Working Age Group - Strategic Framework Development - as of 7/8/2021

Goals:	Objectives:	Strategy:	Activities	Inputs
What are the objectives, if completed, going to lead to? What measurable goals has the workgroup decided on to make sure that it meets the purpose of the group? These should be SMART goals.	*How are we going to implement our workgroup goals? How are the deliverables from the strategy going to be maintained?*	*What types of things do we need to develop to help met our objectives? What deliverables will we have after we perform the activities?*	*What steps need to happen to make sure that we can complete the strategy?*	*What do we need to make the activities happen?*
Goal 1:	**Objective 1**:	**Strategy 1A:**	**Activities**	**Inputs**
Improve Social Determinants of Health factors in Jefferson County. Increase housing capacity in Jefferson County by xx% by 2025 and reducing the percentage of residents below the poverty level by 2% by 2025 from 13% to 11%.	**Increase capacity of transitional supportive housing**	**Strategy 1A:** Coordinate with Bayside to assist in the creation of additional capacity for transitional supportive housing. **Metric:** Metric to be determined by Housing Task Force **Data Source:** Housing Task Force **Current State:** Get numbers from Housing Task Force	**1A.1** Assist Bayside to identify (and pursue) grant and RFP opportunities	Identify individual to act as point of contact and coordination. Metrics: Need current state numbers from Bayside
		Strategy 1B:	**Activities**	**Inputs**
		Strategy 1B: Coordinate with Pfeiffer House to support the current project to increase capacity at Pfeiffer House. Ensure that wrap around services are available to residents to support thier needs. **Metric:** Capacity at Pfeiffer (Currently 2 young adults, to be increased to 10-12 young adults. **Data Source:** Pfeiffer House	**1B.1** Collaborate with Pfeiffer House team to assess/articulate needs to increase capacity and support the development and execution an action plan.	Identify individual to act as point of contact and coordination. **Metrics:** Gather current state numbers from Pfeiffer House

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Goal 1:	**Objective 2**:	**Strategy 2A:**	**Activities**	**Inputs**
Improve Social Determinants of Health factors in Jefferson County: **Increase housing capacity in Jefferson County by xx% by 2025 and reducing the percentage of residents below the poverty level by 2% by 2025 from 13% to 11%.**	**Increase units of Workforce Rental Housing for working age adults.**	**Strategy 2A:** Develop a template/process to identify site(s), financing and other key components. The template process will be tested and refined in Jefferson County. This might include continued CHIP participation in existing housing work occuring in the community and continued support for strategies that support people staying in existing housing (loan support, utility support and other programs). **Metric:** - A template - Units of workforce rental housing **Data Source:** Locate Source **Current State:** 0% vacancy rate on rental housing in Jefferson County.	**2A.1** Organize workgroup to address this specific need for in-county rental housing. **Deliverables:** 1. A template/defined process to allow any non profit to develop workforce rental housing. 2. A workforce rental housing project in Jefferson County with little or no public financing. **2A1.1** Assemble a work group. The proposed workgroup would have persons able to market the objective to private foundations as a solution to affordable workforce housing needs across the US as well as persons experienced in the development process for affordable housing (predevelopment, financing, construction, and compliance). **2A1.2** Identify available sites. **2A1.3** Identify possible sources of private financing. **2A1.4** Market the concept to private foundations as an investment in a solution that would assist communities across the US in solving the workforce rental housing need	Available volunteers to work on project Private sources of funding.

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Goal 1:	**Objective 3**:	**Strategy 3A:**	**Activities**	**Inputs**
Improve Social Determinants of Health factors in Jefferson County. Increase housing capacity in Jefferson County by xx% by 2025 and reducing the percentage of residents below the poverty level by 2% by 2025 from 13% to 11%.	**Address poverty as a factor impacting working age residents of our community** 	**Strategy 3A:** Establish a construction trades training program for young adults in transitional and permanent supportive housing. **Metric:** Number of young adults in transitional or permanent supportive housing with a certificate of completion of training and employed in the construction industry. **Data Source:** ? **Current State:** Not available Are there other strategies that can help us address poverty?	**3A.1** Develop a curriculum outline with local contractors and subcontractors. **3A.2** Identify a training site (Pfeiffer House common area?) **3A.3** Identify volunteer trainers **3A.4** Seek grant opportunities e.g. Lowes **3A.5** Establish a job placement process for graduates (Contact Neil Nelson, who is a local contractor who hires persons in recovery for his business.) **Explore** how this framework crosswalks with AHT's 10-year Housing Plan and SDOH-Poverty	Identify individual to act as point of contact and coordination. **Metrics:** TBD

