NEW JERSEY

ACCESS TO CARE REPORT

2025

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Policy Analysis Improving Access to Care for New Jersey

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Executive Summary

Advanced Practice Nurse (APN) Definition: Advanced Practice Nurses (APNs) treat and diagnose illnesses, advise the public on health issues, and manage chronic disease. APNs hold a Master's or Doctoral degree, in addition to the initial nursing education and licensing required for all Registered Nurses (RNs) (ANA, n.d.). APNs include Certified Nurse Practitioners (NPs), Certified Nurse Midwives (CNMs), Clinical Nurse Specialists (CNSs) and APNs-Anesthesia. While this review is focused on primary care, it has a larger reach beyond those services.

> **Healthcare services in the United States are often criticized as being excessively costly, inefficient and lacking competitive pressure. Scope of Practice restrictions can add layers of administrative costs to the health care sector. Absent Scope of Practice restrictions employers will seek an efficient mix of different types of labor. (Policy Brief from the Hamilton Project, 2018-08)**

New Jersey Impact

Decreased access to affordable primary care in New Jersey will be created by the following factors:

1) An aging population in NJ will increase demand for primary care (13 of the 21 counties have 20% or more of their population 65 years of age or older by 2034) **(Table 1, p12)**.

2) That demand will not be met by the current physician workforce as 13 of the 21 counties in NJ already have a shortage in primary care physicians. As the physician retirement rate increases for this aging workforce, the gap between primary care provision and consumer needs will grow **(Table 2, p15); (Figure 10, p17)**.

3) The demand for mental health providers is not being met as 16 of the 21 counties have a shortage in mental health providers **(Table 3, p16)**.

4) Continued barriers to practice will prevent APNs from providing primary care and closing the access to care gap. Increased cost of APN contracts may dissuade current APNs from providing primary care, even in the limited context in which they are currently able to practice.

5) Out-migration risk of APNs to less restrictive border-states harms the existing nursing workforce by decreasing the supply of APNs working in NJ. Up to 18% of primary care APNs hold a license in NY or PA **(Table 16, p31)**.

6) The number of counties that lack an adequate number of primary care and mental health providers will rise which may increase county-wide health care costs due to increased hospitalization and readmission rates.

7) Healthcare outcomes statewide may decline as affordable primary care is denied to New Jerseyans, especially, the most vulnerable populations **(Tables 5-11, p20-23)**.

8) The patients surveyed believe the quality of care provided by APNs is the same or better than the care provided by physicians **(Figures 3-7, p7-11)**.

9) More than half the states have modernized their legislation to fully remove barriers for nurse practitioners and nurse-midwives providing care. **(Figures 1-2, p3-4)**.

10) Adopting full practice authority for APNs in NJ improves access to high-quality, cost-effective care **(Supporting Evidence, p 34-35).**

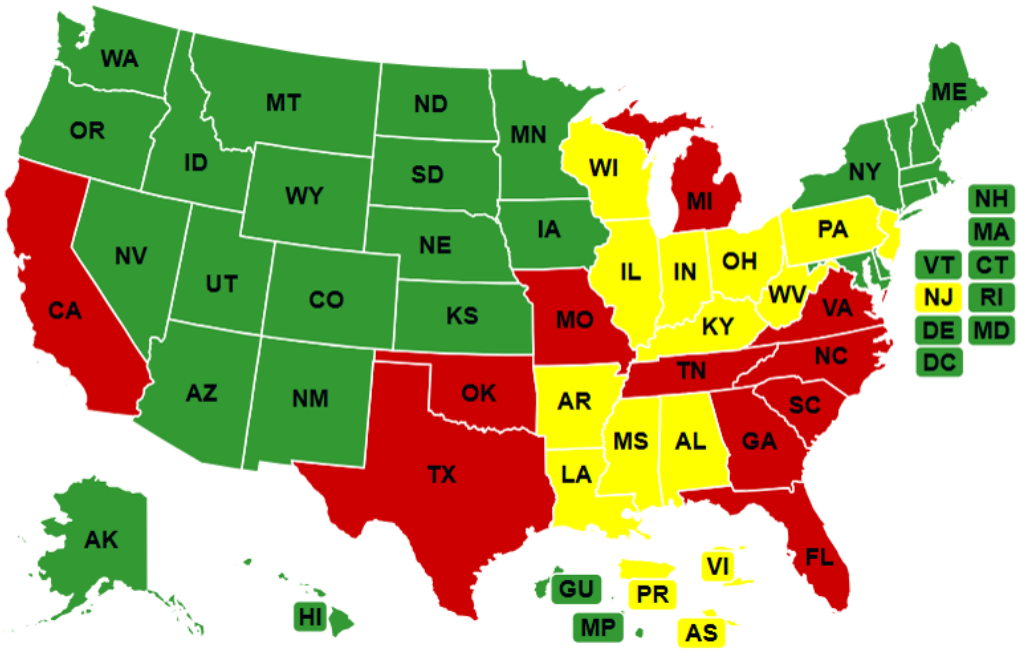
SOLUTION: The proposed legislation would eliminate certain practice restrictions for an APN (Bill S1983/A944).

I. NATIONAL LANDSCAPE

Nurse Practitioners

Today, **27 states and the District of Columbia** have modernized their legislation to fully remove barriers for nurse practitioners providing care.

Figure 1: Nurse Practitioner Practice Map



Full Practice: State practice and licensure laws permit all NPs to evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine, and the National Council of State Boards of Nursing.

Reduced Practice: State practice and licensure laws reduce the ability of NPs to engage in at least one element of NP practice. State law requires a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care, or it limits the setting of one or more elements of NP practice.

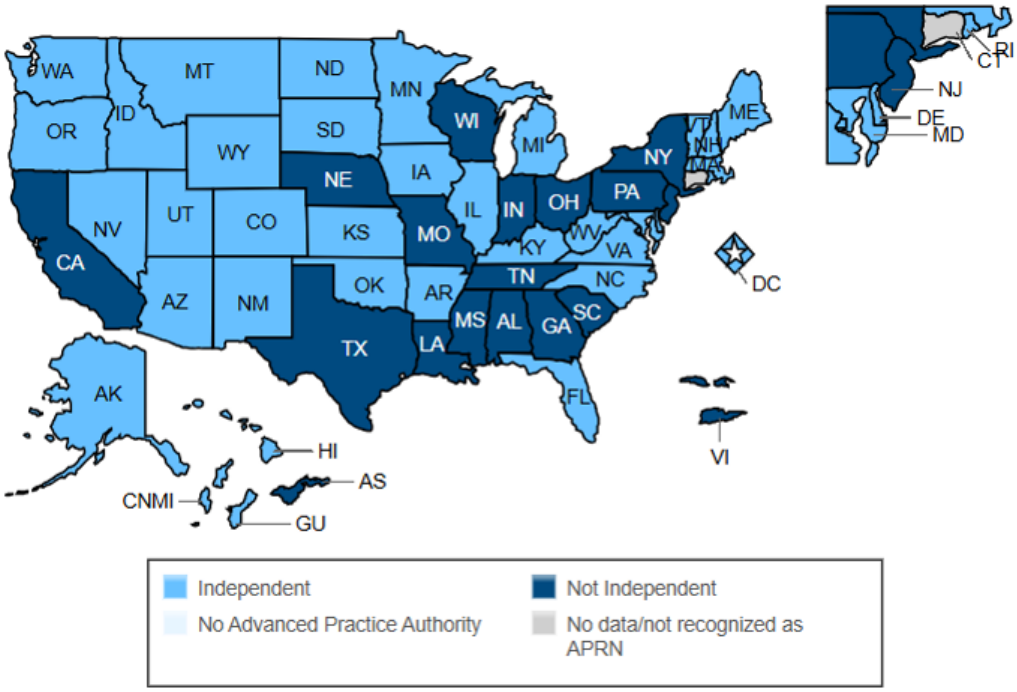
Restricted Practice: State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team management by another health provider in order for the NP to provide patient care.

(Source: American Association of Nurse Practitioners, 2024).

Nurse-Midwives

Nurse-Midwives are educated in graduate-level midwifery programs accredited by the Accreditation Commission for Midwifery Education and pass national certification examination administered by the American Midwifery Certification Board. Nurse-Midwives have a similar issue related to practice as APNs, with currently 28 states and the District of Columbia supporting independent practice authority. **Figure 2** shows the states in which Nurse-Midwives have independent practice authority. In New Jersey, Nurse-Midwives report through the State Board of Medical Examiners.

Figure 2: Nurse-Midwives Independent Practice Map



Independent: No requirement for a written collaborative agreement, no supervision, no conditions for practice, may follow a statutorily required period of practice under a collaborative/supervisory agreement.

Not Independent: A written agreement exists that specifies scope of practice and medical acts allowed with or without a general supervision requirement by a MD, DO, DDS, podiatrist or APRN; or direct supervision required in the presence of a licensed, MD, DO, DDS, podiatrist or APRN with or without a written practice agreement, or other conditions to practice.

Prescriptive Authority: An APRN is authorized to prescribe pharmacologic and non-pharmacologic therapies beyond the perioperative and periprocedural periods.

(Source: National Council of State Boards of Nursing, 2022).

Overview

There is significant **bi-partisan support** for removing barriers to APN practice (Institute of Medicine, 2010; United States (U.S.) Department of Health and Human Services, U.S. Department of the Treasury & U.S. Department of Labor, 2018; Federal Trade Commission, 2014; National Governors Association, 2012, Brookings Institute, 2018, American Enterprise Institute, 2018). The AARP, Robert Wood Johnson Foundation, and the Heritage Foundation also support modernization of legislation to improve access to care by eliminating barriers to APN practice. The Department of Veterans' Affairs (2016) has granted full practice authority to all APNs working in veterans' health administration facilities, thus ensuring quality care for our veterans.

According to The Complexities of Physician Supply and Demand: Projections from 2021-2036 report (AAMC, 2024), there are variables that impact physician shortage. Some of the key points identified from the report include:

> The **primary care physician shortage is projected to be almost twice in 2036 what it was in 2021.** A large portion of the physician workforce is nearing the traditional retirement age of 65. Physicians aged 65 or older were 17% of the active workforce in 2021, and those between age 55 and 64 made up another 25% of the active workforce (p. viii).
>
> Comparison of projected supply and demand for Primary Care physicians predicts a shortage of between 20,200 and 40,400 physicians by 2036 (p.vii). Between 2021 and 2036, changing demographics alone are projected to increase national demand for physicians by about 115,400 FTEs (13.0%). Demand for Primary Care physicians is projected to grow by 35,100 FTEs (13.8%). Higher growth rates are expected for Primary-Care-Trained Hospitalists (7,500 FTEs, 17.6%) and Medical Specialists (28,100 FTEs, 18.4%); lower growth rates are expected for Surgical Specialties (17,400 FTEs, 11.0%) and Other Specialties (27,300 FTEs, 9.7%) (p. 39).
>
> Utilization of physician services and projected growth in demand vary by census region due to differences in demographics and projected population growth, insurance coverage, the prevalence of health risk factors and disease, economic conditions, and care-access barriers. If care were evenly distributed across the United States after adjusting for demographics, socioeconomic factors, and prevalence of disease and health risk factors, physician demand

in 2021 would be distributed as follows across census regions: 341,300 FTEs (38.3%) in the South Region, 196,100 FTEs (22.0%) in the West Region, 192,300 FTEs (21.6%) in the Midwest Region, and 161,300 FTEs (18.1%) in the Northeast Region. Demand growth from 2021 to 2036 is projected to be largest in the South (55,800 FTEs) and West (36,200 FTEs) and smallest in the Midwest (13,100 FTEs) and Northeast (10,300 FTEs). The geographic distributions of primary and non-primary care are similar to the distribution for total physician demand (p.50).

