2019 - 2022

COMMUNITY HEALTH IMPROVEMENT PLAN

Live Well Madera County-Steering Committee

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Dexter Marr	Madera County Environmental Health Department
Dino Lawson	City of Madera Police Department
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Copyright Information

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I. Overview

A. Introduction

The Live Well Madera County (LWMC) Community Health Improvement Plan (CHIP) builds on the 2017 LWMC Community Health Assessment (CHA). The CHIP utilizes the CHA data to identify the top health-related priorities and outline strategies to address the identified needs through collective impact. This plan describes the history and structure of the LWMC partnership as well as the process of community and partner engagement that resulted in an ambitious, yet achievable action plan with shared goals, measurable objectives, and time-framed action steps. Over 30 community and government organizations participated in the plan development through Live Well Madera County resulting in the inaugural three-year (2019-2021) CHIP.

The LWMC CHIP focuses on addressing policies and systems that affect how agencies, industries, and institutions work. LWMC CHIP integrates a Health in All Policies (HiAP) approach to address health outcomes across all community sectors, not only in healthcare and public health. This collaborative approach is essential to improving population health. Secondly, the LWMC CHIP incorporates an equity and social justice lens to all strategies. All goals, priorities, and strategies take into account how ethnicity and race, gender, income, and other factors may disproportionately lead to better or worse health outcomes. Through this approach, the LWMC CHIP aims to improve health equity and eliminate health disparities.

The purpose of this CHIP is to monitor progress toward the two identified strategic health priorities identified in the CHA, **1). diabetes and obesity** and **2). child abuse and neglect** and inform the strategic planning process for all the LWMC participating agencies. As a community plan, it is owned and monitored by the community with the intention to provide a platform for more effective advocacy and leveraging of resources while outlining a path to improved population health for Madera County.

2021 Revision

The LWMC CHIP was adopted in March 2021 with an original timeframe through December 2021. However, due to COVID-19 pandemic, formal LWMC meetings did not place throughout 2020. When meetings resumed in early 2021, it became evident that many participating organizations experienced immediate and long-term impacts to services and that more time was necessary to fully implement the CHIP goals and objectives. In March 2021, the Executive Committee asked workgroup leads to review goals and objectives and to revise activities based upon relevancy and feasibility. These revisions were complete in December 2021 resulting in changes to timelines and objectives as well as the addition of a new workgroup Homeless Solutions. The revised CHIP will be made available to stakeholders and the public in January 2021.

B. Live Well Madera County CHIP: At-A-Glance

Steering Committee Goals

Goal 1: The Live Well Madera County (LWMC) steering committee will incorporate a Health in All Policies (HiAP) approach to assess internal policies and practices.

> **Objective 1.1** By December 2022, increase the number of LWMC Coalition members adopting HiAP approaches into their organization's policies and practices.

Goal 2: The Live Well Madera County (LWMC) steering committee will educate the public and Madera County decision makers about the health and economic impact of Medi-Cal.

> **Objective 2.1** By December 2022, increase the number of decision makers and community influencers with a basic understanding of the health and economic impact of Medi-Cal in Madera County.

Goal 3: The Live Well Madera County (LWMC) steering committee will plan, implement, and publish a community health assessment for 2023-2026.

> **Objective 3.1** By December 2022, publish a LWMC CHA consisting of primary and secondary data from identified sources

Healthy People Strong Communities Workgroup Goals

Goal 4: Expand access to healthy options and services for obesity and diabetes prevention.

> **Objective 4.1** By December 2022, increase the number of flea markets/Farmers' Markets that accept EBT.
>
> **Objective 4.2** By December 2022, expand content and utilization of Unite Us Referral Platform.
>
> **Objective 4.3** By December 2022, explore the opportunity to develop breastfeeding resources or other system/policy changes to increase community access.

Goal 5: Increase resident engagement in healthy neighborhood initiatives that support healthy environments and social cohesion.

> **Objective 5.1**: By December 2022, build capacity of Resident Champions to provide referrals and community support.
>
> **Objective 5.2** By December 2022, increase walkability through walk assessments and recommendations to decision making bodies.
>
> **Objective 5.3** By December 2022, provide trainings for residents to prepare them to participate in city and county planning processes.

Goal 6: Continue to explore and initiate culturally appropriate practices to promote public health.

Objective 6.1 By December 2022, collaborate to support and enhance initiatives of workgroup member agencies.

Objective 6.2 By December 2022, increase HPSC Workgroup members awareness about gestational diabetes and opportunities for prevention of long-term diagnosis as well as family prevention.

Objective 6.3 By December 2022, continue to develop or support implementation of 4-8 school and/or community gardens.

Growing Healthy Families Workgroup Goals

Goal 7: Improve neighborhood conditions, economic self-sufficiency, and social inequities that may contribute to child abuse and neglect (CAN).

Objective 7.1 By December 2021, increase efforts to address community blight (e.g., abandoned building, graffiti, broken streetlights, etc.)

Objective 7.2 By December 2021, increase and promote job preparedness for adults with children.

Objective 7.3 By December 2022, explore opportunities to limit the density of alcohol outlets and restrict advertising through a local ordinance.

Goal 8: Build social cohesion and community involvement

Objective 8.1 By December 2021, expand participation in mentoring programs to increase the number of 'caring adults' in a child's life.

Goal 9: Increase and promote community support and services

Objective 9.1 By December 20212 increase the number of culturally sensitive trainings and screenings offered to the community on topics related to child abuse and neglect.

Objective 9.2 By December 2022, increase the number of parenting programs/classes that are culturally sensitive to parents to strengthen their families.

Objective 9.3 By December 2022, expand low-cost preschool education programs that target children of low-income working families.

Objective 9.4 By June 2022, Community Response Team (CRT) will be fully operating with an action plan for the reduction of drug-related overdose deaths and offering extensive education on harm reduction, overdose education and Naloxone distribution.

Goal 10: Continue to explore and innovate practices to prevent child abuse and neglect and develop a countywide awareness campaign related to child abuse and neglect.

Objective 10.1 By December 2021, collaborate to support and enhance initiatives of workgroup member agencies.

Objective 10.2 By December 2021, explore the development of a community surveillance system to gather local data to fill gaps in knowledge around poverty, alcohol and drug abuse, mental health, and child abuse and neglect.

Homeless Solutions Workgroup Goals

Goal 11: Increase access to health care among individuals experiencing homelessness by expanding mobile health and linkages to services for sexually transmitted diseases, HIV and other communicable diseases; relevant immunizations (including COVID); oral health services; mental health services; health screenings and education; and social support programs such as Medi-Cal, WIC and other support services.

Objective 11.1 By December 2022, expand mobile health services to homeless population

Goal 12: Expand homeless-focused data availability and quality across Madera County agencies.

Objective 12.1 By December 2022, identify best practices for data sharing among agencies providing homeless-focused services.

Goal 13: Open a new Madera County Respite Center.

Objective 13.1 By December 2021, open a respite center for homeless population to recover post-hospital discharge.

Goal 14: Increase Navigation Support for the Homeless Population

Objective 14.1 By December 2021, hire additional outreach and caseworker staff to support navigation of homeless population.

Goal 15: Expand Housing Infrastructure for Homeless Population

Objective 15.1 By December 2022, increase short and long-term housing for the homeless population.

C. Partnership: Live Well Madera County (LWMC)

LWMC served as the guiding partnership for the CHA as well as the CHIP. LWMC, formerly known as the Mobilizing for Action through Planning and Partnerships (MAPP) Committee, formed in 2014 to make healthy behaviors and environments the social norm, and coalesced around the development and design of the first community health assessment published in early 2017.

In early 2018, LWMC restructured partner roles and responsibilities to focus on the CHIP development. The LWMC five-member Executive Committee became responsible for the planning the direction of the coalition. The Executive Committee now consist of Directors from Madera County Department of Public Health, Madera County Department of Behavioral Health, Madera County Department of Social Services, Community Action partnership of Madera County (a community-based organization), and a Regional Pediatric Hospital. The Steering Committee, comprised of decision-makers and leaders of more than 30 agencies, is responsible

for the oversight of the workgroups. Finally, two workgroups were formed to drive work in the CHIP priority areas. The tasks of the workgroups are to identify the entities and/or individuals responsible for defining and implementing the goals, strategies, objectives and activities of the CHIP.

To date, LWMC has successfully developed a vision and mission, decision making criteria, brand/logo, and a formalized structure. The LWMC charter, adopted in November 2018 details the important elements of the coalition. As of 2018, there are over 30 agencies represented on the LWMC steering committee including members from the health, social service, law enforcement, business, education, and faith sectors. See Appendix for full LWMC Chronology.

Live Well Madera County Charter

Approval Date	11 /5 /2018	
Membership	Live Well Madera County (LWMC) is composed of countywide government, healthcare, health plans, business, education, law enforcement, community-based, and faith-based stakeholders who are committed to improve community wellness through focused aligned action.	
Vision and Mission	**VISION:** Healthy behaviors and environments are the social norm. • Access to healthy options and services for physical, mental and spiritual well-being • Safe and connected neighborhoods • Engaged and informed citizens • Healthy communities and worksites • Healthy economic development • Collaborative and accountable leadership • Cultural approach to prevention • Healthy child development • Children grow in healthy families **MISSION:** Assess. Collaborate. Transform. LWMC is committed to an iterative transformational process focused through Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) implementation every 3-5 years. The CHA and CHIP documents are the product and responsibility of all LWMC members. Appropriate CHIP goals and objectives are adopted into member organizations' strategic plans. Measured results reflect the degree to which LWMC organizations collaborate and realize community transformation for Madera County resident wellness.	
Establishment	**October 2014**	LWMC Established (originally named "Healthy Madera MAPP Committee")
	2015-2016	CHA planning and data collection
	2017	CHA published and priority issues identified
	2018	Name updated from Healthy Madera MAPP Committee to Live Well Madera County Decision-making criteria adopted Draft Community Health Improvement Plan (CHIP)

Decision-Making Criteria	1 – Prioritize Upstream 2 – S.M.A.R.T *Specific* *Measurable* *Achievable* *Relevant* *Time-bound* 3 – High Return On Investment 4 – Promote Health Equity 5 – Use Data Effectively
Executive Committee	Comprised of the Department of Behavioral Health Director, the Department of Public Health Director, the Department of Social Services Director, the CAPMC Director, and 1 – 2 Community Leaders. • Co-Chairs of LWMC are selected annually from the Executive Committee and may repeat from year to year, as appropriate. • Convene, plan, and attend LWMC Steering Committee meetings. • Provide administrative leadership and project management. • Promote LWMC participation and goals
Steering Committee	Each LWMC organization is represented by an executive-level decision maker. • When not able to attend quarterly meetings, a designee will attend to represent the organization. • Embody the mission and maintain momentum. • Oversee CHA and CHIP implementation. • Review and approve workgroup approaches to implementing the CHA and CHIP in the community. • Ensure LWMC decisions adhere to the decision-making criteria. • Ensure organizational commitments are met. • Identify and commit resources for CHA and CHIP implementation. • Adopt appropriate CHIP goals and objectives into member organizations' strategic plans.
Workgroups	A representative of each LWMC organization needs to participate in at least one workgroup. • When not able to attend meetings, connect with the workgroup chair to stay current and follow through on commitments. An appropriate designee can also attend to represent the organization. • Workgroup Co-Chairs plan meetings, have consistent attendance and engagement, prepare agendas, prepare trainings, facilitate the meetings, and provides regular reports to the Steering Committee. • Develop the content of the CHA and CHIP. • Implement the CHA and CHIP.

	• Recruit community residents and other organizations to participate in the CHA and CHIP process. • Brainstorms approaches to implementing the CHA and CHIP in the community. • Identifies resources in the community for conducting CHA and CHIP activities.
Meetings	• The Executive and Steering Committees meet on a Quarterly basis. • Workgroups meet as needed to meet the timeline of CHIP implementation and provide reports to Steering Committee.
Charter Review and Amendment	LWMC "Executive Committee" will review the charter on an annual basis and update as needed.

