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The Behavioral Health Ecosystem in New Jersey: An Interview with Frank Ghinassi and Melissa Fox

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Abstract

Behavioral health and physical health have not only been siloed and separated from each other, but behavioral healthcare has also carried the extra burden of stigma, which negatively affects both consumers in need of that healthcare and the delivery of that care and its interwoven ecosystem—providers, insurance carriers, related nonprofits and for-profits, government entities, community organizations, and individuals. But lately, spurred by the pandemic and increased awareness around the importance and impact of behavioral health on overall health and quality of life, we are seeing this ecosystem's priorities shifting in a positive way through the great efforts of social sector changemakers and innovators, like Frank Ghinassi and Melissa Fox, that is leading to greater attention, concern and priority on finding solutions that allow for better behavioral healthcare. That leads to overall better health and community for all. The following is a compilation of two separate conversations with Frank Ghinassi and Melissa Fox[i].

Louise Flaig: When it comes to the behavioral health ecosystem in New Jersey—ecosystems being defined as governing entities, nonprofits, related for-profits, community-based services and organizations and providers and community members, etc.—let's talk about what's working, what's not working, what enables change, and what's hindering change?

Melissa Fox: I think in New Jersey, there is such a wealth of passionate, committed, talented individuals who were really looking to identify ways to make sure that the system is better for the people we serve, and that is something that's wonderful to operate within. I think that there is an openness for partnerships, an openness to answering the question, 'How do we do things better?' There's a lot of passion, commitment, and discussion around what that could be, and there, in general, is open as to how we can do things differently.

At the state level, there are extremely committed, compassionate folks who have been in this space for a long time and have seen the changes that have come and want to work together.

In terms of what's not working, one, of course, is staffing. We've all identified that there is a need. It's a matter of how, then, do we build the pipelines and the connections to allow people to provide these supports that are required in a timely manner? How do we not only make sure that we are bringing in more staff but then also make sure that that staff is reflective of the communities that are being served and who have historically been underserved? That is a big deal right now, and I think that is a case that we have got to figure out as we look at these statistics that clearly point out that severe shortage as it relates to behavioral health services.

Frank Ghinassi: So what's working is, we are increasingly, for the first time in my career, living in an era where the value of behavioral health and addiction services is up. It's up from the government, it's up with employers, it's up in the general public. It's terrible that something like a pandemic has to come along to remind people of where behavioral health and mental health fit into their lives, but people are aware of the need and value access to the service. I think the other thing that's probably up is that, generally speaking, in New Jersey, there does seem to be an awareness at the state level of the extent to of the state impacts things like Medicaid and Medicare services through their role as a state planning entity, and I think they see the value in this. I think they're now growing programs to try to help populations to include not only kids but also seniors, working adults, and individuals who are living with barriers related to social determinants of health: people living with homelessness, living with food insecurity, people living in neighborhoods where violence is prevalent, all of those populations being seen as being both at risk and in need of specialized services. This current environment in the state has been supportive of that. And then finally, through much, much advocacy over the last 10 years, the parity in commercial insurance between what and how your healthcare is paid for as it relates to things that are “physical” in nature versus things that are “behavioral” in nature is better than it was. However, it’s still not so good if you happen to work for a small employer because many of the laws that were written give exemptions.

For things that are not working, it's 2023, and the predominance of behavioral health professionals tends to cluster in urban areas, so I do think there is a disparity between the availability of mental health professionals in urban areas as opposed to rural areas. God help you if you live in a frontier area where you know that kind of access is even harder. I think another problem is, while parity is better than it was, there is still a pretty wide discrepancy between how highly trained professionals with advanced degrees, whether they're MSW degrees, PhDs, or MDs, how they're reimbursed, and the levels at which they're reimbursed. Behavioral health tends to be time-based reimbursement, but most medicine bills on the basis of procedures, and as a result, there's a very big discrepancy between what your paycheck is at the end of the year. But you're also going to find out that most people in private practice are going to tell you I'm not on any insurance panel. So here's my hourly fee; I want you to pay me upfront. If it's Medicaid or Medicare, the problem is even more pronounced. We're going to have to do something about that as a society, either value all healthcare, or we're going have to reckon with the fact that society values physical healthcare and they only kind of value behavioral healthcare, only in a limited way.

