Roundtable on Population Health Improvement
Building Sustainable Financing Structures for Population Health: A Workshop
October 19, 2016

AGENDA
National Academy of Sciences Building • 2101 Constitution Avenue, NW, Washington, DC • Room 125

WORKSHOP OBJECTIVES
In the context of multi-sector collaboration, a focus on dependable (not one-time) resources, and with the aim of improving health, wealth, wellbeing and health equity:

1. Improve the fiscal fluency of decision makers and the public—to move toward common purpose at community scale—explore frameworks for funding reinvestment and reallocation
2. Identify existing opportunities and constraints on realigning funding in ways that are conducive to co-benefits (for all sectors involved)
3. Discuss the strategies, including conditions, needed to realign resources, i.e., what it takes to move funding from one arena to another
4. Explore what decision makers, communities, and other stakeholders need to speak about realignment with confidence, including the possible opportunities to move funds from one part of the system to another

8:30 am Welcome and overview of the day
George Isham, senior advisor, HealthPartners, Inc., senior fellow, HealthPartners Institute for Education and Research; co-chair, Roundtable on Population Health Improvement
Pamela Russo, senior program officer, Robert Wood Johnson Foundation; member, Roundtable on Population Health Improvement; chair, workshop planning committee

9:00 am Overview of audience participation plan
Christopher Parker, associate project director, Georgia Health Policy Center; member, workshop planning committee

9:15 am Sustainable Financing Structures for Population Health: Historical Patterns and Insights for the Future
Moderator: Debbie I. Chang, senior vice president of policy and prevention, Nemours
Anthony Orlando, doctoral student, Sol Price School of Public Policy, University of Southern California
Raphael Bostic, professor, Judith and John Bedrosian Chair in Governance and the Public Enterprise; Chair, Department of Governance, Management and the Policy Process; Sol Price School of Public Policy, University of Southern California

9:45 am Q&A/Discussion
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<th>Time</th>
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<tr>
<td>10:15 am</td>
<td>Network Break</td>
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<tr>
<td>10:30 am</td>
<td><strong>Case example 1: Justice reinvestment</strong>&lt;br&gt;Moderator: Paula Lantz, associate dean for academic affairs and professor of public policy, Gerald R. Ford School of Public Policy, University of Michigan&lt;br&gt;Elizabeth Lyon, deputy director, State Initiatives, Council on State Governments&lt;br&gt;Justice Center&lt;br&gt;Judge Steven Teske, Juvenile Court, Clayton County Government, Georgia</td>
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<tr>
<td>11:15 am</td>
<td>Q&amp;A/Discussion</td>
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<td>11:45 am</td>
<td>Lunch</td>
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<td>12:45 pm</td>
<td><strong>Case example 2: Clean energy financing</strong>&lt;br&gt;Moderator: Mary Pittman, president and CEO, Public Health Institute&lt;br&gt;Michael Bodaken, president, National Housing Trust, Inc.&lt;br&gt;Holmes Hummel, principal, Clean Energy Works&lt;br&gt;Joel Rogers, Sewell-Bascom Professor of Law, Political Science, Public Affairs, and Sociology, University of Wisconsin-Madison; director, COWS</td>
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<tr>
<td>1:45 pm</td>
<td>Q&amp;A/Discussion</td>
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<td>2:15 pm</td>
<td><strong>Overview of examples from other sectors to seed small group conversations</strong></td>
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<td>Energy break</td>
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<td>3:00 pm</td>
<td>Small group work</td>
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<tr>
<td>4:15 pm</td>
<td>Reporting back and discussion</td>
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<tr>
<td>4:35 pm</td>
<td><strong>Audience participation</strong>&lt;br&gt;Christopher Parker</td>
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<td>4:45 pm</td>
<td><strong>Closing remarks and reflections on the day</strong>&lt;br&gt;Pamela Russo&lt;br&gt;Sanne Magnan, co-chair, Roundtable on Population Health Improvement</td>
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<td>5:15 pm</td>
<td>Adjourn</td>
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**URL:** nas.edu/pophealthrt ● **Email:** pophealthrt@nas.edu ● follow the conversation 🐦 #pophealthrt
Roundtable on Population Health Improvement

Building Sustainable Financing Structures for Population Health: A Workshop

Washington, DC - October 19, 2016

BIOSKETCHES OF PRESENTERS AND MODERATORS

Michael Bokaden

Mr. Michael Bodaken serves as President of National Housing Trust, Inc. Mr. Bodaken serves as Vice President of Homes For America, Inc. He served as Head of National Housing Trust for over 13 years. Mr. Bodaken is chiefly involved in administration, business planning, technical assistance and public policy. Mr. Bodaken has been directly involved in providing technical assistance to capable nonprofit organizations interested in purchasing affordable, multi-family housing developments. He served as the Deputy Mayor of the City of Los Angeles with responsibility for, among other things, the housing and community development programs of the City. He is a frequent moderator and panelist at regional and national housing conferences concerning the preservation of multifamily housing. He is Proficient in investment, tax and legal matters concerning housing and community economic development. He practiced as a public interest lawyer with the Legal Aid Foundation of Los Angeles and the San Fernando Valley Neighborhood Legal Services. He is recognized as a key national leader in the affordable housing field and is a frequent moderator and panelist at regional and national housing conferences concerning the preservation of multifamily housing. He serves on the Board of numerous national housing organizations, including Homes for America, Inc., Housing Preservation Project, Urban Vision, Fairfax and Montgomery County Housing Tax Forces, and Stewards for Affordable Housing for the Future (SAHF). Mr. Bodaken has a J.D. degree from Peoples College of Law and a B.A. degree from the University of Iowa.

Raphael Bostic

Raphael Bostic, Ph.D., is the Judith and John Bedrosian Chair in Governance and the Public Enterprise at the Sol Price School of Public Policy at the University of Southern California. His past positions as USC include Director of the Master of Real Estate Development degree program and the founding director of the Casden Real Estate Economics Forecast. He returned to USC after serving for three years in the Obama Administration as the Assistant Secretary for Policy Development and Research at the U.S. Department of Housing and Urban Development. In that position, Dr. Bostic was a principal advisor to the Secretary on policy and research, with the goal of helping the Secretary and other principal staff make informed decisions on HUD policies and programs, as well as budget and legislative proposal. Dr. Bostic led an interdisciplinary team of 150 which had expertise in all policy areas of importance to the department, including housing, housing finance, rental assistance, community development, economic development, sustainability, and homelessness, among others. During his tenure and with his leadership, PD&R funded more than $150M in new research, became an important advisory voice on departmental budget and prioritization decisions, and reestablished its position as a thought leader on policies associated with housing and urban development. Dr. Bostic’s work spans many fields including home ownership, housing finance, neighborhood change, and the role of institutions in shaping policy effectiveness. A particular emphasis has been on how the private, public, and non-profit sectors interact.
to influence household access to economic and social amenities. Dr. Bostic earned his Ph.D. in Economics from Stanford University. He is the recipient of a Special Achievement Award for his work at the Federal Reserve Board of Governors on the Community Reinvestment Act. He served on the NAS Committee to Evaluate the Research Plan of the Department of Housing and Urban Development (Member, 2007-2009).

**Debbie Chang**

As Vice President of Policy and Prevention for Nemours, Ms. Chang is focusing on developing and achieving Nemours’ policy and advocacy goals; identifying, evaluating, replicating and promoting model practices and policies in strategic areas such as innovation in child health promotion, prevention, and Nemours’ integrated system of care; and developing and advancing Nemours’ visionary child health prevention strategy across the enterprise. Ms. Chang is also leading a collaborative learning effort with eight communities across the country to harness and promote innovative policies and practices to improve the health and well-being of children in cross-sectoral (integrating health and other sectors serving children), place-based approaches. During the last five years at Nemours, she created and led Nemours Health & Prevention Services, an operating division devoted to improving children’s health over time through a cross-sectoral, community-based model in Delaware that includes developing, implementing, evaluating, and promoting model prevention interventions. Ms. Chang has over 22 years of federal and state government and private sector experience in the health field. She has worked on a range of key health programs and issues including Medicaid, State Children’s Health Insurance Program (SCHIP), Medicare, Maternal and Child Health, national health care reform and financing coverage for the uninsured. She has held the following federal and state positions: Deputy Secretary of Health Care Financing at the Maryland Department of Health and Mental Hygiene, with oversight for the State of Maryland’s Medicaid program and the Maryland Children’s Health Program; Director of the Office of Legislation for the Health Care Financing Administration (now Centers for Medicare and Medicaid Services); and Director of SCHIP when it was first implemented in 1997. Ms. Chang also served as the Senior Health Policy Advisor to former U.S. Senator Donald W. Riegle, Jr., former chair of the Senate Finance Subcommittee on Health for Families and the Uninsured. She currently serves as the co-Principal Investigator on a Robert Wood Johnson evaluation grant, “Evaluation of School and Child Care Sector Childhood Obesity Prevention Strategies in Delaware.” She is an active member on a number of boards including Grantmakers in Health, Healthy Eating Active Living Convergence Partnership, National Institute for Children’s Healthcare Quality (NICHQ) Policy Advisory, and Obesity National Advisory Committees, and the University of California at Los Angeles Alliance for Information on Maternal and Child Health Support Center National Advisory Panel. Ms. Chang is a senior associate in the Department of Population, Family and Reproductive Health at the Bloomberg School of Public Health, Johns Hopkins University. She has published work on integrating population health and medical care, SCHIP, and Maryland’s Managed Care Program. She holds a master’s degree in Public Health Policy and Administration from the University of Michigan and a bachelor’s degree in Chemical Engineering from the Massachusetts Institute of Technology.

