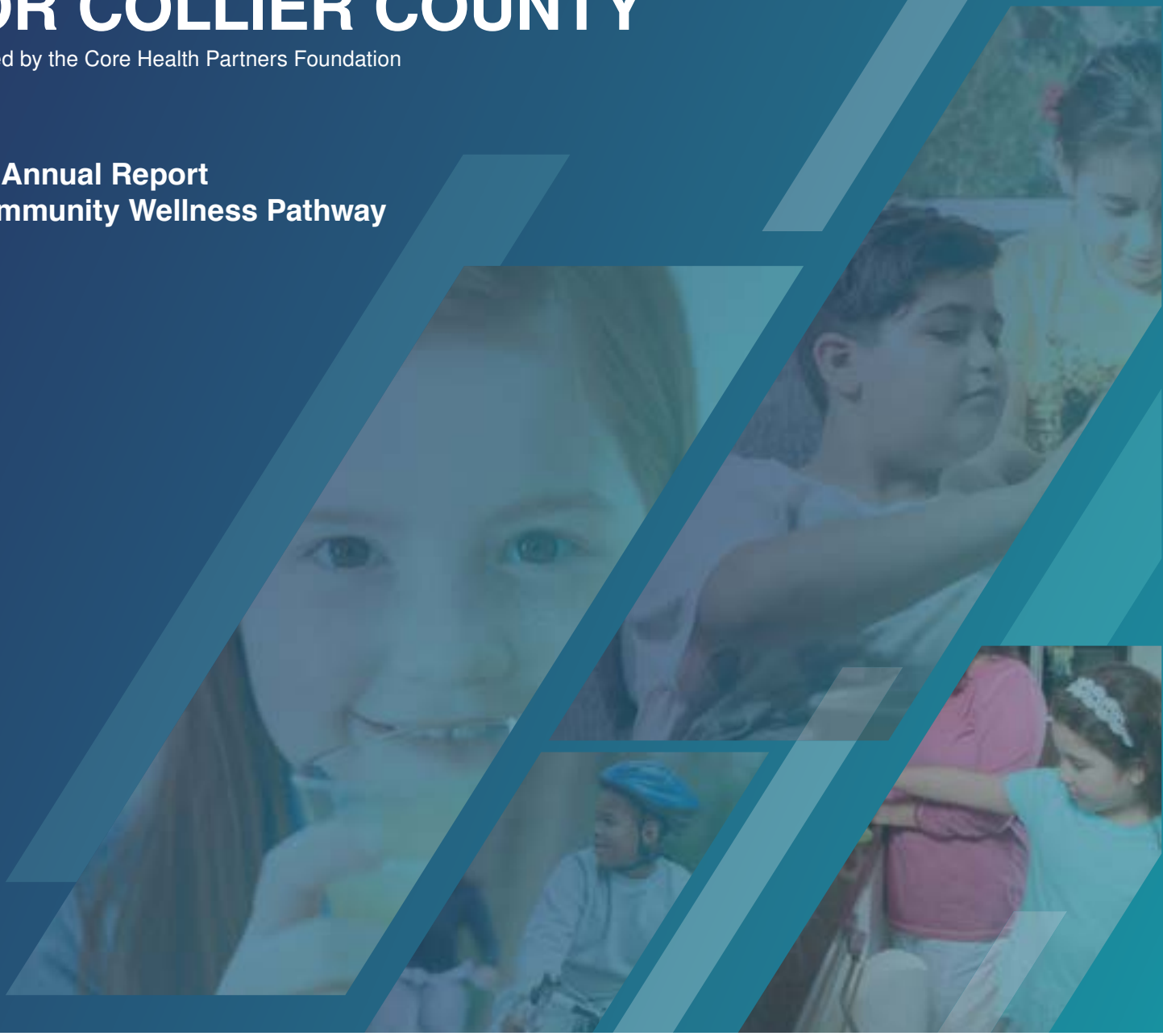
Togetherhood Initiative

A Community Health and Well-being Collaborative

CHILD OBESITY REPORT FOR COLLIER COUNTY

Prepared by the Core Health Partners Foundation

2023 Annual Report & Community Wellness Pathway



DAN DIABETES ALLIANCE NETWORK · FORCE FOR HEALTH PROTECT THE GIFT · Help A Diabetic Child™ · FGCU · UF College of Dentistry UNIVERSITY of FLORIDA · UF College of Medicine Department of Pediatrics UNIVERSITY of FLORIDA · NATIONAL WELLNESS INSTITUTE · healthcare network · CORE HEALTH PARTNERS BRINGING THE CLINIC TO THE COMMUNITY

“The only way we can drive change is to quit working in silos. This is why I am thrilled with the Togetherhood Initiative.

The success in Collier County only occurs when we co-produce the process and the results are what the community seeks and can change.”

Chuck Gillespie, MBA, CWP
CEO, National Wellness Institute

Togetherhood Initiative
A Community Health
and Well-being Collaborative

FOREWORD

TOGETHERHOOD INITIATIVE
THE EVOLUTION FOR COORDINATION OF CARE

Coordination of care in healthcare results in better patient outcomes and significant healthcare cost savings. Failures in care coordination account for $27.2 billion to $78.2 billion in waste per year in the United States. Coordination of care is defined as "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care." This includes determining the patient's needs and preferences and communicating them "at the right time to the right people."

In a community like Immokalee, FL, coordination of care becomes even more difficult because of a lack of services being available, plus the many other health and economic factors that underserved communities face. For this is why Togetherhood provides an ideal model to evolve coordination of care from a health model to a well-being model.

You see, shared vision and co-production are the critical success factors missing in most health and wellness initiatives deployed across the United States. Health and wellbeing programs, services, initiatives, and coalitions today are extremely siloed. Much of the siloed issues stem from a lack of a repository for projects that are easily assessable by the public. Because of the siloed nature of the offerings in health and wellness, the ability to scale programs and services across a large spectrum is greatly lacking. The inability to scale impacts the long-term sustainability of these offerings.

The Third Edition of the book Lifestyle Medicine has a chapter titled Community as a Catalyst for Healthier Behaviors. The chapter, researched and written by Drs. Jane and Peter Ellery, both Sr Fellows with the National Wellness Institute, explain that the association between health, engagement, and community is apparent in initiatives that are focusing on systems and environmental changes. Changes that combine a salutogenic focus with community involvement and co-production models can be initiated by physicians, mayors, urban planners, worksites, and many others in communities. The Togetherhood Initiative allows for Immokalee, FL to not only serve its community with better care coordination, but this initiative becomes the national model for how care coordination can help drive community health and economic vitality.

In 2018, US Surgeon General, Dr Jerome Adams, released his Call to Action. The report outlined that to improve the health of Americans and help foster a more sustainable and equitable prosperity, "Community Health and Economic Prosperity" or "CHEP" for short uses a multipronged approach focused on:

- Engaging businesses to be community change-makers and forces for health in their communities
- Implementing solutions to help improve and sustain the health of communities.
- Strengthening communities to be places of opportunity for health and prosperity for all.

The Togetherhood Initiative meets the Call-to-Action items. But it further expands the capabilities of a health systems already contained, because with the offerings of

[1] *2019 study in the Journal of the American Medical Association*
[2] *The Agency for Healthcare Research and Quality*

what is under a single roof and nearby, the Togetherhood Initiative also elevates coo=on of care, which in turn allows for a better patient experience, improved health for the community, and lower overall costs.

Further, care coordination like the Togetherhood Initiative enables providers to:

- **Work at the top of their credentials.** Physicians have more quality time to care for patients, since patient care coordinators (PCCs) can directly handle or facilitate with the physician's care team a wide range of patient care tasks.
- **Improve utilization management.** Care coordination allows physicians and other care team members to focus on proactive care, rather than react to expensive acute care episodes.
- **Engage patients in their own care.** As extensions of the physician and his/her care team, PCCs can stay closely connected to patients. Regular communications help engage patients and focus their attention on preventative actions.

Consider what can be accomplished within the Togetherhood Initiative and I urge you to consider proper funding to build it into a needed and self-sustaining offering.

Very truly yours,

Chuck Gillespie, MBA, CWP
Chief Executive Officer
National Wellness Institue

NATIONAL WELLNESS INSTITUTE

About National Wellness Institute: The National Wellness Institute (NWI) drives professional standards, provides world-class professional development, produces practical application programming, and creates engagement opportunities that support individuals from a variety of disciplines to promote well-being for all. NWI has been the worldwide leader of the wellness promotion since 1977.

At the core of NWI's offerings are the Wellness Promotion Competency Model, the Six Dimensions of Wellness model, and the Multicultural Competency in Wellness Model, which guide the strategies for cultivating great champions, navigators, and leaders of wellness. The National Wellness Institute's Certified Wellness Practitioner (CWP) is recognized globally as the gold-standard credential for the industry.

Pictured left to right: *Chuck Gillespie, National Wellness Institue; Paul Thein, Core Health Partners; Joe Balavage, Help a Diabetic Child*

Togetherhood Initiative

A Community Health and Well-being Collaborative

Togetherhood Initiative: The Story Behind Our Logo

We'd like to share the story behind the Togetherhood Initiative logos. Our goal was to produce logo that would become an expression of who we are, what we do and what inspire to do through collaboration. Our logo is represented in a simple one color as we felt the emphasis should not be on us, but rather the people we serve and their amazing outcomes and colorful stories in overcoming obstacles to achieve a better wellbeing.

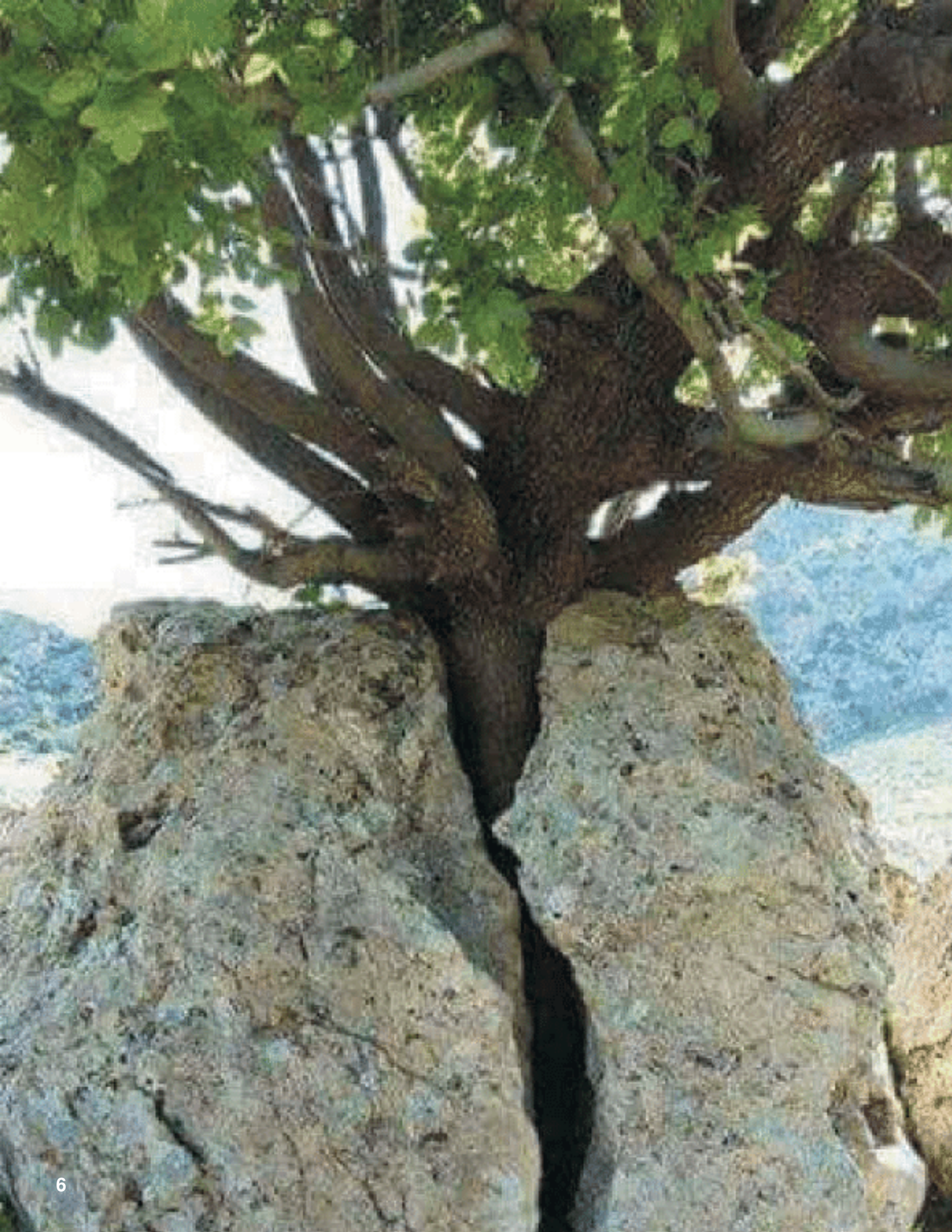
Our first logo represents a seed that is planted in a vast empty field. The seed is shown in the middle of a pinwheel of support. The fan blade of the pinwheel represents the many agencies that circle the seed and work together to provide the energy required to cultivate the seed assuring it grows to a point of nourishing health equity. The circles in between the blades represents the many people who represent the community and those to assure the wind turbine fan blades are turning in an effort that the seed will grow to the point it provides nourishment in areas of despair.

Pathway to Wellness

Throughout times the tree continues to be a powerful and historic symbol, with origins being traced back to 7,000 B.C.The tree of life is represented as one of the organizing principles in biology and additionally has appeared in numerous biblical references, spiritual teachings, and philosophies. The tree represents different things to many different groups, but there are commonalities. The most basic and common commonality is that the tree shows us that all life is connected to represent both love and healing. This is best described through the tree holding steadfast, even in the wind and storms, and the branches sheltering the sun and the rain, showing us love and support.

Togetherhood Initiative chose to use the tree of life in our logo, as we see ourselves as planting seeds that represent our efforts to provide sturdy in support for those in need, like the truck of the tree. The Togetherhood logo has a pathway leading to the truck of the tree paved in stepping stones. These stones are labeled with some of the chronic diseases and conditions that are often barriers, put with the paved path, entitled the "path to wellness", the journey to support is possible. .

You'll notice that Togetherhood Initiative and the Core Health Partners Foundation agencies named under the motto "Pathway to Wellness". This is due to their distinct roles, Togetherhood being one of recruiting and identifying the agencies in the Initiative and the CHP Foundation managing and supporting the pathway.



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Prevalence of Childhood Obesity

Obesity levels in children has more than tripled in the past 30 years.

33%

In 2022 Collier County's Middle and High School obesity level for students was recorded to be 33.1 percent and rising.

48%

Nearly half of the 600+ children

referred to Collier County's 2023 diabetes prevention program reported parents who live with the chronic disease of Diabetes.

