

Increasing Access to a Diverse Mental Health Workforce Through Emergency Reciprocity Licensure

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ABSTRACT: New Jersey's COVID-19 Temporary Emergency Reciprocity Licensure Program provided temporary licenses to more than 31000 out-of-state healthcare practitioners, over a quarter of whom were mental health providers. As the need for mental health care accelerated during the pandemic, especially among health disparity populations, expanding mental health provider pools may be a critical tool to increase access to care. In January 2021, we surveyed New Jersey's temporary licensees. We analyzed over 4500 mental health provider responses to examine the impact of the temporary licensure program on access to mental health care overall and on enhancing a diverse mental health workforce. Over 3700 respondents used their temporary license to provide mental health care to New Jersey patients. About 7% of respondents self-identified as Hispanic, 12% Black, 6% Asian, 1% American Indian or Alaska Native, and 0% (more than 5) Native Hawaiian or other Pacific Islander. They treated about 30100 New Jersey patients, 40% of whom were new to the provider, and 81% delivered care exclusively using telehealth. Respondents conversed with patients in at least 13 languages. About 53% served at least one patient from an underserved racial/ethnic minority group. Our findings suggest that temporary out-of-state mental health providers helped enhance mental health care continuity and access.

Introduction

States govern and oversee healthcare provider licensing and regulation, but, in most instances, states do not offer licensure reciprocity for interstate professional practice.^{1,2} Public health emergencies can cause localized surges in demand for healthcare services, triggering a need for an increased healthcare provider supply. A key strategy to help meet these demands is temporary modifications of professional licensure laws, which can allow for the expansion of provider pools, methods of care delivery, and scopes of practice.³ During the COVID-19 pandemic, at least 45 US states modified their healthcare provider licensure laws through public health emergency legislation and regulatory mechanisms.^{4,5}

On March 9, 2020, as the State of New Jersey became one of the first COVID-19 hotspots in the US, New Jersey Governor Philip D. Murphy signed Executive Order 103, authorizing the state Division of Consumer Affairs (DCA), which houses the professional licensing boards, to “waive, suspend or modify any existing rule, where the enforcement of the rule would be detrimental to the public

welfare during the emergency.”⁸ Via a series of regulatory actions, including administrative orders and waivers pursuant to the authority granted by Executive Order 103, the Division of Consumer Affairs enacted a Temporary Emergency Reciprocity Licensure program on March 20, 2020. This program allowed out-of-state, licensed healthcare

DURING THE COVID-19 PANDEMIC, AT LEAST 45 US STATES MODIFIED THEIR HEALTHCARE PROVIDER LICENSURE LAWS THROUGH PUBLIC HEALTH EMERGENCY LEGISLATION AND REGULATORY MECHANISMS.

providers to obtain a temporary license to provide care to New Jersey residents via telehealth⁶ or in-person similar to a plenary license.⁷⁻¹¹ Although policy decisions regarding licensure reciprocity and professional practice boundaries are historically politically-fraught, the pandemic-related provider supply crisis yielded swift emergency policy response by most states. The goal of these

programs was to increase the healthcare workforce supply to meet pandemic-related surges in demand for both COVID-19 and non-COVID-19 care. As part of New Jersey's program, licensing fees and criminal background checks were waived for individuals holding current, out-of-state licenses in good standing. Twenty-three categories of providers were eligible to participate in the program, including physicians, nurses, and mental health providers.⁹ As of January 2021, the DCA had issued over 30000 temporary licenses to out-of-state healthcare providers. Simultaneous to the establishment of the temporary licensure program, New Jersey and the federal government introduced multiple telehealth expansion efforts,^{6,12} offering broader modalities for care delivery during the COVID-19 emergency.

Expanding provider pools and telehealth offerings is critical, particularly for mental health care, as the already urgent need for mental health providers accelerated during the pandemic. As of 2015, mental health and substance use disorders together surpassed cancer and cardiovascular disease as the leading cause of disease burden in the US.¹³ The US has experienced mental health workforce shortages for years,¹⁴ especially in populations vulnerable to health disparities, which includes rural populations¹⁵ as well as communities from racial and ethnic minority backgrounds.¹⁶ The pandemic exacerbated care gaps and disparities attributable to workforce shortages, as studies show that many mental health providers left their

TWENTY-THREE CATEGORIES OF PROVIDERS WERE ELIGIBLE TO PARTICIPATE IN THE PROGRAM, INCLUDING PHYSICIANS, NURSES, AND MENTAL HEALTH PROVIDERS. AS OF JANUARY 2021, THE DIVISION OF CONSUMER AFFAIRS HAD ISSUED OVER 30000 TEMPORARY LICENSES TO OUT-OF-STATE HEALTHCARE PROVIDERS.

jobs for work outside of healthcare or work with higher pay during this time period.¹⁷ Attrition may also be increasing due to workforce burnout,¹⁸ as psychologists report having a higher number of patients and increased workload in 2021 compared to 2020, with the burden particularly acute among psychologists who are younger, female, and racial/ethnic minorities.¹⁹ Many psychologists have also been working at or above capacity, with nearly

half experiencing burnout and 41% unable to meet treatment demand.¹⁹ Innovative approaches, including interstate licensure reciprocity, are needed to increase the mental health workforce to mitigate growing gaps in mental health demand and supply, which disproportionately burden health disparity populations.

Emergency licensure reciprocity programs implemented during the pandemic thus offer a unique opportunity to examine the impact of more flexible and portable licensure on health services. New Jersey's COVID-19 Temporary Emergency Reciprocity Licensure program is well-positioned for study, as New Jersey was one of the initial COVID-19 hotspots in the US and is one of the most diverse states in the country.^{20,21} The goal of this study was

THE PANDEMIC EXACERBATED CARE GAPS AND DISPARITIES ATTRIBUTABLE TO WORKFORCE SHORTAGES, AS STUDIES SHOW THAT MANY MENTAL HEALTH PROVIDERS LEFT THEIR JOBS FOR WORK OUTSIDE OF HEALTHCARE OR WORK WITH HIGHER PAY DURING THIS TIME PERIOD.

to investigate the impact of emergency licensure reciprocity on access to mental health services overall and access to a diverse mental health workforce in particular. This study expands upon our prior work which analyzed the survey data across six broad health practitioner categories.²² In the previous study, we found that mental health providers were the highest overall utilizers of the New Jersey temporary license. Compared to the other practitioner groups, mental health providers were the most likely to serve existing patients, most likely to use telehealth to deliver care to patients, and least likely to converse with patients in a language other than English. These findings motivated the present analysis to more closely examine trends and variation among the different types of mental health providers who used a temporary license, particularly to serve New Jersey's diverse population.²³ This is the first study to examine the impact of emergency licensure reciprocity on a state's mental health provider supply during the COVID-19 emergency. Findings may inform future licensure policies that aim to enhance mental health care continuity and increase access to diverse provider pools.