**Holmes Hummel**

Holmes Hummel is the founder of Clean Energy Works, a public interest organization that accelerates capital deployment for distributed energy solutions in the power sector. Clean Energy Works is known for building bridges across the “clean energy divide” by using tariffed on-bill financing to address common disqualifying criteria for financing. At the Bloomberg New Energy Finance annual summit, Clean Energy Works won a Fire Award for high impact innovation in finance, receiving recognition for
advancing the Pay As You Save® (PAYS®) system. In 2009, Dr. Hummel was appointed as the Senior Policy Advisor in the U.S. Department of Energy’s Office of Policy & International Affairs, serving through 2013. In that capacity, Holmes stewarded the agency’s energy finance working group, and helped shape strategic priorities on a range of topics, including technology innovation, the water-energy nexus, and climate policy. Dr. Hummel holds a B.S., M.S.E, and PhD from Stanford University with an interdisciplinary approach to energy engineering, climate science, economics and policy.

**George Isham**

George Isham, M.D., M.S., is Senior Advisor to HealthPartners, responsible for working with the board of directors and the senior management team on health and quality of care improvement for patients, members, and the community. Dr. Isham is also Senior Fellow at HealthPartners Research Foundation and facilitates forward progress at the intersection of population health research and public policy. Dr. Isham is active nationally and currently co-chairs the National Quality Forum convened Measurement Application Partnership, chairs the National Committee for Quality Assurances’ clinical program committee and is a member of NCQA’s Committee on Performance Measurement. He is a former member of the Center for Disease Control and Prevention’s Task Force on Community Preventive Services and the Agency for Health Care Quality’s United States Preventive Services Task Force and currently serves on the advisory committee to the director of Centers for Disease Control and Prevention. His practice experience as a general internist was with the United States Navy, at the Freeport Clinic in Freeport, Illinois, and as a clinical assistant professor of medicine at the University of Wisconsin Hospitals and Clinics in Madison, Wisconsin. In 2014 Dr. Isham was elected to the National Academy of Medicine. He has chaired three studies in the National Academies Health and Medicine Division (the program unit of the former Institute of Medicine) in addition to serving on a number of HMD studies related to health and quality of care. In 2003 Dr. Isham was appointed as a lifetime National Associate of the National Academies of Sciences, Engineering, and Medicine in recognition of his contributions to the work of the Health and Medicine Division.

**Paula Lantz**

Paula Lantz, Ph.D., is the Associate Dean for Research and Policy Engagement and a professor of public policy at the Ford School of Public Policy at the University of Michigan. She most recently was professor and chair of the Department of Health Policy and Management at the Milken Institute School of Public Health at George Washington University. From 1994-2011, she was a faculty member at the University of Michigan with a primary appointment in the School of Public Health, and affiliations with the Ford School and the Institute for Social Research. Dr. Lantz, a social demographer, studies the role of public health in health care reform, clinical preventive services (such as cancer screening and prenatal care), and social inequalities in health. She is particularly interested in the role of health care versus broad social policy aimed at social determinants of health in reducing social disparities in health status. She is currently doing research regarding the potential of social impact bonds to reduce Medicaid expenditures. Dr. Lantz is a member of the National Academy of Medicine (elected in 2012) and received an M.A. in sociology from Washington University, St. Louis, and an M.S. in epidemiology and Ph.D. in sociology from the University of Wisconsin.

**Elizabeth Lyon**

Elizabeth K. Lyon oversees the technical support provided to states that are participating in the Justice Reinvestment Initiative. Since joining the CSG Justice Center in 2012, Elizabeth has worked with leaders
over twelve states to ensure that the policies enacted achieve the projected outcomes to reduce spending on corrections and to reinvest in strategies to improve public safety. Elizabeth provides technical assistance tailored to the specific policies in each state. Previously, Elizabeth was the director of governmental relations for the State Bar of Michigan, where she directed the public policy program that included a large state and federal agenda. She holds a B.A. from the James Madison College at Michigan State University.

**Sanne Magnan**

Sanne Magnan, M.D., Ph.D., is the co-chair of the Roundtable on Population Health Improvement. Dr. Magnan served as President and CEO of the Institute for Clinical Systems Improvement (ICSI) until January 4, 2016. Dr. Magnan was previously the president of ICSI when she was appointed by former Minnesota Governor Tim Pawlenty to serve as Commissioner of Health for the Minnesota Department of Health. She served in that position from 2007 to 2010 and had significant responsibility for implementation of Minnesota’s 2008 health reform legislation, including the Statewide Health Improvement Program (SHIP), standardized quality reporting, development of provider peer grouping, certification process for health care homes, and baskets of care. She returned as ICSI’s President and CEO in 2011. Dr. Magnan also currently serves as a staff physician at the Tuberculosis Clinic at St. Paul-Ramsey County Department of Public Health and as a clinical assistant professor of medicine at the University of Minnesota. Her previous experience includes serving as vice president and medical director of Consumer Health at Blue Cross and Blue Shield of Minnesota, where she was responsible for case management, disease management, and consumer engagement. Dr. Magnan holds an M.D. and a Ph.D. in medicinal chemistry from the University of Minnesota, and is a board-certified internist. She earned her bachelor’s degree in pharmacy from the University of North Carolina. She currently serves on the National Academy of Medicine Roundtable on Population Health Improvement; she has served on the board of MN Community Measurement, and the board of NorthPoint Health & Wellness Center, a federally qualified health center and part of Hennepin Health. She was named one of the 100 Influential Health Care Leaders by Minnesota Physician magazine in 2004, 2008 and 2012. Since 2012, she has participated in the Process Redesign Advisory Group for the National Center for Inter-professional Practice and Education coordinated through the University of Minnesota. Recently, she became a Senior Fellow, HealthPartners Institute for Education and Research. She is participating in several Technical Expert Panels for CMS on population health measures (2015-2016), and is a member of the Population-based Payment Workgroup of the Healthcare Payment Learning and Action Network (2015-2016). She is also on the Interdisciplinary Application/Translation Committee of the Interdisciplinary Association for Population Health Sciences.

**Bobby Milstein**

Bobby Milstein, Ph.D., M.P.H., directs ReThink Health’s work in dynamics, systems strategy, and sustainable financing. An expert in health system dynamics and policy, Bobby oversees the on-going development of the ReThink Health Dynamics Model. He spent 20 years at the Centers for Disease Control & Prevention, where he founded the Syndemics Prevention Network and coordinated planning and evaluation activities for a number of public health initiatives. Bobby has a Ph.D. in Public Health Science from Union Institute & University, an M.P.H. from Emory University, and a B.A. from the University of Michigan Honors College.
Anthony Orlando

Anthony W. Orlando, M.Sc., is a Lecturer in the College of Business and Economics at California State University, Los Angeles. He is an op-ed columnist for the Huffington Post, serves as the Managing Partner of the Orlando Investment Group, and works as a Public Policy Researcher at the University of Southern California. His latest book, Letter to the One Percent, is exactly what it sounds like: a letter to the richest one percent of American households. It is a call to action, a plea for compassion, and a manifesto for the future. It tells the story of their extraordinary success — and how the other 99 percent of Americans missed out. Kirkus Reviews hails it as a “powerful, compact primer on American economics.” Reese Schonfeld, the founding President and CEO of CNN, says it “should be read by every one of us.” Orlando received his bachelor’s degree in economics from The Wharton School of the University of Pennsylvania, as well as a master’s in economic history from the London School of Economics and Political Science. His expertise includes economics, finance, American politics and foreign policy, economic and political history, and the history and operation of the movie and television industries. His latest publication, “Employers and Health Insurance Under the Affordable Care Act,” appeared in the Summer 2015 issue of the Annals of Health Law. Also recently, his article “Saving Capitalism from a Painful Demise” appeared in the Winter 2015 issue of the Wharton Magazine. He has co-authored articles on real estate history and the recent housing bubble in the Wharton Real Estate Review and the World Financial Review. He also serves as a financial consultant and researcher for various institutions, where his work ranges from advising government officials to high-profile lawsuits stemming from the recent financial crisis. In the entertainment industry, Orlando oversees a portfolio of projects as president of Sugarloaf Productions. His latest feature films include Autumn Lights, for which he serves as Executive Producer, and Lazy Eye, for which he serves as Associate Producer. He has worked with multiple production companies, including Fierce Entertainment and Big Cat Productions, as well as the movie investment firm PalmStar Media Capital and the TV animation division of Universal Studios. As a client of the prestigious Leigh Bureau, Orlando is a skilled and engaging public speaker who can address a broad range of issues, from politics and macroeconomics to the world of high finance and the art of storytelling. He has appeared on television, both as an interviewee and a political commentator. He is also a member of the American Planning Association, the Association for Public Policy Analysis & Management, Mensa International, and the World Economics Association and a trustee of the philanthropic Orlando Foundation.

