Togetherhood Initiative

A Community Health and Well-being Collaborative

CHILD OBESITY REPORT FOR COLLIER COUNTY

Prepared by the Core Health Partners Foundation

2023 PROGRESS REPORT

“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

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FOREWORD

TOGETHERHOOD INITIATIVE IS THE EVOLUTION OF COORDINATION OF CARE FOR COLLIER COUNTY

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 coordination 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: *Paul Thein, Core Health Partners; Chuck Gillespie, National Wellness Institue; Steve Popper, Meals of Hope; Joe Balavage, Help a Diabetic Child*

The Gaps in Our Community
Florida Department of Health in Collier County

The Healthy Collier Coalition

The Community Health Assessment (CHA) represents a summary report that provides a snapshot of Collier County community strength, needs, and priorities, as they relate to population health.

The goals of the CHA are to discover focal points for health improvement, contributing factors that determine health outcomes, and the most effective community assets and resources that can be mobilized to improve population health.

Through this effort, the Florida Department of Health formed the Healthy Collier Coalition as a partnership of community members and groups working in concert to protect, promote, and improve the health of our community. The Healthy Collier Coalition's goal is to develop a community health improvement plan that includes strategies to address and improve the health needs and those issues of priority as identified by the residents and visitors of Collier County.

Ten health categories were ranked over the past three years by the Collier community and the top five issues of priority focus include Mental Health, Access to Care, Chronic Diseases, Health of Older Adults, and Alcohol/Drug Use.

The (Healthy Collier) Community Health Improvement Plan (CHIP) prioritized chronic disease as one of the county's top four health priority areas for 2020-2023.

The chronic diseases workgroup was influenced by local pediatricians who were concerned about the number of overweight and obese children they were seeing in their medical practices. The workgroup formed a pediatric obesity sub-committee and decided to apply a health equity lens to this health issue to inform the current work of Collier County pediatricians and youth serving agencies, while providing insight for planning future interventions.

While this health issue is multifaceted and complex, the evidence suggests that the social determinants of health (SDOH) domain of social and community context is the largest contributor to the inequity because of the compounding effect that multiple policies, social norms, and cultural factors have on this domain.

HEALTHY Collier

A Health Equity and Health Improvement Coalition

Building a Sustainable Model of Care

The Togetherhood Initiative

www.togetherhood.org

The Togetherhood Initiative is a community, well-being collaborative that will utilize findings in the Collier County Community Health Assessment (CHA) as a tool to validate the need for implementing programs and services. The Togetherhood Initiative is a nonprofit partnership network that focuses on collaboration to leverage services and resources to support areas that are underserved. Through sharing expertise, knowledge, and resources, the Togetherhood Initiative will collectively provide benefits that will enable the community to learn the self-management lifestyle strategies needed for long-lasting, positive, and effective changes.

The Togetherhood Initiative concept was developed during discussions at the YMCA's Healthy Living Advisory Committee (HLAC). Often times the dialogue during these meetings centered on the financial constraints and limitations of any one agency to meet the needs in underrepresented areas such as Immokalee and Golden Gate. The concept of creating a new sustainable model of service to potentially address access through a collaborative medical model supported by non-profits and for-profits that assist in producing meaningful health outcomes was developed in 2021. Senior leadership of the National Wellness Institute (NWI) and a participant on the HLAC helped shape the vision for the well-being collaborative effort.

The concept of Togetherhood was formalized in 2021. Their mission includes leveraging assets of partner agencies such as; brick and motor, labor skills, technology, transportation, training, knowledge of care, and data. Through the Togetherhood program, a pathway to new care models of service now becomes possible. By 2022 the IRS recognized the Togetherhood Initiative as a public charity earning the tax-exempt status required for any potential charitable donations.

The Togetherhood Initiative's first area of focus for Collier County includes introducing collaborative programs that focus on: nutrition education and services along with physical exercise; as well as education including providing resources and support programs for those living with or caring for someone who lives with chronic disease. Health screenings, clinical education, medical therapy, physician support, medical wellness classes, supplies, technology and case management are available and enhanced through the partner agencies collaboration. Scholarships are available for those in need.

The motto for the Togetherhood Initiative is "find your pathway to wellness" and by following this pathway the first proof of concept of measurable outcomes are now being realized. Through the leadership of Meals of Hope and funding by the American Recue Act, the Togetherhood Initiative movement was able to secure and renovate the David Lawrence Building in Immokalee as the service hub for their County wide programs. Several other sites including the YMCAs (Marco Island and Naples) and Grace Place for Families and Children in Golden Gate became auxiliary locations for program services. Scheduling for Togetherhood services is managed from the new Immokalee location but services provided at each site may differ depending on community needs. There are seven sites licensed for outreach services across Collier County and this number is expected to grow.

Bringing the Clinic to the Community

www.mycorehealthpartners.com

Core Health Partners (CHP) operates as a Florida licensed Health Care Clinic under the Agency for Health Care Administration (AHCA). CHP has intentionally created a unique community model of service that focuses to meet the needs of those who live with chronic disease or those who may have a need of a health screening or evaluation of a particular ailment such as a developmental delay or Autism. Many of CHP's licensed locations are medical deserts or areas where the underserved population requires navigation to better understand how to receive the care they desperately need to live well.

CHP has earned, and successfully reaffirmed, their licensed status with Florida's division of Health Quality Assurances and the American Diabetes Association. CHP maintains contracts under Medicare and Medicaid and most all commercial insurance payers to offer medical therapy,

autism testing, and clinical education that includes diabetes self-management.

Core Health Partners employs a licensed and credentialed medical staff in the fields of physical and occupational therapy, speech and language therapy, dietary and nutrition therapy, behavioral health, and sports medicine. CHP's unique model of service goes well beyond the traditional medical approach as they chose to intently emerge their clinical model into environments and spaces that offers convenience to a community in need. CHP focuses on initiating support programs that have the ability to advance positive health outcome during and after the patients' traditional clinical care.

Serving the Needs of a Multiple Language Referrals System and Collecting the Data

Core Health Partners Foundation

The Core Health Partners Foundation (CHPF) was established in July of 2021 to help support and manage the clinic to community partnerships and the model of screenings and navigation guiding the person in need to their individualized path of wellness. The oversight includes the health screenings, developmental milestone screenings, testing, evaluation, and managing supportive interns and volunteers.

The Core Health Partners Foundation has created an HIPAA compliant intake processing system that includes a phone operations system with a trilingual auto attendant with a live bilingual support staff. The system of intake is designed for both medical referrals and non-medial programs following a protocol that first attempts to validate insurance coverages before utilizing scholarship funds for those who qualify and are in crisis. This unique intake process has accommodated thousands of patient visits for over 230-referring physicians and is able to schedule to the nearest or desired location in the language of the person in need. The Togetherhood Initiative program location is the newest location of service that uses this process of intake.

The Core Health Partners Foundation also is responsible for collecting the legally required Health Insurance Portability and Accountability (HIPPA) forms and the necessary legal releases that allows the consent to provide the screenings, therapies, and education. Core Health Partners Foundations also collects the data and reports the matriculation measures to the Togetherhood Initiative partners and stakeholder.. Reports are generated quarterly on barriers and success of the health outcomes. This data is reported as key performance indicators (KPIs) and shared with the partners in the effort of wellness and interested community stakeholders. The purpose of sharing the outcomes data is for analysis and adjustments to strategies, if needed, to achieve desired health outcomes. Core Health Partners Foundation mission and scope of work was approved by the IRS as a public charity in July 21st of 2021.