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Goal 2:	**Objective 1**:	**Strategy 1A:**	**Activities**	**Inputs**
By end of 2022, address county resident service needs effectively. Develop detailed plan to address service gaps for Medical and Behavioral Health care in Jefferson County by 2023	**Deploy available services cooperatively (medical, behavioral health, social, housing, employment) to address resident needs. Utilize the BSO to form collaborative partnerships that work together to reduce and eliminate care gaps in Jefferson County.**	**Strategy 1A:** Break down the current structure of resources and partnership to understand County resources available, and how they integrate with the medical and behavioral health system. **Metric:** Milestone goal plan in place by 2023	**1A.1** Poll community of providers for BH programs to identify funding sources for each Behavioral Health Provider and Program services to identify the range of hubs that need assessment. (funding sources include OCH, 1/10th of 1%, WASPC, ASO, Medicaid, MCO, Domestic Violence, Developmental Disability, recovery programs, etc.). Create an overview of services being funded **1A.2** Develop a model example that provides an overview of the County's behavioral health resources, they are formally connected. Use behavioral health services as a hub from which to show connections (and highlight gaps) between them and community and health-based crisis services including medical, social services, housing, etc.) (OCH may have some of this?)	BH Agency and organization players (DBH, SH, BiR) Metrics: Where do we get them?

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Goal 2 - Cont'd:	**Objective 1**:	**Strategy 1B:**	**Activities**	**Inputs**
By end of 2022, address county resident service needs effectively. Develop detailed plan to address service gaps for Medical and Behavioral Health care in Jefferson County by 2023	**Deploy available services cooperatively (medical, behavioral health, social, housing, employment) to address resident needs. Utilize the BHC to form collaborative partnerships that work together to reduce and eliminate care gaps in Jefferson County.**	**Strategy 1B:** Identify strengths and gaps in services like medical, behavioral health, social, housing, employment to address resident needs through cooperative deployment. **Metric:** Milestone Metric SWOT analysis is complete by 1/2022	**1B.1** Assess the role of primary BH service providers (DBH/Beacon of Hope and Believe in Recovery, etc.) and their partnership with other resources (law enforcement, housing, socials services, funding programs - OCH, 1/10th of 1%, WASPC, ASO, Medicaid, MCO, etc., recovery programs, etc.) identified in 1A.1 to identify strengths and gaps within our community. WAG team to facilitate development a SWOT analysis for services like medical, behavioral health, social, housing, employment.	
		Strategy 1C:	**Activities**	**Inputs**
		Strategy 1C: The B[illegible] develop a plan to address care gaps in our community for Medical and Behavioral Health care. The plan will address individual issues and plans to remediate the gap. **Metric:** Milestone Metric, plan in place by 6/2022	**1B.1** Assess the role of primary BH service providers (DBH/Beacon of Hope and Believe in Recovery, etc.) and their partnership with other resources (law enforcement, housing, socials services, funding programs - OCH, 1/10th of 1%, WASPC, ASO, Medicaid, MCO, etc.) identified in 1A.1 to identify strengths and gaps within our community.	

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Goal 2 - Cont'd:	**Objective 1**:	**Strategy 2A:**	**Activities**	**Inputs**
By end of 2022, address county resident service needs effectively. Develop detailed plan to address service gaps for Medical and Behavioral Health care in Jefferson County by 2023	**Deploy available services cooperatively (medical, behavioral health, social, housing, employment) to address resident needs. Utilize the BHC to form collaborative partnerships that work together to reduce and eliminate care gaps in Jefferson County.**	**Strategy 2A:** Work with BHC membership to develop definitions: BH, crisis services, law enforcement, navigator, case manager, care coordinator, etc.) **Metric:** Milestone metric standard definition list completed by 12-2021	**2A.1** CHIP staff to review public sources for these items and develop a draft document. 2A.2 BAC to review and finalize draft.	?? Metrics: Where do we get them?

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Goal 2 - Cont'd:	**Objective 2**:	**Strategy 3A:**	**Activities**	**Inputs**
By end of 2022, address county resident service needs effectively. Develop detailed plan to address service gaps for Medical and Behavioral Health care in Jefferson County by 2023	**Address current service gap around inter-facility transportation system of mental health patients**	**Strategy 3A:** Perform assessment of how much utilization is currently occurring between JHC/EJFR; With Need established, identify strategies to address this gap **Metric:** Milestone Metric data gathering will be complete by 12/2022	**3A.1** Chief Black's team to provide relevant data **3A.2** Connect with OCH and integrate EJFR/Jefferson County gap quantification data and participate in the OCH-led "priority action development" around regional inter-facility transportation for behavioral health (mental health/SUD) patients.	?? Metrics: Where do we get them?
			Jolene's Idea overview: Suggested focus is under a broad goal of "Delivering Services" - identify funding sources that are butting up against and crossing over each other. Generate clarity in one place around the fractured resource systems in our community so those resources can be better leveraged to address behavioral health challenges, ensure those with those challenges have housing and employment, and give them and us a chance at these clients becoming better parents and intergenerational trauma is reduced along with long term recidivism.	