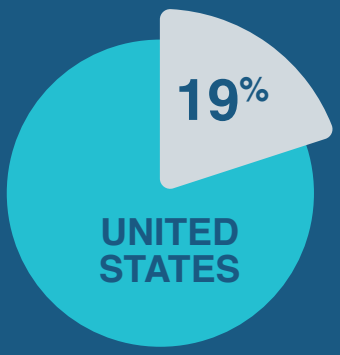
A Growing Epidemic

According to the National Institute of Health, obesity in children has more than tripled in the past 30 years (NIH,6). The childhood obesity has grown from a serious public health issue to a full-blown epidemic in the United States. Obesity now affects nearly 1 in every 5 children (19.7%), or 14.7 million kids nationwide (7, CDC). However, even more troubling are the health measures reported from America's low-income communities.

Many factors contribute to childhood obesity, including lack of physical activity, genetics, poor diet, socioeconomic status, lifestyle & habits, accessibility to healthcare, level of education, transportation, and level of participation in interventions. Being overweight or obese as a child precipitates short-term and long-term health consequences. Obese children are more likely to develop health conditions in adulthood such as, high blood pressure, kidney disease, mental illness, and the increased risk of chronic diseases such as type-2 diabetes, hypertension, cancer, and stroke.

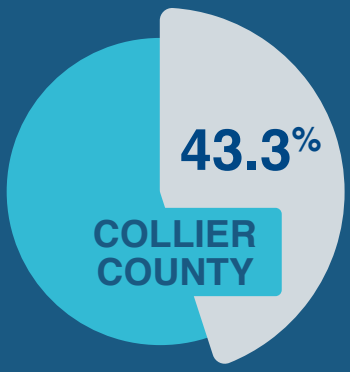
The absence of health equity and education highlights the socio-economic factors that contribute to the rapidly increased rates of childhood obesity in America and in our communities. A community assessment published by the Florida Department of Health in Collier County, entitled 2022 Community Health Assessment (8), and reported Collier County residents listed access to care as the third highest health priority, ranked just behind mental health services and chronic disease care. Low-income neighborhoods in Collier County such as Immokalee, FL and Golden Gate, FL have reported obesity rates even higher than the national, state, and county-wide averages (9). Collier County data reports measures as high as 30% obesity among children who are 2-19 years old (10). A detailed analysis conducted by the county's largest pediatric care provider, Healthcare Network, produced patient records of 43,394 children, demonstrating 43.3% had BMI's classified as overweight or obese (11, Core Health Partners Child Obesity Report, Page 12).

CHILD OBESITY SNAPSHOT



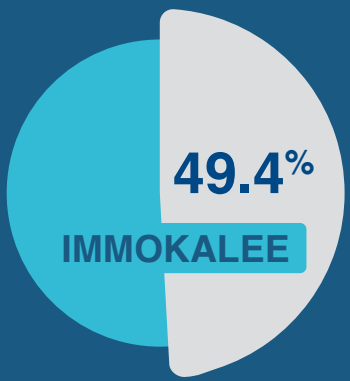
19% of children in the US are affected by obesity

Centers for Disease Control and Prevention (CDC)



According to patient data from Healthcare Network, **43.3%** of children were overweight or obese *(2018 to 2021)*.

Healthcare Network



Fitness testing conducted by the University of Florida (April 2022 - March 2023) in Immokalee revealed that **49.4%** of children tested were overweight or obese.

University of Florida

49.4%

447 Immokalee children were screened for obesity and **49.4%** were found to be overweight or obese; a rate far higher than the county, state, and national averages.

Annually, healthcare costs of obesity in the United States total about

$170 Billion

Obesity in Collier:
Health Equity for Immokalee & Golden Gate

In 2022 Collier County's Middle and High School obesity levels for students was recorded at 33.1 percent, higher than the Florida average and rising. With a population as diverse as Collier's, health care gaps are significant. 34% of Collier's population speak a language other than English, 25% speaking Spanish, and 8% speaking Haitian Creole (12). In 2022 Sections of the community are left with little access to quality care, the need for health equity in Collier is greater in some areas than others.

Many people know Naples, Florida, one of the wealthiest zip codes in the United States, is in Collier County. They don't know that one of the most impoverished in the US is also in Collier County, and that city is named Immokalee, Florida. According to the 2022 United States Census, 28.4% of Immokalee's 28,000 residents live at or below the poverty line, a percentage that is over double the national average of 12.4% (13), and likely under reported due to Immokalee's high percentage of undocumented residents. Immokalee is known for its agriculture. This community is credited with harvesting 90% of the domestic tomatoes in the Nation and is commonly referred to as the tomato capital of the United States, (14, Pulitzer) yet 28% of its citizens struggle to afford to eat the very food they harvest in the fields they work on (15, United States Census). Due to this food insecurity, many are forced to purchase cheap, low quality, and often nutrient deficient foods in order to feed themselves and their families. Because of this, Immokalee is also a hotspot for overweight and obese children.

Nearly half (48%) of the 600 plus children referred to Collier County's 2023 diabetes prevention program reported parents, and sometimes even grandparents, living with the chronic disease of diabetes.

An obesity screening implemented over an 11-month period (April 2022 through March 2023) was conducted in Immokalee. This screening was funded by the Naples Children's Education Foundation (NCEF) and implemented through the University of Florida, through this effort 447 Immokalee children were screened for obesity and 49.4% were found to be overweight or obese; a rate far higher than the county, state, and national averages (17, Childhood Obesity Report).

Another area in Collier that demonstrates a need for obesity interventions is Golden Gate, Florida a community of 25,321 people, with 65% of the population (16,549) being of Hispanic or Latino descent, and 24% of the overall population surviving without any form of health insurance (18, data.census.gov) Golden Gate, a community that accounts for only 7% of Collier County's total population, yet comprised nearly 25% of the total children referred to the CHIP Child Obesity Program over a 1-year period (19,CHP Foundation Data), (October 2022 – October 2023).

Immediate intervention is necessary in Collier County as a whole, and it is extremely essential that health interventions include comprehensive education & lifestyle change, while addressing language and cultural barriers, maintaining the pillars of Health equity.

The Cost of Inaction

Childhood Obesity is on pace to bankrupt the health care system in the United States (20, Gillio, Childhood Obesity Report, Page 24). Without prevention these children will go on to develop multiple chronic health issues earlier in life. Addressing childhood obesity not only helps reduce the number of cases but also promotes healthy behaviors and habits that can last a lifetime. Consequently, implementing policies aimed at preventing excessive weight gain across all age groups becomes crucial to alleviate the extensive health and economic repercussions of the obesity epidemic. While childhood obesity represents a relatively minor fraction of overall obesity-related medical expenses, it plays a pivotal role as a significant precursor to adult obesity. Medical costs for adults who had obesity were $1,861 higher than medical costs for people with healthy weight. This epidemic incurs over $170 billion in excess medical costs annually or about $512 per person in the United States. In 2019, the (21, CDC) Implementing effective prevention programs could reduce this cost significantly.

The University of Florida Bridges the Clinical Gap for Collier Families

Access to medical care is a critical issue for rural and low-income communities within Collier County. Barriers such as awareness, transportation, and access to healthy food can make it difficult for children and families to receive critical healthcare. In response to these barriers, the Naples Childrens Education Foundation (NCEF) supported the University of Florida to launch a Pediatric Endocrinology Telemedicine program, which would enable families in rural communities to obtain care for their children virtually, without jeopardizing their income by taking time off of work to travel into the Naples area. Through NCEF funding a UF Telemedicine -Pediatric Obesity Program was established for Collier county and it has been growing under the direction of Dr Angelina Bernier over the past three years. The UF Telemedicine -Pediatric Obesity Program provides contemporary and effective obesity care to a high risk population of pediatric patients. Dr Bernier is the Medical Director of the UF Pediatric Metabolic & Obesity clinic at the University of Florida and has brought the staged medical treatment therapy to this novel telemedicine program

Referrals from primary care providers, community clinics, health fairs and other health related organizations flow through the Togetherhood Youth Referral system. This referral system is managed by the Core Health Partners Foundation who assure the families are contacted in their native language and they work in conjunction with the UF staff to assure children can receive care through the University's weight and complications management

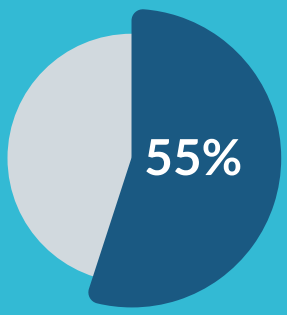
program. The University has developed a system where children are screened with fitness testing, BMI calculations, and lifestyle surveys, and then based on risk undergo evaluation with follow up metabolic laboratory testing and genetic testing for high risk obesity genes to determine the contributing and underlying factors leading to the obesity presentation. Specific areas of need or concern are addressed with appropriate lifestyle treatment and medication therapy as indicated. Telemedicine home visits with the support of a bilingual patient navigator who repeats fitness testing and lifestyle surveys, are completed every three months with careful tracking of progress and escalation of care as needed with evidence of significant impact and improvement.

In this manner on average more than 70 home telemedicine visits have been completed annually in an effective and well received manner by patient families of which more than 50% are non-English speaking.

The UF Telemedicine -Pediatric Obesity Program (T -POP) has continued to partner with the Collier DOH via workgroup meetings, and Immokalee interagency meetings to network and partner with local agencies along with partnering with other local nonprofits in the Naples area including the Gargiulo Education Center to provide healthy meal plans for the upcoming school year as well as with UF Dental, Healthcare Network, help a Diabetic Child, UF/IFAS and the Boys & Girls Club. UF T-POP collaborates with Core Health Partners and the Togetherhood Initiative to support and guide ongoing efforts to prevent childhood obesity. The goal is to support and provide pediatric obesity care in any location in Immokalee and Naples with children and families who do not have access to much needed healthcare for this high risk condition.

MEDICAL LEADERS RECOMMENDING THE PATHWAY

Healthcare Network cares for **61%** of Collier County's pediatric population and **100% of their 15 referring providers** refer to the Pathway to Wellness Obesity program.



56% (34) of the referring providers for the Obesity program come from outside Healthcare network.

Over 330 independent physicians have referred to Core Health Partners' Pathway to Wellness for care of chronic disease or pediatric developmental delays

Marie Pierrelus, RD/N

a Registered Dietitian/Nutritionist, is fluent in English, Spanish, and Haitian Creole. She is based at the Togetherhood Initiative Center in Immokalee.

Carolina Castelli Figley, MD, RD/N, MPH

a Registered Dietitian/Nutritionist and Medical Doctor, is fluent in English, and Spanish. She serves Golden Gate and Naples and is based at the YMCA in Naples.

Bringing the Clinic to the Community

Core Health Partners (CHP) is a medically licensed health care clinic in Collier County. What makes this clinic unique is CHP's model of service. Core Health Partners centers their clinical practice on prevention, education and early intervention. They offer clinical services to the community through neighborhood facilities that are operated by professionals who speak the languages and understand the cultures of the people they serve.

Originally inspired by a group of YMCA employees who had a vision to make a difference in the lives of those suffering with diabetes, this group medically licensed their first two service locations in 2019. Those two locations being the Marco Island YMCA and the Emilio Sanchez Tennis Academy in North Naples Florida. What they found is that while these areas may be located only a few miles apart, they experienced unique and vastly different inequities in their access to health care, and their needs went far beyond just diabetes. The Marco Island YMCA membership base is comprised with a heavy population of seniors, many who live with debilitating chronic diseases, while the tennis academy's client base is largely made up of young student athletes troubled with the lack of preventative care for sports injuries. The varying demands for care across all ages and spectrums of health were troubling, yet inspiring, as it was out of this desperate need that Core Health Partners was born.

Core Health Partners clinical practitioners evaluate each patient as an individual. They are trained to make recommendations for patient treatments that work in conjunction with specific supportive community programs. During the therapist's initial evaluation, they ask a series of questions that help them understand the personal lifestyle choices and unique demands of each client. This understanding assists the therapists in making recommendations for individualized preventative health strategies that maximize the probability of achieving improved health outcomes. Core Health Partners' approach to preventative health is atypical as their strategy goes beyond the walls of a doctor's office into an approach that deepens the quality of accessible health content offerings. What makes Core Health Partners unique is that community programs are woven into most patients' plans of treatment, meaning that part of the therapy every patient receives is delivered through a supportive organization that is determined by the patient's specific needs. Barriers to participation are discussed in the setting of a private clinical evaluation, where solutions, such as use of public transportation, financial scholarships, child watch babysitting, and orientation of the program all assist in promoting participation and are part of the discussion. The patient's participation in non-clinical programs assists in reaching health outcomes and sustaining long-term lifestyle changes.

Core Health Partners has developed these non-clinical services as pathway programs. However, the pathway always starts with a referral made by a medical physician. CHP's recommended pathway programs are aligned with therapy and supported by professional staff that hold specialized certifications or training that prepares them to support the patient's growth. Specific clinical competencies in the pathway programs intentionally align with the recommendations of the medical team. The patient's participation in the program includes measuring if the patient learned specific competencies that are measured along the way and reported back to the clinician. These measures are charted and captured in the form of therapy notes and forwarded on to the referring physician. This integrated system of communication helps the entire team understand when and how to adjust the treatment plan or implement motivation strategies if needed. Core Health Partners employs licensed clinical professionals in the disciplines of physical therapy, Diabetes Self-Management & Education, nutrition, occupational therapy, speech therapy, autism diagnostic testing, and athletic training. CHP has been able to acquire a diverse clinical team in a multitude of professional and ethnic backgrounds with many staff speaking at least two languages, including Spanish and Haitian-Creole.

Since the opening of their first two locations, Core Health Partners has continued their mission of bringing clinical services to community centers to focus on chronic disease prevention, treatment, and intervention. They serve pediatric and adult populations and have earned special recognition by the American Diabetes Association (ADA) for their role in providing Diabetes Education and self-management techniques to those living with type 1 or type 2 diabetes.

Core Health Partners has used their knowledge in diabetes care and their recognition status with the ADA to develop a unique child obesity program that has an understanding for the culture of the community and focuses on early intervention, behavior change and integration with supporting community programs. Core Health Partners is contracted as a medical service provider by Medicaid, Medicare, and most all public and private insurance carriers. They have expanded their service to several Collier County locations that now allow them to conveniently serve the residents of Naples, Marco Island, Immokalee, and Golden Gate where lack of health literacy, language barriers, lack of cultural awareness, food scarcity, and a myriad of other variables all contribute to the high number of children and adults suffering with obesity and other chronic diseases.

Since its inception, Core Health Partners has held a close collaboration with the Healthcare Network, a Federally Qualified Health Clinic (FQHC). Healthcare Networks operation blankets Collier County with 11 locations with 19 practices and 46,195 patients. Many families rely on Healthcare Network for the care of their children which represents 28,375 kids, or 61%, of the Collier County's total pediatric population.

