MADERA COUNTY
COMMUNITY HEALTH IMPROVEMENT PLAN

May 2024

Live Well MADERA COUNTY

Table of Contents

Acknowledgements

Live Well Madera County Executive Committee

Connie Moreno-Peraza
Director – Madera County Department of Behavioral Health Services

Deborah Martinez
Director – Madera County Department of Social Services

Mattie Mendez
Executive Director – Community Action Partnership of Madera County, Inc. (CAPMC)

Sara Bosse
Director – Madera County Department of Public Health

Tim Curley
Director of Public Policy and Advocacy– Valley Children's Healthcare

Live Well Madera County Steering Committee

1. Anthem Blue Cross
2. Big Brothers Big Sisters
3. CalViva Health
4. Camarena Health
5. Centro Binacional Para El Desarrollo Indígena Oaxaqueño (CBDIO)
6. City of Madera Parks/Community Services
7. Community Action Partnership of Madera County
8. Community Health System
9. Court Appointed Special Advocates - Fresno and Madera Counties
10. First 5 Madera County
11. Kaiser Permanente
12. Lideres Campesinas
13. Madera Community Hospital
14. Madera County Board of Supervisors
15. Madera County Child Abuse Prevention Council
16. Madera County Child Support
17. Madera County Community and Economic Development
18. Madera County Department of Behavioral Health Services
19. Madera County Department of Environmental Health
20. Madera County Department of Public Health
21. Madera County Department of Social Services
22. Madera County Probation
23. Madera County Public Library
24. Madera County Sheriff's Office
25. Madera County Superintendent of Schools
26. Madera Unified School District
27. United Way of Fresno and Madera Counties
28. University of California-Cooperative Extension
29. Valley Children's Healthcare
30. Workforce Development Board of Madera County

Prepared by Madera County Department of Public Health

Those listed below were instrumental in the writing and/or design of this report:

Areysy Guerrero, Health Education Specialist

Brayan Preciado, California Pathways Program Fellow

Brian Gamble, Program Manager

Graciela Valdez, Health Education Coordinator

Marizela Terkildsen, Health Education Coordinator

Minh Nguyen, Public Health Program Manager

Phylisha Chaidez, Community Health and Wellness Assistant

Stephanie Nathan, Assistant Public Health Director

Trini Aleman, Epidemiologist

Workgroup Leads

Growing Healthy Families
Deborah Martinez, Director, Madera County Department of Social Services

Pathways to Recovery
Miravel Navarro, Division Manager, Madera County Department of Behavioral Health Services

Healthy People Strong Communities
Tiara Munoz, Program Manager, Madera County Department of Public Health

Suggested Citation

Live Well Madera County. (2024). Community Health Improvement Plan for Madera County. Madera, CA: Madera County Department of Public Health.

Copyright Information




Overview

Introduction

The Live Well Madera County (LWMC) Community Health Improvement Plan (CHIP) is rooted in the latest findings from the 2023 LWMC Community Health Assessment (CHA). This CHIP leverages the CHA data to pinpoint the four primary health-related priorities and to delineate strategies aimed at addressing these identified needs through a collaborative, collective impact approach. This plan highlights the foundation of the LWMC partnership and the community engagement process, which has culminated in an ambitious yet achievable action plan, with shared goals, objectives, and well-defined timelines. Twenty-nine community and government organizations have actively participated in the development of this 2024 – 2026 CHIP.

The LWMC CHIP is focused on shaping policies and systems that influence the operations of various agencies, industries, and institutions. It is intended to address health outcomes across all community sectors. LWMC is also committed to equity across all strategies by considering how factors, such as ethnicity, race, gender, and income, affect health outcomes.

The CHIP is part of a community-driven strategic planning process to achieve health equity, called Mobilizing for Action through Planning and Partnerships (MAPP). MAPP provides a structure for communities to figure out what health problems are most important and how to work together to address them. The purpose of this CHIP is to help Madera County monitor and assess progress towards four strategic health priorities identified in the CHA.

Health Priorities

1. Access to Care

2. Domestic Violence and Child Abuse

3. Substance Use

4. Diabetes and Heart Disease

This plan will play an important role in informing the strategic planning processes of all LWMC participating agencies. As a community-driven initiative, the CHIP is designed to support the community in effectively advocating and mobilizing resources to enhance the overall health and well-being of Madera County's residents.

Partnership: Live Well Madera County (LWMC)

LWMC is the guiding partnership for both the 2023 Community Health Assessment (CHA) and the updated Community Health Improvement Plan (CHIP). Established in 2014, LWMC's core mission has been to promote healthy behaviors and foster environments conducive to well-being.

In 2018, LWMC underwent a strategic restructure and reevaluation of partner roles and responsibilities. A three-tiered structure was formed consisting of an executive committee, steering committee, and workgroups. The LWMC executive committee assumed a pivotal role in shaping the coalition's direction and now consists of directors from Madera County Department of Behavioral Health Services, Madera County Department of Public Health, Madera County Department of Social Services, Community Action Partnership of Madera County, and Valley Children's Hospital. The steering committee oversees the workgroups and is comprised of decision-makers and leaders from organizations across various sectors with primary responsibility for guiding the CHA and CHIP. The workgroups are based upon the CHIP priority areas. They are responsible for defining and implementing the goals, strategies, objectives, and activities of the CHIP. The Madera County Department of Public Health (MCDPH) provides backbone support to LWMC.

LWMC has crafted a vision and mission, decision-making criteria, brand/logo, and further formalized its structural framework. The LWMC charter was adopted in 2018 to provide a blueprint for the coalition's operations to ensure clarity and purpose. The 2024 updated charter reflects LWMC's commitment to equity and the inclusion of community-based organizations and residents. The chronology of the CHA and CHIP process and the LWMC charter are available in the appendix for reference.

Live Well Madera County CHIP: At-A-Glance

Priority: Access to Care
Workgroup: Steering Committee

Goal 1:

Improve healthcare equity within Madera County and the Central California Public Health Consortium Region.

Strategies:

- Engage with regional and state associations and experts.
- Increase reimbursement rates.
- Build a healthcare workforce pipeline.
- Recruit and train Community Health Workers (CHWs).
- Expand reimbursement for CHWs.
- Coordinate messaging with health plans, providers and community based organizations (CBOs).
- Educate the community on proper use of the healthcare system.
- Refer high emergency room users to case management.

Goal 2:

The LWMC Steering Committee will plan, implement, and publish a Community Health Assessment that aligns with the state's 3-year cycle.

Strategies:

- Utilize equitable data collection methods.
- Conduct outreach to historically marginalized populations.
- Encourage and utilize regional data collection.
- Engage with LWMC coalition.

Goal 3:

Uplift and support equity among LWMC member agencies and the community.

Strategies:

- Update governance.
- Incentivize participation for residents and CBOs.
- Conduct targeted recruitment.
- Provide training.
- Implement multi-lingual and multi-modal communication and messaging.

Live Well Madera County CHIP: At-A-Glance

Priority: Domestic Violence and Child Abuse
Workgroup: Growing Healthy Families

Goal 1:

Expand youth-focused healthy relationship education and services.

Strategies:

- Expand youth awareness of the signs of teen dating violence.
- Expand youth awareness of available resources.
- Assess teen dating violence resources in the community.
- Ensure people working with youth (e.g., educators, community leaders) understand the signs of teen dating violence.
- Promote available resources.

Goal 2:

Enhance youth-resiliency education and support.

Strategies:

- Expand education on teen-on-teen violence and bullying prevention.
- Foster positive youth-centered environments.
- Establish a mentorship program to connect youth with positive guidance and support.

Goal 3:

Expand family-focused healthy relationship education and support.

Strategies:

- Increase parents' knowledge about the signs of familial violence.
- Assess familial violence resources in the community.
- Support parents' awareness of available resources.
- Establish community partnerships to broaden the range of available activities.
- Increase awareness of Adverse Childhood Experiences (ACEs) assessments.
- Develop and implement a referral process after ACEs assessments.
- Expand public awareness of resilience-building activities.

Live Well Madera County CHIP: At-A-Glance

Priority: Substance Use
Workgroup: Pathways to Recovery

Goal 1:

Improve access to substance use disorder services for Madera County residents.

Strategies:

- Complete a community-wide asset map to identify gaps and opportunities in substance abuse services.
- Strengthen collaboration and partnerships to expand the capacity of detox and outpatient services.
- Develop culturally sensitive health education programs focused on substance abuse prevention, treatment options, and mental health awareness.

Goal 2:

Decrease opioid use and opioid related fatalities in Madera County.

Strategies:

- Increase awareness about opioid prevention and education opportunities.
- Strengthen community partnerships and coordination.
- Implement training initiatives.

Goal 3:

Increase community engagement to prevent harmful substance use.

Strategies:

- Develop a substance use collaborative to enhance services by coordinating efforts, reducing duplication, and filling gaps in treatment and prevention initiatives.
- Launch a campaign aimed at reducing stigma, promoting awareness, and encourage prevention strategies.

Live Well Madera County CHIP: At-A-Glance

Priority: Diabetes and Heart Disease
Workgroup: Healthy People Strong Communities

Goal 1:

Prevent and manage rates of diabetes and heart disease through education and awareness.

Strategies:

- Establish partnerships with local organizations.
- Diversify program formats.
- Incentivize participation.
- Collaborate with Resident Champions.
- Establish clear guidelines and protocols for referrals.
- Enhance communication between referring entities.
- Organize health education events.
- Launch multimedia campaigns.
- Implement school-based health education programs.

Goal 2:

Implement policy, systems, and environmental changes that support a healthy community and address the social determinants of health.

Strategies:

- Build relationships and conduct outreach to local businesses.
- Offer training and resources to worksites.
- Foster collaboration and consensus-building among stakeholders.
- Develop/amend biking and pedestrian plans.
- Expand smoke-free environments.
- Advocate for policy changes to support healthier lifestyles.
- Increase the number and availability of farmers markets and mobile markets.
- Partner with food assistance programs.
- Engage Resident Champions/CHWs in support of healthy food access.

Goal 3:

Enhance access to affordable prevention services.

Strategies:

- Establish partnerships to facilitate access to assistance programs.
- Increase community awareness about the importance and availability of services.
- Expand the community's awareness about financial assistance programs.

CHIP Approach

CHA and Strategic Priority Selection

The 2023 Live Well Madera County (LWMC) Community Health Assessment (CHA) reflects, community input (primary data) collected from 1,699 surveys, 11 focus groups with 113 participants, and 21 key informant interviews, as well as a combination of state and national data (secondary data) such as the United States Census Bureau and California Health Interview Survey.

The 2023 LWMC CHA identified the biggest health concerns in Madera County. Subsequently, LWMC engaged in extensive outreach activities to collect input from community members and organizations to rank the biggest health concerns in Madera County. Between May 18, 2023 and July 13, 2023, feedback was gathered from 283 participants at 35 events in both English and Spanish. These included 23 presentations, 14 events, and 2 public comments.

