



COMMUNITY HEALTH IMPROVEMENT

2022-2024 Programs Update

COMMUNITY HEALTH IMPROVEMENT OVERVIEW

At UCHealth, our mission is to improve lives. Our community health improvement team in northern Colorado has been improving lives for more than 30 years. Community Health Improvement programs are client- or community-centered and results-driven through use of scientifically supported methods and best practices in service delivery.

Prioritizing our work.

From birth through the later years, UCHealth in northern Colorado offers programs that promote health, prevent illness and address social determinants of health through serving the community's most vulnerable populations.

Social determinants of health are conditions within the environment where people are born, live, learn, work, play, worship and age that affect a wide range of health, functional and quality-of-life outcomes and risks. We recognize and address these conditions by:

- Offering programs and services to low-income individuals at no or reduced cost.
- Minimizing transportation barriers by offering services on-site in schools, neighborhoods, homes and places of worship.
- Connecting underserved clients directly to community services, allowing them improved access to food, clothing, housing, childcare services and transportation.

Partnering with other agencies and organizations, we provide equitable access to high-quality care, decreasing the burden of disease and addressing the priority issues identified in our most recent community health needs assessment. Our partners provide input which helps us prioritize community health needs outside our hospital walls. With their input and the support of our leaders and Boards of Directors, we will focus on the following identified health issues from 2023-2025:

- Behavioral health services including substance-use disorders and suicide prevention
- Access to care
- Chronic conditions

We address these community health needs through the work of our care coordination and community health education/prevention teams.



CARE COORDINATION AND SERVICES IMPACTING SOCIAL DETERMINANTS OF HEALTH

There are three care coordination programs in Community Health Improvement: Medicaid Accountable Care Collaborative, Healthy Harbors and the Postpartum Nurse Home Visit program.

Medicaid Accountable Care Collaborative (MACC) program and Healthy Harbors:

These programs provide intensive, community-based care coordination, case management and supportive services to Medicaid patients and families. Program clients have complex medical and/or behavioral health care needs, often with significant community resource needs, poorly controlled chronic conditions, multisystem involvement and multiple providers or agencies involved in supporting client care and social needs. MACC is adult/family focused while Healthy Harbors supports children under the age of 18.

The overarching goals are to:

- Improve health outcomes.
- Improve client/member and provider experience.
- Improve access to care in the appropriate setting and reduce barriers to care.
- Reduce potentially avoidable, preventable and duplicative costs.

The MACC program launched in 2011 with four full-time staff and has grown to include 20 interdisciplinary staff members, including nurses, licensed behavioral health specialists, case managers, care coordinators and administrative support.

MACC stakeholders include:

Associates in Family Medicine, Health District of Northern Larimer County, Rocky Mountain Health Plans, Salud Family Health Centers, SummitStone Health Partners, UCHealth Community Health Improvement and UCHealth Family Medicine Center.

MACC and Healthy Harbors impact statistics:

2,500 direct referrals received from 2020 to present. Referrals come from Poudre Valley Hospital, clinics, providers and community partners.

3,675 direct referrals to MACC and Healthy Harbors from 2015-2019.

2,550 clients/families with complex care and significant resource needs served since 2015.

250 cases were closed in 2021 with **56.4%** considered stable with goals met.

MACC/HH program outcomes per 3rd party (Tri-West) program evaluation, published in 2019:

- Estimated **\$4,950** savings per patient.
- Estimated **2,675** emergency department visits avoided.
- Estimated **610** inpatient stays avoided.
- **\$6.9M** estimated reduced total cost of care.

TESTIMONIALS

BF* has tearfully stated how thankful she is to have someone to help her navigate the challenges of getting older. She has stated she is not sure what she would do if she did not have MACC's help. BF continues to be a pleasure to work with and I am so happy we can be of service to her.

–Natalie Mirabile, Case Aide, MACC and Healthy Harbors Programs

This was the first Christmas in several years that JM* did not spend alone. He will have direct support moving forward to establish care with a new medical provider, see a dentist and experience the love and support of close family members. When he is stable enough, he can eventually move toward independent housing with a chance of significant improvement in his quality of life. The impact that this program has had with this client is life-changing and lifelong.

–Brian Adams, BSW, MACC Case Manager

When I first met DP*, I would describe him as paranoid, negative, self-focused, stuck and resistant to how community agencies could support him and make a difference in his life. The last time I spoke with him, I would describe our conversation as delightful. He was thoughtful, positive and hopeful for his future. Supports are lining up for him and his future is bright! I have worked with several MACC case managers over the past few years and they have all been wonderful! They assist people/families with critical needs and help navigate other services and systems, simplifying complicated processes and advocating in situations where other services have gaps. Their collaboration and input is invaluable!