II. CHIP Approach

A. CHA and Strategic Priority Selection

Resident Rankings of Top Health Concerns (n=2083)

- Alcohol/drug abuse
- Breathing problems/asthma
- Obesity
- Diabetes
- Teens getting pregnant
- Youth violence

The 2017 LWMC CHA reflects a combination of secondary data from publicly available sources such as the United States Census and California Health Interview Survey (CHIS) as well as primary data collected from 2,189 residents through the 2016 Madera County Community Health Assessment Survey. The Mobilizing for Action through Planning and Partnership (MAPP) process was used to guide the planning processes and assessments for both the CHA and the CHIP. The surveys completed as part of the CHA process asked residents to identify the biggest health problems as well as the biggest social and economic problems in Madera County. Residents ranked **alcohol/drug abuse, breathing problems/asthma, obesity, and diabetes** as the top health concerns. **A lack of jobs, poverty, and homelessness** were ranked as three biggest social and economic problems faced by the community. See Appendix B for full list of resident rankings.

Four priority areas were initially proposed for the CHIP based on the resident survey data and LWMC member input: 1) Diabetes and Obesity 2) Child Abuse and Neglect, 3) Alcohol and Drug Use, and 4) Mental Health. Community engagement took place at eight town hall meetings throughout the County (see Appendix D for presentation list). Meetings were held in English and Spanish in both city and unincorporated communities. During these meetings, residents received CHA results and LWMC fishbone diagrams and provided input related to the proposed priority areas. An analysis of fishbone diagrams (see Appendix E) revealed similar root causes for child abuse and neglect, alcohol and drug abuse, and mental health. Based on the similarities, it was

"Residents defined a healthy and thriving community as one that is a safe place to raise kids, has jobs, and good schools." County Community Health Survey, 2017

decided to combine those three areas under the umbrella of child abuse and neglect with a clear understanding that this priority area would address the interrelated root causes and social determinants of health. Therefore, the two final LWMC priorities are: 1) Diabetes and Obesity and 2) Child Abuse and Neglect.

B. Guiding Principles & Decision-Making Criteria

In March 2018, Madera County had the opportunity to participate in the *Strengthening Rural Local Health Department (LHD) Capacity for to Address Social Determinants of Health (SDOH)* in-person training in Washington, DC, coordinated by The National Association of City and County Health Officers (NACCHO). Representatives from the Madera County Department of Public Health as well as LWMC partners, Madera County Child Abuse Council and the Madera County Department of Community and Economic Development attended the training and learned strategies to develop an actionable upstream CHIP. Using tools from the training, the Steering Committee adopted decision-making criteria to guide the writing of CHIP goals, objectives, and activities (See Table 1):

Table 1: Guiding Principles & Decision-Making Criteria for goals, objectives, and activities

1	**Prioritize Upstream**	A focus on primary prevention and working at the public policy and community levels of the social ecological model. An emphasis on the improvement of the social determinants of health (SDOH) through policy rather than a focus on changing individual behaviors.
2	**S.M.A.R.T**	Specific, Measurable, Achievable, Relevant and Time-bound**.** Goals and objectives are action-oriented, aligned, and focused with the desired outcome and target date or frequency clearly stated.
3	**High Return on Investment**	Activities have a clear benefit, whether economic or social, in relation to the cost. Return on Investment (ROI) will be used to measure the efficiency of the combined community efforts; thus helping to monitor the impact of the strategies.
4	**Promote Health Equity**	Health equity is when every person has the opportunity to attain the highest level of health and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Goals, objectives, and activities will focus on populations and places most in need in order to reduce and ultimately eliminate disparities among excluded or marginalized groups and achieve health equity.
5	**Use Data Effectively**	The use of data to support decisions, implement, and measure positive change, and guide leaders in the allocation of resources and efforts. Existing data along with gaps in data will be identified. Collected data will be accessible, disaggregated, comparative, representative, and actionable.

In addition to the decision-making criteria, other guiding principles provided a framework for the LWMC CHIP Approach.

HEALTH EQUITY: Health equity is defined as everyone having the opportunity to attain their highest level of health. Health equity includes working towards racial equity and intentionally working to remove barriers that may disproportionately and unjustly impact one group over another.

SOCIAL DETERMINANTS OF HEALTH: SDOH are the actual conditions in the places where people live, learn, work, grow, age, shop, and pray. Situations like poverty limit the access to healthy foods and safe neighborhoods. Education is also considered a predictor of better health. Communities with poor social determinants of health have a clear difference in health; thus contributing to unstable housing, unsafe neighborhoods, low wages, and substandard education.

UPSTREAM STRATEGIES: The prioritization of upstream strategies is both part of the decision-making criteria and guiding principles. Upstream strategies focus on policy changes that reduce inequities and improve social and economic conditions rather than on individual behaviors. The LWMC coalition decided to adopt the conceptual framework of social inequalities and health, designed by the Bay Area Regional Health Initiatives Initiative (BARHII Model). The types of data collected in the CHA organized in the following areas/indicators: social inequalities, institutional power, neighborhood conditions, risk behaviors, disease & injury, and mortality.

HEALTH IN ALL POLICIES (HiAP): Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas. In July 2018, both the Executive and Steering Committees committed to incorporating a Health in All Policies approach into the CHIP and a steering committee goal. The HiAP approach taken by LWMC involves completion of an organizational assessment followed by the development of clear action steps to integrate HiAP within each steering committee organization.

COLLECTIVE IMPACT: LWMC is a coalition that utilizes collection impact to work in partnership across multiple sectors. There are five components of collective impact: 1) having a common agenda; 2) shared measurement system; 3) mutually reinforcing activities; 4) continuous communication; and 5) backbone support organization.

C. Development of CHIP Goals and Objectives

Workgroup (WG) Action Plan Development

1. Training of WGs on the MAPP process, purpose of the CHIP, SMART objectives, and upstream policy change.
2. Review of LWMC decision making criteria.
3. Creation of asset inventories.
4. Draft of action plan goals and objectives.
5. Review of evidence based and promising practice strategies using RWJF: *What Works for Health* web tool and review of other accredited CHIPs by consultant.
6. Review of fishbone diagrams.
7. Refinement and narrowing of goals/objectives based on criteria.
8. Development of activities and timelines.

Beginning in March 2018, the two workgroups, Diabetes and Obesity and Child Abuse and Neglect began the process of developing goals, objectives, and activities for their respective priority area. The Diabetes and Obesity workgroup was led by the Madera County Department of Public Health Director and the Director of Programs and Business Development from Camarena Health, a local federally qualified health center (FQHC). The Child Abuse and Neglect workgroup was led by the Director of Community Action Partnership of Madera County, Executive Director of Madera County Child Abuse Prevention Council, and the Director of the Madera County Department of Social Services.

Several workgroup meetings were held between March and December 2018 focused on developing and refining goals and objectives. The MAPP model was followed which focuses on identify strategic issues, formulating goals and strategies, and entering the action cycle. Each workgroup began by creating an asset inventory of current resources and community activities in the priority areas. All identified resources and activities were then plotted by prevention level (primary, secondary or tertiary) and the intervention level (individual, interpersonal, organizational, community, or public policy (see Appendix F for asset inventories) The results of the asset inventory revealed the majority of activities currently focused on the individual level with minimal investment in community and public policy levels. Based on the LWMC decision making criteria both workgroups committed to objectives and goals focused on the primary level of prevention working within the community and public policy intervention levels. Following the completion of the asset inventory there was a review a literature to identify current evidence-based and promising practices. The Robert Wood Johnson Foundation *What Works for Health* web tool was used for that purpose and helped to narrow down and eliminate objectives that were shown through the literature to be ineffective. In addition, the CHIP Consultant reviewed CHIPs of other accredited public health Department to identify best practices and themes. Finally, each workgroup reviewed the previously created fishbone diagrams that identified the root causes of the strategic priority areas. The fishbone diagrams were used to further refine the goals and objectives and ensure they were indeed upstream.

The last steps in the action plan development involved refinement of goals based upon alignment with state and national objectives; and working within small breakout groups to identify time-bound action steps and measures and the appropriate responsible party.

During the planning process, a choice was made by LWMC to reframe the workgroup names from a focus on the negative health conditions to the positive outcomes envisioned by LWMC. In an effort to better reflect the intent and spirit of the community health improvement plan, the Diabetes and Obesity workgroup became ***Healthy People Strong Communities*** and the Child Abuse and Neglect workgroup was renamed ***Growing Healthy Families*** (See Table 2).

Table 2: List of Participating Agencies/Organizations/Departments in Workgroups

Healthy People Strong Communities	***Healthy Families***
• Anthem Blue Cross • Camarena Health • Cal Viva Health • City of Madera Parks and Community Services • Dairy Council of California • First 5 Madera County • Madera Community Hospital • Madera County Department of Behavioral Health Services • Madera County Community & Economic Development • Madera County Department of Public Health • Madera County Department of Social Services • Madera County Probation • Madera County Public Works • Madera County Superintendent of Schools • Madera Unified School District • Madera County Veterans Services • Madera Ministerial Association • UC Cooperative Extension	• California Health Collaborative • City of Madera Parks and Community Services • Community Action Partnership of Madera County, Inc. (CAPMC) • Fresno-Madera CASA • First 5 Madera County • Madera Chamber of Commerce • Madera County Behavioral Health • Madera County Child Abuse Prevention Council • Madera County Department of Public Health • Madera County Department of Social Services • Madera County Probation • Madera County Superintendent of Schools • Madera County Veterans Services • Madera Ministerial Association • Valley Children's Healthcare

III. The Action Plan – Goals, Objectives, Actions and Measures

A. Steering Committee Goals

Goal 1: The Live Well Madera County (LWMC) steering committee will incorporate a Health in All Policies (HiAP) approach and/or equity lens to assess internal policies and practices.

Objective 1.1 By December 2022, increase the number of LWMC Coalition members adopting HiAP approaches into their organization's policies and practices.	**3-Year Objective Measures** ▪ Number of agencies adopting HiAP ▪ Number of agencies receiving HiAP and/or equity training ▪ Number of countywide HiAP initiatives and/or polices adopted	**Objective Leader** Madera County Department of Public Health (MCDPH)
Action Items	**Action Item Measures/ Deliverables**	**Responsible Agencies**
1.1.1 By December 2021, complete an environmental scan of HiAP assessment tools that would enable LWMC steering committee agencies to assess organizational, community, and public policies and practices; emphasis on organizations/internal practices.	▪ Assessment identified in the environmental scan	▪ Live Well Madera County (LWMC) Steering Committee
1.1.2 By December 2022, LWMC agencies will select and complete at least one HiAP assessment to assess organizational, community, and public policies and practices in Madera County. HiAP orientation for agency assessment teams will be provided by the Healthy People Strong Communities Workgroup.	▪ Log of assessments selected by each agency ▪ Assessment results	
1.1.3 By December 2022, identify and implement HiAP training opportunities for LWMC steering committee members and staff from LWMC agencies.	▪ Trainings completed, agendas, sign-in sheets ▪ Training evaluations	
1.1.4 By December 2022, Use HiAP assessment results to identify potential HiAP projects and initiatives to implement or incorporate into the next LWMC Community Health Improvement Plan.	▪ List of projects and initiatives	

Goal 2: The Live Well Madera County (LWMC) steering committee will educate the public and Madera County decision makers about the health and economic impact of Medi-Cal.

