C A L I F O R N I A

HEALTHIER LIVING

Living Your
Best Life…

CA Healthier Living Coalition Meeting

November 19, 2014
Los Angeles, CA

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Living Your
Best Life…

Where We Are and Where We Are Going

Lora Connolly
CA Department of Aging

Kathryn Keogh and Dianne Davis
Partners in Care Foundation

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New Older Americans Act Requirements

- By July 2016, Older Americans Act Health Promotion & Disease Prevention funds (Title IIID) must be used to support the highest level of Evidence-Based programs.
- This year, Area Agencies on Aging (AAAs) will be planning & preparing to make this transition (if they have not already done so).
- This may create new opportunities for collaboration in making CDSME programs available to more Californians.

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Title IIID Evidence-Based Criteria

1. Demonstrated to be effective for improving the health and wellbeing or reducing disease, disability and/or injury among older adults; *and*
2. Proven effective with older adult population, using Experimental or Quasi-Experimental Design; *and*
3. Research results published in a peer-review journal; *and*
4. Fully translated in at least 1 community site; *and*
5. Includes developed dissemination products available to the public.

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Using SNAP- Ed Funding to Support Evidence Based Physical Activity Interventions

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Evidence Based Programs through SNAP-Ed Funding

- SNAP=Supplemental Nutrition Assistance Program (CalFresh in California) & administered by CA Dept of Social Services (CDSS).
- CDA is collaborating with CDSS to use SNAP-Ed funding to help educate older adults in making healthy food choices & encouraging increased physical activity through evidence based programs.
- Target population = Nutrition sites where 50% of participants have incomes =/less than 185% of federal poverty level.

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SNAP-ED Funding

- CDA will administer contracts with 22 AAAs & distribute $2.5 million over FFY 2014-2015.
- AAAs will provide evidence-based SNAP-Ed nutrition education and obesity prevention interventions. Program examples: Tai Chi, Matter of Balance, Eat Smart Live Strong.
- Interventions must focus on preventing disability not managing existing chronic conditions (so funding could not support CDSMP or other Stanford programs).
- But, this funding could be used to support programs that complement CDSMP, e.g. continued physical activity after completing a workshop.

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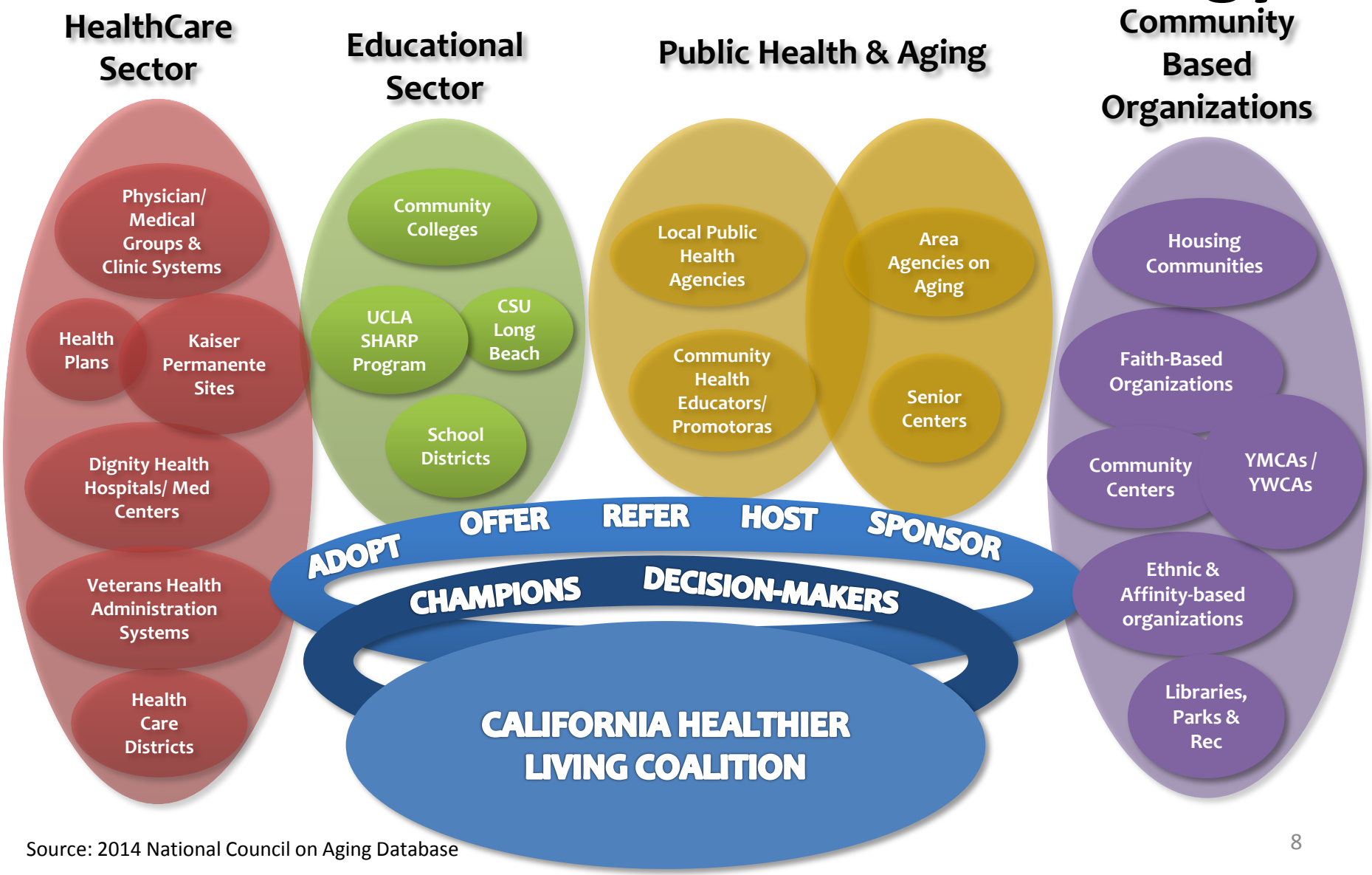
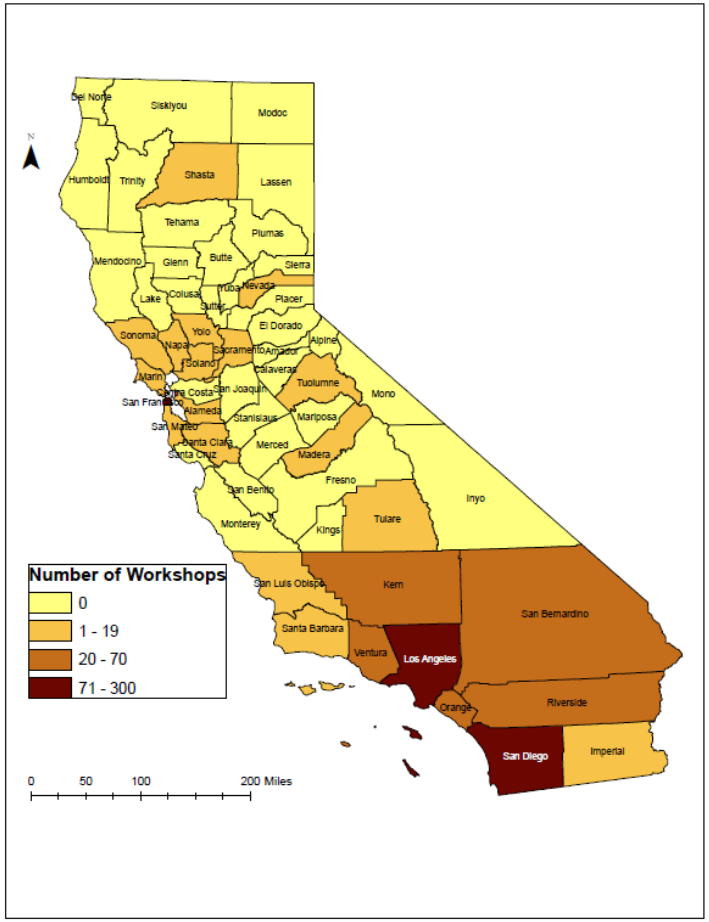
California Dissemination Strategy



Source: 2014 National Council on Aging Database

CDSME Current Availability by County



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PARTICIPANT CHARACTERISTICS

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Workshop Participant Age

	65-69 years	70-74 years	75-79 years	80-84 years	85-89 years	90+ years
CA	15.4%	15%	13.7%	9.5%	5%	1.5%
US	15%	14%	11.7%	8.6%	5.2%	2.3%

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Source: 2014 National Council on Aging Database

Workshop Participant Race and Ethnicity

	White	Pacific Islander	Native American	Multi-Racial	Asian	African American
CA	**60%**	**1%**	**1%**	**2%**	**18%**	**18%**
US	**69%**	**1%**	**2%**	**2%**	**4%**	**22%**

In CA, 48.6% of participants are Hispanic/Latino, compared to 17.8% in all states.

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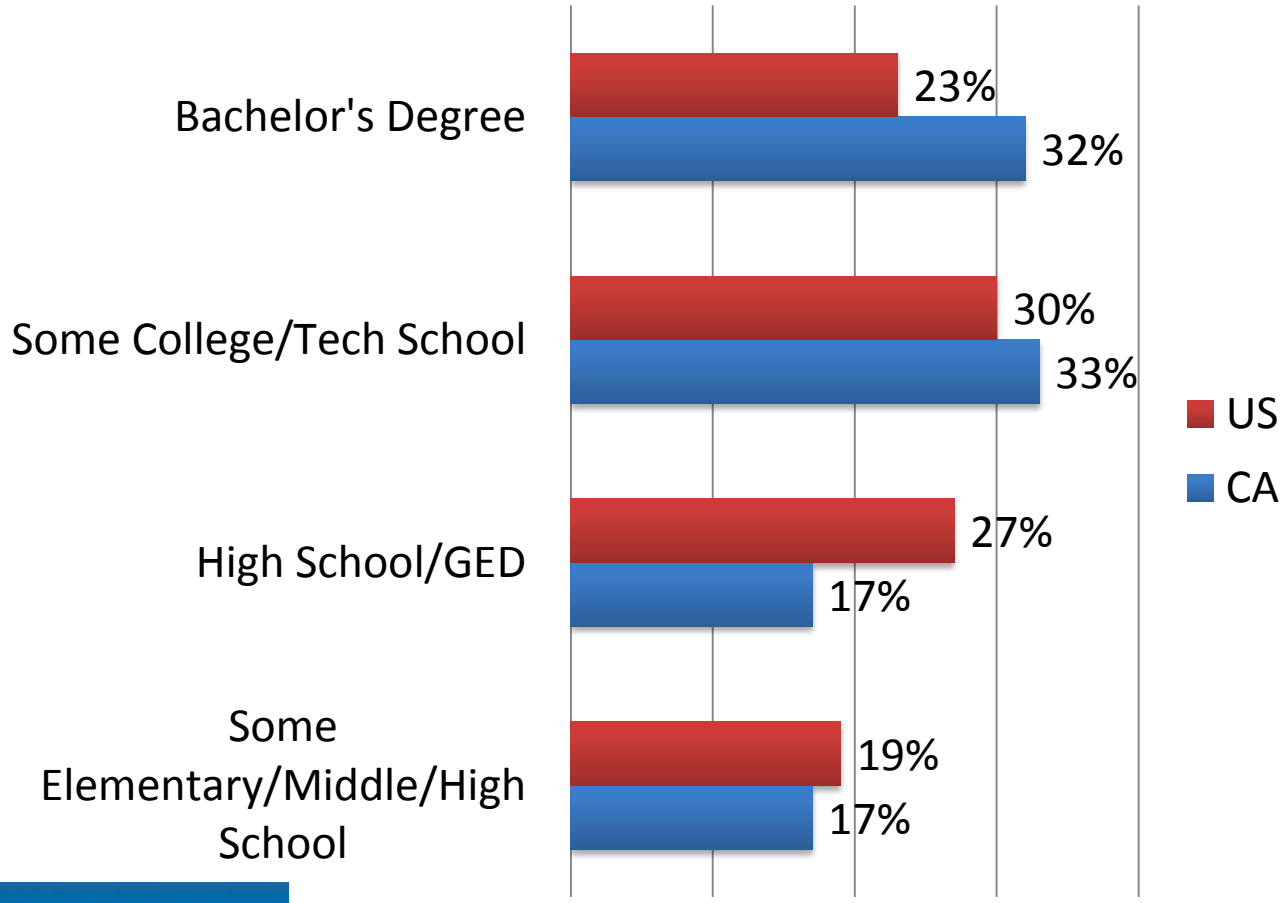
Source: 2014 National Council on Aging Database

