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Using evidence to improve population health

Building State Capacity to Address Behavioral Health Needs Through Crisis Services and Early Intervention

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Policy Points

- States such as Arizona, Georgia, and Tennessee have developed behavioral health crisis models of care that provide early intervention and divert individuals in crisis from hospitals, jails, and prisons.
- The behavioral crisis model assembles a network of services comprising: a 24-hour crisis call center hub; community-based mobile crisis teams; and facilities designed to stabilize patients.

ABSTRACT

Many states are focused on building a coordinated continuum of behavioral health care that includes a wide array of community-based services as well as inpatient services through public and private hospitals. To help ensure patients experiencing a behavioral health crisis are able to get the right care at the right time in the right place, states such as Arizona, Georgia, and Tennessee have developed behavioral health crisis models of care that provide early intervention and divert individuals in crisis from hospitals, jails, and prisons. This model assembles a network of services comprising three components: a 24-hour regional or statewide crisis call center hub; community-based mobile crisis teams that evaluate and stabilize the individual; and facilities designed to stabilize patients for eventual recovery. Mental health crisis programs have shown good results both clinically and fiscally. States are playing a growing role in implementing comprehensive programs that are funded through Medicaid, state-only revenue dollars, county and local monies, and donations and investments by insurers and private health care organizations within the community. COVID-19 has severely constrained state and local budgets for the foreseeable future, which makes it even more important to make the case to improve crisis services.

INTRODUCTION

Over the past 40 years, state mental health systems and the US Department of Veterans Affairs (VA) have been shifting resources and workforce from mental health inpatient to community-based services. Most recently, the Supreme Court's 1999

Olmstead decision[1] mandated that states integrate the services provided to individuals with disabilities, including individuals with mental illness, into the community. Today only 2% of the 7.3 million mental health clients served by state mental health agencies are inpatients in a state psychiatric hospital, and only 4% of the 1.5 million veterans with a mental illness served by the VA receive inpatient mental health services in a VA medical center.

Remaining state inpatient psychiatric hospital beds are usually reserved for forensic patients committed by the courts for evaluation or long-term stays. Nonforensic inpatient psychiatric hospital treatment has often moved to private psychiatric hospitals or to psychiatric units or "scatter beds" in general hospitals. Other beds are available in licensed residential treatment units, nonresidential treatment centers that provide intensive 24-hour treatment services but are not licensed as "inpatient" services, VA medical centers, Department of Defense medical centers, and psychiatric inpatient units within jails and prisons.

Although there has been a decrease of more than 500,000 psychiatric beds since the 1950s,[2] the continuum of care is now much broader. Behavioral health crisis programs can provide a timely and safe alternative to costly emergency department visits and hospitalizations, as well as the need for law enforcement or involvement in the criminal justice system.[3] Statewide programs currently use a variety of approaches to establish communications, service coordination, and training to address emergent behavioral health needs. This report summarizes some of the approaches taken to meet these needs by offering focused, coordinated care in an integrated community setting.

Crisis programs may be even more critical now as the country copes with the ongoing COVID-19 pandemic, which has highlighted the importance of community treatment and of avoiding jails and emergency departments. Social isolation, fears of infection, and job loss, for example, have heightened the need for behavioral health services. Further, the trauma caused by the pandemic may produce episodes of personal crisis that will, now more than ever, need to be delivered in a community setting.

BEHAVIORAL HEALTH CRISIS PROGRAMS: AN OVERVIEW

Core Components

The behavioral health crisis model is based on the 2016 Crisis Now recommendations developed by the National Action Alliance for Suicide Prevention and refined by the global consultant RI International. As outlined in an online toolkit, National Guidelines for Behavioral Health Crisis Care, published by the Substance Abuse and Mental Health Services Administration (SAMHSA), the model operates around the central principle of a "no wrong door" or "no refusal" approach to accessing care for mental health and substance use in real time. Crisis Now model programs have three core components:

1. Services are organized around a 24-hour regional or statewide crisis call center hub that receives calls.
2. Community-based mobile crisis teams receive the calls and take the individual to a facility designed to stabilize the individual for eventual recovery.
3. Participating facilities offer trauma-informed and "suicide-safer" care, which is designed to monitor for suicide risk and intervene when necessary with specific evidence-based approaches delivered by mental health professionals and peer specialists.