Heredia, Costa Rica: Virtual office bilingual support team schedules the Togetherhood sites. **Picture in back:** Marilyn Porras, SME Subject Matter Expert, William Molina, Senior Team Lead. **Pictured in front:** Francinny Zamora, Patient Benefit Coordinator

The Pathway to Wellness

The Togetherhood Initiative offers solution pathways for our community to learn how to improve their health and wellness. The Togetherhood Initiative pathway programs focus on providing health screenings that directly lead to early intervention, that may include offering the necessary education, therapies, and technology for managing developmental delays, or chronic diseases.

Pathway to wellness programs is often medically integrated with community programs that best support living and managing, sustaining and/or improving the identified condition. Many of the programs offered are hybrid partnerships with area non-profits or education and/or clinical programs held at the non-profit community centers, government centers, churches, early education centers and local parks.. Together, the partner agencies provide the access and support necessary to serve the needs that are intended to keep the participants on track while reporting their touch and data points for purposes of outcomes measure. Togetherhood's goal is simply for agencies to work in tandem so that the resources of the participating entities can be leveraged while sharing in costs. The Togetherhood Initiative's method of collaboration is designed to provide outcome data that advance funding opportunities and the philanthropy needed to sustain the programing and keep access open in areas that would otherwise be unserved.

This report is a dissection of the Togetherhood Initiatives work in the area Child Obesity. The Partners in this area of work are unique and our report is designed to provide measures to help guide the non-profits and other stakeholders focus on the key performances that have the potential to advance the health outcomes, benefit our community, and sustain our efforts.

The Concerns of this Initiative

An Introduction to Child Obesity in America

Childhood obesity is a serious problem in the United States. Obesity prevalence among children and adolescents is too high and as a result many children and adolescents are at risk for poor health.

The Center for Disease Control's (CDC) National Center for Health Statistics (NCHS) data brief (2017-2022) documented the following facts on children and adolescents, aged 2-19 years;

- **The prevalence of obesity nationally was 19.7% and affected about 14.7 million children and adolescents.**
- **Obesity prevalence was 12.7% among 2- to 5-year-olds, 20.7% among 6- to 11-year-olds, and 22.2% among 12- to 19-year-olds. Childhood obesity is also more common among certain populations.**
- **Obesity prevalence was 26.2% among Hispanic children, 24.8% among non-Hispanic Black children, 16.6% among non-Hispanic White children, and 9.0% among non-Hispanic Asian children.**
- **Obesity-related conditions include high blood pressure, high cholesterol, type 2 diabetes, breathing problems such as asthma and sleep apnea, and joint problems.**

Source: CDC National Center for Health Statistics (NCHS) data brief

A Snapshot of Florida Youth

Body Mass Index among Florida's children aged 2 years to less than 5 years

14.8% were overweight
(85th to < 95th percentile BMI-for-Age)

13.4% were obese
(≥ 95th percentile BMI for-Age)

The medical definition of childhood obesity is having a body mass index (BMI) at or above the 95th percentile on the Centers for Disease Control and Prevention's (CDC) specific growth charts. Children's BMI factors differ from adults. For children, BMI is age- and sex-specific because their body compositions vary as they age. They also vary between children assigned male at birth and children assigned female at birth.

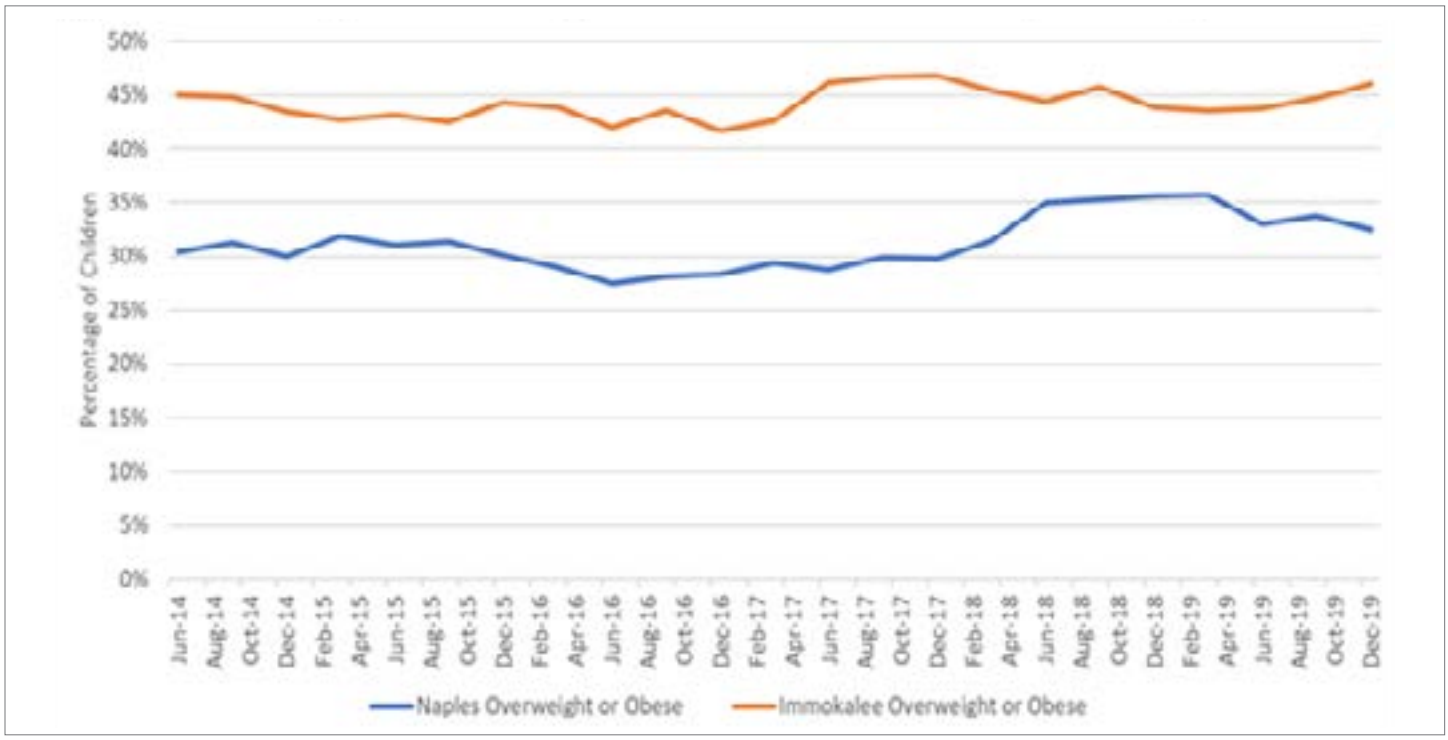
You can calculate your child's BMI by dividing their weight in kilograms by their height in meters squared (kg/m2). For instance, if your 10-year-old child weighs 102 pounds (46.2 kg) and is 56 inches tall (1.4 m), their BMI would be 23.6 kg/m2. This places them in the 95th percentile for BMI-for-age, which means they have obesity.