Their pediatric medical practice is under the leadership of their Chief of Pediatrics, Dr. Salvatore Anzalone, who has played a pivotal role in improving the health equity and well-being of children In Collier County. He has championed Core Health Partners as a community instrument for families to embrace early interventions in autism, developmental delays, family nutrition, and child-obesity. Dr.Anzalone chairs the Healthy Collier Community Health Improvement Plan (CHIP) Youth Referral Network subcommittee. Recognizing that people were working in silos, Dr.Anzalone, has taken a team approach that emphasizes bringing the experts together. He believes that this is the way you can make a real impact in managing these children's needs and getting results (UF Dr. Gator, College of Medical News, 1). Through his leadership 100% of Healthcare Network's 15 pediatric physicians have fully embraced the process of referring children with concerns of obesity & high BMI to Core Health Partners Nutrition Therapy and the obesity pathway program. Pediatrician care providers from outside Healthcare Network have also fully engaged in the obesity program. The number of referrals on a month-to-month basis demonstrates consistent growth in 2023, with 56%, or 34 referring physicians coming from outside Healthcare Network. The strong buy-in by the vast majority of the pediatric care providers has led to over 600 overweight or obese children, and their families, being offered a chance for change. With such a strong cohort of children served, and the measurably improved clinical outcomes, the collaborative program may become the answer for other communities to consider as they seek a way to break the cycle of obesity with a "Pathway to Wellness".

Dr. Salvatore Anzalone
Medical Director for Pediatrics, Healthcare Network

"What a wonderful opportunity, this is just the beginning and it's going to be the start of something unique"

Why Core Health Partners

Through screenings, testing, offering prevention programs, implementing therapies, collection of program data, and providing health education, Core Health Partners special recognition status has become well known in the Collier Community. Over 330 independent physicians, including those employed by major health systems and hospitals in the Southwest Florida region, chose to refer to Core Health Partners for care of chronic disease or pediatric developmental delays. This is most likely due to Core Health Partners' special clinical certifications coupled by their innovative patient intake and scheduling system and the support partners recruited to participate in the pathway to wellness. The process starts with a multilingual team that offers the patient an appointment with a licensed clinical professional who also speaks and understands their language. Typically, appointments happen in a familiar community center, such as a YMCA environment that is near to where the families live, work and play. Service locations alone are much less stressful than traditional treatment models that require the patient to return to the hospital, or clinic-based setting for their therapy. CHP attempts to locate their services in these friendly atmospheres that are surrounded by wellness activity that aid in preparing the patient to consider engagement in lifestyle change.

Core Health Partners has earned contracts with most insurance companies to deliver their diabetes self-management, autism testing and therapy programs at these sites, additionally, CHP has developed an automated system to invoice philanthropy by individual appointment, making their system of care efficient for the grant or philanthropy funded initiatives. This multilingual system of scheduling and data reporting has caught the eye of many in the medical community. The technology used in Core Health Partners scheduling protocols and pathway data collection bestowed CHP as a Top 30 medical innovator in South Florida by the T2M Med Tech Corridor. KPMG, a giant in the world of Health Innovation, also selected Core Health Partners to serve on their national Health Equity Task

SPECIAL RECOGNITION

American Diabetes Association.

*The American Diabetes Association Recognizes this education service as meeting the National Standards for Diabetes Self-Management Education and Support.

CORE HEALTH PARTNERS

FLORIDA TOP 30 COMPANY

MEDICAL INNOVATION 2023

T2M MEDTECH CORRIDOR

CORE HEALTH PARTNERS

U.S. TOP 100 COMPANY

HEALTH EQUITY 2023

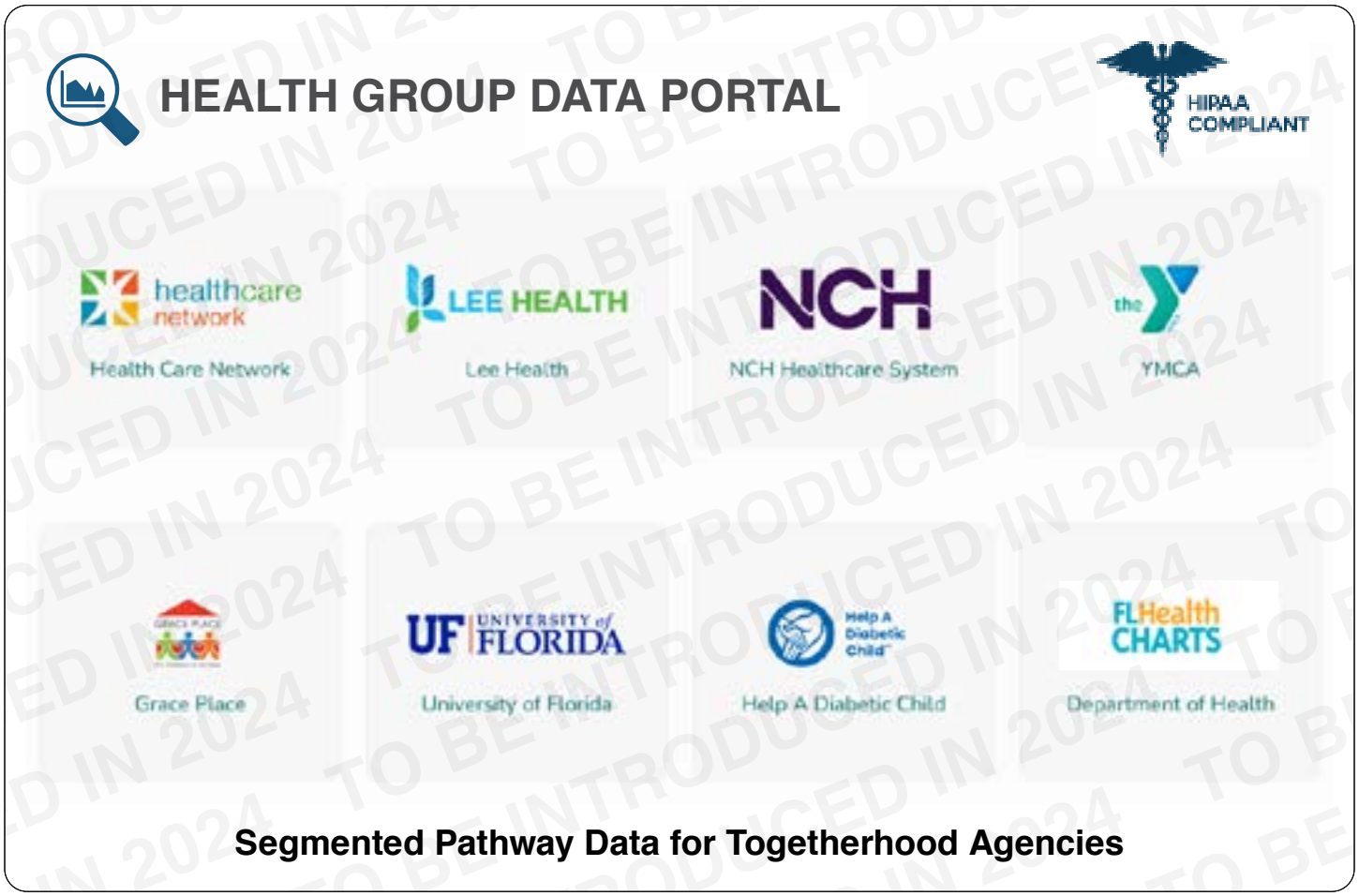
KPMG

Health Equity: Changing the Course

Seeking a Sustainable Model for Health Equity

Delivering auxiliary clinical support programs to largely underinsured, Medicaid supported, transient, migrant working populations is attractive for philanthropy. However, long-term sustainability forces a different conversation. The traditional top-down model of grant & philanthropy funding often ignores program sustainability of the service itself, therefore becoming a short-term solution for long-standing problems. Low reimbursements by Medicaid further exasperates the challenges for any medical clinic or hospital system to sustain programs to meet the needs of these low-income communities. Auxiliary services for: preventative care, education, and chronic disease management, are often seen as a losing financial proposition for most clinics. Language & cultural barriers contribute to a high rate of missed appointments, leaving little to no reimbursement, and making it nearly impossible for these services to be sustained long-term.

Adding to the dilemma is the fact obesity services themselves are often left totally ignored and unfunded by most insurances, including Medicaid. Sadly, funding in America's medical reimbursement system is not proactive and reimbursements for treatments typically begins when the clinical diagnosis moves from obesity to a full-fledged chronic disease, like Type-II diabetes. The solution simply isn't throwing more resources at a non-profit. The answer is structured, methodological, through management and deployment of education and by leveraging community assets designated to specific areas of community need. Where results are measured and reported back to participating agencies.



Segmented Pathway Data for Togetherhood Agencies

Togetherhood Initiative

A Community Health and Well-being Collaborative

Togetherhood Initiative:
Planting Seeds to Sustainable Programs

The concepts of the Togetherhood Initiatives developed post Covid-19 through the Collier County YMCAs Healthy Living Advisory Committee(Y-HLAC). Consisting of leadership from across Collier; drawing on expertise from agencies representing medical professionals, health & wellness, mental health, non-profits, and the civic sector for the counties 385,000 residents. Through the Y-HLAC conversations held by the agency leaders, in and outside of this forum, the model for the Togetherhood Initiative was formed. The goal of Togetherhood is to provide programs and assets as a potential pathway to wellness through blending the support of philanthropy, grant funding, university participation, Medicaid reimbursements, and other private Insurance funding. The Togetherhood Initiative model is solution focused and community based.

Recognizing neighborhoods across the county presented different problems. The discussions on providing aid led to conceptual formation of unique initiatives modeled specifically for agency collaboration. Sustainability is best assured when collaboration lowers delivery costs associated with program operations, while at the same time providing long-term, sustainable, community benefit solutions. The answers of a sustainable solutions led to developing a business model where partner agencies would come together to share in overhead costs such as staffing, facility rents, technology, and data reporting. Success would be defined through elevating the individual agencies' work through measurable health outcomes produced by the collaborative.

Two participant agencies from the Y-HLAC, Core Health Partners and Help a Diabetic Child (HADC), a non-profit focused on providing insulin, medical supplies, and scholarship to the under-insured, first conceptualized the concept for Togetherhood when these two agencies worked alongside each other at a local food pantry distribution line in Immokalee. Even most of the food choices on the pantry line were well below the nutritional standards to support and manage the wellness of those living with diabetes. It was disturbing that the residents living in crisis were left with little structure or education for their wellness. The critical needs exposed during these tests led HADC and CHP to discuss what supporting agencies could help develop a case for supporting the cause.

It was at this point that the course of action became clear, Immokalee is a community in crisis and needs help. A collaborative for diabetes prevention, education and self-management was formed as the first Togetherhood Initiative. This provided a place for residents to look beyond charity for a pathway to educate themselves on improving their personal wellness. This movement of collaboration, designed to be fluid and duplicated in other neighborhoods in need, was formalized as the Togetherhood Initiative. Leadership structure was documented in writing and submitted to the Florida Department of State, who approved incorporation in April of 2022. The operating structure and mission were then reviewed by the IRS, who determined the Togetherhood Initiative to be an independent, standalone public charity with (501c3) status. Immokalee's local mental health agency, the David Lawrence center for Behavioral Health, let it be known that they had space in their building for Togetherhood's first headquarters if a plan for success could achieved. Collaborative work that produces measurable health outcomes, that plan became the genesis for the very first Togetherhood Initiative Center.

The First Initiative:
Health Equity to Immokalee

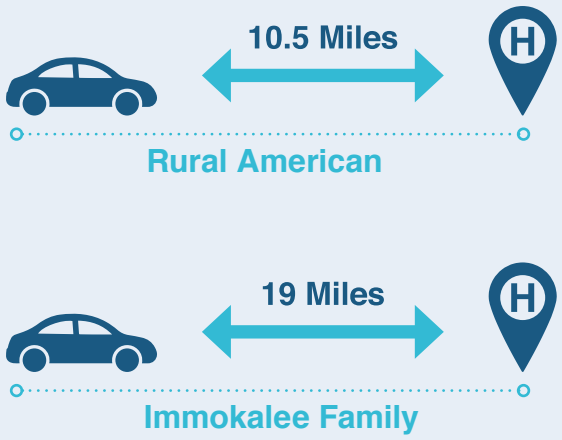
The impoverished community of Immokalee has a history of piloting programs that promise much but often deliver very little in the form of sustaining health equity. Health promotion, health screenings, and community health fairs don't supply long term education, engagement, or treatment and sadly the community has seen grant funded community Initiatives come and go. The wealth of Naples often sparks the effort and takes the lead on such concepts, or universities receive federal, state, and sometimes philanthropy funding for yet another research initiative. This top-down model often ignores program sustainability and the service itself becomes a short-term solution for long-standing community problems.

Through support of a Federally Qualified Health Clinic (FQHC), Health Care Network, comprehensive medical services, across Collier County, and in communities like Immokalee and Golden gate have been well received. However, the case for health equity in focused areas for preventative care, therapies, health education, and emergency services, especially, in Immokalee, have been largely ignored. The magnitude of health inequities for the residents of rural Immokalee magnified during the outbreak of the COVID-19 pandemic. The virus that overtook the United States, ravaged Immokalee. Immokalee experienced one of the highest positive case rates in the country, suffering disproportionate deaths (3, Pulitzer Center). The people of Immokalee were left deserted. With little options for understanding or managing the symptoms of their diabetes during this time of crisis; conditions of insulin control, high blood pressure, mental health, and maternal health were left untreated.

According to a Pew research study, Americans in rural areas live and average of 10.5 miles away from a local hospital (4) and the families of Immokalee were forced to travel a distance nearly twice as far, 19 miles or 45 minutes. Compounding the problem for these impoverished families is the fact many have no transportation or fiscal resources to get the help needed in neighboring towns.

PEOPLE IN IMMOKALEE LIVE FURTHER TO NEAREST HOSPITAL

Average distance to nearest hospital for:



Today, the people of Immokalee are victimized by a different challenge. The national childhood obesity epidemic and a future of preventable illness. . The needs of Immokalee and its proximity to Collier County made it the perfect place for Togetherhood's first headquarters and the staging ground of its primary mission. Immokalee became the proof-of-concept for the Togetherhood Initiative's first tentpole program and the foundation of its first pathway to wellness; the Core Health Partner's Childhood Obesity Program.

A Year in Review and a Glimpse into the Future

In 2023, the efforts of the CHIP Child Obesity committee gained momentum. They did so through transforming the obesity effort from isolated grant funded work in health promotion and research into a collaborative community program that focuses on pooling assets and resources for the benefit of community health. Over the past twelve months the Collier obesity program benefited by strengthening a pathway solution for the child and family in need. The year 2023 started with a goal of guiding approximately 450 obese or overweight children to the newly innovated "Childhood Obesity Pathway" program. Scheduling the children and their families who were identified by a physician led to the development of unique multilingual protocols. Designed to be as supportive and culturally considerate as possible, these protocols are administered by a scheduling team solely focused on this process. Collecting data is required to improve and better understand the barriers that impact participation. Data was studied intensely throughout 2023 and appropriate adjustments to improve the number of children moving from program referral to participation were tested. As a result, an effort to recruit a variety of agencies and stakeholders to agree to collaborate to help reach these families and guide them through the program to the point of reaching a measurable health outcome.