Another thing that's wrong, systemically, is that we are seeing a shortage of mental health professionals, and it's becoming increasingly a challenge to convince young people, especially if they're going to go on for doctoral-level studies, that it's in their best interest and their family's best interests to go into behavioral health. The need has gone up, the willingness to seek care has gone up, and I think the supply, the supply is not keeping match with it.

Louise: What do you feel is hindering innovation and change within the system?

Melissa: The funding. How do you find the dollars to be able to allow us to do some of the changes that we want? You know, even with that, there are some opportunities to innovate, and I think that's where people are finding their way. As we continue to talk about these extended supports roles as peer specialists and community health workers. How do we ensure that there is a sustainable stream of support that would allow them to work with and for and within this system?

Louise: Given how behavioral health systems are set up to be pretty regimented, with services so directly tied to reimbursement everywhere, how do you create innovation within that?

Melissa: I think technology is giving us many different pathways to develop innovations to support behavioral health, and that is not typically something that requires a significant amount of investment. It's about using our data differently. It's about partnering differently with individuals and organizations in the communities who can help to bring that knowledge and expertise to bear. Imagine within communities where we have seen disparities for many years being able to get ahead of the train and understand the trends better by diving more deeply into the data and figuring out what they need. The other pathway is innovative partnerships. Reimbursement tends to be very tight, but partnering differently and stepping outside of what we've typically done, and as we're talking about this ecosystem that's available, making sure that we understand that the existing ecosystem is sometimes not inclusive of some of the other voices and participants who really need to be involved. Opening those partnerships up to include local faith-based organizations or local community advocates, or social justice organizations. Now you're truly creating a different, innovative model that is more reflective of the needs of the communities. There's plenty of opportunity to do innovation, even within our very limited reimbursement models. It just takes thinking a little bit differently.

Louise: Let’s talk about the Public Health Institute. Acenda received a grant to launch a Public Health Institute, which never existed in New Jersey. Tell me more about this; why is there a need for it?

Melissa: I'm loving that New Jersey now has its own Public Health Institute. This allows an independent entity to convene stakeholders differently than maybe we have in the past as it relates to the public health needs within our state. It's also important to note that this is the first PHI in the country that is founded on a principle of health equity. We will look at the priorities of our state and the public health priorities of our state through the lens of equity and then challenge ourselves on where the opportunities are to strengthen the system to be able to accomplish what it is that we need to accomplish. As we're trying to reduce health disparities, what do we need to do within the public health space to do that? It's wonderful because we will be inclusive of the local public health, state, public health leadership, New Jersey Department of Health, social advocates, social justice organizations, and all these folks to talk about public health in a way that we haven't been able to before because it's kind of siloed.

There's been a lot of work for 30 years to get us to this point. Robert Wood Johnson Foundation was able to be a leader in bringing this funding and making it available to have this happen. Philanthropy kind of allows for that flexibility in making some things happen.

Louise: What policy or regulation changes could make a difference in the ecosystem in terms of impacting and improving the effectiveness of how it all works?

Frank: I think number one: we can continue to work on treating disorders of affect and addictions the same way we treat other disorders. We're stuck with the language right, whereas this is physical health, as if one is sort of a "real" disorder and the other one is sort of "in your head" disorder, when in fact you know there's prodigious research that would indicate that, whether it's bipolar disorder or addiction or schizophrenia or depression or whatever, those proclivities and those vulnerabilities are as much baked into your genes as are your proclivity toward obesity and diabetes and heart disease. But I think that's an opportunity in policy. The other thing is we need to get more creative policy-wise in encouraging young people to seek out education in psychiatry or psychology or social work, and maybe that's systematic work around tuition remission. We should be doing a better job of doing that with behavioral health as well. And then we do not pay people equally for all that, and we need to.