Chris Parker

Chris Parker, M.B.B.S., M.P.H. is an associate project director at the Georgia Health Policy Center. He holds a leadership role in many of the center’s projects related to public health and program evaluation. His areas of expertise include strategic planning and evaluation, with a particular interest in projects that link population health and health care. Parker is a skilled facilitator who has guided a significant number of multisectoral, state, and local organizational strategic and evaluation plans. He is the co-principal investigator for Bridging for Health: Improving Community Health through Innovations in Financing, sponsored by the Robert Wood Johnson Foundation. He also leads the center’s growing health care workforce portfolio with a focus on Georgia’s primary care assets to address gaps in light of the Affordable Care Act, as well as the center’s work on community health needs assessments. As a trained family physician, who has worked with underserved populations and faith-based organizations, Parker brings his clinical and community linked experiences to addressing current and long-standing public health issues.
Mary Pittman

Mary A. Pittman, Dr.P.H., is president and chief executive officer of the Public Health Institute (PHI). A nationally recognized leader in improving community health, addressing health inequities among vulnerable people and promoting quality of care, Pittman assumed the reins at PHI in 2008, becoming the organization's second president and CEO since its founding in 1964. Her primary focus has been guiding the development of a strategic plan that builds on existing PHI program strengths to achieve greater impact on public policy and practice in public health. "In a changing environment, strategic planning is an ongoing process, not an end product," she said. Pittman's overarching goal is for PHI to become known for leadership in creating healthier communities. To this end, PHI continues to work closely with the state on many programs, including the Supplemental Nutrition Assistance Program. What's more, she advocates that all PHI projects take the social determinants of health into account to better address health disparities and inequities. Under Pittman's leadership, PHI has emphasized support for the Affordable Care Act and the Prevention and Public Health Fund, the integration of new technologies and the expansion of global health programming. Other top priorities are: increasing advocacy for public policy and health reform, and addressing health workforce shortages and the impacts of climate change on public health. Under Pittman, PHI has created Dialogue4Health.com, the online platform for conferencing and social networking, and has been recognized as a preferred place to work. She strives for PHI's independent investigators to work together to achieve a synergy in which the sum of their contributions is greater than the whole. Pittman has deep, varied and multi-sectoral experience in local public health, research, education, and hospitals. Before joining PHI, Pittman headed the Health Research and Educational Trust, a Chicago-based affiliate of the American Hospital Association, from 1993 to 2007. Previously, she was president and CEO of the California Association of Public Hospitals and a director of the San Francisco Department of Public Health. Pittman has authored numerous peer-reviewed articles in scientific journals and two books. She has served on the PHI board of directors since 1996. Pittman also serves on numerous boards and committees, including the World Health Organization's Health Worker Migration Global Policy Advisory Council and the National Patient Safety Foundation's board of governors.

Joel Rogers

Joel Rogers is the Sewell-Bascom Professor of Law, Political Science, Public Affairs, and Sociology at the University of Wisconsin-Madison, where he also directs COWS, the national high-road strategy center. Rogers has written widely on American politics and democratic theory. Along with many articles, his books include The Hidden Election, On Democracy, Right Turn, Metro Futures, Associations and Democracy, Works Councils, Working Capital, What Workers Want, Cities at Work, and American Society. Joel has also worked with and advised many politicians and social movement leaders, and founded, co-founded, and helped operate several progressive NGOs (including the New Party, Economic Analysis Research Network, Apollo Alliance, Emerald Cities Collaborative, and State Innovation Exchange). He is a contributing editor of The Nation and Boston Review. Along with various academic honors, he is a MacArthur Foundation Fellow, and identified by Newsweek as one of the 100 living Americans most likely to shape U.S. politics and culture in the twenty-first century.
**Pamela Russo**

Pamela Russo is a senior program officer at the Robert Wood Johnson Foundation since 2000. The major area of her work is improving health at the community level, based on the understanding of health as the result of interactions between social, environmental, behavioral, health care and genetic determinants. This area of programming includes developing robust collaborative partnerships across different sectors, agencies and organizations and requires addressing the root causes underlying inequities in the determinants between different populations or neighborhoods. Her program portfolio includes transforming the governmental public health system, including national accreditation as a platform for quality improvement; health impact assessment and more routinely bringing a health lens to decisions made in other sectors; working with communities to bridge sectors, including health care, public health, social services and others, and to identify and implement financing innovations to sustain their progress in improving the health of all in their communities; supporting predictive modeling showing the value of community-level prevention based on the best available evidence, and making those models useful to decision-makers in communities and states. Russo is a member of the National Academy of Medicine Roundtable on Population Health. Prior to joining the Foundation, Russo was an associate professor of medicine, researcher in clinical outcomes, and program co-director for the master’s program and fellowship in clinical epidemiology and health services research at the Cornell University Medical Center in New York City. Her education includes a B.S. from Harvard College, MD from the University of California, San Francisco, and an M.P.H. in epidemiology from the University of California, Berkeley, School of Public Health, followed by a residency in primary care general internal medicine at the Hospital of the University of Pennsylvania and a fellowship in clinical epidemiology and rheumatology at Cornell.

**Steve Teske**

Judge Steven C. Teske is the Chief Judge of the Juvenile Court of Clayton County, GA, and regularly serves as a Superior Court Judge by designation. He was appointed juvenile court judge in 1999. Judge Teske authored the School-Justice Partnership Model to reduce delinquency by promoting academic success using alternatives to suspensions and school-based arrests. Teske has testified before Congress on four occasions and several state legislatures on detention reform and zero tolerance policies in schools. The Governor has appointed him to the Children and Youth Coordinating Council, Governor’s Office for Children and Families, DJJ Judicial Advisory Council, JDAI Statewide Steering Committee, and the Georgia Commission on Family Violence. Teske was also appointed to the Georgia Criminal Justice Reform Commission and serves as chair of the Oversight and Implementation Committee (juvenile justice). He has served on the Council of SAGs of the Coalition of Juvenile Justice and the Federal Advisory Committee for Juvenile Justice, which advises the President and Congress on juvenile justice issues. He chairs the Southern Region of the Coalition of Juvenile Justice. He is a member of the National Council of Juvenile and Family Court Judges and has served on the Board of Directors. He currently chairs the School Pathways Steering Committee and is vice-chair of the Juvenile Justice Advisory Committee. He is past president of the Georgia Council of Juvenile Court Judges and the Clayton County Bar Association. He has written several articles on juvenile justice reform published in the Juvenile and Family Law Journal, Journal of Child and Adolescent Psychiatric Nursing, Juvenile Justice and Family Today, Family Court Review, and the Georgia Bar Journal. His book, Reform Juvenile Justice Now, is a collection of essays on juvenile justice issues. He is a Toll Fellow of the Council of State Governments and received his J.D., M.A., and B.I.S. degrees from Georgia State University in Atlanta, GA.
The National Academies of
SCIENCES • ENGINEERING • MEDICINE

Roster of Roundtable on Population Health Improvement

Co-Chairs

George J. Isham, MD, MS (Co-chair)
Senior Advisor, HealthPartners
Senior Fellow, HealthPartners Institute for Education and Research
HealthPartners, Inc

Sanne Magnan, MD, PhD (Co-chair)

Co-Chair Emeritus

David A. Kindig, MD, PhD
Professor Emeritus of Population Health Sciences
Emeritus Vice Chancellor for Health Sciences
University of Wisconsin-Madison
School of Medicine

Members

Terry Allan, RS, MPH
President, National Association of County and City Health Officials
Health Commissioner
Cuyahoga County Board of Health

John Auerbach, MBA
Associate Director for Policy
Acting Director, Office for State, Tribal, Local and Territorial Support
Centers for Disease Control and Prevention

Catherine Baase, MD
Global Director of Health Services
The Dow Chemical Company

Gillian Barclay, D.D.S., M.P.H., Dr.P.H.
Raphael Bostic, PhD
Professor
Judith and John Bendrosian Chair in Governance and the Public Enterprise
Sol Price School of Public Policy
University of Southern California

Debbie I. Chang, MPH
Vice President, Policy and Prevention
Nemours

Karen DeSalvo, M.D., M.P.H., M.Sc.
Acting Assistant Secretary for Health
U.S. Department of Health and Human Services

Charles J. Fazio, MD
Senior Vice President and Medical Director
HealthPartners Health Plan
HealthPartners

George Flores, MD, MPH
Program Officer
The California Endowment

Kathy Gerwig, MBA
Vice President, Employee Safety, Health and Wellness and Environmental Stewardship Officer
Kaiser Permanente

Mary Lou Goek, MSW
Executive Director
United Way of Santa Cruz County

Marthe R. Gold, MD
Visiting Scholar
New York Academy of Medicine

Garth Graham, MD, MPH, FACP
President
Aetna Foundation

Gary Gunderson, MDiv., DMin., DDiv.
Vice President of Faith & Health Ministries
Medical Center Administration
Professor, Social Sciences & Health Policy
Wake Forest School of Medicine

Wayne Jonas, MD
President and Chief Executive Officer
Samueli Institute

Robert M. Kaplan, PhD
Professor Emeritus, Distinguished Professor
Department of Health Policy and Management
Fielding School of Public Health
University of California, Los Angeles

Paula Lantz, PhD
Professor and Associate Dean for Research and Policy Engagement
Gerald R. Ford of Public Policy
University of Michigan

Michelle Larkin, JD, MS, RN
Assistant Vice President, Program Portfolios
Robert Wood Johnson Foundation

Thomas A. LaVeist, PhD
Chair
Department of Health Policy and Management
George Washington University

Jeffrey Levi, PhD
Professor
Department of Health Policy
Milken Institute School of Public Health
George Washington University

Sarah R. Linde, MD
RADM US Public Health Service
Chief Public Health Officer
Health Resources and Services Administration

Sharrie McIntosh, MHA
Vice President for Programs
New York State Health Foundation

Phyllis D. Meadows, PhD, RN, MSN
Senior Fellow, Health Program
Kresge Foundation
Associate Dean for Practice, Office of Public Health Practice
Clinical Professor, Health Management and Policy
School of Public Health
University of Michigan

Bobby Milstein, PhD, MPH
Director
ReThink Health

José T. Montero, MD, MHICDS
Vice President of Population Health and Health Systems Integration
Cheshire Medical Center/Dartmouth Hitchcock Keene

Mary Pittman, DrPH, MPH, MCP
President and CEO
Public Health Institute

Pamela Russo, MD
Senior Program Officer
Robert Wood Johnson Foundation
Vision:
The roundtable's vision is of a strong, healthful, and productive society which cultivates human capital and equal opportunity. This vision rests on the recognition that outcomes such as improved life expectancy, quality of life, and health for all are shaped by interdependent social, economic, environmental, genetic, behavioral, and health care factors, and will require robust national and community-based actions and dependable resources to achieve it.