The established collaborative pathway cemented into the Togetherhood Initiative. Community leaders, mission-driven non-profits, government agencies, for-profits all engaged in an effort to collaborate in building a pathway that supports the needed lifestyle changes to combat obesity and diabetes. New technologies and several protocol initiatives were designed and tested with the goal of improving program matriculation, engagement between families and their pediatric care provider and the possibility of third-party payment by Medicaid and private insurances for parts of the program support.

Engaging the non-profit agencies to come out of their silos, to work and come together under one common goal, was a milestone that is now a foundation to build on in 2024. Collier County's health systems, schools, non-profits, and governmental agencies played a pivotal role in identifying at-risk youth in 2023. At the request of the Immokalee school principals, and health workers, an online referral system was developed. This technology now allows anyone with access to a computer or cell phone to gain the information needed on how to enter the pathway. During 2023 the Togetherhood Child Obesity program

placed less emphasis on funding health fairs and producing pamphlets, moving to a more methodological approach. The implementation of technologies to gather quality data that can be reviewed and refined in real-time. An example of this technology being applied into engagement strategy is Core Health Partners' use of bilingual phone attendants that offer a personal response and point of contact for all inquiries. This data archived as part of the CHIP committee led to many healthy discussions on program effectiveness. Core Health Partners Foundation, a 501(c)(3) organization was specifically created for HIPPA complaint data collection and management to sustain medical program environments in areas of need.

Through the review of the data, the CHIP committee assisted in the creation of an effective pathway to wellness program that combines clinical services with supportive programs at the community level. The patients' engagement and support become multi-layered, the content of these services and programs is derived from the Effective Model of Diabetes Care, always including direct communication with referring physicians. The care model used in the pathway utilizes the ADCES7 Self-Care Behaviors, the standard of the American Diabetes Association (ADA). These behaviors are directly linked to increased likelihood of improved patient health outcomes (National Library of Medicine, 22). Through the pathway the children and their families undergo a series of personalized visits with a clinically licensed registered dietitian who follows a unique protocol that includes charting data that helps form their recommendation for a path forward that will sustain a change in lifestyle. The dietitian's documentation encompasses subjective data on patients' health and lifestyle, transcribed into a mathematical variable for objective data review. The assessment leads to the development of recommended care plans that include supportive community programs.

These community programs specifically incorporate the 7 competencies of care proven to be an effective guide for the motivated person to sustain a healthy lifestyle.

The data captured along the patient's journey is captured by the Core Health Foundation and shared with the Togetherhood Initiative community partners. The data drives the plan, and the partner agencies enhance Pathway programs options. Sharing the data helps patient motivation, while deepening our community understanding of health disparities. Devising new strategies for maximizing community benefit is an ongoing goal.

In 2023, the obesity collaboration witnessed unprecedented growth, surpassing all expectations. By December of 2023 the Pathway to Wellness expanded to include nearly 50 pediatric care providers who referred over 600 children. This marked an incredible milestone for Togetherhood, striving to establish a unique yet replicable model of community service.

COMPETENCY	CHP NUTRITION COUNSELING	95210 KIDS ON THE GO	FORCE FOR HEALTH GAMIFICATION	YMCA
DISEASE PROCESS AND TREATMENT	✓		✓	
NUTRITION MANAGEMENT	✓	✓	✓	✓
PHYSICAL ACTIVITY	✓	✓	✓	✓
PREVENTION, DETECTION, & TREATMENT OF ACUTE COMPLICATIONS	✓		✓	✓
PREVENTION, DETECTION, & TREATMENT OF CHRONIC COMPLICATIONS	✓		✓	✓
DEVELOPING STRATEGIES TO ADDRESS PSYCHOSOCIAL ISSUES	✓	✓	✓	✓
DEVELOPING STRATEGIES TO PROMOTE HEALTH/BEHAVIOR CHANGE	✓	✓	✓	✓

2023 KEY PERFOMANCE INDICATORS

Indications and Limitations of Insurance Paying for Services

By June 2023 Core Health Partners attempted to run test with patients who had health insurance to prove is the coverage may pay for the medical nutrition therapy services. This test would provide the facts need to budget philanthropy costs, or a method outside insurance coverage, to continue the costs of service.

The Togetherhood Intake team was instructed to contact each insurance payer and submit their physicians signed referrals to the pathway support program as a traditional pre-authorization protocols. The intake team provided all documents and asked the various insurances to cover the of medical nutrition therapy. Approximately 106 referrals were sent through this preauthorization process. The insurances participating in our test included Aetna, BCBS, Cigna, UHC, Simply Healthcare, Meritain, and Allegiance and only one carrier (Aetna) paid. It's also important to note that Aetna paid for only for 2 patients. It is important to note that no families were turned away during this test. When the insurance declined to pay for service the families were offered full scholarships for service w/or co-pay. These scholarships were provided though the Naples Children's Education Foundation and the Core Health Partners Foundation. No families were denied service.

The amount Aetna paid for both parties was $97.44 for a 15 min visit and an additional $85.59 for the 15 minute extension, funding $183.03 total for the 30 minutes clinical consult. The diagnoses code used was E66.9 which is obesity unspecified, and Z68.54, BMI, which are both not covered as defined in the National coverage Determination (NCD) guidelines. The fact Aetna paid some limited claims with this scenario does not correlate to paying any futures claims. Our test seems to prove that insurances follow the NCD guidelines and diabetes and renal disease must be defines in the referral and signed off by the physician to assure insurance payments. Specific language on NCD coverages, including the Diagnostic Codes (ICD) are outlines and available in the Appendix of this document **(Appendix C)**.

Performance

Tested: 109 Families with Insurance Processed for Insurance to Cover Costs

Results: 2 of 109 Paid for Service

Fee Paid: $183.03 for Medical Nutrition Therapy

Amount Paid: $97.44 for a 15 min and $85.59 for the 15 minute

Regulations on National Insurance Covering Costs of Nutrition Therapy (MNT)

Basic Insurance coverage of MNT, for the first year a beneficiary receives MNT, with either a diagnosis of renal disease or diabetes as defined at 42 CFR 410.130 is three hours of administration. Basic coverage in subsequent years for renal disease or diabetes is two hours. The dietitian/nutritionist may choose how many units are administered per day as long as all of the other requirements in this NCD and 42 CFR 410.130-410.134 are met. Pursuant to the exception at 42 4CFR 410.132(b)(5), additional hours are considered to be medically necessary and covered if the physician determines that there is a change in medical condition, diagnosis, or treatment regimen that requires a change in MNT and orders additional hours during that episode of care.

If the physician determines that receipt of both MNT and DSMT is medically necessary in the same episode of care, Medicare will cover both DSMT and MNT initial and subsequent years without decreasing either benefit as long as DSMT and MNT are not provided on the same date of service. The dietitian/nutritionist may choose how many units are performed per day as long as all of the other requirements in the NCD and 42 CFR 410.130-410.134 are met. Pursuant to the exception at 42 CFR 410.132(b)(5), additional hours are considered to be medically necessary and covered if the physician determines that there is a change in medical condition, diagnosis, or treatment regimen that requires a change in MNT and orders additional hours during that episode of care.

See Appendix D

A Family History of Diabetes with Children Participating in the Program

Core Health Partners Foundation scanned the medical history of the 233 children who participated in the Obesity Pathwaay program to determain if diabetes in the family was prevelant. The evidence proved that 47% of the children (109) have a family history of diabetes in their home.

This discovery led to suggestions that efforts should be made to engage the familiy practioner in the process and through a signed medical referral a Diabetes Self Management and Education (DSME) program could be delivered by Core Health Partners who is already Recogized by the required agency to deliver the service in these same community settings. Through this referral Core Health Partners (CHP) can taylor a program for the family that sspecifically incorporate the 7 competencies of care proven to be an effective guide to motivated the person and their family to embrace and sustain healthy lifestyle change.

CHP could easily focus the DSME program to help educate the person living with diabetes and the entire family on how they could best manage life with diabetes, including Healthy Eating, Physical Activity, Monitoring Blood Glucose, Taking Medication, Stress Reduction and other proven techniques for reduction of the child's obesity and care of person who lives with diabetes. Details of Core Health Partners Nationally Recognized DSME program in located the Appendix *(Appendix E)* as well as the diagnostic codes required for insurance to pay for the service *(Appendix D)* . Insurance typically pays for 9 hours of DSME over the first year of the referral and 3 hours of Medical Nutrition Therapy. Specific language on NCD coverages, including the Diagnostic Codes (ICD) are outlines and available in the Appendix of this document *(Appendix D)*.

Performance

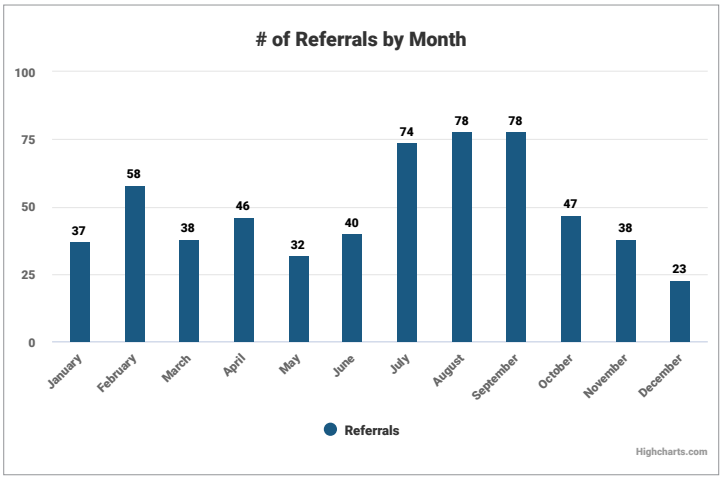
Tested: 233 Families medical History

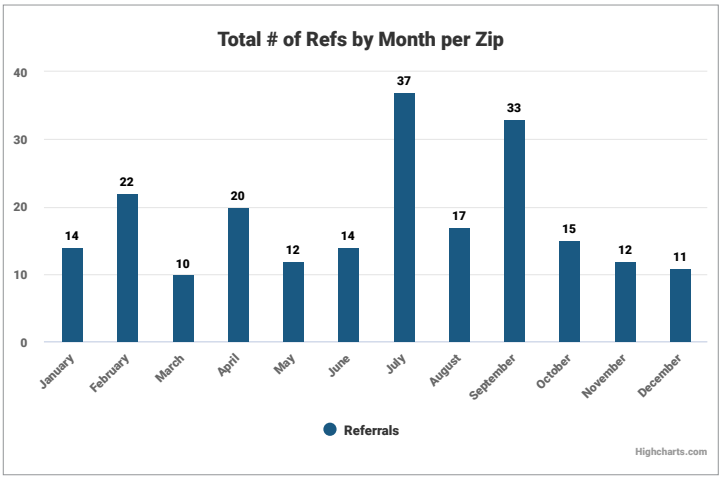
Results: 109 (47%) of the Children have a history of a family members with Diabetes.

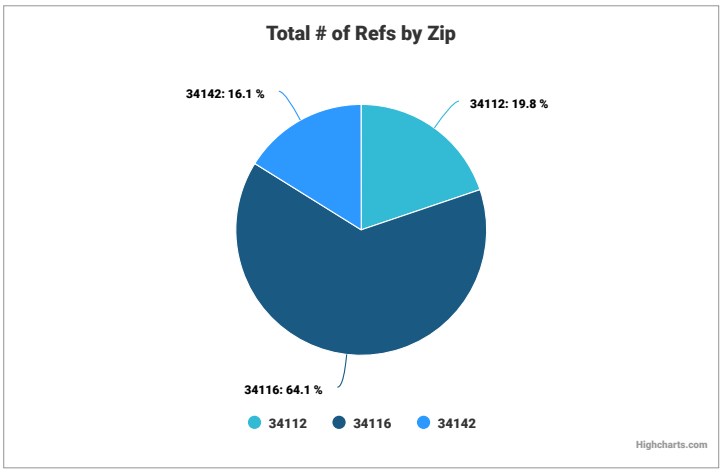
Suggestion: Seek a Medical Referral by the Family Practitioner for Diabetes Self-Management and Education Training (DSME) and Medical Nutrition Therapy.

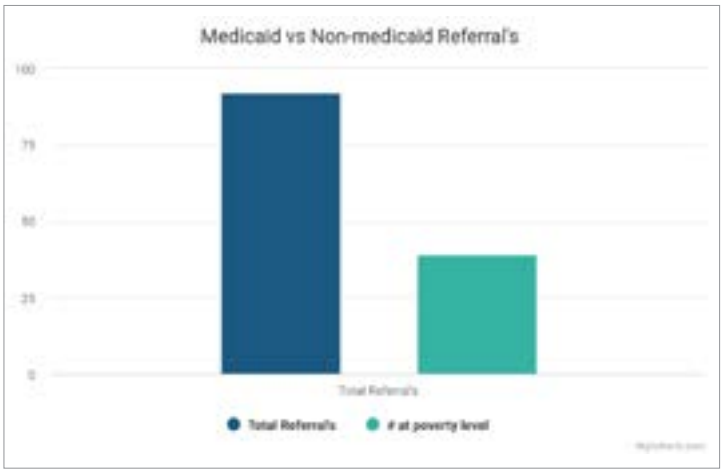
Patient Health Data 2023		
Total pts seen: 233	**Average age:** 12.5	**Male:** 59%, **Female:** 41%
Famly Hx DM:	109	47%
2 or more visits:	121	52%
3 or more visits:	82	35%
4 or more visits:	56	24%
5 or more visits:	28	12%
6 or more visits:	12	5%
Decrease in BMI:	71	30%
Avg. decrease in BMI:	-1.4	
3+ visits & dec. BMI	47	57%
4+ visits & dec. BMI	34	61%
5+ visits & dec. BMI	18	64%
6+ visits & dec. BMI	10	83%

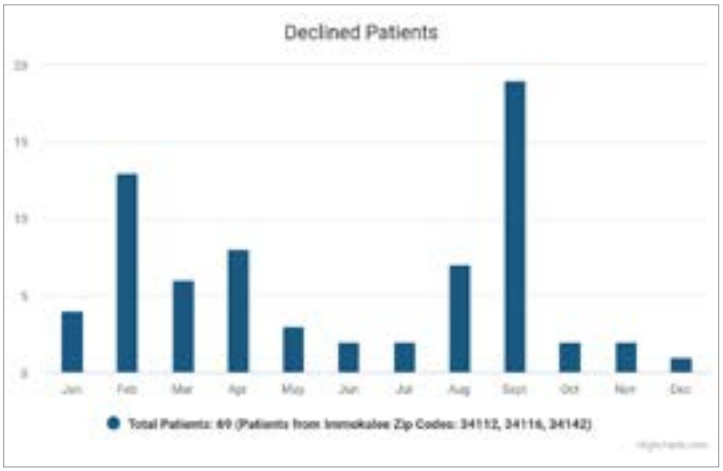
KEY PERFOMANCE INDICATORS

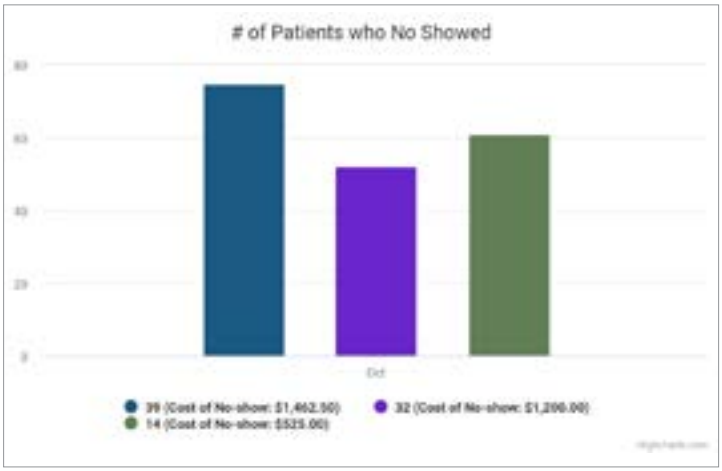












Strategic Initiatives Planed for the Pathway in 2024

In our attempt to sustain the newly formed pathway services and control costs we realize we now need a focused community playbook. We need to shift course and utilize the clinical staff at the highest level of service. It is clear their talents should be focused on patient care and training. In 2024 we will place and emphasis on protocols. This includes intake the pathway intake and scheduling processes that lead to maximizing the number of patients reaching the schedule. trainings, data collection, clinical trainings and using technology to engage and reach our community. We do not plan to use technology to replace traditional health fairs or scheduled presentations; however, the goal is to work off one community calendar and utilize one neutral brand that explains the pathway to wellness, the Togetherhood Initiative.