Objective 2.1 By December 2022, increase the number of decision makers and community influencers with a basic understanding of the health and economic impact of Medi-Cal in Madera County.	**3-Year Objective Measures** ▪ Number of decision makers and community influencers with a basic understanding of the health and economic impact of Medi-Cal in Madera County	**Objective Leader** Madera County Department of Social Services (DSS)
Action Items	**Action Item Measures/ Deliverables**	**Responsible Agencies**
2.1.1 By September 2019, gather data about the health and economic impact of Medi-Cal.	▪ Data gathered	▪ LWMC Steering Committee
2.1.2 By June 2021, develop key messages and informational materials about the health and economic impact of Medi-Cal.	▪ Key messages ▪ Materials developed	
2.1.3 Between July 2021-December 2022, disseminate materials developed.	▪ Measures detailed in the dissemination plans such as number of presentations. ▪ Response questionnaire provided to decision makers and community influencers after information is provided.	

Goal 3: The Live Well Madera County (LWMC) steering committee will plan, implement, and publish a community health assessment for 2023-2026.

Objective 3.1 By December 2022, publish a LWMC CHA consisting of primary and secondary data from identified sources.	**3-Year Objective Measures** ▪ Published CHA	**Objective Leader** Madera County Department of Public Health (MCDPH)
Action Items	**Action Item Measures/ Deliverables**	**Responsible Agencies**
3.1.1 By September 2021, create a plan for primary data collection that aligns with local hospitals including and not limited to focus groups.	▪ Data plan with timelines	▪ LWMC steering committee
3.1.2 By December 2021, identify secondary data sources	▪ List of data sources	
3.1.3 By June 2022 complete collection of primary and secondary data.	▪ Collected data	

3.1.4 By December 2022, Compile and publish the CHA that identifies strategic priorities for the next CHIP	▪ Published CHA	

B. Healthy People Strong Communities Workgroup Goals Strategic Priority: Diabetes and Obesity

"The cost of diabetes in Madera County… is estimated to be $63,306,667.00 annually".

Brown P, Gonzalez M, & Sandhu R.

Goal 4: Expand access to healthy options and services for obesity & diabetes prevention.

Objective 4.1 By December 2022, increase the number of flea markets/Farmers' Markets that accept EBT.	**3-Year Objective Measures** ▪ Number of flea/FM markets with EBT ▪ Flea Market Survey data	**Objective Leader** MCDPH
Action Items	**Action Item Measures/ Deliverables**	**Responsible Agencies**
4.1.1 By December 2022, provide technical assistance to the market manager to implement EBT.	▪ EBT is implemented ▪ Satisfaction surveys from vendors	▪ Center for Wellness and Nutrition ▪ City of Madera ▪ Flea Market Manager ▪ Madera Community Hospital (MCH) ▪ Madera County Environmental Health Division (EH) ▪ MCDPH ▪ UC Cooperative Extension
4.1.2 By December 2022, promote EBT availability at the flea market/farmers' market.	▪ Promotional materials	
4.1.3 By December 2022, conduct post flea market/farmers customer survey.	▪ Number surveys collected ▪ Data analysis report	
4.1.4 By December 2022, research and explore the feasibility of a policy that requires all flea markets/farmers' markets to accept EBT.	▪ Key informant interviews	

Objective 4.2 By December 2022, expand content and utilization of Unite Us Referral Platform.	**3-Year Objective Measures** ▪ Number of participating organizations	**Objective Leader** Camarena
Action Items	**Action Item Measures/ Deliverables**	**Responsible Agencies**
4.2.1 Between March 2021-December 2021, conduct education and awareness efforts to CBOs and	▪ List of presentations provided.	▪ Anthem Blue Cross ▪ CalViva Health

	other service organizations on the use of the Unite Us Platform.		▪ Camarena Health ▪ DSS ▪ First 5 Madera County ▪ Madera County Department of Behavioral Health Services (BHS) ▪ Madera County Superintendent of Schools (MCSOS) ▪ Madera Unified School District (MUSD) ▪ MCDPH ▪ Valley Children's Healthcare (VCH)
4.2.2	By December 2021, conduct an asset assessment of resources currently available for obesity, diabetes, co-morbidities, and the social determinants of these conditions and encourage organizations working on these issues to be a part of the Unite Us platform.	▪ Asset list ▪ Participant list of organizations	
4.2.3	By June 2022, conduct a gap analysis of resources available versus unavailable for obesity, diabetes, co-morbidities, and the social determinants of these conditions.	▪ Gaps identified	
4.2.4	By December 2022, assess organizations addressing the issues of obesity, diabetes, co-morbidities, and the social determinants of these conditions to determine if there has been an increase in the number of organizations that are utilizing the Unite Us platform.	▪ Assessment/list of organizations	

Objective 4.3 By December 2022, explore the opportunity to develop breastfeeding resources or other system/policy changes to increase community access.	**3-Year Objective Measures** ▪ Number of support groups established ▪ Number of systems/policy changes made to support breastfeeding	**Objective Leader** MCDPH/Camarena Health
Action Items	**Action Item Measures/ Deliverables**	**Responsible Agencies**
4.3.1 By March 2019, identify surveys and other scan tools to assess breastfeeding supports in the clinical, community, and worksite settings.	▪ Scan/survey tools	▪ Anthem Blue Cross ▪ CalViva Health ▪ Camarena ▪ First 5 Madera County ▪ MCDPH ▪ MCDPH-Women, Infant, Children (WIC) ▪ MCH ▪ VCH
4.3.2 By March 2020, conduct a scan of local breastfeeding resources.	▪ List of breastfeeding resources	
4.3.3 By September 2021, develop a plan with recommendations and priorities for increasing breastfeeding support.	▪ Completed plan with recommendations	
4.3.4 By December 2022, implement at least two recommendations from plan.	▪ List of implemented recommendations ▪ Adopted policies/protocols	

Goal 5: Increase resident engagement in healthy neighborhood initiatives that support healthy environments and social cohesion.

Objective 5.1 By December 2022, build capacity of Resident Champions to provide referrals and community support.	**3-Year Objective Measures** ▪ Number of trainings/ meetings ▪ Number of Resident Champions actively referring to resources ▪ Number of referrals from Champions to other resources	**Objective Leader** MCDPH
Action Items	**Action Item Measures/ Deliverables**	**Responsible Agencies**
5.1.1 By December 2021, meet with community partners to develop a plan to train Resident Champions, Promotores, and Community Health Workers in providing referrals and community support.	▪ Meeting notes ▪ Plan for engagement	▪ CalViva Health ▪ Camarena ▪ Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO) ▪ City of Madera Police ▪ MCCED ▪ MCDPH
5.1.2 By December 2021, formulate a planning group to develop training for those managing Promotores/Resident Champion groups.	▪ List of meetings	
5.1.3 By June 2022, host meetings and conduct training for Resident Champions, Promotores, and Community Health Workers to educate and inform them on the tools and resources to provide referrals and community support.	▪ Training agenda ▪ Training materials	
5.1.4 By June 2022, begin documenting process of referral conducted by trained Resident Champions, Promotores, and Community Health Workers.	▪ Tracking tool of referrals made by Resident Champions, Promotores, and Community Health Workers	
5.1.5 By December 2022, complete first 6-month status report on the number of referrals from Resident Champions, Promotores, and Community Health Workers to other resources.	▪ Status Report	

Objective 5.2 By December 2022, increase walkability through walk assessments and recommendations to decision making bodies.		**3-Year Objective Measures** ▪ Number of recommendations implemented	**Objective Leaders** City of Madera Planning/MCDPH
Action Items		**Action Item Measures/ Deliverables**	**Responsible Agencies**
5.2.1	By May 2021, select and convene Walkability Task Force including HPSC Workgroup members, transportation experts (planning, public works, etc.), other agencies, and adult and youth community members.	▪ List of Walkability Task Force Members ▪ Meeting minutes	▪ City of Madera Planning ▪ CBDIO ▪ Dairy Council of California ▪ MCCED ▪ Madera County Public Works (Public Works) ▪ MCDPH ▪ MCSOS ▪ MUSD ▪ UC Cooperative Extension
5.2.2	By June 2021, research walkability assessment tools and select/develop appropriate walkability assessment tool.	▪ Walkability assessment tool	
5.2.3	By December 2022, conduct walkability assessments in selected neighborhoods.	▪ Completed walkability assessments	
5.2.4	By December 2022, create recommendations for improving walkability in selected neighborhoods.	▪ List of recommendations	
5.2.5	By December 2022, develop report detailing at least three recommendations that were adopted and implemented by decision-making bodies.	▪ Documentation of recommendations adopted and implemented	

Objective 5.3 By December 2022, provide trainings for residents to prepare them to participate in city and county planning processes.		**3-Year Objective Measures** ▪ Number of people participating in planning events/meetings within Madera County ▪ Number of planning events/processes promoted to the public through MCDPH	**Objective Leader** City of Madera Parks & Community Services
Action Items		**Action Item Measures/ Deliverables**	**Responsible Agencies**
5.3.1	By September 2021, document and promote all upcoming meetings with officials to reinforce the community's participation in the city & county planning process.	▪ Number of meetings ▪ Number of officials ▪ Number of community members	▪ CalViva Health ▪ Camarena ▪ CBDIO ▪ City of Madera Parks &

5.3.2 By November 2021, provide trainings to community members and community partners on the purposes and processes of County/City Planning Commissions.	▪ Understanding how government system works – Pre and Post Evaluations	Community Services ▪ City of Madera Planning ▪ MCCED ▪ MCDPH ▪ Ministerial Association ▪ MUSD
5.3.4 By January 2022, trained community residents will commit to attending and participating in the city/county planning meetings on a regular basis.	▪ Number of meetings community residents committed to attend ▪ Number of trained community residents attending	
5.3.5 By December 2022, trained community residents will report their attendance at the city/county planning meetings regularly.	▪ Number of meetings attended ▪ Number of trained community residents attending	

Goal 6: Continue to explore and initiate culturally appropriate practices to promote public health.

Objective 6.1 By December 2021, collaborate to support and enhance initiatives of workgroup member agencies.	**3-Year Objective Measures** ▪ HPSC Workgroup Participation Satisfaction Survey results	**Objective Leader** HPSC Workgroup Leaders
Action Items	**Action Item Measures/ Deliverables**	**Responsible Agencies**
6.1.1 By December 2021, develop criteria and a process for adding Workgroup agenda items.	▪ Agenda Item Request Form	▪ Camarena ▪ MCDPH
6.1.2 By December 20212 HPSC Workgroup members will be able to add relevant agenda items aligns with HPSC vision to workgroup meeting agendas.	▪ Agency-added agenda items	
6.1.3 Beginning January 2022, annually complete a HPSC Workgroup Participation Satisfaction Survey to include overall participation satisfaction, alignment of workgroup activities to agency/program mission and goals, collaboration by members in non-CHIP agency/program activities, and the degree to which collaboration enhances non-CHIP agency/program activities.	▪ HPSC Workgroup Participation Satisfaction Survey results	

Objective 6.2 By December 2022, increase HPSC workgroup members awareness about gestational diabetes and opportunities for prevention of long-term diagnosis as well as family prevention.	**3-Year Objective Measures** ▪ Potential objectives for the next Community Health Improvement Plan	**Objective Leader** MCH
Action Items	**Action Item Measures /Deliverables**	**Responsible Agencies**
6.2.1 By December 2021, identify key stakeholders and decision makers relevant to gestational diabetes, comorbidities, and the social determinants of the condition.	▪ List of key stakeholders and decision makers	▪ Anthem Blue Cross ▪ CalViva Health ▪ Camarena ▪ First 5 Madera County ▪ MCDPH ▪ MCH ▪ VCH
6.2.2 By December 2022, host a learning forum for interested key stakeholders and decision makers relevant to gestational diabetes.	▪ Learning Forum Minutes ▪ Learning Forum Sign-In	
6.2.3 By December 2022, identify potential objectives for the next Community Health Improvement Plan.	▪ List of potential objectives for the next Community Health Improvement Plan	

Objective 6.3 By December 2022, continue to develop school and community garden implementation efforts. .	**3-Year Objective Measures** ▪ Implementation plan for community farm (if deemed viable)	**Objective Leader** MCDPH
Action Items	**Action Item Measures/ Deliverables**	**Responsible Agencies**
6.3.1 By September 2021, conduct assessment of interest in training in the development of school and/or community gardens.	▪ Assessment tool ▪ Assessment results	▪ MCCED ▪ MCDPH ▪ UC Cooperative Extension
6.3.2 By December 2022, provide a training on the development of school and community gardens.	▪ Training agenda ▪ Training materials ▪ Training participant's assessment/evaluation of training	

C. Growing Healthy Families Workgroup Goals

Strategic Priority: Child Abuse and Neglect
Sub-Strategies: Alcohol/Drug Abuse & Mental Health

"Safety and security don't just happen; they are the result of collective consensus and public investment. We owe our children, the most vulnerable citizens in our society, a life free of violence and fear."
-Nelson Mandela

Goal 7: Improve neighborhood conditions, economic self-sufficiency, and social inequities that may contribute to child abuse and neglect (CAN).