Mission:
The IOM Roundtable on population health improvement intends to catalyze urgently needed action toward a stronger, more healthful, and more productive society. The roundtable will therefore facilitate sustainable collaborative action by a community of science-informed leaders in public health, health care, business, education and early childhood development, housing, agriculture, transportation, economic development and nonprofit and faith-based organizations.
BUILDING SUSTAINABLE FINANCING STRUCTURES FOR POPULATION HEALTH (AND ITS DETERMINANTS)

RESOURCES/READINGS

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Big-picture

- Bridging for Health: Improving Community Health Through Innovations in Financing Booklet at http://ghpc.gsu.edu/bfhfinancingbooklet/
  “Numerous financing innovations are emerging in both public and private sectors. Foundations are funding initiatives like AHEAD (Alignment for Health Equity and Development) and SCALE (Spreading Community Accelerators Through Leaning and Evaluation). Bridging for Health is aiding communities in the pursuit
of financing mechanisms that rebalance and align investments in health. Private equity investors are participating in Pay for Success arrangements. Federal and state governments are also stimulating innovation through the Center for Medicare & Medicaid Innovation, which is launching 60-plus initiatives.”


  On October 17, 2016, Leavitt Partners releases “‘Measuring Total Investments in Health: Promoting Dialogue and Carving a Path Forward,’ a landscape assessment of research and discussions related to total spend on health, which is defined as health expenditures that extend beyond traditional clinical care costs or total cost of care measures to include costs related to the social determinants of health.”

  “Two key findings from the assessment include:
  - The value of total spend on health analyses is that they help reframe the issue of what produces health to consider more than just medical spend.
  - Despite the growing interest in total spend on health research, challenges in establishing consistent definitions and methodologies in total spend on health research have resulted in disparate calculations, potentially limiting future work.

  Leavitt Partners offers four steps for advancing the concept of total spend on health and encourages thought leaders and researchers engaged in measuring total investments in health to look for opportunities for increased collaboration to enable greater consistency.”


Innovative, sustainable funding structures in non-health & health sectors

Environment, energy, and housing


- *National Housing Trust/Enterprise. R Street Apartments: Green Affordable Housing Preservation in the Heart of Washington, DC. Fact Sheet.


- *National Housing Trust, Inc. Affordable Housing and Health. Fact Sheet.


- Video of Denise Fairchild speaking about energy democracy (from New Economy Coalition) [https://www.youtube.com/watch?v=uE8FWors3TU](https://www.youtube.com/watch?v=uE8FWors3TU) (accessed October 15, 2016).

**Justice reinvestment**

  - Check out the graphic showing how the resource piece fits into the policy initiative.
- Oregon Justice Reinvestment website—data and metrics on the categories of programming supported by JR including transition services, skill building (GED and employment support), treatment services: [http://www.oregon.gov/cjc/data/Pages/jri.aspx](http://www.oregon.gov/cjc/data/Pages/jri.aspx)
According to this report, states in Fiscal Year 2010 were expected to collect $25.1 billion in revenue from the tobacco settlement and tobacco taxes, but are spending just 2.3 percent of it — $567.5 million — on tobacco prevention and cessation programs (the states also receive $62 million in federal grants for tobacco prevention, for total funding of $629.5 million). In the past year, states have cut funding for tobacco prevention by $103.4 million – more than 15 percent.

- Multiple references, http://publichealthlawcenter.org/topics/tobacco-control/tobacco-control-litigation/master-settlement-agreement

**Flexible funding models: public and public-private**

- Sustainable Investments in Health: Prevention and Wellness Funds


- Trust for America’s Health. 2016. Sustainable Funding for Healthy Communities Local Health Trusts: Structures to Support Local Coordination of Funds. http://files.constantcontact.com/81a3f1bb201/7605f7ef-5435-4b42-9786-cb0e61fa5754.pdf

$100M Chicago Fund to Help Investors Make a Positive Impact.  
https://nextcity.org/daily/entry/100m-chicago-fund-benefit-chicago-impact-investors  
(accessed September 24, 2016).

“We expect Benefit Chicago will have the capacity to put 15-year money on the street, which we think is fantastic,” Holmes adds. All Benefit Chicago investments will be in the form of debt or equity; no grants will be made out of the fund.”

This is an attempt to redirect capital from conventional investments to place-based impact. The sources are a mix of philanthropies and donor advised funds, with a relatively long time horizon.

Models and Best Practices: State & Local Investments  

includes more than a dozen examples of investments in community economic development, including Alaska Permanent Fund Corporation (APFC). Website.  
http://www.apfc.org/home/Content/aboutAPFC/aboutAPFC.cfm  
(accessed September 23, 2016)

APFC is a state-owned corporation, based in Juneau, that manages the assets of the Alaska Permanent Fund and other funds designated by law, such as the Alaska Mental Health Trust Fund.

Title IV-E California Well-Being Project  
http://www.childsworld.ca.gov/PG1333.htm

The California Well-Being Project provides participating counties with the flexibility to invest existing resources more effectively in proven and innovative approaches that better ensure the safety of children and the success of families. This flexibility enables the opportunity to reinvest resources into more cost efficient approaches that achieve better outcomes.

Reinvesting by the health sector; health care delivery reform & population health

Democracy collaborative. Engaging with eds, meds, and other anchor institutions to help them help communities. Website.  
http://democracycollaborative.org/democracycollaborative/anchorinstitutions/Anchor%20Institutions

State Levers to Advance Accountable Communities for Health.  
http://www.nashp.org/state-levers-to-advance-accountable-communities-for-health/


Could "Loose Change" from Medicaid Managed Care Help to Fuel Population Health Efforts? http://newsatjama.jama.com/2015/06/24/jama-forum-loose-change-for-population-health/


Can Hospitals Heal America's Communities: “All in for Mission” is the Emerging Model for Impact http://democracycollaborative.org/content/can-hospitals-heal-americas-communities-0

Hospitals Aligned for Healthy Communities http://hospitaltoolkits.org/?mc_cid=c922514de2&mc_eid=77b8e17464


Vielkind, J. (2012, August 7). Health officials: invest savings. $10B saved through changes to Medicaid program would be used for other state services. Times Union (Albany) http://www.timesunion.com/local/article/Health-officials-invest-savings-3767222.php


-- The Whole Person Care Pilot "will allow Medi-Cal (California’s Medicaid program) to pay for additional services for low-income people who incur high costs due to their health conditions. The services will include assistance in accessing physical and behavioral health services, housing, food, and other social supports. It’s an unprecedented opportunity to effectively address primary causes
of illness and to reduce our reliance on the criminal justice system as our principal response to mental health and substance-use issues."

Accounting practices


National economic policy


- National Priorities Project. Web page offers dimensions of national economic policy 101 – on the racial wealth gap, the meaning of the estate tax, why federal spending on prisons matters and should be understood by all, etc. https://www.nationalpriorities.org/


  If my calculations are correct, we can end child poverty for $62 billion per year. Is that a lot? No, it’s not. It’s $578 per non-poor family — but (if Twitter analytics are to be believed) my typical reader will pay less because I’ll put it on a sliding scale for you.


Overview portals for innovations in financing population health

- Financing Regional Health Transformation: A Primer for Changemakers http://www.rethinkhealth.org/financing
Loans and community development financing

  [http://content.healthaffairs.org/content/30/11/2042.abstract](http://content.healthaffairs.org/content/30/11/2042.abstract)
- Equity with a Twist
- St. Louis Finally Gets a Regional Community Development System

Taxes & tax credits

- Center for Economic Progress. (2016). *Rethinking the EITC.*
  [http://www.economicprogress.org/content/rethinking-eitc](http://www.economicprogress.org/content/rethinking-eitc) (accessed October 11, 2016).
- King County Best Starts for Kids Levy
  [http://beststartsforkids.com/about/](http://beststartsforkids.com/about/); and
- Healthy Diné Nation tax
- What Philadelphia's Soda Tax Can Teach Us About Health Framing

**Legal settlements**
- Public Health Trust (using litigation settlement funds to improve public health)
  [http://www.phi.org/focus-areas/?program=public-health-trust](http://www.phi.org/focus-areas/?program=public-health-trust)

**Bonds**

**Business models that aim to expand opportunity**
- Why Chobani Gave Employees A Financial Stake In Company's Future
- Homeboy Industries (trains and employs previously incarcerated individuals)

**Organizational strategy**
- Creating value from long-term bets -
Making multifamily homes healthy and affordable through energy efficiency

Affordable rental housing is critical for low income Americans, but many apartments are in need of repair and come with higher energy bills. Increasing the energy efficiency of rental housing saves energy, improves resident health, and maintains reasonable rents. This helps families, communities, and affordable building owners. Additionally, many states require utilities to invest in energy efficiency. Improving the efficiency of these apartments helps utilities meet their mandated goals.

The mission of the Energy Efficiency For All project (EEFA) is to link the energy and housing sectors together in order to tap the benefits of energy efficiency for millions of poor Americans. We work with a range of partners in twelve states to promote effective utility energy efficiency programs for all affordable building owners, and ensure healthy and inexpensive housing for residents.

Before the renovations at Galen, we constantly had to worry about fixing our thermostat to make the room comfortable... All of these things help me save money. I don’t have to worry about health problems associated with my unit or even think about out of control bills for utilities. It’s great!

Dewitt, Galen Terrace Resident

1 18 MILLION Number of American households living in buildings with 5+ apartments.
1 15% Amount spent by low-income families on energy bills (compared to 2% by high-income).
1 6.2 MILLION Number of low-income Americans with asthma.
1 $3 BILLION Annual energy savings in 2020 from more efficient multifamily buildings.

1 Galen Terrace’s 84 families banded together to secure energy efficiency renovations to their aging building. Residents have seen 60% electricity savings and 20% water savings.
Everyone benefits from investments in energy efficiency in affordable multifamily housing

**UTILITIES** - Helps meet efficiency goals and improves services to customers most in need.

**BUILDING OWNERS** - Reduces operating costs which frees up capital for maintenance and increases asset value.

**RESIDENTS** - Saves money through lower energy bills and creates healthier, comfortable living environments by improved unit upkeep.