Methods

We conducted a cross-sectional survey of New Jersey temporary licensees. The survey instrument was developed by officials from the New Jersey DCA and researchers from Rutgers University and drew upon validated survey questions and theoretical frameworks²⁴ to capture the impact of the program on healthcare workforce supply. See Appendix A for the survey questions. The DCA fielded the survey January 7-21, 2021 by emailing a survey link that allowed for anonymous reply and 2 reminder emails to all providers (N=31805) who obtained a New Jersey temporary license between March 20, 2020 and January 6, 2021.²⁵ There were 10449 total survey respondents (33% response rate, which is similar to prior provider surveys in New Jersey²⁶ and nationally²⁷)—4689 of whom were mental health providers and are the focus of this study. Additional results from the survey are reported elsewhere.²²

We created 5 mental health provider respondent sub-groupings: (1) psychologists; (2) social workers; (3) professional counselors; (4) mental health prescribers, which includes psychiatrists, nurse practitioners (including Advanced Practice Nurses), and physician assistants who indicated a psychiatry specialty; and (5) other mental health providers, which includes alcohol and drug counselors, marriage and family therapists, and nurses specializing in psychiatry.

We performed descriptive analyses to identify the reach and impact of the mental health providers who used the temporary license. Analyses were conducted using R statistical software.²⁸ Counts less than 10 were denoted as “less than 10” to ensure respondent anonymity, per recommended best practice.²⁹ The study was approved by the Rutgers University Institutional Review Board.

Results

Among the 4689 total mental health provider respondents, 3726 (79.5%) reported that they used their temporary license to provide mental health services to at least one New Jersey-based patient. These 3726 respondents are hereinafter referred to as “license-using respondents” or the “license-using group.” The remaining 963 mental health provider respondents obtained but had not, at the time of the survey, used their temporary license. Among the 518 who provided a reason for not using the temporary license, the top reasons were: did not receive treatment requests (eg, no

referrals for new patients, existing patients who relocated did not seek care; 54.6%) and no job placement (unable to find employment; 13.7%). The license-using group is the focus of this study. For a breakdown of the provider types who

THIS IS THE FIRST STUDY TO EXAMINE THE IMPACT OF EMERGENCY LICENSURE RECIPROCITY ON A STATE'S MENTAL HEALTH PROVIDER SUPPLY DURING THE COVID-19 EMERGENCY. FINDINGS MAY INFORM FUTURE LICENSURE POLICIES THAT AIM TO ENHANCE MENTAL HEALTH CARE CONTINUITY AND INCREASE ACCESS TO DIVERSE PROVIDER POOLS.

responded to the survey, see Appendix B. The license-using respondents held primary licenses from every state in the US except Mississippi. Most were licensed in New York (1409; 37.8%), Pennsylvania (932; 25.0%), California (173; 4.6%), Massachusetts (138; 3.7%), and Maryland (120; 3.2%). These five states accounted for almost 75% of all the license-using respondents.

Table 1 describes the self-identified demographics of the license-using respondents. The majority were non-Hispanic, white women between the ages of 18-59. However, there were many respondents from underrepresented racial/ethnic groups. About 7% of respondents identified as Hispanic, 12% Black, 6% Asian, 1% American Indian or Alaska Native, and 0% (more than 5) Native Hawaiian or other Pacific Islander. About 75% of Black respondents were either social workers or professional counselors. About 45% of Asian respondents were psychologists.

Table 2 shows the number of patients treated by the license-using respondents during the study period. In total, license-using respondents reported treating an estimated 30096 New Jersey patients. Respondents served a mixture of new and existing patients, with about 40% of patients new to the provider and 60% existing patients. Psychologists, social workers, and providers in the “other mental health providers” category treated more existing patients than new patients compared to professional counselors and mental health prescribers who treated similar percentages of both.

Table 1

Demographics of respondents to a survey of out-of-state mental health providers who were granted a New Jersey temporary license between March 2020 and January 2021

Demographics	All Mental Health Care Providers		Psychologists		Social Workers		Professional Counselors		Mental Health Prescribers		Other Mental Health Providers	
	n	%	n	%	n	%	n	%	n	%	n	%
	N = 3726		N = 1276		N = 1131		N = 848		N = 206		N = 265	
Ethnicity												
Non-Hispanic	3364	90%	1171	92%	1002	89%	765	90%	188	91%	238	90%
Hispanic	268	7%	75	6%	97	9%	65	8%	10	5%	21	8%
Prefer Not to Answer	94	3%	30	2%	32	3%	18	2%	<10	4%	<10	2%
Race												
White	2832	76%	1046	82%	863	76%	591	70%	144	70%	188	71%
Black	435	12%	62	5%	158	14%	167	20%	15	7%	33	12%
Asian	223	6%	101	8%	38	3%	40	5%	28	14%	16	6%
American Indian or Alaska Native	26	1%	<10	0%	<10	1%	<10	1%	<10	0%	<10	1%
Native Hawaiian or other Pacific Islander	<10	0%	<10	0%	<10	0%	<10	0%	<10	0%	<10	0%
Other	84	2%	28	2%	18	2%	16	2%	<10	4%	14	5%
Prefer Not to Answer	201	5%	65	5%	62	5%	43	5%	12	6%	19	7%
Gender												
Female	2938	79%	968	76%	948	84%	699	82%	120	58%	203	77%
Male	679	18%	277	22%	147	13%	123	15%	81	39%	51	19%
Undesignated/ Non-binary	43	1%	<10	1%	17	2%	16	2%	<10	0%	<10	1%
Prefer Not to Answer	66	2%	24	2%	19	2%	10	1%	<10	2%	<10	3%
Age												
18-39 years old	1455	39%	484	38%	454	40%	354	42%	64	31%	99	37%
40-59 years old	1608	43%	527	41%	475	42%	401	47%	99	48%	106	40%
60 years or older	594	16%	231	18%	187	17%	86	10%	38	18%	52	20%
Prefer Not to Answer	69	2%	34	3%	15	1%	<10	1%	<10	2%	<10	3%

Notes. Sample includes survey respondents who reported using the temporary license to provide mental health services to at least 1 New Jersey patient. Counts less than 10 are denoted as "<10" to enhance respondent anonymity. Respondent could select more than 1 race; sum may be greater than 100%. Mental health prescribers were defined as physicians, nurse practitioners, and physician assistants who indicated a psychiatry specialty. Other mental health providers were defined as alcohol and drug counselors, marriage and family therapists, and nurses specializing in psychiatry.

