POLICY BRIEF

Supporting Individuals with Complex Needs

Care Delivery that Provides the Right Services and Supports in the Right Settings

Courtney E. Burke
Sally R. Dreslin

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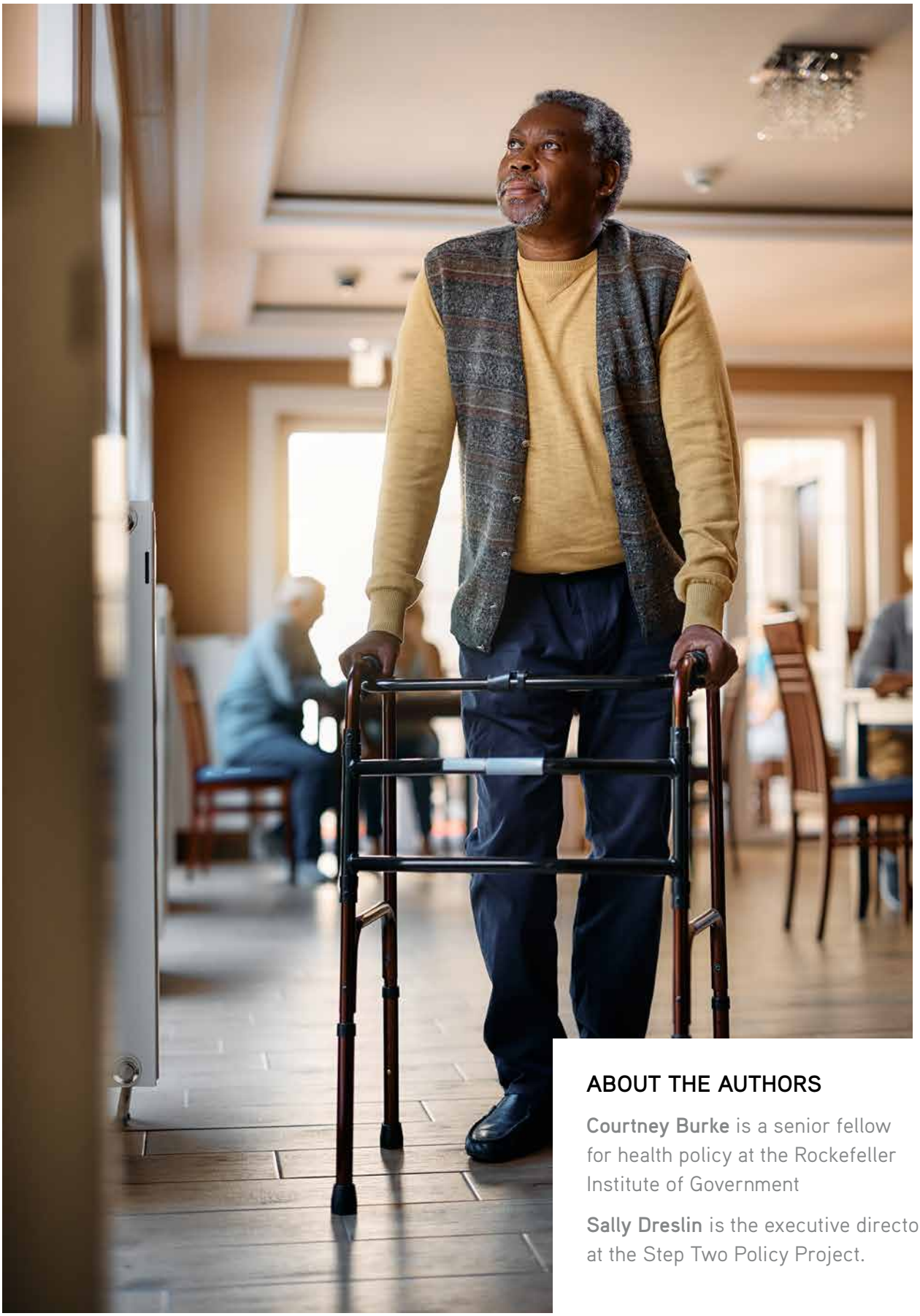
S2P Step Two Policy Project



ABOUT THE AUTHORS

Courtney Burke is a senior fellow for health policy at the Rockefeller Institute of Government

Sally Dreslin is the executive director at the Step Two Policy Project.