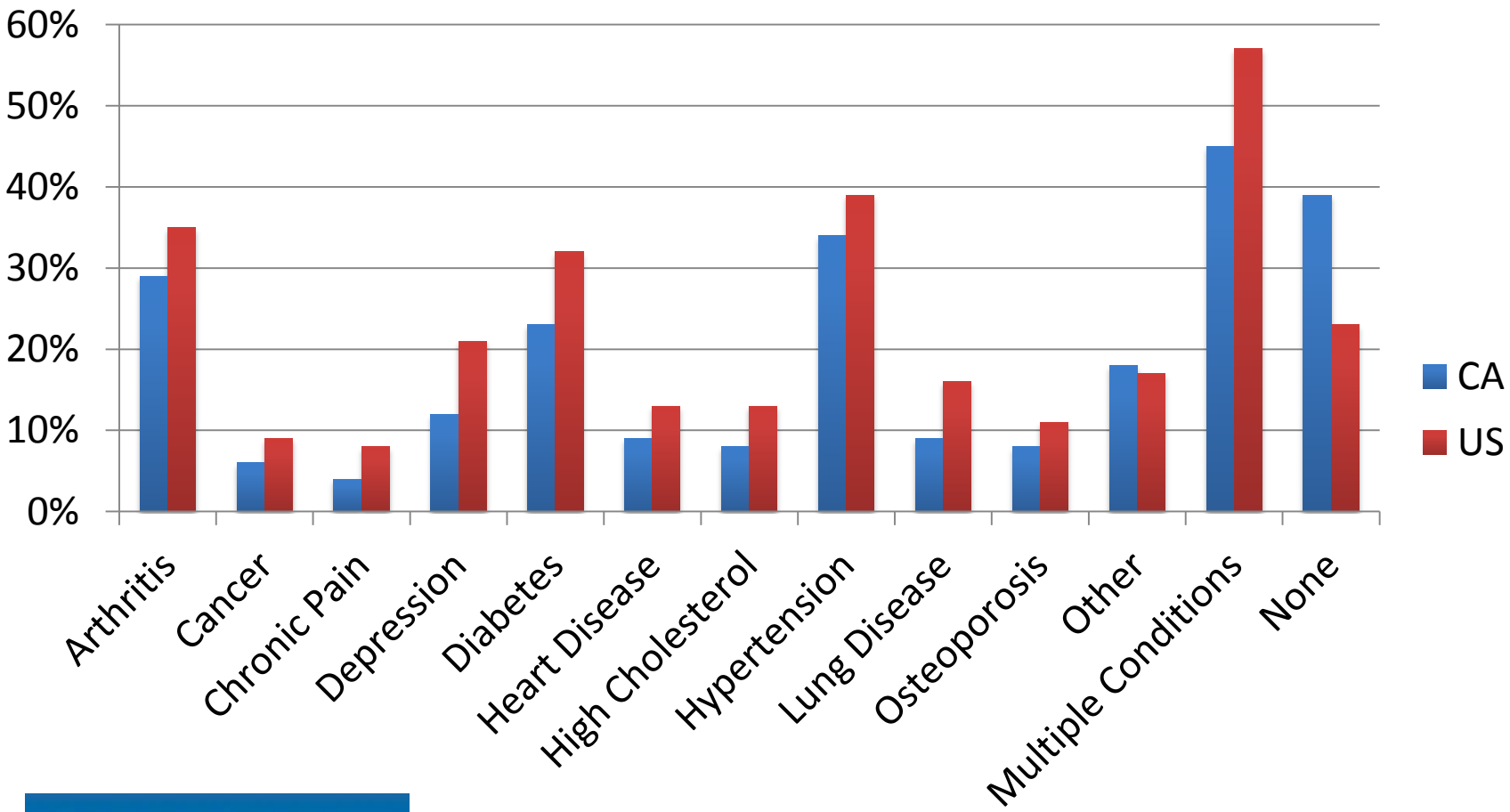
Workshop Participant Educational Level



CALIFORNIA HEALTHIER LIVING

Source: 2014 National Council on Aging Database

Workshop Participant Chronic Conditions



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Source: 2014 National Council on Aging Database

Workshop Participants
Disability Status and Living Arrangements

Disability Status

- Approximately 46% of California and US participants reported being disabled.

Living Arrangements

- Participants were more likely to live with someone (CA 69%; US 57%)

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Source: 2014 National Council on Aging Database

EVOLUTION OF PROGRAMS BEING OFFERED IN CALIFORNIA

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Types of Workshops Offered

2012

Chronic Disease Self-Management Program (CDSMP)

Tomando Control de su Salud

2013

Diabetes Self-Management Program (DSMP)

Spanish DSMP

2014

Chronic Pain Self-Management Program (CPSMP)

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Source: 2014 National Council on Aging Database

CDSME Workshops

- *CDMSP:*
  - offered in 23 counties
- *Tomando:*
  - offered in 17 counties
- *DSMP:*
  - offered in 6 counties (Kern, Los Angeles, Nevada, Sacramento, San Diego, and San Francisco)
- *DSMP Spanish:*
  - offered in 3 counties (Kern, Los Angeles, and San Diego)
- *CPSMP:*
  - offered in 4 counties (Alameda, Los Angeles, Nevada, and Ventura)

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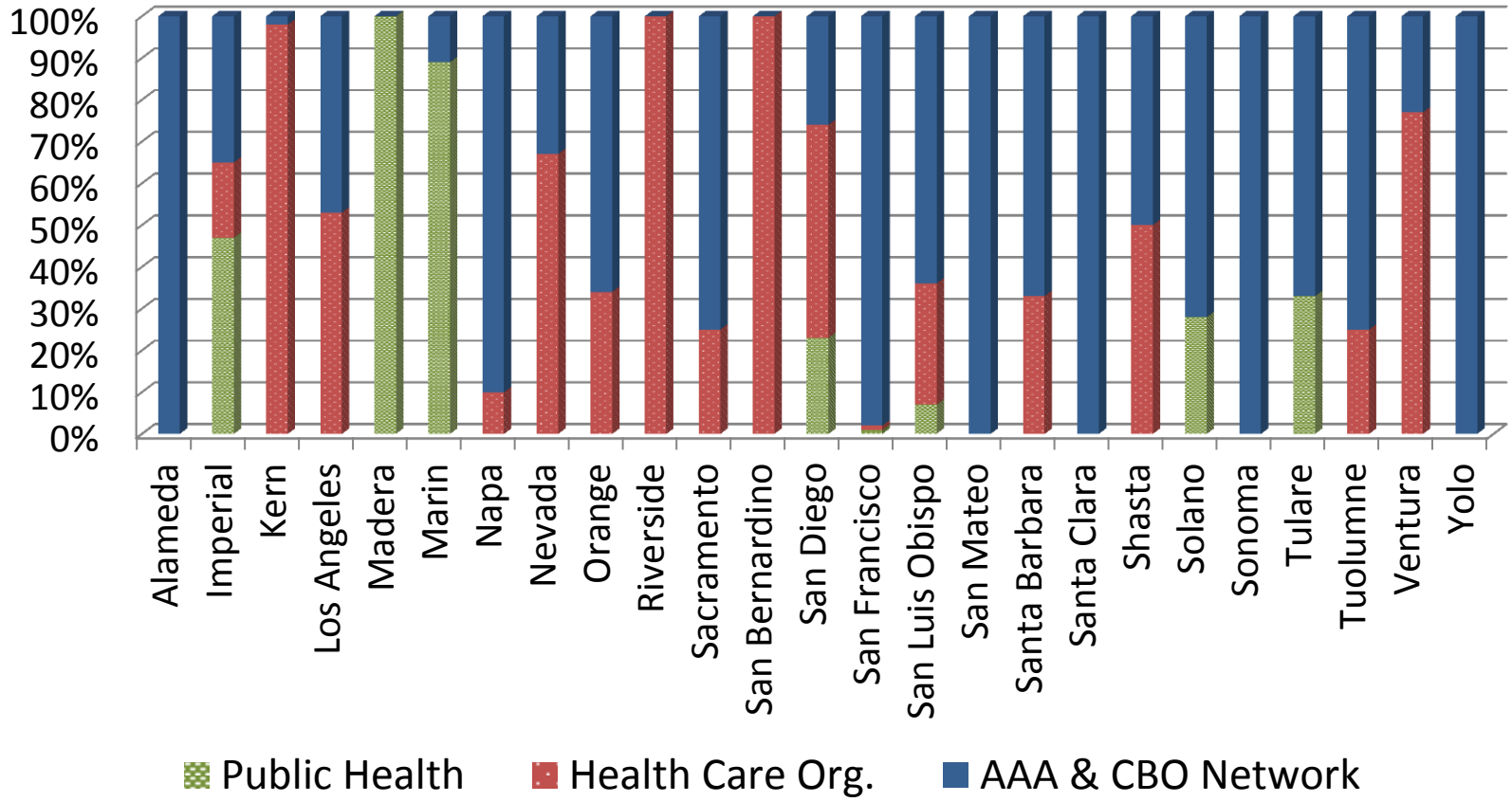
Source: 2014 National Council on Aging Database