Table 3 shows telehealth use by provider type, including the share of patient care time using telehealth and the share of the telehealth time by modality (ie, audio vs. video). All licensing-using respondents spent most of their New Jersey patient care time using telehealth; in fact, 80.9% of respondents spent all of their patient care time

using telehealth. The group that reported the lowest share of time using telehealth was “other mental health providers;” 21.3% of which spent none of their patient care time using telehealth. Across all 5 groups, respondents were more likely to use video-based telehealth than audio-only telehealth. Respondents in the “other mental

Table 2

Estimated number of New Jersey patients treated as reported by respondents to survey of out-of-state mental health providers who were granted a New Jersey temporary license between March 2020 and January 2021

Provider Type	N	# of New Patients	# of Existing Patients	Total # of Patients
Psychologists	1276	2220	4719	6939
Social workers	1131	3921	5054	8975
Professional counselors	848	3194	3647	6841
Mental health prescribers	206	2222	2588	4810
Other mental health providers	265	667	1864	2531
All	3726	12224	17872	30096

Notes. Sample includes survey respondents who reported using the temporary license to provide mental health services to at least 1 New Jersey patient. Mental health prescribers were defined as physicians, nurse practitioners, and physician assistants who indicated a psychiatry specialty. Other mental health providers were defined as alcohol and drug counselors, marriage and family therapists, and nurses specializing in psychiatry.

Table 3

Telehealth use to care for New Jersey patients as reported by respondents to survey of out-of-state mental health providers who were granted a New Jersey temporary license between March 2020 and January 2021

Provider Type	Share of Patient Care Time Using Telehealth				Share of Telehealth Time by Modality				
	None	Less Than Half	Half or More	All	All Audio	Mostly Audio	Equally	Mostly Video	All Video
Psychologists	0.3%	9.0%	2.9%	87.8%	1.7%	1.5%	3.0%	19.8%	74.0%
Social workers	1.1%	16.2%	1.9%	80.8%	3.4%	2.6%	7.7%	20.4%	66.0%
Professional counselors	0.8%	16.4%	1.8%	81.0%	2.1%	1.8%	5.1%	23.3%	67.7%
Mental health prescribers	3.8%	3.4%	2.6%	90.2%	1.6%	1.0%	2.8%	23.1%	71.4%
Other mental health providers	21.3%	11.7%	2.3%	64.7%	0.8%	3.5%	9.2%	18.7%	67.8%
All	5.5%	11.3%	2.3%	80.9%	1.9%	2.1%	5.6%	21.1%	69.4%

Notes. Sample includes survey respondents who reported using the temporary license to provide mental health services to at least 1 New Jersey patient. Mental health prescribers were defined as physicians, nurse practitioners, and physician assistants who indicated a psychiatry specialty. Other mental health providers were defined as alcohol and drug counselors, marriage and family therapists, and nurses specializing in psychiatry.

health providers” category (which includes nurses) were slightly more likely to use audio-based telehealth compared to the other respondent groups.

Table 4 shows the languages that respondents used to converse with their New Jersey patients. Most spoke only English with their patients. However, respondents also reported conversing with their patients in Spanish (165 respondents), Arabic,

Table 4
Languages used to converse with New Jersey patients as reported by respondents to survey of out-of-state mental health providers who were granted a New Jersey temporary license between March 2020 and January 2021

Language	All Mental Health Care Providers N = 3,726	
	n	%
English only	3457	93%
Spanish	165	4%
Arabic	<10	0%
Chinese (including Mandarin and Cantonese)	12	0%
Haitian Creole	14	0%
Hindi	11	0%
Italian	<10	0%
Korean	<10	0%
Gujarati	<10	0%
Polish	<10	0%
Portuguese	<10	0%
Russian	15	0%
Tagalog (including Filipino)	<10	0%
Other	38	1%

Notes. Sample includes survey respondents who reported using the temporary license to provide mental health services to at least 1 New Jersey patient. Counts less than 10 are denoted as “<10” to enhance respondent anonymity. Respondent could select more than 1 language; sum may be greater than 100%. Breakdown by practitioner type not shown due to small counts; small counts removed to ensure respondent anonymity.

Chinese, Haitian Creole, Hindi, Italian, Korean, Gujarati, Polish, Portuguese, Russian, and Tagalog.

Table 5 shows characteristics of patients served by license-using respondents, which highlights ways in which respondents provided care to health disparity populations (eg, racial and ethnic minorities and those with less privileged socioeconomic status).³⁰ While most respondents indicated that their patients had insurance, some also served New Jersey’s Medicaid and uninsured population—331 (7.1%) reported serving at least 1 Medicaid or uninsured patient. Forty-four percent of these respondents (147 of the 331) indicated that more than 25% of their patients were Medicaid enrollees or uninsured. About two-thirds of the license-using respondents (n=2559) reported serving at least 1 patient with a chronic or severe mental health diagnosis or substance use disorder—1655 of which had more than 25% of their patients in this category. About 53% (n=1975) reported serving at least 1 patient from an underserved racial or ethnic minority population—1011 of which had more than 25% of their patients in this category. About 18% (n=683) reported serving at least 1 patient with a physical disability—201 of which had more than 25% of their patients in this category.

Discussion

Our survey results revealed that at least 3700 mental health providers who held primary licenses in other states used their temporary New Jersey license to provide mental health services to over 30000 New Jersey-based patients during the study period (March 2020-January 2021). The program enabled patients with already-established care to maintain care continuity and patients seeking new care to have increased access to mental health services. With increasing deaths of despair (ie, deaths attributable to drugs, alcohol, and suicide)^{31,32} and a growing shortage of mental health providers across the US,^{14,17} especially from health disparity backgrounds,³³ increased access to mental health services for even 1 individual, let alone 30000, has the potential to save lives.³⁴ The expansion of interstate reciprocity licensure represents a significant public health emergency response initiative with potentially far-reaching impact for mental health care accessibility.