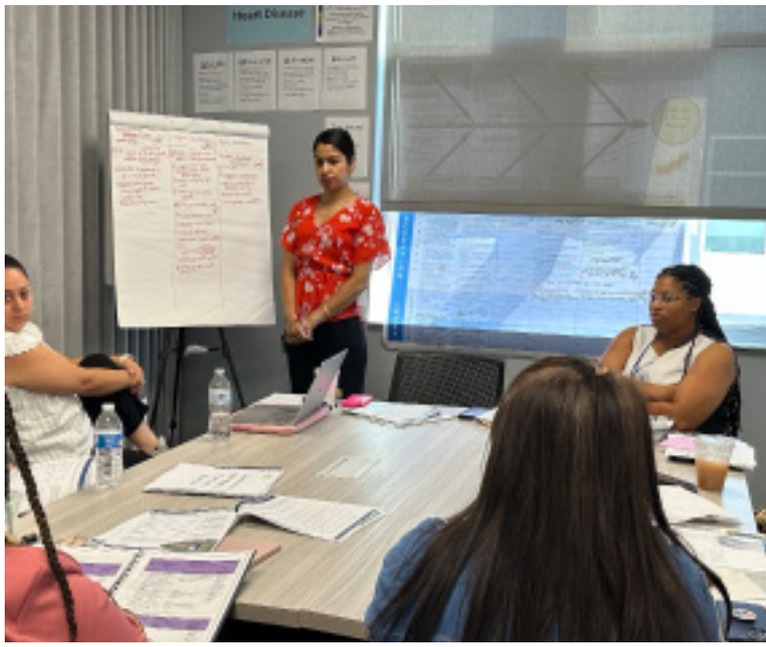
LWMC convened in June 2023 and used the following criteria to prioritize the health issues that emerged from the CHA.

Criteria for Prioritizing Health Issues

1. Size of Problem/Magnitude
2. Seriousness/Severity
3. Importance to Community Members
4. Ability to Have a Measurable Impact
5. Equity/Need Among Vulnerable Populations

The coalition reconvened in July 2023 to carefully assess and further narrow the identified health concerns. Through this collaborative process, four key priorities emerged as the focus for the Community Health Improvement Plan:

1. Access to Care
2. Domestic Violence and Child Abuse
3. Substance Use
4. Diabetes and Heart Disease



Decision-Making Criteria

Live Well Madera County (LWMC) adhered to a set of decision-making criteria to craft the community health improvement plan (CHIP). These criteria played a key role in shaping the goals, objectives, and activities to maximize the impact of the CHIP.

Decision-Making Criteria

- Prioritize Upstream
- S.M.A.R.T.I.E. Objectives
  - Specific
  - Measurable
  - Achievable
  - Relevant
  - Time-bound
  - Inclusive
  - Equitable
- High Return on Investment
- Promote Health Equity
- Use Data Effectively

Development of CHIP Goals and Objectives

In September 2023, two structured sessions further engaged the LWMC Steering Committee in the development and refinement of CHIP goals and objectives. These sessions utilized tools like the fishbone diagram to explore the root causes of the four health priorities, and the asset inventory worksheet to identify gaps in community resources for addressing the priorities. These tools helped the Steering Committee thoroughly analyze the health priorities and are included in the appendix.

Three workgroups were established to focus on addressing the specific priorities of diabetes and heart disease, domestic violence and child abuse, and substance use. Recognizing the connection to all of these issues, the priority of access to care was integrated into the Steering Committee's overarching goals. Each workgroup continued to collaborate through April 2024 to create goals and objectives for their respective priority area.

Monitoring and Refinement

The Live Well Madera County (LWMC) Community Health Improvement Plan (CHIP) will undergo diligent monitoring and refinement by the coalition to ensure it is responsive to the evolving needs of Madera County. The current CHIP will be readily accessible on the MCDPH website, and any updates to workgroup goals or objectives will be published annually.

Monitoring and Evaluation Approaches:

1. The LWMC Executive Committee will conduct quarterly reviews and rely on workgroups to provide progress updates, report challenges, seek assistance, and propose refinements. Frequent updates will be provided during quarterly meetings and as needed for the initiative's success.
2. LWMC workgroups are the front line of implementation of CHIP activities and will regularly assess progress and plan refinements. Workgroup meetings enable members to fine-tune efforts related to CHIP objectives to foster continuous improvement.
3. MCDPH will monitor CHIP implementation and offer recommendations to the LWMC Executive Committee.

LWMC will celebrate successes and derive lessons learned to support improvement. LWMC will collaborate to advance CHIP objectives as new initiatives surface in Madera County. This may involve partnerships with emerging initiatives and seamlessly incorporate them into LWMC's framework with the overarching goal of fostering growth and progress in community health initiatives.

Appendix

Workplan:

Steering Committee Goals - Access to Care

CHIP Goal 1	Improve healthcare equity in Madera County and the Central California Public Health Consortium Region.		
SMARTIE Objectives	**Objective 1:** By 2028, increase access to services among those who are on Medi-Cal.	**Objective 2:** By 2028, increase the use of Community Health Workers (e.g., Promotoras, Resident Champions) in Madera County to connect and refer to services.	**Objective 3:** By 2028, increase health literacy among the Medi-Cal population.
Measures	• Gaps identified in the regional healthcare continuum gap assessment. • Number of new Medi-Cal programs/initiatives that expand access to Medi-Cal services. • Number of new healthcare workforce development programs in region	• Number of "trained" Community Health Workers (CHWs) in Madera County • Number of agencies receiving reimbursement for the use of CHWs • Number of agencies that report using CHWs	• Percent of Medi-Cal population who can identify appropriate emergency room (ER) vs. urgent care use • Percent of residents identified as "frequent patients to ER" • Number of residents receiving health literacy information
Strategies We will implement these approaches to achieve our objectives and goal	• Engage with regional and state associations and experts to explore strategies. • Conduct a regional healthcare continuum gap assessment. • Increase Medi-Cal rates/payments in Central California. • Build a healthcare workforce pipeline.	• Recruit and train CHWs. • Expand reimbursement for CHWs. • Use success stories to promote use of CHWs.	• Coordinate messaging with health plans, providers, and community based organizations (CBOs). • Educate the community on proper use of the healthcare system. • Refer high ER users to case management.
Activities	1. Complete a scan of associations/groups Live Well Madera County members are participating on around access to care. 2. Pursue policy solutions such as: Medi-Cal equity enhancement. 3. Participate in healthcare continuum gap assessment. 4. Increase and promote healthcare careers and pathway programs.	1. Identify a basic training for CHWs. 2. Identify and facilitate technical assistant for agencies seeking to bill for CHWs. 3. Develop pathways for CHWs to be hired by agencies. 4. Track referrals and use of CHWs across county.	1. Develop and test messaging. 2. Coordinate with CHWs, CBOs, and other methods to conduct outreach and referrals to services. 3. Use focus group or surveys to assess population knowledge of what's an appropriate ER visit.
Priority Population	• Eastern Madera County • African American/Black • LGBTQ+ • Medi-Cal population		
Objective Leaders	• Anthem Blue Cross • CalViva • Central California Public Health Consortium • Madera County Department of Behavioral Health Services • Madera County Department of Public Health • Madera County Department of Social Services	• Anthem Blue Cross • CalVivia • Camarena Health • Madera County Department of Public Health	

Workplan:

Steering Committee Goals

CHIP Goal 2	The Live Well Madera County (LWMC) Steering Committee will plan, implement, and publish a Community Health Assessment that aligns with state 3-year cycle.		
SMARTIE Objectives	**Objective 1:** By 2025, publish a refresh to the 2023 Community Health Assessment (CHA).	**Objective 2:** By 2028, publish a new CHA.	**Objective 3:** By 2029, publish a new Community Health Improvement Plan (CHIP).
Measures	• Number of updated data sets in CHA	• Published CHA	• Published CHIP
Strategies We will implement these approaches to achieve our objectives and goal	• Utilize equitable data collection methods. • Conduct outreach to historically marginalized populations. • Encourage and utilize regional data collection.	• Utilize equitable data collection methods. • Conduct outreach to historically marginalized populations. • Encourage and utilize regional data collection.	• Live Well Madera County (LWMC) engagement
Activities	1. Participate in the regional CHA workgroup. 2. Oversee primary and secondary data collection. 3. Analyze data. 4. Publish report.	1. Participate in regional CHA workgroup. 2. Oversee primary and secondary data collection. 3. Analyze data. 4. Publish report.	1. Lead community and stakeholder sessions to inform prioritization. 2. Prioritize health issues. 3. Develop goals and objectives. 4. Publish CHIP.
Priority Population	• Eastern Madera County • LGBTQ+ • African American/Black		
Objective Leaders	• LWMC Steering Committee • Madera County Department of Public Health (MCDPH)		• LWMC Steering Committee • LWMC workgroups • MCDPH

Workplan:

Steering Committee Goals

CHIP Goal 3	Uplift and support equity among Live Well Madera County (LWMC) member agencies and the community.		
SMARTIE Objectives	**Objective 1:** By 2028, increase diverse membership in LWMC at all levels to include community based organizations (CBOs) and resident representation from historically disinvested groups.	**Objective 2:** By 2028, increase knowledge of equity principles among LWMC members and the community.	**Objective 3:** By 2028, increase communication about LWMC among members, stakeholders, and the broader community.
Measures	• Number of LWMC agencies signing participation agreement • Number of non-agency affiliated residents participating in LWMC • Number of CBOs groups representing historically disinvested groups participating in LWMC	• Number of individuals/ agencies receiving equity training • Percent of LWMC members with increase in knowledge or capability to implement equity strategies	• Number of messages • Number of newsletters
Strategies We will implement these approaches to achieve our objectives and goal	• Update governance. • Incentivize participation for residents and CBOs. • Conduct targeted recruitment.	• Provide training.	• Implement multi-lingual and multi-modal communication and messaging.
Activities	1. Update the charter to explicitly include equity. 2. Develop recruitment materials for LWMC. 3. Support resident and CBO participation through strategies such as stipends and other incentives. 4. Develop a resident engagement strategy.	1. Identify training. 2. Identify onboarding training for new members that includes equity. 3. Develop an ongoing training plan.	1. Develop a communication plan. 2. Create a mechanism for capturing success stories.
Priority Population	• Eastern Madera County • LGBTQ+ • African American/Black		
Objective Leaders	• Executive Committee		• Backbone Agency

Workplan:

Growing Healthy Families- Domestic Violence and Child Abuse

CHIP Goal 1	Expand youth-focused healthy relationship education and services.	
SMARTIE Objectives	**Objective 1:** Reduce the incidence of teen dating violence in Madera County.	**Objective 2:** Recruit and train 12 Resident Champions to strengthen the network of support for youth-focused healthy relationship education and services.
Measures	• Number of teen dating violence incidents • Number of asset maps completed • Number of learning opportunities conducted • Number of youth who complete a training	• Number of champions • Number of learning opportunities conducted • Number of champions who complete a training • Number of community education events
Strategies We will implement these approaches to achieve our objectives and goal	• Expand youth awareness of the signs of teen dating violence. • Expand youth awareness of available resources. • Assess teen dating violence resources in the community.	• Ensure people working with youth (e.g., educators, community leaders) understand the signs of teen dating violence. • Promote available resources to ensure people working with youth know what resources are available.
Activities	1. Develop or identify educational material for youth (e.g., teen dating violence, mental health, resilience, resources). 2. Facilitate learning opportunities with youth (e.g., workshops, presentations). 3. Conduct evaluations to assess youth's overall satisfaction with educational activities and awareness of available resources (e.g., feedback form, pre/post-survey). 4. Conduct a county asset map of resources addressing teen dating violence and share the list of resources with youth and youth-serving organizations. 5. Identify target neighborhoods or populations based on their need for resources.	1. Recruit a diverse group of Resident Champions. 2. Develop or identify educational material for Resident Champions (e.g., Commercial Sexual Exploitation of Children Education, Healthy Teen Dating). 3. Facilitate learning opportunities with Resident Champions (e.g., workshops, presentations). 4. Identify target neighborhoods based on their need for resources. 5. Conduct community education events (e.g., forums, presentations) with diverse community groups (e.g., Native/Indigenous).
Priority Population	Madera County youth (3-15 years of age)	
Objective Leaders	• Madera County Department of Social Services • Madera Unified School District	

Workplan:

Growing Healthy Families- Domestic Violence and Child Abuse

CHIP Goal 2	Enhance youth-resiliency education and support.	
SMARTIE Objectives	**Objective 1:** By 2028, decrease incidents of teen-on-teen violence and bullying among youth in Madera County.	**Objective 2:** By 2028, establish a mentorship program supporting youth resiliency.
Measures	• Number of teen-on-teen violence and bullying incidents • Percent of change in incident rates	• Number of youth participants • Percent of completion/retention rate • Number of pre/post evaluations
Strategies We will implement these approaches to achieve our objectives and goal	• Expand education on teen-on-teen violence and bullying prevention. • Foster positive youth-centered environments.	• Establish a mentorship program to connect youth with positive guidance and support.
Activities	1. Develop (or identify) and implement anti-bullying curriculum for youth (e.g., Commercial Sexual Exploitation of Children Education). 2. Conduct awareness campaigns. 3. Provide learning opportunities for educators to identify and address incidents of violence and bullying (e.g., workshops, presentations). 4. Establish confidential mechanisms for students to report incidents. 5. Conduct evaluations to assess youths' and educators' overall satisfaction with educational activities and awareness of available resources (e.g., feedback form, pre/post-survey). 6. Collaborate with law enforcement to ensure a coordinated response to reported incidents.	1. Conduct mentor recruitment events with diverse populations (e.g., neighborhood watch, school/city Boards, clubs, church groups, parent groups). 2. Develop mentor training workshops. 3. Establish a matching system for youth and mentors. 4. Organize regular activities to support youth resiliency and positive relationships between youth and mentors, including celebrating achievements. 5. Research and secure funding opportunities. 6. Conduct regular evaluations to assess youths' and mentors' overall satisfaction with program activities (e.g., surveys, feedback sessions).
Priority Population	Madera County youth (3-15 years of age)	
Objective Leaders	• Community Action Partnership of Madera County • Madera County Department of Social Services	

Workplan:

Growing Healthy Families- Domestic Violence and Child Abuse

CHIP Goal 3	Expand family-focused healthy relationship education and support.		
SMARTIE Objectives	**Objective 1:** By 2028, reduce the prevalence of familial violence in Madera County.	**Objective 2:** By 2028, offer Adverse Childhood Experiences (ACEs) assessments to the referred population.	**Objective 3:** By 2028, increase the opportunities to participate in resilience building activities, therapy, or interventions.
Measures	• Number of familial violence incidents • Number of asset maps completed • Number of learning opportunities conducted • Number of parents who complete a training • Number of evaluations. • Percent of satisfaction in evaluations	• Number of referred population offered an ACEs assessment • Percent of ACEs assessments completed	• Number of resilience-building activities • Number of therapy or intervention sessions conducted • Number of participants
Strategies We will implement these approaches to achieve our objectives and goal	• Increase parents' knowledge about the signs of familial violence. • Assess familial violence resources in the community. • Support parents' awareness of available resources.	• Increase awareness of ACEs assessments. • Develop and implement a referral process for ACEs assessments.	• Expand public awareness of resilience-building activities. • Establish community partnerships to broaden the range of available activities.
Activities	1. Develop or identify educational material for parents (e.g., familial violence, mental health, resilience, resources, Commercial Sexual Exploitation on Children, substance abuse). 2. Facilitate learning opportunities with parents (e.g., workshops, presentations). 3. Conduct evaluations to assess parent's overall satisfaction with educational activities and awareness of available resources (e.g., feedback form, pre/post-survey). 4. Conduct a county asset map of resources addressing familial violence and share the list of resources with parents. 5. Identify target neighborhoods or populations based on their need for resources.	1. Develop or identify informational materials (e.g., purpose and benefits of ACEs assessments). 2. Collaborate with service providers and community partners to streamline the referral process. 3. Implement a system to track and report measures on ACEs assessments conducted.	1. Develop a calendar of resilience-building activities, therapy sessions, and interventions available throughout the community. 2. Educate the community about the benefits and availability of activities. 3. Collaborate with mental health professionals, community organizations, and schools to provide a range of activities and increase the community's access. 4. Collect feedback from participants to assess the effectiveness and satisfaction levels of activities.
Priority Population	Madera County youth (3-15 years of age)		
Objective Leaders	• Madera County Department of Social Services • Madera County Behavioral Health		

Workplan:

Pathways to Recovery- Substance Use

CHIP Goal 1	Improve access to substance use disorder services for Madera County residents.
SMARTIE Objectives	**Objective 1:** By 2028, increase access to behavioral healthcare services and substance abuse treatment.
Measures	• Number of people accessing behavioral healthcare services, including substance abuse treatment • Percent of change in the availability of detox and outpatient services • Number of culturally relevant substance abuse prevention programs implemented
Strategies We will implement these approaches to achieve our objectives and goal	• Complete a community-wide asset map to identify gaps and opportunities in substance abuse services. • Strengthen collaboration and partnerships to expand the capacity of detox and outpatient services. • Develop culturally sensitive health education programs focused on substance abuse prevention, treatment options, and mental health awareness.
Activities	1. Engage community stakeholders to create an asset map highlighting available substance use disorder services and areas for improvement. 2. Collaborate with providers to identify opportunities to expand and improve services (e.g., Screenings, referrals, comprehensive and culturally relevant treatment). 3. Create a county-wide policy for data sharing and care coordination to increase timely access to substance use disorder services. 4. Develop a coordinated plan for ongoing mobile crisis response services. 5. Develop or identify culturally sensitive educational materials. 6. Collaborate with diverse community partners to host at least 8 workshops and learning opportunities to increase awareness, targeting professionals and community members working with vulnerable populations.
Priority Population	• City of Madera • Eastern Madera County • Individuals 25-29 years old • Non-Hispanic White residents
Objective Leaders	• Madera County Department of Behavioral Health Services • Madera County Department of Public Health • Madera County Department of Social Services

Workplan:

Pathways to Recovery- Substance Use

CHIP Goal 2	Decrease opioid use and opioid related fatalities in Madera County.
SMARTIE Objectives	**Objective 1:** By 2028, increase awareness and access to opioid prevention and education opportunities in Madera County.
Measures	• Number of participants in opioid prevention and education programs • Percent of increase in awareness of opioid prevention and education • Number of Narcan kits distributed
Strategies We will implement these approaches to achieve our objectives and goal	• Increase awareness about opioid prevention and education opportunities. • Strengthen community partnerships and coordination. • Implement training initiatives.
Activities	1. Conduct workshops for medical providers to enhance their ability to identify early signs of opioid misuse. 2. Distribute educational materials and resources to medical facilities. 3. Conduct workshops on opioid prevention (e.g., Narcan) for people entering local corrections facilities. 4. Distribute Narcan kits to incarcerated people upon their release. 5. Conduct training for law enforcement to appropriately handle situations involving opioid misuse.
Priority Population	• City of Madera • Eastern Madera County • Individuals 25-29 years old • Non-Hispanic White residents
Objective Leaders	• Madera County Behavioral Health Services • Madera County Sheriff's Office

Workplan:

Pathways to Recovery- Substance Use

CHIP Goal 3	Increase community engagement to prevent harmful substance use.
SMARTIE Objectives	**Objective 1:** By 2028, initiate community collaborative focused on prevention of harmful substance use.
Measures	• Number of members actively participating in the collaborative • Percent of change in community attitudes and awareness of substance use and mental health • Number of media impressions • Number of materials created
Strategies We will implement these approaches to achieve our objectives and goal	• Develop a substance use collaborative to enhance services by coordinating efforts, reducing duplication, and filling gaps in treatment and prevention initiatives. • Launch a campaign aimed at reducing stigma, promoting awareness, and encourage prevention strategies.
Activities	1. Recruit a diverse group of stakeholders (e.g., community leaders, healthcare professionals, educators, multi-sector representation). 2. Organize quarterly collaborative meetings to discuss, plan, and implement substance use prevention strategies. 3. Establish benchmark data and indicators within the collaborative to track progress and measure the impact of substance use prevention efforts. 4. Advocate for policies that support prevention. 5. Engage and collaborate with policymakers to implement changes that align with prevention goals. 6. Develop and distribute educational materials on mental health and substance use disorders, including highlighting treatment options, debunking myths, and sharing personal testimonies. 7. Use various communication channels (e.g., social media, community events, local media) to deliver messages for reducing stigma and promoting treatment options. 8. Organize events, campaigns, and activities to raise awareness about stigma reduction and the importance of seeking treatment. 9. Develop collaborative model and goals.
Priority Population	• City of Madera • Eastern Madera County • Individuals 25-29 years old • Non-Hispanic White residents
Objective Leaders	• Madera County Behavioral Health Services • Madera County Department of Public Health • Madera County Department of Social Services

Workplan:

Healthy People Strong Communities- Diabetes and Heart Disease

CHIP Goal 1	Prevent and manage rates of diabetes and heart disease through education and awareness.		
SMARTIE Objectives	**Objective 1:** By 2028, increase the availability of diabetes and chronic disease prevention and management classes or programs.	**Objective 2:** By 2028, increase referrals from providers and community organizations to appropriate services.	**Objective 3:** By 2028, increase awareness of diabetes and heart diseases and risk factors among youth and adults.
Measures	• Number of classes • Number of sites • Attendance/retention rates	• Number of providers receiving and/or giving referrals • Number of community based organizations (CBOs) receiving and/or giving referrals • Number of referrals that access services	• Number of social media/multi-media campaigns • Number of outreach/education events • Number of schools/youth sites receiving education
Strategies We will implement these approaches to achieve our objectives and goal	• Establish partnerships with local organizations (CBO's churches, clinics, etc). • Diversify program formats and delivery methods. • Incentivize participation. • Collaborate with Residents Champions/Community Health Workers (CHWs) to promote classes.	• Establish clear guidelines and protocols for referrals. • Enhance communication and collaboration between referring entities. • Promote community resources to providers. • Collaborate with Resident Champions/CHWs to increase referrals.	• Organize regular community workshops and health education events. • Launch multimedia campaigns. • Implement school-based health education programs.
Activities	1. Deploy the Madera County Department of Public Health (MCDPH) mobile health team to underserved areas within the community. 2. Develop and promote online classes for diabetes and chronic disease management. 3. Partner with diverse organizations to expand access. 4. Partner with health insurance companies to offer reimbursement or discounts for employees or members.	1. Create standardized referral forms or electronic referral systems to streamline the referral process. 2. Host regular meetings where providers and community organization representatives can discuss patient needs, available services, and collaboration opportunities. 3. Develop resource directories or databases listing community organizations, support groups, and services available to patients.	1. Annually host a "Know Your Numbers" Event focused on diabetes and chronic disease management. 2. Utilize media channels such as websites, radio, ads, social media, newsletters to disseminate information and spread awareness of resources. 3. Offer parent workshops and family events to involve parents in discussions about health promotion and disease prevention. 4. Integrate curriculum focused on nutrition and physical activity into schools to reduce obesity.
Priority Population	• African American/Black • Hispanic/Latino • Asian & Pacific Islanders • City of Madera • Eastern Madera County		
Objective Leaders	• Anthem Blue Cross • CalViva • Camarena Health • MCDPH (Diabetes Prevention Program Staff)	• Anthem Blue Cross • CalViva • Camarena Health • MCDPH (Mobile Health team)	• Anthem Blue Cross • CalViva • Camarena Health • Madera Unified School District

Workplan:

Healthy People Strong Communities- Diabetes and Heart Disease

CHIP Goal 2	Implement policy, systems, and environmental changes that support a healthy community and address the social determinants of health.		
SMARTIE Objectives	**Objective 1:** By 2028, increase number of worksite wellness programs and or policies.	**Objective 2:** By 2028, implement community policies and environmental changes that expand smoke free environments and places for physical activity.	**Objective 3:** By 2028, increase access points for healthy food such as farmers markets, food banks, swap meets, full-service grocery stores, community supported agriculture, etc.
Measures	• Number of worksites/ businesses with worksite wellness programs or policies • Number of policies at worksites	• Number of land use, park or active transportation plans with Live Well Madera County/community input • Number of smoke free policies/ environments	• Number of new/updated food sites • Number of people serviced
Strategies We will implement these approaches to achieve our objectives and goal	• Build relationships and conduct outreach to local businesses. • Offer training and resources to worksites.	• Foster collaboration and consensus-building among stakeholders through regular meetings, and collaborative decision-making processes. • Develop/amend biking and pedestrian plans to improve infrastructure, safety, and accessibility for active transportation. • Expand smoke-free environments to reduce secondhand smoke risk. • Advocate for policy changes to support healthier lifestyles and create environments that facilitate healthy choices. • Engage Resident Champions/ Community Health Workers (CHWs) in support of healthy land use and smoke-free policies.	• Identify underserved neighborhoods and areas with limited access to healthy food options. • Increase the number and availability of farmers markets and mobile markets in underserved areas to provide convenient access to fresh, locally grown produce. • Partner with food banks and other food assistance programs to distribute food to underserved populations. • Engage Resident Champions/CHWs in support of healthy food access.
Activities	1. Design brochures, flyers, and presentations highlighting the benefits of worksite wellness programs/policies. 2. Plan and host webinars/ workshops to educate worksite representatives about worksite wellness best practices and available resources. 3. Offer one-on-one consultations, toolkits, and technical assistance to worksites interested in implementing or enhancing their wellness programs/ policies.	1. Establish a multi-sectoral task force or advisory committee for the development of community-wide plans. 2. Conduct a comprehensive assessment of existing plans and engage planning experts to implement changes based on community insight. 3. Advocate for the adoption of smoke-free policies in indoor and outdoor public spaces. 4. Collaborate with policymakers, legislators, and community leaders to develop and enact policies that promote active transportation.	1. Implement nutrition education and cooking classes to empower individuals to make healthy food choices. 2. Establish new farmer markets and/or mobile markets to increase access. 3. Partner with local food banks, pantries, and community organizations to increase the availability of fresh fruits, vegetables.
Priority Population	• African American/Black • Hispanic/Latino • Asian & Pacific Islanders • City of Madera • Eastern Madera County		
Objective Leaders	• CalViva • County Board of Supervisors • Resident Champions	• Behavioral Health • City Parks and Recreation • Madera Unified School District • Resident Champions	• First 5 • Madera County Department of Public Health • University of California Cooperative Extension Fresno • Women, Infants, Children (WIC) program

Workplan:

Healthy People Strong Communities- Diabetes and Heart Disease

CHIP Goal 3	Enhance access to affordable prevention services.	
SMARTIE Objectives	**Objective 1:** By 2028, increase availability of screenings and preventive care services for diabetes and cardiovascular disease.	**Objective 2:** By 2028, increase access to Medi-Cal and other healthcare financial assistance programs.
Measures	• Percent of increase in screening services (A1C, high blood pressure) • Number of preventive care services performed • Number of mobile health visits	• Percent of increase in the use of financial assistance programs • Number of outreach events and presentations about Medi-Cal
Strategies We will implement these approaches to achieve our objectives and goal	• Establish partnerships to expand access and availability. • Increase community awareness about the importance and availability of services.	• Expand the community's awareness about financial assistance programs. • Establish partnerships to facilitate access to assistance programs.
Activities	1. Partner with providers to increase access to screenings and preventive care services. 2. Collaborate with local organizations (e.g., community centers, churches) to host screening events and health clinics. 3. Promote mobile health services available through Madera County Department of Public Health (MCDPH), Camarena Health, and other providers. 4. Conduct community presentations and workshops to educate residents about the benefits of early screening and preventive care. 5. Collaborate with Resident Champions/ Community Health Workers to increase awareness of screening services.	1. Develop and distribute informational materials for community members to learn about available resources (e.g., free or low-cost preventative services). 2. Partner with community organizations to conduct workshops and presentations for residents, including assistance with Medi-Cal enrollment.
Priority Population	• African American/Black • Hispanic/Latino • Asian & Pacific Islanders • City of Madera • Eastern Madera County	
Objective Leaders	• Anthem Blue Cross • CalViva • Camarena Health • MCDPH	• Anthem Blue Cross • CalViva • Camarena Health • Madera County Department of Social Services • MCDPH • Resident Champions

Madera County Health Improvement Timeline 2021-2024

Chronology of the Community Health Improvement Process

1

March 2021

Regional health departments, the Central Valley Health Policy Institute (CVHPI), and the Hospital Council collaborate to collect Community Health Assessment (CHA) primary data.

2

July 2021

The Hospital Council recruits community-based organizations (CBOs) to help collect CHA primary data.

3

September 2021

The Hospital Council trains CBOs to conduct surveys, focus groups, and key informant interviews (KIIs) starting in October 2021.

4

November 2021

CBOs finish conducting surveys, focus groups, and KIIs. The Hospital Council sends the data to CVHPI for analysis.

5

January 2022

CVHPI completes data analysis.

6

February 2022

Live Well Madera County (LWMC) meets to discuss potential data sources to use in the CHA.

7

August 2022

CHA primary and secondary data is presented to LWMC.

8

November 2022

LWMC partners identify resources and assets to address the CHA's top 10 health problems.

9

February 2023

LWMC reviews the CHA's design elements and provides input before finalizing.

10

March 2023

Madera County Department of Public Health (MCDPH) facilitates the Forces of Change assessment with LWMC partners.

11

May 2023

CHA is published.

12

June - July 2023

CHA outreach in the community begins.

13

July 2023

LWMC holds special prioritization meetings to narrow health issues identified in the CHA & select 4 focus areas.

14

September 2023

LWMC hosts 2 sessions to draft the Community Health Improvement Plan (CHIP) goals addressing the 4 focus areas.

15

October 2023

MCDPH drafts goals/ objectives based on notes from CHIP planning sessions.

16

November 2023

MCDPH presents first draft of CHIP goals/objectives/ activities to LWMC.

17

Nov. 2023 - April 2024

Workplan objectives are developed by LWMC workgroups.

18

April 2024

CHIP is designed in-house by MCDPH.

19

May 2024

LWMC steering committee reviews the final draft of the CHIP and provides minor edits.

20

May 2024

The 2024 CHIP is published online and is announced with a media release.

Live Well Madera County Charter

Purpose	Live Well Madera County (LWMC) was established in 2014 with the shared commitment of countywide government, healthcare, health plans, business, education, law enforcement, community-based, and faith-based stakeholders. The purpose of LWMC is to collaboratively enhance community wellness through equitable, strategic, and aligned action.
Mission and Vision	**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. **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
Equity and Value	**EQUITY:** Live Well Madera County is committed to fostering a culture of inclusion and equity across all sectors of our community. We recognize the inherent value of diversity and strive to create an environment that respects and celebrates the unique contributions of all individuals. We are committed to addressing systemic disparities, eliminate barriers to health and well-being, and promote equitable access to resources and opportunities. We believe in inclusive decision-making and recognize the importance of including those from marginalized communities and with lived expertise in the design of strategies and in leadership roles to ensure shared power. **VALUE:** LWMC values equity, collaboration, and innovation as we strive to create a community where every person has equitable access to achieve their highest level of health.
Decision-Making Criteria	1. Prioritize Upstream 2. S.M.A.R.T.I.E. **S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime-bound, **I**nclusive, **E**quitable 3. High Return On Investment 4. Promote Health Equity 5. Use Data Effectively

Executive Committee	The Executive Committee serves as the administrative leadership body of the coalition. • The Executive Committee is comprised of the Department of Behavioral Health Director, the Department of Public Health Director, the Department of Social Services Director, a leader from the healthcare sector, and 1 – 2 community members or community-based organization leaders with lived expertise and/or who represent historically marginalized communities. • Co-Chairs are selected annually from the Executive Committee and may repeat terms for continuity. At least one co-chair will be a community member and/or leader from a community-based organization on the Executive Committee. • Advance the mission, vision, and values of LWMC. • Actively convene, plan, and attend LWMC Steering Committee meetings. • Promote LWMC participation and goals. • Proactively seek opportunities and support to sustain the group.
Steering Committee	The Steering Committee serves as the governing body of the coalition, ensuring representation and commitment from each participating organization and welcoming participation from Madera County residents, especially those with lived expertise. • Executive-level decision makers represent each LWMC organization during quarterly meetings or designate a representative when necessary. • Residents not affiliated with an organization are also encouraged to participate in steering committee meetings. Residents who express interest will sign a letter of participation agreeing to actively collaborate and participate and must also participate in a workgroup. • Embody the LWMC mission and uphold momentum for community wellness. • Oversee the implementation of the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). • Review and approve workgroup strategies for CHA and CHIP implementation. • Ensure that LWMC decisions align with established decision-making criteria. • Monitor and ensure organizational commitments to the coalition's objectives. • Identify and allocate resources in support of CHA and CHIP implementation. • Collaborate to adopt relevant CHIP goals and objectives into the strategic plans of member organizations.