–Rachel Souders, Intake/Waiting List Case Manager with Foothills Gateway, Inc.

I just wanted to let you know that I finally got into my own apartment! I was approved for a housing voucher and surprisingly was approved at the Villages Apartments. I moved in on Friday with just my bed, clothes and TV, lol, but I'll get there slowly...anyway, I just wanted to thank you so, so very much from the bottom of my heart for all your help and caring and compassion. I wouldn't have gotten through those few horrible months without your help! You're an amazing woman and it's clear you truly love your job and helping people. There needs to be more people like you in this world! Thank you for EVERYTHING!!!

–JH*, former MACC client

*Initials are given to protect patient privacy.





Postpartum Nurse Home Visit program:

Community health nurses visit newborns and families covered by Medicaid in their home environment or in one of CHI's office/clinic sites. These visits give the nurses an opportunity to assess the newborn, provide lactation support and communicate with the primary care provider. If ongoing complex care needs are anticipated, these nurses refer newborns and their families to MACC, Healthy Harbors or other community programs for ongoing support.

Postpartum Nurse Home Visit program impact statistics:

221 moms and **224** infants seen.

Affiliate partners:

Associates in Family Medicine, Larimer County Department of Health, Salud Family Health Centers, UCHealth Family Medicine Center and UCHealth Medical Group.

TESTIMONIAL

Recently I went to a postpartum nurse home visit with a mom and newborn. Mom explained that she was pumping and cup feeding because she could not get baby to latch. After a feeding evaluation, I educated the mom on the use of a nipple shield and explained why pumping would be beneficial. We decided to schedule a second follow-up visit. When I returned five days later, mom had baby latched and was feeding her without the nipple shield. Mom was so relaxed and happy. It was great to see such progress on feedings and the confidence the mom had gained in just a few days.

–Julie Knighton, RN

COMMUNITY HEALTH EDUCATION/PREVENTION

Community health education programs have been positively impacting our community for more than 30 years, serving people at every age and stage of life.

Aspen Club/senior services:

This program provides health education, prevention and healthy aging programs/services for adults age 50 and forward. Program offerings include:

- **Advance care planning:** Guidance for completion of advance directives for health care decisions.
- **Education and prevention:**
 - Aging Mastery Program: Celebrating the gift of longevity and encouraging mastery of behaviors that lead to improved health.
 - Am I Hungry? mindful eating program: Learning to eat with the intention to care for oneself.
 - Chronic disease self-management: Identifying health risks and steps to successful self-management of a chronic health condition or issue.
 - EnhanceWellness coaching: Connecting participants with a personal health and wellness coach to improve physical, emotional and social well-being.
 - Fall prevention workshops: Reducing fall risk factors through awareness and improved strength.
 - Health screenings: Providing medication and supplement reviews, balance screenings, blood pressure checks and hearing screenings.
 - Powerful Tools for Caregivers: Providing caregivers the tools to increase self-care and confidence to handle difficult situations and emotions while caring for a family member or friend.
 - Wellness education: Providing a variety of programs focused on improving health and well-being.
- **Medicare counseling:** In partnership with the State Health Insurance Assistance Program (SHIP), we offer free and unbiased insurance counseling and assistance to Medicare-eligible individuals, their families and caregivers. Our services often result in our members saving thousands of dollars by aligning them with the plan that best fits their lives.

Aspen Club impact statistics (FY 2022):

6,021 participants in Aspen Club programs, services and events.

453 new members added in the last fiscal year.

1,321 participants received Medicare counseling, education and outreach.

\$560,966 in estimated Medicare savings during the Medicare Part D enrollment period.

301 participants in evidence-based classes including, Stepping On, Balance Screening, CarFit, EnhanceWellness, Chronic Disease Self-Management and Let's Get Moving.

100% of participants in three fall-prevention classes indicated a reduction in fear of falling.

467 participants in advance care planning.

373 participants taking advantage of Aspen Club health screenings.

100% of Aging Mastery Program participants would recommend this education to a friend in need.

47% of participants in medication/supplement reviews were advised to follow up with their physician to discuss reducing their pill burden. Of those who participated, **38%** were found to be taking medications potentially inappropriate for older adults and participants were recommended to stop a total of 48 supplements (e.g. duplications, excessive quantities, perceived harm or lack of documented benefit).