Importantly, our survey results revealed that the New Jersey Temporary Emergency Reciprocity Licensure Program enabled at least 689 mental

Table 5**Characteristics of patients served as reported by respondents to survey of out-of-state mental health providers who were granted a New Jersey temporary license between March 2020 and January 2021**

Patient Characteristic	All Mental Health Care Providers		Psychologists		Social Workers		Professional Counselors		Mental Health Prescribers		Other Mental Health Providers	
	n	%	n	%	n	%	n	%	n	%	n	%
	N = 3726		N = 1276		N = 1131		N = 848		N = 206		N = 265	
Covered by Medicaid or uninsured												
None	2716	73%	941	74%	834	74%	636	75%	124	60%	181	68%
1-10%	140	4%	34	3%	42	4%	38	4%	10	5%	16	6%
11-25%	44	1%	14	1%	16	1%	<10	0%	<10	4%	<10	1%
> 25%	147	4%	40	3%	56	5%	31	4%	<10	4%	12	5%
Don't know	671	18%	247	19%	183	16%	139	16%	48	23%	54	20%
Chronic or severe mental health diagnosis or substance use disorder												
None	1002	27%	387	30%	275	24%	233	27%	12	6%	95	36%
1-10%	599	16%	173	14%	215	19%	159	19%	11	5%	41	15%
11-25%	305	8%	98	8%	97	9%	83	10%	10	5%	17	6%
> 25%	1655	44%	585	46%	483	43%	328	39%	158	77%	101	38%
Don't know	157	4%	33	3%	61	5%	45	5%	<10	3%	11	4%
Underserved racial or ethnic minority populations												
None	1528	41%	610	48%	440	39%	312	37%	62	30%	104	39%
1-10%	582	16%	164	13%	191	17%	154	18%	37	18%	36	14%
11-25%	382	10%	136	11%	109	10%	83	10%	31	15%	23	9%
> 25%	1011	27%	312	24%	322	28%	250	29%	41	20%	86	32%
Don't know	215	6%	54	4%	69	6%	49	6%	27	13%	16	6%
Physical disabilities												
None	2693	72%	945	74%	820	73%	638	75%	104	50%	186	70%
1-10%	376	10%	117	9%	99	9%	101	12%	31	15%	28	11%
11-25%	106	3%	38	3%	32	3%	14	2%	14	7%	<10	3%
> 25%	201	5%	89	7%	58	5%	26	3%	13	6%	15	6%
Don't know	342	9%	87	7%	122	11%	69	8%	36	17%	28	11%

Notes. Sample includes survey respondents who reported using the temporary license to provide mental health services to at least 1 New Jersey patient. Counts less than 10 were denoted as "<10" to enhance respondent anonymity. Mental health prescribers were defined as physicians, nurse practitioners, and physician assistants who indicated a psychiatry specialty. Other mental health providers were defined as alcohol and drug counselors, marriage and family therapists, and nurses specializing in psychiatry.

health providers from underrepresented racial and ethnic groups to provide care in New Jersey in at least 13 different languages. New Jersey has a dense and diverse population, with approximately 21.5% of its population identifying as Hispanic/Latino, 15.3% Black or African American, 10.3% Asian, 0.7% American Indian or Alaska Native, and 0.1% Native Hawaiian or other Pacific Islander.²³ The influx of non-white providers may have increased the supply of mental health providers who were linguistically, racially, or ethnically congruent to New Jersey patients. Our findings also show that 331 of those mental health providers served at least 1 patient who was uninsured or covered by Medicaid, and 2559 were treating patients diagnosed with serious mental illness or substance use disorders. Given the known disparities in access to mental health services

THE EXPANSION OF INTERSTATE RECIPROCITY LICENSURE REPRESENTS A SIGNIFICANT PUBLIC HEALTH EMERGENCY RESPONSE INITIATIVE WITH POTENTIALLY FAR-REACHING IMPACT FOR MENTAL HEALTH CARE ACCESSIBILITY.

for patients who are uninsured or have Medicaid coverage, as well as the shortage in mental health providers who work with patients with serious mental illness,³⁵ increasing the number of providers who work with these patient populations is key for improving access to mental health care for all Americans, not just the wealthy, healthy, and insured.

Due to the lack of diversity among healthcare providers in the US in general, relative to non-Hispanic whites, patients from racial and ethnic minorities have lower rates of racial/ethnic concordance with their healthcare providers.^{36–38} People often appear to prefer receiving treatment from a healthcare provider matching their own racial or ethnic background, especially groups in the early stages of acculturation and language acquisition.^{39–42} However, finding providers that match patient preferences can be a barrier to receiving health care.⁴¹ In race-, ethnicity-, or language-discordant patient-provider consultations, there are lower levels of patient satisfaction and higher rates of miscommunication.^{38,43} In mental health intake visits, concordant patient-provider dyads engage in more

patient-centered communication and have better continuance rates.⁴⁴ While there have been many attempts to provide cultural competency training to providers to overcome discordance between providers and patients, evidence is limited in the effectiveness of the trainings.⁴⁵ Our study suggests that introducing flexibility into professional licensure through emergency reciprocity licensure expanded the availability of providers from health disparity backgrounds in New Jersey, a state with large numbers of residents from health disparity backgrounds—potentially improving health equity.

While telehealth has great potential to expand the reach and availability of mental health providers, the limitations of telehealth, especially as they pertain to health equity, are also important to note. Our study revealed that out-of-state mental health providers mainly used telehealth, particularly video-based modalities. Even prior to the pandemic, mental health providers who used telehealth were increasingly relying on video-based modalities.⁴⁶ Historically, however, health disparity populations have limited digital access and digital literacy,^{47–49} and during the pandemic, socially vulnerable communities were more likely to use audio-only telehealth.⁵⁰ Mental health providers, including those working across state lines, should be aware of how telehealth modalities may mitigate or perpetuate disparities in relation to “digital divides,” and policymakers should consider how telehealth-related regulatory approaches and reimbursement changes^{51,52} may effect health equity.

Additionally, 60% of the mental health providers in our study indicated that they utilized the temporary licensure program to see existing patients who are now located in New Jersey (eg, the patient moved to New Jersey during the pandemic and sought care via telehealth), thus allowing patients to maintain continuity of care. It should be noted that federal and New Jersey telehealth waivers^{6,12} permitted out-of-state providers to treat existing patients via telehealth without a temporary license; however, our findings suggest that some of our survey respondents may have obtained a New Jersey temporary license as a precaution to ensure they could maintain care continuity, even though they did not need one.

Continuity of care in mental health is a critical aspect of successful care delivery and health improvement.^{53,54} There are a number of reasons why patients may temporarily relocate, for example, college students going home due to COVID-19

closures or summer break,⁵⁵ seasonal workers performing time-limited work,⁵⁶ and older adults migrating to warmer climates for the winter.⁵⁷ Patients feel more supported and have better health outcomes when they can meet with their mental health providers consistently and in a timely manner.⁵⁸ COVID-19 federal and state telehealth waivers^{6,12} relaxed originating site requirements which led to increased adoption of telehealth during the pandemic and helped to facilitate continuity of care.⁵⁹ Our findings suggest that by offering mental health providers a pathway to temporary reciprocity licensure in tandem with telehealth waivers, providers were able to follow patients across state lines via telehealth, thus ensuring continuity of care and best practices in mental health treatment.