**COMMUNITY** - Increases spending on non-energy necessities by residents, creates local jobs and preserves affordable rents.

---

**TO SEIZE THIS OPPORTUNITY, ENERGY EFFICIENCY FOR ALL IS WORKING WITH PARTNERS TO:**

- Provide technical resources for regulatory filings and utility program design
- Build state-based coalitions and connect them into a national network
- Connect, educate and support stakeholders to boost capacity and influence
- Inform the public and policymakers about energy efficiency and its many benefits
- Share lessons and best practices among networks
- Support affordable building owners in their pursuit of efficiency retrofits

---

**COLLABORATION AMONG A DIVERSE SET OF STAKEHOLDERS IS CRITICAL TO OUR SUCCESS:**

We are bringing together utilities, public utility commissions, state and local housing agencies, lenders, community organizers, elected officials, the multifamily building sector, the affordable housing community and the energy efficiency industry — so that we speak one another’s language, understand each other’s limitations and capabilities, and find the intersection of our respective goals.

If you would like to work with us, please email info@EE4A.org.

---

**ABOUT THE ENERGY EFFICIENCY FOR ALL PROJECT**

We are a partnership of organizations blending expertise in affordable housing, energy efficiency, finance, building owner and utility engagement. We work closely to support local groups by bringing tools and resources that help increase energy efficiency in affordable multifamily homes.

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**www.EE4A.org**
R Street Apartments: Green Affordable Housing Preservation in the Heart of Washington D.C.

DEVELOPER: NHT/Enterprise and Hampstead Co.
LOCATION: Washington, DC
BUILDING TYPES: Residential
PROJECT TYPE: Affordable Housing Preservation

PROJECT COST: $24.5 million
NUMBER OF UNITS: 124
COMPLETION DATE: April 2009
CERTIFICATIONS: Enterprise Green Communities

NHT/Enterprise and the Hampstead Companies partnered to acquire, preserve and improve 124 units of affordable housing and add 6 additional market rate rental apartments in the highly-desirable location of Logan Circle.

Through a resourceful three-tiered development approach to affordable housing, R Street has greatly impacted the community by adding to the affordable housing stock and improving the immediate social and economic fabric of the residents, setting new standards for affordable housing “best practices,” employing cost-effective and innovative designs through energy efficiency and sustainable development, offering outstanding social services for residents, receiving broad community support from local and federal government officials, demonstrating savvy development standards and exemplifying the importance of cost-effective and long-term affordable housing. R Street’s $24.5 million acquisition and renovation was completed in April 2009.

In 2009 the development team recognized the chance to not only improve the physical needs of the property but to also reduce operating expenses and improve the health of its residents. And in 2012, NHT/Enterprise worked with the D.C. Sustainable Energy Utility to perform a tune-up to the building.

**ENERGY EFFICIENCY STRATEGIES**

**Electrical**
- Energy Star high efficiency refrigerators
- Energy Star programmable thermostats
- High efficiency split system HVAC units, minimum 13 SEER
- High efficiency water heaters in all units
- Compact Fluorescent Lightbulbs (CFL) in all units and common areas
- Daylighting sensors on exterior security, perimeter and parking lot lights
- Energy efficient LED exit signs in all common corridors
- Water heater and hot water supply insulation

**Building Envelope**
- New roofing installed with high insulation value and solar reflective covering (R-30)

**GREEN STRATEGIES**

In order to further provide a healthy living environment at R Street Apartments and improve the quality of life there, the following green measures were incorporated:
- Water reducing, low-flow (1.5 gpm) shower heads, lavatory faucets, and kitchen sinks
- Low-flow toilets
- Permeable Pavers
- Rain barrels at all downspouts
- Non-toxic paints, adhesives, sealers, floor-coverings and wall-coverings
- Non-toxic paints and paints
- Green Label Certified Carpets
- Optimal use of other alternative and sustainable building products, including recycled content products
- Relating to site work; erosion control and stormwater management measures
## R STREET APARTMENTS - GREEN COSTS 2007

**PREDEVELOPMENT COSTS**
- Green Development Specialist: $10,500.00
- Engineer/Energy Auditor Review: $5,000.00
- Landscape Architect or Arborist: $800.00
- Other: $0.00

**TOTAL PREDEVELOPMENT**: $16,300.00

**CONSTRUCTION COSTS**
- Green Construction Items:
  - Energy star refrigerators: $7,000.00
  - Green seal interior paints and primers: $12,690.00
  - Special adhesives, sealers & primers: $19,690.00
  - Toilet Replacement: $12,400.00
  - Recycling of construction waste: $3,750.00
  - Using Material with recycled content: $6,500.00
  - Using certified, salvaged or engineered wood: $11,000.00
  - Energy star light fixtures: $9,500.00

  **Subtotal Group 1**: $19,690.00

- Rain Barrels for downsputs: $6,000.00
- Insulate cold water pipes under sinks: $0.00

  **Subtotal Group 3**: $6,000.00

- Label all storm drains or inlets: $300.00
- Energy star reflective roofing: $300.00

  **Subtotal Group 4**: $300.00

**TOTAL CONSTRUCTION COSTS**: $71,140.00

**OTHER COSTS**
- Post Rehab Property Testing by Energy Auditor: $3,500.00
- Preparation of Owner's Manual: $1,200.00
- Other: Green Home Guide for Residents: $2,700.00

**TOTAL OTHER COSTS**: $7,400.00

**TOTAL GREEN COSTS**: $94,840.00

**TOTAL PROJECT COSTS**: $24,766,224

**GREEN % OF TOTAL PROJECT COSTS**: 0.38%
EMO Energy Solutions, LLC used the Energy Gauge software to project energy usage and savings for each unit type in the R Street Apartments project. Average savings for all unit types is 19% with individual unit savings ranging from 12% to 39%. A summary table is provided below along with a graphical presentation. Additionally, EMO is providing a pivot table containing the output data capable of generating a variety of graphs for presentation.

<table>
<thead>
<tr>
<th>Apartment Type</th>
<th>Base KWH</th>
<th>Base Cost</th>
<th>Improved KWH</th>
<th>Improved Cost</th>
<th>% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A - East Middle</td>
<td>10,374</td>
<td>$ 809.00</td>
<td>8,973</td>
<td>$ 687.00</td>
<td>15%</td>
</tr>
<tr>
<td>Type A - East Top</td>
<td>10,950</td>
<td>$ 854.00</td>
<td>9,109</td>
<td>$ 701.00</td>
<td>18%</td>
</tr>
<tr>
<td>Type A - West Middle</td>
<td>10,639</td>
<td>$ 829.00</td>
<td>9,443</td>
<td>$ 728.00</td>
<td>12%</td>
</tr>
<tr>
<td>Type A - West Top</td>
<td>10,811</td>
<td>$ 843.00</td>
<td>9,078</td>
<td>$ 698.00</td>
<td>17%</td>
</tr>
<tr>
<td>Type B - East Middle</td>
<td>8,577</td>
<td>$ 669.00</td>
<td>7,329</td>
<td>$ 563.00</td>
<td>16%</td>
</tr>
<tr>
<td>Type B - East Top</td>
<td>8,888</td>
<td>$ 693.00</td>
<td>7,452</td>
<td>$ 573.00</td>
<td>17%</td>
</tr>
<tr>
<td>Type B - West Middle</td>
<td>8,793</td>
<td>$ 686.00</td>
<td>7,630</td>
<td>$ 586.00</td>
<td>15%</td>
</tr>
<tr>
<td>Type B - West Top</td>
<td>9,431</td>
<td>$ 735.00</td>
<td>7,480</td>
<td>$ 575.00</td>
<td>22%</td>
</tr>
<tr>
<td>Type C - Middle</td>
<td>9,927</td>
<td>$ 774.00</td>
<td>8,492</td>
<td>$ 654.00</td>
<td>16%</td>
</tr>
<tr>
<td>Type C - Top</td>
<td>10,393</td>
<td>$ 810.00</td>
<td>9,067</td>
<td>$ 699.00</td>
<td>14%</td>
</tr>
<tr>
<td>Type D - Middle</td>
<td>8,509</td>
<td>$ 664.00</td>
<td>7,322</td>
<td>$ 563.00</td>
<td>15%</td>
</tr>
<tr>
<td>Type D - Top</td>
<td>9,108</td>
<td>$ 710.00</td>
<td>7,960</td>
<td>$ 611.00</td>
<td>14%</td>
</tr>
<tr>
<td>Type G - Middle</td>
<td>10,889</td>
<td>$ 850.00</td>
<td>9,347</td>
<td>$ 521.00</td>
<td>39%</td>
</tr>
<tr>
<td>Type G - Top</td>
<td>11,343</td>
<td>$ 884.00</td>
<td>9,508</td>
<td>$ 733.00</td>
<td>17%</td>
</tr>
<tr>
<td>Basement 1432</td>
<td>13,672</td>
<td>$ 1,068.00</td>
<td>10,592</td>
<td>$ 819.00</td>
<td>23%</td>
</tr>
<tr>
<td>Basement 1416 1428 - 1 Rear</td>
<td>13,186</td>
<td>$ 1,028.00</td>
<td>10,387</td>
<td>$ 802.00</td>
<td>22%</td>
</tr>
<tr>
<td>Basement 1416 1428 - 2 Side</td>
<td>12,130</td>
<td>$ 946.00</td>
<td>9,566</td>
<td>$ 738.00</td>
<td>22%</td>
</tr>
<tr>
<td>Basement 1440 - 1 Rear</td>
<td>12,966</td>
<td>$ 1,011.00</td>
<td>10,025</td>
<td>$ 774.00</td>
<td>23%</td>
</tr>
<tr>
<td>Basement 1440 - 2 Side</td>
<td>12,111</td>
<td>$ 944.00</td>
<td>9,561</td>
<td>$ 738.00</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$15,807.00</td>
<td>$12,763.00</td>
<td></td>
<td></td>
<td><strong>19%</strong></td>
</tr>
</tbody>
</table>
Affordable housing helps improve the health of renters by freeing up limited financial resources for nutritious food, health care, and prescriptions.