Workgroups	The workgroups are designed to foster collaboration and inclusivity by involving representatives from each participating organization and welcoming community residents.
	• A representative from each LWMC organization on the steering committee actively participates in at least one workgroup.
	• Residents not affiliated with an organization are also encouraged to participate in workgroup meetings. Residents who express interest will sign a letter of participation agreeing to actively collaborate and participate.
	• Participants unable to attend meetings will connect with the workgroup co-chairs to stay informed and fulfill commitments.
	• Designated alternate representatives may attend to represent the organizations when primary representatives are unavailable.
	• Actively contribute to the content development of the CHA and CHIP.
	• Implement the CHA and CHIP.
	• Recruit community residents and other organizations to participate in the CHA and CHIP process.
	• Brainstorm innovative approaches for implementing the CHA and CHIP within the community.
	• Identify local resources for conducting CHA and CHIP activities.
	• Co-Chairs are selected during the development of each CHIP cycle from participating LWMC representatives, with the opportunity for repeated terms as appropriate. Volunteers will be requested to fill co-chair roles. If there are multiple volunteers, then a vote will take place among workgroup participants.
	• The role of co-chairs includes the following:
	  • Prepare agendas, plan, and facilitate meetings.
	  • Provide regular updates to the Steering Committee and a monthly update to the backbone agency on progress made towards achieving goals and objectives.
	  • Track progress and maintain documentation on the LWMC shared Google Drive folder, including updating the Google spreadsheet related to workgroup goals.

Backbone Agency	The backbone agency serves as the foundational support, facilitating effective collaboration and coordination among the Executive Committee, Steering Committee, and Workgroups. • Coordinate efforts of the Executive Committee and facilitate communication among its members. • Provide administrative and project management support to ensure the smooth functioning of LWMC committees. • Ensure alignment of LWMC initiatives with the overall mission and vision. • Engage community residents, organizations, and stakeholders to foster relationships contributing to the coalition's community-centric approach. • Collaborate with all levels of LWMC to identify and allocate resources for successfully implementing the CHA and CHIP.
Charter Review Amendment	At a minimum the LWMC Executive Committee will review the charter at the start of each community health assessment cycle and update as needed.

Table of Amendment

Version	Description	Date	Approved By
1.0	Creation of Charter	3/15/2019	LWMC Executive Committee
2.0	Added equity and value statements; Updated decision-making criteria from SMART to SMARTIE; Revised Executive Committee membership to specify inclusion of residents and/or community-based organizations; Revised Steering and Workgroup sections to include resident participation and specify selection of leads.	4/1/2024	LWMC Executive Committee

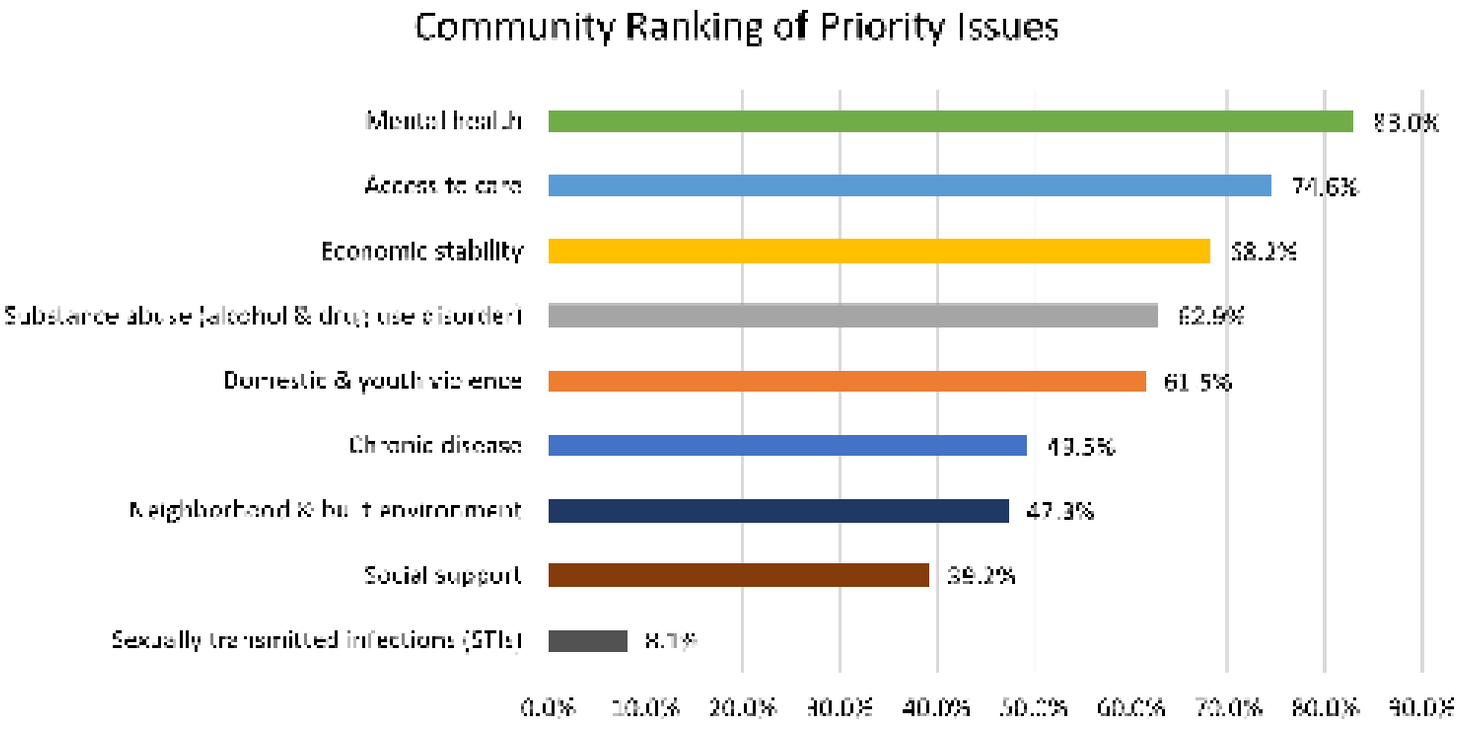
Community Health Assessment and Prioritization Outreach

Date	Community Event Name/Location	Location	Event Type	Audience
5/18/2023	MCDPH All Staff	Madera	Presentation	Stakeholder
5/18/2023	National Association for the Advancement of Colored People-Madera	Madera	Presentation	Public
5/24/2023	Culture of Health- MCDPH Community Wellness Fair	Madera	Presentation	Public
5/31/2023	Library	Oakhurst	Mobile event	Public
6/1/2023	Save Mart	Chowchilla	Mobile event	Public
6/3/2023	Summer Jam	Oakhurst	Mobile event	Public
6/5/2023	Healthy People Strong Communities Workgroup	Madera County	Presentation	Stakeholder
6/7/2023	Madera City Council Meeting	Madera	Public Comment	Public
6/8/2023	Dollar General	Chowchilla	Mobile event	Public
6/9/2023	Summer Jam	Madera	Mobile event	Public
6/10/2023	Madera Rescue Mission	Madera	Mobile event	Public
6/12/2023	Madera Unified School District	Madera	Presentation	Stakeholder
6/12/2023	Madera County Library	Madera	Mobile event	Public
6/13/2023	Valley Bowl	Madera	Mobile event	Public
6/13/2023	Anthem Madera County Community Advisory Committee	Madera	Presentation	Stakeholder
6/13/2023	Chowchilla City Council Meeting	Chowchilla	Presentation	Stakeholder/ Public
6/14/2023	Flea Market	Madera	Mobile event	Public
6/14/2023	Facebook Live Spanish	Madera County	Presentation	Public
6/15/2023	Elder Abuse Resource Fair, Rotary Park	Madera	Mobile event	Public
6/15/2023	Library Summer Kickoff	Madera	Mobile event	Public
6/15/2023	Facebook Live English	Madera County	Presentation	Public
6/16/2023	Fastway Chicken	Madera	Mobile event	Public
6/16/2023	MCDPH Resident Champions	Madera	Presentation	Public
6/16/2023	Students Working Against Tobacco Youth Coalition Retreat	Madera	Presentation	Public
6/17/2023	Tesoro Viejo Farmer's Market	Madera	Event	Public
6/19/2023	Live Well Madera County Steering Committee	Madera	Presentation	Stakeholder
6/21/2023	Behavioral Health Advisory Board	Madera	Presentation	Stakeholder
6/22/2023	Sierra San Joaquin Jobs (formerly CERF) Meeting	Madera	Presentation	Stakeholder
6/24/2023	Fairmead & Friends: Resource Fair	Chowchilla	Event	Public
6/27/2023	Madera County Tobacco Control Coalition	Madera	Presentation	Stakeholder/ Public
6/28/2023	Madera County Maternal Wellness Coalition	Madera	Presentation	Stakeholder/ Public
7/11/2023	Chowchilla Task Force	Chowchilla	Presentation	Stakeholder
7/13/2023	Eastern Madera Task Force	Oakhurst	Public Comment	Stakeholder
7/13/2023	Housing the Homeless Committee	Madera	Presentation	Stakeholder
8/2/2023	Oral Health Advisory Committee	Madera	Presentation	Stakeholder
8/3/2023	Emergency Preparedness Subcommittee	Madera	Presentation	Stakeholder
8/7/2023	Valley Children's Healthcare and Guild's Center for Community Health Advisory Council	Madera	Presentation	Stakeholder
8/7/2023	Healthy People Strong Communities Workgroup	Madera	Presentation	Stakeholder
8/15/2023	Board of Supervisors Meeting	Madera	Presentation	Stakeholder