Implementation Site



CALIFORNIA HEALTHIER LIVING

Source: 2014 National Council on Aging Database

CA CDSME Program Workshops by Languages

English

Spanish

Chinese

Vietnamese

Tagalog

Somali

Arabic

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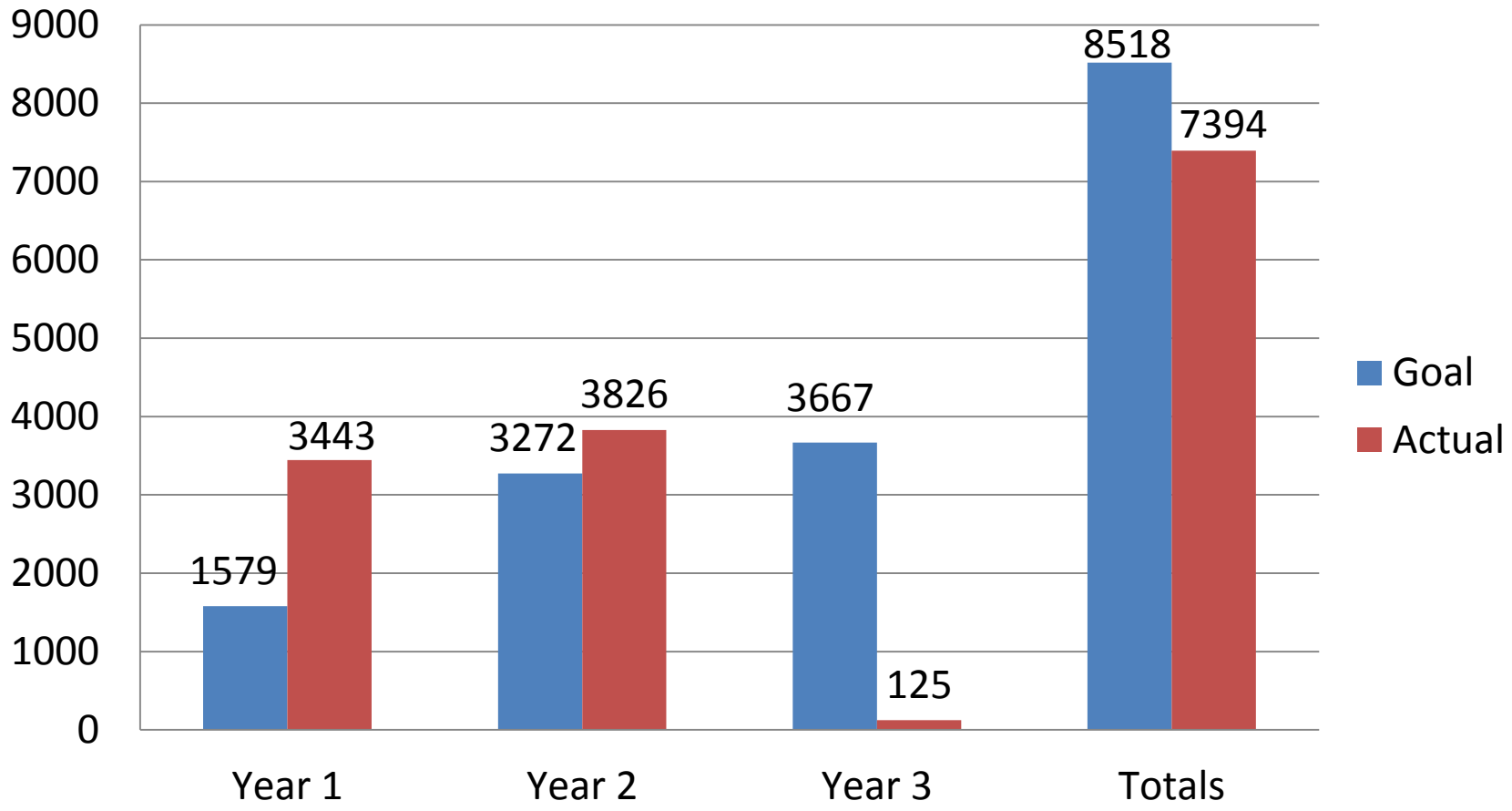
CA CDSME Goals—AoA Grant



CALIFORNIA HEALTHIER LIVING

Source: 2014 National Council on Aging Database

Californians Who Could Benefit from These Programs…

7.5 million younger and older Californians have a disability due to physical, mental or emotional conditions.

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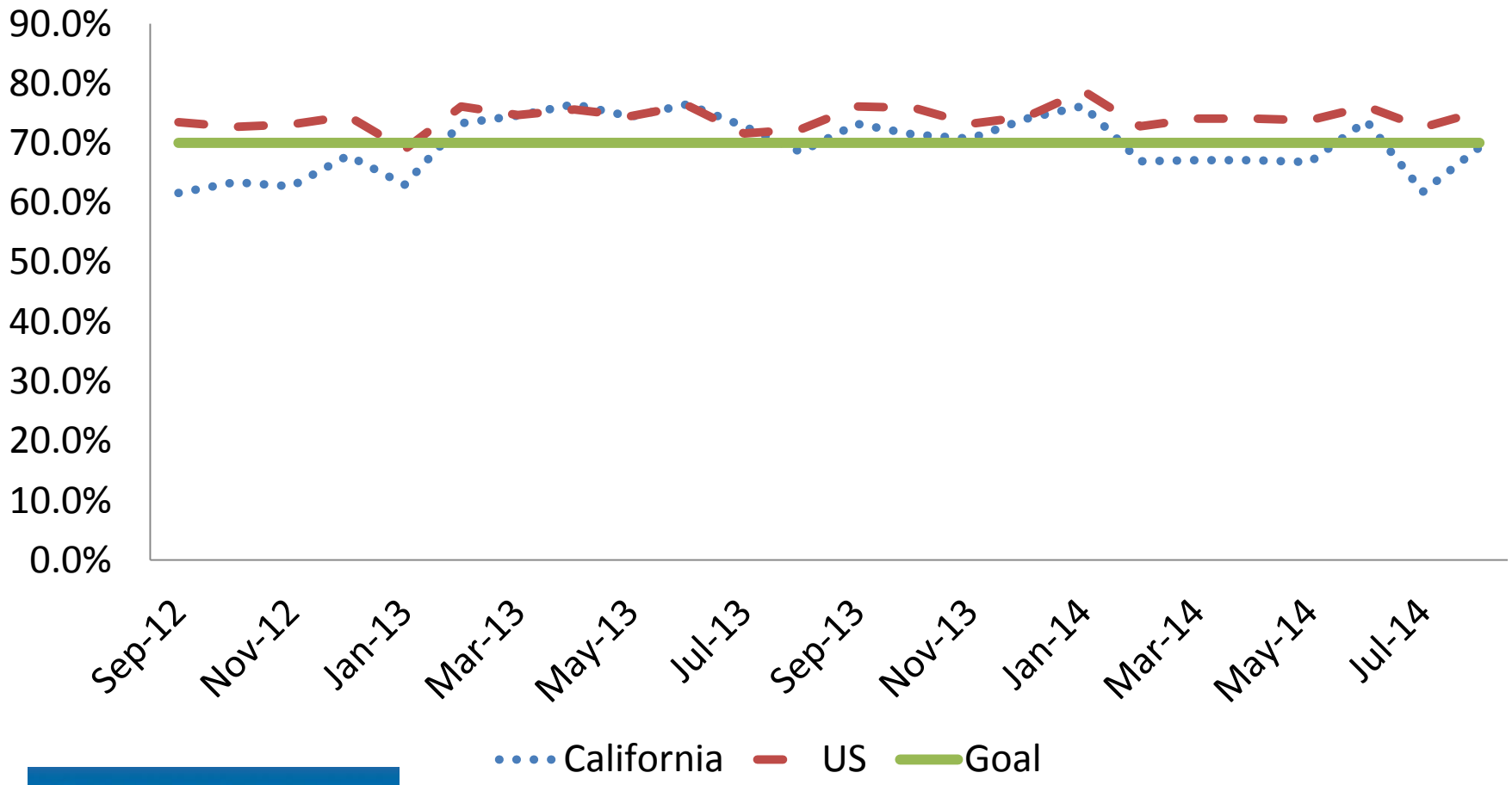
Workshop Participant Retention Rates



CALIFORNIA HEALTHIER LIVING

Source: 2014 National Council on Aging Database

OTHER ACHIEVEMENTS

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Fidelity		Outreach	
Develop and distribute Affiliate Agreement	✓	Created www.CAHealthierliving.org to introduce and promote Evidence-Based Programs throughout the State.	✓
Perform Workshop Fidelity Monitoring through data: appropriate participant enrollment throughout the workshop series, consecutive workshop dates and session length, and appropriate number of facilitators.	✓	Enhanced and standardized CDSME Outreach Materials through collaboration between CDA, CDHP, and Partners.	✓
Developed CDSME Quality Assurance Plan to serve as an on-going evaluation mechanism to assess progress toward providing quality CDSME programs and outcomes including Semi-Annual Best Practices Calls.	✓	Expanded collaboration with Health Insurers and systems	✓
On-going Phone Support & Check-in with counties and organizations	✓		
Data Collection, Reporting, & Analysis	✓		

California Healthier Living Website		Leader Recruitment and Retention Activities	
Customizable County Pages	✓	Distributed Leader Recruitment Forms • Leader Application • Leader Interview Form • Leader Agreement	✓
Statewide Training Calendar	✓	Increased PEDAL & PATH Meetings	✓
Downloadable Data Forms	✓	Provided Data security training	✓
Downloadable Outreach Materials	✓	Widespread Workshop Participant Reminder Phone Calls	✓
CA HL Membership Application	✓	Site Coordinator Education of CDSME Workshops	✓
Access to Past Webinars	✓	Webinars • PEDAL/PATH • Data Forms Training • Making the Case for CDSME	✓

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Coming Soon

Participant Success Stories: Storytelling Templates *under development*. Anticipated release date first quarter 2015 (webinar).		Refresher Course Curriculum • California • Colorado • Oregon • Arizona • New York	
Additions to CA Healthier Living website: • Health Provider & Health Systems Page • Font Resizer Widget to increase readability • EBP Discussion Forum • Online Prevention and Public Health Funds (PPHF) Reporting		Statewide eNewsletter	

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http://www.cahealthierliving.org/

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Home Programs Counties Partners About Us Leader Trainings
Workshop Resources Healthier Living Coalition Workshop Coordinator

Connect Online

Living Your Best Life...

What does it mean to you? Live your life to its fullest and sign-up for a self-management program today! Program workshops are designed to empower you to take small steps to make big life changes. more>>>

FIND PROGRAMS SEARCH BY COUNTY

TELL A FRIEND

California Healthier Living
Physical Activity Programs
PROGRAMS FOR HEALTHIER LIVING

Physical activity programs provide support, information, and resources to help you succeed in making physical activity a part of your everyday life and improve your overall health. more

California Healthier Living
Self-Management Programs
WORKSHOPS FOR HEALTHIER LIVING

Self-management program workshops help you learn techniques and strategies on how to manage your chronic health condition every day. Available in English and Spanish. more

California Healthier Living
Falls Prevention Programs
PROGRAMS FOR HEALTHIER LIVING

Learn more about proven programs for falls prevention and to reduce the fear of falling. more

Menu

Home
Programs
Counties
Partners
About Us

Counties

Alameda Calaveras Del Norte Fresno Humboldt Imperial Kern Kern (Español)
Los Angeles Madera Marin Mendocino Merced Monterey Napa Nevada/Sierra
Orange Riverside Sacramento San Bernardino San Diego San Francisco
San Joaquin San Luis Obispo San Mateo Santa Barbara Santa Clara Shasta Siskiyou
Solano Sonoma Sutter Tulare Tuolumne Ventura Yolo Yuba

About Us

Since 2006, the California Department of Public Health and the California Department of Aging have been collaborating to support and enhance statewide access to evidence-based programs for adults with chronic health conditions and disabilities. more>>>
healthierliving@cdph.ca.gov

Bringing medicine, patients and community-based services together.