Objective 7.1 By December 2021, increase efforts to address community blight (e.g., abandoned building, graffiti, broken streetlights, etc.)	**3-Year Objective Measures** ▪ Number of adults and youth participating as volunteers ▪ The type of data collection method ▪ Engagement of enforcement participation ▪ Pre and Post results of the "Perceived Blight Survey"	**Objective Leaders** Community Action Plan Madera County (CAPMC); and City of Madera Police (Code Enforcement)
Action Item	**Action Item Measures/ Deliverables**	**Responsible Agencies**
7.1.1 By December 2021, conduct a scan and develop a list of resources and groups currently addressing blights such as the graffiti abatement team, code enforcement, etc.	▪ List of resources ▪ List of groups (e.g., organizations and agencies) currently addressing blight.	▪ Arts Council ▪ BHS Committee ▪ Chamber of Commerce ▪ City of Madera Planning ▪ City of Madera Police (Code Enforcement) ▪ City of Madera Public Works ▪ Community Action Plan Madera County (CAPMC); ▪ DSS ▪ First 5 Madera County ▪ Madera County Probation ▪ Madera County Sherriff's Department ▪ MCCED ▪ Ministerial Association ▪ Youth Leadership Institute
7.1.2 By December 2021, add additional resources to 3-1-1 that include the ability of the community to report issues of blight including abandoned vehicles, graffiti, garbage, abandoned housing, shopping carts, etc.	▪ List of resources within 3-1-1 ▪ Quarterly report on the number of calls to 311 related to blight	
7.1.3 By December 2021, work with Habitat for Humanity to increase their involvement in Madera County.	▪ Quarterly list of active volunteers ▪ Madera project list	
7.1.4 By December 2021, utilize Geographic Information System (GIS) to create an interactive map to provide the geographic inventory of blight (i.e., overlay with CAN and diabetes/obesity).	▪ GIS blight areas available on the MC website and used to target mitigation efforts	
7.1.5 By December 2021, conduct education and outreach efforts to community-based organizations (CBOs) including churches and youth organizations, to increase the number of adults and youth	▪ Sign-In Sheets ▪ Quarterly list of active volunteers ▪ Number of organizations involved ▪ Number of educational presentations	

participating as volunteers to mitigate issues with graffiti and other blight reduction efforts.		

Objective 7.2 By December 2021, increase and promote job preparedness for adults with children.	**3-Year Objective Measures** ▪ Number of adults who have participated in Welfare-to-work or other job training program (e.g., adult school)	**Objective Leader** Workforce Development
Action Items	**Action Item Measures/ Deliverables**	**Responsible Agencies**
7.2.1 By December 2021, educate eligible adults and employers about CalWORKs to increase the number of adults that are participating in Welfare-To-Work.	▪ DSS to report on a quarterly basis the number (%) of families that are not participating in WTW ▪ DSS to report on the efforts taken to re-engage with this population	▪ BHS ▪ CAPMC/Resource and Referral Alternative Program ▪ Chamber of commerce ▪ DSS ▪ Madera Adult School ▪ Workforce Development
7.2.2 By December 2021, begin media awareness campaign of the impact of parental mental health and substance (e.g., alcohol and drug) abuse on children and available services.	▪ Number of media components developed ▪ Media impressions	
7.2.3 By December 2021, increase referrals of adults with children to BH for mental health and substance (e.g., alcohol and drug) abuse treatment.	▪ Baseline report of adults with children being referred to BH for MH, SA or both and by agency ▪ Quarterly report of the number of adults with children receiving services from BH	
7.2.4 By December 2021, promote adult schools for job preparedness (i.e. HSD/GED/Soft Skills/Job Skills).	▪ Baseline report from each adult school in the county for referrals of adults with children attending in each of the targeted segments (i.e. HSD/GED/Soft Skills/Job Skills) ▪ Quarterly report of number of adults with children participating/attending an adult school. ▪ Action plan to increase adult school enrollment	
7.2.5 By December 2021, provide adults with children services from Workforce Development.	▪ Baseline report of the number of adults with children receiving services from WD ▪ Quarterly report of the number of adults with children receiving services from WD	

Objective 7.3 By December 2022, explore opportunities to limit the density of alcohol outlets and restrict advertising through a local ordinance.	**3-Year Objective Measures** ▪ Identified strategies and resources to support passage of zoning ordinances or other policy change	**Objective Leader** MCDPH
Action Items	**Action Item Measures/Deliverables**	**Responsible Agencies**
7.3.1 By November 2021, review existing policies from Madera and neighboring communities.	▪ Analysis of policies and identify those that need to be amended or created to reach our goals	▪ ABC/Alcohol and Tobacco Board ▪ BHS ▪ Chamber of Commerce ▪ City of Madera Planning Department ▪ City of Madera Police ▪ Madera County Sheriff's Department ▪ MCDPH ▪ MCCED ▪ MCSOS
7.3.2 By December 2021, collect data related to the number and location of alcohol outlets. MC will utilize its Geographic Information System (GIS) to create an interactive map to provide the geographic inventory of alcohol outlets.	▪ Analysis of density of liquor stores ▪ Analysis of advertising	
7.3.3 By June 2022, engage youth and youth groups as partners to address this objective by participating in PhotoVoice, walk audits, etc. to document current state of alcohol retailers and advertising.	One-time report of volunteers that includes number of youth volunteers and youth volunteer activities.	
7.3.4 By December 2022, develop a public policy awareness campaign that would be designed to advocate for the adoption and implementation of policies.	▪ Outline of elements of a public policy awareness campaign with timelines, objectives and outcomes.	

Goal 8: Build social cohesion and community involvement.

Objective 8.1 By December 2021, expand participation in mentoring programs to increase the number of 'caring adults' in a child's life.	**3-Year Objective Measures** ▪ Number of mentors available ▪ Number of youth participating in the mentoring programs	**Objective Leaders** Big Brothers, Big Sisters; MUSD
Action Items	**Action Item Measures/Deliverables**	**Responsible Agencies**
8.1.1 By December 2019, assess the availability, needs, and use of mentoring programs including the availability of mentors across the entire county and those from diverse backgrounds (e.g., women, racial/ethnic groups, socio-economic status).	▪ Gap Analysis	▪ Big Brother, Big Sisters ▪ Chamber of Commerce ▪ City of Madera Police Department ▪ MCSOS

8.1.2 By December 2020, identify and implement strategies that focus on the recruitment of diverse (i.e., geographically diverse as well as gender and race/ethnicity) mentors countywide based on gap analysis.	▪ List of recommendations/strategies	▪ MUSD
8.1.3 By December 2021, promote available and benefits of mentoring programs to parents, organizations, worksites, and youth.	▪ Number of organizations reached ▪ Number of educational presentations	

Goal 9: Increase and promote community support and services

Objective 9.1 By December 2022, increase the number of culturally sensitive trainings and screenings offered to the community on topics related to CAN.	**3-Year Objective Measures** ▪ Number of Trainings provided ▪ Number of Diverse Curricula ▪ Number of Participants	**Objective Leader** MCCAPC
Action Items	**Action Item Measures/Deliverables**	**Responsible Agencies**
9.1.1 By August 2022, conduct mandated reporting trainings including disciplines versus abuse.	▪ Trainings needs assessments ▪ Calendar of trainings ▪ Sign-In Sheets	▪ BHS ▪ CBDIO ▪ Child Abuse and Prevention Council ▪ City of Madera Police ▪ DSS ▪ First 5 Madera County ▪ MCCAPC ▪ Ministerial Association ▪ MCSOS
9.1.2 By December 2022, provide trauma informed care (ACEs) training.	▪ Number of Trainers ▪ Calendar of trainings ▪ Number of trainings ▪ Number of participants	
9.1.3 By December 2022, develop a Commercial Sexual Exploitation of Children (CSEC) Protocol.	▪ Number of presentations to stakeholders ▪ Develop MOUs for partners ▪ Endorsed MOUs between partners	
9.1.4 By December 2022, provide cultural competency trainings that include the understanding of Implicit Bias to providers and staff.	▪ Number of trainers ▪ Calendar of trainings ▪ Number of trainings ▪ Number of participants	
9.1.5 By June 2022, train residents on topics such as implicit bias, trauma, abuse and neglect, domestic violence, substance (e.g., alcohol and drug) abuse, and community resources.	▪ Number of trainings provided	

Objective 9.2	**3-Year Objective Measures**	**Objective Leader**

By December 2022, increase the number of parenting programs/classes that are culturally sensitive to parents to strengthen their families.	▪ Number of Home Visitation programs ▪ Number of families with complete home visitation programs ▪ Number of parenting classes ▪ Number of families who have completed parenting classes ▪ Results of PRE & POST Tests - Measurement tools demonstrate growth (Knowledge/Behaviors)	DSS
Action Items	**Action Item Measures/Deliverables**	**Responsible Agencies**
9.2.1 By December 2022, expand 2evidence-based home visiting programs.	▪ Number of diverse curricula utilized ▪ Number of CBO's utilizing curricula ▪ Success stories (at least one per curriculum) ▪ Parent satisfaction surveys ▪ Results of PRE & POST Tests	▪ BHS ▪ CAPMC ▪ CBDIO ▪ DSS ▪ First 5 Madera County ▪ First 5 Madera County ▪ MCCAPC ▪ MCDPH ▪ MCSOS ▪ MUSD ▪ State Pre-School
9.2.2 By December 2022, expand evidence-based parenting classes/programs.	▪ Number of parents participating in ACEs program ▪ Number of parents participating in Abuse versus Discipline programs ▪ Number of Parents participating on Stress/Resiliency programs ▪ Number of parents participating in programs such as Project Protect, Parent Project, and Door of Hope Program ▪ Number of parents participating in Financial Management trainings	
9.2.3 By December 2021, develop an Ad Hoc Committee to explore Foster Youth Services Cohorts.	▪ List of Committee Members ▪ Meeting Agendas ▪ Meeting Minutes ▪ Number of Youth Cohorts	

Objective 9.3 By December 2023, expand low-cost preschool education programs that target children of families who qualify.	**3-Year Objective Measures** ▪ Number of preschool program types ▪ Number of preschool education sites ▪ Number of children participating in preschool programs per site ▪ Number of children participating during 2019 ▪ Number of children participating during 2020 ▪ Number of children participating during 2021	**Objective Leader** MCSOS / Local Planning Council (LPC)

