



COMMUNITY HEALTH IMPROVEMENT

2026-2028 Programs Update

Community Health Improvement overview

At UCHealth, our mission is to improve lives. Our Community Health Improvement (CHI) team in northern Colorado has improved lives for more than 30 years. CHI programs are client- or community-centered and results-driven through use of scientifically supported methods and best practices in service delivery. We also work closely with other UCHealth teams throughout northern Colorado who provide community-health education through their programs. Those incredible programs are also represented within this document.

Prioritizing our work.

UCHealth in northern Colorado offers programs that promote health, prevent illness and address social drivers of health through serving the community's most vulnerable populations from birth through advanced age.

Social drivers 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. We recognize and address these conditions by:

- Offering programs and services to low-income individuals at reduced or no cost.
- Minimizing transportation barriers by offering on-site services 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.

By partnering with other agencies and organizations, we help 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. With the input of our partners on community-health needs outside of our hospitals and the support of our leaders and Boards of Directors, we have identified three areas of focus for 2026-2028:

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

We address these community-health needs through the work of our care coordination and community-health education and prevention teams. We also support the work of our partners to ensure our communities thrive.



Care coordination and services impacting social drivers of health

There are three care coordination programs in CHI: 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 their 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 duplicate costs.

The MACC program launched in 2011 with four full-time staff members and has grown to include 19 interdisciplinary staff members, including nurses, licensed behavioral health specialists, case managers, care coordinators and administrative support.

MACC stakeholders include:

Salud Family Health Centers, UCHealth Family Medicine Center and UCHealth Medical Group. The MACC program also collaborates with the Health District of Northern Larimer County and Northeast Health Partners.

MACC and Healthy Harbors impact statistics:

4,900 direct referrals received from 2020 to present. Referrals come from Poudre Valley Hospital, clinics, providers and community partners.

4,700 direct referrals to MACC and Healthy Harbors from 2015-2019.

3,500 clients/families with complex care and significant resource needs served since 2014.

260 cases were closed in 2025 with **70%** considered stable with most goals met.

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

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

TESTIMONIALS

You did a wonderful job of guiding me through the Medicaid process, advising me on housing, assisted living and any other need I had in regard to my health. But in addition to that, and in my mind, way more important, was the way you did it. I never felt judged or looked down upon. I always felt that I was being treated with dignity and respect. In return, that gave me a feeling of self-worth. Looking back over the past year, I'm going on nine months sober and clean. I've gone from weighing 120 lbs. and looking like death to being a healthy 205 lbs. I went from being in a wheelchair to being able to walk almost a mile without any aid. All of which, in big part, is due to you. I am very thankful to have crossed paths with you and have your help on my journey to good health. There's no doubt I would not be where I'm at without you.

– Shared by Andrea Hooley, RN, MACC Community Health Nurse

Ricky* is an incredibly bright, highly educated, high-spirited, positive, sober, self-sufficient individual originally born in Colombia who fell on hard times while living in northern Colorado. He single-handedly acted as his own lawyer to gain his citizenship 40 years ago to become an American citizen. Since that point, he earned two graduate degrees from CSU and is currently working on his third in data science. He had been living with friends until his prostate cancer diagnosis, at which point he moved to an assisted living facility. The cancer had metastasized to his spine as tumors that were extremely painful. He didn't meet the required level of care to remain in assisted living, nor could he afford to stay. For these reasons, Ricky was being evicted from the facility with nowhere else to go. Knowing Ricky had a MACC care manager who was on his side and working on his behalf was the support he needed to have hope and keep moving forward. Through our work together, Ricky found housing and employment, deciding to become a bi-lingual medical interpreter.

– Shared by Emily Davidson, MPH, MACC Outreach Specialist

*Names 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 and mother, provide lactation support, communicate with the primary care provider and connect families to community resources. 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:

77% of home visits were completed with both mom and baby being seen.

350 home visits scheduled.

Affiliate partners:

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

TESTIMONIAL

I worked with a client who delivered her baby by C-section, had not received follow-up care after delivery and was homeless. She had a history of drug use prior to pregnancy and was fearful of relapse. Through our visit, I was able to connect her with many types of support. Following the help of many amazing teams, she, her partner and their baby were able to get into stable housing, her body is free from substances, and her baby continues to do well and meet milestones. She is an example of how people thrive with the amazing support and resources that are provided through the Family Medicine Center, MACC program, MAT program, Postpartum Nurse Home-Visit program, Food Pantry and FMC Postpartum Support group along with the Family Housing Network. This team approach has allowed this client to maintain sobriety, find housing, provide for basic needs and get support for positive mental health.