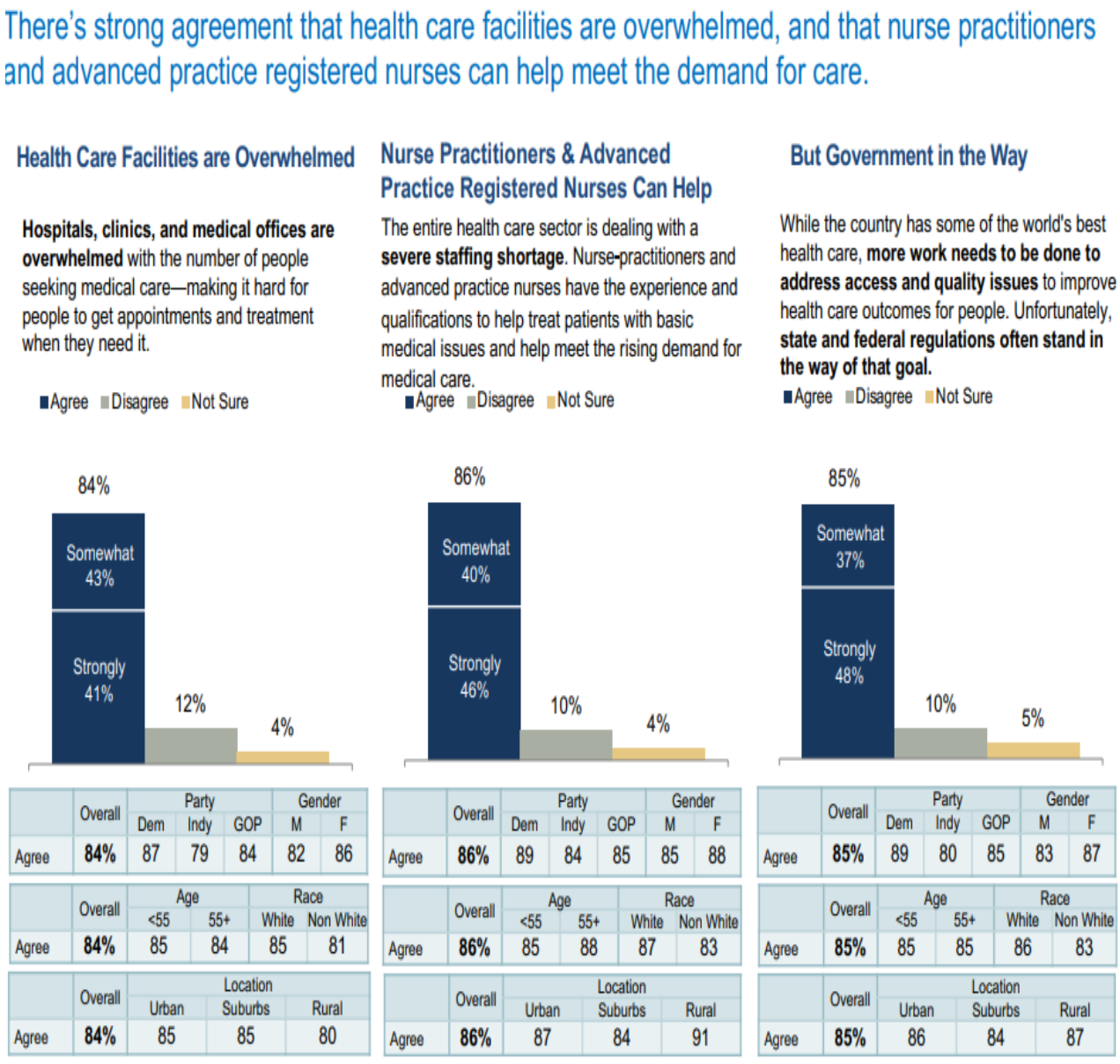
Voice of the Patient Survey (National and State)

The GS Strategy Group conducted a national poll (N = 1000) from January 6-10, 2023. They polled likely voters to understand the consumer opinion on a range of policies that would improve access to care. Both national and state data will follow.

National Poll Results

Figure 3 and **Figure 4** below show the consumer's point of view regarding APN practice nationally.

Figure 3: National Patient Survey Results



	Overall	Party			Gender	
		Dem	Indy	GOP	M	F
Agree	**84%**	87	79	84	82	86

	Overall	Age		Race	
		<55	55+	White	Non White
Agree	**84%**	85	84	85	81

	Overall	Location		
		Urban	Suburbs	Rural
Agree	**84%**	85	85	80

	Overall	Party			Gender	
		Dem	Indy	GOP	M	F
Agree	**86%**	89	84	85	85	88

	Overall	Age		Race	
		<55	55+	White	Non White
Agree	**86%**	85	88	87	83

	Overall	Location		
		Urban	Suburbs	Rural
Agree	**86%**	87	84	91

	Overall	Party			Gender	
		Dem	Indy	GOP	M	F
Agree	**85%**	89	80	85	83	87

	Overall	Age		Race	
		<55	55+	White	Non White
Agree	**85%**	85	85	86	83

	Overall	Location		
		Urban	Suburbs	Rural
Agree	**85%**	86	84	87

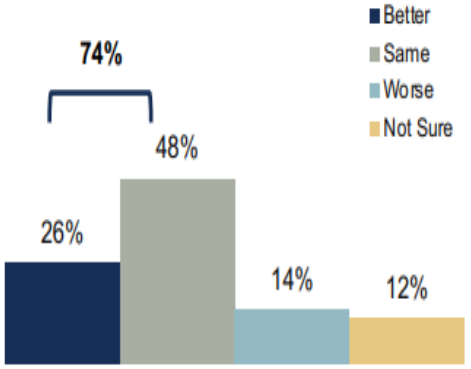
(Source: GS Strategy Group, 2023).

Figure 4: National Patient Survey Results

Voters believe nurse practitioners deliver quality care and most say they are likely to see one.

Nurses Provide Better/Same Quality of Care

Do you believe the quality of care received from nurse practitioners instead of doctors would be better, worse, or basically the same?



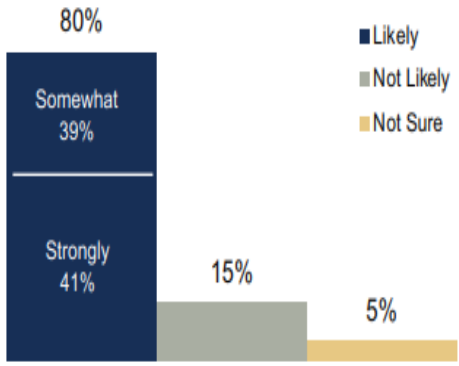
	Overall	Party			Gender	
		Dem	Indy	GOP	Male	Female
Better/Same	**74%**	80	72	70	77	71
Better	**26%**	36	16	22	32	20
Same	**48%**	44	56	48	45	51
Worse	**14%**	12	14	17	13	15
NET Better	*+12*	*+24*	*+2*	*+4*	*+19*	*+5*

	Overall	Race		Age	
		White	Non White	<55	55+
Better/Same	**74%**	74	76	78	68
Better	**26%**	26	29	36	11
Same	**48%**	48	47	43	57
Worse	**14%**	15	14	13	16
NET Better	*+12*	*+11*	*+15*	*+23*	*-5*

	Overall	Location		
		Urban	Suburbs	Rural
Better/Same	**74%**	81	69	74
Better	**26%**	41	18	17
Same	**48%**	40	51	57
Worse	**14%**	11	16	16
NET Better	*+12*	*+30*	*+2*	*+1*

High Likelihood of Seeing Nurse Practitioner for Care

And how likely would you be to consider seeing a nurse practitioner instead of a doctor at some of your health care appointments if it meant you could be seen sooner?



	Overall	Party			Gender	
		Dem	Indy	GOP	Male	Female
Likely	**80%**	83	77	78	81	78
Not Likely	**15%**	13	17	17	14	16
NET	*+65*	*+70*	*+60*	*+61*	*+67*	*+62*

	Overall	Race		Age	
		White	Non White	<55	55+
Likely	**80%**	81	76	83	75
Not Likely	**15%**	15	16	12	20
NET	*+65*	*+66*	*+60*	*+71*	*+56*

	Overall	Location		
		Urban	Suburbs	Rural
Likely	**80%**	82	77	81
Not Likely	**15%**	13	17	15
NET	*+65*	*+69*	*+60*	*+66*

(Source: GS Strategy Group, 2023).

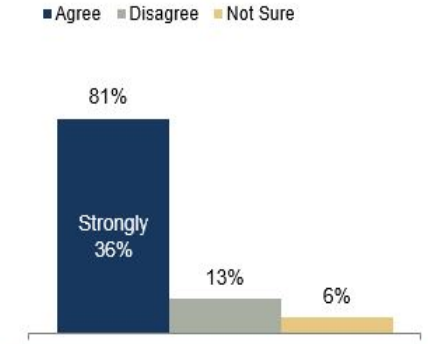
New Jersey Poll Results

Similar questions were asked for NJ by the GS Strategy Group from April 3-8, 2023. They polled consumers (N = 800) on a range of polices that would improve access to care. Results from NJ consumers can be found in **Figures 5-7**.

Figure 5: NJ Patient Survey Results

Health Care Facilities are Overwhelmed

Hospitals, clinics, and medical offices are overwhelmed with the number of people seeking medical care—making it hard for people to get appointments and treatment when they need it.