Action Items	Action Item Measures/Deliverables	Responsible Agencies
9.3.1 By September 2021, assess data to determine the number of low-income working families with children 0-5.	▪ Data reports of "working poor" preschooler 0-5 ▪ GIS Map of concentration of "working poor" preschoolers ▪ GIS Map of preschool locations	▪ CAPMC ▪ DSS ▪ First 5 Madera County ▪ LPC ▪ MCSOS ▪ MUSD
9.3.2 By September 2021, evaluate the service options to expand preschool access as needed.	▪ Gap analysis	
9.3.3 By December 2021, explore voucher system and/or scholarships to buy unused preschool slots.	▪ Summary report of research	
9.3.4 By December 2021, partner with Head Start/State Preschool to add "working poor" children for extra slots (difference between enrollment and licensing).	▪ Number of slots ▪ Number of children enrolled defined as being in working poor families	
9.3.5 By August 2022, explore viable new locations or identify facilities for potential preschools.	▪ List of potential locations	
9.3.6 By June 2023, develop an ad hoc committee to assess the factors contributing to preschool access.	▪ Meeting agendas and minutes	

Objective 9.4 By June 2022, Community Response Team (CRT) will be fully operating with action plan for the reduction of drug-related overdose deaths, and offering extensive education on Harm Reduction, Overdose Education and Naloxone Distribution.	**3-Year Objective Measures** ▪ Reduction in opioid-related overdose fatalities ▪ CRT members, partners and volunteers have an action plan in place to respond to an opioid-related sentinel event ▪ CRTs are established with regular meetings, action plan in place, and sustained with additional funding,	**Objective Leader** BHS & Health Management Agency (HMA)
Action Items	**Action Item Measures/Deliverables**	**Responsible Agencies**
9.4.1 By December 2021, host a community workshop on OUD 101, harm reduction, data specific to Madera, and requests for participation.	▪ List of community members wanting to participate	▪ BHS ▪ HMA ▪ DSS ▪ CAPMC ▪ MCSO ▪ Camarena Health ▪ Pistoresi Ambulance

9.4.2	By December 2021, Member and Partner recruitment	▪ 6 - 12 Members and partners oriented and meeting regularly	▪ John O'Connor ▪ Nayely Chavez
9.4.3	By December 2021, Outreach efforts to Latinx and tribal community members	▪ At least 1-2 Latinx and tribal community members participating in efforts	▪ John O'Connor ▪ Nayely Chavez
9.4.4	By December 2021, CRTs have created an action plan for 2022.	▪ Action plan in place, will include hosting overdose education and naloxone distribution events, outreach campaign to address stigma and the importance of harm reduction	▪ CRT Members ▪ HMA to support
9.4.5	By March 2022, qualitative research is complete with specific recommendations to CRT members	▪ 3 focus groups with individuals with lived experience and 10 stakeholder interviews ▪ Final analysis complete	▪ Marci Eads ▪ Nayely Chavez
9.4.6	By December 2022, develop an ad hoc committee to assess the factors contributing to preschool access.	▪ Meeting agendas and minutes	▪ CRT Members ▪ HMA

Goal 10: Continue to explore and innovate practices to prevent child abuse and neglect and develop a countywide awareness campaign related to child abuse and neglect.

Objective 10.1 By December 2021, collaborate to support and enhance initiatives of workgroup member agencies.	**3-Year Objective Measures** ▪ Number of collaborations initiated or discussed at GHF Workgroup meetings ▪ GHF Workgroup Participation Satisfaction Survey results	**Objective Leader** Workgroup Chairs
Action Items	**Action Item Measures/Deliverables**	**Responsible Agencies**
10.1.1 By December 2021, HPSC Workgroup members add relevant agency items that align with the HPSC Vision to Workgroup meeting agendas.	▪ Agency-added agenda items	▪ CAPMC ▪ DSS ▪ MCCAPC
10.1.2 Beginning January 2019, annually complete a HPSC Workgroup Participation Satisfaction Survey to include overall participation satisfaction, alignment of workgroup activities to agency/program mission and goals, collaboration by members in non-CHIP agency/program activities, and the degree to which collaboration enhances	▪ HPSC Workgroup Participation Satisfaction Survey results	

non-CHIP agency/program activities.		

Objective 10.2 By December 2021, gather local data to fill gaps in knowledge around poverty, alcohol and drug abuse, mental health, and child abuse and neglect.	**3-Year Objective Measures** ▪ Action Plan for Surveillance System	**Objective Leader** MCDPH
Action Items	**Action Item Measures/Deliverables**	**Responsible Agencies**
10.2.1 By June 2021, identify existing data sources and data collection activities and determine gaps related to child abuse and neglect and related upstream factors.	▪ Summary of existing data ▪ Gap analysis	▪ BHS ▪ DSS ▪ MCDPH
10.2.2 By September 2021, assess feasibility of ongoing data collection system for child abuse and neglect, alcohol and drug abuse, and behavioral health.	▪ Feasibility Assessment	
10.2.3 By December 2021, determine action steps for next CHIP for implementation of data surveillance system (if deemed feasible).	▪ Action plan for surveillance system	

D. Homeless Solutions Workgroup Goals

Goal 11: Increase access to health care among individuals experiencing homelessness by expanding mobile health and linkages to services for sexually transmitted diseases, HIV and other communicable diseases; relevant immunizations (including COVID); oral health services; mental health services; health screenings and education; and social support programs such as Medi-Cal, WIC and other support services.

Objective 11.1 By December 2022, expand mobile health services to homeless population	**3-Year Objective Measures** ▪ Number of mobile health services offered	**Objective Leaders** MCDPH
Action Item	**Action Item Measures/ Deliverables**	**Responsible Agencies**

11.1.1 By June 2022, assess and coordinate with other mobile health services to fill in service gaps and leverage a one-stop shop approach to reach homeless populations.	▪ Mobile health services plan	▪ Camarena ▪ MUSD
11.1.2 By December 2022, implement mobile services based upon data and needs of homeless population.	▪ Mobile health services	

Goal 12: Expand homeless-focused data availability and quality across Madera County agencies.

Objective 12.1 By December 2022, identify best practices for data sharing among agencies providing homeless-focused services.	**3-Year Objective Measures** ▪ Data sharing plan	**Objective Leaders** MCDPH
Action Item	**Action Item Measures/ Deliverables**	**Responsible Agencies**
12.1.1 By December 2022, explore data sharing methodology (i.e., data sharing portal, MOUs) that provide access to all partnered agencies providing homeless-focused services.	▪ Summary of best practices for data sharing ▪ Data Sharing Plan	▪ CAPMC ▪ BHS ▪ MCH

Goal 13: Open a New Madera County Respite Center

Objective 13.1 By December 2021, open a respite center for homeless population to recover post-hospital discharge.	**3-Year Objective Measures** ▪ Remodel of men's and women's respite care units ▪ Remodel and operational funding ▪ Respite center launch	**Objective Leaders** CAPMC
Action Item	**Action Item Measures/ Deliverables**	**Responsible Agencies**
13.1.1 By July 2020, Develop a plan for a respite center at the Madera Rescue Mission (Mission).	▪ Written Plan	▪ Madera Rescue Mission (MRM) ▪ MCDPH ▪ MCH ▪ BHS
13.1.2 By April 2021, Identify and secure funding streams for physical remodel of identified space at MRM and ongoing cost.	▪ Budget for respite center ▪ Funding proposals ▪ Funding contracts	

13.1.3 By April 2021, Remodel men's and women's respite care units at the MRM	▪ Remodeled units	
13.1.4 By May 2021, develop policies and procedures (PPGs) for respite center referral and operations.	▪ Site Visit at Fresno Respite Care Center ▪ PPGs	
13.1.5 By June 2021, host an open house and launch respite center.	▪ Open House event	

Goal 14: Increase Navigation Support for the Homeless Population

Objective 14.1 By December 2021, hire additional outreach and caseworker staff to support navigation of homeless population.	**3-Year Objective Measures** ▪ Number of staff trained and hired	**Objective Leaders** CAPMC
Action Item	**Action Item Measures/ Deliverables**	**Responsible Agencies**
14.1.1 By December 2021, launch the Homeless Engagement for Living Program (HELP) Navigation Center	▪ Hire and train 2 outreach workers and 4 case workers	▪ MRM
14.1.2 By December 2021, add additional caseworker at Madera Rescue Mission	▪ Hire and train a caseworker at MRM	

Goal 15: Expand Housing Infrastructure for the Homeless Population

Objective 15.1 By December 2022, increase short and long-term housing for the homeless population.	3-Year Objective Measures ▪ Number of beds/units	**Objective Leaders** CAPMC
Action Item	**Action Item Measures/ Deliverables**	**Responsible Agencies**
15.1.1 By December 2021, implement No Place Like Home (NPLH) behavioral health program to expand housing targeting homeless and behavioral health clientele.	▪ 16 beds at Sugar Pine ▪ 7 beds at La Esperanza ▪ 22 beds in Oakhurst	▪ BHS ▪ MRM ▪ Self Help Enterprises ▪ County Administration

15.1.2 By December 2022, plan Bridge Housing Project at Madera Rescue Mission	▪ Funding application ▪ Funding contract ▪ Completed plan	
15.1.3 By December 2022, submit application for Project Homekey	▪ Completed application	

Goal 16: Expand Sobering and Rehabilitation Infrastructure for the Homeless Population

Objective 16.1 By December 2022, expand sobering and rehabilitation beds for the homeless population.	3-Year Objective Measures ▪ Number of beds/units	**Objective Leaders** BHS
Action Item	**Action Item Measures/ Deliverables**	**Responsible Agencies**
16.1.1 By March 2022, develop a plan for 6-10 beds Detoxification Alcohol and Drug Center, under the Governor's multi-year initiative CalAIM, California Advancing and Innovating Medi-Cal, through Managed Care Plans Community Supports funding	▪ Plan for alcohol and drug detoxification	▪ CAPMC
16.1.2 By March 2022, finalize reimbursement rates and contracts with the Managed Care Plans	▪ Completed contracts	
16.1.3 By June 2022, identify and contract with service providers for alcohol and drug detoxification beds	▪ 6-10 alcohol and drug detoxification beds	
16.1.4 By August 2022, submit application to Department of Healthcare Services (DHCS) to become a Drug Medi-Cal Organized Delivery System (DMC-ODS) county to expand capacity for persons with primary Substance Use Disorders (SUD), under CalAIM DMC-ODS and other funding for SUD services	▪ Application submitted to DHCS	

IV. Alignment with State and National Priorities

Alignment of local CHIP objectives with California and national priorities is important for gaining greater impact with available resources. National and state goals set targets that encourage collaboration among local municipalities. And, these broader goals set funding priorities to support local work. Table 3 illustrates the alignment of local, state and national goals with some examples. These examples are not an exhaustive list of state and national goals that align with the LCWM goals rather they offer a sample of how LCWM local goals is provided as an example of alignment.

The state of California's health priorities are outlined in Let's Get Healthy California (LGHC). Started in 2012, LGHC is led by a Task Force of health and healthcare leaders throughout the state. The Task Force developed six goal areas and identified key indicators to measure our progress towards the goal of California becoming the healthiest state in the nation.

National health priorities are detailed in Healthy People 2020 (HP2020). Since 2010, Health People sets 10-year health goals for the nation. HP2020 is a highly quantitative plan with four goals monitored by the National Center for Health Statistics:

1. Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death;
2. Achieve health equity, eliminate disparities, and improve the health of all groups;
3. Create social and physical environments that promote good health for all; and
4. Promote quality of life, healthy development, and healthy behaviors across all life stages.

LCWM Priority 1 focuses on the prevention of diabetes and obesity. Local goals target change in social and physical environments that contribute to greater physical activity and better nutrition. These parallel national goals that target the built environment that includes where people live, work, and socialize. Physical activity, healthy diet, and services to screen and treat diabetes are priorities across national, state and local levels.

LCWM Priority 2 focuses on the prevention of child abuse and neglect. National priorities emphasize attention on assessment and intervention for mental health, neglect, and sexual abuse. More specific areas include attention to depression and trauma. State priorities for this area are broader, focusing on improvement in quality of life and service delivery. LWMC priorities align with both with goals for neighborhood and social cohesion as well as improvements in service delivery.