\$190,091 in community benefit (programs or activities that promote health in response to community needs) were contributed by Aspen Club/senior services.



TESTIMONIALS

The Aspen Club patient passport information is critical to have readily available in situations such as calling 911 for a loved one. In a stressful situation, it is so helpful to have the necessary information for the paramedics so they can do their job efficiently and professionally.

Alan, thank you for the amazing life-changing service you provide—educating, informing, guiding me and so many to understand the complexities of Medicare to ensure loved ones make informed, wise choices. Thank you, thank you, thank you for taking time to meet with me. You are definitely an answer to prayer.

I'm at a loss for how full my heart feels. Thank you so much for your kindness, expertise and patience. I have been up at night worrying about this and you have brought me peace.

I appreciate you so much. This is the second time your service has helped me with a complicated situation. I feel a lot more relaxed now that we've spoken.

You have taken my stress level from about 110 down to 4. This will allow me to sleep tonight.

Alan's explanation was clear and easy to understand. He is obviously extremely knowledgeable about Medicare and was so easy to talk with. What a gem! So often nowadays we feel like we are talking with a computer. The experience with Alan is the opposite—he is so genuinely human and a call that I was dreading actually turned out to be enjoyable. I never thought I would say that about a call about Medicare!

Chronic disease self-management education programs:

Chronic disease self-management classes are designed to empower participants in living their best and healthiest lives.

Am I Hungry? mindful eating program:

This eight-week workshop focuses on learning to eat with the intention of caring for oneself with the attention necessary for noticing and enjoying food and how it affects your body.

Am I Hungry? impact statistics:

Of those who completed the feedback form (five of nine), participants reported:

100% would recommend program to a friend.

100% agree facilitator was knowledgeable.

100% agree facilitator was supportive and helpful.

100% reported feeling more in charge of eating behaviors as result of taking the class.

100% learned information and tools needed to change behavior.

TESTIMONIALS

I enjoyed listening to others in the group. It helped keep me from feeling so alone with my struggles with food. It was very powerful to me because I felt supported. The facilitator was phenomenal. The class wasn't about what you can or can't eat but learning that you have choices and tools to make the best decisions for you.

—Amanda N.

The Am I Hungry? class has helped me shift my thinking and awareness from eating because it's necessary to support my body's functions to a much greater appreciation for foods and what my hunger/fullness levels are—to name only a few concepts taught in the class. My mindfulness of how I appreciate and experience eating is gradually extending to other parts of my life in daily routines and encounters with the world around me. My life is and will continue to be tremendously enriched for having participated.

—Barbara S.

The emphasis on no shame over our eating choices was very helpful, and the instructor embodied this beautifully in her demeanor and personal examples. I liked the opportunities to check in with the other participants each week. Not all about successes, but some about important learnings from our failures.

—Peter K.



Mind Over Matter: Healthy Bowels, Healthy Bladder (MOM):

This evidence-based incontinence class teaches self-efficacy, nutrition and hydration information as well as pelvic floor exercises designed to empower women over the age of 50 and improve their quality of life.

Mind Over Matter impact statistics:

Of those who completed the feedback form (16 of 30), participants reported:

100% said the class felt comfortable, private and conducive to learning.

100% said their voice was welcomed and respected in MOM sessions.

100% said Mind Over Matter sessions were well-organized and ran smoothly.

100% would recommend MOM to other women.

TESTIMONIALS

Excellent class—I learned a lot and am working on exercises daily.

Thanks again for the class. I really like how sensitive topics were addressed so matter-of-factly so no one needed to feel awkward or embarrassed.

Your class was life-changing.

Personally, one of the best classes I have ever taken.

Almost all women could use this information.





Community support:

Community Partnership with Housing Catalyst:

Our community health educators have created a unique partnership with Housing Catalyst residents, people who have historically experienced chronic homelessness and are now participating in Permanent Supportive Housing. Our team of educators delivers healthy food from the Food Bank of Larimer County, provides nutrition and mindfulness education as well as blood pressure checks. They also connect residents with other resources to help manage chronic illnesses. Residents have access to free acupuncture through this partnership.

Housing Catalyst impact statistics:

7,120 pounds of food have been delivered—the equivalent of **5,934** meals.

TESTIMONIALS

You all have no idea how much this helps me and how much I appreciate this food and what you are doing.

This program is amazing.

Can't thank you enough for taking the time to bring this food over.

This makes my day every week!

I love the fruits and vegetables you bring.

I look forward to this every week.