Resident Ranking of Health Issues

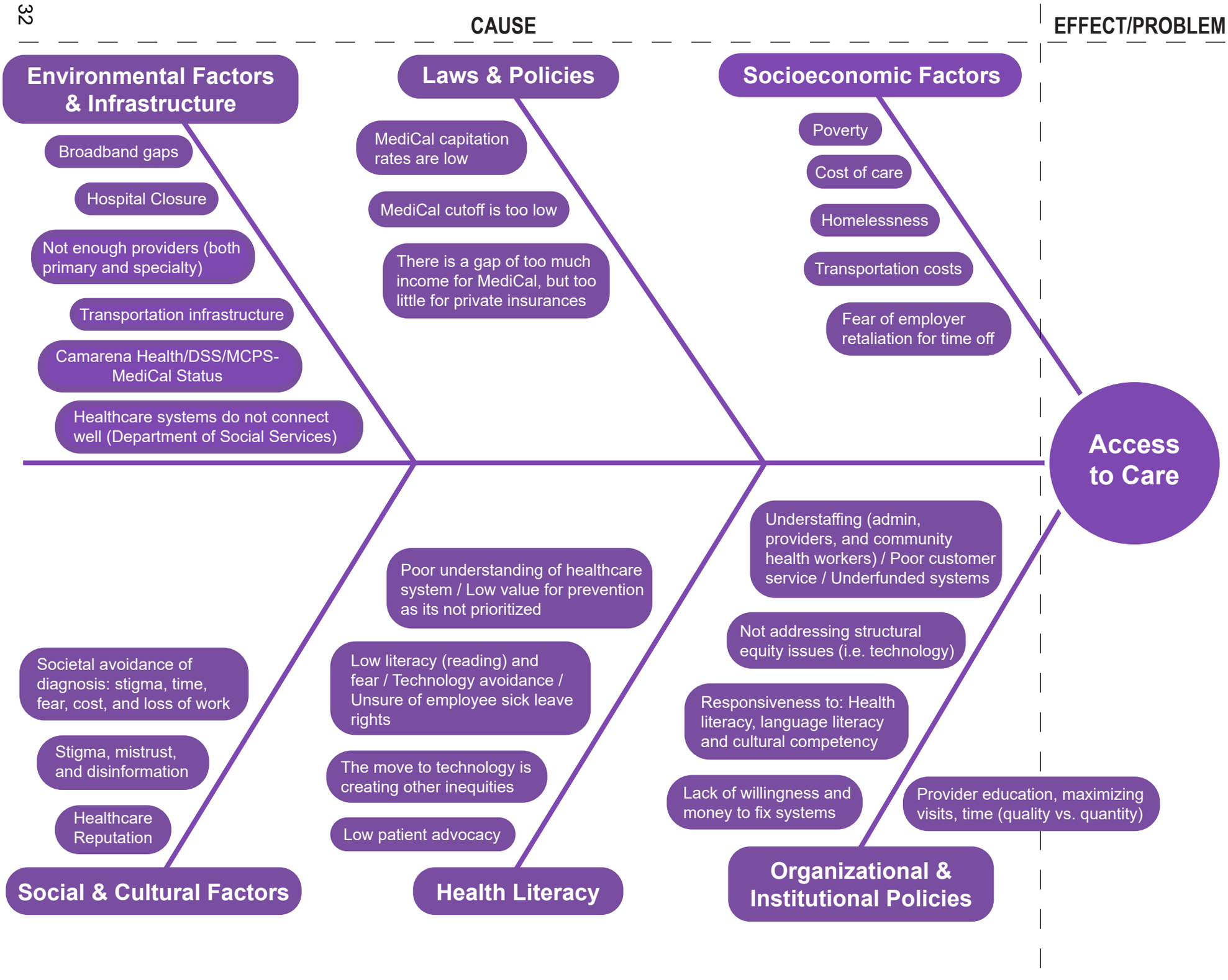
LWMC Community Outreach May 2023 - June 2023

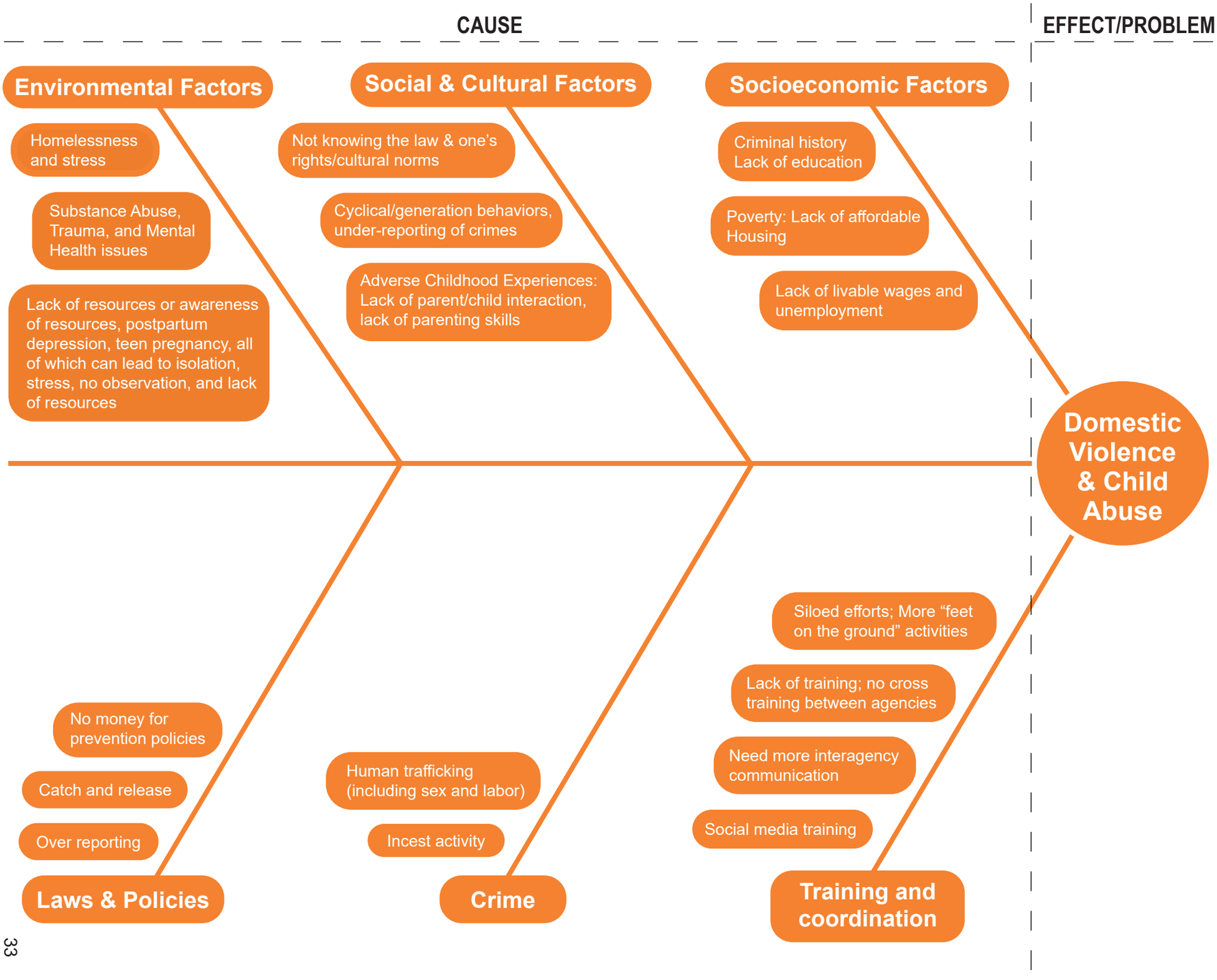
After publishing the Community Health Assessment, Live Well Madera County conducted several outreach activities listed on the previous page to gather the community's feedback on the most important health issues and inform the prioritization of focus areas to address in the Community Health