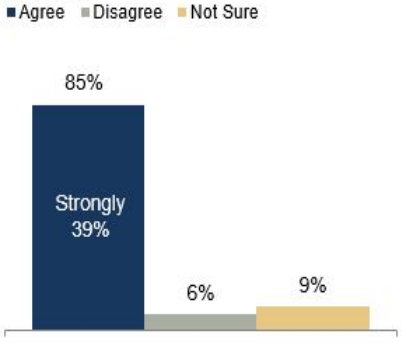
	Overall	Party			Gender	
		Dem	Indy	GOP	M	F
Agree	**81%**	84	77	78	76	84
Strongly	**36%**	38	34	32	33	38

	Overall	Age		Race	
		<55	55+	White	Non White
Agree	**81%**	84	77	80	81
Strongly	**36%**	40	30	34	43

	Overall	Location		
		Urban	Suburbs	Rural
Agree	**81%**	84	80	82
Strongly	**36%**	46	33	38

Nurse Practitioners & Advanced Practice Nurses Can Help

The entire health care sector is dealing with a **severe staffing shortage**. Nurse-practitioners and advanced practice nurses have the experience and qualifications to help treat patients with basic medical issues and help meet the rising demand for medical care.



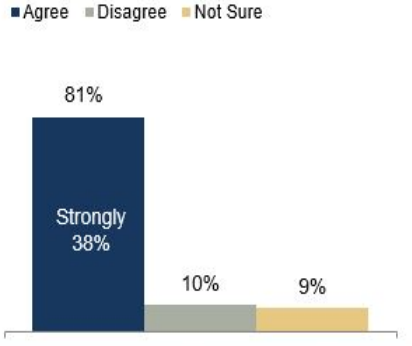
	Overall	Party			Gender	
		Dem	Indy	GOP	M	F
Agree	**85%**	84	88	85	86	85
Strongly	**39%**	40	37	39	38	40

	Overall	Age		Race	
		<55	55+	White	Non White
Agree	**85%**	85	85	85	84
Strongly	**39%**	40	38	38	42

	Overall	Location		
		Urban	Suburbs	Rural
Agree	**85%**	86	86	80
Strongly	**39%**	39	39	38

But Government in the Way

While the country has some of the world's best health care, **more work needs to be done to address access and quality issues** to improve health care outcomes for people. Unfortunately, **state and federal regulations often stand in the way of that goal.**



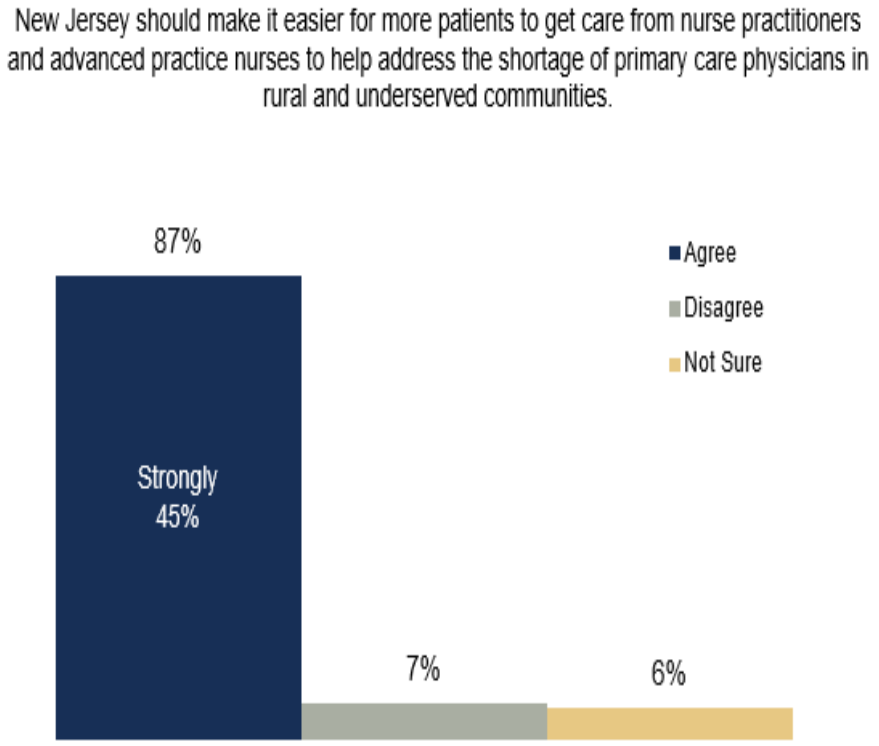
	Overall	Party			Gender	
		Dem	Indy	GOP	M	F
Agree	**81%**	80	82	82	81	80
Strongly	**38%**	40	38	32	33	41

	Overall	Age		Race	
		<55	55+	White	Non White
Agree	**81%**	84	76	80	85
Strongly	**38%**	41	33	35	44

	Overall	Location		
		Urban	Suburbs	Rural
Agree	**81%**	82	82	70
Strongly	**38%**	41	37	37

(Source: GS Strategy Group, 2023).

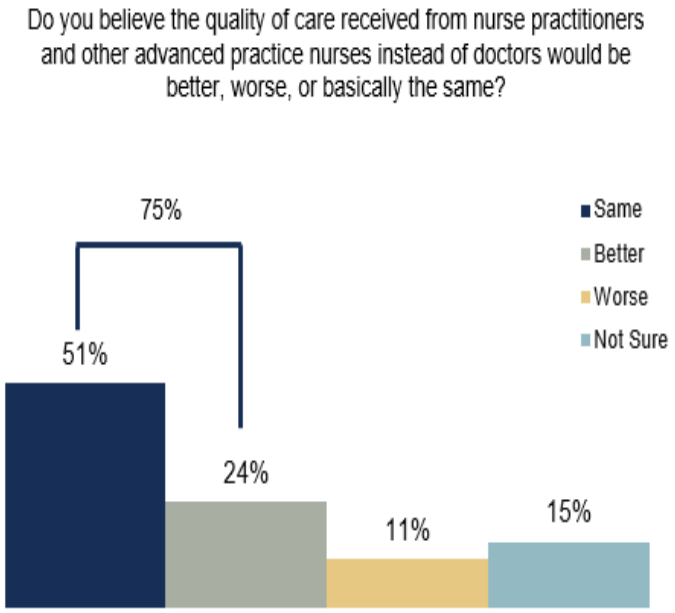
Figure 6: NJ Patient Survey Results



	Overall	Party			Gender		Race		Age		Location		
		Dem	Indy	GOP	Male	Female	White	Non White	<55	55+	Urban	Suburbs	Rural
Agree	**87%**	89	88	86	86	88	87	90	90	84	86	88	85
Strongly	**45%**	47	46	41	43	46	43	52	52	36	44	45	46

(Source: GS Strategy Group, 2023).

Figure 7: NJ Patient Survey Results



	Overall	Party			Gender		Race		Age		Location		
		Dem	Indy	GOP	Male	Female	White	Non White	<55	55+	Urban	Suburbs	Rural
Same	**51%**	48	55	53	48	43	51	47	49	53	42	53	54
Better	**24%**	29	19	20	27	22	22	34	32	14	39	20	27
Worse	**11%**	10	8	13	10	11	12	5	8	13	6	12	6

(Source: GS Strategy Group, 2023).

II. NEW JERSEY LANDSCAPE

The New Jersey Collaborating Center for Nursing (NJCCN) reviewed current data to identify the potential impact of barriers to APN practice on healthcare in New Jersey. There is mounting evidence that these barriers affect access, cost, and quality of care. New Jersey has an aging population across all counties **(Table 1)**; a 50% increase in healthcare spending from between 2011-2020 (**Figure 8**), and disparities in healthcare outcomes (**Tables 5-11**). New Jersey has 13 counties with a primary care physician shortage compared to the national ratio **(Table 2)**. New Jersey has 16 counties with a mental health provider shortage compared to the national ratio **(Table 3)**. New Jersey's healthcare landscape is changing and healthcare provisions must expand to accommodate the evolving needs of New Jersey residents.

Aging Population

Table 1: Percentage of 65 Years and Over Population by County 2023-2034

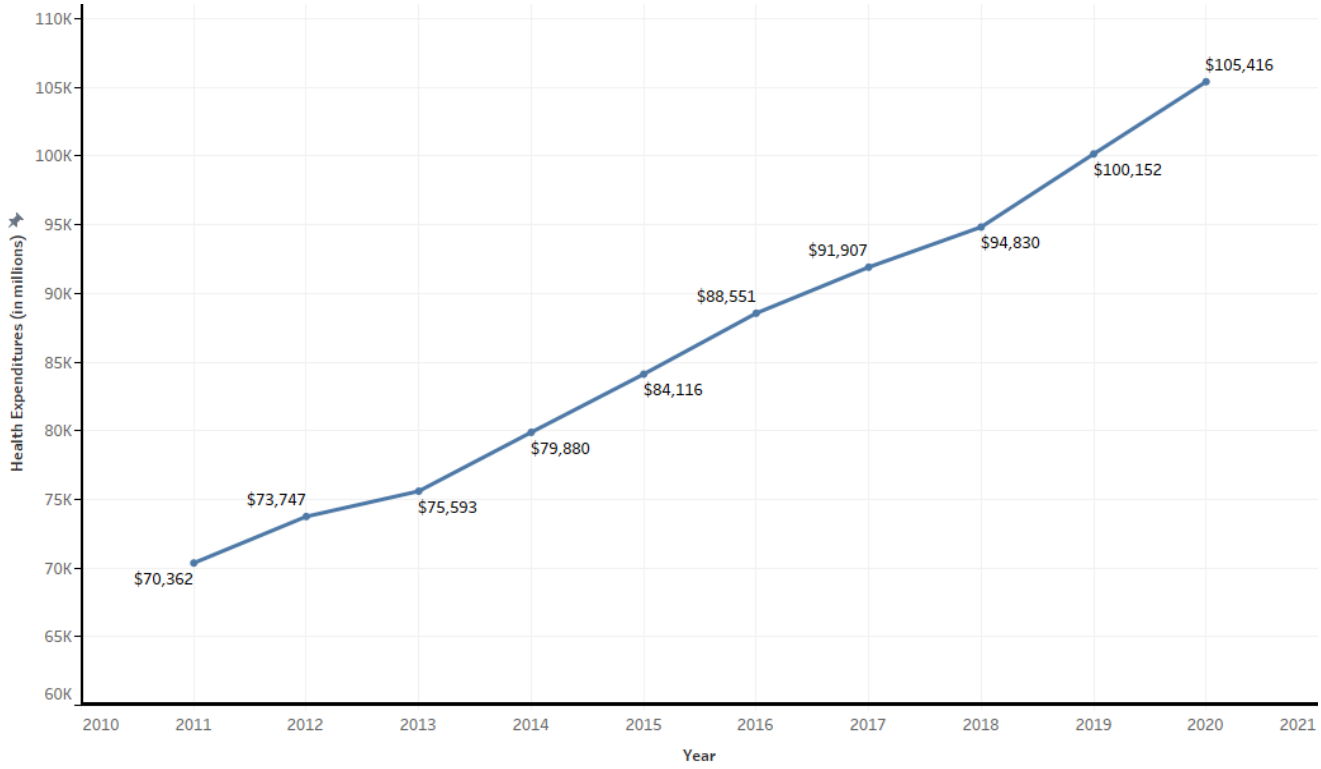
County	65+ Years % (2023)[1]	65+ Years % (2034)[2]	% Change (2023-2034)
Atlantic	20.6	21.7	1.1
Bergen	18.7	21.4	2.7
Burlington	18.8	20.9	2.1
Camden	16.9	19.5	2.6
Cape May	30.6	28.0	-2.6
Cumberland	16.2	17.1	0.9
Essex	14.7	16.7	2
Gloucester	17.4	20.3	2.9
Hudson	13.1	13.4	0.3
Hunterdon	21.7	26.4	4.7
Mercer	16.6	19.8	3.2
Middlesex	16.7	19.9	3.2
Monmouth	19.8	21.9	2.1
Morris	18.8	20.2	1.4
Ocean	23.0	25.1	2.1
Passaic	16.5	18.3	1.8
Salem	19.5	23.6	4.1
Somerset	17.6	22.3	4.7
Sussex	19.4	25.6	6.2
Union	15.6	17.6	2.0
Warren	20.3	24.7	4.4

Note: Yellow indicates elderly (65+) population over 20%.