Stably housed children show lower levels of depression and developmental delays than homeless children.

Energy efficient affordable housing reduces exposure to hazardous materials and airborne toxins.

Housing, Health and Savings

A retrofit by Southwest Minnesota Housing Partnership lead to annual energy savings of $118/unit and eliminated adult cases of chronic bronchitis.

Hospital stays cost $1,900/day.
Supportive housing costs only $30/day.

A one year stay in a nursing home funded by Medicaid costs about $50,000. A one year stay in elderly housing with supportive services would cost only $25,000.

Mission Creek Apartments in San Francisco is owned by Mercy Housing. It is home to 50 elderly residents who were relocated from a city-run nursing home. By providing affordable housing and adult day care, Mission Creek has improved the quality of residents’ lives. It has also saved the city $29,000 per resident per year in health care costs, with annual savings to the city totaling $1.45 million.

For more reasons why we preserve:
http://www.nhtinc.org/why_preserve_affordable_homes.php

For more on housing and health see Center for Housing Policy’s Insights from Housing Policy Research Series:
http://www.nhc.org/vital_links.html

Steven C. Teske, MA, JD

Steven C. Teske, MA, JD, is Judge, Juvenile Court of Clayton County, Jonesboro, Georgia, USA.

PROBLEM: School officials throughout the United States have adopted zero tolerance policies to address student discipline, resulting in an increase in out-of-school suspensions and expulsions. The introduction of police on school campuses also increased the referral of students to the juvenile courts. Although school personnel generally view zero tolerance policies as a constructive measure, this approach denies recent research on adolescent brain development that mischief is a foreseeable derivative of adolescence.

METHODS: A case study method examined one juvenile court’s innovative multi-integrated systems approach related to the adverse trends associated with zero tolerance policies.

FINDINGS: A multi-disciplinary protocol resulted in more effective youth assessments that reduced out-of-school suspensions and school referrals; increased graduation rates by 20%; and decreased delinquent felony rates by nearly 50%. The resulting protocol changed how the system responds to disruptive students by significantly reducing out-of-school suspensions and school referrals, and putting into place alternatives as well as providing community resources to address the underlying causes of the behavior.

CONCLUSION: A multi-systems approach that targets the reasons for disruptive behavior improves student educational and behavioral outcomes.

Public education in the United States is replete with inequalities that are defined along racial, ethnic, and socioeconomic lines. These inequalities more often than not produce lower graduation rates contributing to higher rates of criminality among our youth (Mendez, 2003). Recent educational policies have exacerbated the problem with the advent of standardized and mandated graduation tests. As many as 58% of minority students in the ninth grade do not graduate (Wald & Losen, 2003). Despite the overwhelming data reflecting the adverse impact of these inequalities and testing standards, there appears to be little to no effort among policy makers to ameliorate the problem. On the contrary, it appears that policy makers, in an attempt to address school discipline using a zero tolerance approach, have increased the racial and ethnic gap while simultaneously widening the net to include students with diagnosable mental health problems (Skiba et al., 2006). Recent research indicates the ineffectiveness of zero tolerance strategies in secondary public schools, how such strategies are harmful to children, and how such policies actually increase risks to school and community safety.

Using a systems model, it is revealed that school systems in general are limited in their resources to adequately respond to disruptive behavior, creating an overreliance on zero tolerance strategies. The purpose of this article is to show the importance of connecting the school system with other systems serving students to assess disruptive students and access alternative modalities to treat the underlying reasons for the disruptive behavior that can reverse the negative outcomes of zero tolerance.

Literature Review: the Problem With Zero Tolerance Policies

Definition of Zero Tolerance

The history and etymology of the term “zero tolerance” can be traced back to the 1980s during State and Federal efforts to combat drugs, or what became known during the 1980s as the “war on drugs.” It was not long before the term was applied to various subjects, including environmental...
pollution, trespassing, sexual harassment, to name a few. Arguably, its widespread application to minor offenses can be attributed to the "Broken Windows" theory of crime (Kelling & Coles, 1997). This theory analogizes the spread of crime to a few broken windows in a building that go unrepaired and consequently attract vagrants who break more windows and soon become squatters. The squatters set fires inside the building, causing more damage or maybe destroying the entire building. The broken windows theory argues that communities should get tough on the minor offenses and clean up neighborhoods to deter serious crimes. Thus, it becomes necessary to punish minor offense violators.

By the early 1990s, school systems began to adopt this "Broken Windows" approach, or zero tolerance, for minor school infractions by suspending students for up to 10 days. These infractions typically involved fighting, disruption in school, and smoking. This is evident in the near doubling of students suspended annually from 1.7 million in 1974 to 3.1 million in 2001 (Poe-Yamagata & Jones, 2000). The most incongruent use of out-of-school suspension (OSS) is for truancy infractions. Suspending a student who does not want to attend school is illustrative of the inherent problems with zero tolerance policies, and has led some to refer to zero tolerance as "zero intelligence" or "zero evidence" (Richardson, 2002).

Considering its origin and use over the years, zero tolerance can best be defined as a “philosophy or policy that mandates the application of predetermined consequences, most often severe and punitive in nature, that are intended to be applied regardless of the seriousness of behavior, mitigating circumstances, or situational context” (Skiba et al., 2006). The severity and punitive nature of zero tolerance practices escalated with the placement of police on school campus, resulting in a considerable increase in the number of students arrested and referred to juvenile court for infractions once handled by school administrators. The study of this occurrence has been referred to as the “school-to-prison pipeline” (Wald & Losen, 2003).

Within the context of school discipline, zero tolerance policies operate under the assumption that removing disruptive students deters other students from similar conduct while simultaneously enhancing the classroom environment. As the research below shows, this assumption fails to consider various factors that impede the zero tolerance policy goal of maintaining a safe and disciplined learning environment.

### Effects of Zero Tolerance Approaches

Zero tolerance policies are generally viewed by school systems as a viable approach to school discipline to maintain safe classrooms. However, professionals in other related fields such as mental health, social services, and the courts have begun to question the effectiveness of these policies, resulting in various studies on the matter. The studies to date show that zero tolerance strategies have not achieved the goals of a safe and disciplined classroom. On the contrary, some studies suggest that such strategies are harmful to students and may make schools and communities less safe (Wald & Losen, 2003).

### School as a Protective Factor

Students bring to school their unique individual and environmental characteristics, some of which may produce negative behaviors (Barber & Olsen, 1997). Negative characteristics are referred to as risk factors that, if untreated, may lead to disruptive conduct, delinquency, and even more negative behaviors.

The risk principle, as used in the field of corrections, has useful application in understanding the ineffectiveness of zero tolerance policies within the school setting. In the context of juvenile justice, risk is defined as a child’s probability to commit a crime, or to re-offend. Studies consistently show that factors predicting the risk of delinquent behavior include antisocial attitudes, associates, personality, and a history of antisocial behavior (Andrews & Bonta, 1998). Other risk factors include substance abuse and alcohol problems, family characteristics, education, and employment (Gendreau, Little, & Goggin, 1996). The importance of assessing risk factors is reflected in studies showing that intensive interventions are required in high-risk youth to reduce recidivism. Conversely, studies show that intensive interventions applied to low-risk youth increase the risk of re-offending (Andrews, Bonta, & Hoge, 1990). Today, many juvenile justice systems use an objective risk assessment, a tool that measures the child’s risk to re-offend, to determine which offenders are in need of intensive supervision and treatment. Without it, many low-risk youth would be harmed by too much intervention.

Because being in school is a protective factor against delinquent conduct (U.S. Department of Health and Human Services, 2001), suspending and removing students from school for normal teenage behaviors is counterproductive. Besides being counterproductive, suspension increases the risk of antisocial and delinquent behaviors. Zero tolerance policies apply sanctions across the board regardless of the risk level of the student. Studies have found that disciplining harshly with OSS and criminal sanctions regardless of the risk level of the student exacerbates the problem by making students worse (Andrews & Bonta, 1998; Mendez, 2003). A longitudinal study on the disciplining of elementary and middle school students found that OSS is a predictor of future suspensions (Mendez, 2003). The study also found that OSS contributes to poor academic performance and failure to graduate.

The research shows that students handled by punishment alone are less likely to succeed (Mendez, 2003). This finding is the same for youth in the correctional setting; that is, the
The use of punishers to modify behavior increases the risk of re-offending (Andrews, Bonta, & Wormith, 2006; Lowenkamp & Latessa, 2004).

The Surgeon General’s report on youth violence indicated that a child’s connection to school was one of only two protections against risk factors for violence (U.S. Department of Health and Human Services, 2001). Other studies found that students’ belief that adults and peers in school care about them is related to lower levels of substance abuse, violence, suicide attempts, pregnancy, and emotional distress (McNeely, Nonnemaker, & Blum, 2002). Studies also reveal that this belief, referred to as school connectedness, is linked to school attendance, graduation rates, and improved academics (Rosenfield, Richman, & Bowman, 1998; Battin-Pearson et al., 2000).

The research shows that students who disrupt are typically not assessed to determine the reasons for the behavior (Mendez, 2003). The failure of schools to assess disruptive students may be explained by the goal of zero tolerance policies, which focus solely on punishment as a tool to modify behavior and which minimize the need to ask why a student is disruptive.