Supporting Individuals with Complex Needs

Overview

Individuals with complex medical, behavioral, and social needs often cycle through health, behavioral health, and social service systems and frequently end up in an inappropriate care setting or with insufficient services and supports. When individuals with complex needs have trouble accessing the right supports and inappropriately end up in the wrong setting, they are not being optimally supported. Accepted public policy and best healthcare practices emphasize that such individuals should be cared for in the most integrated setting possible—those that a person would typically live in which do not typically include institutions or other congregate (centralized residential facility) care settings.[1]

This policy brief provides an overview of how complex needs can be understood, why this issue is important for policymakers, how "complex care" is defined, and why current service systems have difficulty supporting these individuals. In addition, because the implementation of cross-sector and innovative models of care delivery are key to addressing this system-wide challenge, the brief highlights a sample of promising care delivery models in New York State. However, although there are models that have been shown to improve the coordination of services across different programs and systems, there are not a lot of rigorously evaluated studies for the wide variety of people with multiple complex needs.

This paper presents emerging and promising models by complex needs care providers that were recently convened for a discussion of best practices by the Rockefeller Institute of Government in collaboration with the Step Two Policy Project and in coordination with the NYU McSilver Institute for Poverty Policy and Research. The models in this paper have not yet been rigorously evaluated by outside entities. The

providers discussed here and their partners have conducted self-evaluations using metrics such as patient satisfaction, reductions in inpatient stay days, or health outcomes. Given that these providers have seen early success in these areas, the brief takes learnings from the experiences of these providers and suggests where policymakers might focus their efforts to improve care. The paper also makes recommendations as to how to develop these ideas and models further to best support people with complex needs.

Who Are Individuals with Complex Needs?

Individuals with complex medical, behavioral, or social needs can be generally characterized as such because of the extent of their needs for services in one or several of these areas. Examples of the types of people who might be considered as having complex needs could include those who are frail and older individuals, those with intellectual and developmental disabilities (I/DD), serious mental illness, substance-use disorders, and those who are justice-involved, have extensive medical needs, or have underlying health-related social needs. In short, they have significant and often overlapping needs that require a range of services and supports, which are associated with high costs.

Nationally, individuals with complex medical, behavioral, and social needs often have difficulty accessing appropriate services and supports in the settings that are most appropriate for them. The *Health Affairs* journal notes "obstacles to progress for the complex needs populations are often rooted in the design and fragmentation of systems; solutions, therefore, must embrace a systems-focused approach."[2] One of the biggest areas of fragmentation occurs between community-based organizations (CBOs) that focus on an individual's social needs and healthcare services organizations (HSO), which focus on health needs.[3] The Center for Health Care Strategies has noted some of the ways CBOs and HSOs are fragmented, including their historical inability to share data on an individual across systems and a lack of coordination across funding streams to support individuals.

What Is the Impact and Cost to Individuals and Society of Not Addressing the Needs of Complex Individuals?

In addition to making it difficult to receive needed services, when individuals are placed in the wrong setting—such as an institution or hospital or if they are unhoused—it can cost millions of dollars.[4] A report issued by the Healthcare Association of New York State (HANYS) of 52 New York hospitals found that over the course of three months 1,115 patients were experiencing discharge delays amounting to a total of 60,000 delay days (defined as more than four avoidable days in the emergency department and/or more than 14 avoidable days in an inpatient unit).[5] The three-month period in which the survey was conducted was between April 1 and June 30, 2022. The total cost associated with these delays was $169 million. While the COVID-19 pandemic has

highlighted these challenges in the hospital sector, they have in fact been happening for years.[6, 7] From the point of view of the individual who needs services, the health and human service delivery system is siloed in terms of where they can receive services and supports, how and whether those services are paid for, which types of professional staff can provide those services, and whether and how data are shared across different types of providers.

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How Are Some States Beginning to Address Care Fragmentation?