Partners in Care
FOUNDATION℠
changing the shape of health care

Building an Integrated System of Care & Services:

Community Partnerships for Whole-Person Care

Dianne Davis, MPH
Senior Director
Partners in Care Foundation

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Facing the Future Together

Networks of Aging, Public Health and CBOs enabling all boats to rise together and give us scale to compete successfully in post-Accountable Care Act markets

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The Tipping Point

- National Movement Towards Evidence Based Self-Management Programs with Many Options for Moving Forward:
  - QIN-QIO - Quality Innovation Network - Quality Improvement Organization
    - Improve healthcare services through:
      - education, outreach, sharing best practices,
      - using data to measure improvement,
      - working with patients and families and convening community partners for communication and collaboration

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The Tipping Point

- Work to improve the quality of healthcare for targeted health conditions and priority populations and to reduce the incidence of healthcare-acquired conditions to meet national and local priorities
  - **Community Based Diabetes Education**

– Large Community Movements
  - Healthy Aging Regional Collaborative – South Florida
  - Healthy Living Center of Excellence – Massachusetts
  - **Los Angeles Alliance for Community Health & Aging (LAACHA)**

– Health System Contracts
  - Networks

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Improving Population Health Using Integrated Networks for Medical Care and Social Services

- Develop prototype networks that link *Aging, Public Health and community-based social service agencies* to the health care sector
- Goals:
  - Establish the value proposition for integrated health care and social services systems
  - Create networks (CBOs & PH / Aging) to deliver home and community-based services
  - Successfully contract with health plans
  - Deliver high quality person-centered care
  - Disseminate learning

Why Focus on Integrated Networks for Medical Care and Social Services?

- Improve health care for adults with chronic conditions through *comprehensive, coordinated, and continuous expert and evidence-based services*
- Add supportive social services to medical care
  - Improve health outcomes
  - Reduce the cost of medical care
- Government/OAA funding threatened
  - Opportunity to compensate for these services through health plans, which are large, often multi-regional and multi-state

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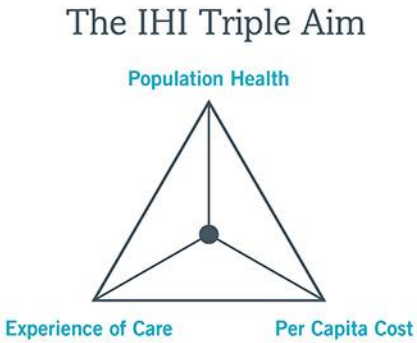
Theory behind the Network

- IF Aging / Public Health / CBOs join together to present a unified, multiregional contracting entity to large healthcare organizations
- AND they can meet the quality, volume, confidentiality, geographic coverage and information needs of healthcare
- AND they can demonstrate their value in terms of the Triple Aim of Institute for Health Improvement



- AND they are competitively priced
- THEN they will *win* contracts with healthcare entities and *perform* well

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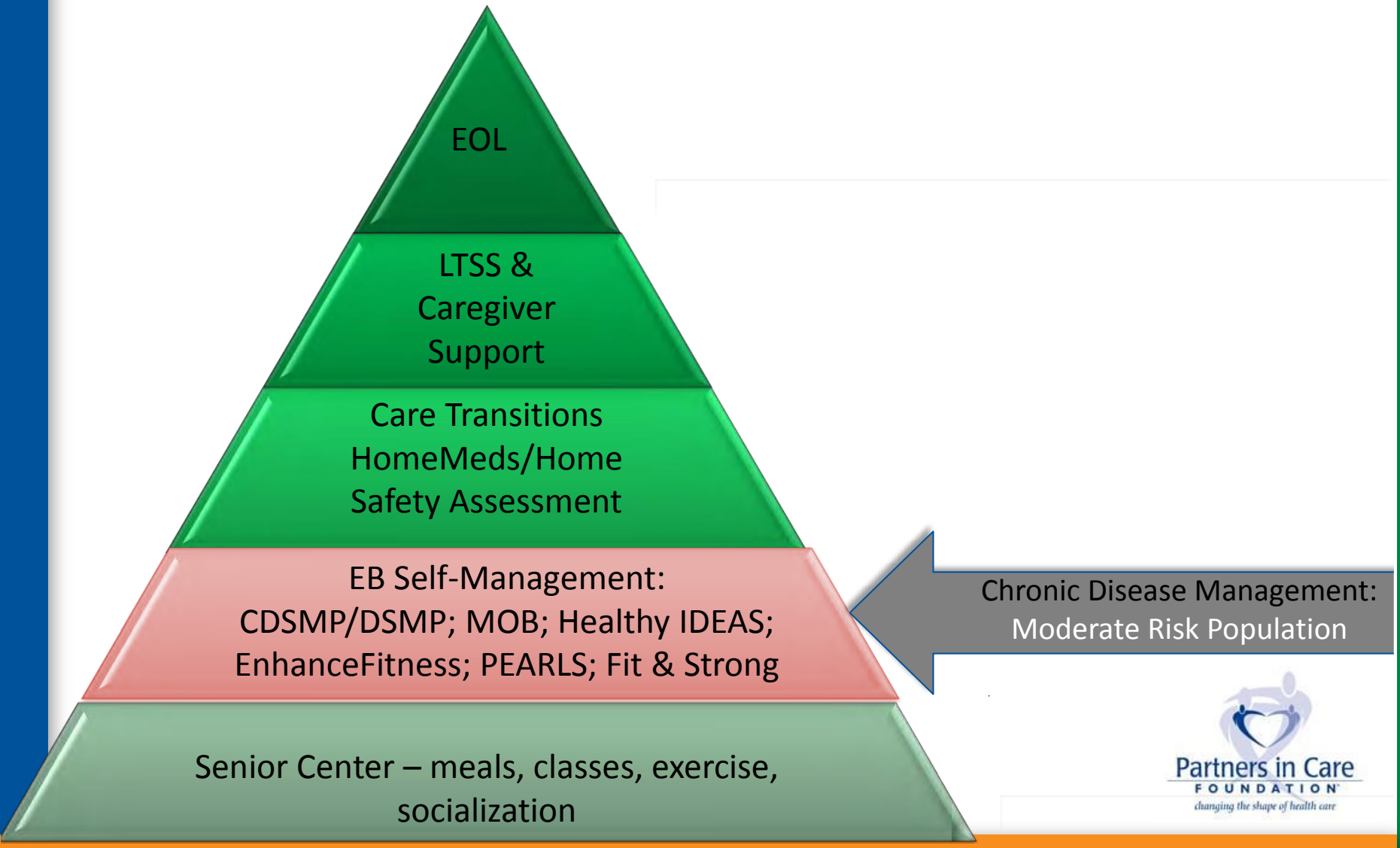
Network Service Lines – Value Proposition: Who Pays and Who Saves?



Why Be in a Network?

What Networks Do for Members and for the Healthcare System

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Why belong to a network?

- **Health System Contracting is expensive**
  - Legal fees – one contract $40,000+
- **Contracting is time consuming** – multiple meetings every week over 9 months – ~2,000 hours of team time *for one contract*
  - Build the relationship – prepare materials, business case
  - Negotiate the contract
  - Roll out the program
    - Develop workflows
    - Policies & procedures
    - Hire staff
    - Training
  - Reporting & evaluation

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Challenges to You
as Individual Organizations

- ✓ **Competition** – Large **national** companies like APS Healthcare
  - ✓ Promise efficient service, unified IT, analytics, quality assurance
- ✓ **Medical Loss Ratio – Billing**
  - ✓ **Health Plans must spend 85% on clinical care & quality**
    - ✓ **No more pilots under administrative budget**
    - ✓ **To be clinical, you need license &/or accreditation**
  - ✓ **Accreditation** is costly ($33,000+)
    - ✓ Requires huge effort…better through a single entity
    - ✓ May be required for contracting with health plans *other than* Medi-Cal, especially Medicare

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Huge investment for healthcare too,

but reaping an integrated regional / statewide contract

- Every meeting with us was a meeting for them
- Lawyers for them, too
- These are innovations for them, so single investment is best
- Department Managed Health Care has to approve every contract
- Health plan has accreditation issue with NCQA – temporary exemption, but…

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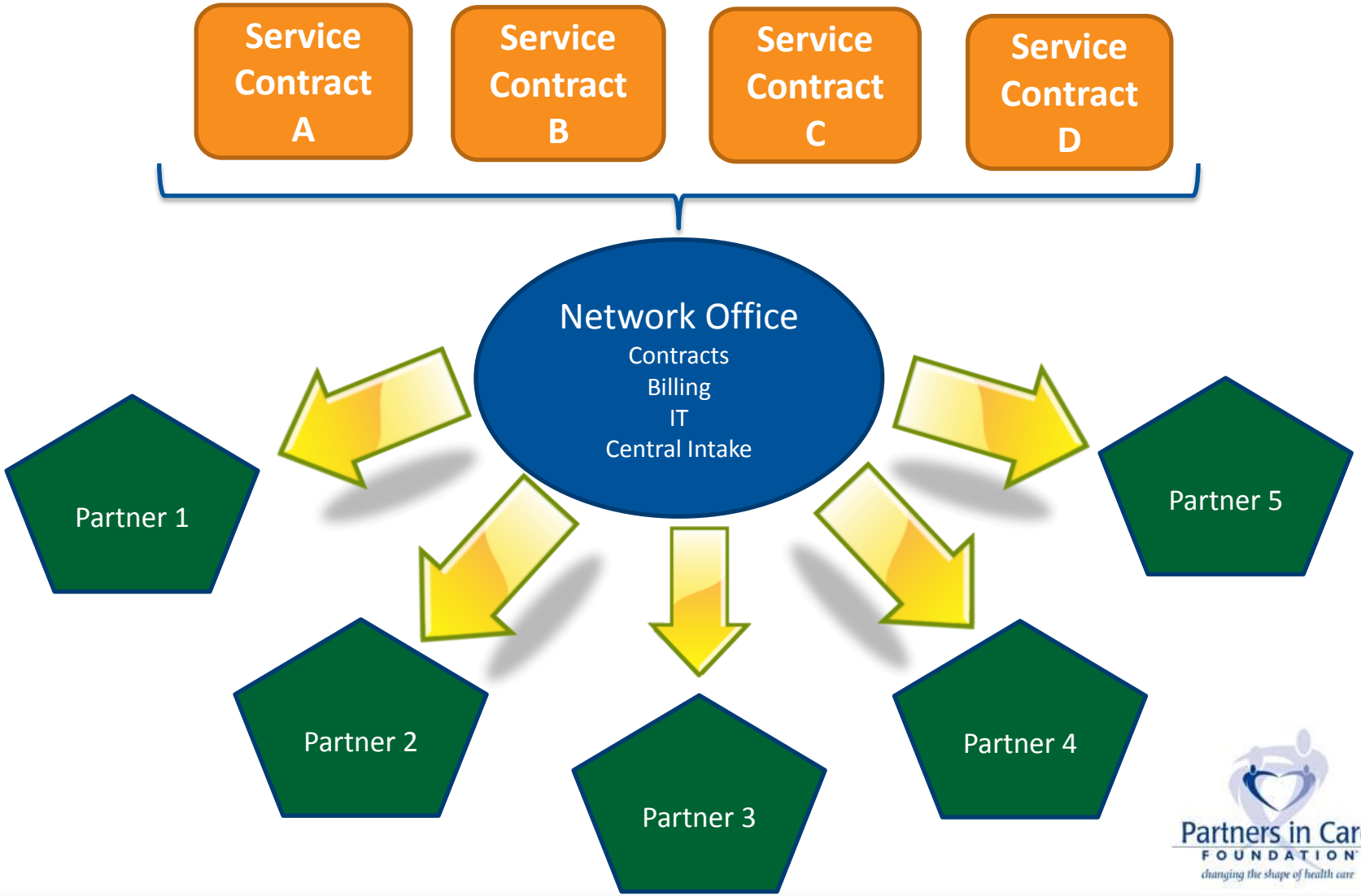
Opportunities for a Network