In some programs, individuals can access crisis services directly or local law enforcement officials conduct a "warm handoff," exchanging relevant patient information—with the patient's involvement—to the crisis services facility. Such handoffs should be no longer than 10 minutes to avoid having to divert law enforcement personnel from their other public safety duties.[4]

Impact on Costs

Several studies find that crisis services can lead to significant cost savings due to reduced inpatient utilization, emergency department diversion, jail diversion, and a more appropriate use of community-based behavioral health services.[5] The Crisis Now business case profiling the crisis system in Maricopa County, Arizona, which includes all three core components, led to a potential reduction in inpatient spending of $260 million, after adding the $100 million investment in crisis continuum.[6]

In an April 2013 study by Wilder Research, the authors used claims data to calculate a return on investment of mental health crisis stabilization programs in the east metropolitan area of the Minnesota Twin Cities of Minneapolis and St. Paul. The authors examined the impact of the program on utilization of health care including emergency department use, outpatient services, and inpatient psychiatric services. They also investigated the cost of inpatient hospitalization (all-cause and behavioral health only) following crisis stabilization compared to costs before intervention. Programs served 315 patients at an average cost of mental health crisis stabilization of $1,085. The study found that the net benefit for mental health crisis stabilization services was a return of $2.16 for every dollar invested.[7]

Funding Sources

Funding for behavioral health crisis programs comes from a variety of sources. In a 2014 SAMHSA publication, all 50 states and the District of Columbia reported they had crisis services components funded by Medicaid.[8] Programs are also funded through the VA, grant and contract monies from SAMHSA, and community health center funding from the Health Resources and Services Administration.[9] State government grants and contracts provide between 60% and 70% of all funding, with private donations constituting between 15% and 30% of funding.[10]

While private insurance benefit packages cover some crisis intervention elements, crisis services are typically not included in most benefit packages. Grants are sometimes used to cover specialized programs such as crisis intervention teams or specialized crisis services programs for victims of trauma.

To be effective, crisis care must leverage funding from all available sources. Most important, coordinated funding approaches ensure that services are driven by needs rather than by funding. Collaborative funding also promotes coordination of care among multiple agencies, and duplicative services are easier to identify and eliminate.[11]

CRISIS PROGRAMS IN PRACTICE

Although many states are trying to make sure that all three behavioral health crisis program components are available to residents, others have implemented crisis service models that contain at least some of the elements in the Crisis Now model. In addition, services may be managed regionally or locally, so services may be available in one part of a state but not another. Often, as is happening now in Arizona and as occurred in Georgia, the success of the model in one community leads to its expansion throughout the state.

Congressional Recognition of the Need for Easier Access to Crisis Assistance

In August 2018, the US Congress passed the National Suicide Hotline Improvement Act of 2018, requiring the Federal Communications Commission (FCC) to study the feasibility of designating a simple, easy-to-remember three-digit dialing code for a newly re-designated National Suicide Prevention and Mental Health Crisis Hotline System. The number is currently 1-800-273-8255 (TALK). The final August 2019 FCC report to Congress proposed that 988 be the designated number, and proposed FCC regulations published in January 2020 made that recommendation formally.[1] In October 2020, the President signed the National Suicide Hotline Designation Act, making the 988 line the universal telephone number to reach national crisis services. Implementation of the three-digit call number will make crisis services provided by a lifeline more instantly accessible and thereby more effective in responding to personal mental health crises, suicidal ideation, and drug overdoses.