(Source: U.S. Census Bureau[1], accessed 2025; New Jersey Department of Labor and Workforce Development[2], 2017).

Health Care Spending

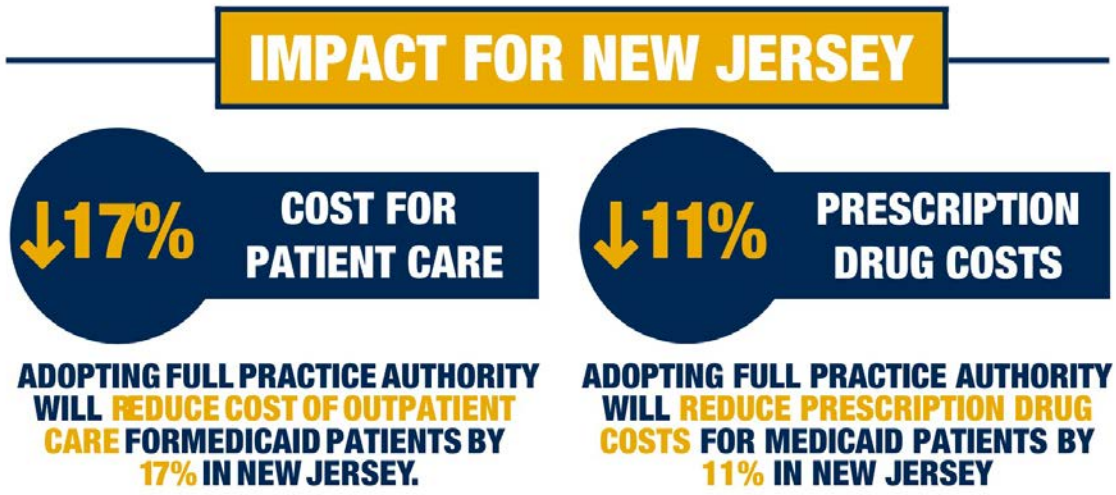
Figure 8: Health Care Expenditures in New Jersey (in millions) 2011-2020



(Source: Kaiser Family Foundation, 2022).

In New Jersey, healthcare spending per capita (inflation-adjusted) in 2020 was $13,867 (CMS, 2020).

Figure 9: Projected Economic Impact of Full Practice Authority in New Jersey



(Source: West Virginia University, 2022).

Primary Care and Mental Health Access

1) Primary care physicians alone are not enough to meet the current and future demand of primary care in New Jersey.
2) The 2024 data from County Health Rankings shows that the ratio of primary care physicians in NJ on average is 1279:1 of which 13 counties exceed that number with Salem County having the highest ratio at 4065:1. (**Table 2**)
3) There is also a lack of mental health providers. New Jersey has an average of 343:1, with 14 counties over that ratio. Hudson County has the highest ratio at 1082:1. (**Table 3**) Mental health and substance abuse disorders are of major importance in addressing the primary care needs of New Jersey residents. Approximately 1,140 (12%) of New Jersey's APNs respondents (N=9,333) identified as psychiatric nurse practitioners, which can help improve access to mental health providers (NJCCN, 2025).

Primary Care Physicians by County as Compared to NJ and U.S.

Thirteen counties in NJ do not have an adequate supply of primary care physicians as compared to the NJ primary care physicians ratio. Thirteen counties do not meet the U.S. primary care physician ratio.

Table 2. Primary Care Physicians by County

	Primary Care Physicians	Primary Care Physicians Rate[1]	Primary Care Physicians Ratio[2]
United States			**1330:1**
New Jersey	**7,245**	**78**	**1279:1**
Atlantic	197	72	1396:1*
Bergen	1,082	113	882:1
Burlington	352	76	1319:1*
Camden	516	99	1015:1
Cape May	51	53	1876:1*
Cumberland	60	39	2560:1*
Essex	645	75	1325:1*
Gloucester	162	53	1879:1*
Hudson	333	47	2109:1*
Hunterdon	143	110	909:1
Mercer	349	90	1106:1
Middlesex	778	90	1106:1
Monmouth	708	110	912:1
Morris	476	93	1073:1
Ocean	249	38	2606:1*
Passaic	269	52	1926:1*
Salem	16	25	4065:1*
Somerset	381	110	907:1
Sussex	66	45	2205:1*
Union	352	62	1625:1*
Warren	63	54	1846:1*

Note 1: Yellow indicates too few primary care physicians compared to NJ average.
Note 2: * indicates too few primary care physicians compared to U.S. average.

Definition:
[1]Primary Care Physicians Rate: Primary care physicians per 100,000 population.
[2]Primary Care Physician Ratio: Population to primary care physician ratio.

(Source: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps NJ Report, 2024).

Mental Health Providers by County as Compared to NJ and U.S.

In NJ, the number of patients to providers is 343:1 with a range of 96:1 to 1082:1. Fourteen out of 21 counties have limited access to mental health providers as compared to the NJ mental healthcare provider ratio. This can be decreased by modernizing APN practice legislation. There are 16 counties that do not meet the U.S. mental health provider ratio.

Table 3: Mental Health Providers by County

	Mental Health Providers	Provider Rate[1]	Provider Ratio[2]
United States			**320:1**
New Jersey	**26,968**	**291**	**343:1**
Atlantic	563	204	490:1*
Bergen	2,926	307	326:1*
Burlington	4,878	1,047	96:1
Camden	1,989	379	264:1
Cape May	119	124	804:1*
Cumberland	200	132	757:1*
Essex	2,231	263	381:1*
Gloucester	476	155	644:1*
Hudson	650	92	1082:1*
Hunterdon	374	288	347:1*
Mercer	1,475	387	258:1
Middlesex	1,936	225	445:1*
Monmouth	2,206	342	292:1
Morris	1,692	331	302:1
Ocean	1,300	198	504:1*
Passaic	843	164	610:1*
Salem	75	115	868:1*
Somerset	1,067	308	325:1*
Sussex	323	221	452:1*
Union	1,350	237	422:1*
Warren	286	258	388:1*

Note 1: Yellow indicates too few primary care providers compared to NJ average.
Note 2: * indicates too few primary care providers compared to U.S. average.

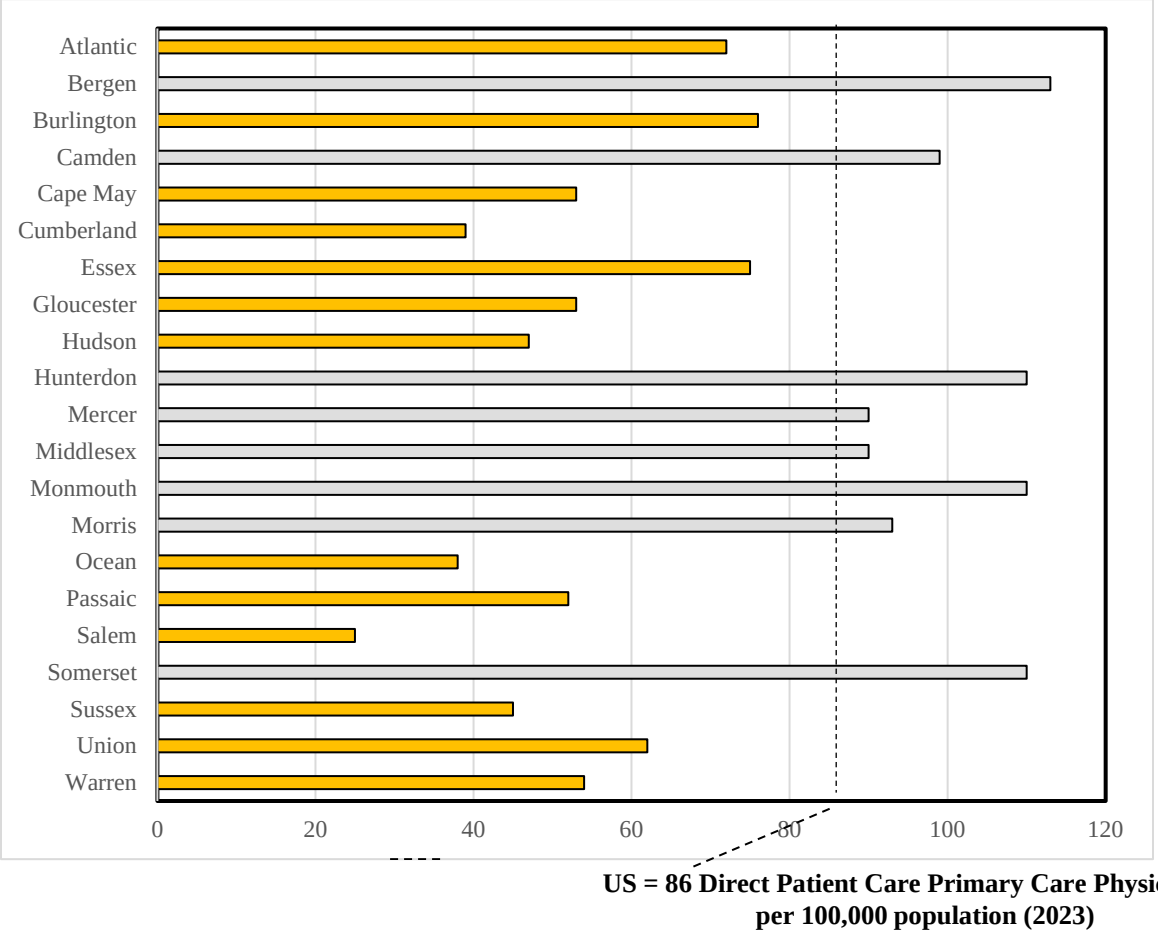
[1]Provider Rate: Mental health provider per 100,000 population.
[2]Provider Ratio: Population to mental health provider ratio.

(Source: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps NJ Report, 2024).