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Network Office Function 1: Business Office

- Shared sales & marketing
- Negotiate and hold contracts
- Billing & service authorization
- Maintain IT infrastructure
- Legal support
- Call center/communications systems
  - Outreach and engagement for EB programs
- Policies/procedures – HIPAA/HITECH

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Network Office Function 2: Quality Assurance

- Support accreditation through business office
- Ensure consistent delivery of service
- Fidelity to evidence-based models
- Performance data
- Supervision by licensed personnel when required (e.g., LCSW, RD, RN)
- R & D – evaluation

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Network Office Function 3: Meet Health Plan Due Diligence Requirements

- Credential network members to assure compliance with contract terms
  - HIPAA/HITECH security
  - IT Systems for data exchange
  - Insurance
  - Staff – drug testing, background check, TB test, etc.
  - License/certification/accreditation

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Usual work, *new standards*

- What we do now can affect outcomes for health plans, hospitals, ACOs and provider groups
- Strategic approach
  - Geographic availability
  - Requirement for a minimum number of workshops per year spaced out across the year
    - Language
- We have to do it better & faster
  - New Culture: How high?!! Accountability
    - Just doing it vs. doing it right and getting outcomes
- We have to measure & improve constantly
  - Data – Contracting partners MUST share data and information so we can improve…***and demonstrate outcomes!***

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Contact

- Partners in Care Foundation
  - June Simmons, CEO
    - 818.837.3775
    - jsimmons@picf.org
  - Dianne Davis, Senior Director
    - 818.837.3775 (116)
    - ddavis@picf.org
  - www.picf.org; www.HomeMeds.org

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Healthier Living Coalition Meeting

California Department of Public Health Update

November 19, 2014

Majel Arnold, MS & Mary Strode, MS

Chronic Disease Control Branch

Presentation Outline

I. Overview of CDC Chronic Disease Prevention Grants & Collaboration Opportunities

II. Spotlight on the California Arthritis Partnership Program & Collaboration Opportunities

III. Online Storytelling Tools – Sneak Peak

I. Q & A

Overview of Chronic Disease Prevention Grants from CDC

- Prevention First: Advancing Synergy for Health (1305)

  State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health

- Prevention First Supplemental (1305 Supplemental)

  State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health

- Lifetime of Wellness: Communities in Action (1422)

  State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease

Prevention First: Advancing Synergy for Health (1305)

- Goal: To support a statewide implementation of cross-cutting approaches to promote health and prevent and control chronic diseases and their risk factors, as well as to maintain coordination and collaboration across programs
- 5-year grant term: 7/1/2013-6/29/2018
- Multiple stakeholders
- 4 Chronic Disease Prevention and Health Promotion Domains
  1. Epidemiology and Surveillance
  2. Environmental Approaches
  3. Health System Interventions
  4. Improving Community-Clinical Linkages

Prevention First: 1305 Supplemental

- Goal: To implement evidence and practice-based interventions to prevent and control diabetes, heart disease, and stroke in order to reach large segments of the population in the state
- 4-year grant term: FFY 9/30/14-6/29/18
- Multiple stakeholders
- 4 Local Health Departments (LHDs): Alameda, Monterey, Madera, Sacramento

Prevention First: 1305 Supplemental LHD Role

- **Domain 3: Health System Intervention**
  - Improve the quality, effective delivery and use of clinical and other preventive services
- **Domain 4: Community-Clinical Linkages**
  - Ensure that communities support and clinics refer patients to programs that improve management of chronic conditions

Lifetime of Wellness: Communities in Action (1422)

- Goal: CDPH, through partnerships with LHDs, will implement focused community health interventions that intensively deliver health system and community supports and create or strengthen healthy environments
- 4-year grant term: 9/30/14-6/29/18
- Multiple state and local level partners
- 6 LHDs: Shasta, Solano, Tulare, Fresno, San Joaquin, Merced

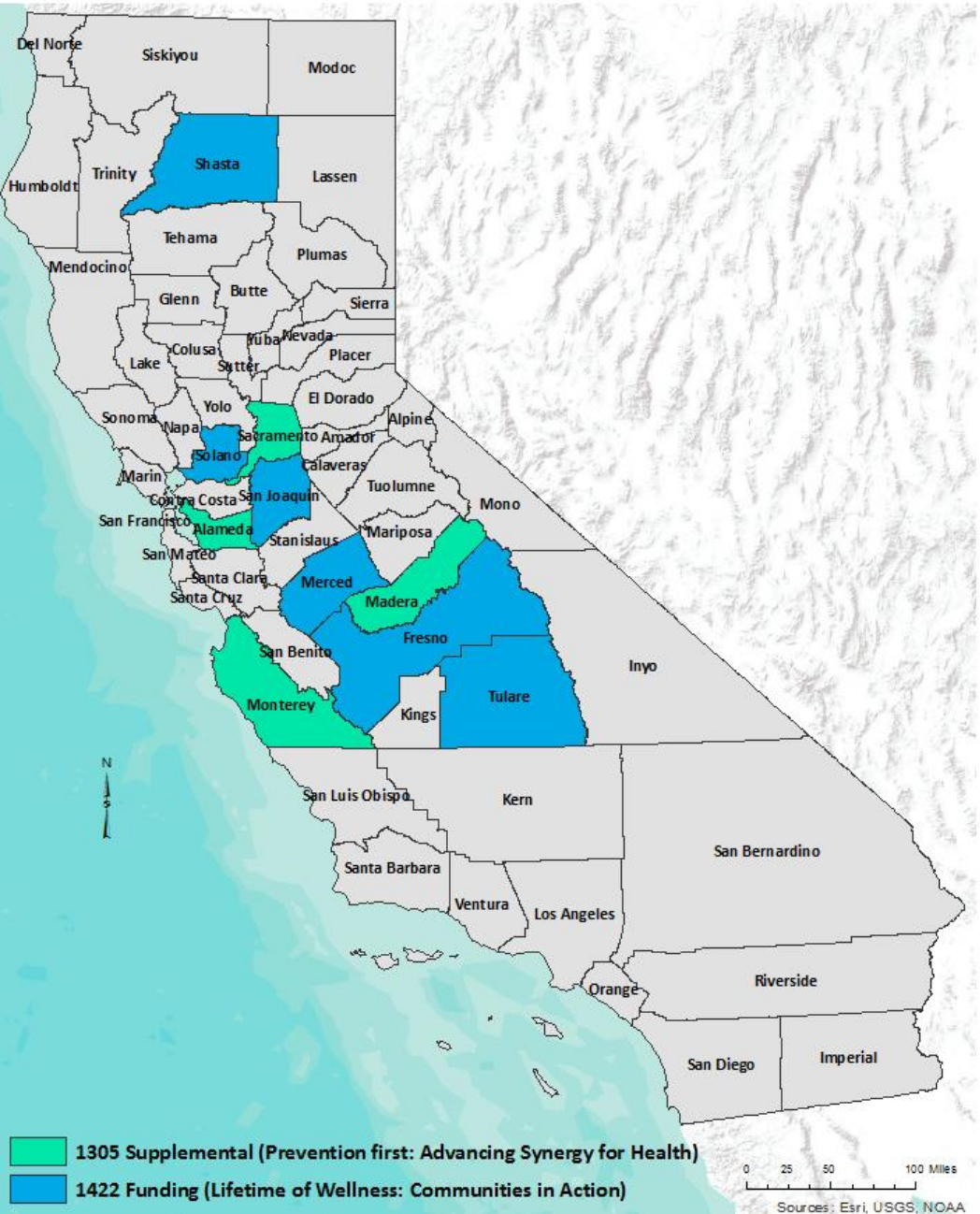
Lifetime of Wellness: Communities in Action (1422)

- LHD activities:
  - **COMPONENT 1a:** Environmental strategies to promote health and support and reinforce healthful behaviors
  - **COMPONENT 1b:** Strategies to build support for healthy lifestyles, particularly for those at high risk, to support diabetes, heart disease and stroke prevention efforts

Lifetime of Wellness: Communities in Action (1422)

- LHD activities:
  - **COMPONENT 2a:** Health system interventions to improve the quality of health care delivery to populations with the highest hypertension and prediabetes disparities
  - **COMPONENT 2b:** Community clinical linkage strategies to support heart disease, stroke and diabetes prevention efforts

CDPH Chronic Disease Prevention Grant (CDC)
Local Health Department Participation
2013-2018



Prevention First Supplemental (1305): Sacramento, Alameda, Monterey, Madera

Lifetime of Wellness: Communities in Action (1422): Shasta, Solano, San Joaquin, Merced, Fresno, Tulare

Collaboration Opportunities

- Cross-promote chronic disease prevention and management interventions (e.g., DSMP, NDPP, CDSMP)
- Increase referrals
- Share resources and best practices
- Develop systems partners

Spotlight on the California Arthritis Partnership Program

- Highlights of FY 13/14 (Year 2)
  - 6,551 people reached through physical activity and self-management interventions (2,541 PA & 3,965 SM)
  - 426 leaders trained (does not include leaders that received an update training)
  - 50 activity delivery system partners for PA and SM
  - 142 intervention courses
  - Ongoing collaboration with partners
  - A year of change!

Spotlight on the California Arthritis Partnership Program

- Contractors for FY 14/15 (Year 3)
  - Arthritis Foundation-Pacific Region
    - WWE implementation
    - Health Communications Campaign
  - YMCA – Sequoia Branch
    - EnhanceFitness classes and instructor training
  - Fresno County Health Department
    - CDSMP workshops and leader training
  - Partners in Care Foundation
    - CDSMP coordination, training, technical assistance, partnership development

CDPH California Department of PublicHealth

Collaboration Opportunities

- Prevention First: Advancing Synergy for Health Grant
- Lifetime of Wellness: Communities in Action Grant
- Department of Motor Vehicles
- Healthier U (State of California employee wellness program)
- Many others!

Sneak Peek: Online Storytelling Tools

- Easy way to share your powerful success stories!
- Online Chronic Disease Prevention Messaging Toolkit: http://www.cdph.ca.gov/programs/cdcb/Pages/New!OnlineChronicDiseasePreventionMessagingToolkit.aspx
- CDC Success Story Tool: https://nccd.cdc.gov/DCHSuccessStories/default.aspx
- Future Webinar Winter 2015

Questions?

