree to share savings with Medicaid ACOs, and at the time of this writing only UnitedHealthCare has agreed to do so. **(See Table 10)**

TABLE 10.
Challenge

Recommendations

PCMH certification requires adoption of EHRs, which in turn requires both financing and staff training and technical assistance.

Expand the reach of HIT capacity, help practices adopt EHRs, develop the HIOs further, and ensure adequate connectivity across HIOs.

Expand the efforts and focus of NJ-HITEC and New Jersey Primary Care Association to include more community health centers.

PCMH certification requires financing to pay for the care coordination and case management functions. Fee-for-service payments are not designed to cover this type of service.

Pay PCMHs a per-member-per-month case management fee to support services for Medicaid beneficiaries.

New Jersey will miss a major opportunity to enhance care coordination for its one of its most vulnerable—and expensive—populations if the state fails to develop a Medicaid Health Home program that includes diabetes and overweight as eligible conditions.

Design a Medicaid Health Home program to include diabetes and overweight as eligible conditions. The program should eventually extend to the entire state, even if it begins on a targeted regional basis. Provider eligibility to serve as a Health Home should be determined based on stakeholder consultation. The payment methodology should be a bundled payment design, wherein participating MCOs only retain a nominal portion of the payment.

New Jersey's healthcare system is particularly fragmented and geared toward expensive specialty care.

Monitor the successes and challenges of the CPC initiative through the CMS Innovation Center and consider implementing all or part of CPC for Medicaid in New Jersey should the initiative save money for Medicare while improving the quality of care.

Monitor the outcomes of the Medicare ACO model known as the Medicare Shared Savings Program and determine which elements, if any, may be beneficial for the state to embrace independently.

Without MCO participation in the gainsharing model, Medicaid ACOs may not receive sufficient reimbursement to finance the case management services needed to keep beneficiaries healthy.

Encourage MCOs to participate in the Medicaid ACO programs and to share savings with ACOs.



Coordinated Care Models: Community Health Workers and Pharmacists

In addition to primary care physicians and APNs, other healthcare professionals such as community health workers (CHWs) and pharmacists can contribute enormously to the care of people living with, or at risk for, type 2 diabetes. CHWs have the capacity to join and make a difference in type 2 diabetes prevention and management. In a meta-analysis of eighteen studies, involvement of CHWs was associated with greater improvements in diabetes knowledge, positive lifestyle changes, increased self-management behaviors, and decreased use of the emergency department.

In a similar manner, the integration of pharmacists into primary care teams can

be an asset for people living with diabetes. Pharmacists are readily accessible and have high rates of patient interaction. For diabetes care specifically, pharmacists can help identify high-risk patients, educate patients about proper self-management, address adherence to medications, refer patients to other needed health services, and monitor a patient's condition for complications. Pharmacists can also be certified as diabetes care educators and provide additional specialized education, including formal courses on diabetes self-management. New Jersey has recently made important progress in expanding the role of pharmacists by adopting regulations for collaborative practice agreements between physicians and pharmacists. **(See Table 11)**

TABLE 11. Challenge	Recommendations
Inadequate use of CHWs and pharmacists as members of case teams for patients with type 2 diabetes.	<p>Form a policy-making body for CHW issues and build a CHW professional organization.</p> <p>Develop a statewide standardized curriculum jointly with CHWs and other healthcare profession groups and develop a formal CHW credentialing system.</p> <p>Ensure appropriate training and education for both CHW employers and supervisors.</p> <p>Require reimbursement for CHWs through alternative payment models such as bundled payments.</p> <p>Reimburse pharmacists for medication therapy management in the Medicaid program and develop a pilot program within the New Jersey Division of Medical Assistance and Health Services to reimburse pharmacists for Patient Self-Management Program for Diabetes services within Medicaid.</p>

Conclusion

No single person, organization, or agency can implement all of these recommendations. However, by working together, government, non-profit organizations, and motivated New Jerseyans from every walk of life can truly move New Jersey forward.

PATHS

Providing Access to Healthy Solutions



CENTER FOR HEALTH LAW
& POLICY INNOVATION
Harvard Law School



Bristol-Myers Squibb
Foundation

discoveryusa
better the world

This report was made possible by the support of the Bristol-Myers Squibb Foundation (BMSF). The views expressed within do not necessarily reflect those of BMSF.

Please contact chlpi@law.harvard.edu with questions or to request a full copy of the report.