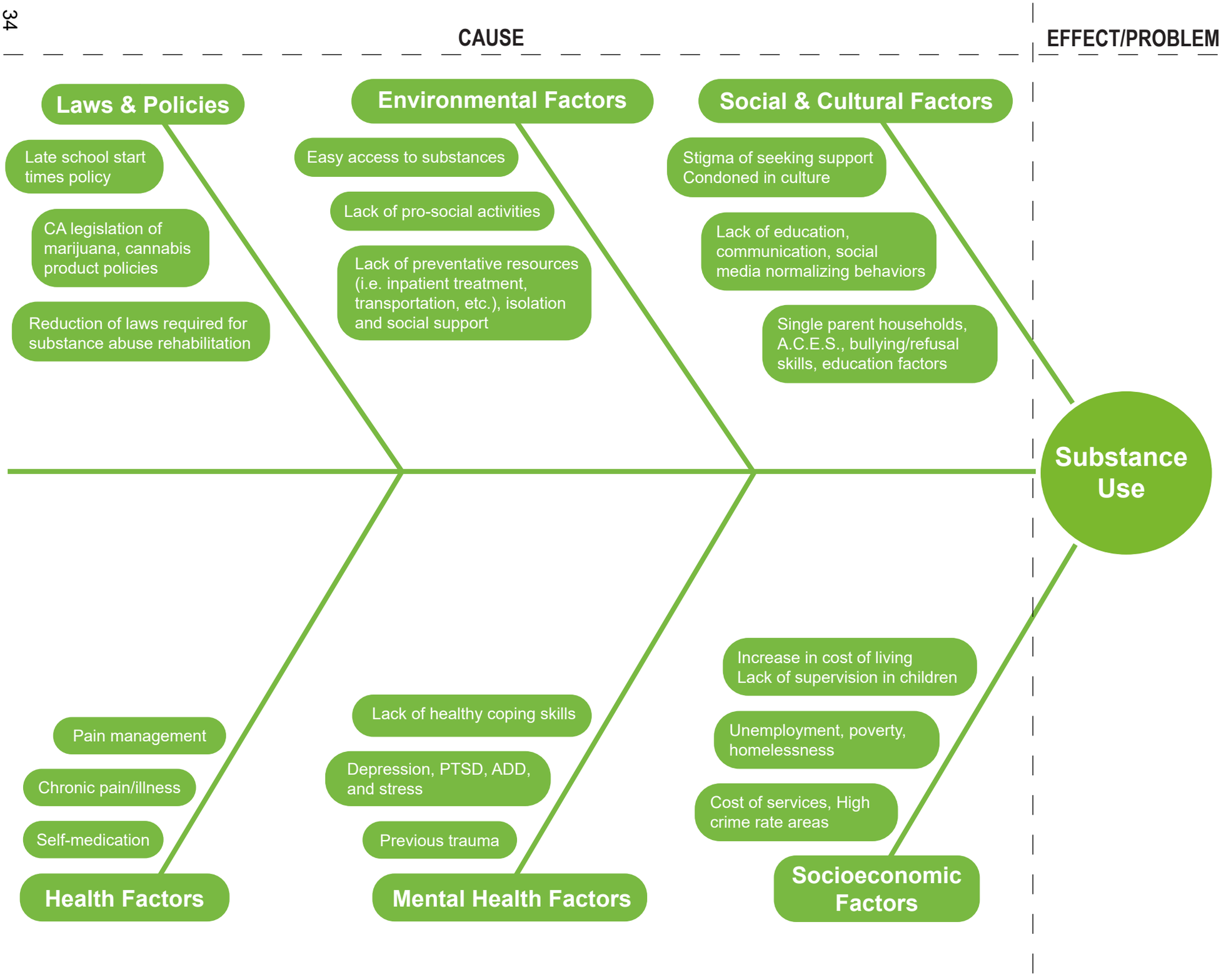


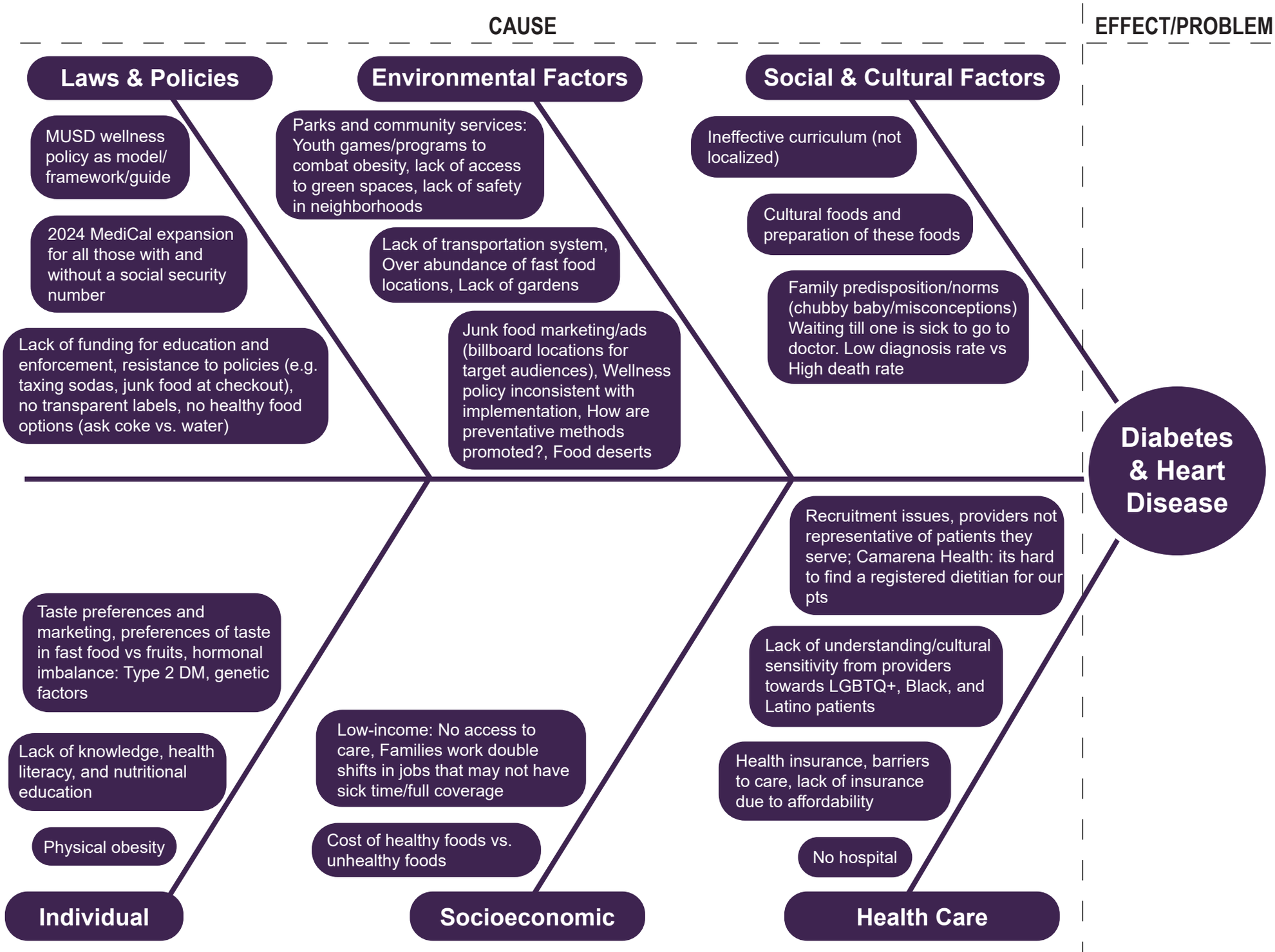
Fishbone Diagrams for Identifying Health Priorities' Root Causes

Live Well Madera County developed the fishbone diagrams on the following pages to explore the root causes of the health priorities and inform the development of goals and objectives to address them. In the "Cause" section of the diagram, the root causes are grouped into categories (e.g., environmental, socioeconomic, institutional). The following fishbone diagrams are for Access to Care, Domestic Violence and Child Abuse, Diabetes and Heart Disease and Substance Use.


CAUSE
EFFECT/PROBLEM
Environmental Factors & Infrastructure
Broadband gaps
Hospital Closure
Not enough providers (both primary and specialty)
Transportation infrastructure
Camarena Health/DSS/MCPS-MediCal Status
Healthcare systems do not connect well (Department of Social Services)
Laws & Policies
MediCal capitation rates are low
MediCal cutoff is too low
There is a gap of too much income for MediCal, but too little for private insurances
Socioeconomic Factors
Poverty
Cost of care
Homelessness
Transportation costs
Fear of employer retaliation for time off
Access to Care
Social & Cultural Factors
Societal avoidance of diagnosis: stigma, time, fear, cost, and loss of work
Stigma, mistrust, and disinformation
Healthcare Reputation
Health Literacy
Poor understanding of healthcare system / Low value for prevention as its not prioritized
Low literacy (reading) and fear / Technology avoidance / Unsure of employee sick leave rights
The move to technology is creating other inequities
Low patient advocacy
Organizational & Institutional Policies
Understaffing (admin, providers, and community health workers) / Poor customer service / Underfunded systems
Not addressing structural equity issues (i.e. technology)
Responsiveness to: Health literacy, language literacy and cultural competency
Lack of willingness and money to fix systems
Provider education, maximizing visits, time (quality vs. quantity)


CAUSE
EFFECT/PROBLEM
Environmental Factors
Homelessness and stress
Substance Abuse, Trauma, and Mental Health issues
Lack of resources or awareness of resources, postpartum depression, teen pregnancy, all of which can lead to isolation, stress, no observation, and lack of resources
Social & Cultural Factors
Not knowing the law & one's rights/cultural norms
Cyclical/generation behaviors, under-reporting of crimes
Adverse Childhood Experiences: Lack of parent/child interaction, lack of parenting skills
Socioeconomic Factors
Criminal history Lack of education
Poverty: Lack of affordable Housing
Lack of livable wages and unemployment
Domestic Violence & Child Abuse
No money for prevention policies
Catch and release
Over reporting
Laws & Policies
Human trafficking (including sex and labor)
Incest activity
Crime
Siloed efforts; More "feet on the ground" activities
Lack of training; no cross training between agencies
Need more interagency communication
Social media training
Training and coordination


CAUSE
EFFECT/PROBLEM
Laws & Policies
Late school start times policy
CA legislation of marijuana, cannabis product policies
Reduction of laws required for substance abuse rehabilitation
Environmental Factors
Easy access to substances
Lack of pro-social activities
Lack of preventative resources (i.e. inpatient treatment, transportation, etc.), isolation and social support
Social & Cultural Factors
Stigma of seeking support Condoned in culture
Lack of education, communication, social media normalizing behaviors
Single parent households, A.C.E.S., bullying/refusal skills, education factors
Substance Use
Pain management
Chronic pain/illness
Self-medication
Health Factors
Lack of healthy coping skills
Depression, PTSD, ADD, and stress
Previous trauma
Mental Health Factors
Increase in cost of living Lack of supervision in children
Unemployment, poverty, homelessness
Cost of services, High crime rate areas
Socioeconomic Factors


CAUSE
EFFECT/PROBLEM
Laws & Policies
MUSD wellness policy as model/ framework/guide
2024 MediCal expansion for all those with and without a social security number
Lack of funding for education and enforcement, resistance to policies (e.g. taxing sodas, junk food at checkout), no transparent labels, no healthy food options (ask coke vs. water)
Environmental Factors
Parks and community services: Youth games/programs to combat obesity, lack of access to green spaces, lack of safety in neighborhoods
Lack of transportation system, Over abundance of fast food locations, Lack of gardens
Junk food marketing/ads (billboard locations for target audiences), Wellness policy inconsistent with implementation, How are preventative methods promoted?, Food deserts
Social & Cultural Factors
Ineffective curriculum (not localized)
Cultural foods and preparation of these foods
Family predisposition/norms (chubby baby/misconceptions) Waiting till one is sick to go to doctor. Low diagnosis rate vs High death rate
Diabetes & Heart Disease
Taste preferences and marketing, preferences of taste in fast food vs fruits, hormonal imbalance: Type 2 DM, genetic factors
Lack of knowledge, health literacy, and nutritional education
Physical obesity
Individual
Low-income: No access to care, Families work double shifts in jobs that may not have sick time/full coverage
Cost of healthy foods vs. unhealthy foods
Socioeconomic
Recruitment issues, providers not representative of patients they serve; Camarena Health: its hard to find a registered dietitian for our pts
Lack of understanding/cultural sensitivity from providers towards LGBTQ+, Black, and Latino patients
Health insurance, barriers to care, lack of insurance due to affordability
No hospital
Health Care

Asset Inventory: Access to Care						
PREVENTION LEVEL	INTERVENTION LEVEL					
		Individual	Interpersonal	Organizational	Community	Public Policy
	PRIMARY	Mobile Health – MCDPH, Camarena Health, and Oral Health		Employee Assistance Programs Referrals from large employers	Referral Systems	Medi-Cal Expansion (Eligibility for all – January 2024)
		Health Clinics – Schools, Urban and Rural			MUSD Referral Resource Line	Medi-Cal Reimbursement for Community Health Workers/ Promotoras
					Community Health Workers from Anthem	
		Transportation – MCP's			CalAIM-ECM	
		Employee Wellness, Referral, and Helplines (For large employers)			Expansion of Ambulance Service	
		Telehealth with MD (Camarena Health)				
		Medi-Cal Enrollment (DSS & Camarena Health)				
		Perinatal Mental Health and Care Navigators (Dads are included as well)				
		Parent University at Fresno State to teach education to parents				
	SECONDARY	Health Clinics (CalViva's and Camarena Health's Promotoras)		Camarena Health – More Specialists		
		Diabetes Prevention Program (Mobile Health – Med/Dental MCDPH and Camarena Health)		MUSD – MH Specialists		
		Transport via Managed Care Plans (MCP & telehealth)		MCSOS – Navigator Program		
		Helplines (Health Online) MCP's, Private Ins.				
	TERTIARY	Health clinics (Diabetes Education and Case Management, MCP)	Narcan Distribution	Camarena Health – More Specialists		
		Mobile Health: MCDPH, Camerena Health (Med/Dental, Transport – MCPs)		MUSD – Mental Health Specialists		
		Telehealth with MDs at Camarena Health (Case Management: To help close gaps in care, and for those with 2 or more diagnosis)		MCSOS – Navigator Program		