There are some similarities across all three levels for both priority areas. One is an emphasis on policy and systems change that can improve health equity and reduce health disparities. Another commonality is the attention to cultural and linguistically appropriate interventions and services that would also improve health care and outcomes for all.

National, State and Local Priority Issue Alignment

Table 3: Alignment of National, State and Local (LCWM) Priority Issue

LEVEL	Obesity & Diabetes	Child Abuse and Neglect
MADERA COUNTY	- Expand access to healthy options and services for obesity and diabetes prevention - Increase resident engagement in healthy neighborhood initiatives that support healthy environments and social cohesion - Continue to explore and initiate culturally appropriate practices to promote public health	- Improve neighborhood conditions, economic self-sufficiency, and social inequities that may contribute to child abuse and neglect - Build social cohesion and community involvement - Increase and promote community support and services - Innovate surveillance practices and awareness campaigns to prevent child abuse and neglect
CALIFORNIA*	- Increase fitness and healthy diets - Decrease obesity and diabetes - Increase controlled high blood pressure and high cholesterol - Increase culturally and linguistically appropriate services - Increase walking and biking	- Increase mental health and well-being - Increase culturally and linguistically appropriate services - Increase walking and biking - Increase safe communities - Increase access to primary and specialty care
UNITED STATES**	- Increase physical activity - Reduce screen time - Build environments to make physical activity easy - Build environments to make good nutrition easy - Increase population who is at healthy weight - Increase consumption of fruits and vegetables - Increase diabetes diagnosis for those with diabetes - Reduce diabetes incidence	- Reduce child maltreatment and self-injuries - Reduce sexual violence - Increase access to trauma care - Reduce alcohol and substance abuse (including prescription drug abuse) - Increase services for abuse and addition - Increase depression screening and treatment - Increase child and adult assessment and treatment for mental health

* Priorities identified from Let's Get Healthy California Taskforce Report, 2012-2022

** Priorities identified from HP 2020

V. Monitoring and Refinement

The LWMC CHIP will be directly monitored by the LWMC workgroups and overseen by the Steering and Executive committees. A monitoring plan will be created to track progress, and to identify opportunities for improvement. The CHIP is a living document that will be regularly reviewed and refined to ensure it is relevant and beneficial for Madera County. The current document, reflecting any updates or modifications will be available on the Madera County Department of Public Health website. In addition, any changes to workgroup goals or objectives will be printed annually.

Monitoring and evaluation of progress will occur in three ways.

1. The LWMC Executive Committee will review progress and discuss refinements during quarterly meetings. The Executive Committee will rely on each Workgroup to provide updates on progress, report challenges and barriers, request assistance, and nominate recommendations to improve the CHIP. Workgroups will provide this information during quarterly meetings, and more often when appropriate for the good of the initiative.

2. Each LWMC Workgroup will review progress and consider refinements during regular meetings. The Workgroups are the frontline of implementation for most of the activities in the CHIP. Members of each Workgroup are best positioned to understand and improve efforts related to their CHIP objectives. Workgroup meetings will be an opportunity to discuss and plan refinements.

3. The MCDPH will monitor and evaluate progress with the CHIP as part of its Strategic and Quality Improvement Plans which include objectives and activities for MCDPH's lead in LWMC and the CHIP. The Accreditation Coordinator will organize review of the CHIP according to these two plans. As MCDPH identifies areas for modification and improvement, recommendations will be provided to the Executive Committee.

LWMC will use these methods to identify and celebrate successes and lessons for how to improve along the way. As new initiatives and projects emerge in Madera, the LWMC members will work with them to ensure CHIP objectives are advanced and avoid unnecessary duplication. This may include partnership with new initiatives and incorporating new initiatives into LWMC. The aim will be to grow and advance the work accomplished through LWMC.

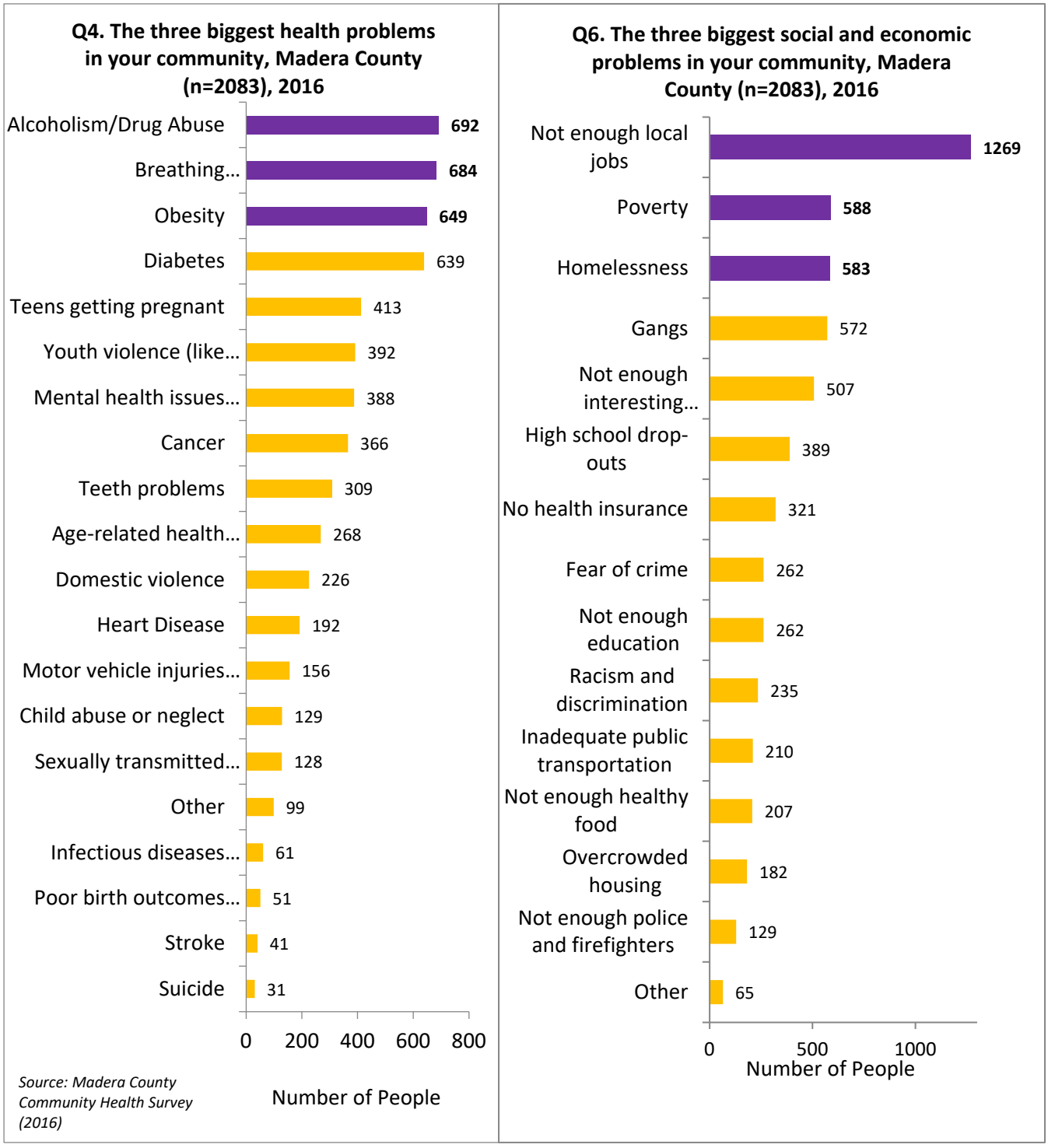
VI. Appendices

Appendix A

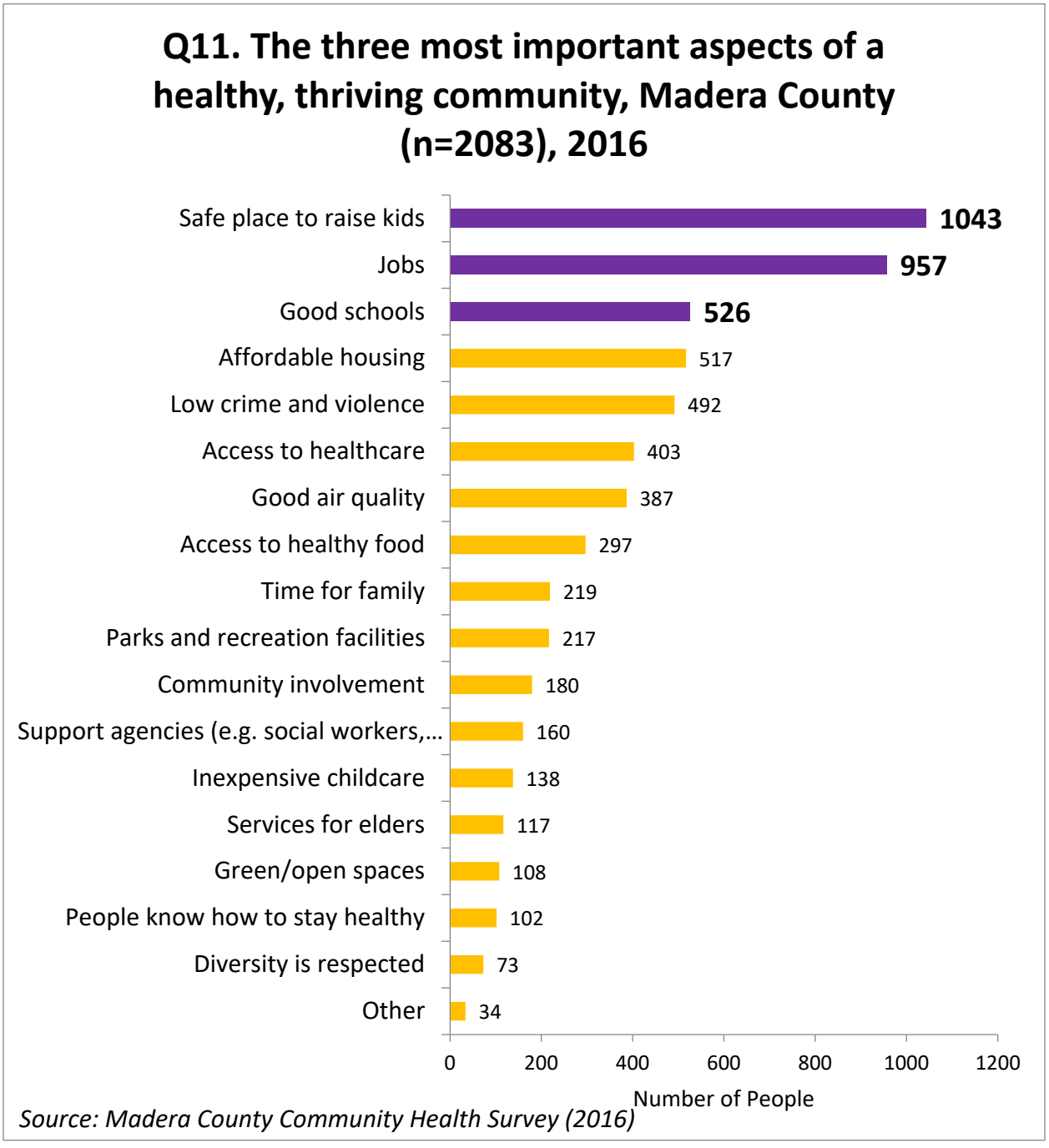
Chronology

October 2014 -December 2014	Varied Madera County department heads decided to initiate collaboration in a more fructiferous manner by engaging in conversations about the creation of a countywide coalition.
January 2015 - May 2015	The coalition was formed and began meeting monthly.
April 2015 - December 2015	The Steering Committee created the Community Health Assessment (CHA) tool. Members collected 2180 surveys countywide. 2180 (1720 face-to-face and 460 electronic) collected in the 5 county districts by 15 different agencies.
January 2016 - March 2017	The CHA data analysis was conducted by the University of California-Merced. The Steering Committee discussed CHA findings and chose the four health priorities denoted in the Community Health Improvement Plan (CHIP) which is currently in development. The CHA findings were presented at 8 town hall meetings throughout the county.
September 2017 **November 2017**	The CHA was published and became available on-line in the Madera County website http://www.madera-county.com/index.php/dph-home The CHA was published in the ***Evaluation and Planning ELSEVIER International Journal*** https://www.sciencedirect.com/science/article/pii/S0149718917301209
December 2017 - February 2018	The Steering Committee changed its name to "Live Well Madera County" and the two workgroups were defined. The two workgroups were officially established: • Healthy People Strong Communities (Obesity and Diabetes) • Growing Healthy Families (Child Abuse and Neglect)
March 2018 – February 2019	The LWMC Steering Committee adopted the decision-making criteria to write the CHIP. The LWMC Coalition developed goals, objectives, and activities to finalize the CHIP. February 2019: Adoption of the CHIP.