Contact Information & CAPP Website

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- Mary Strode, MS, Program Director, CAPP

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- Monica Nelson, Program Coordinator, CAPP

  Monica.Nelson@cdph.ca.gov

- CAPP Website: http://www.cdph.ca.gov/programs/CAPP/

Taraqi Dehendai Sehat:
Addressing Health Disparities in the Afghan Community

Presented by:

Karen Grimsich, MPH **Raymond Grimm, Ph.D.**
Human Services Department
City of Fremont, CA

November 19, 2014

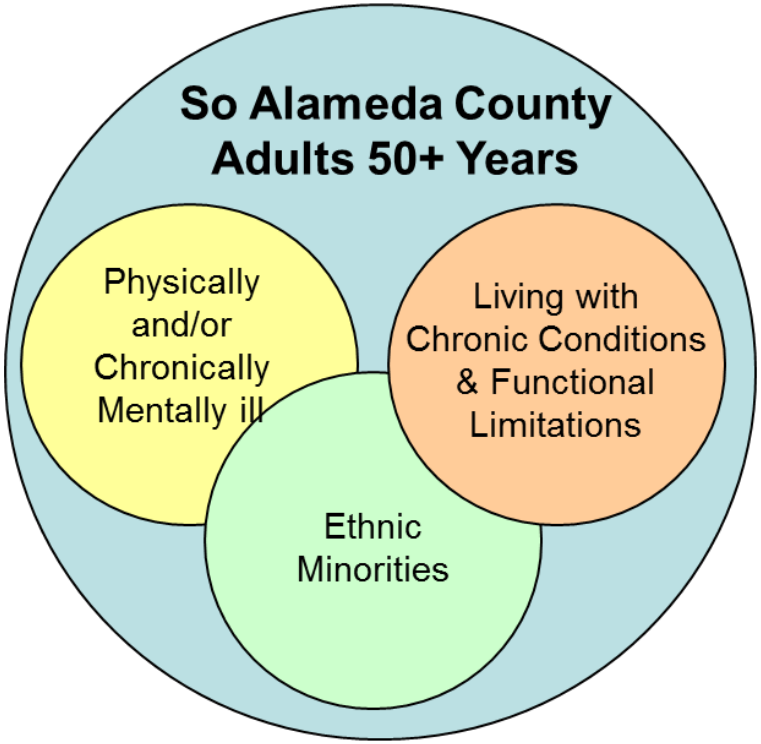
CITY OF Fremont
Human Services Department

Human Services Department

Division	Program
Administration	• Grant Making to Non-Profit Organizations • Federal Grants Administration • Mobility and Transportation
Youth & Family Services	• Promoting Healthy Child Development • Counseling and Parent education • Delinquency Diversion & Intervention
Family Resource Center	• Family Strengthening Services • FRC Service Integration • Economic stability and asset development
Aging & Family Services	• Creating an Aging Friendly Community • Senior Center – Focus on Health and Wellness • Senior Support Services/Mobile Mental Health Team

Promote Aging in Place/Community

Who We Serve
Target Population



What Issues We Address
Issues

- Access to Services
- Coordination of Care
- Culturally Appropriate Workforce
- Isolation & Mental Health

What We Do
Services

- Care Coordination
- Counseling
- Community Health Workers
- Wellness Classes
- Transportation

What Our Clients Get
Outcomes

- Increased Wellness,
- Self Empowerment
- Community Engagement
- Health Management

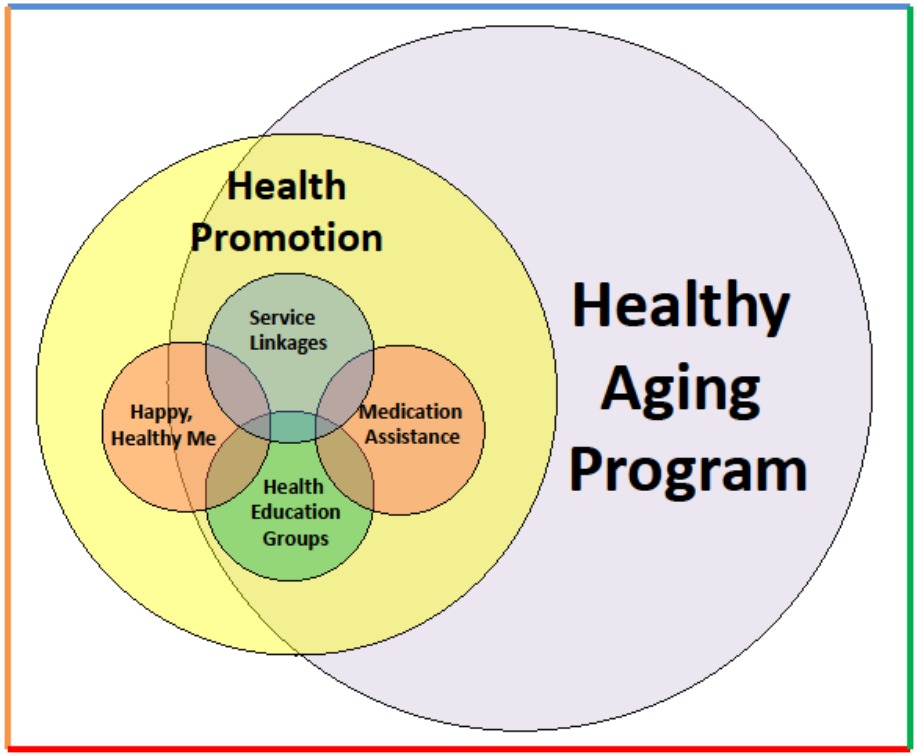
IDENTIFIED NEEDS OF THE AFGHAN COMMUNITY

- High utilization of emergency rooms
- “Doctor shopping” and collection of multiple medications
- High rates of multiple chronic conditions, both health and psychological (e.g., PTSS)
- Due to language and economic barriers, inability to access health, social and other community services resulting in significant health disparities
- Social isolation, especially among women

AFGHAN ELDERLY ASSOCIATION

- Established 15 years ago to address social-emotional needs
- Expanded health promotion programs in partnership with Fremont's Human Services Dept.
- Figure 1 illustrates AEA's current programs that address the 'ecology of needs'

Figure 1: Afghan Elderly Association Programs



AEA PROGRAM DESCRIPTIONS AND GOALS

Afghan Elderly Association (AEA) and City of Fremont Human Services Department (COF)

Healthy Aging and Health Promotion Programs

	Healthy Aging Program (HAP)	**Taraqi Dehendai Sehat aka Health Promotion Program**: Taraqi Dehendai Sehat reaches out to frail Afghan elders in their homes and at the weekly Health Aging Program. Health Promoters are trained by and consult with staff from City of Fremont's Aging and Family Services. The Program consists of the four components: 1) Service Linkage, 2) Enhance Wellness, 3) Medication Management, and 4) the Chronic Disease Self-Management (**CDSMP**) and other Support Group Program (**Support Groups**). **Program Objectives** are to improve the physical and mental health of older Afghan adults by increasing access to health services for service recipients, educating clients about healthy behaviors, and modeling healthy activities.			
		Service Linkage	**Happy, Healthy Me Program**	**Medication Assistance**	**CDSMP & Health Education Groups**
Program Description	The **Healthy Aging Program (HAP)** is a weekly program serving more than 350 seniors. Weekly 80-130 Afghan participants come together at a day-long event that includes nutrition, education, health promotion, exercise, socialization, and other activities that promote equity and quality-of-life. HAP is located in the cities of Fremont and Hayward.	The **Service Linkage** program links Afghan seniors to an array of services – health, social services, transportation, housing, legal, etc. They provide translation and assistance with completing documents related to citizenship, immigration, taxes, Medi-Cal, and other needed resources. Additionally, they conduct community outreach.	**Enhance Wellness** is an evidence-based, self-management program that is focused on increasing physical and social activity and independence. It emphasizes personal choice and responsibility for deciding how to integrate healthy behaviors into daily life in order to manage chronic conditions.	**Medication Management** collaborates with City of Fremont Human Services Department's Public Health Nurse to decrease medication errors. Utilizing medication review and education, the program increases elder Afghans' compliance with medical protocols	• The Stanford ***Chronic Disease Self-Management Program*** (**CDSMP**) is an evidence-based, 6 week group that trains self-management skills to adults with chronic disease. • AEA also offers other **health education groups,** such as the diabetes support group
Goals	***Within a cultural setting, AEA promotes well-being, socialization, and a safety net of resources and assistance for Afghan elders.***	***Link Afghan Elders to resources, facilitate access to services, and provide assistance on matters that concern their quality of life and participation in the larger community.***	***Encourage and promote health-related behavior change that will improve quality-of-life.***	***Improve health by increasing elders' knowledge and proper use of medications.***	***Empower elders to manage chronic health conditions and improve their quality of life.***

HAPPY, HEALTHY ME PROGRAM AIMS (FLINDERS CHRONIC CONDITION MANAGEMENT PROGRAM™)

- Increase awareness of the impact chronic disease on individuals,
- Collaboratively identify strategies & interventions that may assist in improving the individual's ability to self-manage
- Improve the health status of individuals by encouraging, empowering & enabling them to become active partners, with their care providers, in the management of their health
- For health promoters: Develop capacity to use the Flinders Chronic Conditions Management Program™

WHY THE FLINDER'S PROGRAM™

- Promotes self-management skills
- Personally empowering
- Evidence-based (10+ years of data shows that it works!)
- Skills relatively easy to learn by Health Promoters
- Systematically monitors outcomes and results
- Based upon principles of motivational interviewing, problem-solving and CBT

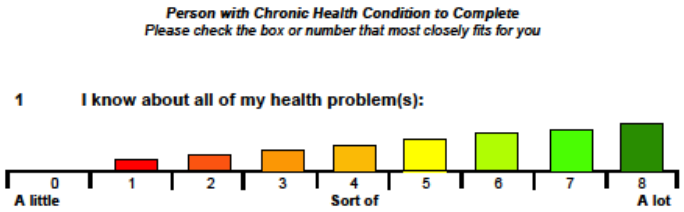
7 PRINCIPLES OF SELF-MANAGEMENT

- **K**now your condition
- Be actively **I**nvolved with the health practitioners to make decisions & navigate the system
- Follow the **C**are plan that is agreed upon with the GP & other health practitioners
- **M**onitor symptoms associated with the condition(s) & **R**espond to, manage & cope with the symptoms
- Manage the physical, emotional & social **I**mpact of the condition(s) on your life
- Live a healthy **L**ifestyle
- Readily access **S**upport services.

'KIC MR ILS'

FLINDERS TOOLS

- Partners in Health Scale
  - Independently completed by client
  - 12 questions covering the
  - 7 principles of self-management
  - Takes 5-10 minutes to complete



- Cue and Response Interview
  - Health practitioners explore same 12 questions as the Partners in Health scale using open-ended cue questions
  - Answers are scored.
  - Cue questions explore:
    - Understanding/knowledge
    - What actually happens
    - What are their strengths
    - What are the barriers.

NAME:.....Assessment Date:.....Review Date:.....

CUE QUESTIONS	Notes	HP's Score	Pt's Score
1. KNOWLEDGE OF CONDTION(S): • **What do you know about your condition(s)? e.g. causes, effects, symptoms?** • **What could happen to you with this condition?** • What does your family/carer understand about your condition?			
2. KNOWLEDGE OF TREATMENT: • **What can you tell me about your treatment?** • What have been the side effects of your treatment? • **What may happen if the treatment is stopped?** • What other treatment options including alternative therapies do you know about? • What does your family/carer understand about your treatment?			
3. MEDICATIONS AND TREATMENT MANAGEMENT: • **What stops you from taking your medication as prescribed by your doctor/health worker? (e.g. consider lack of understanding, frequency, side effects, costs, other barriers)** • What other vitamins, supplements or social drugs do you take? • **What stops you from carrying out your other treatments?(Consider knowing what to do and why: time, energy, physical, other barriers)**			

FLINDERS TOOLS: PROBLEM AND GOALS ASSESSMENT

- Problem statement based on 3 questions
  1. Naming the problem,
  2. What happens to the client because of the problem,
  3. How this makes the client feel

"Because I'm often short of breath I don't go out much & I feel frustrated & angry".