Louise: So then, related to the piece about education, what's the role of Rutgers' health professions schools with regard to efforts around education and training to address the workforce crisis and the shortage? What you're doing currently within the ecosystem, and what within the behavioral health ecosystem do you think needs to be done more of, or better in, this area of education and training?

Frank: Great question. Number one: I think Rutgers operates in one of the most diverse states in the country. Rutgers has done a good job of trying to recruit and retain individuals into the healthcare professions who reflect that diversity. And why is that important? Well, there's a lot of research that if healthcare providers, in some way, not universally but in some way reflect the communities they serve, the likelihood of engaging and retaining patients can be enhanced.

Number two: they do a wonderful job of allowing these young healthcare professionals, whether it's a nurse or a pharmacist or a dentist or a physician or psychologist or social worker, to practice and do their practicum or their internship, their fellowships, in very diverse and very interesting healthcare delivery sites. They do that, I think, as well as anybody in the country. I spent 10 years in the Boston Harvard system, so I saw it there, and then I spent 19 years at the University of Pittsburgh Medical Center doing this, and so I've seen it there, and I've now spent seven years here, and I can tell you that Rutgers does as good, if not a better job as any of those systems in really helping individuals practice in communities of great need, in making sure that they are training in those communities.

Number three: Rutgers' biomedical and health sciences division, which does all the training in all of the areas, is committed to inter-professional training, they blend different disciplines and train them together, and they teach them about their respective contributions to the overall health of the individual. I think Rutgers is doing a good job at training individuals to work as a member of

a team and not only appreciate their contribution but to understand and value the contribution of the other team members in behavioral health, for example, extensively in integrated behavioral and physical healthcare. And Rutgers has embraced incorporating a behavioral health specialist into that team. They're literally in the mix, seeing somebody for that 12-minute primary care visit. They identify either a behavioral health diagnosis possibly, or they identify some issue that is preventing them from managing a physical health disorder, diabetes, or asthma. Very often, that intervention happens right there in the exam room before the patient even leaves the appointment, and I think that's going to be one of the futures of medicine, is that you're going to get your behavioral health treatment not only in buildings that say behavioral health but also buildings that say primary care, pediatric care, obstetrics, cardiology. Why isn't everybody doing this? A lot of people were trained if they uncovered something behavioral, it was almost like, well, that's not my problem. I want you to go see my buddy Doctor Smith in a different building next Tuesday at two o'clock. If the parents are busy, parents and the kids are busy, and they all have a little stigma about it, what's the likelihood of them going there next Tuesday? It turns out it's very low, whereas if it happens right in practice, almost in real time, the likelihood that they're going to be open to it is much higher.

The part where we have the opportunity to improve: We educate, train, and graduate thousands of young people in healthcare across all those professions. I do not think we are where we need to be in convincing them to stay. Many of them are trained and leave. There are many factors to that. You know, a lot of them finish with a lot of debt, and New Jersey is not a cheap place to live. We need to help young people who want to stay here be able to stay here until they get established.

Louise: Is there anything else in the behavioral health ecosystem that we haven't touched on that you want to talk about before we wrap it up?

Frank: I think we've largely touched on a lot of the components: baking behavioral health into traditional kinds of care, cleaning up the payment system, cleaning up the ability to get people back and forth to those appointments, improving the diversity in the talent pool, convincing young people that once they train, New Jersey is someplace that they want to stay. These are all partial solutions to a very complicated and, again, we're going to have to continue to work on stigma because maybe one thing that's unique to the New Jersey culture versus maybe a more homogeneous state.

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[i] Frank Ghinassi is the President and CEO for Rutgers Health University Behavioral Health Care. Melissa Fox is the Chief Operating Officer, Acenda Integrated Health.