Appendix B


Q4. The three biggest health problems in your community, Madera County (n=2083), 2016
Alcoholism/Drug Abuse 692
Breathing… 684
Obesity 649
Diabetes 639
Teens getting pregnant 413
Youth violence (like… 392
Mental health issues… 388
Cancer 366
Teeth problems 309
Age-related health… 268
Domestic violence 226
Heart Disease 192
Motor vehicle injuries… 156
Child abuse or neglect 129
Sexually transmitted… 128
Other 99
Infectious diseases… 61
Poor birth outcomes… 51
Stroke 41
Suicide 31
0 200 400 600 800
Number of People
Source: Madera County Community Health Survey (2016)
Q6. The three biggest social and economic problems in your community, Madera County (n=2083), 2016
Not enough local jobs 1269
Poverty 588
Homelessness 583
Gangs 572
Not enough interesting… 507
High school drop-outs 389
No health insurance 321
Fear of crime 262
Not enough education 262
Racism and discrimination 235
Inadequate public transportation 210
Not enough healthy food 207
Overcrowded housing 182
Not enough police and firefighters 129
Other 65
0 500 1000
Number of People

Appendix C


Q11. The three most important aspects of a healthy, thriving community, Madera County (n=2083), 2016
Safe place to raise kids
1043
Jobs
957
Good schools
526
Affordable housing
517
Low crime and violence
492
Access to healthcare
403
Good air quality
387
Access to healthy food
297
Time for family
219
Parks and recreation facilities
217
Community involvement
180
Support agencies (e.g. social workers,…
160
Inexpensive childcare
138
Services for elders
117
Green/open spaces
108
People know how to stay healthy
102
Diversity is respected
73
Other
34
0
200
400
600
800
1000
1200
Number of People
Source: Madera County Community Health Survey (2016)

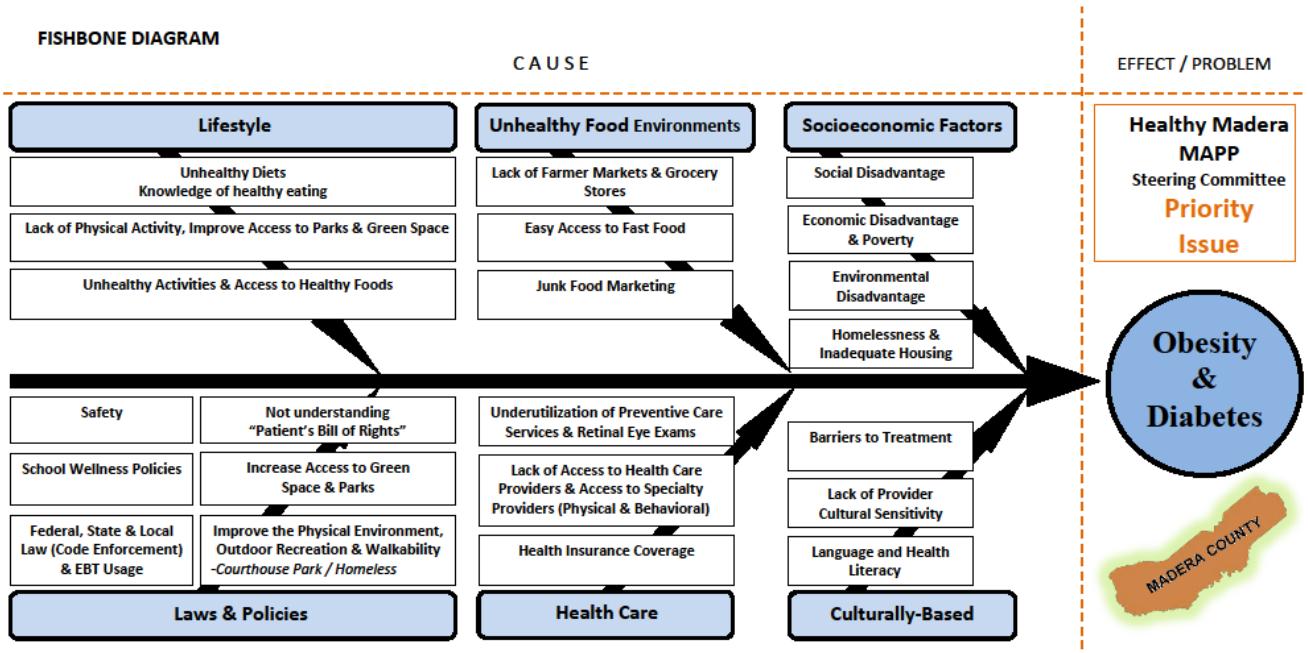
Appendix D

Community Presentations

• District 3 Town Hall Meeting	05/17/2016
• Department of Behavioral Health- Advisory Board	10/19/2016
• Fairmead Community & Friends	10/24/2016
• The Youth Commission	11/15/2016
• Grupo de Promotoras de Salud "Vision & Compromiso"	11/30/2016
• Grupo de Promotoras "CAL-Viva"	12/08/2016
• Social Agencies Linking Together (S.A.L.T.)	12/08/2016
• Health Improvement Town Hall Meeting MCPHD	12/13/2016
• North Fork Rancheria of Mono Indians of CA (District 5)	02/24/2017

Appendix E

FISHBONE DIAGRAM

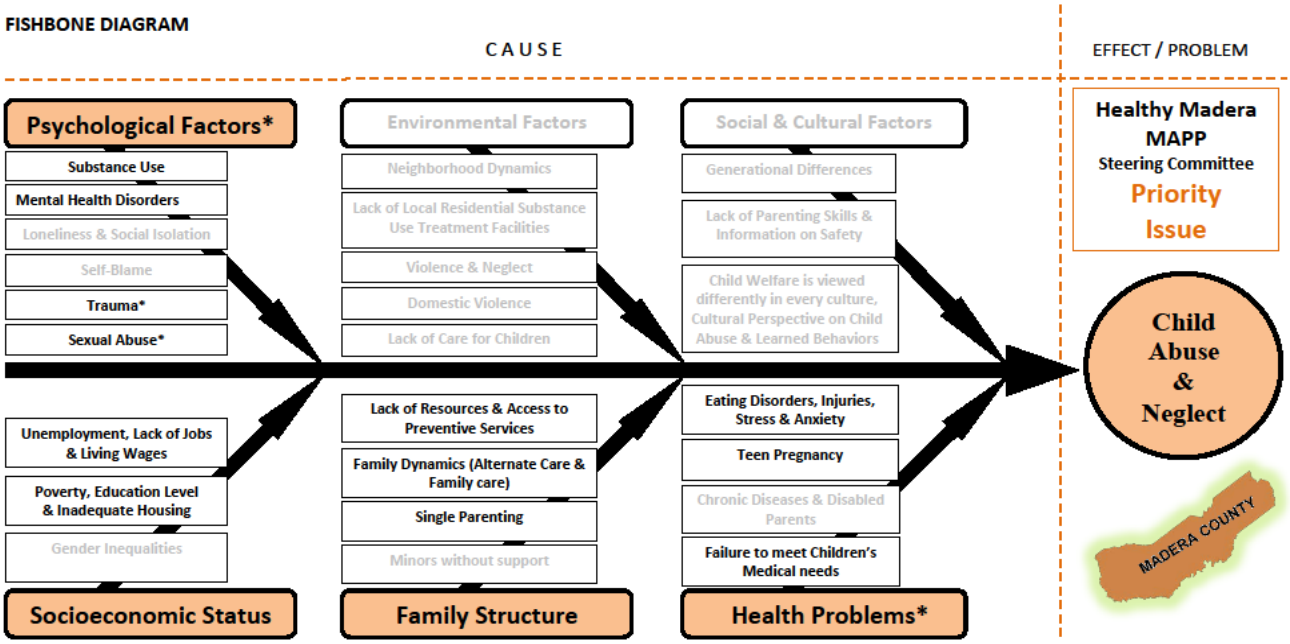


MAPP Steering Committee

*Mobilizing for Action through Planning and Partnerships (MAPP) is a strategic approach to community health improvement. This tool helps communities improve health and quality of life through community-wide strategic planning. Using MAPP, collaborative agencies in Madera County seek to achieve optimal health by identifying and using our resources wisely, taking into account our unique circumstances and needs, and forming effective partnerships for strategic action.