Several pre-pandemic licensure mechanisms designed to facilitate flexibility and portability may be informed by lessons from the COVID-19 temporary licensure programs.⁶⁰ One mechanism that has been widely-discussed by researchers during the pandemic is the interstate licensure compact.^{61–63} Interstate licensure compacts predate the pandemic and are different from reciprocity-based licensure. Interstate licensure compacts are typically designed to allow healthcare providers to have primary or home state licensure plus either a multistate license or an option for expedited additional licenses in order to practice in their home state as well as other participating compact states. For example, as of February 2023, the Psychology Interjurisdictional Compact (PSYPACT), which serves as an interstate compact for psychologists, has been enacted in 35 US states and territories (including Washington, DC) and fully implemented in 33 (including New Jersey), which serves as an interstate compact for psychologists.⁶⁴ Twenty-three of those states/territories enacted the PSYPACT during the pandemic (ie, after March 2020). Other non-psychologist mental health providers are working on similar programs, including professional counselors who are in process of establishing the Counseling Compact, with 15 states already enacting it into law.⁶⁵ The National Association for Social Workers has initiated the development of the Social Work Licensure Compact.⁶⁶ From an access-to-care perspective, the utility of such interstate compacts will likely depend on how they—and related reimbursement policies—impact, facilitate, or hinder telehealth-based practice.

It is worth noting the potential pitfalls of licensure reciprocity. Ultimately, licensure reciprocity is a

“zero-sum game” for workforce supply—providers shift into areas of need or demand, while the total volume of providers does not change. Evaluation and optimization of interstate licensure does not satisfy pressing needs or approaches to increase the overall number of providers. In addition, there is limited research on the effects of licensure reciproc-

OUR FINDINGS SUGGEST THAT BY OFFERING MENTAL HEALTH PROVIDERS A PATHWAY TO TEMPORARY RECIPROCITY LICENSURE IN TANDEM WITH TELEHEALTH WAIVERS, PROVIDERS WERE ABLE TO FOLLOW PATIENTS ACROSS STATE LINES VIA TELEHEALTH, THUS ENSURING CONTINUITY OF CARE AND BEST PRACTICES IN MENTAL HEALTH TREATMENT.

ity or the relative value and drawbacks of compact-based licensure structures. State-specific licensing allows significant variability across regulations, and further research is encouraged to establish the extent to which variation or standardization impact key metrics. A qualitative study of licensure stakeholders reported that areas meriting further study include: care quality delivered by out-of-state providers; impact on care costs (related to relocation packages); and impact of increased market competition on smaller provider organizations.⁶⁷ At the same time, evaluation of telehealth-based mental health care continues. Additional visibility into modality-specific quality, access, and affordability considerations will likely prove valuable. We encourage further research on licensure reciprocity and interstate licensing compacts to help inform considerations for licensure policy change.

Limitations

This study had limitations. First, the New Jersey program was implemented early in the pandemic when COVID-19 cases were concentrated in a few US regions, including New Jersey. Program results may have differed if the program was implemented during a time in which pandemic-related workforce needs were more widespread across the country. Second, this was a cross-sectional survey that aimed to estimate the impact of the program on healthcare workforce supply, conducted in January 2021. We are unable to offer insights into temporary license usage beyond that point in

the pandemic, and the survey did not include specific questions about interstate licensure compacts. We were also unable to assess whether or how providers holding primary licenses in New Jersey obtained and/or used temporary licenses through programs offered by other states. Third, the survey had a 33% response rate, 45% of whom were mental health providers. The response rate is similar to prior surveys of healthcare providers in New Jersey²⁶ and nationally,²⁷ but care should be taken not to generalize beyond the study sample, as non-respondents' characteristics are unknown. Fourth, the survey may overrepresent certain mental health provider types who received a New Jersey temporary license. For example, psychologists and social workers are 64% of the license-using respondent pool, while mental health prescribers are only 6% (see Appendix B). We stratified our analyses where possible to reduce bias from overrepresented groups and found that trends were generally similar across the provider types. Fifth, respondents self-reported how they used their temporary license and the characteristics of their patients. There isn't a centralized source to confirm the self-reports although claims data could provide additional insight in some areas. Further efforts would be needed to create and maintain a database to capture licensee activities specific to this study population.

Conclusion

New Jersey's Temporary Emergency Reciprocity Licensure program was highly utilized by mental health providers with primary licenses from outside of New Jersey—many of whom are from underrepresented racial and ethnic groups. This increased provider supply resulted in at least 30000 New Jersey individuals, many of whom are also from health disparity populations, receiving mental health care provided by the temporary licensees. The use of New Jersey's temporary licensure program suggests that this program was a timely policy response that helped increase access to mental healthcare and access to a diverse mental health workforce during the pandemic. As our nation continues to battle a burgeoning healthcare workforce crisis,¹⁸ there is an urgent need to increase identification, implementation, and study of innovative licensure policy approaches in order to enhance mental health care continuity, access, and equity.