Defining the role and scope of our pathway agencies will be a priority in 2024, as we hope to streamline any duplication of efforts in our attempt to control costs. The Togetherhood Initiative is the umbrella organization that focuses on youth referrals agencies participating in support of the patients' wellbeing should align their work. In 2024 we hope to further engage the Blue Zones, Collier Cares, Safe and Healthy Children's Coalition, Collier County School District, and our area's medical providers into the pathway. By working together, we can integrate efforts and services in benefit the community.

In 2024 the BlueZones project will take on a leadership role in coordinating the promotion of our pathway programs and in that effort, we plan to streamline in Collier Cares, and the Safe and Health Childrens' Coalition. We also plan to utilize the leadership of Healthcare Network and Core Health Partners to maintain a protocol that maximizes the potential for lifestyle change and a positive health outcome. The goal for 2024 is to have a single clinical note system and protocol that can become the standard of care for all physicians, dietitians, and participating non-profits.

Strategic Promotion of the Youth Referral Pathways

Collier Cares Search of Services:

Togetherhood Self-Referral Requests:

Strategic Protocols for Scheduling and Matriculation

Pathway to Medical Referral Form (for Insurance funded therapy):


the

A Decade of Work that Brought us all Together

Milestones in the Diabetes Prevention and Self-Management Efforts

March 2015

On this date Dr. Mark Attkinson, the Director of the Diabetes Institute at the University of Florida and the American Diabetes Association (ADA) Eminent Scholar for Diabetes Research provided an outreach discussion on the state of diabetes. The UF Diabetes Institute serves as the umbrella organization under which research, treatment and education are coordinated. The connection to Dr. Attkinson sparked an ongoing dialog with local non-profit and for profit agencies concerning what they could accomplish through collaboration.

October 22, 2015

On this day Roger Ludwig of the Weny Charitable Trust and former National President of the American Diabetes Association (ADA), Dr. David Marrero, unveil a new Diabetes Education Center designed to serve the community within the walls of the Naples YMCA.

Marrero, a type 1 diabetes himself and expert in community health, is credited with developing the National YMCA's original Pre-Diabetes Prevention Program YDPP (YDPP). Philanthropist Roger Ludwig, of the Weny Charitable Trust, is the father of a child who lives with Type one diabetes. Ludwig's father Charles Ludwig was one of the original Board members of the Collier County YMCA. Together Marrero, Ludwig, YMCA CEO Paul Thein and staff, as well as members of the community participated in an effort to expand health equity and improve on the Y's existing platform for diabetes prevention an education.

Roger Ludwig, is shown in the photo standing over Dr David Marrero, the former president of the American Diabetes Association. Marrero is credited with developing the National YMCA's Pre-Diabetes Prevention Program (Y-DPP).

March 29, 2016

On this date Healthcare Network and Golisano Children's Health Center celebrated the opening of pediatric outreach facilities on the Naples YMCA Campus. Healthcare Network names their facility after well-known philanthropist Jerry Nichols. Opening pediatric care and rehabilitation services for children begins the discussion and sets the foundation for developing integrated pathway programs with the YMCAs and other area community centers.

Photo: Jerry Nichols, center left, shakes hands with Healthcare Network after cutting the ribbon celebrating the Nichols Pediatric Center at the Greater Naples YMCA on Tuesday, March 29, 2016.

January 28, 2016

On this date the Naples YMCA voted in to redirect funds from the Weny Charitable Trust to area non-profit Help a Diabetic Child (HADC) to be utilized in developing a community based nationally recognized clinical model for chronic disease self-management and education. Through collaboration an experienced group of former YMCA employees from the first medically integrated YMCA (Des Moines Iowa) and the former director of education from the American Diabetes Association (ADA) started the plan for bringing the clinical services to the community. This momentum crafted Core Health Partners as a medical clinic specifically designed to meet the unmet needs of the community.

December 28, 2017

A unique medical health clinic, designed to bring clinical and educational services to the community, was formed by former YMCA employees. Entitled Core Health Partners, this clinical concept was incorporated under Florida's Secretary of State on this date.

September 01, 2018

On this date the YMCA of South Collier Marco Island and Core Health Partners entered into an agreement centered on these two agencies working together to bridge the gap between the clinic and the community. Through this agreement the parties agreed jointly to create medically-integrated programs, educational offerings, and services as resources to build a healthier community. They agreed to co-develop integrated YMCA and clinical programs with measurable data to enhance the traditional Y programs.

September 12, 2018

On this date the State of Florida approved incorporation status for the Diabetes Alliance Network (DAN). This agency's specific purpose is to provide individuals with comprehensive, current, and accurate guidance to services related to diabetes and its complications through a network of community agencies.

Picture: Collier County Board of Commision bestows a Proclomation to Help a Diabetiic Child on behalf of the collabertive group's efforts in diabetes education and support.

Paul Thein, Core Health Partners, Joe Balavage, Diabetes Alliance Network, Steve Wheeler, Healthcare Network, Debbie, FSW, Dolph and Sharron Von Arch, and Tami Bavalage, HDAC

October 11, 2018

On this date the YMCA of South Collier Marco Island and Core Health Partners entered into an agreement centered on these two agencies working together to bridge the gap between the clinic and the community. Through this agreement the parties agreed jointly to create medically-integrated programs, educational offerings, and services as resources to build a healthier community. They agreed to co-develop integrated YMCA and clinical programs with measurable data to enhance the traditional Y programs.

July 01, 2019

On this date the American Diabetes Association (ADA) recognized the education services of Core Health Partners as meeting the National standards for teaching Diabetes Self-Management and Education as a program to be delivered at the YMCA of South Collier Marco Island location.

Pictured: Carolina Castelli Figley, MD, RDN, Nohely Torres, RDN

08/09/2019

Help a Diabetic Child (HADC) coordinated a diabetes summer camp experience at the Marco YMCA during this week that had professional clinical participation from the Core Health Partners clinical staff and volunteers by other health professionals representing the hospitals, school district staff, and medical staff from the University of Florida Diabetes Research Institute.

July 28, 2019

On this date, Healthcare Network hosted a two-day Diabetes Symposium on July 28th and 29th. The symposium included experts from the National Wellness Institute, the American Diabetes Association, and the University of Florida Diabetes Research Institute. Participants from various organizations, including YMCAs, Help a Diabetic Child, and healthcare providers, attended the event. The goal was to promote awareness of the recently approved Diabetes Self-Management and Education program for delivery by Core Health Partners in unique community locations.

November 03, 2019

On this date, Help a Diabetic Child sponsored the 5th annual Von Arx Family Foundation opened Diabetes and Wellness Conference. Top experts in diabetes and wellness provided education as a forum to further health equity to advance public knowledge on diabetes education, wellness, prevention and research. Notable presenters included the University of Florida Medical College Diabetes Institute, Tulane University School of Medicine, Healthcare Network, Naples Community Hospital, Lee Health, Core Health Partners, the Collier County YMCAs, FSW School of Nursing, and the National Wellness Institute and more.

Fenruary 17, 2020

On this day the State of Florida approved, through granting medical licensure (HC 12138) by the Agency for Healthcare Administration (AHCA) to Core Health Partners. The first two licenses granted to CHP were for the Marco Island YMCA and the Sanchez Academy (HC12136) location, serving north Naples.

June 2, 2020

On this date Healthcare Network opens $15M Nichols Community Health Center in Golden Gate. The three-story Nichols Community Health Center is named after Naples philanthropist Jerry Nichols for his substantial gift for the project. The mission of the Nichols center is to be a comprehensive medical home to the fast-growing region of Golden Gate with an estimated 36,000 residents living in the area, many of whom lack access to primary care services.

09/17/2020

On this date the Dean for the University of Florida Medical College signed a Memorandum of Understanding outlining the University of Florida's goals to provide telehealth medical services to the children of Collier County in underserved areas. The University specifically outlined their goal to deliver endocrinology telemedicine services and access to receive other healthcare services consistent with the American Diabetes Association (ADA) recommendations.

July 24, 2021

On this date Core Health Partners Foundation was incorporated under Florida's Secretary of State.

October 18, 2021

Access to health services and education is extended to the Golden Gate City community through and agreement between Core Health Partners and Grace Place for Families.

March 23, 2022

Department of Treasury/ IRS determined the Core Health Partners Foundation to be a 501c3 status, public charity on this date.

October 19, 2022

On this date Core Health Partners started a pediatric screening program for the Golden Gate families with children enrolled at Grace Place for Families and Children. Children were screened by medical professionals for developmental delays and child obesity. A series of informational meetings were held in Gold Gate on the Grace Place campus with Core Health Partners a bilingual occupational therapist, speech therapist, and dieticians.

Picture: Core Health Partners bilingual Dieticians, Itchaqueria Fontanaz RD/N, and Alejandra Francis, RDN stand in-between CHP's CEO and President Paul Thein and the Lara Fisher, CEO of Grace Place.

December 13, 2022

On this date Health Planning Council of SWFL, Inc. gave a boast to health equity granted Core Health Partners a mini-grant to expand their Nationally recognized Diabetes Self-Management and Education (DSME) training program to the underrepresented areas of Collier County. This funding led to the American Diabetes Association program to be delivered to the communities of Immokalee and Golden Gate. The DSME is a fully funded service by Medicaid and most all insurances, providing the education without costs to those who live with diabetes.

January 20, 2023

An early unveiling of the Togetherhood Center movement was held on this date in Immokalee Florida. Over 300 attendees, including dignitaries from the Department of Health, Collier County Commission, Greater Immokalee Chamber of Commerce, School District leadership and Non-profits all supported the event.

April 19, 2023

The Togetherhood Initiative Center completed renovation on a building in Immokalee and officially open a collaborative health and wellness center on this date.

Picture: Community partners unveiled the Togetherhood Initiative Center during ribbon cutting ceremony. Recognizing the need for preventive medical care and wrap around services, non-profit leaders came together to serve the people of Immokalee.

June 17, 2023

T2M Medtech Corridor bestowed Core Health Partners as a Top 30 Health Innovation company, for the South Florida region.

July 01, 2023

On this date Core Health Partners reaffirmed the American Diabetes Association's Recognition status that is required to deliver and invoice Medicaid, Medicare and most the commercial insurances for the Diabetes Self-Management and Education (DSME) program. In addition to the Marco and Sanchez Academy location locations, new approved sites were added to include the Togetherhood Center in Immokalee, Grace Place Center for Families & Children (Golden Gate) and Help a Diabetic Child's new office space on Davis Blvd (Old Naples).

August 07, 2023

Help a Diabetic Child (HADC) hosts an open house to announce the new Diabetes Resource & Advocacy Center location in Naples (Davis Blvd).

October 11, 2023

On this date Core Health Partners Foundation attended KPMG's Health Equity and Artificial Intelligence Taskforce meetings. These meetings were invite only and limited to only 100 innovative health equity leaders nationwide.

November 04, 2023

On this date, Medicaid approvals and licensure (No. 11042280) were granted for Core Health Partners clinical services to be offered at the Togetherhood Initiative Center of Immokalee.

Mission Moments

Pathway to Wellness Impact Stories

CHILD OBESITY

Background

A 12-year-old boy lives with his father and stepmother. The child's parents are highly supportive of his health and nutrition goals.

Condition: Overweight

During the initial assessment, the child expressed frustration with their unsuccessful attempts to lose weight.

Pathway to Wellness

Child was referred by his Pediatrician for medical nutrition therapy at the YMCA.

Our Impact

Initial Evaluation
Height: 5' 1 1/2"
Weight: 161
BMI: 29.9

Current Status
Height: 5' 2 1/4"
Weight: 139.9
BMI: 25.4

Total weight reduction: 22 pounds in 4 months

The patient is now consuming three well-balanced meals on a daily basis and occasionally enjoys a snack after school. Moreover, he has significantly reduced his sugar intake while increasing his protein intake. In addition, he ensures to drink six bottles of water throughout the day.

To further support the patient's progress, the family has made a positive change by having dinner at home every night instead of eating out. Furthermore, the child is actively engaged in physical activity by working out with a personal trainer twice a week and playing baseball.

TYPE 1 DIABETES

Background

A 14-year-old Hispanic girl living with her stepfather, mother, and younger siblings.

Condition: Type 1 Diabetes

The child struggled with managing blood glucose levels and maintaining a safe range, unsure about proper dietary choices and meal planning.

Pathway to Wellness

A family in crisis was referred to a local nonprofit for assistance with expired insurance and insulin needs. The nonprofit covered the cost of a telemedicine visit with Endocrinology and provided funding for crisis insulin. They also supplied technology to improve the management of the child's blood glucose levels.

Our Impact

Initial Evaluation:

HbA1c: 11.9%

Physical Activity Level: Little to no activity

Eating Habits: Poor eating habits, high sugar and carbohydrate diet.

Current Status:

HbA1c: 9.7%

Physical Activity Level: increased physical activity level to at least 4 times a week

Eating Habits: Increased intake of fruits and vegetables, decreased sugar intake.

Total HbA1c Reduction: 2.2%

With the assistance of Togtherhood agencies and active participation in a Diabetes Self Management program with dietitian support, the patient made notable improvements in eating habits and physical activity. By making simple changes like reducing sugary drinks and snacks, increasing vegetable intake, and engaging in sports four days a week, the patient successfully reduced her HbA1c by 2.2%.