Arizona

Arizona's behavioral health crisis system is operated by the state Medicaid agency and the Arizona Health Care Cost Containment System and is administered by three regional behavioral health authorities (RBHAs) that contract with community behavioral health providers. Crisis services include 24-hour crisis telephone services, mobile crisis response teams, and facility-based crisis stabilization, among other associated services delivered in these settings within the first 24 hours of a crisis episode for Medicaid-eligible individuals and within 72 hours for non-Medicaid-eligible individuals. For Medicaid-eligible individuals, continuing services after the initial crisis episode are furnished through a member's enrolled health plan.

In a network analysis conducted in FY 2020, Arizona's crisis system included the following:

- Three regional 24-hour crisis telephone hotlines
- 80-plus contracted mobile crisis teams
- 21 crisis centers, including subacute facilities, 24-hour crisis stabilization/observation and detox facilities, 24-hour outpatient clinics, and crisis respite

The goal of crisis care in Arizona is to provide recovery-oriented solutions to stabilize the individual within the community and avoid unnecessary hospitalization, incarceration, and/or placement in a more restrictive setting. Crisis system providers must accept all referrals, adhere to a "no wrong door" approach, ensure prioritization and implementation of streamlined practices for law enforcement and public safety personnel, and use certified peer and family support specialists with lived experience throughout the continuum of crisis care.

In FY 2019, Arizona live-answered more than 440,000 calls to its crisis lines within 18 seconds and dispatched mobile crisis response teams more than 48,000 times. In Maricopa County, Arizona's most populated county, approximately 62,000 individuals were admitted to crisis stabilization and detox facilities annually, with local law enforcement engaging 23,000 individuals experiencing a behavioral health crisis and delivering them directly to mobile crisis teams or crisis facilities without admission to hospital facilities.

In Pima County, Arizona Complete Health RBHA has partnered to co-locate crisis call specialists at the 911 communications center. Crisis staff are available to divert inbound calls from 911 dispatchers for individuals experiencing a behavioral health crisis. Additionally, crisis staff initiate outbound calls to individuals who have been identified by law enforcement as needing follow-up. This partnership allows crisis staff to initiate and prioritize crisis mobile team response, mitigating law enforcement involvement and reducing calls to 911, while connecting the community with behavioral health care.

In FY 2019, Arizona spent approximately $163 million on crisis services, including crisis hotlines, mobile crisis response, and crisis stabilization services throughout the state. Medicaid funded $134 million, and $28 million was funded through state revenues as well as county funds and grants in order to serve individuals who were not Medicaid eligible.[12]

Georgia

Since 2011, the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)—driven in part by a 2010 settlement agreement with the US Department of Justice to provide enhanced community services and mobile crisis teams[13]—has invested $256 million in new funding to expand its crisis system. The state

implemented mobile crisis and intensive therapy services such as assertive community treatment, intensive case management, and community support teams in 2011, adding to an existing statewide Crisis and Access Line created in 2006. There are now 509 adult crisis stabilization urgent care center outpatient beds at 94% occupancy and 71 crisis stabilization urgent outpatient beds at 85% occupancy in 26 crisis stabilization units. In FY 2019, DBHDD was fielding 15,000 mobile crisis dispatches resulting from 250,000 crisis phone calls annually.[14]

The state's spend on behavioral health crisis services in FY 2019 was $58.2 million, of which $12.8 million came from the Medicaid program budget and $45.4 million from state general revenues.[15]

An analysis of over a decade of Level of Care Utilization System data in Georgia from individuals who were engaged by a face-to-face crisis response service offers insight into what types of service best align with the needs of a community. The statewide crisis line data set used in the analysis included a total of 1.2 million records. Individuals treated fell into the following categories:

- 14% (59,269 of 431,690) were directly referred to acute care hospitals.
- 54% (234,170 of 431,690) were referred to crisis receiving and stabilization facilities.
- 32% (138,251 of 431,690) underwent valuation by the mobile crisis team with referral to care as needed.[16]