As noted by the National Bureau of Economic Research, care fragmentation occurs when the delivery of healthcare is spread across a large number of providers and results in inefficiencies in the delivery of services.[8] Several states are now looking to use their Medicaid programs to incentivize more collaboration in patient/individual care between CBOs and HSOs and fund what is called health-related social needs (HRSN). For example, California's CalAIM waiver seeks to create a more "coordinated, person-centered, and equitable health system," with a focus on those with the most complex needs.[9, 10] Other states are designing new delivery models for HRSN by creating "Coordinated Care Organization" (CCO) contractual requirements around reinvestment and community partnerships that include the term Social Determinants of Health and Equity Partner ("SDOH-E Partner"). The SDOH-E is defined by Oregon as a "single organization, local government, one or more of the Federally recognized Oregon tribal governments, the Urban Indian Health Program, or a collaborative, that delivers SDOH-E related services or programs, or supports policy and systems change, or both within a CCO's service area." The Center for Health Care Strategies has also noted that in Massachusetts, the state is using "accountable care organizations to contract with the state's designated 27 Community Partners in their service area, which specialize in providing care coordination supports for members either with behavioral health or long-term services and supports needs."[11]

What Should the Delivery of Complex Care Look Like?

The delivery of complex care operates at both the individual level and at the systemic level by providing person-centered, coordinated care for individuals, i.e., services and supports for individuals across multiple providers, care settings, and sectors, and by creating "ecosystems of organizations" that collaborate to serve and support individuals with complex health and social needs.[12]

The core elements of an effective complex care delivery model typically include several key characteristics.[13] Fundamental are multidisciplinary care teams with a trained care coordinator at the hub that follows an individualized care plan. Effective multidisciplinary

care teams facilitate outreach and interaction among the individual, the care coordinator, and the care team. Other key characteristics include provider responsiveness and accessibility; medication management and reconciliation; the extension of care into the community and ensuring strong linkages to social services, such as housing, food, and transportation. Finally, recognizing the importance of ensuring smooth transitions of care, complex care delivery models must promptly engage individuals after hospital stays or other changes in settings.

Complex care strives to be "person-centered, equitable, cross-sector, team-based, and data-driven."

There is a significant body of literature that has identified elements of care delivery that result in providing the right services and supports for individuals with complex needs.[14] Models and practices for supporting individuals with complex medical, behavioral, or social care needs have further developed in recent years. The Camden Coalition is one example of an organization that offers resources, toolkits, and technical assistance to support the adoption of a patient-centered, complex care-oriented model of service delivery.[15]

The National Center for Complex Health and Social Needs, the Center for Health Care Strategies, and the Institute for Healthcare Improvement published a *Blueprint for Complex Care* in 2018 that is designed to help providers across different disciplines better support complex care delivery.[16] The *Blueprint* states that complex care strives to be "person-centered, equitable, cross-sector, team-based, and data-driven." Team-based care relies on clinicians and other care team members, in sufficient quantity, who are well-trained in their specific role, can facilitate access to the health-related social needs of the individuals they are supporting, are team-oriented and able to function effectively as team members, and are patient-focused. A data-driven approach relies on access to and the utilization of data and technology, such as electronic health records, remote monitoring tools, and cross-sector data analytics to support person-centered decision-making, quality improvement, and communication across the team and in care delivery.

How Are Providers in New York State Innovating?

To increase the likelihood that an individual ends up in an appropriate setting, the Rockefeller Institute of Government in collaboration with the Step Two Policy Project, and in coordination with the NYU McSilver Institute for Poverty Policy and Research,[17] worked with several providers to identify promising practices. The Rockefeller Institute and Step Two convened the providers to share practices with each other and with state officials from the New York State agencies that oversee services in these areas. These agencies included the Department of Health, the Office of Children and Family Services (including the Council on Children and Families), Office of Temporary and Disability Assistance,the Office of Mental Health, the Office for People with Developmental Disabilities, the State Education Department, and the Office for Alcohol and Substance Abuse Services.

The following are brief descriptions of the types of providers we spoke to, their provider collaborations, and the innovative models of care delivery they are utilizing. The structure of these programs and their results are all self-reported and have not been subject to peer reviewed evaluation. However, some of the metrics that have been self-tracked have promising results, as outlined below.