New Jersey Primary Care Physicians as Compared to National Data

Figure 10 indicates thirteen New Jersey counties fall below the **national** of 86 direct patient care primary care physicians per 100,000 population. Data shows a high correlation between poor health outcomes and an overall shortage of primary care providers. Counties in New Jersey that are below the national benchmark are highlighted in orange below.

Figure 10: Primary Care Physicians per 100,000 Population in NJ Counties



Note: *National of 86 direct patient care primary care physicians per 100,000 population is taken from the '*U.S. Physician Workforce Data Dashboard - 2024 Key Findings and Definitions*' published by AAMC. (https://www.aamc.org/data-reports/data/2024-key-findings-and-definitions)

(Source: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps NJ Report, 2024).

NJ Primary Care APNs per 100,000 Population

For the purposes of this report, Primary Care APNs are defined as Nurse Practitioner (NPs) and Certified Nurse Midwives (CNMs) whose employment setting is not a hospital. This is a conservative approach to identifying APNs in primary care, as APNs in hospital settings may also provide primary care.

New Jersey has 19,351 active and inactive licensed APNs (NJBON, 2024). In the 2023-2024 license renewal survey period, 15,617 APNs responded out of 19,351 licensed APNs. The number of Primary Care APNs in New Jersey is 8,616 (NJCCN, 2025). **Table 4** shows the number of primary care APNs and per 100,000 population by county of employment based on 15,617 APN survey responses. Note that 3,734 APNs did not respond to the licensure renewal survey and 3,544 (41%) primary care APNs did not report their county of employment; therefore, the actual number of primary care APNs per 100,000 population by county is higher than the numbers in the table below.

Table 4: Number of Primary Care APNs by County of Employment

	Primary Care APNs[1]	Primary Care APNs per 100,000 Population[2]
New Jersey	**8,616**	**-**
Atlantic	214	78
Bergen	536	56
Burlington	321	68
Camden	426	81
Cape May	55	58
Cumberland	83	54
Essex	454	53
Gloucester	150	49
Hudson	199	28
Hunterdon	48	37
Mercer	305	80
Middlesex	354	41
Monmouth	505	79
Morris	311	60
Ocean	310	47
Passaic	214	42
Salem	15	23
Somerset	220	63
Sussex	49	34
Union	254	44
Warren	49	44
Missing	3,544	-

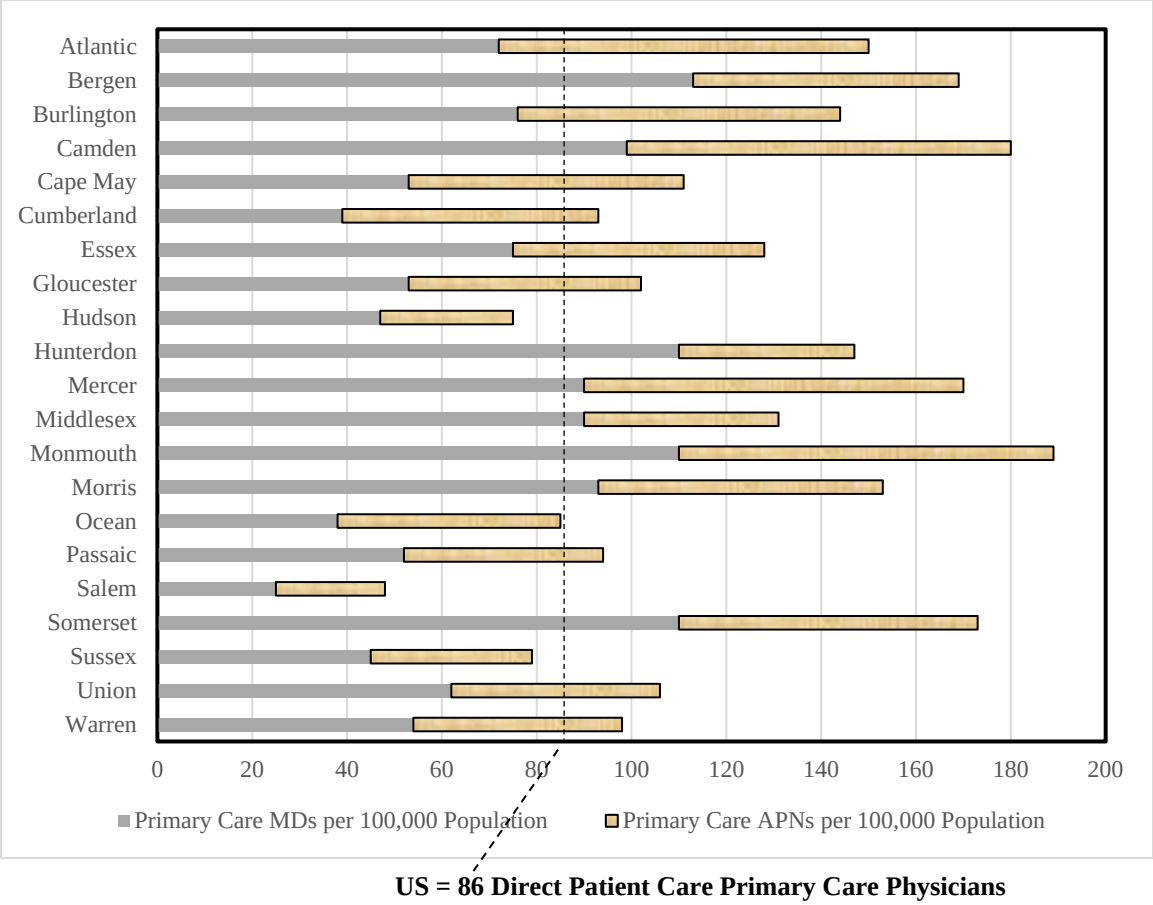
(Source: NJCCN[1,2], 2025; United States Census Bureau[2], 2023).

NJ Primary Care Physicians and Primary Care APNs Combined

To meet the rising demand for primary care, primary care APNs must practice to the top of their licensure and certification. This is a nationwide solution to an impending crisis. **Figure 11** outlines the impact of APNs to physicians in primary care in NJ counties.

Adding APNs to physicians in primary care reduces the number of counties facing a shortage from 13 to 4 (**Figure 11**). Note that the 3,544 primary care APNs who did not report county of employment were not included.

Figure 11: Primary Care Physicians and Primary Care APNs Combined



Note: *National of 86 direct patient care primary care physicians per 100,000 population is taken from the '*U.S. Physician Workforce Data Dashboard - 2024 Key Findings and Definitions*' published by AAMC. (https://www.aamc.org/data-reports/data/2024-key-findings-and-definitions)

(Source: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps NJ Report, 2024; NJCCN, 2025).

III. HEALTH OUTCOMES IN US AND NJ

New Jersey counties show disparities in length and quality of life (**Table 5**). There are also statewide disparities in health outcomes between different ethnic groups especially in the southern portion of New Jersey (**Tables 6-11**).

Length of Life and Quality of Life

Table 5: Length of Life and Quality of Life in US compared to NJ

Health Outcome Measures	US Avg.	NJ Avg.	NJ County Minimum	NJ County Maximum
Length of Life				
Premature Death[1]	8,000	6,500	4,300	12,400
Life Expectancy	77.6	79.2	73.5	82.9
Quality of Life				
Poor or Fair Health	14%	14%	10%	21%
Poor Physical Health Days[2]	3.3	3.2	2.6	4.4
Poor Mental Health Days[3]	4.8	4.4	4.0	5.4
Low Birthweight[4]	8%	8%	6%	10%

(Source: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps NJ Report, 2024).

1. Years of potential life lost before age 75, per 100,000 population.
2. Average number of physically unhealthy days in past 30 days reported by adults.
3. Average number of mentally unhealthy days in past 30 days reported by adults.
4. Percent of babies had low birth weights (under 5 pounds, 8 ounces).

Premature Death

In New Jersey, there were 6,500 years of life lost to deaths before age 75 per 100,000 people which ranged from 4,300 to 12,400 across counties in the state.

Table 6: Premature Death (Worst five counties)

County	Deaths	County Value*	Asian	Black	Hispanic	White
New Jersey	**106,997**	**6,500**				
Salem	1,297	12,400	NA	22,600	11,100	10,500
Cumberland	2,746	10,600	NA	14,100	9,200	10,500
Atlantic	4,540	9,700	4,400	16,800	7,500	9,500
Cape May	1,692	9,200	NA	13,300	8,000	9,200
Camden	7,790	9,000	2,500	15,000	8,800	7,900

*Years of life lost to deaths before age 75 per 100,000 population.
Note: Data used from 2019-2021.

(Source: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps NJ Report, 2024).

Life Expectancy

In New Jersey, the average life expectancy was 79.2 years which ranged from 73.5 to 82.9 years across counties in the state.

Table 7: Life Expectancy (Worst five counties)

County	County Value*	Asian	Black	Hispanic	White
New Jersey	**79.2**				
Salem	73.5	NA	65.4	80.2	74.9
Cumberland	74.0	81.0	70.3	76.6	74.1
Atlantic	75.9	91.0	69.2	80.3	76.1
Camden	76.2	87.7	70.9	78.5	77.1
Cape May	76.8	NA	70.5	86.7	76.8

*County Value: Average number of years a person can expect to live.
Note: Data used from 2019-2021.

(Source: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps NJ Report, 2024).

Poor or Fair Health

In New Jersey, 14% of adults reported that they were in fair or poor health which ranged from 10% to 21% across counties in the state.

Table 8: Percentage of Poor or Fair Health (Worst five counties)

County	County Value*
New Jersey	**14%**
Cumberland	21%
Passaic	18%
Essex	17%
Atlantic	17%
Hudson	17%

*County Value: Percentage of adults reporting fair or poor health.
Note: Data used from 2021.

(Source: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps NJ Report, 2024).

Poor Physical Health Days

In New Jersey, the average number of physically unhealthy days reported by adults in the past 30 days was 3.2 which ranged from 2.6 to 4.4 days across counties in the state.

Table 9: Average Number of Physically Unhealthy Days in the Past 30 Days (Worst five counties)

County	County Value*
New Jersey	**3.2**
Cumberland	4.4
Salem	4.0
Ocean	3.9
Camden	3.7
Atlantic	3.7

*County Value: Average number of physically unhealthy days reported in past 30 days.
Note: Data used from 2021.

(Source: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps NJ Report, 2024).

Poor Mental Health Days

In New Jersey, the average number of mentally unhealthy days reported by adults in the past 30 days was 4.4 which ranged from 4.0 to 5.4 days across counties in the state.

Table 10: Average Number of Mentally Unhealthy Days in the Past 30 Days (Worst five counties)

County	County Value*
New Jersey	**4.4**
Cumberland	5.4
Salem	5.4
Atlantic	5.3
Camden	5.3
Gloucester	5.2

*County Value: Average number of mentally unhealthy days reported in past 30 days.
Note: Data used from 2021.