Sources of Breastfeeding Data: CDC. Division of Nutrition, Physical Activity, and Obesity Breastfeeding Report Card 2011.

How Collier County Children Measure Up

Percentage of Children Ages 2-5 from the Collier County WIC Program Certified as Overweight or Obese

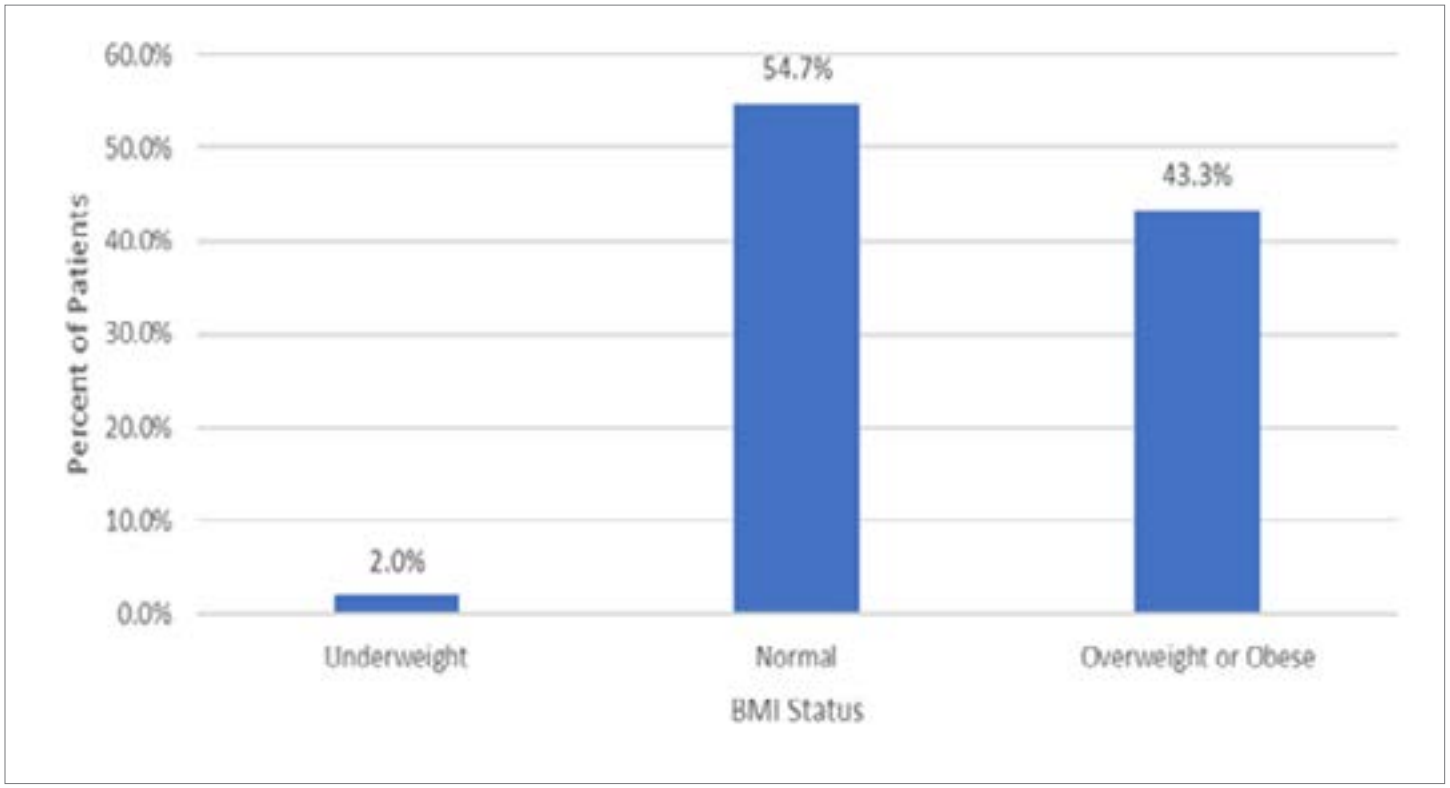
Data from the federally funded Women, Infants, and Children (WIC) program demonstrates children receiving services in the ages 2-5 years old from the Naples site, prove a prevalence of overweight and obesity was notably less than the participating children from Immokalee (See chart below).



BMI Status of Healthcare Network of Southwest Florida Pediatric Patients, 2018-2021

With no other local data readily available, a sub-committee member organizations (Healthcare Network of Southwest Florida) agreed to provide their patient data for analysis. A sample of 43,394 records of anonymous data for patients aged 3-17 from 2018 to 2021 was analyzed by DOH-Collier.

Overall, 15.7% of these patients were classified as overweight (having a BMI between 85% and 95% higher than the average BMI by age) while 27.6% were classified as obese (having a BMI greater than 95% than the average BMI by age), for a combined total of 43.3% being overweight or obese. The chart below shows the comparison of three BMI status classifications in this patient population sample.

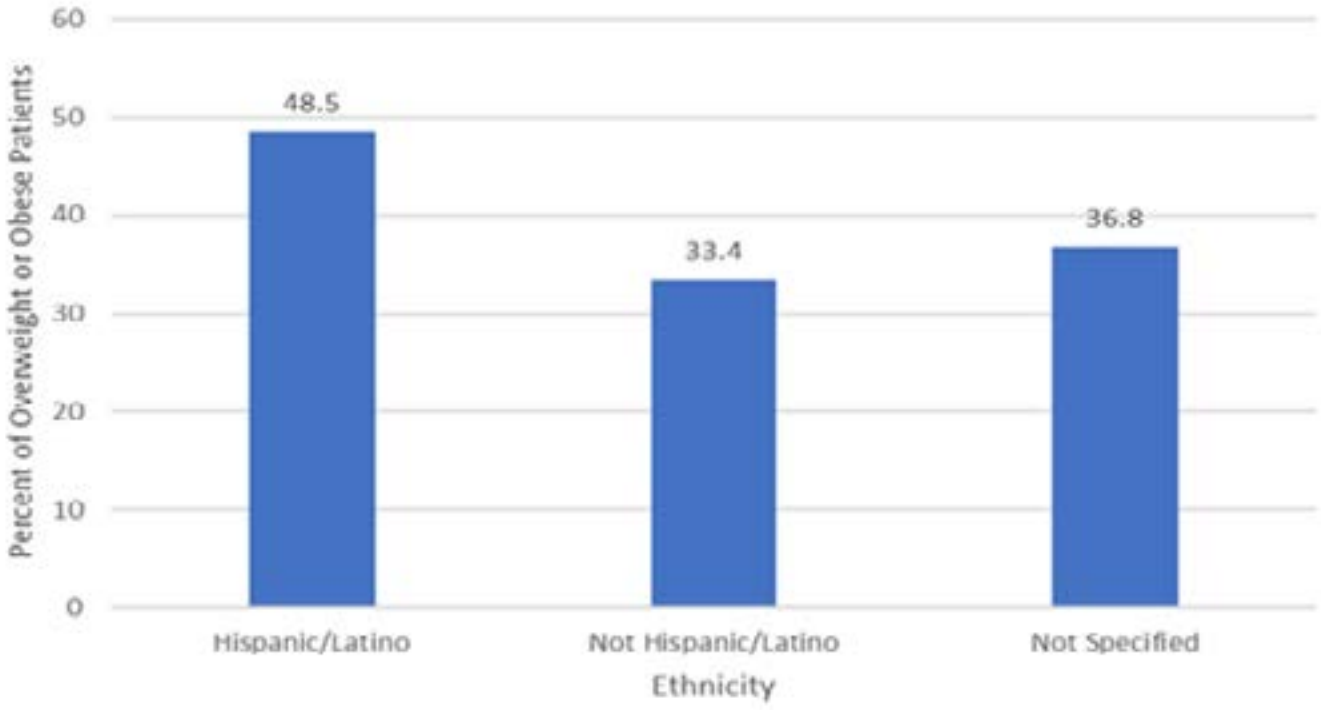


Data Source: Healthcare Network of Southwest Florida. Analysis by Florida Department of Health in Collier County.