JA 11/14/2016

FISHBONE DIAGRAM



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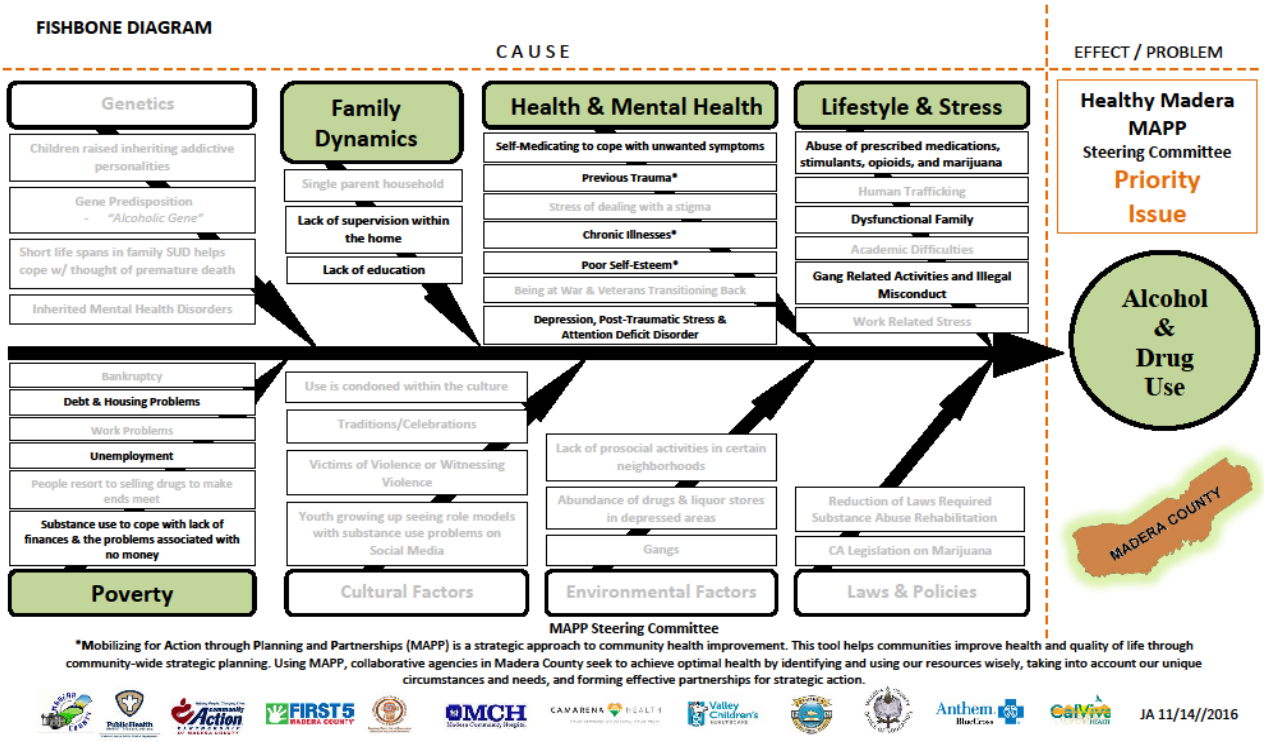
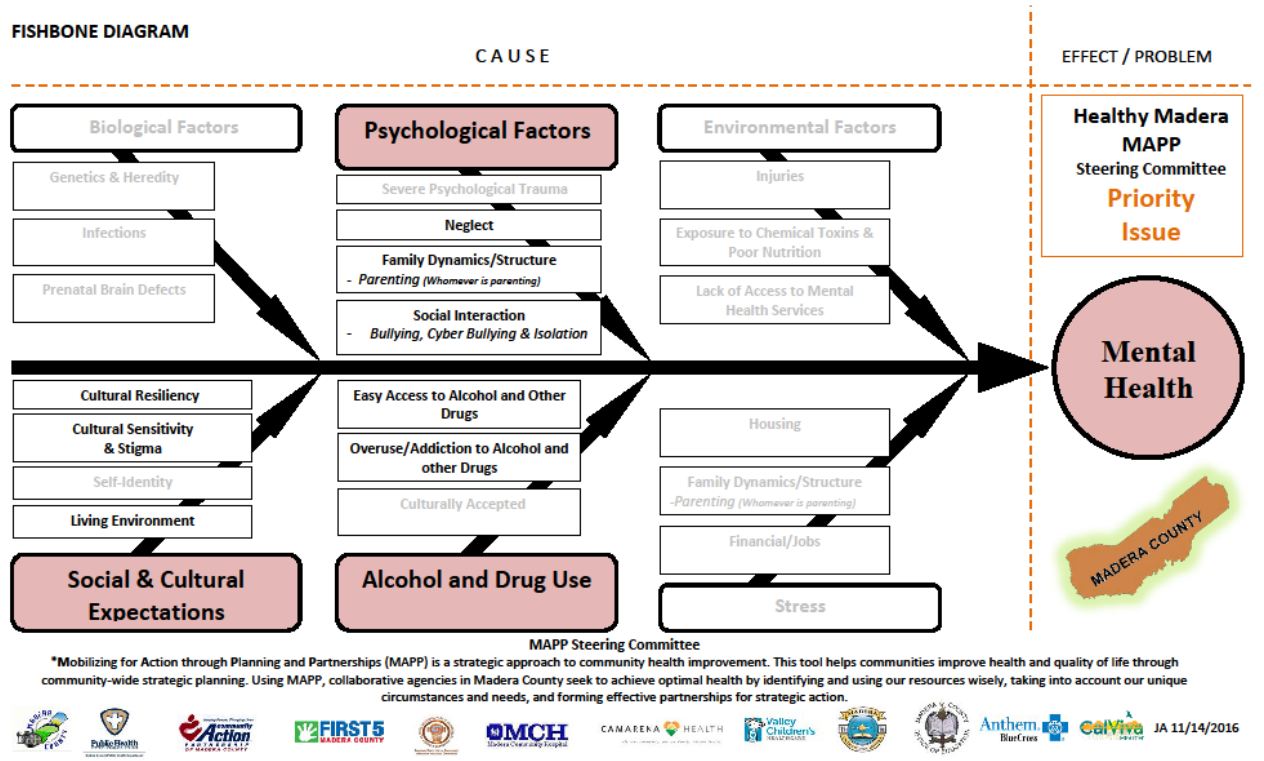
JA 11/14/2016

Appendix E (cont.)





Appendix F

LIVE WELL MADERA COUNTY – Obesity & Diabetes Workgroup — **ASSET INVENTORY**

INTERVENTION LEVEL

PREVENTION LEVEL

	INDIVIDUAL		INTERPERSONAL	ORGANIZATIONAL	COMMUNITY	PUBLIC POLICY
PRIMARY	Medical Assistant Health Coach Education / Camarena Health	Promotores de Salud / Home Interventions	Nutrition Education Seniors & Family Center / UC CalFresh	Retail healthy checkout isles / Food Fair, Baby Nutrition	SNAP-Ed Partnership Coalition (MCDPH)	School Meals / Summer Lunch Program
	Parent Nutrition Education (UC CalFresh & Dairy Council & MCDPH & MUSD)	Promotores de Salud / 4 Series Nutrition Classes	Walk to School Events (UC CalFresh & Dairy Council & MCDPH & MUSD)	Senior meals Program (Sites and Homebound)	Community Gardens – UC CalFresh (1 Senior site, 1 City –Madera Coalition for Community Justice)	Access to Parks, Trails, and Recreational Facilities
	Retail food demonstrations, signage, displays / Food Fair Baby Nutrition	Promotores de Salud / Promotoras Ahead of Childhood Obesity (Coming soon)	Direct Nutrition Education to Seniors/Family Centered -UC CalFresh	School Gardens - UC CalFresh	Social Media Outreach - MCDPH	Farmers Market
	Rethink your drink food demonstrations / MCDPH & UC CalFresh	All ages PA programs	Walk to School Events – UC CalFresh	Mobile Food Vendor at School	Fruit and Veggie Fest- MCDPH	Joint Use Agreement (MUSD & City)
	National Diabetes Prevention Program (NDPP) : Diabetes prevention classes / MCDPH	PA Education CATCH Program / UC CalFresh for After School K-12		LSWP advising and Implementation (UC CalFresh & Dairy Council & MCDPH & MUSD)		LSWP Advising and Implementation – UC CalFresh
	K-12 Nutrition education (UC CalFresh & Dairy Council & MCDPH & MUSD & Camarena)	Parent/Child Health Education / Camarena Health and UC CalFresh		Summer Meal Programs – National School / Lunch & Breakfast		
	Patient DM health Education / Camarena Health	Health Fairs / Outreach Events DM Education / UC CalFresh Community		Smarter Lunchrooms (UC CalFresh & Dairy Council & MCDPH & MUSD)		
	Youth Center Education/Cooking Classes MCDPH	Physical Activity Education (CATCH) – UC CalFresh		Walking Club at MUSD – Students, Staff at 2 sites		
	Direct Nutrition Education Pre-K- 12 and Parents – UC CalFresh	CalViva Adult Nutrition & PA Education		MUSD Wellness Committee - MUSD		
	Indirect Education (Health Fairs, Community Events, etc.) – UC CalFresh	Diabetes Basics & Know Your Numbers forum: diabetes, blood pressure, cholesterol, BMI (screenings) - CalViva				
	Direct Nutrition Education to Youth and Adults – UC CalFresh					
SECONDARY	BMI - Family Health Services, Rapid Care, Chowchilla MC	DM Support Group English / Camarena Health				
	Diagnostic Testing / Outpatient Laboratory	DM Clinical Support Group Spanish / Camarena Health				
	Parent/Child Health Education for Dx / Camarena Health	Access to Clinicians / Family Health Services, Rapid care, Chowchilla MC				
	Patient DM Health Education for Dx Camarena Health					
TERTIARY	Patient DM Health Education for Dx Camarena Health	Project Dulce: Diabetes Management Classes / Camarena Health	School Nurses at MUSD			
	Project Dulce: Diabetes Management Classes at Madera Community Hospital	Treatment of advance Disease / Madera Community Hospital				
	Treatment and Surveillance Access to Medical Specialists Medical Specialty Clinic	Comprehensive Diabetes Care / Family Health Services, Rapid Care, Chowchilla MC				

COMMUNITY HEALTH IMPROVEMENT MODEL

LIVE WELL MADERA COUNTY – Child Abuse & Neglect Workgroup — **ASSET INVENTORY**

INTERVENTION LEVEL

PREVENTION LEVEL

	INDIVIDUAL		INTERPERSONAL	ORGANIZATIONAL	COMMUNITY	PUBLIC POLICY
PRIMARY	Child Care Resources and Referrals (CAPMC)	Rad Kids Program for the general population (MCCAPC)	Parenting Classes (BHS)	Child Abuse Prevention Workshops provided to parents and staff – How to report C.A.N. (CAPMC)	Parent Project - 5 agencies certified to provide classes to parents with strong will children. Classes are 10 weeks (CAPMC)	
	Advocacy for families in need of child care services (CAPM)	Family Advocacy 1-1 Education (MCCAPC)	Community Resiliency Event – Family Fun Day (BHS)	Mandated reporter training staff on ACES & ASQ-3 & ASQ-SE-2 & Building resilience & HT CSEC & Trauma Informed (MCCAPC)	Project Protect Training /Curriculum (MCSOS)	
	Working with child care providers area of health & safety (CAPMC)	Individual Mental Health Services (VS)	Mentoring Program (Faith and PD)		Mental Health Coordination (VS)	
	Quality Improvement, stress management for providers and parent (CAPMC)	Provide Community Education on CAN (DSS)	Staying connected with your teen classes (Parenting Classes) to the general public (MCCAPC)	Positive behavioral Interventions & Support Training (MCSOS)	Family Advocacy 1-1 connect with appropriate resources (MCCAPC)	
	Post-Partum Depression Group (BHS)	Positive Parenting Curriculum (MCDPH)	Educate Veterans & Families (VS)		Parent Project – Education (Faith and PD)	
	Child Abuse 101 Education to families (MCCAPC)	Case Management – Home Visiting Program (MCDPH)	Staying connected with your teen classes (Parenting Classes & Court Ordered) (MCCAPC)		Minimize Stressors (VS)	
	Child Development Resilient Families (MCCAPC)	Counselors & Social Workers on Staff (MCSOS)				
	ACES (MCCAPC)	Referrals to Community Services (e.g. anger management) (MCDPH)				
	Teen Classes on Money Management and Relationship Skills (MCCAPC)	Provide Public Assistance to families (DSS)				
	Mental Health Education (BHS)					
SECONDARY	Mandated Reporting – Suspected C.A.N. (MCDPH)		Childcare Providers Education Classes R & R (MCDPH)	MH education for early detection (BHS)	Collaboration with Law Enforcement and other Comm. Agencies to address C.A.N. (DSS)	
	Wellness Center for Adults & Youth (BHS)				Contracts with Comm. Agencies to prevent C.A.N. (e.g. first 3, CAPMC) (DSS)	
	Investigate Referrals on CAN (DSS)				Mandated reporter training (DSS)	
	Observations from unrelated calls for service (Faith and PD)				Coalition around trauma (BHS)	
	Victim Services providing information and support on crime, rape crisis & domestic violence (CAPMC)				Mandated CPS reporting (MCSOS)	
TERTIARY	Counseling Services (Faith and PD)		Strengthening Families Program (SFP) MOU with Probation and DSS 14 week family class (CAPMC)		Treatment courts (VS)	
	Trauma Sensitive Practice – Training (MCSOS)		Staying connected with your parent classes – youth classes and the general public (MCCAPC)		Foster Youth Services - Law & Services (MCSOS)	
	Therapy (BHS)		Staying connected with your parent classes – youth classes "court ordered" (MCCAPC)		McKinny Vento – Homeless (MCSOS)	
	Provide Services to families who have abused or neglected their children (DSS)				Partnerships in place - CAPMC & VS & MCCAPC VS representative at JSD (MCCAPC)	

COMMUNITY HEALTH IMPROVEMENT MODEL