A survey of higher-performing mobile crisis teams has found that approximately 70% of those engagements resulted in community stabilization. The remaining 30% were connected to facility-based care that aligned with their assessed needs.[17]

According to DBHDD, a successful crisis system partners with law enforcement, hospital associations and emergency departments, and community providers, as well as peers. The department believes incorporating the state's network of peers with lived experience within its crisis services model was critical to the model's success, a move that required cultural change as much as systemic change.[18]

Georgia was the first state to pay for certified peer services through its Medicaid program, and 43 states have followed suit.[19] A 2007 Centers for Medicare and Medicaid Services State Medicaid director letter authorized reimbursement for peer support services under Medicaid as a component of a comprehensive mental health and substance use service delivery system, allowing the program to reimburse providers for these services either as part of a bundled service package or as a stand-alone service.[20]

Georgia Focuses on Training in Peer Services

Georgia peer initiatives have focused on:

- The infusion of the voices of lived experience across several populations, including youth, parents, addiction recovery peers, and forensic peers, for maximum system impact
- Teaching participants how to take an active role in their own services; the principles of recovery; the characteristics of peer-run, peer-directed support; and how to get the most from behavioral health services
- Helping providers incorporate recovery principles into practice and teaching all stakeholders—particularly youth—recovery messaging in order to better address stigma, advocate for individuals living with behavioral health challenges, and educate family, friends, and community
- Providing nontraditional peer and family support in the community

Tennessee

The Tennessee Department of Mental Health and Substance Abuse Services established its crisis response teams in 1991. The next year it added short-term (48-hour) respite services that offer residents a community-based temporary reprieve from environmental stressors contributing to a mental health emergency. These services include medication management, illness management and recovery services, peer support, and referral to other, longer-term services and follow-up.[21] Crisis stabilization units and walk-in centers were added in 2008.[22]

The crisis services program has 13 mobile crisis teams throughout the state and seven crisis stabilization units in the walk-in centers. Respite services have been established at five locations.[23] The state's free, statewide, 24-hour call center routes anyone experiencing a mental health crisis to a trained crisis specialist in the caller's geographic area. The call center in 2019 fielded more than 103,000 calls from adults and 22,000-plus calls from youth, for whom the state maintains a separate crisis services network.[24]

Total investment in the services in the most recent year was $45.3 million. The statewide crisis hotline is funded through $50,000 in state general revenue monies, while the mobile crisis teams are funded by blending $5 million from the state with $20.75 million from Medicaid. The respite services are funded with about $500,000 in state money and $163,241 in Medicaid. The crisis stabilization and walk-in units are funded with $15 million in state general revenue and $3.7 million from the Medicaid program.[25]

CONGRESSIONAL ALLOCATION FOR CRISIS SERVICES DURING THE COVID-19 PANDEMIC

Congress allocated $425 million for SAMHSA as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act.[26] Of that amount, $100 million was appropriated for grants, contracts, and cooperative agreements with public entities to respond to mental health or substance use emergencies. In April, SAMHSA awarded 60 grants of not more than $2 million to states and not more than $500,000 to territories and tribes/tribal organizations to provide services and support for children and adults impacted by the COVID-19 pandemic over the following 16 months.[27]

It is clear that during and after the ongoing COVID-19 pandemic, community-based behavioral health services will become ever more essential. The trauma associated with social distancing and fear of infection, combined with the perceived threat of infection in a hospital environment, will likely accelerate the movement to address behavioral health crises through early intervention in a non-institutional environment. The movement toward crisis services may be further driven by a surfeit of available hospital beds diverted to treating the coronavirus. State budgets limited by a drop in tax revenues attributable to business slowdowns and failures caused by lockdown measures strengthens the case for using cost-effective approaches to treating individuals in crisis.