Analysis of the data from Healthcare Network of Southwest Florida by several different socio-economic variables demonstrated a consistent pattern with the other two data sources and identified a disparity in Hispanic children, who are significantly more likely to be classified as overweight or obese (48.5%) in comparison to other ethnic groups (~35%).

Percent of Overweight or Obese Healthcare Network of Southwest Florida Pediatric Patients, 2018-2021, by Ethnicity

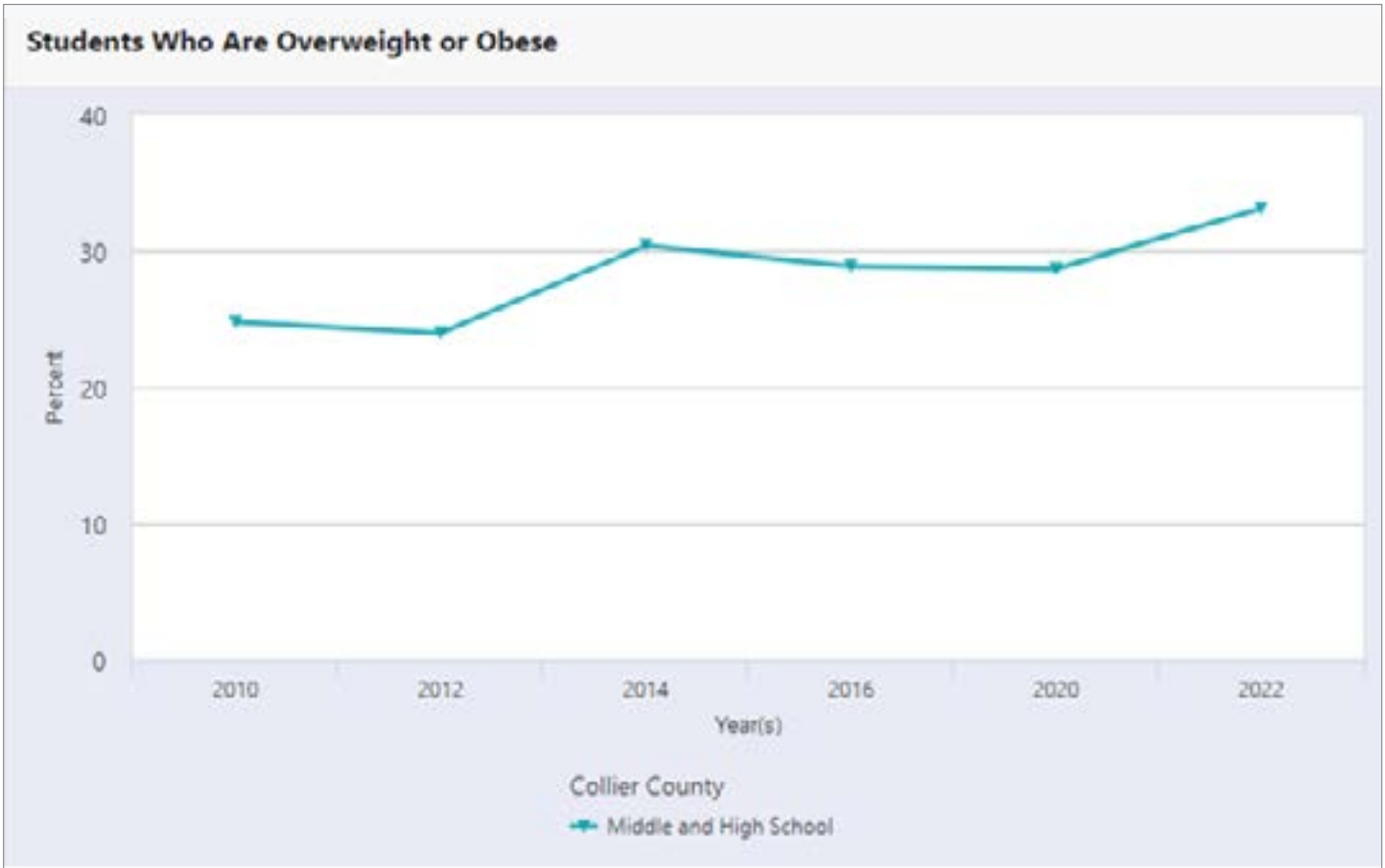
Analysis of the data from Healthcare Network of Southwest Florida by several different socio-economic variables demonstrated a consistent pattern with the other two data sources and identified a disparity in Hispanic children, who are significantly more likely to be classified as overweight or obese (48.5%) in comparison to other ethnic groups (~35%).



Data Source: Healthcare Network of Southwest Florida. Analysis by Florida Department of Health in Collier County.

Collier County Middle and High School Students Who Are Overweight or Obese

In 2022 the State of Florida recorded a state-wide obesity level of 31.7 percent for all Middle and High School students, while Collier County's level for the same population of school children recorded higher level of obesity (33.1 percent) and rising.