Hospital and Homecare Collaboration, Focused Primarily on Older Individuals Needing Discharge or Recently Discharged from a Hospital

In this model, a program was developed to serve people with chronic diseases who were at high risk for hospital readmission, but who did not need the clinical services that are provided by a Certified Home Health Agency. Under this model, individuals benefit from the presence of a nurse to help keep them engaged in receiving the right care and enhance their skills in illness self-management. A dedicated registered nurse acts as a coach who specializes in helping patients shape and follow their care plans for 30 days following discharge from a hospital. They do this by providing medication reconciliation and management to ensure that the individual has all the updated medications and dosages following their hospital stay and that they are not continuing any previous or contraindicated medication therapies, they also provide assistance with setting up primary care and follow-up appointments, education and self-management of the patients own care (for example, promoting healthy behaviors related to diet and activity or disease-specific skills such as checking blood glucose levels for diabetics), an assessment of the patient's living environment, and assistance implementing remote patient monitoring as indicated. The registered nurses are trained in the Care Transitions Intervention (CTI) model developed by Dr. Eric Coleman, which strives to bridge the transition from the hospital to home for at-risk patients.[18] This intervention has been demonstrated to be effective in reducing readmissions to the hospital.[19] The registered nurse coach program expanded early in the COVID-19 pandemic to support COVID-19-positive patients in the community and to help preserve inpatient bed capacity for those who were more acutely ill. According to a survey of patients conducted by the provider utilizing this model in New York, it resulted in lower readmission rates and patient satisfaction of 100 percent from August 2021 through November 2022.

Home and Community-Based Healthcare Agency Focused on Care Older Adults with Chronic Disease and on People with Intensive Behavioral Health Needs Including Serious Mental Illness and /or Substance Use Disorder

Two innovative care models operated by this agency involve intensive transitional care programs for those with serious mental illness and for those with substance-use disorder. Specifically, they are focused on individuals with two or more hospital admissions and/or four or more emergency department visits over 12 months. The care models rely on an interdisciplinary team to address health-related social needs that include community support and integration and utilization of trauma-informed recovery and harm reduction strategies. According to the providers administering and tracking the results, the two models resulted in a 31.9 percent decrease in hospital readmissions compared to non-enrolled individuals and a 53.5 percent decrease in

hospital readmissions compared to non-enrolled individuals, respectively. Additionally, the model serving individuals with serious mental illness demonstrated a 60 percent increase in member retention 90 days post-enrollment (engagement is an important metric in care for those with serious mental illness), and the model serving individuals with substance-use disorder resulted in a 14.9 percent decrease in plan expenditures after one year. Another care model implemented by this agency focuses on post-acute care management. This model provides 60 days of services and involves managing individuals who are at high risk of hospital readmission, most of whom are 65 years or older with multiple chronic conditions. It includes an in-home nurse assessment with medication reconciliation and management. They facilitate a primary care visit within 10 days of hospital discharge, and they use remote patient monitoring and virtual visits to coordinate medical, behavioral health, and social services. The agency uses data analytics and risk stratification to manage care. According to the provider administering this model, it resulted in reductions in readmission rates.

Behavioral Health Services Agency Focused on Individuals with Serious Mental Illness and/or Significant Medical Needs

Individuals served by this care model include those with serious mental illness being served by Assertive Community Treatment (ACT) teams, a community-based mobile and multidisciplinary approach to serving people with serious mental illness.[20] These individuals often experience significant health disparities compared with individuals without serious mental illness. The behavioral health programs work in close cooperation with an onsite primary care provider. As part of this program, clinicians created a patient registry for people served by ACT teams. The registry data included assessments from ACT nursing staff and data from the primary care nurse practitioner who was available for member engagement and consultations with the ACT team. According to the provider administering this model, it resulted in an increase in cardiometabolic screening for the individuals with serious mental illness being served by ACT teams. This is particularly important for individuals with serious mental illness because they experience reduced lifespans of approximately 25 years, compared to individuals without, due to medical comorbidities such as heart disease, obesity, and diabetes.[21]