(Source: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps NJ Report, 2024).

Low Birthweight

In New Jersey, 8% of newborns had low birth weights (under 5 pounds, 8 ounces), ranged from 6% to 10% across counties in the state.

Table 11: Percentage of Low Birthweight (Worst five counties)

County	County Value*	Asian	Black	Hispanic	White
New Jersey	**8%**				
Cumberland	10%	10%	14%	9%	8%
Essex	9%	9%	13%	7%	6%
Camden	9%	10%	14%	9%	7%
Passaic	9%	11%	15%	9%	7%
Salem	9%	NA	13%	10%	7%

*County Value: Percentage of live births with low birthweight (< 2,500 grams)
Note: Data used from 2016-2022.

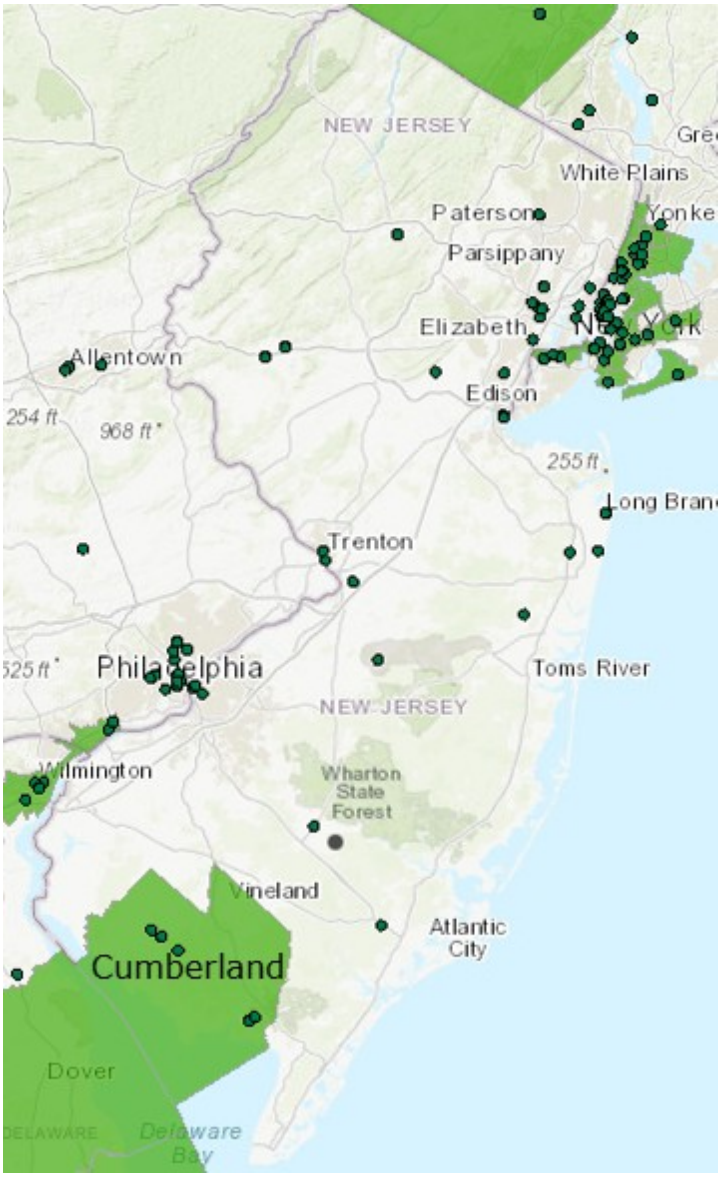
(Source: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps NJ Report, 2024).

IV. HEALTH PROFESSIONAL SHORTAGE AREAS IN NJ

Figures 12 and 13 show the most recent Health Professional Shortage Areas (HPSAs) for primary care and mental health.

Primary Care Shortage Areas

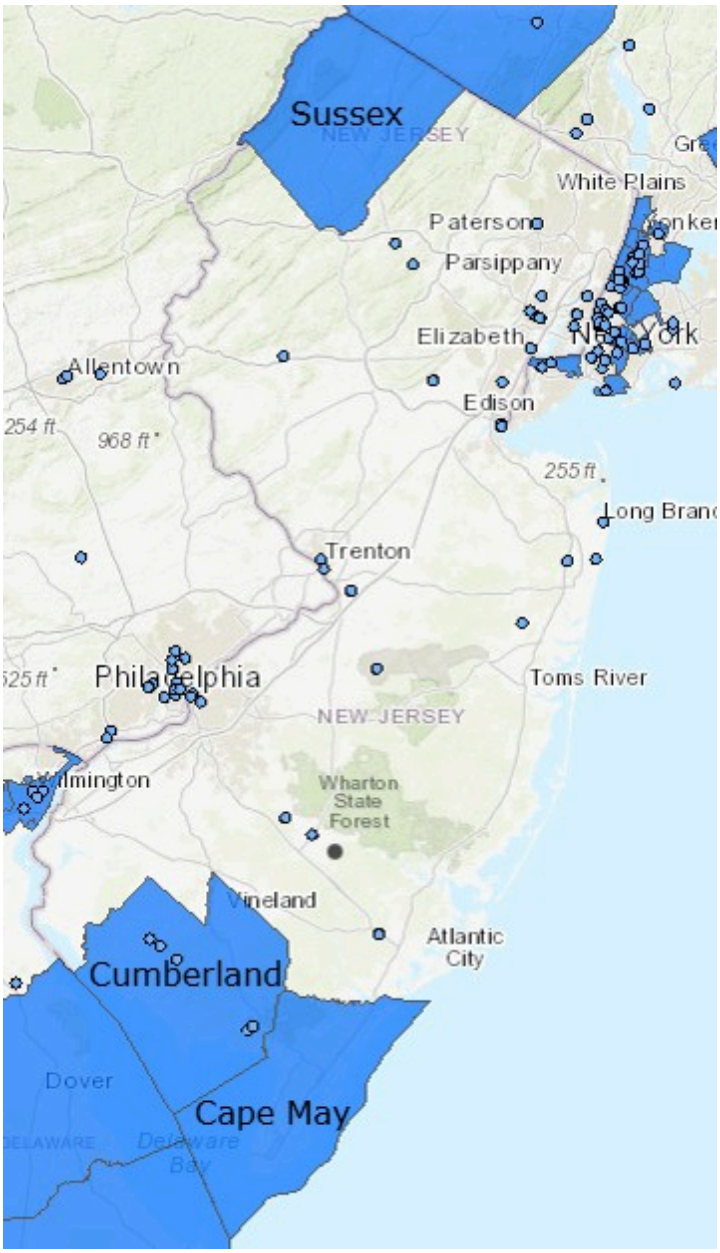
Figure 12: Primary Care Health Professional Shortage Areas



(Source: Health Resources & Services Administration, 2025).

Mental Health Shortage Areas

Figure 13: Mental Health Professional Shortage Areas

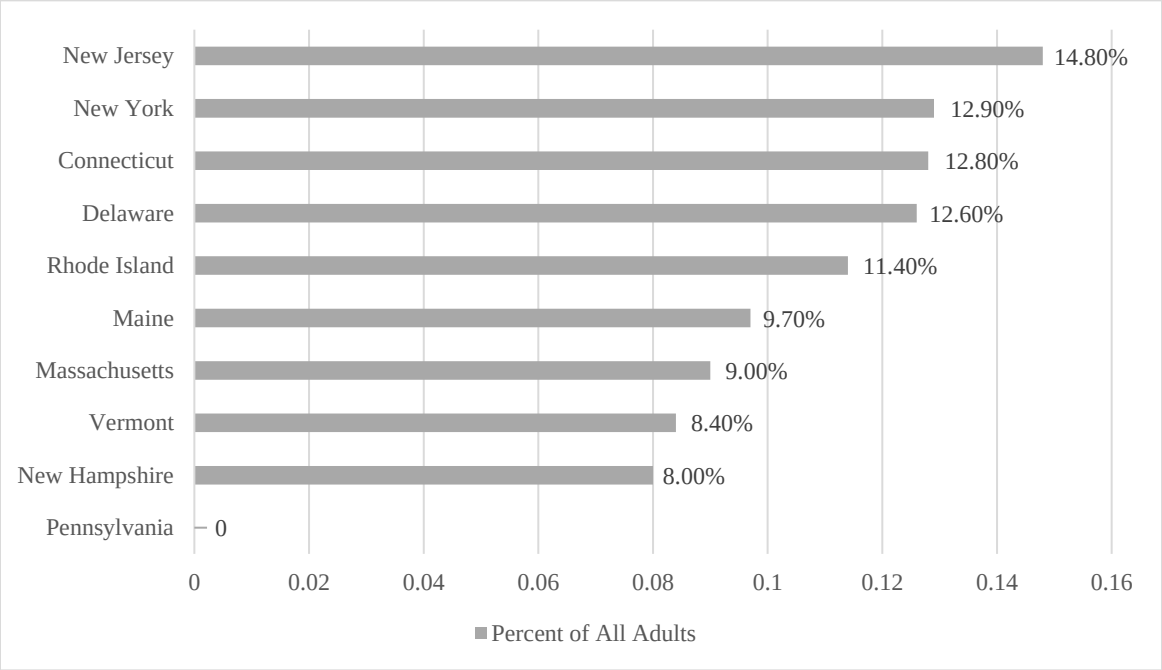


(Source: Health Resources & Services Administration, 2025).

Lack of Providers in the North-East

In New Jersey**, 14.8% of adults reported that they do not have a personal health care provider** – which is **among the worst levels** in all states in the North-East (**Figure 14**). Nurse practitioner with full practice authority will increase the probability of patients having routine checkups, having a usual source of care and being able to get an appointment when needed. (Adams & Markowitz, 2018.

Figure 14: Adults Who Report Not Having a Personal Doctor/Health Care Provider among the North-East



Note: No data available for Pennsylvania.
(Source: Kaiser Family Foundation, 2023).

V. INCOME AND HEALTH DISPARITIES by COUNTY

Table 12 compares the health outcomes rankings to health factors as defined by County Health Rankings (University of Wisconsin Population Health Institute, 2024), as well as the per capita income levels for each county. Health Outcomes indicate length of life and quality of life, while health factors represent health behaviors, clinical care, social and economic factors, and physical environment. Counties with lower income tend to experience lower health outcomes and health factors.

Boosting the supply of practitioners in lower income counties may improve the overall health index for the state of New Jersey. This can also reduce hospital readmission rates and complex care management, both of which are costlier than providing preventative care.