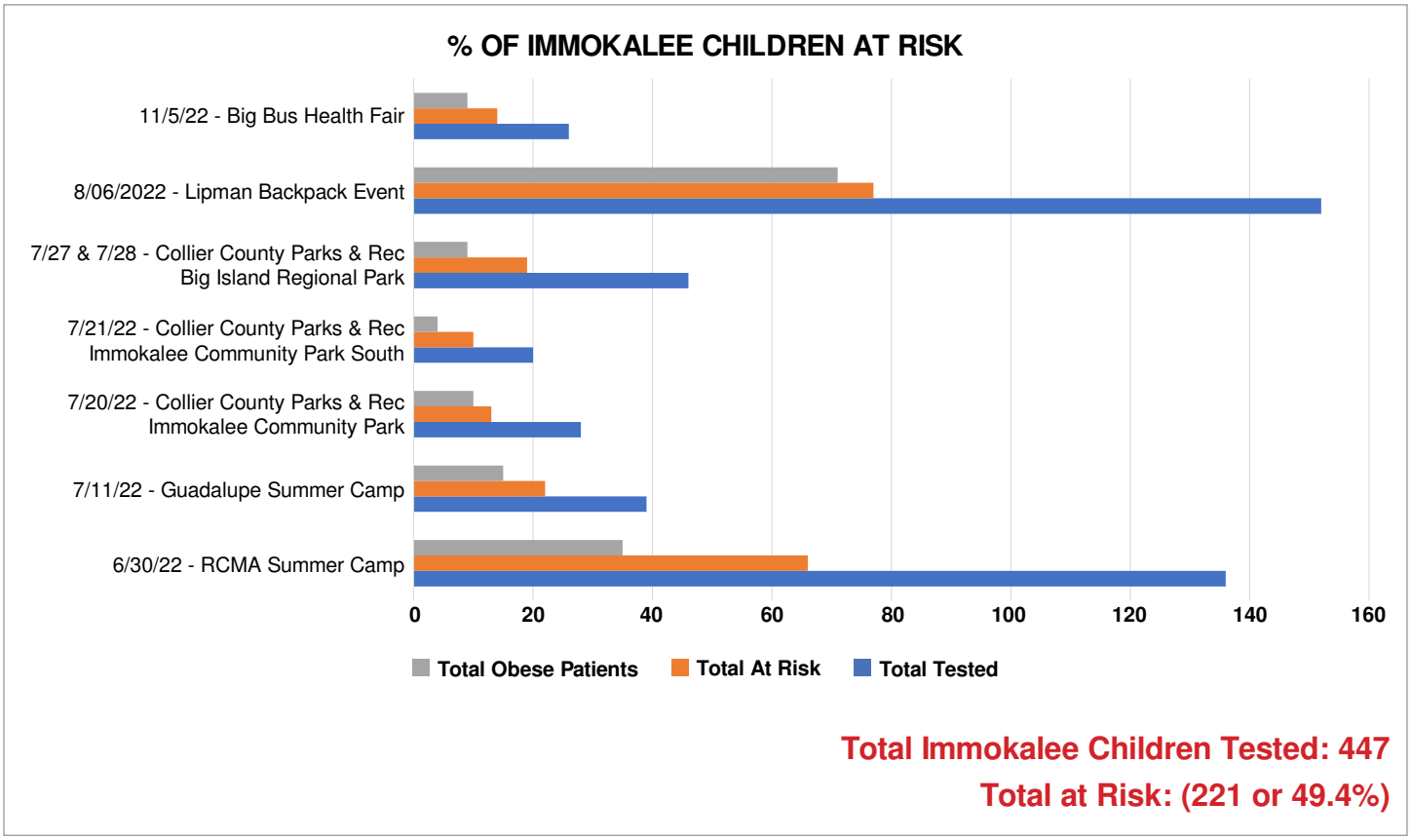


Data Source: Florida Department of Health, Division of Community Health Promotion, Florida Youth Tobacco Survey (FYTS).

Comparing the Body Mass Index (BMI) levels of the Children Living in Immokalee

Over the period of approximately 11-months (April- 202 through March 2023), the University of Florida pediatric staff implemented fitness testing at several Collier County nonprofit childcare centers. The test included recording the Body Mass Index (BMI) of 447-children from the Immokalee area. The BMI data captured determined 49.4% of the children being at a level considered overweight, or obese. The percentage is slightly higher (6.1%) than the 43.3% reported from the larger sample of 43,394 of pediatric records supplied by Healthcare Network. The increase in percentages at risk may be due to the larger percent of Hispanic children living in the Immokalee region, who were likely to be tested, compared to the larger sample size from a cross section of Collier County. Hispanic children are significantly more likely to be classified as overweight or obese (48.5%) in comparison to other ethnic groups (~35%).

Alarming is the fact that both the University of Florida and Healthcare Network's BMI samples for Collier County youth report significantly higher percentages of children at risk then the middle and high school students reported overweight or obese (33.1 percent) by the Florida Department of Health, Division of Community Health Promotion.



Total Immokalee Children Tested: 447

Total at Risk: (221 or 49.4%)

The Importance of Physical Activity in a Child's Formative Years

Regular physical activity is one of the most important things people can do to improve their health.

According to the physical activity guidelines for Americans approximately 80 percent of children in are not meeting their recommended daily physical activity levels. The recommendation for physical activity by the U.S. Department of Health and Human Services, Guidelines for Americans suggests Preschool-aged children (ages 3 through 5 years) should be encouraged to move and engage in active play as well as in structured activities, such as throwing games and bicycle or tricycle riding. These activities strengthen bones. And children this young should do activities that involve hopping, skipping, jumping, and tumbling. The recommendations for school-age children suggest at least 60 minutes of aerobic activity, plus strength training activities each day. Sadly 80 percent of American children are falling short.

The benefits of children meeting the standard have been proven to improve attention and memory, increasing academic performance, while reducing the risk of depression. The recommendations suggest children engage in 30 minutes of aerobic and strengthening activates at school and an additional 30 minutes outside of school hours.

Maintaining this pattern of activity maintains normal blood sugar levels, improves blood pressure, strengthens bones while regulating body weighty, reducing fat and lowering the risk of chronic diseases including type two diabetes. Childhood adiposity is a risk factor not only for adult-onset diabetes primarily characterized by obesity or insulin resistance, but also for subtypes primarily characterized by insulin deficiency or autoimmunity.

Source: 1 U.S. Department of Health and Human Services, Physical Activity Guidelines for Americans, 2 edition

2 Childhood adiposity and novel subtypes of adult-onset diabetes: a Mendelian randomization and genome-wide genetic correlation study, Received: 18 October 2022 / Accepted: 24 January 2023

A Collaberative Approach to Medical Nutrtion Therapy

Connecting the clinical services to the community is as key factor and reaching the child and family in manner they can relate and understand becomes increasingly important. Best practice in effective nutrition program plans will include Family-based counseling that is inclusive of parent training or modeling. Coordination of Care becomes a key factor to the success of the nutrition therapy plan. The dietitian should collaborate with members of the health-care system, including the peditirican and the teachers and caregivers that surround the child for hours each day. Engaging this type of support assists planning and implementing behavior, physical activity and adjunct therapy strategies. Effective multi-component pediatric weight management interventions benefit from the diverse expertise of different health-care and care providing professionals.

Children require a certain amount of calories for growth and development. However, when they take in more calories than they use, their body stores the extra calories as fat. Excessive sugar intake by soft drink, increased portion size, and steady decline in physical activity have been playing major roles in the rising rates of obesity all around the world. Consequently, both over-consumption of calories and reduced physical activity are involved in childhood obesity.

The eating habits your child picks up when they're young will help them maintain a healthy lifestyle when they're adults. Interventions to reduce pediatric obesity should be multi-component and include diet, physical activity, nutrition counseling and parent or caregiver participation. Multi-component weight-management programs are more successful than single component programs for short-term and longer-term (more than one year) improvement in child and adolescent obesity. A nutrition prescription should be formulated as part of the dietary intervention in a multi-component pediatric weight-management program. The exact specification of nutrients and energy is often translated into a specific eating plan.

Nutrition counseling, delivered by an RD (which is inclusive of goal-setting, self-monitoring, stimulus control, problem-solving, contingency management, cognitive restructuring, use of incentives and rewards and social supports), should be a part of the behavior therapy component of a multi-component pediatric weight-management program.

Where your child lives also a direct effect on their risk of developing obesity. The foods and drinks that schools and daycare centers serve your child have a direct effect on their diet. They also contribute to the amount of physical activity your child gets every day. Other socioeconomic factors that contribute to childhood obesity include:

- The cost and accessibility of healthy food options.
- Your network or social support system.
- Limited access to recreational facilities or parks in your community, or other safe places to be active.