Public Hospital and Mental Hygiene Agency Collaboration Focused on Individuals with Mental Illness, Substance-Use Disorder, or Disabilities with Extended Lengths of Stay in a Hospital

This care model includes a combination of crisis intervention and intensive care management for adults with intellectual and/or developmental disabilities. It includes psychological and psychosocial evaluations, case management, counseling, and behavior support. This intensive care management complements services provided at the agency's respite house by supporting individuals who are from outside the partnering hospital system. The respite house component of this program includes beds that provide for safe hospital discharges for adults with intellectual or developmental disabilities who no longer need hospital care but may not be able to return to their prior residence. The provider created a new title and credential for

the direct support staff in the respite house, who were also paid a higher wage. This model decreased avoidable inpatient days for the partnering hospital and resulted in individuals transitioning to long-term home or community residences following their stay at the respite house. At the time of reporting, 27 of the 31 individuals admitted to the respite house had returned home or to a residence following an average length of stay of approximately 120 days, which otherwise would have been as a hospital inpatient instead of a resident in the respite house.

Academic Medical Center Main Hospital Focused on Any Patient with an Inpatient Stay Over 20 Days

This provider created a Complex Case Team to address issues related to all inpatient units. Central to the success of this model is a decision-making, interdisciplinary team that focuses on providing a safe path to discharge for any patient at the medical center with a length of stay over 20 days. Another aspect of the program that contributes to its success is the development of standardized protocols and procedures, along with partnerships with outside legal organizations, that help to address and resolve guardianship issues or issues involving an individual's immigration status more quickly. This model decreased the number of avoidable inpatient days at the hospital.

Public Hospital Focused on any Patients with a Diagnosed or Suspected Diagnosis of an Intellectual or Developmental Disability and/or Mental Illness

This provider created an Intellectual/Developmental Disability and Mental Health Specialty Unit to focus on adults with neurodevelopmental disabilities and complex medical, psychiatric, and behavioral needs. To be eligible under this model, individuals must be enrolled in the New York State Office for People with Developmental Disabilities waiver service, be eligible for the New York State Crisis Services for Individuals with Intellectual and/or Developmental Disabilities program, and be actively receiving services. The model supports individuals when they transition back into the community following their inpatient stay. As reported by this provider, this model resulted in clarification of diagnoses, reduced polypharmacy, reduced emergency department utilization, higher patient satisfaction, and increased connection to care in the community for the individuals following their discharge.

Academic Medical Center Pediatrics Department Focused on Children with Complex Needs Related to their Intellectual and/or Developmental Disabilities

This provider, a separate academic medical center from the one described above, established multispecialty inpatient and outpatient services for children with intellectual and/or developmental disabilities and their families. These services utilize an interdisciplinary team to integrate behavioral health in primary care settings. This approach allows the provider to address an individual's multiple clinical needs and focuses on interdisciplinary assessment, medication reconciliation, developmental monitoring, and parent/family education. The provider noted that their pilot model resulted in reduced emergency department utilization, increased patient and family

satisfaction, transfers to lower levels of care, and reductions in challenging behavior.

In addition to the provider models described above, two other models were part of the discussions. One was a human services provider developing a model to better serve youth with complex behavioral and social needs who would otherwise be languishing in hospital settings; and the other was a specialty hospital for children with I/DD and significant physical disabilities that plans to open soon.

Identified Challenges and Policy Actions

There were a handful of major themes raised by providers related to the challenges of establishing, operating, and sustaining cross-sector/cross-state agency, patient-centered models of care. They included: 1) inadequate flexibility and lack of alignment of state (and federal) statutes and regulations governing the establishment and operations of service programs across sectors, 2) lack of program start-up funding (other than foundation funding), 3) lack of reimbursement for many of the services included in providing complex care, 4) difficulty accessing and sharing patient and service-related data across service sectors and across provider types, 5) a severe shortage of staff in every component of the care delivery team, and 6) inadequate flexibility and preparation of the existing workforce to effectively work with individuals with complex health, behavioral health, and social needs.