Stronger Together

Our Dedicated and Passionate Pathway Leaders

MEDICAL PATHWAY OVERSIGHT & CLINICAL CARE

Dr. Salvatore Anzalone

Dr. Salvatore "Sal" Anzalone, a native of New York, currently holds the position of Vice President of Clinical Business Development at Healthcare Network. In this role, he forges partnerships and acts as a strategic collaborator to enhance organizational excellence. Dr. Anzalone's focus is on crafting strategic solutions that align the business with community needs and overarching strategic goals.

His academic journey began at Carson-Newman College in Tennessee, where he graduated with high honors, Magna Cum Laude. He then pursued his medical degree from the University of Florida, graduating in 1986. Post-graduation, he completed his pediatric training at the University of Tennessee, where he also held the position of chief pediatric resident.

Prior to joining Healthcare Network in Collier County in 2014, Dr. Anzalone dedicated 25 years to pediatric practice in Wyomissing, PA. Quickly recognized for his leadership abilities, he was appointed as Physician in Charge in 2016 and later assumed the role of Medical Director of Pediatrics in 2018. In these capacities, he has provided care for over 35,000 pediatric patients, working closely with clinical directors and medical directors on patient safety, quality of care, and clinical informatics, aiming to establish an integrated, collaborative practice for the future.

Dr. Anzalone is deeply committed to preventing cancers caused by the human papillomavirus (HPV) infection and actively advocates for increasing HPV vaccination rates. He initiated a successful pilot program at Healthcare Network to boost HPV vaccination rates among adolescents and collaborated with other pediatric clinics to standardize medication formulary for children's care clinics.

A firm believer in continuous learning and the promotion of healthy lifestyles, Dr. Anzalone has served as a Pediatric professor at Reading Hospital Medical Center and as a clinical preceptor at both the University of Pennsylvania Nursing School and Drexel University. His exceptional teaching skills earned him the "Outstanding Teacher Award" from residents at St. Joseph's hospital. Additionally, he is a certified Instructor of both PALS and BLS. His efforts in combating childhood obesity in SWFL have been recognized by his alma mater, the University of Florida, as Doctor Gator.

Dr. Anzalone, who is fluent in Italian and Spanish, lives in Naples with his wife. They enjoy spending their free time with their four adult children, two of whom have followed in their father's footsteps and become doctors. A fervent University of Florida football fan, Dr. Anzalone takes great pride in cheering for his son Alex, a former UF player and current Detroit Lions player.

Dr. Angelia Bernier

Dr. Angelina Bernier is Board Certified Physician in the areas of Pediatrics and Pediatric Endocrinology and she serves as a pediatric endocrinologist at the University of Florida and she serves as the Medical Director of the Metabolic & Obesity clinic. Dr. Bernier is the Pediatric Medical Advisor of the UF Health Bariatric Surgery Center and a member of the UF Diabetes Institute, serving as Program Director of the Pediatric Endocrine. Through her leadership she has brought together a multidisciplinary team to provide contemporary, comprehensive care in the form of genetic screening, metabolic and physical fitness assessments along with use of new pharmacotherapies. Her clinical expertise and innovation is in the care of children with obesity and diabetes. Dr. Bernier, born in Florida with a Cuban and Mexican heritage, is fluent in English and Spanish

Dr. Asjad Khan

Dr. Khan is a Board Certified in Pediatrics and Endocrinology. He completed medical school at Mount Sinai School of Medicine in New York, N.Y. followed by a residency in pediatrics at Winthrop University Hospital in Mineola, N.Y. where he served as chief resident. He remained at Winthrop University Hospital to complete a fellowship in pediatric endocrinology and later helped establish the pediatric endocrinology program at New York Methodist Hospital in Brooklyn, N.Y. Dr. Khan has been caring for pediatric diabetes patients locally since 2007 when he provided key guidance in establishing the pediatric endocrinology program at Golisano Children's Hospital.

Dr. Robert Gillio

Robert Gillio, MD is an experienced clinician, award winning health educator, and community engagement expert for population health initiatives. He was trained at the Mayo Clinic, and treated critically ill patients the first half of his career. The second half has been innovating on approaches to reduce adult disease with a focus on issues such as childhood obesity. He has innovated with 15 patents and has done work at national disaster sites when not engaged in youth health literacy and empowerment. He has raised on $12 million in funding for use of the school nurse in this role and has published on statewide programs involving hundreds of thousands of youth records. He is now offering his Force for Health Network tools to assist the Togetherhood Initiative.

Dr Chaithanya-Renduchintala ("Chait")

Dr Chaithanya-Renduchintala ("Chait"), works with the infectious disease and travel health initiative and is an Assistant Professor with the University of Central Florida's Rosen College of Hospitality Management with the department of Tourism, Events and Attractions.at the Rosen College of Hospitality Management. He holds a master's degree in Bio Medical Science and a PhD Modelling and Simulation from the University of Central Florida. His research interests include travel and health data modeling with a focus on community health and resiliency. In community health, his interests include utilization of synthetically generated health data to facilitate collaboration and data sharing across organizations, generation of community scale

knowledge graphs, community health outcome modeling, community health systems design, community scale AI applications, community health network analysis and evidence-based community health planning.

Prior to joining RCHM, He worked as a senior community health data analyst for the Cleveland Clinic Foundation. In this capacity, he analyzed data sets from EPIC , Unite US and the Redcap survey system related to collaborative community health interventions. Previously, He worked with over 60 health care partners to develop and implement the Community Health Improvement Plan for Orange County, Florida Department of Health.

Dr. Stella Nemuseso

Dr. Stella Nemuseso is a leading figure and distinguished leader in the global healthcare sector, renowned for her groundbreaking contributions to community health and health equity. Originating from Zimbabwe, she founded Dynamic Therapy and Wellness Services, Inc., also known as Dynamic Lifestyle Institute, in Florida in 2004, showcasing her expertise in integrating holistic healthcare with proactive wellness practices. As a strong advocate for aging well and the incorporation of nutraceuticals in healthcare, Dr. Nemuseso promotes a holistic and forward-thinking wellness model. Her role as a retired university professor has been pivotal in shaping the education and mentorship of future healthcare leaders, with a particular focus on fostering diversity in STEM , chronic diseases management, technology and physical therapy.

Dr. Nemuseso possesses a comprehensive skill set that includes networking, consulting, research, technology integration, project management, and coaching, all of which have been crucial in her work with chronic disease management and patient care, especially in integrating psychological aspects. Renowned as an international speaker, she actively shares her insights and experiences, continually seeking collaborative and mentoring opportunities. Her dedication to coaching, project management, and advocacy for proactive wellness and nutraceuticals underscores her leadership and commitment to driving advancements in the healthcare industry.

CLINICAL LEADERS IN THE OBESITY PATHWAY

Carolina Castelli Figley, MD, RDN

Dr. Castelli-Figley received her Medical Degree in 2007 after finishing a residency at several medical facilities and hospitals in the Mahoning valley including North Side Hospital in Youngstown Ohio, Trumbull Memorial Hospital in Warren Ohio as well as St. Joseph Health Center also in Warren, Ohio. Later Dr. Castelli Figley obtained her Master's in Public Health at The Consortium of Eastern Ohio Master of Public Health (CEOMPH) at NEOMED in Rootstown, Ohio. In 2016 Dr. Castelli Figley completed the Coordinated Program in Dietetics at Youngstown State University.

Dr. Castelli- Figley works with Core Health Partners where she directly serves the children and families who are referred to the Child Obesity program.

Berlinda Abed, MS, RDN, LDN

Berlinda Abed, "Lindy" serves as a clinical dietitian teaching appropriate diet education to patients, including nutrition counseling to patients who live with chronic disease. Lindy was a leader in the design of Core Health Partners (DSME) innovative Diabetes Self-Management and Education Program (DSME) and the detailed protocols for scheduling patients to the community centers. Through Lindy's leadership the diabetes education program has proven to meet the National best practice standards of the American Diabetes Association (ADA). Obtaining this National Recognition allows Medicaid, or the patient's private insurance provider, to fund the patients program with a physician's referral. Lindy has obtained grant funding to expand the diabetes program to the communities of Golden Gate, Immokalee and at Help a Diabetic Child's (HADC) new office on Davis Blvd (Naples). Lindy has been instrumental in building the Child Obesity program to the National standards of best practice self-care model and she oversees the data collection that assures the competencies are being met. In addition to her contribution in the areas of chronic disease education and child obesity, Lindy oversees CHP's dietician Intern program for collegiate students nearing the end of their program seeking experience in the clinic to community model.

Nohely Torres, RD/N

Nohely Torres is a bilingual culinary nutrition educator with a passion for improving people's health through nutrition and cooking. With a bachelor's degree from San Diego State University and a dietetic internship completed in Naples,Fl, she has gained a deep understanding of the relationship between food and health.

Nohely's previous work as a nutrition and lactation counselor in California inspired her to become certified as a Culinary Nutrition Specialist. Her expertise in both nutrition and culinary arts allows her to provide a holistic approach to health and wellness. Nohely is dedicated to empowering individuals and communities to make healthier choices through nutrition education and cooking classes.

When she's not working, Nohely loves spending time in nature, going to the beach, and traveling to new places. She believes that experiencing different cultures and cuisines is an important part of staying inspired and connected to the world.

Marie E. Pierrelus, RD/N

Marie Pierrelus is originally from the Caribbean and was raised in South Florida. While in college, she took a nutrition course which led her to appreciate the preventive role that nutrition plays in the development of chronic illnesses. Consequently, she earned a Bachelor's and Master's Degree in Food Science and Human Nutrition from the University of Florida. She completed her dietetic internship with Pasco County Health Department with placements at South Miami Hospital and Miami Children's Hospital, and a Didactic Program in Dietetics with Kansas State University.

Marie's expertise is in public health nutrition with more than 15 years of experience in positions such as Nutrition Educator, Public Health Nutritionist, and Public

Health Nutritionist Supervisor with the Florida Department of Health in Collier County (WIC Program). She also brings a wealth of experience in pediatric, prenatal, postpartum, and lactation nutrition. Marie is a Certified Lactation Counselor and holds a Certificate in Adult and Pediatric Weight Management. In addition to community nutrition, Marie worked in pediatric inpatient and outpatient settings and provided medical nutrition therapy in the neonatal ICU and pediatric specialty clinic of Golisano Children's Hospital of Southwest Florida.

Marie embraces diversity and believes in providing culturally competent nutrition counseling/education to her patients. She incorporates multicultural understanding in her practice and speaks English, Haitian Creole, and Spanish. In her spare time, Marie likes to spend time with her family, travel, and listen to audiobooks. She looks forward to providing patient-centered care as a Registered Dietitian Nutritionist with the Core Health Partners team.

Diana Vittorio, RDN, LD

Diana Vittorio has been working as a Registered Dietitian Nutritionist in Naples since 2014. Prior to moving to Naples, she graduated Valedictorian with a Bachelor of Science in Dietetics from Life University in Atlanta, Georgia. Her comprehensive internship was completed locally at Naples Community Hospital and Women, Infant and Children's Services in Collier County.

Diana's experience includes nutritional counseling in both individual as well as group settings at both Von Arx Diabetes and Nutrition Center and Cederquist Medical Wellness Center. She is most passionate about helping people manage and improve inflammatory conditions such as diabetes, cardiovascular disease, obesity, and food allergies with nutrition therapy as well as lifestyle modifications. She takes an empathetic and compassionate approach in guiding her patients towards making positive choices in order to reverse their inflammation and optimize their health.

PROGRAM COMPLIANCE & QUALITY CONTROL

Dr. John Querci

Dr Querci, is a positive servant leader with over 40-plus years of experience as a physician. With his boundless energy and team player attitude, John enjoys treating and dealing with people from all walks of life. His passion has always been to help others live to their fullest potential. This is the driving force in his desire to assist the expansion efforts of CHP's unique clinic to community model of service. Dr. John Querci serves as the medical director of Core Health Partners (CHP). Through the experience of Dr. Querci and leadership he has guided Core Health Partners to develop their "clinic to community" movement that includes licensing services within the walls of community centers and the YMCAs. .

John Querci attended Kings College in Wilkes-Barre, Pa where he majored in

Biology. He graduated from Temple University and later the Philadelphia College of Osteopathic Medicine. He completed rotating internships at Detroit Osteopathic Medicine (Detroit, Michigan) and a residency in Internal Medicine at Wayne State University Center. Dr. Querci is Board Certified by the American Board of Specialties, with current Resuscitation certifications in; Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), Advanced Trauma Life Support (ATLS). John Querci is a resident of SW Florida and is licensed to practice medicine in New York, Pennsylvania, South Dakota, and Florida.

JoEllen Condon, RDN, LD, CDE

JoEllen served as the National Managing Director of the American Diabetes Association (ADA) Education Recognition Program (ERP). During her time at ADA, she was responsible for ADA's status as a Medicare National Accrediting Organization for Diabetes Self-Management Education and Support (DSMES). She also worked with the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), the Diabetes Advocacy Alliance (DAA), the American Association of Diabetes Educators (AADE), Indian Health Services (IHS), State Health department leaders. As director of the Enterprise Resource Planning (ERP), she managed the ERP National Committee, fifty ERP volunteer auditors, 1,700 ADA Recognized DSMES programs with 3,700 sites. JoEllen Condon also collaborated with American Association of Diabetes Educators (AADE) and managed the reviewers and writers for the 2017 National Standards for DSMES. JoEllen led the development of the ERP DSMES live symposium, auditor training, and the development of the ERP Quality Coordinator Guide.

JoEllen Condon is the quality control director for Core Health Partners. She holds a Bachelors' Degree in Nutrition and Dietetics from Virginia Tech and is a Registered Dietitian/Nutritionist and Certified Diabetes Educator. Ms Condon has thirty plus years of dietetics and management experience. She originally started working alongside Core Health Partners when she was contracted by the Diabetes Alliance Network (DAN) to help redesign a community model for the delivery of Diabetes Self-Management and Education (DSME). After her work with gained National Recognition of the American Diabetes Association (ADA), Jo Ellen began taking a hands on approach serving as Core Health Partners' as Quality Control Director of the program.

Besides her role with Core Health Partners, JoEllen Condon provides diabetes education at the Anne Arundel Medical Group Diabetes and Endocrine Specialists Program in Annapolis, Maryland and she also consults with national organizations through her private practice, RDiabetes EmpowerMNT, LLC. Her national work focuses on diabetes program development and mentoring of new diabetes professionals.