**Mental Health**

Although there have been less data collected regarding the impact of zero tolerance on students with diagnosable mental health disorders, a report by the American Psychological Association Zero Tolerance Task Force stated that “students with disabilities, especially those with emotional and behavioral disorders, appear to be suspended and expelled at rates disproportionate to the representation in the population” (Skiba et al., 2006). Studies of youth with mental health disorders in the juvenile justice system support this position of the task force. A report of the Surgeon General found higher rates of mental disorders among the youth in the juvenile justice system (U.S. Department of Health and Human Services, 2002). The Texas Youth Commission (TYC) reported a 27% increase in the number of youth with mental disorders entering the juvenile justice system between 1995 and 2001 (Reyes and Brantley, 2002). In 2001 alone, the TYC reported that 67% of the intakes were for nonviolent offenses (Reyes & Brantley, 2002). School systems have become the greatest feeder of the youth into the system since the inception of zero tolerance policies (Rimer, 2004).

Children with mental or emotional disorders are prone to have academic difficulties, and are less likely to succeed if subjected to suspension and expulsion. One study found that 73% of youth with serious emotional disorders who did not graduate were arrested within 5 years (Garfinkle, 1977; Wagner et al., 1991). It is estimated that juvenile justice facilities are three to five times more likely to have youth with emotional disabilities than public schools (Leone & Meisel, 1997).

Arguably, the greater number of youth with emotional disabilities in the juvenile justice system is the result of the school-to-prison pipeline effect caused by zero tolerance policies. These studies support the “school-to-prison pipeline” theory which posits that zero tolerance policies increase dropout rates, leading to higher rates of arrest for this population (Wald & Losen, 2003).

**Racial and Ethnic Disparity**

Minority youth are disproportionately suspended and referred to court on school-related offenses. Black students are 2.6 times as likely to be suspended as White students (Wald & Losen, 2003). For example, in 2000, Black students represented 17% of the student population yet represented 34% of the suspended population (Wald & Losen, 2003).

According to the Zero Tolerance Task Force of the American Psychological Association, there is no evidence connecting the disparity to poverty or assumptions that youth of color are prone to disruptive and violent behavior (Skiba et al., 2006). On the contrary, studies indicate that overrepresentation of Black students is related to referral bias on the part of school officials (Skiba, 2000).

This disproportionate minority suspension is related to the racial and ethnic disparities in the juvenile justice system, thereby lending additional support to the “school-to-prison pipeline” argument; that is, removing students from positive learning environments and criminalizing normative immaturity increases the risk of incarceration (Skiba, 2000). For example, in 1998 Black youths with no prior criminal history were six times, and Latino youths three times, more likely to be incarcerated than White youths for the same offenses (Poe-Yamagata & Jones, 2000). Although youth of color make up one-third of the adolescent population, they represent two-thirds of all the youth detained in secure facilities (Poe-Yamagata & Jones, 2000).

Another evidence in support of the “school-to-prison pipeline” effect is the considerable number of adult inmates that have not graduated high school. In 1997, 68% of state prisoners had not graduated (Sentencing Project, 1997). One study found that suspension and expulsion is the most significant contributing factor for subsequent arrest among adolescent females (American Bar Association & The National Bar Association, 2000).

**Adolescent Brain Research**

The most pressing reason that zero tolerance policies are not an effective means of modifying disruptive behavior is that it disregards all adolescent brain development research. Zero tolerance strategies ignore the unrefined skills associated with an adolescent’s developmental capacity to manage emotions and conflicts. Recent adolescent brain research using...
magnetic resonance imaging (MRI) found that the frontal lobe of the brain, which filters emotion into logical response, is not fully developed until about age 21 (Giedd et al., 1999). Youth generally rely on parts of the brain that generate emotions because the frontal lobe is not developed. As described by medical researcher Dr. Deborah Yurgelun-Todd of Harvard Medical School, “one of the things that teenagers seem to do is to respond more strongly with gut response than they do with evaluating the consequences of what they’re doing” (American Bar Association, Juvenile Justice Center, 2004). Youth are biologically wired to exhibit risk-taking behaviors, impulsive responses, and exercise poor judgment.

The implications of these MRI studies are relevant to how punishment should be applied in secondary schools as well as what should be done to improve the social, emotional, and academic outcomes for the youth. A zero tolerance policy that results in the suspension and/or arrest of students for behavior that is neurologically normative at this age can exacerbate the existing challenges facing the youth. Their developmental immaturity strongly implies that youth are still in a cognitive structuring stage. Youth are under neurological construction, and should be surrounded by positive adults, peers, and institutions to enable them to become responsible adults (Giedd et al., 1999). Dr. Jay N. Giedd, a brain imaging scientist, described the importance of how adults should manage the youth stating, “You are hard-wiring your brain in adolescence. Do you want to hard-wire it for sports and playing music and doing mathematics—or for lying on the couch in front of the television?” (Weinberger, Elvevag, & Giedd, 2005).

Schools are positive institutions found to be a protective buffer against negative influences (U.S. Surgeon General, 2001). Zero tolerance policies that remove students who do not pose a serious threat to safety may very well be increasing the risk of negative outcomes for the student, school, and the community.

**Methodology: the Systems Model**

The common definition of a system is “a set of interacting components, acting interdependently and sharing a common boundary separating the set of components from its environment” (Bozeman, 1979). As shown in Appendix Figure 1, the systems model employed to analyze organizations includes inputs in the form of demands and supports from the environment, and outputs in the form of services or products generated internally by the organization back into the environment. Although there are a variety of techniques to analyze systems, the Linear Programming Model (LPM) is a good beginning toward understanding the juvenile justice system because it seeks to determine the desired outcomes by identifying the best available resources. Conceptually, the LPM finds “those values of \( x \), the variables that maximize the linear objective \( z \) while simultaneously satisfying the imposed linear constraints and the nonnegativity constraints” (Bozeman, 1979). For example, the goal of any system is to identify a desired outcome (i.e., outputs as shown in Appendix Figure 1) and improve or enhance the outcome. LPM engages systems on how to achieve their desired outcome by identifying supports to the system while simultaneously recognizing constraints that work against the acquisition of the desired outcome. Once identified, the system should develop strategies to increase the supports and decrease the constraints.

**Redefining Juvenile Justice System**

Upon application of this model to the juvenile justice system, it becomes clear from the start that the term “juvenile justice system,” if the term is intended as a system designed to achieve a desired outcome, does not have a “common boundary” as described in the definition of a system. Historically, juvenile justice systems have been defined as the juvenile court or a single bureaucracy commonly called a department of juvenile justice. Using a systems model, specifically LPM, a true definition of a juvenile justice system is much broader and encompasses multiple systems that must work in unison if the desired outcome is to be achieved.

For example, the desired outcome of a juvenile justice system is the reduction in recidivism. As discussed previously, the research shows that reducing recidivism requires the targeting of high-risk offenders and identifying their criminogenic or crime-producing needs using assessment tools and matching them with effective treatment modalities. These crime-producing needs, factors that promote antisocial behavior, include lack of nurturing and supervision at home (family), poor performance in school (education), lack of pro-social activities (recreation), substance abuse, antisocial cognition (attitudes, values, and beliefs), and antisocial associates (friends) (Andrews, Bonta, & Wormith, 2006). The problem is that each of these factors, in order to be effectively addressed, are linked to different organizations within the larger public system; that is, organizations with their own “set of interacting components, acting interdependently and sharing a common boundary separating the set of components from its environment.” Simply stated, these independent organizations, including social services, mental health, school system, juvenile court, and juvenile justice agency, operate in silos under separate budgets, policies, and operating procedures which together operate as a constraint. From a systems theory perspective, the problem is not only the “disconnect” in communication, but also the complex system with multiple points of entry with no clear exit (Buckley, 1967; Teske & Huff, 2010). Needless to say, a complex, disconnected system is inefficient, and worse, mystifying to youth and families having to navigate this “non-system” (Teske & Huff, 2010).
The Multi-Integrated Systems Theory, as shown in Appendix Figure 2, assumes that any desired outcome may be dependent on services provided by multiple organizations as opposed to a single entity. This is determined by assessing the desired outcome to find what variables are necessary to maximize the outcome using an LPM. If achieving the desired outcome is dependent on multiple systems, it becomes necessary to connect those systems using an integrated approach.

The Judicial Leadership Approach

Although various mechanisms may be employed to integrate multiple systems, Clayton County utilized the judicial leadership approach to bring relevant stakeholders together to develop written Memorandum of Understandings (MOUs) or protocols. Judicial leadership is the key within a juvenile justice system because the juvenile court is the common denominator of all child service agencies. The intersection of juvenile justice is the juvenile court, and the juvenile judge is the traffic cop (Teske & Huff, 2010). Of all stakeholders, juvenile judges possess the greatest influence, and it is hurtful to children in a disconnected system when judges fail to use that influence to connect the independent silos. As pointed out by former National Council of Juvenile and Family Court Judges president Judge Leonard P. Edwards (1992), “This may be the most untraditional role for the juvenile court judge, but it may be the most important.”

The key to winning the battle against this ineffective non-system is engaging the stakeholders to change the system to ensure needs assessments are conducted, to ensure delivery of a comprehensive continuum of care, and to fill gaps in service delivery. However, system change through collaboration requires written protocols to guarantee compliance and sustainability. Facilitating key stakeholders to develop protocols is the final role of the judge in creating an effective system of care for the youth.

The Collaborative Approach in Clayton County

Beginning in 2003, the juvenile judge in Clayton County brought stakeholders together to develop protocols to reverse the negative trends of zero tolerance policies. The research discussed previously, showing the correlation between suspensions, expulsions, and arrests and an increase in drop-out and recidivist rates, served as the blueprint for system integration using MOUs. For example, because the use of suspensions and arrests for minor infractions is associated with decreased graduation rates and increased juvenile crime, mechanisms were put in place to reduce suspensions and arrests and consequently keep students in school. Additionally, the mechanisms included appropriate assessment and treatment alternatives to address the disruptive behavior.