References

1. Mullangi S, Agrawal M, Schulman K. The COVID-19 pandemic—An opportune time to update medical licensing. *JAMA Intern Med.* 2021;181(3):307-308. doi:10.1001/jamainternmed.2020.8710
2. ASTHO. Understanding Licensing, Credentialing, Certification, and Privileging Fact Sheet. Published online 2012. Accessed March 21, 2023. <https://www.astho.org/advocacy/state-health-policy/legal-preparedness-series/scope-of-practice-toolkit/>
3. Assistant Secretary for Preparedness and Response. About ESAR-VHP US Department of Health and Human Services. Published 2020. Accessed March 9, 2023. <https://www.phe.gov/esarvhp/Pages/about.aspx>
4. Federation of State Medical Boards. US States and Territories Modifying Licensure Requirements for Physicians in Response to COVID-19 (Out-of-state physicians in-person practice; license renewals). Updated February 27, 2023. Accessed March 9, 2023. <https://www.fsmb.org/siteassets/advocacy/pdf/state-emergency-declarations-licensures-requirements-covid-19.pdf>
5. NCSBN. State Response to COVID-19. Published May 2, 2022. Accessed May 4, 2022. https://www.ncsbn.org/public-files/APRNState_COVID-19_Response.pdf
6. New Jersey Division of Consumer Affairs. Telehealth services during the COVID-19 pandemic: frequently asked questions (FAQs). Accessed March 9, 2023. <https://www.njconsumeraffairs.gov/COVID19/Documents/FAQ-Telehealth.pdf>
7. Office of the Attorney General. AG Grewal: NJ temporarily waives rules for out-of-state healthcare providers to offer services to NJ residents during COVID-19 emergency. The State of New Jersey Department of Law & Public Safety. Published March 20, 2020. Accessed March 9, 2023. <https://www.nj.gov/oag/newsreleases20/pr20200320a.html>
8. Governor Philip D. Murphy. Executive Order No. 103: Governor Murphy declares a state of emergency and a public health emergency, effective immediately. March 9, 2020. Accessed March 9, 2023. <https://nj.gov/infobank/eo/056murphy/pdf/EO-103.pdf>
9. State of New Jersey Department of Law and Public Safety Division of Consumer Affairs. Temporary rule waiver. Published March 19, 2020. Accessed March 9, 2023. <https://www.njconsumeraffairs.gov/COVID19/Documents/Accelerated-Temp-Board-Waivers-Combined.pdf>
10. Governor Philip D. Murphy. Executive Order No. 112.; April 1, 2020. Accessed March 9, 2023. <https://www.njconsumeraffairs.gov/COVID19/Documents/EO-112.pdf>
11. New Jersey Division of Consumer Affairs. COVID-19 waivers of licensing rules. Accessed March 9, 2023. <https://www.njconsumeraffairs.gov/COVID19/Pages/C19-Waivers-of-Licensing-Rules.aspx>
12. Centers for Medicare and Medicaid Services. COVID-19 emergency declaration blanket waivers for health care providers. Accessed March 9, 2023. <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>
13. Kamal R, Cox C, Rousseau D, for the Kaiser Family Foundation. Costs and outcomes of mental health and substance use disorders in the US. *JAMA.* 2017;318(5):415-415. doi:10.1001/jama.2017.8558

14. HRSA Health Workforce. Behavioral health workforce projections, 2017-2030. US Health Resources & Services Administration. Accessed March 9, 2023. <https://bh.w.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/bh-workforce-projections-fact-sheet.pdf>
15. Thomas D, MacDowell M, Glasser M. Rural mental health workforce needs assessment - A national survey. *Rural and Remote Health*. 2012;12(4):2176. doi:10.22605/RRH2176
16. Mongelli F, Georgakopoulos P, Pato MT. Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus*. 2020;18(1):16-24. doi:10.1176/appi.focus.20190028
17. Barna M. Mental health workforce taxed during COVID-19 pandemic: Worker shortage hinders access. *Nations Health*. January 2022;51(10):1-14.
18. Office of the Surgeon General. New Surgeon General advisory sounds alarm on health worker burnout and resignation. HHS.gov. May 23, 2022. Accessed March 9, 2023. <https://www.hhs.gov/about/news/2022/05/23/new-surgeon-general-advisory-sounds-alarm-on-health-worker-burnout-and-resignation.html>
19. American Psychological Association. 2021 COVID-19 practitioner survey. October 19, 2021. Accessed March 9, 2023. <https://www.apa.org/pubs/reports/practitioner/covid-19-2021>
20. New Jersey Department of Health. Complete health indicator report - Population demographics. New Jersey state health assessment data. Accessed March 9, 2023. https://www.doh.state.nj.us/doh-shad/indicator/complete_profile/Demographics.html
21. New Jersey Department of Health. Healthy NJ 2020. Accessed March 9, 2023. <https://www.nj.gov/health/chs/hnj2020/>
22. Nguyen AM, Schaler-Haynes M, Chou J, et al. Impact of the New Jersey COVID-19 temporary emergency reciprocity licensure program on healthcare workforce supply. *Health Aff (Millwood)*. August 2022;41(8):1125-1132. doi:https://doi.org/10.1377/hlthaff.2022.00249
23. US Census Bureau. US Census Bureau quick facts: New Jersey. Accessed March 9, 2023. <https://www.census.gov/quickfacts/NJ>
24. Penchansky R, Thomas JW. The concept of access: Definition and relationship to consumer satisfaction. *Med Care*. 1981;19(2):127-140. doi:10.1097/00005650-198102000-00001
25. Dillman DA, Smyth JD, Christian LM. Mail and internet surveys: The tailored design method. 4th ed. John Wiley & Sons; 2014.
26. Abt SRBI Inc. Health Research Division. New Jersey primary care practice survey: Methodology report and data memo; 2015.
27. Barnhart BJ, Reddy SG, Arnold GK. Remind me again: Physician response to web surveys: The effect of email reminders across 11 opinion survey efforts at the American Board of Internal Medicine from 2017 to 2019. *Eval Health Prof*. 2021 Sep;44(3):245-259. Epub 2021 May 19. doi: 10.1177/01632787211019445.
28. R Core Team. R: A language and environment for statistical computing. Published online 2018. Accessed March 9, 2023. [https://www.scirp.org/\(S\(lz5mqp453ed5np55rrgict55\)\)/reference/ReferencesPapers.aspx?ReferenceID=2342186](https://www.scirp.org/(S(lz5mqp453ed5np55rrgict55))/reference/ReferencesPapers.aspx?ReferenceID=2342186)
29. Wasserman C, Ossiander E. Washington State Department of Health Agency standards for reporting data with small numbers. May 2018. Accessed March 9, 2023. <https://doh.wa.gov/sites/default/files/legacy/Documents/1500//SmallNumbers.pdf>
30. Minority health and health disparities: Definitions and parameters. NIMHD. Accessed March 9, 2023. <https://www.nimhd.nih.gov/about/strategic-plan/nih-strategic-plan-definitions-and-parameters.html>
31. Martínez-Alés G, Jiang T, Keyes KM, Gradus JL. The recent rise of suicide mortality in the United States. *Annu Rev Public Health*. 2022;43(1):99-116. doi:10.1146/annurev-publhealth-051920-123206
32. Petterson S, Westfall JM, Miller BF. Projected deaths of despair from COVID-19. Well Being Trust; May 8, 2020. Accessed March 9, 2023. https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair_COVID-19-FINAL-FINAL.pdf
33. Lin L, Stamm K, Christidis P. How diverse is the psychology workforce? *American Psychological Association Datapoint*. February 2018, Vol 49, No. 2. Accessed March 9, 2023. <https://www.apa.org/monitor/2018/02/datapoint>
34. Ku BS, Li J, Lally C, Compton MT, Druss BG. Associations between mental health shortage areas and county-level suicide rates among adults aged 25 and older in the USA, 2010 to 2018. *Gen Hosp Psychiatry*. 2021;70:44-50. doi:10.1016/j.genhosppsych.2021.02.001
35. Olfson M. Building the mental health workforce capacity needed to treat adults with serious mental illnesses. *Health Aff (Millwood)*. 2016;35(6):983-990. doi:10.1377/hlthaff.2015.1619
36. Cooper LA, Powe NR. Disparities in Patient Experiences, Health Care Processes, and Outcomes: The Role of Patient-Provider Racial, Ethnic, and Language Concordance. Commonwealth Fund New York. July 1, 2004. Accessed March 9, 2023. <https://www.commonwealthfund.org/publications/fund-reports/2004/jul/disparities-patient-experiences-health-care-processes-and>
37. Jerant A, Bertakis KD, Fenton JJ, Tancredi DJ, Franks P. Patient-provider sex and race/ethnicity concordance: A national study of healthcare and outcomes. *Med Care*. 2011;49(11):1012-20. doi:10.1097/MLR.0b013e31823688ee
38. Laveist TA, Nuru-Jeter A. Is doctor-patient race concordance associated with greater satisfaction with care? *J Health Soc Behav*. 2002;43(3):296-306.
39. Cabral RR, Smith TB. Racial/ethnic matching of clients and therapists in mental health services: a meta-analytic review of preferences, perceptions, and outcomes. *J Couns Psychol*. 2011;58(4):537-554. doi:10.1037/a0025266
40. Jang Y, Yoon H, Kim MT, Park NS, Chiriboga DA. Preference for patient-provider ethnic concordance in Asian Americans. *Ethn Health*. 2021;26(3):448-459. doi:10.1080/13557858.2018.1514457
41. Snyder CR, Truitt AR. Exploring the Provider Preferences of Multiracial Patients. *J Patient Exp*. 2020;7(4):479-483. doi:10.1177/2374373519851694
42. Takeshita J, Wang S, Loren AW, et al. Association of racial/ethnic and gender concordance between patients and physicians with patient experience ratings. *JAMA Netw Open*. 2020;3(11):e2024583. doi:10.1001/jamanetworkopen.2020.24583