Family Medicine Center (FMC) Food Pantry:

The food pantry at FMC provides access to high-quality foods for community members in need.

FMC Food Pantry impact statistics (FY 2022):

11,472 total visits.

2,101 unique households served.

6,124 unique individuals served.

1,410 unique individuals served per month (average).

Total distributed food: More than **300,000** pounds.

41.6% of distributed food was fresh produce.

More than **21,000** diapers distributed.

TESTIMONIALS

It is the best place to come for fruits and veggies, especially low-sugar or gluten-free foods. It helps save me financially.

It not only helps with food, but with stress on how or what to feed my kids.

I feel healthier and I like the kindness with which they serve.

Community education:

Healthy Hearts and Minds:

For more than 30 years, Healthy Hearts and Healthy Kids Club have been serving our communities. Now combined into one team, UCHealth Healthy Hearts and Minds will continue to serve, inspire and empower people to live extraordinary lives.

Since 1992:

60,000 students received a free biometric screening. **90,000** students received heart-health education.

Healthy Hearts and Minds' curriculum is designed to save lives and prevent cardiovascular and other chronic diseases using education, connection and lifestyle modification through a variety of school and community based programs.

School-based health education:

Fun and interactive sessions are delivered in school classrooms and include the latest information on physical activity, mental well-being, nutrition, smoking/vaping, signs and symptoms of heart attack and stroke, lifesaving hands-only CPR and AED use.

Healthy Hearts and Minds School Program impact statistics (FY 2022):

12 school districts.

120 schools.

537 classrooms.

6,000+ learn hands-only CPR and how to use an AED.

12,254 students educated.

School-based biometric screenings:

6,415 students received a free biometric screening. Allowing students to learn their own screening results, such as lipids, blood pressure and BMI, can empower them to make better health choices or sustain their current positive habits. These biometric screenings allow a student one-on-one time with a UCHealth health professional to ask questions about their screening results and health habits. This team is then able to provide follow-up or referral for any abnormal results or mental health needs to the Healthy Hearts and Minds Family Program, a primary care provider or local resources.

Healthy Hearts and Minds Family Program:

Entire families participate in an innovative, one-year lifestyle intervention program with the goal of preventing cardiovascular and other chronic diseases. Each person receives access to nutrition and exercise information, mental health resources and nurse consultations.

Healthy Hearts and Minds Family Program impact statistics:

1 Fitbit Health Equity Study to increase the voice of the Hispanic community in research.

121 participants.

39 families.

BStrongBFit:

216 4th-6th grade girls participate in an eight-week program designed to promote health and wellness through running with an emphasis on self-esteem.

Healthy Kids 5210+ Challenge:

16,492 individuals from 3,500 families participated in the 5210+ Challenge which provides education around 5210+ health habits: 5 fruits/vegetables each day, 2 hours or less screen time, 1 hour of physical activity, 0 sugary drinks + good sleep. Students, their families and staff keep track of their health habits and win T-shirts and wellness dollars for their schools.

Healthy Kids Run Series:

1,940 registered participants have the opportunity of attending in-person 1-mile fun runs or doing 1-mile courses on their own. This summer run series is designed to motivate families to get outside and be active together.

Healthy Kids Summer Challenge:

2,831 individuals from 723 families accepted the challenge to be more active, improve their mental health and practice 5210+ health habits during summer months.

TESTIMONIALS

One thing I am very glad I learned is the number 988 to call if you need help.

–Lopez Elementary School student

I learned that exercise can also improve memory and control stress.

–Rice Elementary School student

Thanks for making the world a healthier place!!

–Weld County student

I learned a lot from the health screening and actually seeing the numbers in front of me and having someone explain it. Thank you to those of you who helped us learn more about our health.

–University High School student

Me encanto la manera de hacer que los niños se motiven a comer verduras y hacer ejercicio y mirar menos television. Gracias.

–St. Vrain School District parent

This has been a huge incentive for staff to help make better choices and focus more on their mental health.

–Milliken Middle School teacher

Thanks for this fun 5210+ challenge!! My goal was to prioritize sleep which was great to focus on. It helped me be a better teacher for my students.

–Thompson School District staff member

I love the local initiatives you do to keep our community healthy!

–Weld District 6 staff member



Stroke Education/Prevention program:

The UCHealth Northern Region Stroke Program strives to reduce the incidence, disability and mortality associated with stroke through prevention, recognition and timely treatment.