Rating Scale

How much of a problem is this for me?

0	1	2	3	4	5	6	7	8
Not at all		Very little		Somewhat		A fair bit		A lot

FLINDERS TOOLS: PROBLEM AND GOALS ASSESSMENT

- **Goal statement**
  1. Linked to the problem statement
  2. Client goals (not person doing assessment)
  3. Smart and easily evaluated using 0-8 scale
  4. Mid-range goal (6-9 months) with a degree of challenge
  5. May be a maintenance goal for people who are effectively self-managing.

"In order to increase my stamina, I will do ½ hour of low-impact exercise"

Rating scale

My progress towards achieving this goal is?

0	1	2	3	4	5	6	7	8
No progress				**50%**				**Complete success**

FLINDERS TOOLS: CARE PLAN

- **Contains:**
  - Identified issues from the C&R Interview & P&Gs
  - Agreed goals/management aims ('What I want to achieve')
  - Agreed interventions ('Steps to get there/small & manageable')
  - Who is responsible
  - Sign off
  - Review dates

AFGHAN ELDERLY ASSOCIATION
CCSM Program
Chronic Condition Management Plan

Client Name: AA **HP:** PB **Date:** 2/3/2014

Client Problem Statement: I am afraid of going out and walking without someone. That results in my not walking and then I have more pain. That makes me feel terrible.	How much of a problem is this for me 0 1 2 3 4 5 6 7 8 Not at all very little somewhat a fair bit a lot
Client Goal Statement: Every day I would like to walk ½ hour with a friend or family member, if possible, without excessive fear of falling down	My progress towards achieving this goal 0 1 2 3 4 5 6 7 8 No success 25% 50% 75% complete success

IDENTIFIED ISSUES [INCLUDING SELF MANAGEMENT] From C & R and goal	*WHAT I WANT TO ACHIEVE*	*STEPS TO GET THERE*	*WHO IS RESPONSIBLE*	*Date to be reviewed*	*PROGRESS (e.g. no progress, some progress, completed)*

COMPARING FLINDERS AND CDSMP

Flinders Program™

- Generic - one to one
- Evidence-based
- Ongoing follow-up and monitoring
- Trainers - accredited health practitioners to health practitioners
- Doctor client partnership with client sharing decisions & taking responsibility
- Assessment & care planning, behavioral change (goal setting)
- Provides a way to increase referrals to Stanford CDSMP course
- Based on cognitive & behavioural principles & techniques in addition to motivational interviewing

Stanford CDSM Program

- Generic – group
- Evidence-based
- No follow-up
- Trainers - health practitioners & peers to patients
- Promotes improved communication in doctor/patient relationship
- Generic skills – goal setting, problem solving, symptom management
- Provides referrals to HHM Program
- Based on cognitive & behavioural principles & techniques

OTHER TOOLS AND RESOURCES

Flinders Tools

- Symptom action plan
- Monitoring diary
- Checklist
- Best practice guidelines
- Next steps

External resources

- Other health practitioners
- Community activities
- Support packages
- Helplines e.g. Senior Help Line
- Libraries
- Internet

Courses/ Groups

- CDSMP
- Drug & alcohol services
- Walking / exercise groups
- Group programs
- Self-help / support groups
- Health education classes

Coping skills

- Problem solving
- Stress management
- Symptom management
- Medication management
- Assertiveness training

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For more information on the Flinders Chronic Condition Program

http://www.flinders.edu.au/medicine/sites/fhbhru/self-management.cfm

RE-AIM BREAKOUT GROUPS

CALIFORNIA
HEALTHIER LIVING

RE-AIM Best Practices

Reach

- *Program reaches target audience*

Effectiveness

- *Program effectiveness in retaining participants to achieve program goals*

Adoption

- *Expansion of program offerings throughout the target area*

Implementation

- *Program delivers intervention as intended by its developers*

Maintenance

- *Program Sustainability. The extent to which a program becomes institutionalized or part of the routine organizational practice and policy.*

CALIFORNIA HEALTHIER LIVING

LUNCH

CALIFORNIA
HEALTHIER LIVING

NETWORKING

CALIFORNIA
HEALTHIER LIVING

Lora Connolly

RECOGNITION

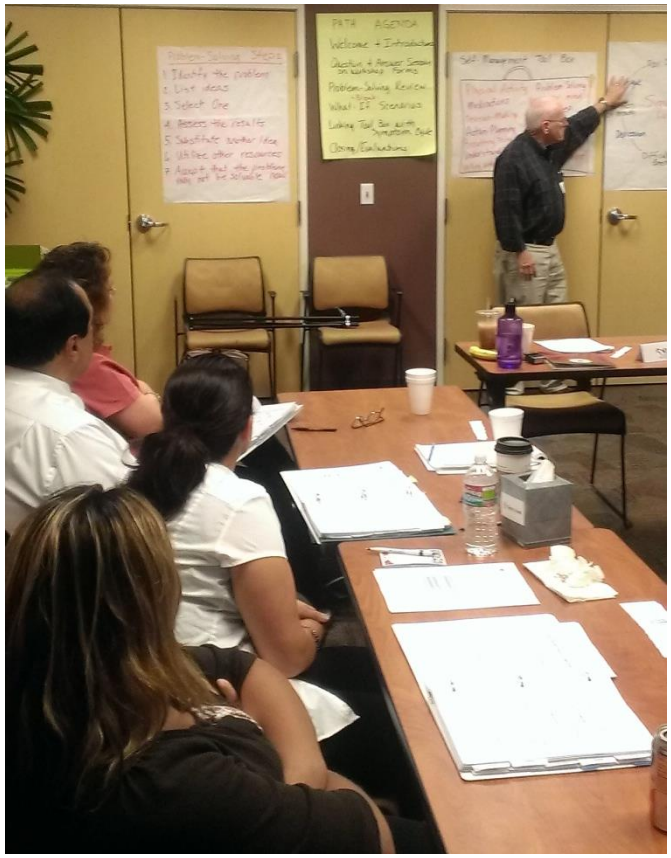
CALIFORNIA
HEALTHIER LIVING

Fidelity Observations

Sydni Aguirre
T-Trainer, CDSMP
November 19, 2014

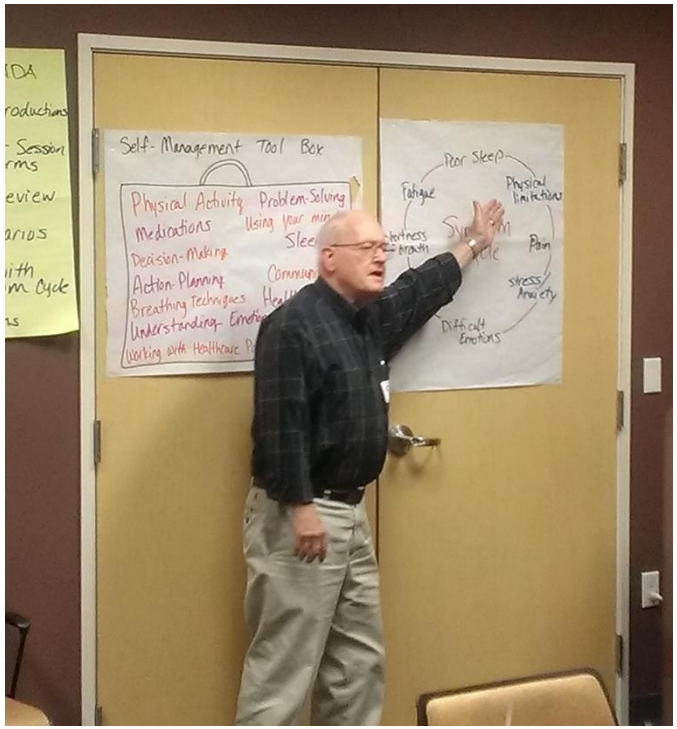
Agenda

- Fidelity Definition
- Most common Fidelity Issues
- Serious Fidelity Issues
- Fidelity Observation Process
- Steps to conduct a Fidelity Observation
- Sample Leader Invitation
- Observation Overview for Observer
- Fidelity Observation Checklist
- Fidelity Observation Feedback
- Steps for a second Fidelity Observation
- Leader to Leader Feedback Form



Fidelity Defined

"Program Fidelity, at the organizational level refers to how closely administrators, peer leaders trainers and evaluators follow the program as intended by the developers. This includes consistency of delivery of the program's core elements such as information, methods, timing and type of resources."



(2012 Program Fidelity Manual, Stanford Self-Management Program, Page 4)
http://patienteducation.stanford.edu

Most common issues observed

- Agenda not posted or handed out
- Leaders forgets to ask for clarification after brainstorm
- Leaders tolerate cross talk during brainstorm
- Leaders allow participants to talk too long or leaders stifle discussion
- Leaders leave out a step in Action Planning
- Leaders write in a manner that is difficult for participants to read
- Leaders forget to remind participants how to respond during feedback activity
- Leaders forget steps in the problem solving process
- Time limits are not observed

Serious Fidelity Issues

- Leaders provide material that is not in the manual
- Leaders use the manual but prepare their own lecture
- Leader(s) invite lecture guests to class
- Leaders/Trainers openly disagree and argue in front of the group
- Leaders give medical advice to participants
- Leaders do not follow the times and sequence of activities and sessions indicated in the manual
- Any other behavior(s) observed that disrupt the flow of the workshop or detract from workshop fidelity

FIDELITY OBSERVATION PROCESS

- All leaders must be observed once a year
- For new leaders - during their first workshop
- Fidelity Observation can be performed by the Program Coordinator, Master Trainer or experienced Leader
- Notification will be given 2 weeks prior to the observation
- Observations will be performed using the ***Fidelity Observation Checklist***
- Comments should be given to the leaders immediately after the session by the Observer

STEPS TO CONDUCT A FIDELITY OBSERVATION

- Select the observer - determine if coaching is needed so that his or her role is very clear
- Notify leaders ahead of time
- Send ***Fidelity Observation Invitation Letter*** and ***Fidelity Observation Checklist*** that Observer will be using
- Confirm with leader(s) when feedback will be given
- Reassure the leaders that this should be a positive experience
- Remind leaders to ask the group for approval of an observer the session before the visit
- Observer is not to participate in workshop

Fidelity Observation Invitation

Today's Date

Fidelity Observation Invitation

Hello (leader name),

Thank you for being a community leader for (Program Name). Dignity Health appreciates your commitment to deliver Stanford's self-management programs as written and intended by the creators of the program.

I hope (or Observer _____ plans) to visit session (_) on (date) for your ***Fidelity Observation*** at (location of program). ***Fidelity Observations*** are regularly scheduled for all new and existing leaders. It gives me the opportunity to see and affirm all the great things you are doing. It also gives you a chance to ask questions and receive coaching from an experienced Leader or Master Trainer. If it works for both you and your co-leader, let's plan to stay 30-45 minutes after the session to discuss the ***Fidelity Observation Checklist*** which I will use during the observation.

I've attached the ***Fidelity Observation Checklist*** for your reference. The checklist details key leader skills for the 6-week program. I will use this during the observation and use it as a guide during the feedback. I'll bring copies for all three of us.