After bringing together the aforementioned providers in the health, behavioral health, and human services sectors from across New York State who work with individuals with complex needs and who have developed innovative care models, the Rockefeller Institute and Step Two then had providers present their care models to state policymakers. In seeing the work of these providers, policymakers commented, that although they operate different programs and work with different populations, many of the providers' approaches to providing services and supports are the same and so are many of their challenges.

As a result of this convening, collectively, these providers and policymakers agreed to work to 1) create, scale, and replicate sustainable care delivery models, 2) facilitate the expansion of cross-sector care delivery models, 3) enhance the training and development of the healthcare workforce to more effectively work with complex populations, 4) rethink how to deploy the healthcare workforce to reimagine credentials and roles, 5) support state agency collaboration when individuals are in crisis, and 6) determine ways to leverage federal opportunities.

In addition to the specific provider models noted above, at the time of this paper's publication, New York State is seeking a waiver from the federal government that will enable the Medicaid program to pay for health-related social needs. The New York Health Equity Reform (NYHER) proposal would create social care networks (SCNs), which would further incentivize providers from CBOs and HSOs to work together by building the infrastructure to share data about individuals across systems.[22] It also proposes to make Medicaid funding available to CBOs that support and deliver care that is considered health-related and for social needs. All of this will require new data integration, contracting capabilities, and accountability and outcome measure tracking.

Measuring the Impact of Policy and Care Delivery Changes

To know if any of the identified models that providers have developed have made an impact, and to understand if the proposed changes in the NYHER 1115 Waiver application improve the delivery of care to individuals with complex needs, better measures are needed. Because the field of complex care is still evolving, there are few standardized, rigorous, and widely used methods or metrics to document the impact of policy or care delivery interventions for individuals who receive complex care. But there are possible learnings emerging from our work with providers in New York State. For example, from our convening of providers, we noted that the types of impact measures that providers use range from reductions in hospital emergency department and inpatient avoidable admissions days and costs, to reductions in readmissions to emergency department or inpatient units within 30 days of a discharge, to improvements in connections to community services, and extended engagement with service delivery providers. The development and wide adoption of such measures could be beneficial. One of the best resources developed to date from the Camden Coalition, the National Center for Complex Health and Social Needs, and the Institute for Healthcare Improvement, identifies five domains for measurement, including effectiveness, equity, health and well-being, service delivery, and cost and makes eight recommendations to improve measurement.[23] The recommendations include such things as determining a pathway for a standard denominator or definition for the population of interest, promoting measures where the patient drives the priorities, and building capacity to capture best practices.

Conclusion

Individuals with complex care needs are falling through the cracks of the health, behavioral health, and human services service systems. It is important to engage providers who are working with people with complex needs across differing segments of the population to learn from their experiences and to allow them to learn from one another about best practices and problem-solving. Given the promising models of collaborative care delivery that were identified through this work, there is an opportunity to parlay successful models to other providers in different regions of the state. Entities such as NYU's McSilver Institute, which addresses the needs of underserved and vulnerable populations through research, policy, and practice, and has participated in the provider and state discussions outlined in this brief, are seeking ways to expand such models.

The Rockefeller Institute and Step Two will look for opportunities to enhance the training and development of the healthcare workforce to engage more effectively with complex populations and consider how to reimagine healthcare team roles. The Rockefeller Institute and the Step Two Policy Project will assist in determining ways to leverage federal opportunities to better support this heterogeneous population.

A promising conclusion from our work is that efforts to increase the visibility of the issue of scarcity of care settings, services, and supports for individuals with complex needs and build a community of practice of diverse providers who care for complex populations is underway. As we understand each provider's experiences and identify effective workforce teams and care delivery models, we will make recommendations for the adoption of these practices and related policies on a larger scale with the goal of providing person-centered services and supports in the most appropriate settings for individuals with complex needs.

Endnotes

1 "ACL Commemorates the 24th Anniversary of the Landmark Supreme Court Decision Olmstead v. L.C.," Administration for Community Living, June 22, 2023, https://acl.gov/news-and-events/announcements/acl-commemorates-24th-anniversary-landmark-supreme-court-decision.