Stroke Education/Prevention program impact statistics (FY 2022):

Stroke support group:

191 people reached through the monthly stroke survivor and caregiver support group (which is open to any prior stroke patients and their family/caregivers). Patients are provided information about the support group during their hospitalization. The community has access to the support group sessions through Aspen Club, Fort Collins Recreator and the American Heart Association.

Stroke Survivor to Survivor (SS2S):

59 participants. We are one of only about 50 facilities that have partnered with American Heart Association to provide this outreach service to stroke patients. Volunteer stroke survivors call discharged stroke patients to offer support, companionship and a layer of empathy that only stroke victims understand.

Community outreach events:

8,000+ people in northern Colorado communities through a variety of community outreach activities with stroke education at the heart of our efforts.

Clinical education—EMS/fire:

230 participants from the Greeley and Longmont Fire Departments participated in a training highlighting stroke symptoms, treatment options and evidence-based workflows.

130 participants (in seven sessions) at UCHealth EMS New Hire Academy presentations were reminded of the importance of EMS-activated stroke alerts, stroke symptoms, treatment options and case studies to improve identification of stroke in the field when the community calls 911.

Clinical education—Nursing:

271 NIHSS certification classes for emergency department and inpatient nurses (15 sessions) that highlight stroke pathophysiology, symptoms, treatment and assessment as well as impact to the community when we can improve stroke patient outcomes.

50 education sessions for new emergency room nurses reinforcing best practices, treatment options, timely identification of stroke symptoms and expected workflows to positively impact patient outcomes.

1,348 quarterly education posters distributed to all emergency room nurses highlighting appropriate/timely identification of stroke symptoms, evidence-based workflows, impact to patient outcomes and treatment options.

Clinical education—Providers/clinic staff:

130 local providers participated in journal club education and discussion on stroke identification and treatment, educational lectures on updated stroke practices, treatment options and updates and best practice sharing to ensure care for hospitalized stroke patients aligns with care guidelines and improves transition back to the community.

Practice sharing:

1,000+ health care professionals, sharing stroke education best practices.

Family education:

Our team of nationally certified instructors teach childbirth, breastfeeding/chestfeeding and baby care classes, improving the health of parents and infants.

Family education impact statistics:

Participants reported:

100% feel more prepared to give birth.

100% had the information they needed to make decisions about labor pain-management strategies.

96% are aware of when to seek medical support for postpartum mood disorders such as depression or anxiety.

100% felt more confident in their ability to communicate with their health care team during labor.

98% felt prepared to breastfeed.

98% are aware of community breastfeeding support services.

96% feel more prepared to care for their newborn.

99% have a better understanding of infant safe sleep practices.

TESTIMONIALS

I was so unsure of options and had no idea where to start for a birth plan. Now I feel confident creating a plan and taking my newborn home.

Very informative and helpful. I feel more prepared than I did before class.

Would highly recommend this class. Should be a requirement.

Class went above and beyond expectations. Thankful to find such a good quality, in-person class at a fair price.

The swaddling and car seat information was great! Also all the information about cues and sleep were awesome.

I really appreciated getting to have a general conversation about newborn behavior and infant safe sleep practices. It was nice to hear the information as well as get a chance to actually practice with things like swaddling and putting on a diaper.



Injury prevention:

Car seat education and distribution program:

Families attend a one-hour class to learn how to properly install a car seat and correct harnessing of their child(ren). At the end of the class they receive a brand new, appropriately sized car seat for a small requested donation. Classes are offered three times per month in Larimer County, with one class in Spanish.

Car seat distribution impact statistics (FY 2022):

154 seats distributed.

Hospital fit station:

This program provides a free, 30-minute consultation with a certified Car Seat Technician for new families on the PVH and MCR Women's Care units to learn how to properly use their car seat with their newborn. Of the families we helped, 64% of them were utilizing their car seat incorrectly before the educational session.

Hospital fit station impact statistics:

1,424 families between PVH and MCR.

Strap and Snap:

A 45-minute interactive presentation to 3rd graders in Larimer County and parts of Weld County teaches students safe biking skills and why helmet use is important.

Strap and Snap impact statistics:

1,200 students educated and more than **500** helmets distributed.

TESTIMONIAL

I absolutely love this program. It is definitely a huge help for us families who cannot afford to buy a brand new car seat for their child. I am so thankful and grateful for this program. Thank you!!

TESTIMONIAL

Our educator was amazing. So knowledgeable. Helped ensure the correct fit for our newborn and toddler car seats. What an amazing program this is! Thank you!

TESTIMONIAL

I have already had a student comment about how they were going to ride their bike, forgot their helmet, so they turned around again to go get it from home. The presentation made an impact!

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