First-Episode Psychosis and the Coordinated Specialty Care Model

Approximately 100,000 US adolescents and young adults experience a first episode of psychosis each year, with psychotic symptoms—delusions and hallucinations—that often derail completing school or entering the workforce.[28] The youth experiencing these psychosis symptoms will often delay treatment between one and three years,[29] increasing their risk for suicide, involuntary emergency care, and increasingly poor clinical prospects.[30]

Evidence-based early intervention services such as coordinated specialty care (CSC) support clinical and functional recovery by reducing the severity of first-episode psychotic symptoms, keeping individuals in school or at work, and putting them on a path to better health.

In FY 2014, Congress began appropriating money to fund a 5% set-aside for early intervention services in the annual federal Mental Health Block Grant provided to states. The set-aside and the appropriation were increased to 10% beginning in FY 2016. Today there are more than 260 CSC programs in 49 states.[31] Nevertheless, private insurers and the majority of Medicaid programs fail to cover the array of services included under the CSC model.

CONCLUSION

Behavioral health crisis models of care can help provide early treatment and divert individuals in crisis from hospitals, jails, and prisons. This model ideally includes a 24-hour regional or statewide crisis call center hub; community-based mobile crisis teams that evaluate and stabilize the individual; and facilities designed to stabilize patients for eventual recovery. Today there are a variety of types of programs, with different sources of funding. To achieve a consistent and comprehensive approach to behavioral health crisis, advocates must work to create a sustainable funding stream that supports the model. Especially in the wake of COVID-19, it will be important for states to invest in behavioral health crisis models to better meet residents' needs and potentially save money by reducing the need for emergency department visits, unnecessary hospitalizations, and the involvement of the criminal justice system.

NOTES

[1] *Olmstead* v. L.C., 527 U.S. 581 (1999).

[2] Lutterman T, Shaw R, Fisher W, Mandersheid R. *Trend in Psychiatric Inpatient Capacity, United States and Each State,* 1970 to 2014. Alexandria, VA: National Association of State Mental Health Program Directors and the NASMHPD Research Institute; August 2017. https://www.nasmhpd.org/sites/default/files/TAC.Paper_.10.Psychiatric%20Inpatient%20Capacity_Final.pdf. Accessed February 21, 2020.

[3] NASMPHD's Technical Assistance Coalition. *A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Booking Associated with Mental Illness.* Alexandria, VA: National Association of State Mental Health Program Directors; 2018.

[4] Substance Abuse and Mental Health Services Administration. *National Guidelines for Behavioral Health Crisis Care,* pp. 57-58. Rockville, MD: SAMHSA; 2020. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf. Accessed October 14, 2020.

[5] Truven Health Analytics, for the Substance Abuse and Mental Health Services Administration. *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.* Rockville, MD: SAMHSA; 2014. https://www.nasmhpd.org/sites/default/files/SAMSHA%20Publication%20on%20Effectiveness%20%26%20Cost-Effectiveness%20of%2C%20and%20Funding%20Strategies%20for%2C%20Crisis%20Services%206-5-14_8.pdf. Accessed June 8, 2020.

[6] NASMPHD's Technical Assistance Coalition. *A Comprehensive Crisis System.*

[7] Leite Bennett A, Diaz J. *Crisis Stabilization Claims Analysis: Technical Report Assessing the Impact of Crisis Stabilization on Utilization of Healthcare Services.* St. Paul, MN: Wilder Foundation; 2013. https://www.wilder.org/sites/default/files/imports/Crisis_stabilization_technical_report_4-13.pdf. Accessed June 8, 2020.

[8] Truven Health Analytics, for the Substance Abuse and Mental Health Services Administration. *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.*

[9] Ibid.

[10] National Council for Behavioral Health. *Crisis Services Survey Report.* Washington, DC: National Council for Behavioral Health; 2019. https://www.thenationalcouncil.org/wp-content/uploads/2019/04/Crisis-Services-Survey-Report-2019.pdf?daf=375ateTbd56. Accessed October 14, 2020.