Importance of Early Identification and Intervention (Screenings/ Well Visit Referrals) and Nutrition (MNT)

Partner Agencies in Phase 1 of the Togetherhood Child Obesity Pathway

The pathway leads children and families in need to a community-based prevention programs that delivers evidence-based prevention services to at-risk infants, toddlers, and school-aged children.

Naples Children and Education Foundation (NCEF)

NCEF's unique approach, which emphasizes collaboration between organizations and bridges public and private resources, has become a blueprint for how to transform a community, one issue at a time.

Grant funding by NCEF facilitated UF Health bring telemedicine program for obese and diabetic children to underserved area of Collier County.

The University of Florida

UF Health Metabolic & Obesity Clinic is addressing complications of excess weight and obesity in high-risk populations. UF leads by offering multidisciplinary team that combines provider resources, comprehensive metabolic screening, physical fitness assessments and innovative use of cutting-edge pharmacotherapy

Meals of Hope

Offers access to nutritious food, including prepackaged meals that meet the nutritional standards and correct proportioned size. The food offered by Meals of Hope is used in the medical nutrition therapy program by the registered licensed dietitians. Serves as the Immokalee Together Initiative Center tenant and liaison with the landlord David Lawrence Behavioral Health.

Core Health Partners

Operates the HIPAA compliant intake process system that facilitates the dissemination of information in multiple languages and processes scholarships, bridges the person in need to their best path to wellness through answering question in their native language and, if needed, schedules and appointment with a medical provider.

Core Health Partners also serves as a clinical provider for medical nutrition therapy, meeting with the child and or family to discuss nutritional health. Documentation notes from the clinical sessions are copied and delivered, through the HIPAA compliant electronic health records system, to the referring pediatric providers for meaningful follow up at the child's ongoing well visits. Matriculation and health outcomes records are kept on file for reporting purposes.

University of Florida Dental

Provides oral hygiene services and sealants to children in need.

Area Pediatricians

Refer children in need of child obesity support and services to the program.

Help A Diabetic Child (HADC)

HADC Purchases diabetes medical supplies, insulin and services which include endocrinology, mental health, and educational visits to underserved, uninsured, and underinsured children and young adults who live with diabetes and cannot afford these life saving services and care.

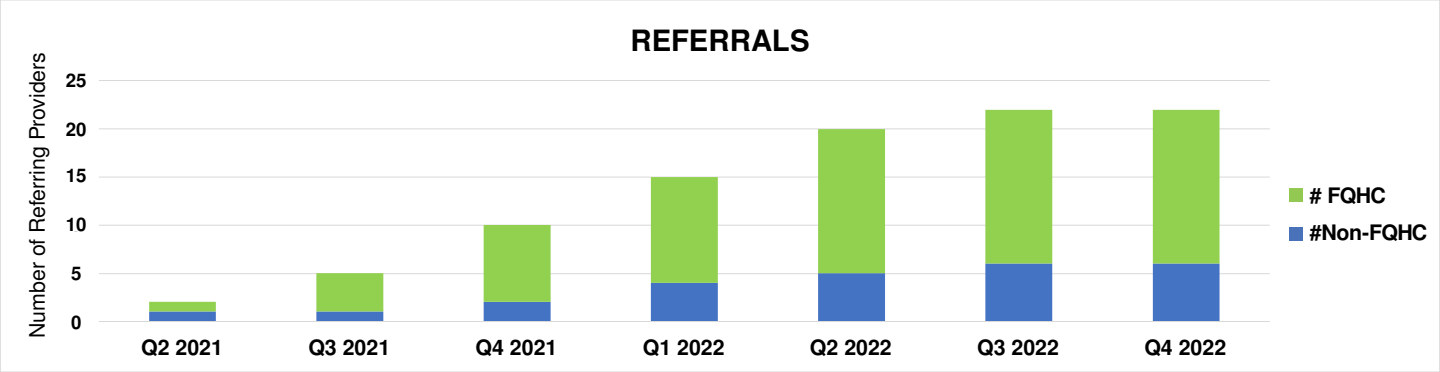
Bikes for Tykes

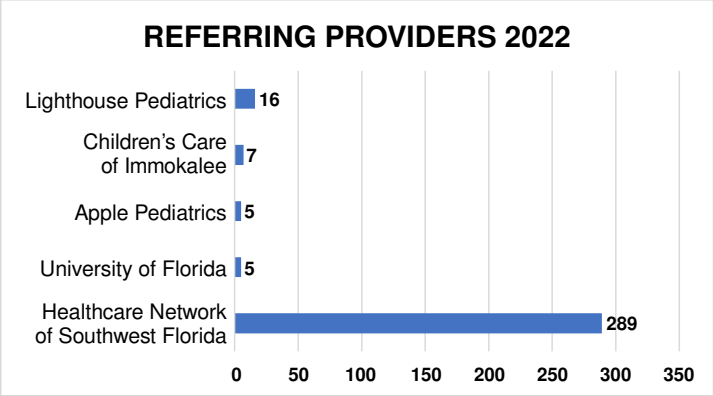
Offers a bicycle as a motivation tool to those children referred to the child obesity program that follow the program plan assigned.