The stakeholders included the school superintendent, chief of police, directors of mental health and social services, and a community volunteer. The judge appointed a neutral person from outside the county to facilitate the discussion. The judge served in a limited capacity as the convener of the meetings. Initially, the group’s goal was to reduce referrals from all schools in Clayton County to the juvenile court, affecting approximately 52,000 students. As the meetings progressed, the discussion on how to reduce school referrals generated more questions. What are school administrators to do with these disruptive students no longer referred to the court? When should police intervene in school disruption matters? How do we identify the underlying problems causing the disruption? What do we do to address those problems given the limited capacity and resources of the schools? How do we ensure the safety of the schools? The collaborative process generated new and difficult questions that extended the time to develop a system to meet the goal. The judge convened the meetings at least twice a month, with the facilitator assigning tasks to each member between meetings. The process to develop a system for reducing referrals to the juvenile court took 9 months. Following cross-training of police, school administrators and other relevant personnel, mental health and social service providers, and court personnel, the newly developed system was implemented at the beginning of the 2004–2005 academic year.

The stakeholders agreed that two MOUs were required to accomplish a reduction in suspensions and arrests while simultaneously securing alternative treatment measures. The first MOU, titled the “School Reduction Referral Protocol,” called for the reduction in the arrests of students for certain misdemeanor offenses using a three-tier process. The student and parent received a warning on the first offense, a referral to a conflict resolution workshop on the second offense, and referral to the court on the third offense. The second MOU created a multidisciplinary panel to serve as a single point of entry for all child service agencies, including schools, when referring children, youth, and families at risk for petition to the court. The panel, called the Clayton County Collaborative Child Study Team (Quad C-ST), meets regularly to assess the needs of students at risk for court referral and recommends an integrated services action plan to address the students’ disruptive behavior. The panel consists of a mental health professional, the student’s school social worker and counselor, a social services professional, juvenile court officer, approved child service providers, and is moderated by a trained facilitator provided by the court. The panel linked the child and family to services in the community not available to the school system. The panel developed an array of evidence-based treatment programs such as functional family therapy, multisystemic therapy, cognitive behavioral programming, wrap-around services, and more. These professionals avoided the “overlapping” effect by targeting the mechanism to fund
Results

The findings of the studies highlighted in the literature review are also reflected in the data collected from Clayton County, GA. The data were collected using the Juvenile Court Automated Tracking System (JCATS). Data were entered into JCATS on each referral received from the school police, including the nature of the offense, the school, grade level, race, sex, and gender.

After police were placed on middle and high school campuses in the mid-1990s, the number of referrals to the juvenile court increased approximately 1,248% by 2004. Most of the referrals were misdemeanor offenses involving school fights, disorderly conduct, and disrupting public school, which are infractions previously handled in school with disciplinary measures. At the same time, the more serious felony offenses did not increase.

During these same years, the OSS numbers increased (Clayton County Public School System, 2010). As these numbers increased, the graduation rates decreased to 58% by 2003 (Clayton County Public School System, 2010).

Altogether, one-third of all delinquent referrals to the court were from the school system, and most were minor offenses (Clayton County Juvenile Court, 2010). These referrals contributed to an increase in probation caseloads averaging approximately 150 probationers per caseloads. The majority of the caseloads involved minor offenses and consisted of kids not considered a high risk to re-offend or a public safety risk.

Consequently, the high-risk and serious offenders were not adequately supervised because of the overwhelming number of probationers. In other words, resources were wasted on the youth who made us mad instead of concentrated on the youth who scared us. This resulted in high recidivist rates that compromised community safety.

By 2003, with referrals, probation caseloads, and recidivist rates increasing, and graduation rates decreasing, the system was under stress. It was time to evaluate how the system should respond to disruptive students in light of the research indicating that punishment alone, whether by suspension, expulsion, or arrest, exacerbates the problem for the students, schools, and the community. These findings demonstrate the importance of a dualistic approach in integrating community systems to reduce reliance on punitive measures while at the same time providing additional resources for school systems to assess and treat disruptive students. As shown in Figure 3, following the School Referral Reduction Protocol, referrals to the court were reduced by 67.4%. By distinguishing felonies and misdemeanors, we see that the school police spent most of their time arresting students for low-level offenses. The implementation of the protocol produced a residual effect in the felony referral rate with a decrease of 30.8%. According to school police, the warning system was used for some felony offenses involving typical adolescent behavior. The decision by school police over time to extend their discretion to use the warning for certain offenses outside the scope of the protocol indicates a shift in cognition; that is, understanding that discipline should be applied on a case-by-case basis. This resulted in greater reductions in referrals.

After the protocol was implemented, the number of students detained on school offenses was reduced by 86%. The number of youth of color referred to the court on school offenses was reduced by 43%.

Another by-product of the protocol was a reduction in serious weapons on campus by 73%. These involve weapons outside the discretion of police and must be referred to the court by law. At the same time, the School Referral Reduction Protocol went into effect; the Quad C-ST began work to develop alternatives to OSS and connect the school system with other community providers. These alternatives resulted in an 8% decrease in middle school OSS (Clayton County Public School System, 2010).

After implementing these integrated systems, the school system observed a gradual increase in graduation rates, resulting in a 20% increase by the end of the 2009 school year, which surpassed the statewide average. By 2004, the juvenile felony rate in Clayton County reached an all-time high, but declined 51% after creating the integrated systems.

Discussion: Implications for Mental Health Professionals

The results support the research that overuse of suspension and court referrals decreases graduation rates and is counterproductive in promoting school and community safety. The results also support the research that chronically disruptive students should be assessed to determine the underlying causes of the disruptive behavior, and services provided to address the causes. The problem to date has been how to make this happen for school systems that are not equipped to conduct mental health assessments and provide mental health and other services. The results support a multi-integrated systems approach that creates a single point of entry in which schools may refer difficult students for assessment and treatment by appropriate providers. This allows schools to rely more on assessment and treatment instead of the traditional punishment approach which is ineffective if used alone to modify behavior among students with chronic disruptive behavior.
The results appear to refute the notion that zero tolerance policies promote school safety. On the contrary, the results reflect an increase in school safety with the decrease in weapons on school campus. A survey of school police to explain the significant decrease in weapons on campus indicated that the protocol, by significantly reducing the arrest rate, increased the presence of police on campus. This increased presence promoted a friendly engagement with students on campus, which was bolstered by the students’ change in perception of the police because they made fewer arrests. Consequently, police state that students share information that leads to solving crimes as well as crimes about to occur on campus. “Schools are a microcosm of the community” as stated by the supervisor of the school police unit (Richards, 2009). If one wants to know what is going on in the community, talk to the students. However, the students must want to talk to you. Therefore, the aim of school policing is to gather intelligence of student activity through student engagement.

The results suggest that graduation rates may be connected to serious juvenile crime in the community. Arguably, it could be posited that more students graduating from high school would lead to a reduction in the juvenile crime rate. The implications for mental health professionals working with adolescents to improve their school performance begin with an understanding that mental health professionals are at a disadvantage because of the inherent limitations of school systems to appropriately address those student behaviors that diminish the opportunity to graduate. Based on the case study of the Clayton County Public School System, which appears to mirror most school systems in the country, the lack of resources to assess and provide treatment for chronically disruptive students creates a greater demand for punishers in the form of suspensions, expulsions, and arrests. Thus, zero tolerance policies become the primary approach to address disruptive behavior absent other viable alternatives. Unfortunately, this approach avoids connecting students with services to change behavior and instead, through suspensions and arrests, oftentimes places students in settings that exacerbate the behavior, and further diminishes their chance to succeed.

Realizing that zero tolerance policies are a by-product of a multisystems failure, it would be contradictory to think that a mental health system will work in isolation to correct the problem. In that knowledge, this singular service provider failure becomes more apparent in families of poverty given their limitations to navigate the systems of care in their respective community. A study of families in poverty indicated that mental health service delivery “must be multifaceted with agency cooperation and collaboration as well as multidisciplinary teams” (Dashiff, DiMicco, Myers, & Shepard, 2009). Another reason is that the types of effective programs that promote pro-social behavior are best delivered in the home and school and not the sterile environment of a mental health office setting. For example, some effective approaches include communication skills, conflict resolution, social skills development, positive behavior reinforcement, engagement of parents, and school-based family therapy (Bruns, Moore, Stephan, Pruitt, & West, 2005).

This study further implies that no single system can adequately address disruptive behavior in the school setting. Although approximately 75% of all mental health service contacts occur in the schools, one study indicated that direct mental health service delivery in the school setting did not impact suspension rates (Bruns et al., 2005). The study did suggest that such delivery was difficult absent school policies to provide for alternatives to suspension. It is difficult to deliver treatment if the student is repeatedly suspended and/or arrested, causing disruption in service delivery. This implies, as does the study of Clayton County, that other systems such as social services, school police, prosecutors, and juvenile justice should be involved to help develop alternatives to suspensions and arrests.

Finally, and probably the most important implication, is the multisystems integration approach that employs a single point of entry to allow school systems to immediately access interventions to address the underlying causes of disruptive behavior. As this case study reveals, the multiple systems involved with adolescents, when brought together on a regular basis, guided by a written protocol with clear objectives, will enhance the effectiveness of mental health and other professionals while promoting a student’s academic performance.

References


Clayton County Juvenile Court. (2010). Juvenile Court Automated Tracking System. Canyon Services, Phoenix, AZ.


Appendix

Figure 1. The Systems Model (Adapted From Easton, 1957)

Figure 2. The Multi-Integrated Systems Model (Adapted From the Systems Model as Shown in Figure 1)

A desired output that is dependent on outputs from multiple systems must be integrated or connected as shown by the arrows to achieve the output.
**Figure 3.** Line Graph Showing the Increase in Referrals After Police Were Placed on Campus and the Decrease After the Protocol Became Effective in 2004