Asset Inventory: Substance Use						
PREVENTION LEVEL	INTERVENTION LEVEL					
		Individual	Interpersonal	Organizational	Community	Public Policy
	PRIMARY	School Presentations (MUSD/BHS/DSS)	Parent Workshops (MUSD / BHS)	School-based Presentations (MUSD/BHS/DSS)	Social Media Campaigns (BHS)	Tobacco-Free Housing (Public Health)
		Parent Workshops (MUSD/BHS/DSS)	Perinatal Classes (BHS)	Prevention Trainings – Employee (MUSD/ BHS)	MUSD Referral Resource Line	
		Resource Fairs (DSS / BHS)	Social Media Campaigns (MUSD / BHS)		Community Health Workers from Anthem	
	SECONDARY	COPE Trainings (BHS / Public Health)		C.O.P.E. Training		
		Why Vape / Yosemite High (YUSD)				
	TERTIARY	Diversion Workshops	Narcan Distribution	Parent Workshops	C.A.R.E.S. (BHS)	M.A.P. (DSS)
		Incarceration		Drug Felony Court	MRM (BHS)	
		Outpatient Services M.A.P. Access Line Crisis C.A.R.E.S.		M.A.P. Mental Health Court Veterans Court		
		Residential (BHS)				
		Detox Services (BHS)				
		A.A. and N.A. Celebrate Recovery CalViva / Kick it CA CalAIM: 8 Providers				

Asset Inventory: Domestic Violence and Child Abuse

PREVENTION LEVEL

INTERVENTION LEVEL

	Individual		Interpersonal
PRIMARY	Childcare Resources and Referrals (CAPMC)	Rad Kids Program for the general population – MCCAPC, MUSD & Probation	Parenting Classes (BHS)
	Advocacy for families in need of childcare services (CAPMC)	Family Advocacy 1-1 Education (MCCAPC)/CAPMC. Parents as Teachers	Community Resiliency Event – Family Fun Day (BHS)
	Working with childcare providers area of health & safety (CAPMC). Trauma Informed training	Kingsview Youth Empowerment Program – Silvia Ramirez. Loving Solutions Program	Mentoring Program (Faith and PD)
	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)
	Post-Partum Depression Group (BHS)	Positive Parenting Program (CAPMC). Strengthening Parenting Program	Educate Veterans & Families (VS)
	Child Abuse 101 Education to families (MCCAPC)	Case Management – Home Visiting Program (MCDPH)	Staying connected with your teen classes (Parenting Classes & Court Ordered) (MCCAPC)
	Child Development Resilient Families (MCCAPC)	Counselors & Social Workers on Staff (MCSOS)	
	ACES (MCCAPC). Ages and Stages Questionnaire	Referrals to Community Services (e.g. anger management) (MCDPH)	
	MUSD – Rosa Galindo. DSS – Cool Aunt	Provide Public Assistance to families (DSS)	
	Mental Health Education (BHS) Individual Mental Health Services VS		
SECONDARY	Mandated Reporting – Suspected C.A.N. (MCDPH)	Wellness Center for Adults & Youth (BHS) (Hope House)	Childcare Providers Education Classes R & R (MCDPH)
	Investigate Referrals on CAN (DSS)	Observations from unrelated calls for service (Faith and PD)	
	Victim Services providing information and support on crime, rape crisis & domestic violence (CAPMC)		
TERTIARY	Counseling Services (Faith and PD)	Trauma Sensitive Practice –Training (MCSOS)	Strengthening Families Program (SFP) MOU with Probation and DSS 14-week family class (CAPMC)
	Therapy (BHS)	Provide Services to families who have abused or neglected their children (DSS)	Staying connected with your parent classes – youth classes and the general public (MCCAPC)
			Active Parenting, Teens, MUSD, Mike Farmer

Asset Inventory: Domestic Violence and Child Abuse (cont.)		
INTERVENTION LEVEL		
Organizational	**Community**	**Public Policy**
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)	CCP Plan. DSS – CDHHS
Mandated reporter training staff on ACES & ASQ-3 & ASQ-SE-2 & Building resilience & HT CSEC & Trauma Informed (MCCAPC)	Project Protect Training /Curriculum (MCSOS)	FSPSA Reimbursement
Positive behavioral Interventions & Support Training (MCSOS)	Mental Health Coordination (VS)	
EAP (Policy)	Family Advocacy 1-1 connect with appropriate resources (MCCAPC)	
DSS – Lisa Project	Parent Project – Education (Faith and PD) (CAPMC, MUSD, Probation)	
	Minimize Stressors (VS)	
	John Wells	
MH education for early detection (BHS)	Collaboration with Law Enforcement and other Comm. Agencies to address C.A.N. (DSS)	
Mental Health and Addiction Program DSS and BHS	Contracts with Comm. Agencies to prevent C.A.N. (e.g. first 5, CAPMC) (DSS)	
Child Advocacy Council (CAC). CSEC	Mandated reporter training (DSS)	
	Coalition around trauma (BHS)	
	Mandated CPS reporting (MCSOS)	
CDRT	Treatment courts (VS)	
	Foster Youth Services - Law & Services (MCSOS)	
	McKinny Vento – Homeless (MCSOS)	
	Partnerships in place - CAPMC & VS & MCCAPC VS representative at JSD (MCCAPC)	

Asset Inventory: Diabetes and Heart Disease				
PREVENTION LEVEL	INTERVENTION LEVEL			
		Individual		Interpersonal
	PRIMARY	Medical Assistant Health Coach Education / Camarena Health	Promotores de Salud / Home Interventions – CalViva	Nutrition Education Seniors & Family Center / UC CalFresh
		Parent Nutrition Edu (UC CalFresh & Dairy Council, MCDPH, & MUSD)	Promotores de Salud / 4 Series Nutrition Classes – CalViva	Walk to School Events (UC CalFresh & Dairy Council & MCDPH & MUSD)
		Camarena Health store tours	Promotores de Salud / Promotoras Ahead of Childhood Obesity (Coming soon) – CalViva	Direct Nutrition Education to Seniors/Family Centered -UC CalFresh
		Rethink your drink food demos / MCDPH & UC CalFresh	All ages PA programs. Card-free activities	
		National Diabetes Prevention Program classes / MCDPH	PA Education CATCH Program / UC CalFresh for After School K-12	
		K-12 Nutrition ed. (UC CalFresh & Dairy Council & MCDPH & MUSD & Camarena Health)	Parent/Child Health Education / Adult Camarena Health and UC CalFresh. AAA (aging)	
		Health Fairs / Outreach Events DM Education / UC CalFresh/Camarena Health	Youth Center Education/Cooking Classes / Parks and Rec, DSS, Juvenile	
		Direct Nutrition Education to Youth and Adults – UC CalFresh	Asthma Basics & Asthma Action Plan: Promotora Charla (1 class) - CalViva	
		Nutrition Label: Promotora Charla (1 class) CalViva	Social Media Outreach - MCDPH	
		Indirect Edu. (Health Fairs, Community Events, etc.) – UC CalFresh	Fit Families for Life Weight Mgmt. Class Series (1 Class & 3 classes) - CalViva	
		Promtoroes Health Network Bailoterapia: Promotora lead physical activity (1 class) - CalViva		
	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. Maternal Fetal Care Services at Valley Children's Hospital	DPP, Anthem, and MCDPH: DM Onset (12 months)	
	TERTIARY	Patient DM Health Education for Dx Camarena Health	Project Dulce: Diabetes Mgmt. Classes /Camarena Health	School Nurses at MUSD
		Anthem: Mail A1C tests	Camarena Health: Self-measured blood pressure program with remote patient monitoring	
		Treatment and Surveillance Access to Medical Specialists Medical Specialty Clinic	Comprehensive Diabetes Care / Family Health Services, Rapid Care, Chowchilla MC	

Asset Inventory: Diabetes and Heart Disease (cont.)		
INTERVENTION LEVEL		
Organizational	**Community**	**Public Policy**
MC Food Bank – Brown bag and SNAP Store	SNAP-Ed Partnership Coalition (MCDPH)	SSB policy at Head Start Centers, only low-fat milk, and water
Senior meals Program (Sites and Homebound) - inactive	Community Gardens – UC CalFresh (1 Senior site, 1 City –Madera Coalition for Community Justice)	Build parks / Community Develop Dept.
School Gardens - UC CalFresh, Library, and MCDPH	Diabetes Basics & Know Your Numbers forum: diabetes, blood pressure, cholesterol, BMI (screenings) - CalViva	
Mobile Food Vendor at School	Promotores Health Network Walking Club: Promotora lead physical activity (1 class) - CalViva	
Walking Club at MUSD – Students, Staff at 2 sites	School Meals / Summer Lunch Program Access green spaces	
Smarter Lunchrooms (UC CalFresh & Dairy Council & MCDPH & MUSD)	Development of a new Farmers Market Parks. Food Bank – Farm to Table. MCC Food Pantry	
Summer Meal Programs – National School / Lunch & Breakfast	Parks and Rec. – Activity and Wellness classes	
Local School Wellness Policy advising, adoption and implementation (UC CalFresh & Dairy Council & MCDPH & MUSD)	CalFresh Parks Service – Medical Mile Pilot Program (Access to parks for certain populations)	
Alliance for Healthier Generations	Trails in Madera with fitness equipment Connecting with underground passing	
Peaceful playgrounds – MUSD/Climate Dept		
MCC Nutritional standards, policies, and or protocols. Anthem: Send Medically tailored meals		
MUSD Food pantry/clothing AED Access at schools/public buildings		
	MCDPH Mobile Van – DM Screenings	
Camarena Health – More Specialists		
MUSD – Mental Health Specialists		
MCSOS – Navigator Program		

Live Well Madera County Community Health Improvement Plan
May 2024

MaderaCounty.com/CHIP

Madera County Department of Public Health
1604 Sunrise Ave. Madera, CA 93638
(559) 675-7893

Madera County Department of Public Health

@madhealthy_

@MaderaDPH