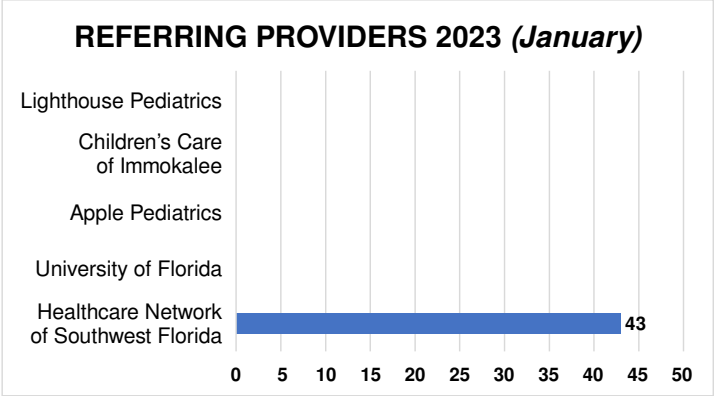
Healthcare Network of Southwest Florida

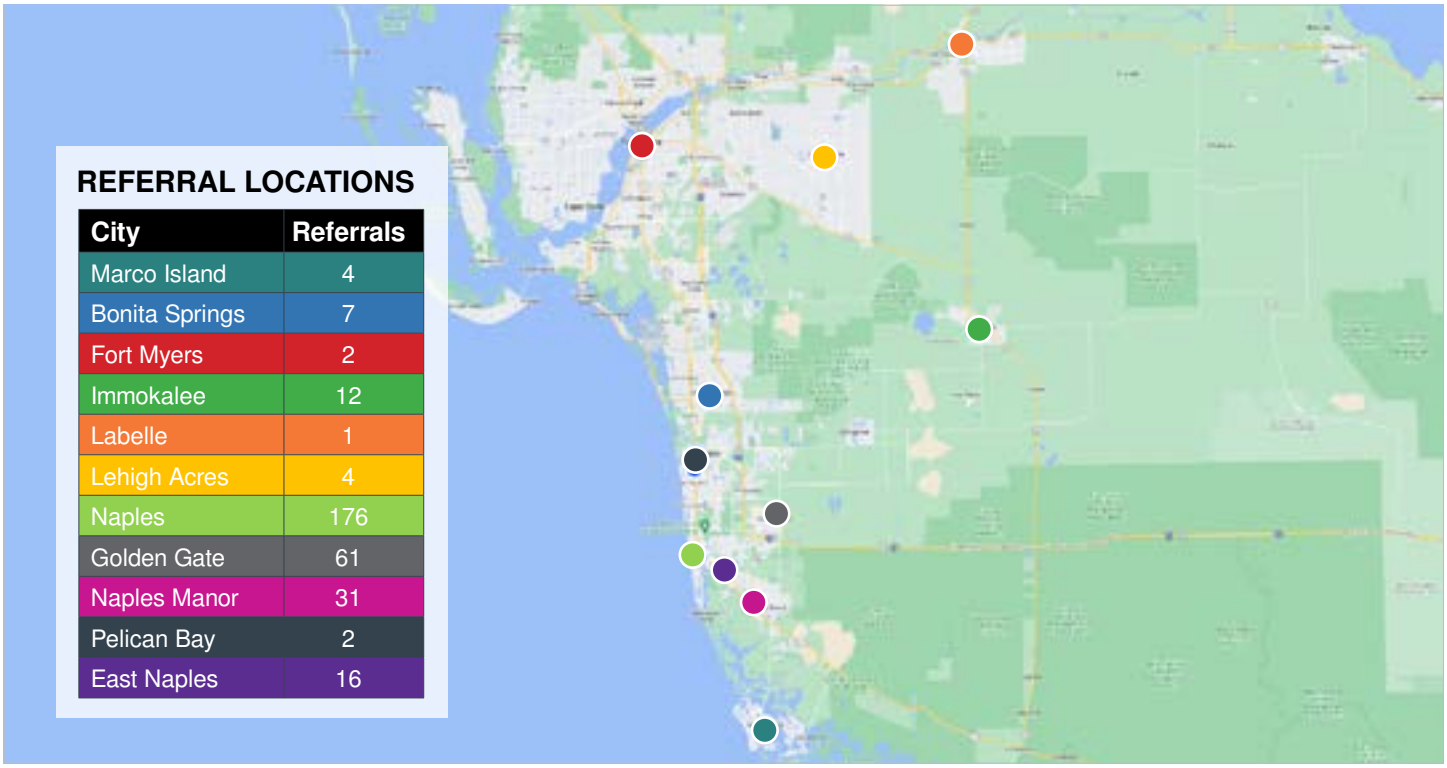
Healthcare Network of Southwest Florida is a leader in prevention and education and is a champion for the child obesity prevention movement for Collier County and Dr. Salvatore Anzalone, the medical director of pediatrics is helping shape the Child Obesity model.

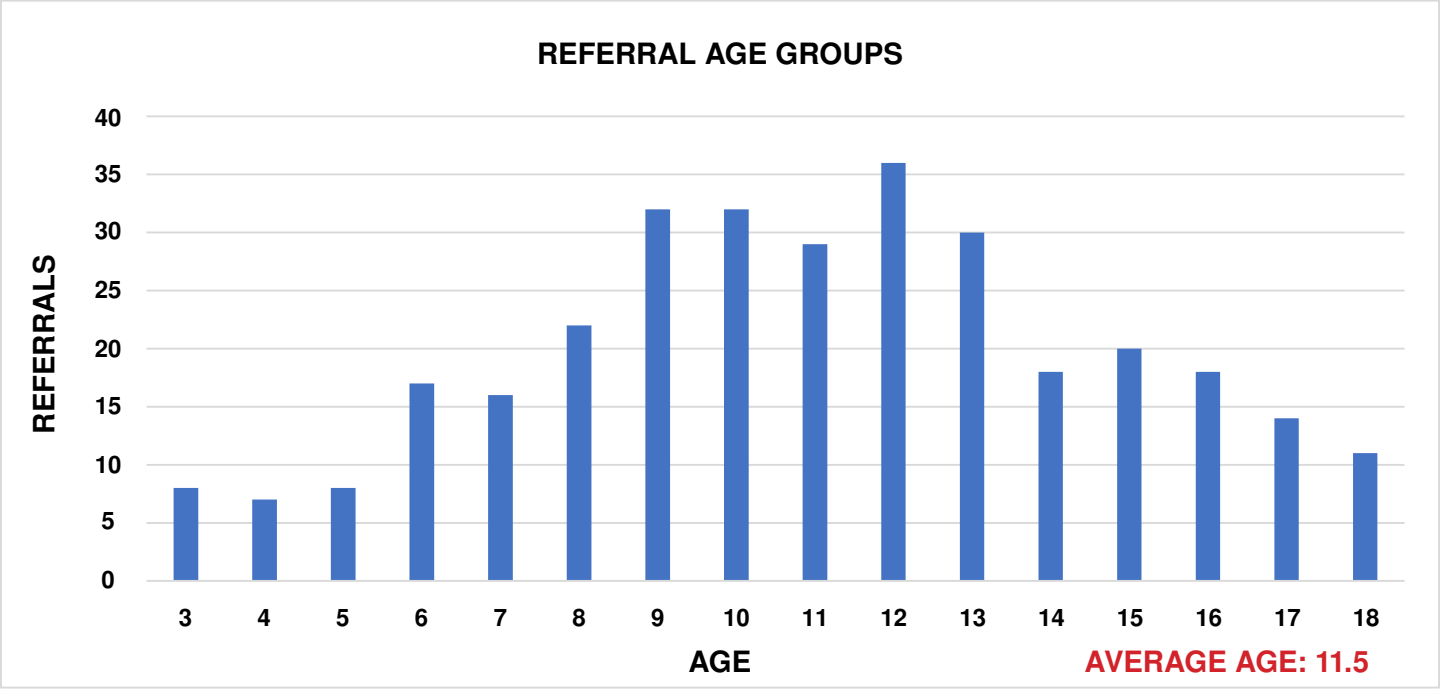
Who is Referring to the Child Obesity Program