43. Cooper L, Roter D. Patient-provider communication: The effect of race and ethnicity on process and outcomes of healthcare. Smedley BD, Stith AY, Nelson AR, editors. *Unequal treatment confronting racial ethnic disparities in health care*. National Academies. 2003:552-593.
44. Alegría M, Roter DL, Valentine A, et al. Patient-clinician ethnic concordance and communication in mental health intake visits. *Patient Educ Couns*. 2013;93(2):188-196. doi:10.1016/j.pec.2013.07.001
45. Bhui K, Warfa N, Edonya P, McKenzie K, Bhugra D. Cultural competence in mental health care: a review of model evaluations. *BMC Health Serv Res*. 2007;7(1):15-15. doi:10.1186/1472-6963-7-15
46. Wootton AR, McCuistian C, Legnitto Packard DA, Gruber VA, Saberi P Overcoming technological challenges: Lessons learned from a telehealth counseling study. *Telemed E-Health*. 2020;26(10):1278-1283. doi:10.1089/tmj.2019.0191
47. National Center for Education Statistics. Children's internet access at home. US Department of Education, Institute of Education Sciences. May 2021. Accessed March 9, 2023. <https://nces.ed.gov/programs/coe/indicator/cch>
48. Ryan C, Lewis J. Computer and internet use in the United States: 2015. September 11, 2017. Accessed March 9, 2023. <https://www.census.gov/library/publications/2017/acs/acs-37.html>
49. Dorsey ER, Topol EJ. State of telehealth. Campion EW, ed. *N Engl J Med*. 2016;375(2):154-161. doi:10.1056/NEJMr1601705
50. Chang JE, Lai AY, Gupta A, Nguyen AM, Berry CA, Shelley DR. Rapid transition to telehealth and the digital divide: Implications for primary care access and equity in a post-COVID era. *Milbank Q*. 2021;99(2):340-368. doi:10.1111/1468-0009.12509
51. State of New Jersey Department of Human Services. Governor Murphy announces departmental actions to expand access to telehealth and tele-mental health services in response to COVID-19. March 22, 2020. Accessed March 9, 2023. <https://www.state.nj.us/humanservices/news/press/2020/approved/20200323.html>
52. Centers for Medicare & Medicaid Services. Additional background: Sweeping regulatory changes to help US healthcare system address COVID-19 patient surge. CMS.gov Newsroom. March 30, 2020. Accessed March 9, 2023. <https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient>
53. Biringer E, Hartveit M, Sundfjør B, Ruud T, Borg M. Continuity of care as experienced by mental health service users - a qualitative study. *BMC Health Serv Res*. 2017;17(1):763. doi:10.1186/s12913-017-2719-9
54. Ride J, Kasteridis P, Gutacker N, et al. Impact of family practice continuity of care on unplanned hospital use for people with serious mental illness. *Health Serv Res*. 2019;54(6):1316-1325. doi:10.1111/1475-6773.13211
55. Conrad RC, Hahm HC, Koire A, Pinder-Amaker S, Liu CH. College student mental health risks during the COVID-19 pandemic: Implications of campus relocation. *J Psychiatr Res*. 2021;136:117-126. doi:10.1016/j.jpsychires.2021.01.054
56. Mobed K, Gold EB, Schenker MB. Occupational health problems among migrant and seasonal farm workers. *West J Med*. 1992;157(3):367-373.
57. Smith SK, House M. Snowbirds, sunbirds, and stayers: Seasonal migration of elderly adults in Florida. *J Gerontol Ser B*. 2006;61(5):S232-S239. doi:10.1093/geronb/61.5.S232
58. Burns T, Catty J, White S, et al. Continuity of care in mental health: understanding and measuring a complex phenomenon. *Psychol Med*. 2009;39(2):313-323. doi:10.1017/S0033291708003747
59. Ainslie M, Brunette MF, Capozzoli M. Treatment interruptions and telemedicine utilization in serious mental illness: Retrospective longitudinal claims analysis. *JMIR Ment Health*. 2022;9(3):e33092. doi:10.2196/33092
60. Courtney B. Five legal preparedness challenges for responding to future public health emergencies. *J Law Med Ethics*. 2011;39(S1):60-64. doi:10.1111/j.1748-720X.2011.00568.x
61. Mehrotra A, Nimgaonkar A, Richman B. Telemedicine and medical licensure — Potential paths for reform. *N Engl J Med*. 2021;384(8):687-690. doi: 10.1056/NEJMp2031608
62. Lippert A. Ensuring effective and quality care during a pandemic. *J Nurs Regul*. 2020;11(1):58-60. doi: 10.1016/S2155-8256(20)30062-4
63. Adashi EY, Cohen IG, McCormick WL. The Interstate Medical Licensure Compact: Attending to the underserved. *JAMA*. 2021;325(16):1607-1608. doi:10.1001/jama.2021.1085
64. Map - Psychology Interjurisdictional Compact (PSYPACT). Accessed March 9, 2023. <https://psypact.site-ym.com/page/psypactmap>
65. National Center for Interstate Compacts. Counseling Compact. Accessed March 9, 2023. <https://counselingcompact.org/>
66. National Association of Social Workers. Interstate Licensure Compact. NASW - National Association of Social Workers. Accessed March 9, 2023. <https://www.socialworkers.org>
67. Nguyen AM, Farnham JJ, Ferrante JM. How COVID-19 emergency practitioner licensure impacted access to care: Perceptions of local and national stakeholders. *J Med Regul*. 2022;108(4):7-19. doi:10.30770/2572-1852-108.4.7