[11] Clare SC. Blending and Braiding Funds to Support a System of Care. Presented at: The Second Annual Commonwealth of Virginia CSA Conference, April 2013, Roanoke, VA.

[12] Ibid.

[13] *United States v. State of Georgia,* US District Court for Northern District of Georgia, Atlanta Division, 1:10-CV-249-CAP. https://www.ada.gov/olmstead/documents/georgia_settle.pdf. Accessed June 4, 2020.

[14] Johnson MS. Presentation to the Reforming States Group: Peer Services and Community Crisis in Georgia, New Orleans, LA, November 13, 2019.

[15] Ibid.

[16] Substance Abuse and Mental Health Services Administration. *National Guidelines for Behavioral Health Crisis Care,* pp. 12-13.

[17] Ibid.

[18] Ibid.

[19] Gordon SY, Zubritsky CD, Cantiello HA, Keogh BE. Older Adults Peer Support: Finding a Source for Funding. Alexandria, VA: National Association of State Mental Health Program Directors; 2017. https://www.nasmhpd.org/content/ta-coalition-assessment-working-papers-older-adults-peer-support-finding-source-funding. Accessed April 26, 2020.

[20] State Medicaid Director Letter #07-011. August 15, 2007. Baltimore, MD: Center for Medicaid and State Operations. https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507A.pdf. Accessed October 15, 2020.

[21] Crisis Respite Services. Tennessee Department of Mental Health and Substance Use Services website. https://www.tn.gov/behavioral-health/need-help/crisis-services/respite.html#:~:text=Crisis%20Respite%20Services%20provides%20short,Medication%20management. Accessed June 7, 2020.

[22] Williams M. April 14, 2020, Presentation on the State of Tennessee's Crisis Delivery Model: Improving Access to Care using the National Guidelines for Crisis Care – Best Practice Toolkit: State of Tennessee's Crisis Delivery Model. Alexandria, VA: National Association of State Mental Health Program Directors. https://nasmhpd.adobeconnect.com/pq57ozzv2w8v/. Accessed October 28, 2020.

[23] Tennessee Department of Mental Health and Substance Abuse Services. Tennessee Crisis Services Statewide Map. https://www.tn.gov/content/dam/tn/mentalhealth/documents/TN_Crisis_Services_Map_2019.pdf. Accessed April 26, 2020.

[24] Infographic: Tennessee Statewide Crisis Services. Tennessee Department of Mental Health and Substance Abuse Services website. https://www.tn.gov/behavioral-health/need-help/crisis-services/crisis-infographic.html. Accessed April 26, 2020.

[25] April 14, 2020, Presentation on the State of Tennessee's Crisis Delivery Model.

[26] Pub. L. 116–136.

[27] FG-20-006 Individual Grant Awards. Substance Abuse and Mental Health Services Administration website. https://www.samhsa.gov/grants/awards/2020/FG-20-006. Accessed April 26, 2020.

[28] National Institute of Mental Health (NIMH), Centers for Medicare & Medicaid Services' Center for Medicaid and CHIP Services (CMCS), Substance Abuse and Mental Health Services Administration (SAMHSA). *Coverage of Early Intervention Services for First Episode Psychosis.* Joint informational bulletin. October 6, 2015. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf. Accessed April 26, 2020

[29] Ibid.

[30] Marshall M., et al. Association Between Duration of Untreated Psychosis and Outcome in Cohorts of First-Episode Patients: A Systematic Review. *Archives of General Psychiatry.* 2005;62:975-983. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1108403. Accessed *JAMA Psychiatry.* October 28, 2020.

[31] NIH Announces Funding Awards for National Early Psychosis Learning Community. Press release. National Institute of Mental Health website. https://www.nimh.nih.gov/news/science-news/2019/nih-announces-funding-awards-for-national-early-psychosis-learning-community.shtml. Published September 20, 2019. Accessed April 26, 2020.

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