Joe Balavage

Joe Balavage's background is in business as well as pre-hospital emergency care as a Paramedic Level 2. He was in one of the first classes of EMT Paramedics certified by the Pennsylvania Department of Health. Balavage was appointed as Chief of Medic 1 which was the first Advanced Life Support Paramedic Unit placed in service in Luzerne County, Pennsylvania. During his tenure as a Paramedic, he served as Board Member to the Emergency Medical Services of Northeastern Pennsylvania, an agency appointed by the Pennsylvania Department of Health to oversee all aspects of pre-hospital emergency care within a 7 County Region of the State. Joe also served as an instructor to new paramedics and to physician assistant students. During his time working in local Emergency Departments, Joe had the opportunity to meet with and develop the first fully operational Walk-In Medical center in the area he served. He subsequently was named as President of a Medical Billing company, as well as a medical management company that provided services to multiple Urgent Care Centers in Eastern Pennsylvania.

Joe Balavage is co-founder of Help a Diabetic Child and the President of the Diabetes Alliance Network (DAN). In his leadership role with Dan, a 501c3 non-profit, he leads the innovation efforts of diabetes and prevention and protects the integrity of the diabetes and diabetes prevention model of care. Through a committee structure DAN assures the DSME program and the diabetes prevention programs remain at the cutting edge through implementing new technologies, having access to the best education for the clinicians to teach new best practices in self-management. Through DAN the DSME and the clinic to community model remains yet nimble and effective for potential duplication in other communities around the Nation. Joe Balavage passionately serves as a community liaison for Core Health Partners work in the area of chronic disease education and programs.

PROGRAM MANAGEMENT, PATHWAY INTERGRATION & INNOVATION

Paul J. Thein, ED.S.

Paul Thein, a champion in the fight for equity, has an impressive tenure in managing programs that benefit the underrepresented and disadvantaged populations. As a senior administrator in higher education, Thein focused on assuring access for the underrepresented populations. His efforts led to successful grant applications that secured over $10 million in Federal Department of Education funding. Thein's responsibility also include institutional oversight for the California state funded Education Opportunity and Program Services (EOPS), and Matriculation program, AmeriCorps Volunteer Program and the Mini Corps, an innovative California Education program to educate the children of the migrant workers.

After leaving higher education for a Chief Executive Officer position in the YMCAs, Thein continued the theme of providing access to the underrepresented. He led an effort that resulted in the Mayo Clinic and the local Regional State Community College renovating space for community access to health information and education. Thein expanded access to the work force by keeping the YMCA's fitness facility open 24 hours a day, meeting the needs of the workforce. Thein championed multiple capital campaign that rebuild and renovates traditional fitness centers into Healthy Living Campuses with health, education, and many clinical partnership programs.

Thein's educational background includes a Bachelor's in Physical Education, a Master's of Science, and an Educational Specialist degree in Education Leadership. His background and experiences in education, community engagements, and health education led to several unique pilot programs including the State of Georgia piloting a child obesity awareness program that promoted eating locally grown and fresh food, while engaging family activities at the State Parks.

After proving himself in the YMCA movement, Thein left to join a group of former Y staff that opened the first ever medically integrated YMCA (Clive Iowa). Their collective vision led to creating pathway programs that led those from the clinical office to a highly trained a caring staff at the YMCA facilities. Core Health Partners and the Core Health Partners Foundation serves that the clinical bridge in the funnel of medical referrals needing clinical support on their journey to wellness.

Cindy Love

Cindy Love has been a servant leader of the YMCA movement for over ___x__ years, including ---X—years with the Marco YMCA. She successfully merged two independent YMCAs (Marco and Naples into one Association that now serves the needs of all Collier County. Cindy is the CEO of the newly formed Collier County YMCAs. She also serves the President Elect of the Florida Alliance of YMCAs, an organization that has been a vibrant part of Florida communities for more than 130 years.

The State Alliance of YMCAs provides a single, unified voice for the YMCA Associations in Florida. Their role is to create a healthier and more active state for future generations. Through Cindy's leadership SW Florida she has lead a series of initiatives that has strengthened the community. Under Cindy's leadership the YMCA diabetes self-management programs has earned National Recognition by the American Diabetes Association while the Y's literacy programs for youth have been the model for the many Ys across Florida. Cindy's YMCA have pioneered many models of service to benefit the wellbeing of the children and families, including drowning prevention, child obesity, diabetes, hunger, and diabetes camp for children. .Under Cindy's leadership the Collier YMCAs have promoted medical integration as a model of building a healthy community. The medical integrated model specifically supports those who battle living with chronic disease.

Reggie Wilson

Reggie Wilson serves as the Healthy Communities Coordinator for DOH-Collier, playing a crucial role in coordinating the Healthy Collier CHIP Chronic Disease workgroup and the Child Obesity Initiative. His tireless efforts leave an enduring impact on the well-being of Collier County, both in the present and for a healthier future. Through fostering collaborations, advocating for positive change, and implementing cutting-edge programs, Reggie continues to make a significant contribution to the community.

Garrett Barr

With a Bachelor's of science degree in Entrepreneurial Studies, Garrett is dedicated to assist Core Health Partners in revolutionizing the Health Care industry through innovation, technology, and a passion for improving patient experiences that lead to measurable health outcomes. Garrett Barr is a dynamic Health Care Innovation Specialist with a track record of transforming traditional clinical programs to integrated pathways for more effective healthcare delivery. With expertise in emerging technologies and strategic thinking, Garrett drives positive change and enhances patient outcomes through protocols for community integration with the necessary data collection that is implemented within considerations of HIPPA compliance. As a leader of Togetherhood, he aspires to shape the future of healthcare by identifying innovative solutions and guiding the participating organizations to maximize efficiency in the pursuit of quality of care with the highest possible health outcomes.

Richard Tamer

As the Executive Director at the YMCA of Collier County, Richard has become synonymous with transformative community health measures. Over seven years of tireless dedication to the Y, they've not only shaped programs but also nurtured essential relationships with local leaders, cementing the Y's pivotal role in public well-being. With a strategic vision and a heart dedicated to service, Richard continues to drive impactful change, creating a healthier tomorrow, one community at a time.

Reilly Smith

Reilly Smith, the Healthy Living Director at the YMCA of Collier County, champions community health and wellness. Armed with a Bachelor's degree in public health, she propels impactful wellness initiatives at the YMCA, aiming to educate and empower every individual in the community, young and old. Her leadership is steering the YMCAs efforts to combat childhood obesity, diabetes, and chronic diseases, forging a path to community-wide health and happiness.

Carmen Scott Dawson

Carmen Scott Dawson approaches health equity through innovation. After becoming disabled Carmen Scott Dawson created AdVanz, LLC dba Adreamz Institute. Advanz, and clients advocated, secured, and directed investments of over $20 million for a wide array of projects that led to the creation or stabilization of over 100 full time living wage jobs and multiple part-time living wage jobs.

Carmen has focused his entrepreneurial leadership on creating broadband enabled, innovation-based communities, that drive workforce programs, and economic development. Carmen is a leader of innovations that are specifically designed to impact and improve health outcomes in target communities. Through Carmen's collective works along with his unwavering commitment to broad based innovation development he earned Congressional and Senatorial Letters of Recognition. He has also been bestowed with federal, state, and local citations and proclamations from numerous government officials, including being awarded YMCA "African American Achiever of the Year."

Carmen Dawsons' service to the community boards includes earning a position with the Eastside YMCA of Harborcreek and an appointment to the Eerie County Pennsylvania's premiere Authority's Board of Directors, the ECGA and ECCSFA, where he served as treasurer.

Kristen Waight, Diabetes Navigator

Kristen attended Florida Gulf Coast University, where I graduated with a Bachelor of Science degree in Biology with a minor in Chemistry. With a deep-rooted passion for empowering individuals to live well. Kristen works for the University of Florida and is assigned to Collier County as a dedicated diabetes navigator committed to guiding and supporting individuals along their journey to better health and wellness. As someone who personally experienced the impact of diabetes within my own family, her journey is fueled my commitment to making a positive difference in the lives of those navigating similar paths. In Kristen's free time I enjoy playing tennis, capturing the beauty of nature through landscape photography, and traveling.

An Expert's Review of the Togetherhood Initiate and the Clinic to Community Model.

Dr. Robert Gillio

Member Society of Physician Entrepreneurs

Childhood Obesity will bankrupt the health care system in the United States. It's not that it is that expensive in the short term to care for or ignore these patients. It's that over 50% will go on to become very expensive patients with multiple chronic health issues earlier in life. These include diabetes, heart disease, hypertension, worn out joints, and some cancers.

The return on investment is estimated by the CDC that a $1 investment in prevention will save $6 in costs and that an increase in exercise in sedentary teens and adults can save $61 billion dollars in health care costs, annually. Health care payers with the most to gain in addressing this problem are sabotaged by the fact that a 16% of child's coverage may change annually years and almost certainly, will not be with the same carrier 20-30 years from now. Therefore, we cannot rely on our payers who are in the business of making a margin on paying for programs and services with the money they get from collecting taxes or premiums or capitation fees, to see a direct investment in this problem now, as a good investment, because that person will be in a different plan.

I care a great deal about this as a father of 5 daughters that are becoming mothers. I worry that those children and grandchildren, even if healthy and not obese, will have to finance a sick care system caring for the current youth that will be sick adults. The system is set up to profit off sick care. In addition to health care sick care business reform into a true health care system, families, organizations, and providers need to start right now creating a "Pathway to Wellness".

In my experience I have attempted to use my entrepreneurial skills to invent solutions, share them with the world, and be mentored and then mentor others. I have changed careers from treating preventable chronic disease to finding ways to prevent or delay the morbidity and mortality thereof. I have worked with and found solutions collaborating with White House officials, Surgeons General, Secretaries of Health, for-profit companies, not-for-profit agencies, and leaders in local government, schools, YMCA's, gangs, and faith sites. Now I chose to

About Dr. Robert Gillio:

- Happily married father of 5 daughters
- Population Health and Pulmonary Physician
- 2001 September 12 Foundation "Hero Award" for work on and after 911 including helping create the Ground Zero Clinic and World Trade Center Registry and securing about 10 billion dollars in funding
- 2006 New Orleans Best Partner in Education for creating Force for Health with New Orleans teens as health advocates in their family
- 2012 National Distinguished Service to Health Education Award
- 2005 -2015 PA Health eTools Childhood Obesity project
- 2019 PA Rural Health Value Based Care demonstration project implementation plan author

Dr. Robert Gillio
Member, Society of Physician Entrepreneurs
Chief Medical Officer
CMO, The Force for Health Network

continue to address obesity, and other mental, physical, and safety issues and harness the efforts of my colleague with their social and health care creativity as a member of the Society of Physician Entrepreneurs (SOPE) and their active chapter in your area.

That is why the rest of us need to take the lead and work together in our community and surround the child with a togetherhood philosophy and approach. Using unconventional community partners working together with the providers, creates an intake, care, and intervention capability that can touch all children, and the client children, with support and teamwork and a pathway to staying healthy or regaining a healthy status. I learned this with my work with the Highmark Foundation, and funding from Blue Cross in PA where our Health- e-Tools Coordinated School Health portal, attempted to use the school setting as a supportive community with screening, referral, and program. The "Whole School, Whole Community, Whole Child" (WSCC) program from the ACS was derived from the work of our advisor and my co-publisher of Stemming the Flood, about childhood obesity in a 10-year tracking of the same children. The Force for Health Network we are creating is a direct result of that experience where the child, family, organizations, and the community can work together of health issues as empowered health literate partners stiving for the same outcome.

The data shows that early identification, referral, family intervention, organizational, community, gamification and incentives, and health care support can work. What excites me and why I wish to volunteer to assist this county, is that you are creating a model for the state and nation. Your Togetherhood initiative with Core Health Partners is starting to show that their "Pathway to Wellness" work with multilingual intake engine for referral and care services, is inviting and overcomes barriers to making healthy decisions. The primary care doctors need to keep referring patients as they have begun to do. Now it is time for the rest of the folks around this table and the county, to join in and share what they can offer on the referral or intervention side. This includes specific services for the client's child and family, and also addressing the social determinants, such as lack of safe exercise facilities, park access, food desserts, costly food, transportation issues, and other barriers. It also means helping advance health literacy and access across the entire community.

Togetherhood is all of us creating a community where the healthy decision is the easy decision, and where there is a pathway to wellness that is supported and used. As a proud member of SOPE and one that has been focused on the health of children and communities for my career, I am here to learn from and endorse this Togetherhood initiative and its Pathways to Wellness intake engine, and the work of Core Health Partners. I urge all interested community partners to join the hood and work together with the leadership.

Thank you on behalf of the overweight children that need assistance.

Respectfully,

Robert Gillio, MD

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Medicaid Enrollment Churn and Implications for Continuous Coverage Policies
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LIST OF APPENDICES

Appendix A: Participating Agencies Integrating Services to the Child Obesity Pathway to Wellness

Florida Department of Health in Collier County (DOH-Collier)

Website: https://collier.floridahealth.gov
Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

Togetherhood Initiative

Website: http://togetherhood.org
Mission: To provide a single access point through a collaboration to those in the community who suffer with chronic medical conditions, food insecurities, behavioral health problems, obesity concerns, and physical and occupational health conditions

Core Health Partners Foundation

Website: https://mycorehealthpartners.com/contact-us

Healthcare Network

Website: https://healthcareswfl.org
Mission: To provide quality healthcare accesibale to all.

Core Health Partners

Website: https://mycorehealthpartners.com
Mission: Create, deliver, and sustain preventative health management environments that ignite the spirit, engage the mind, and strengthen the body.

University of Central Florida College of Hospitality

Website: https://hospitality.ucf.edu
Mission: The educational mission of UCF Rosen College is to provide students with advanced classroom studies and a working knowledge of the hospitality and tourism industry, and to apply creative decision-making techniques in responding to those opportunities.

Diabetes Alliance Network

T2M MedTech Corridor

Website: https://t2mcorridor.com
Mission: To empower healthcare innovators, professionals, end users, scientists, engineers, and entrepreneurs to collaboratively design and develop cutting-edge medical technology solutions with laser focus on reduction of disparities, inefficiencies, and life-threatening liabilities.

YMCA of Collier County

Website: https://ymcacollier.org
Mission: To put Judeo Christian principles into practice through programs that build healthy spirit, mind and body for all.

Force for Health

Website: https://theforceforhealth.com

NCH Safe and Healthy Children's Coalition

Website: https://safehealthychildren.org/about-us

Mission: To facilitate and implement programs to combat childhood obesity, prevent childhood drowning and reduce SIDS.

Bikes for Tykes

Website: https://bikesfortykes.org

Mission: The mission of the Angel Wheels Bike Build programs is to strengthen communities through gifting of bicycles to children in order to promote healthy living in childhood and beyond.

Naples Children's and Education Foundation

Website: https://www.napleswinefestival.com/about-us

Mission: Supports effective, disciplined charitable programs that significantly improve the physical, emotional and educational lives of underprivileged and at-risk children in Collier County

University of Florida Medical College

Website: https://med.ufl.edu

Mission: to improve health care in Florida, our nation, and the world through excellence and consistently superior leadership in education, clinical care, discovery, and service.