Table 12. Comparison of Health Outcome, Factors, and Income Levels by County

County	Health Outcomes (2024)[1]	Health Factors (2024)[1]	Per Capita Income (2023)[2]	Median Household Income (2019-2023)[2]
Hunterdon	1	3	$71,070	$139,453
Morris	2	1	$69,226	$134,929
Bergen	3	4	$62,986	$123,715
Somerset	4	2	$70,321	$135,960
Monmouth	5	5	$65,545	$122,727
Middlesex	6	6	$49,417	$109,028
Sussex	7	7	$56,471	$114,316
Union	8	12	$51,850	$100,117
Burlington	9	8	$53,077	$105,271
Hudson	10	14	$53,998	$90,032
Ocean	11	13	$43,900	$86,411
Warren	12	10	$48,232	$99,596
Mercer	13	9	$52,101	$96,333
Passaic	14	17	$40,241	$87,137
Gloucester	15	11	$47,760	$102,807
Cape May	16	16	$54,325	$88,046
Essex	17	18	$48,021	$76,712
Camden	18	15	$44,380	$86,384

County	Health Outcomes (2024)[1]	Health Factors (2024)[1]	Per Capita Income (2023)[2]	Median Household Income (2019-2023)[2]
Atlantic	19	19	$41,448	$76,819
Salem	20	20	$39,397	$78,412
Cumberland	21	21	$33,587	$64,499

(Source: University of Wisconsin Population Health Institute[1], County Health Rankings & Roadmaps NJ Report, 2024; U.S. Census Bureau[2], QuickFacts, 2024).

VI. SUPPLY TRENDS OF APN WORKFORCE IN NEW JERSEY

Graduation Rates

Graduation rates for APNs allow for a larger pipeline of primary care providers. **Table 13** shows the number of graduates from 2018-2023. There is an upward trend in the number of APN graduates which could help increase the number of primary care providers.

Table 13: Post-Licensure Graduation Rates 2018-2021 for Students who Qualify to Become APNs Upon Entering the Workforce

Program	2018	2019	2020	2021	2022	2023
MSN*	377	435	416	378	400	510
DNP	137	190	155	204	199	242

***Note: Not all MSN graduates are potential APNs.**

(Source: NJCCN, 2025).

APN/NP Breakdown

New Jersey has 19,351 licensed APNs (NJBON, 2024). In the 2023-2024 New Jersey Board of Nursing (NJBON) license renewal surveys, 15,617 APNs responded out of New Jersey's 19,351 licensed APNs. APN respondents accounted for 81% of the APN workforce in New Jersey. The majority of APNs are identified as NPs. In this survey period, there were 12,995 out of 15,617 APN respondents reported that they have a nurse practitioner certification (NJCCN, 2025).

Table 14: Number of APNs and NPs in NJ

Total number of active and inactive APNs in New Jersey	19,351[1]
Number of APNs 2023-2024 survey respondents	15,617[2]
Number of NPs 2023-2024 survey respondents	12,995[2]

(Source: New Jersey Board of Nursing[1], 2024; NJCCN[2], 2025).

NP Specialty

Table 15 shows a majority of the NPs in NJ are already educated in Primary Care. There were 11,629 NPs out of 12,995 NPs that reported their primary area of focus in the 2023-2024 New Jersey Board of Nursing (NJBON) license renewal survey. **Table 15** shows the nurse practitioner specialties of the 9,333 NPs after excluding Adult/Gerontology/Acute, Others, and missing data (NJCCN, 2025).

Table 15: Nurse Practitioner Primary Area of Focus

NP Specialty	N = 9,333
Family	3,940
Adult/Gerontology Primary	2,926
Psychiatric	1,140
Pediatrics	895
Women's Health	432

(Source: NJCCN, 2025).

VII. RISK of APN OUT-MIGRATION

Primary Care APNs Out-Migration to NY/PA by County

Table 16 shows primary care APNs who hold a license to practice in New York or Pennsylvania and are at risk of migrating out by county. This risk has increased as New York has removed restrictions on APN practice. Pennsylvania is currently in the process of removing barriers. Pending legislation increases the urgency of addressing APN practice in New Jersey, if out-migration is to be avoided.

Table 16: Out-Migration Risk by County to NY or PA

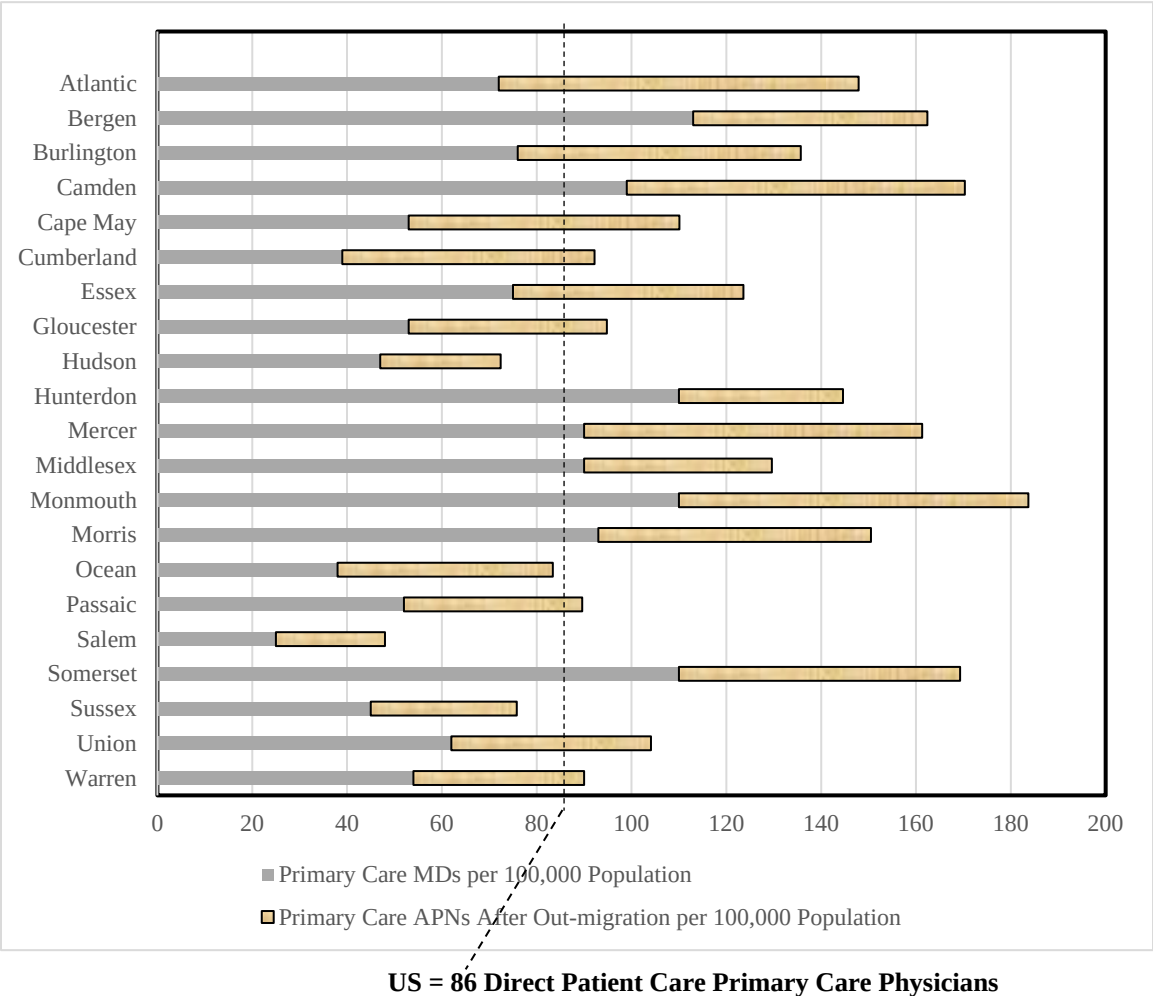
County (Based on Employment)	Primary Care Advanced Practice Nurses	Primary Care APNs that hold NY/PA licenses	% Primary Care APNs that hold NY/PA licenses
Atlantic	214	5	2%
Bergen	536	63	12%
Burlington	321	41	13%
Camden	426	50	12%
Cape May	55	1	2%
Cumberland	83	2	2%
Essex	454	40	9%
Gloucester	150	21	14%
Hudson	199	20	10%
Hunterdon	48	3	6%
Mercer	305	33	11%
Middlesex	354	12	3%
Monmouth	505	31	6%
Morris	311	15	5%
Ocean	310	11	4%
Passaic	214	21	10%
Salem	15	0	0%
Somerset	220	13	6%
Sussex	49	4	8%
Union	254	13	5%
Warren	49	9	18%

Note: The 1,329 primary care APNs who held NY or PA license were employed in other states are not included. (Source: NJCCN, 2025).

Combined Primary Care Physicians and APNs After Out-Migration

Figure 15 outlines the potential impact of Primary Care APNs out-migration. **Out-migration could impact 4 counties leaving them unable to meet the national of 86 direct patient care primary care physicians per 100,000 population.** Sustained out-migration can adversely impact the health outcomes of all New Jersey counties.

Figure 15: Primary Care Physicians and Primary Care APNs per 100,000 Population After APN Out-migration



Note: *National of 86 direct patient care primary care physicians per 100,000 population is taken from the '*U.S. Physician Workforce Data Dashboard - 2024 Key Findings and Definitions*' published by AAMC. (https://www.aamc.org/data-reports/data/2024-key-findings-and-definitions)

(Source: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps NJ Report; NJCCN, 2025).

New Jersey Nurse Practitioners Active in Other States

Table 17 shows 3,500 (27%) of the 12,995 Nurse Practitioner respondents indicated that they are active in states other than New Jersey. This results are for all NPs across all employment settings. It is important to note that New York, Delaware, and Connecticut allow for full practice authority.

Table 17: NP Active in Other States

	N=3,500	%
New York	1,536	44
Pennsylvania	1,263	36
Delaware	74	2
Connecticut	35	1
Other	541	15
Missing	51	1

VIII. SUPPORTING EVIDENCE

For over a quarter of a century, NJ APNs have reduced practice authority requiring a Joint Protocol (a written agreement) with a collaborating physician creating both an operational and financial barrier to access to care, despite decades of evidence supporting that APNs deliver high quality care, especially among the most vulnerable patients.

Even with an adequate growth of APNs, primary care will remain insufficient if the joint protocol barrier persists (Cadmus et al., 2020). In fact, APN growth was slower in states with restrictive scope-of-practice regulations compared to those states in which APNs have with full practice authority (Auerbach et al., 2020). To improve access to care across the state, APNs are especially needed in various specialties, such as primary care, rural settings, and emergency care.

Regulating APNs with these barriers to practice are decisions often based on politics, rather than evidence. This report provides recent evidence that documents the provision of high-quality, cost-effective care delivered by APNs while improving patient outcomes.

Quality

- Another recent meta-analysis of 22 randomized controlled trials (the highest level of evidence) found that APNs significantly lowered hospital readmissions and improved patient satisfaction (Fajarini et al., 2025).
- A meta-analysis of 10 randomized controlled trials, evaluating APNs in primary care compared to physicians, found that APNs provided longer consultation times resulting in improved patient satisfaction and comparable quality outcomes including physiologic measures (Swan, et al, 2015).

