



CHIP Workgroup – WAG

June 10, 2021, 4-4:30pm (Meeting #5)

@ Zoom Link

<https://zoom.us/j/98311732852?pwd=OFM2M0N1eUdJcmgweVUvL25lcC94UT09>

The CHIP partnership is an innovative collaboration between Jefferson Healthcare (JCH), Jefferson County, the City of Port Townsend, and Jefferson County Public Health (JCPH), devoted to identifying the most pressing health priorities for Jefferson County and activate efforts that will lead to improvements



Agenda – WAG Meeting #5

- Introductions/Updates since 5/13 meeting – 5 Minutes
- Strategic Framework Update and refinement – 20 Minutes
- Strategic Framework Completion– 5 minutes



- Note: WAG-related meeting materials are posted at:
<https://www.behealthyjefferson.com/workingageworkgroup>



Strategic Frameworks

Discussion



Strategic Framework Discussion

- Framework focus ideas - not yet represented
 - Transportation - name a specific gap to address? Framework?
- Review evolution since our 5/13 meeting
 - Template/Plan - Working Rental? - Housing (Peggy Webster)
 - Moving 911 Resource Challenge to Elder Age-Band
- Framework Completion Timeline
- Next steps: What activities are needed to make goals and strategies happen?



Proposed Strategic Results Framework - Peggy

Working Age Group - Strategic Framework Development - as of 6/8/2021

Goals:	Objectives:	Strategy:	Activities	Inputs
<i>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.</i>	<i>How are we going to implement our workgroup goals? How are the deliverables from the strategy going to be maintained?</i>	<i>What types of things do we need to develop to help meet our objectives? What deliverables will we have after we perform the activities?</i>	<i>What steps need to happen to make sure that we can complete the strategy?</i>	<i>What do we need to make the activities happen?</i>
Goal 1:	Objective 1:	Strategy 1A:	Activities	Inputs
Improve Social Determinants of Health factors in Jefferson County. Specifically Increase capacity of housing in Jefferson County by xx% by 2025 and Reduce the percent of residents below the poverty level by 2% by 2025 (from 13% to 11%)	Increase capacity of transitional supportive housing	<p>Strategy 1A: Coordinate with Bayside to assist in the creation of additional capacity for transitional supportive housing.</p> <p>Metric: XX additional capacity of this housing Team, what might be a good metric for this? Data Source: Bayside</p> <p>Current State: Get numbers from Bayside</p>	1A.1 Assist Bayside to identify (and pursue) grant and RFP opportunities	<p>Identify individual to act as point of contact and coordination.</p> <p>Metrics: Need current state numbers from Bayside</p>
		Strategy 1B:	Activities	Inputs
		<p>Strategy 1B: Coordinate with Pfeiffer House to support the current project to increase capacity at Pfeiffer House.</p> <p>Metric: Capacity at Pfeiffer (Currently 2 young adults, to be increased to 10-12 young adults).</p> <p>Data Source: Pfeiffer House</p>	1B.1 Collaborate with Pfeiffer House team to assess/articulate needs to increase capacity and support the development and execution an action plan.	<p>Identify individual to act as point of contact and coordination.</p> <p>Metrics: Gather current state numbers from Pfeiffer House</p>

[Link to proposed Strategic Framework](#)



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<p><i>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.</i></p> <p>Goal 1:</p> <p>Improve Social Determinants of Health factors in Jefferson County. Specifically Increase capacity of housing in Jefferson County by xx% by 2025 and Reduce the percent of residents below the poverty level by 2% by 2025 (from 13% to 11%)</p>	<p><i>How are we going to implement our workgroup goals? How are the deliverables from the strategy going to be maintained?</i></p> <p>Objective 2:</p> <p>Increase units of Workforce Rental Housing for working age adults.</p>	<p><i>What types of things do we need to develop to help met our objectives? What deliverables will we have after we perform the activities?</i></p> <p>Strategy 2A:</p> <p>Develop a template/process to identify site(s), financing and other key components. The template process will be tested and refined in Jefferson County.</p> <p>Metric: - A template - Units of workforce rental housing</p> <p>Data Source: Locate Source</p> <p>Current State: 0% vacancy rate on rental housing in Jefferson County.</p>	<p><i>What steps need to happen to make sure that we can complete the strategy?</i></p> <p>Activities</p> <p>2A.1 Organize workgroup to address this specific need for in-county rental housing.</p> <p>Deliverables:</p> <ol style="list-style-type: none"> 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. <p>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).</p> <p>2A1.2 Identify available sites.</p> <p>2A1.3 Identify possible sources of private financing.</p> <p>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</p>	<p><i>What do we need to make the activities happen?</i></p> <p>Inputs</p> <p>Available volunteers to work on project</p> <p>Private sources of funding.</p>

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

[Link to proposed Strategic Framework](#)



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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 BHC 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. Delete: (medical, behavioral health, social, housing, employment, etc.). 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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<p>Goal 2 - Cont'd:</p> <p>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</p>	<p>Objective 1:</p> <p>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.</p>	<p>Strategy 1B:</p> <p>Strategy 1B: Identify strengths and gaps to address resident needs through cooperative deployment. ??</p> <p>Metric: ??</p> <p>Data Source: ??</p> <p>Current State: ??</p>	<p>Activities</p> <p>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, social 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.</p>	<p>Inputs</p>
		<p>Strategy 1C:</p> <p>Strategy 1C: The BHC to 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.</p> <p>Metric: Milestone Metric, plan in place by 6/2022</p>	<p>Activities</p> <p>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, social 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.</p>	<p>Inputs</p>

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Goal 2 - Cont'd: 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	Objective 1: 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	Activities 2A.1 CHIP staff to review public sources for these items and develop a draft document. 2A.2 BAC to review and finalize draft.	Inputs ?? Metrics: Where do we get them?

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Goal 2 - Cont'd:	Objective 2:	Strategy 3A:	Activities	Inputs
<p>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</p>	<p>Address current service gap around inter-facility transportation system of mental health patients</p>	<p>Strategy 3A: Perform assessment of how much utilization is currently occurring between JHC/EJFR; With Need established, identify strategies to address this gap</p> <p>Metric: ??</p> <p>Data Source: ?</p> <p>Current State: ??</p>	<p>3A.1 Chief Black's team to provide relevant data</p> <p>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.</p>	<p>??</p> <p>Metrics: Where do we get them?</p>
<p>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.</p>				

[Link to proposed Strategic Framework](#)



Next Steps & Meeting



Discussion: Framework Completion Timeline

- Assure development and documentation of Working Age-Band Strategic Framework action plan is completed by August for inclusion in the 2021 CHIP Update.
- Activity ownership assigned before August
- 2021 CHIP Update Presented to Joint Board for Approval
- Address any Joint Board Feedback and seek Final Approval
- Upon approval, CHIP begins to facilitate Age-Band Workgroups to execute Strategic Plan



Final Thoughts?

- Agenda Items for Next Meeting?

See you next:

Thursday, July 8, 2021, 4pm

Zoom Conference Call



Thank You for all your hard work!