Grace Place Center for Families and Children

Website: https://graceplacenaples.org

Mission: Grace Place puts faith into action, providing pathways out of poverty by educating children and families

Help a Diabetic Child

Website: https://helpadiabeticchild.org

Blue Zones

Website: https://southwestflorida.bluezonesproject.com

Collier Cares

Webiste: https://colliercares.org

Appendix B: Job Description for Wellness Pathway Case Manager

Position Title: Wellness Pathway Case Manager

Reports to: Healthy Living Director

Job Status: Full-Time

FLSA Status: Exempt Position

Supervised: by YMCA

Preferred Qualifications:

- Bilingual (English and Spanish)
- Bachelor's Degree preferred
- Two years of nursing experience in community nursing, critical care, home health, or a related field
- Experience with utilization review and discharge planning required

Position Summary: The Wellness Pathway Case Manager , operating under the supervision of the YMCAs of Collier County, collaborates with health providers and agencies associated with the Togetherhood Initiative. This grant-funded position oversees wellness pathway compliance for referred patients. Including management of patient caseloads to ensure program participation and retention through coordinated care initiatives at the YMCA and beyond. The Case Manager serves as a patient advocate, identifying community resources, and works closely with the Healthy Living Director, the clinical team, referring physicians, and the families of referred patients. Applicants must demonstrate technological literacy and the ability to assess, analyze, and utilize various technological platforms and databases within the capacity of the role and day-to-day operations. Additionally, knowledge of the health system, including insurance carrier and coverage navigation, is a requirement. The deployment, utilization, and understanding of the principles of health equity are integral aspects of this role, ensuring that services provided contribute to equitable healthcare outcomes for all.

Essential Functions:

- Collaborate in overseeing the practice's chronic disease registries.
- Develop comprehensive, collaborative care plans based on provider treatment plans and evidence-based guidelines.
- Manage high-risk and chronic disease patients through various communication channels and support programming.
- Provide individualized patient education and support .
- Communicate changes in patient status with the care team and perform after-visit summaries.
- Identify barriers to treatment goals, arrange follow-up services, and facilitate diagnostic services, including nutritional programming.
- Utilize protocols for delivering patient care and report quality measures.
- Liaise with insurance companies and patient's families
- Assist providers with shared medical appointments and group visits.
- Participate in team meetings, staff meetings, and quality improvement projects.
- Assist in oversight of nutritional food programs and presentations.
- Apply training of these programs within The Togetherhood Initiave

Competencies:

- Ability to work independently and exercise basic clinical judgment.
- Strong organizational, time management, and analytical skills.
- Excellent communication skills, both verbal and written.
- Proficient in computer usage and electronic medical records.
- Customer service-oriented and respectful of confidentiality.
- Decision-making skills, delegation ability, and flexibility.
- Positive attitude and project management skills.
- Teamwork and ability to work under pressure.
- Must be proficient with Microsoft Excel
- Basic knowledge and understanding of the principles of food safety

Work Environment:

- Various service locations within the Togetherhood Iniative
- Indoors & Outdoors dependent on program needs
- Shared Office Space
- Fast-paced with occasional high-pressure situations
- Work hours subject to office needs
- Possible exposure to bodily fluids, infectious specimens, and other medical conditions
- May wear Personal Protective Equipment (PPE)

Physical Demands:

- Frequent sitting, standing, walking, grasping, carrying, and speaking
- Occasional reaching, bending, stooping, and lifting up to 60 pounds
- Frequent use of computer, keyboard, copy, fax machine, and phone
- Occasional travel to attend meetings or trainings

Appendix C: Nutrition Services Billing Reference Sheet

Nutrition Services Procedure Codes				
CPT Code	**Service**	**Hours Allowed**	**Time Units**	**Who Can Provide**
DSME – 1st Year (CMS)				
G0108	DSME (1-on-1 with RDN)	10 hours total DSME 1st year	30 minutes	DSME Team Member
G0109	DSME Group (2-20 patients)		30 minutes	
DSME – 1st Year (Commercial)*				
98960	1-on-1	10 hours total DSME 1st year	30 minutes	DSME Team Member
98961	Group (2-4 patients)		30 minutes	
G0108/9860	DSME – 2nd year	2 hours	30 minutes	
MNT – 1st year				
97802	Initial Assessment	3 hours total |MNT 1st year	15 minutes (Limit 2 hrs/day)	RD only
97803	Follow Up			
97804	Group 2-20 patients		30 minutes (Limit 3 hrs/day)	
97802/97803	MNT – 2nd year	2 hours	15 minutes (Limit 2 hrs/day)	
MNT – 2nd Referral Same Year**				
G0270	1-on-1	No limit, referring provider must specify on referral	15 minutes (Limit 2 hrs/day)	RD only
G0271	Group 2-20 patients		30 minutes (Limit 3 hrs/day)	

*G codes for Medicare may also be used for commercial, check with codes they want used

**2nd referral same year due to change in Dx, medical condition, treatment regimen. No specific limit on number of additional hours, but referring provider must indicate number of hours on second referral.

Common ICD Codes Covered by Insurance for MNT/DSME		
Disease Type	**Description**	**ICD 10 Code**
Chronic Kidney Disease (CKD)	Chronic Kidney Disease (Stage 1)	N18.1
	Chronic Kidney Disease (Stage 2) (Mild)	N18.3
	Chronic Kidney Disease (Stage 3) (Moderate)	N18.3
	Chronic Kidney Disease (Stage 3) (Unspecified)	N18.30
	Chronic Kidney Disease (Stage 3a)	N18.31
	Chronic Kidney Disease (Stage 3b)	N18.32
	Chronic Kidney Disease (Stage 4) (Severe)	N18.4
	Chronic Kidney Disease (Stage 5)	N18.5
	End Stage Renal Disease	N18.6
	Chronic Kidney Disease (Unspecified)	N18.9
Type 1 Diabetes Mellitus:	With hyperglycemia	E10.65
	With other specifications	E10.69
	With unspecified complications	E10.8
	Without complications	E10.9
Type 2 Diabetes Mellitus:	With hyperglycemia	E11.65
	With other specified complications	E11.69
	With unspecified complications	E11.8
	Without complications	E11.9
Gestational Diabetes Mellitus:	Pre-existing DM, type 1, in pregnancy, childbirth and puerperium	24
	Pre-existing DM, type 1, in pregnancy	24.01
	Pre-existing DM, type 2, in pregnancy	24.11
	Gestational DM	24.4
	Gestational DM in pregnancy	24.41

Appendix D: Diabetes Self-Management Education (DSME) Program

SESSION	TOPIC	LENGTH	SESSION FOCUS & GOALS
A	What Do I Do Now? 	2 Hours	• Diabetes language • Stress and coping mechanisms • What is diabetes? • Diabetes ABCs • Symptoms of hyperglycemia • Self-monitoring of blood glucose
B	What Can I Eat? 	3 Hours	• Healthy eating • Physical activity
C	How Can I Take Control? 	2 Hours	• What's in your medicine bag? • Sick days & diabetes management • Dining out • What's in your glass?
D	How Do I Stay On Track? 	2 Hours	• Diabetes supplies • Traveling with diabetes • Preventing complications • Diabetes support

Appendix E: RD Sample Assessment Template for Pathway Program

Togetherhood Initiative

Togetherhood Initiative Center
429 N 1st Street
Immokalee, Florida 34142
(239) 932-0180
info@togetherhood.org

Medical Referral: (949) 404-8793
chpvirtualoffice@hpiinc.com

RD Sample Assessment Template for Pathway Program

CC:
- Referring Diagnosis
- Referring physician

Subjective:
- Patient and/or guardian concerns/questions.
- Reported level of physical activity. Past medical history.
- Family history.
- Typical day 24-hour food recall.
- Food allergies/intolerances.
- Food preferences.

Objective:
- Height
- Weight
- BMI
- Weight History
- Nutrition-related labs as available
- Clinical findings.

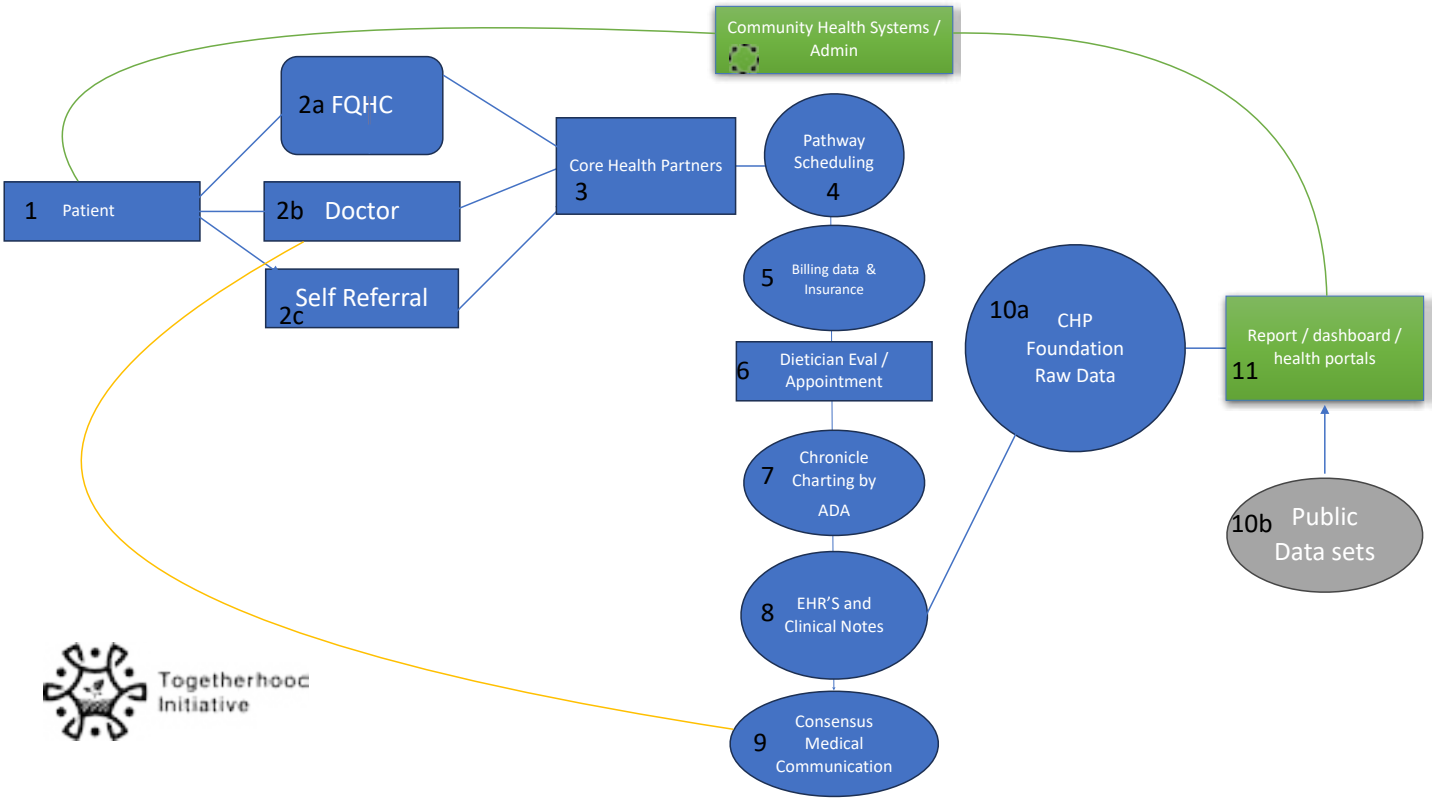
Assessment:
- Problem Etiology and Symptoms (PES) statement
- Topics of nutritional counseling/education
- Concerns addressed
- If applicable, estimated energy requirements.
- Patient's motivation level for change.

Plan:
- Education provided: 95210
- Community Programming: YMCA Partnership, Force For Health Gamification
- Patient-centered Goals.
- What RD will monitor.
- When follow-up requested/scheduled.

NOTE: In accordance with HIPPA Regulations the assessment is shared with Core Health Partners Foundation (CHPF).

This assesment becomes the standard for medical care for the diabtes and prediabetes pathway to wellness and certain data points are aggregated and desimated through a controlled HIPPA compliant portals and process. This allows the approved Togtherhood Initiative partners to understand and improve the effectiveness of the pathway program, including the matricuatlion of the patient.

Appendix F: Pathway to Wellness Flow Chart



Key Community Committees

Collier County CHIP

Pediatric Obesity Subcommittee Membership

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& Nutritionist for Diabetes and Prediabetes
Core Health Partners

Lisa Adamczyk RN, Director Community Health, Nursing, Family and Personal Health
Florida Department of Health in Collier County

Dr. Salvatore Anzalone, Medical Director of Pediatrics
Healthcare Network

Joe Balavage, President
Diabetes Alliance Network

Tami Balavage, President
Help a Diabetic Child

Dr. Angelina Bernier
University of Florida Pediatric Endocrinology

Dr. Dawn Bertram Stewart, Pediatrics Specialist
Apple Pediatrics

Dr. Susanna Boker
PANIRA Health Care Clinic

Tracy Bowen, Coordinator Health
& Physical Education
Collier County Public Schools

Dr. Krista Casazza, Associate Dean for Research and Scholarship
Florida Gulf Coast University

Zachery Casella, Health & Wellness Specialist
University of Florida/YMCA of Collier County

Carmen Dawson, Chapter President
South Florida Society of Physician Entrepreneurs

Dr. Corin Dechirico, Chief Medical Officer
Healthcare Network

Frank Diaz
Florida Department of Health in Collier County

Paula DiGrigoli, Director Women's & Children's Services of Collier County
Naples Community Hospital

April Donahue, Executive Director
Collier County Medical Society

John Drew, Organizational Planning
& Development Program Consultant
Florida Department of Health in Collier County

Chuck Gillespie, CEO
National Wellness Institute

Dr. Robert Gillio, Chief Medical Officer
Force for Health

Jennifer Gomez, Community Health Promotion Director/ Environmental Health
Florida Department of Health in Collier County

Megan Greer, Executive Director
Blue Zones Project

Dr. Douglas Edward Halbert, Pediatrician
Healthcare Network

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Richard Tamer, Operations Director
YMCA of Collier County

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University of Florida Health

Paul Thein, ED.S. President
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Reggie Wilson, Healthy Communities Coordinator
Florida Department of Health in Collier County

Kim Woodrow, Director
Naples Community Hospital School of Nursing

Sarah Zaiser-Kelly, Grants Director
Naples Children and Education Foundation

Togetherhood Initiative Center
429 N 1st Street
Immokalee, Florida 34142
(239) 932-0180
info@togetherhood.org

Togetherhood Program Outreach Sites

Healthcare Network
12655 Collier Blvd
Naples, FL 34116

Healthcare Network
1454 Madison Ave W
Immokalee, FL 34142

Grace Place for Children & Families
4300 21st Ave SW
Naples, FL 34116

YMCA of Collier County (Naples)
5450 YMCA Rd, Naples
FL 34109

YMCA of Collier County (Marco)
101 Sand Hill St
Marco Island, FL 34145

Emilio Sanchez Academy Florida
2035 Sanchez-Casal Way
Naples, FL 34105