Feel free to introduce me to the group as an observer only and that I will not be participating in the workshop. Please notify the group at session (__) that I will be present at the next session.

Let me know if you have any questions between now and then.
Have a great day!

Sincerely,
Coordinator

(send ***Fidelity Observation Checklist*** along with Invite)

Dignity Health

Fidelity Observation Overview for **OBSERVER**

Fidelity Observation Overview for OBSERVER

Purpose

The purpose of providing a ***Fidelity Observation*** is to support the workshop leader, share ideas and to provide feedback that ensures Program Fidelity. It is an opportunity to strengthen the workshop leader model and to maintain quality of Stanford's evidence-based self-management programs. All workshop leaders will be observed annually. A leader's first fidelity observation should occur during the first workshop they co-lead and performed by Program Coordinator, Master Trainer or experienced Leader who has been coached on giving leader feedback.

Process

- The ***Fidelity Observation Checklist*** is a guide for delivering the program and will be used to conduct the observation. The ***Fidelity Observation Checklist*** highlights key leader skills that are essential when delivering Stanford's self-management programs.
- Coordinator will send the ***Fidelity Observation Invitation*** along with the ***Fidelity Observation Checklist*** to the leaders being observed.
- Prior arrangements should be made for the fidelity observer to attend a specific session. Observers should never show up unannounced.
- Coordinator should never schedule an observation for session #1. Sessions 2, 3, 4, or 5 are best for fidelity observations.
- Leaders will inform the group the session prior that an observer will be attending the next session for quality assurance of the program. Leaders can introduce the observer as a guest who is observing the workshop leaders only. The observer is not to participate or be called upon as an "expert" during the session.
- Prior to the session beginning, briefly review what will happen and ask if they have any questions about the ***Fidelity Observation Checklist***.
- Feedback should happen directly after the session once all the participants have left. Leaders will be instructed to stay for 30-45 minutes after the session for this feedback session. Feedback steps are on following page.
- The ***Fidelity Observation Checklist*** will be completed by the observer. The workshop leader and observer will review and sign the checklist after the feedback session. The observer will send this completed checklist to the program coordinator who will then email leader observation highlights and areas of improvement along with next steps (if need be) to the leaders.
- Coordinator will maintain a copy of the ***Fidelity Observation Checklist*** in leader file.

Payoff

Participants will have the desired outcomes of the evidence-based program. Leaders will know what is expected of them. Organization will have less leader and participant attrition.

Steps to Provide Observation Feedback

1st Step: Set a positive tone

- Thank the participant for their delivery. Make some general very brief comment about their delivery that sets a positive tone.
- Even if their performance has not gone particularly well, you should be careful not to be too unduly critical. Find something generally positive to say.

2nd Step: Allow Self-Criticism

- Say to the leader: "Let's start with you" or "Let's first hear from each of you how you think your presentation went?" The purpose of this question is to open up the feedback process allowing those "on the spot" the opportunity to take the initiative minimizing external evaluation. Also, as the observer you want to determine the level of self-awareness the person has over their performance.
- Ask "Is there anything in particular that you would do differently?" This question gives leaders the opportunity to seek guidance on any difficulty that has arisen or to demonstrate an awareness of where they went wrong.
- Finally, ask "Would you identify one or two things that you believe you did particularly well?" This question gives leaders the opportunity to comment on their strengths.

3rd Step: Offer Observer Feedback

- Remember the principle of the "Feedback Sandwich" — Observer feedback should begin and end with positive statements, with the corrective/constructive feedback sandwiched in between. Start your feedback with 2-3 things that the leader did well.

- Then, in a non-threatening-non confronting way, fill in any gaps or observations that the leaders have left out. Try to get the leader to identify any area for improvement by asking question that focus on the specific critical area. For example, you might ask "What happened when Mary did not write down Jean's idea during the brainstorming?" or "What did you say to the participant who did not want to make an action plan?" or "What did you do when your partner skipped the chart?"
- You then want to follow-up with leaders suggesting ways of improving that situation like "How might you do this differently?" You may need to explain why a particular course of action or response is recommended.

Fidelity Observation Checklist

Dignity Health.

Fidelity Observation Checklist

Healthier Living: ☐ CDSMP ☐ DSM ☐ PSM

Date: _____ Session Attended: _____

Workshop Leader: _____ Observer: _____

Site Name: _____ Number of participants in class: _____

Skills	Y/N	Comments/Suggestions
Class Prep – Arrived on time with material and charts – Appropriate classroom set-up: protecting confidentiality, seating arranged in a "U" or circle, lighting, temperature, ADA, noise and distractions, ability of all trainees to see and hear, charts are appropriately placed and easily viewed		
Delivery of Workshop – Agenda handed out or displayed on wall – Followed curriculum as scripted in leader manual – Clearly explained topics and activities and linked symptom cycle to tool box often – Presentation style appropriate and articulate with good eye contact and inflection – Modeled activities correctly – Acknowledged participants responses		
Feedback/Problem Solving – Asked person to state their action plan and respond with accomplished, partially accomplished, not able to accomplish, etc. – Commented appropriately on action plan when participant was successful, partially accomplished or had to modify – If problems occurred, leader asked what barriers existed and did they try a solution? – Leader asked person if they would like help – Leader asked group if they ever had same/similar problem – Followed 7 steps to problem-solving – Limited to 3 'yes but' – Suggested person make a note of suggestions offered and to choose one idea		
Group Interaction – Encouraged group participation – Limited personal stories – Handled problem people effectively – Adhered to activity times – Worked well with co-leader		

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Fidelity Observation Checklist

Brainstorming – Reviewed Brainstorm Chart – Encouraged participants to produce as many ideas as possible – Repeated ideas – Reminded group not to comment on ideas – Did not allow discussion/questions – Used silence to produce more ideas – Did not respond positively or negatively to ideas – Offered own response only at end – Reviewed the list by reading ideas – Provided opportunity for clarification – Commented on alcohol use or recreational drug use if needed		
Action Planning – Used chart to point out steps as trainees shared their action plans – Pointed out "will" if participant used try, should, want or think – Helped identify barriers if confidence level is less than 7 – Asked the group for suggestions before the leaders offered responses if needed		
Fidelity – Delivered all content material according to the leaders manual – Accurately paraphrased sections of activities (provided info clearly, without adding or deleting material that changed the content) – Class started on time, followed recommended time for activities, class ended within 2 ½ hours		

Additional Comments:

Signature of Workshop Leader: _____

Signature of Fidelity Observer: _____

Feedback after Fidelity Observation

- Clearly document observations
- Feedback can be giving one-on-one or together
- Use the “Feedback Sandwich” approach – provide constructive feedback “sandwiched” between encouraging, positive feedback
- Provide clear detailed feedback about highlights and problems observed
- Ask how they could have improved or made it better
- Offer examples of how to improve that situation
- If leader demonstrated several common fidelity issues or if serious fidelity issues were presented or you simply still have concerns, schedule a second observation for the following session

Steps for second Fidelity Observation

1. Schedule second observation for the next session
2. Reinforce that Healthier Living (CDSMP) is an evidence-based program; if fidelity is not followed the licensed agency is in jeopardy of losing their license
2. Within 48 hours email leader detailing the concerns or problem areas
3. Send another invite to leader for the following session if possible
4. Complete ***Fidelity Observation Checklist*** again

Follow-up Observation Session

- Document all observations in detail
- The Observer will follow the usual policy for fidelity coaching (Refer to ***Steps to Provide Observation Feedback***)
- Be sure to congratulate the leader on any corrections made in response to feedback from the first feedback session
- If initial fidelity concerns were remedied, no additional action is required
- Submit a copy of the follow-up visit to the program coordinator

If serious concerns still exist . . .

- Clearly document and communicate your concerns to the Leader
- Use the Leaders Manual and/or the Fidelity Manual as reference http://patienteducation.stanford.edu
- A letter detailing the observations from the follow-up fidelity coaching will be sent to the leader within 48 hours
- Letter should also be sent to the program coordinator
- If needed, a conference call or meeting should be scheduled with Observer, Leader, Coordinator, and/or representative from the licensed agency to explain next steps.
- If acceptable, offer other ways leader can help with program

Leader to Leader Feedback

- Some areas do not have a program coordinator that can arrange for a Fidelity Observation
- Leaders will have an opportunity to evaluate each after each session using the leader to leader feedback form
- The idea is to create a comfortable atmosphere to give tangible feedback to their co-lead

LEADER TO LEADER FEEDBACK FORM

Leader to Leader Feedback

Dignity Health.

Leaders – Please take time after each session to review these questions with your co-lead. You may write these down for your partner to reference for future sessions. This feedback form will remain confidential unless additional clarification is requested from the program coordinator. References of suggested items to comment on are listed on the back side of this form.

Share at least one positive or encouraging observation about your partner's presentation skills.

1.

2.

Share at least one area of improvement or new approach to your partner's presentation skills.

1.

2.

Please list any additional item(s) that need clarification. Return this portion or email question(s) to program coordinator. Thank you.

Leader to Leader Feedback

Dignity Health.

Leader Skills
Workshop preparedness
– Arrived on time (at least 30 minutes before each session) and prepared to deliver material
– Followed curriculum as scripted in leader manual
– Clearly explained topics and activities and linked symptom cycle to tool box when needed
– Presentation style appropriate and articulate with good eye contact and inflection
– Modeled activities correctly
– Acknowledged participants responses
Activity 1 (Feedback) in session 2-6
– During Activity 1 (Feedback) in session 2-6, leader asked participant to state their action plan and gave the direction to respond with accomplished, partially accomplished, not able to accomplish, or proceeded to problem-solving if participant agreed to it.
– Commented appropriately on action plan when participant was successful, partially accomplished or had to modify
– If problems occurred, leader asked what barriers existed and did they try a solution?
– Leader asked person if they would like help before engaging the group to brainstorm solutions
– Leader asked group if they ever had same/similar problem
– Followed 7 steps to problem-solving
– Limited to 3 'yes but'
– Suggested person make a note of suggestions offered and to choose one idea
Group Interaction
– Encouraged group participation
– Limited personal stories
– Handled problem people effectively
– Adhered to activity times

Leader Skills
Brainstorming
– Reviewed Brainstorm Chart or rules verbally
– Encouraged participants to produce as many ideas as possible
– Repeated ideas
– Reminded group not to comment on ideas until after the brainstorm is complete
– Did not allow discussion/questions
– Used silence to produce more ideas
– Did not respond positively or negatively to ideas
– Offered own response only at end
– Reviewed the list by reading ideas
– Provided opportunity for clarification
– Commented on alcohol use or recreational drug use if needed
Action Planning
– Leader stood by chart and pointed to steps as participants shared their action plans
– Pointed out "will" if participant used try, should, want or think
– Helped identify barriers if confidence level is less than 7
– Asked the group for suggestions, participant agrees to it, before the leader offered responses if needed
Fidelity
– Delivered all content material according to the leaders manual
– Accurately paraphrased sections of activities (provided information clearly, without adding or deleting material that would change the content)
– Class started on time, followed recommended time for activities and ended within 2 ½ hours

Questions?

Lora Connolly and Majel Arnold

CLOSURE AND EVALUATION

CALIFORNIA HEALTHIER LIVING

ADJOURNMENT

CALIFORNIA
HEALTHIER LIVING

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