Appendices

Appendix A. List of survey questions used in the analysis of mental health providers who used the New Jersey Temporary Emergency Licensure Reciprocity Program

Characteristics

1. What is your profession?

- Acupuncturist
- Advanced Practice Nurse
- Alcohol and Drug Counselor
- Athletic Trainer
- Audiologist
- Dentist
- Genetic Counselor
- Hearing Aid Dispenser
- Marriage and Family Therapist
- Nurse (other than Advanced Practice Nurse)
- Occupational Therapist
- Optician (Ophthalmic Dispenser or Ophthalmic Technician)
- Optometrist
- Perfusionist
- Pharmacist
- Physical Therapist
- Physician
- Physician Assistant
- Professional Counselor
- Psychoanalyst
- Psychologist
- Respiratory Therapist
- Social Worker
- Other: _____

2. Have you used your NJ temporary license to provide care to New Jersey residents during the pandemic?

- Yes (skip to Q In which months...)
- No

3. Why didn't you use the NJ temporary license? _____ (open text), then skip to Demographics section

4. In which months have you cared for NJ patients? (check all that apply)

- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

5. What types of COVID-related care have you / are you providing to NJ patients? (check all that apply)

- Testing (PCR, rapid test, and antibody)
- Treating COVID+ patients in inpatient settings (hospitalized)
- Treating COVID+ patients in outpatient settings
- Providing or facilitating connections to social services (eg, food banks)
- Providing mental health or behavioral health services
- Other (specify): _____

6. What types of non-COVID-related care have you / are you providing to NJ patients? (check all that apply)

- Lab tests
- Treating patients in inpatient settings (hospitalized)
- Treating patients in outpatient settings
- Providing or facilitating connections to social services
- Providing mental health or behavioral health services
- Other (specify): _____
- None

New Jersey Patients

7. Approximately how many NJ patients have you served using your NJ temporary license? _____ (integer value)

8. About what share of your NJ patients was... new to you? (optional)

- ____%

9. About what share of your NJ patients... were covered by Medicaid/NJ Family Care/Uninsured?

- None
- 1-10%
- 11-25%
- > 25%
- Don't know

10. About what share of your patient care time for NJ patients was telehealth (phone, video, or e-visit)?

- ____%

11. Of the care delivered to NJ patients via telehealth, about what share was by AUDIO only (ie, not FaceTime or other video interface)?

- ____ %

12. Of the care delivered to NJ patients via telehealth, about what share was by VIDEO (eg, FaceTime, Zoom, patient portal, or comparable platforms)?

- ____ %

13. In what languages have you conversed with NJ patients, other than English? (check all that apply)

- Arabic
- Chinese (including Mandarin and Cantonese)
- Haitian Creole
- Hindi
- Italian
- Korean

- Gujarati
- Polish
- Portuguese
- Russian
- Spanish
- Tagalog (including Filipino)
- Other (specify): _____
- None

14. How are you getting paid for the services you are providing to NJ patients using your NJ temporary license? (Check all that apply)

- Reimbursed by private insurer
- Government program (Medicare, Medicaid)
- Salary or locum tenens
- Volunteer
- Other (specify): _____
- Don't know

15. About what share of your NJ patients... have a chronic or severe mental health diagnosis or substance use disorder?

- None
- 1-10%
- 11-25%
- >25%
- Don't know

16. About what share of your NJ patients... are from underserved racial/ethnic minority populations (eg, Black/African American, Hispanic/Latinx, immigrant, etc.)?

- None
- 1-10%
- 11-25%
- >25%
- Don't know

17. About what share of your NJ patients... have physical disabilities?

- None
- 1-10%
- 11-25%
- >25%
- Don't know

Demographics

18. In which state is your primary out-of-state license issued?

- Dropdown list of states

19. Do you consider yourself Hispanic or Latino?

- Yes
- No
- Prefer Not to Answer

20. Which category or categories best describe your race? (check all that apply)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Prefer Not to Answer
- Other: _____

21. What is your gender?

- Female
- Male
- Undesignated/Non-binary (Note: “Undesignated/Non-binary” encompasses all gender identities that are not exclusively male or female, including, but not limited to: intersex, agender, amalgagender, androgynous, bigender, demigender, genderfluid, genderqueer, neutrois, nonbinary, pangender, third sex, transsexual, Two Spirit, or otherwise unspecified.)
- Prefer Not to Answer

22. What is your age range?

- 18-29 years old
- 30-39 years old
- 40-49 years old
- 50-59 years old
- 60-69 years old
- 70 years or older
- Prefer Not to Answer

Appendix B. Distribution of the participants who responded to a survey of out-of-state healthcare practitioners who were granted a New Jersey temporary license between March 2020 and January 2021

	Received temporary license		Received temporary license and used temporary license to provide mental health services	
	n	%	n	%
Psychologists	1494	32%	1276	34%
Social workers	1485	32%	1131	30%
Professional counselors	1101	23%	848	23%
Mental health prescribers	233	5%	206	6%
Other mental health providers	376	8%	265	7%
TOTAL	4689	100%	3726	100%

Notes. Sample includes survey respondents who reported using the temporary license to provide mental health services to at least 1 New Jersey patient. Mental health prescribers were defined as physicians, nurse practitioners, and physician assistants who indicated a psychiatry specialty. Other mental health providers were defined as alcohol and drug counselors, marriage and family therapists, and nurses specializing in psychiatry.

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