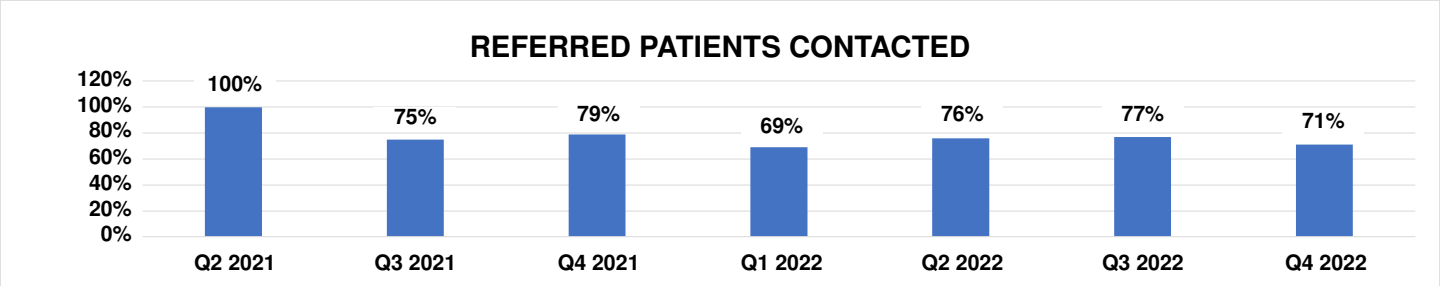






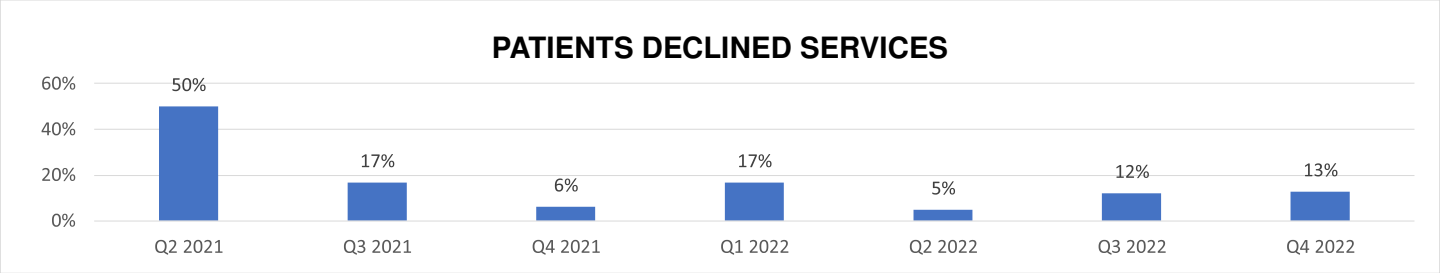


What Happens with the Referred Patient?



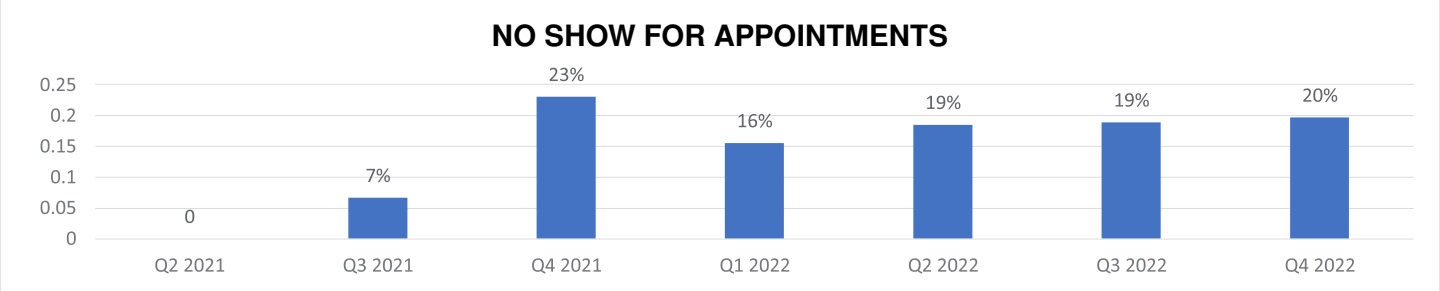
Unable to Reach the Patient

Multiple attempts (four) to reach the custodial guardian of the referred patient before the bilingual intake team passes the referred patient and scheduling responsibility on to a local case manager. The intake team passes responsibility on patient scheduling only after they attempt to reach the family in multiple ways, phone, texts and email. Once a total of four attempts are made without success the responsibility is passed from the intake team back to the Togetherhood Initiative partners who now have the responsibility. This needs to be an area of focus as some case management and follow up should continue to take place.



Patient Chose to Decline the Scholarship and Appointment

More information needs to be provided, in the native language, to the referred family explaining the child obesity program services, specifically explaining why this program is important. The evidence shows that the Togetherhood Initiative's intake and scheduling team is successful on reaching the vast majority of the families, yet many are self-selecting declining the scholarship. More education is needed to educate these families and it should be noted that the scheduling technology system allows informational emails and text to be sent explaining the program benefits. It is thought that many parents may selects to decline simply because they do not fully understand the future health risks obesity has on the their child's quality of life. Information could also be delivered explaining Tele-Health options and/or home visits. These are all available in Spanish and English.



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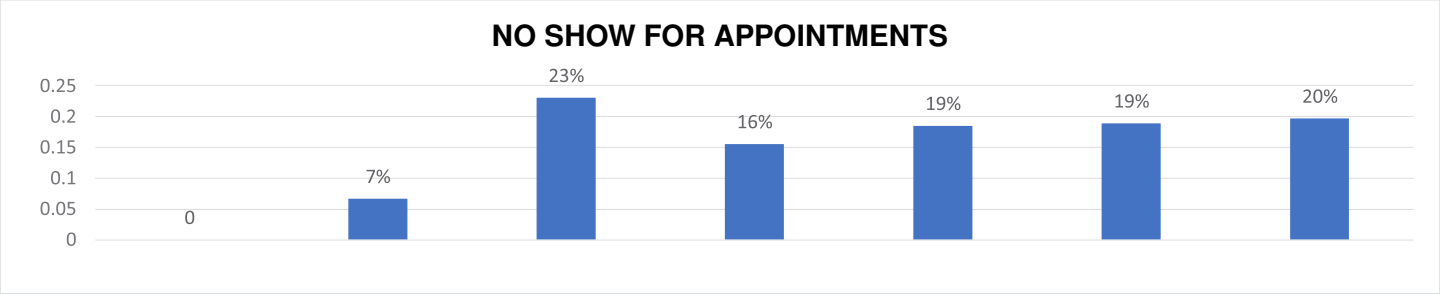

What Percent Agreed to the Appointment but did not Show?

The flow vertical chart (below) represents the automated bilingual communication that is sent to the referred patient once they agree to schedule their medical nutrition therapy (MNT) appointment. The icons on the left and right of the vertical line represents the multiple methods of communication (i.e., email, phone, or text) that are sent prior to the patients as reminders after they agree to a scheduled visit. Even though these communications are sent in the patients' native language (English and Spanish) as helpful reminders, yet approximately 20 percent of these children in need don't show for their appointment. The patients that miss these sessions remain as patients in progress and are reported by name and date to the Togetherhood partner agencies and to each of the referring physicians through the clinical note. There is a need to focus on these cases and continue to educate the family on the importance of attending the nutrition therapy sessions, MNT.

Data Contributor: Garrett Barr - *Garrett Barr is a student in his senior year at Florida Gulf Coast University Daveler & Kauanui School of Entrepreneurship, where he is preparing to graduate with a Bachelor of Science In Entreprenurial Studies and a focus in Communicative Studies as areas of expertise. Garrett has multiple years of experience in the Health Care Industry, and is currently serving as an administrative assistant for Core Health Partners and as a Laison for the Togetherhood Initiative.*

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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Key Community Committees

Collier County CHIP

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Department of Health, Collier

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Healthcare Network of Southwest Florida

Joe Balavage, President
Diabetes Alliance Network

Tami Balavage, President
Help a Diabetic Child

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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
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Naples Community Hospital

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Collier County Medical Society

John Drew, Organizational Planning & Development Program Consultant
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National Wellness Institute

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Immokalee, FL 34142

Bloom Day School
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Naples, FL 34110

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

YMCA of Collier County (Naples)
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FL 34109

YMCA of Collier County (Marco)
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