2 "Complex Care," *Health Affairs*, accessed September 25, 2023, https://www.healthaffairs.org/topic/2514.

3 Diana Crumley, Rob Houston, and Amanda Bank, *Incorporated Community-Based Organizations in Medicaid Efforts to Address Health-Related Social Needs: Key State Considerations* (Hamilton, NJ: Center for Health Care Strategies, April 2023), https://www.chcs.org/media/Incorporating-Community-Based-Organizations-in-Medicaid-Efforts-to-Address-Health-Related-Social-Needs_050523-1.pdf.

4 *The scope of complex case discharge delays in New York state* (Rensselaer, NY: Healthcare Association of New York State (HANYS), February 2023), https://www.hanys.org/communications/publications/scope_of_complex_case/.

5 Ibid.

6 Matt Richtel, "Hundreds of Suicidal Teens Sleep in Emergency Rooms. Every Night," *New York Times*, May 9, 2022, https://www.nytimes.com/2022/05/08/health/emergency-rooms-teen-mental-health.html.

7 "Pediatric Emergency Department Boarding," Children's Mental Health Campaign, accessed September 25, 2023, https://www.childrensmentalhealthcampaign.org/pediatric-emergency-department-boarding/.

8 "Fragmentation in the Delivery of Health Care," *Bulletin on Aging & Health* 2 (June 2017): 3, National Bureau of Economic Research, https://www.nber.org/bah/2017no2/fragmentation-delivery-health-care.

9 Crumley, Houston, and Bank, *Incorporated Community-Based Organizations in Medicaid Efforts to Address Health-Related Social Needs: Key State Considerations*.

10 "Medi-Cal Transformation: Our Journey to a Healthier California for All," California Department of Health Care Services, accessed September 25, 2023, https://www.dhcs.ca.gov/CalAIM/Pages/CalAIM.aspx.

11 Crumley, Houston, and Bank, *Incorporated Community-Based Organizations in Medicaid Efforts to Address Health-Related Social Needs: Key State Considerations*.

12 Mark Humowiecki, et al., *Blueprint for Complex* Care (Camden, NJ: Camden Coalition, The National Center for Complex Health & Social Needs, December 2019), https://www.chcs.org/media/Blueprint-for-Complex-Care_UPDATED_030119.pdf.

13 Peter Long, et al., *Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health* (Washington, DC: National Academy of Medicine, 2017), https://nam.edu/wp-content/uploads/2017/06/Effective-Care-for-High-Need-Patients.pdf.

14 "All Resources," The Playbook, accessed September 25, 2023, https://bettercareplaybook.org/all-resources.

15 "Resources," The Camden Coalition, accessed September 25, 2023, https://camdenhealth.org/resources/.

16 Humowiecki, et al., *Blueprint for Complex Care*.

17 McSilver Institute for Poverty Policy and Research, New York University, accessed September 25, 2023, https://mcsilver.nyu.edu/.

18 "About CTI," Care Transitions Intervention, accessed September 25, 2023, https://caretransitions.health/about.

19 *Care Transitions Model* (New York, NY: John A. Hartford Foundation, 2007), https://www.johnahartford.org/ar2007/pdf/Hart07_CARE_TRANSITIONS_MODEL.pdf.

20 "Assertive community treatment," Wikipedia, updated August 1, 2023, https://en.wikipedia.org/wiki/Assertive_community_treatment.

21 Marth Sajatovic, et al., "Best Practices: Optimizing Care for People With Serious Mental Illness and Comorbid Diabetes," *Psychiatric Services* 62, 9 (September 2011): 1001–3, https://doi.org/10.1176/ps.62.9.pss6209_1001.

22 "New York Health Equity Reform (NYHER)," New York Department of Health, updated October 2022, https://www.health.ny.gov/health_care/medicaid/redesign/med_waiver_1115/2022-10-03_faqs.htm.

23 *Standardizing quality measurement in complex care* (Camden Coalition of Healthcare Providers and The National Center for Complex Health & Social Needs, May 21, 2020), https://camdenhealth.org/wp-content/uploads/2020/05/Quality-measure-brief-final.pdf.

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