Access

- Nationally, there is projected shortage of 20,200 - 40,400 primary care physicians by 2036 (GlobalData Plc, 2024). In New Jersey, HRSA projects a shortage of 3,870 primary care physicians and physician assistants by 2036, and a projected surplus of 670 primary care nurse practitioners can start to fill the gap (HRSA, 2024).

- To address the shortage of primary care physicians, barriers to effective utilization of APNs must be removed, so they can care for patients with multiple chronic diseases (Geller & Swan, 2021).
- Nurse led clinics have improved access for underserved communities, however, there is a need for financial stability by establishing APN full practice authority and credentialing APNs as Medicaid-primary care providers that reimburse APNs at the same rate as physicians (Tobbell, 2025).
- In a systematic review of 17 studies examining the effectiveness of APN care for mental health conditions in primary care, seven studies in restrictive practice states found limited access to mental health care (Turi et al., 2023). There were also six studies that found APN led care was associated with clinical and statistical improvements in depression and/or anxiety (Turi et al., 2023).

Economic Impact

- In a meta-analysis of 22 randomized controlled trials representing over 7,500 patients comparing the use of APNs to other health professionals found APNS reduced total patient costs, lowered direct costs, and decreased hospitalizations (Fajarini et al., 2025).
- An international scoping review of APNs found the primary care they delivered was associated with fewer emergency department visits (9 of 11 studies); fewer hospital admissions/readmissions (9 of 10 studies); and significantly lower costs (7 of 8 studies) (Horton et al., 2024).
- In long term care, Canadian researchers in Quebec found that the cost benefits of having NPs manage the most common complications in long term care including falls, pressure ulcers, polypharmacy, restraint use, and acute hospitalizations resulted in an average savings of almost $3 million dollars (Dangwa et al., 2022).
- Adopting full practice authority in NJ would: 1) reduce the cost of outpatient care for Medicaid patients in NJ by 17%, and 2) reduce prescription drug costs for Medicaid patients by 11% (Poghosyan et al., 2019).

References

Adams, E.K. & Markowitz, S. (2018). *Improving Efficiency in the Health-Care System: Removing Anticompetitive Barriers for Advanced Practice Registered Nurses and Physician Assistants.* The Hamilton Project, Brookings. https://www.hamiltonproject.org/wp-content/uploads/2023/01/AM_PB_0620.pdf

American Academy of Nurse-Midwives (2022). Nurse-*Midwives State Practice Authority*. https://www.midwife.org/workforce-study-data-release

American Association of Nurse Practitioners (AANP) (2024). *Nurse Practitioner State Practice Environment.* https://www.aanp.org/advocacy/state/state-practice-environment

Association of American Medical Colleges (AAMC) (2024). *U.S. Physician Workforce Data Dashboard - 2024 Key Findings and Definitions.* https://www.aamc.org/data-reports/data/2024-key-findings-and-definitions

Association of American Medical Colleges (AAMC) (2024). *The Complexities of Physician Supply and Demand: Projections From 2021 to 2036.* https://www.aamc.org/media/75236/download?attachment

American Nurses Association (ANA) (n.d.). *Advanced Practice Registered Nurse (APRN).* https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/aprn/

Auerbach, D. I., Buerhaus, P. I., & Staiger, D. O. (2020). Implications of the rapid growth of the nurse practitioner workforce in the U.S. Health Affairs, 39(2), 273–279. https://doi.org/10.1377/hlthaff.2019.00686

Buerhaus, P. (2018) *Nurse Practitioners: A Solution to America's crisis.* Washington, DC: American Enterprise Institute.

Cadmus, E., de Cordova, P.B., Weaver, S., Ravichandran, A. (2020). Access to care in New Jersey: Making the case for modernizing legislation. *Journal of Nursing Regulation*, 11(1), 37-41

Centers for Medicare & Medicaid Services (2020). *USA Facts: Healthcare spending per capita in New Jersey.* https://usafacts.org/topics/health/state/new-jersey/

Dangwa, P., Scanlan, J., & Krishnan, P. (2022). Integrating Nurse Practitioners Into Long-term Care: A Call for Action. *The Journal for Nurse Practitioners*, *18*(5), 488–492. https://doi.org/10.1016/j.nurpra.2022.02.010

Fajarini, M., Setiawan, A., Sung, C. M., Chen, R., Liu, D., Lee, C. K., Niu, S. F., & Chou, K. R.

(2025). Effects of advanced practice nurses on health-care costs, quality of care, and patient well-being: A meta-analysis of randomized controlled trials. International Journal of Nursing Studies, 162, 104953. https://doi.org/10.1016/j.ijnurstu.2024.104953

Federal Trade Commission (2014). *Policy Perspective: Competition and the Regulation of Advanced Practice Nurses.* https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf

Geller, D. E., & Swan, B. A. (2021). Recent evidence of nurse practitioner outcomes in a variety of care settings. Journal of the American Association of Nurse Practitioners, 33(10), 771–775. https://doi.org/10.1097/JXX.0000000000000451

GlobalData Plc. (2024). The Complexities of Physician Supply and Demand: Projections from 2021 to 2036. Washington, DC: AAMC

GS Strategy Group (2023). National Opinion on Expanding Patient Choices.

Health Resources and Services Administration (HRSA) (2022). *Primary Care Workforce Projections 2022-2037.* https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nursing-projections-factsheet.pdf.

Health Resources and Services Administration (HRSA) (2021). *Table 4 Selected Patient Characteristics for NJ.* https://data.hrsa.gov/tools/data-reporting/program-data/state/NJ/table?tableName=4

Health Resources and Services Administration (HRSA) (2021). *Table 5 Staffing and Utilization for NJ.* https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2021-table-5-fact-sheet.pdf

Health Resources and Services Administration (HRSA) (2024). Workforce Projections Dashboard. https://data.hrsa.gov/topics/health-workforce/workforce-projections

Health Resources and Services Administration (HRSA) (2025). Quick Maps – Primary Care Health Professional Shortage Areas. https://data.hrsa.gov/maps/quick-maps?config=mapconfig/HPSAPC.json

Health Resources and Services Administration (HRSA) (2025). Quick Maps – Mental Health Health Professional Shortage Areas. https://data.hrsa.gov/maps/quick-maps?config=mapconfig/HPSAMH.json

Horton, M., Dixon, J., Turi, E., Balusu, C., Paikoff, C., Maier, C.B., & Poghosyan, L. (2024). Advanced practice nurses in primary care and their impact on health service utilization, costs and access globally: A scoping review. The Journal of Clinical Nursing, 1-10. https://doi.org/10.1111/jocn.17614

Institute of Medicine (IOM) (2011). *The Future of Nursing: Leading Change, Advancing Health.* Washington, DC: National Academies Press (US). https://www.ncbi.nlm.nih.gov/pubmed/24983041

Kaiser Family Foundation (2022). *Health Care Expenditures by State of Residence (in millions).* https://www.kff.org/other/state-indicator/health-care-expenditures-by-state-of-residence-in-millions/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Kaiser Family Foundation (2023). Adults Who Report Not Having a Personal Doctor/Health Care Provider by Sex https://www.kff.org/other/state-indicator/percent-of-adults-reporting-not-having-a-personal-doctor-by-sex/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

National Council of State Boards of Nursing (2022). *CNM Independent Practice Map*. https://www.ncsbn.org/nursing-regulation/practice/aprn/aprn-consensus-implementation-status/cnm-independent-practice-map.page

National Governors Association (2012). *The Role of Nurse Practitioners in Meeting Increased Demand for Primary Care.* https://www.nga.org/publications/the-role-of-nurse-practitioners-in-meeting-increasing-demand-for-primary-care/

New Jersey Collaborating Center for Nursing (NJCCN) (2025). New Jersey Nursing Data and Analysis Report. https://njccn.org/wp-content/uploads/2025/02/NJCCN_New_Jersey_Nursing_Data_and_Analysis__2025_-Final_website-rev.pdf

New Jersey Department of Labor and Workforce Development. (2017). *NJ Population and Labor Force Projection of 2014-2034.* https://www.nj.gov/labor/labormarketinformation/demographics/population-labor-projections/index.shtml

Poghosyan, L., Timmons, E. J., Abraham, C. M., & Martsolf, G. R. (2019). The economic impact of the expansion of Nurse Practitioner Scope of Practice for Medicaid. *Journal of Nursing Regulation, 10(*1), 15-20. https://doi.org/10.1016/S2155-8256(19)30078-X

State of New Jersey, 221st Legislative Session, Assembly No. A944, Eliminates certain practice restrictions for advanced practice nurses. https://pub.njleg.state.nj.us/Bills/2024/A1000/944_I1.HTM

State of New Jersey, 221st Legislative Session, Senate No.1983, Eliminates certain practice restrictions for advanced practice nurses. https://pub.njleg.gov/Bills/2024/S2000/1983_I1.HTM

Swan, M., Ferguson, S., Chang, A., Larson, E., & Smaldone, A. (2015). Quality of primary care by advanced practice nurses: a systematic review. International journal for quality in health care: Journal of the International Society for Quality in Health Care, 27(5), 396–404. https://doi.org/10.1093/intqhc/mzv054

The New Jersey Hospital Association (2018). *Profile of New Jersey Federally Qualified Health Centers.* http://www.njha.com/media/536242/2018-Profile-of-NJ-FQHC-Report.pdf

Tobbell D. (2025). The Role of Communities in Nurse-Led Clinics, 1965-2000: Lessons From History. Policy, Politics & Nursing practice, 26(1), 6–15. https://doi.org/10.1177/15271544241289416

Turi, E., McMenamin, A., Kueakomoldej, S., Kurtzman, E., & Poghosyan, L. (2023). The effectiveness of nurse practitioner care for patients with mental health conditions in primary care settings: A systematic review. Nursing Outlook, 71(4), 101995. https://doi.org/10.1016/j.outlook.2023.101995

U.S. Department of Health and Human Services, U.S. Department of the Treasury, & U.S. Department of Labor (2018). *Reforming America's healthcare system through choice and competition.* http://www.njccn.org/wp-content/uploads/2018/12/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf

U.S. Census Bureau (2025). *Quick Facts.* https://www.census.gov/quickfacts/fact/table/NJ/PST045222

U.S. Census Bureau (2025). *Quick Facts.* https://www.census.gov/quickfacts/fact/table/NJ/INC110223

University of Wisconsin Population Health Institute (2024). *County health rankings state report.* https://www.countyhealthrankings.org/health-data/new-jersey?year=2024

VA Office of Public and Intergovermental Affairs (2016). *VA Grants Full Practice Authority to Advanced Practice Registered Nurses.* https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2847

West Virginia University, John Chambers College of Business and Economics, The Knee Center for the Study of Occupational Regulations (2022). Dr. Timmons created data report for NJ.