– Michele Mayes, RN, IBCLC

Community-health education/prevention

Community-health education programs have positively impacted 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 and services for adults age 50 and older. Program offerings include:

- **Advance care planning:** Guidance for completion of advance directives for health care decisions.
- **Education and prevention:**
 - Caregiver Stress-Busting Program: Relieving caregiving stress through stress management techniques and relaxation and coping strategies.
 - Chronic disease self-management (Living Well): Identifying health risks and steps to successful self-management of a chronic health condition or issue.
 - CircleTalk: Creating connection through conversation using a fun, unique, non-repeating curriculum to support new meaningful connections and inspire sharing.
 - 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 Coaches for Hypertension Control: Helping improve the health of those diagnosed with high blood pressure through educational classes, blood pressure self-monitoring and goal setting.
 - 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 2025):

13,454 Aspen Club members.

6,600 unduplicated participants in Aspen Club programs, services and events.

727 new members added in the last fiscal year.

1,306 participants received Medicare counseling, education and outreach.

\$517,291 in estimated Medicare savings during the Medicare Part D enrollment period.

1,885 participants in general health classes.

1,083 participants in evidence-based classes.

1,429 participants helped with Advance Directives through educational classes and completion of forms.



TESTIMONIALS

Cathy gave me a balance assessment at the Windsor Rec Center. She was warm, friendly and informative. Cathy took the time to write a plan to help prevent me from falling. Her concern for my health was genuine. I'm following her advice, bought a balance pad and will follow her instructions.

Amazing! I was given personalized strategies to work on. I will now follow up with my current PT to expand my efforts with their help and this additional information.

I just finished Aspen Club's Virtual Medicare 101 presented by Alan. I am so thankful to have had this platform to learn about the Medicare program! Several times I have reviewed and even studied the information on the SSA website and had never achieved clarity. However, after Alan's presentation, I feel I actually have a grasp on the ins and outs of the Medicare alphabet, and we can now make an informed decision with confidence. Kudos to Alan for his clear and concise presentation style. He was personable and approachable. Thank you again for the services the Aspen Club offers and employees like Alan.

Medicare is a complicated Labyrinth; the Aspen Club is a godsend. Alan and Scott have helped with Medicare, we've completed advance directives for health care and I know I can reach out with future needs from your team. Thank you so much.

It is so nice to have the opportunity to meet individually with someone regarding advance directives, to fill out the forms and to have them immediately notarized. This is a wonderful service for people. Thank you so much.

Kat presented information about advance directives at my workplace. I worked with her afterward to put my advance directives in place. She was very helpful by explaining what the documents mean and what an agent does. Without her help, I doubt I would have felt confident filling out the form and a living will. I appreciate this Aspen Club service and believe it will help with the rest of my estate planning. Thanks!

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, 49 participants reported:

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

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

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

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.

It was so nice to discuss bothersome symptoms that I might be reluctant to mention to my doctor.

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

Great program—it motivated me to work on bladder problems with exercise and brain training.





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 fresh produce and other nutritious food from the Food Bank for Larimer County and the FMC food pantry. Additionally, they provide nutrition education, blood pressure checks and connect residents to resources for chronic disease management and care coordination.

Housing Catalyst impact statistics (FY 2025):

24,678 pounds of food have been delivered—the equivalent of **20,310** 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.

You are an essential, if not the most essential, service to our community. I thank you all very kindly.

The CHI team are depended on by many of us at Redtail Ponds. They are always nice and considerate.

Many of us depend on food we can no longer afford. This helps a lot.

I am thankful for all the effort put towards us—the food, keeping my belly full, keeping more food stamps in my pocket and keeping my refrigerator stocked.

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 2025):

9,385 total visits.

2,027 unique households served.

6,699 unique individuals served.

2,627 unique individuals served per month (on average).

Total distributed food: **319,484** pounds.

44% of distributed food was fresh produce.

68,771 diapers distributed.

TESTIMONIALS

Best food bank in town. Polite and respectful staff.

This place has really helped me with my food needs.

Love this little food bank; keep up the great work and thank you for helping me out.



Community education:

Healthy Hearts and Minds:

For more than 30 years, the Healthy Hearts and Minds team has been serving our communities with heart health education and biometric screenings to help children and families live healthy lives.

Since 1992:

78,800+ students received a free biometric screening.

125,000+ students received heart-health education.

The HH&M 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.

HH&M School Program impact statistics (FY 2025):

11 school districts.

6,500+ learn hands-only CPR and how to use an AED.

114 schools.

10,186 students educated.

460 classrooms.

School-based biometric screenings:

5,186 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.

HH&M 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.

HH&M Family Program impact statistics:

97 participants.

26 families.

296 follow up family program visits.



TESTIMONIALS

I have a goal to turn off my phone after an hour, and maybe instead go outside and walk my puppy! And I won't vape/smoke because it's bad for my lungs.

– Kruse Elementary student

Something I have learned was the signs of heart attacks and strokes. My dad is older and has heart problems so in the future this will be a gift to me to help him and know the signs.

– Northridge High School student

I would like to set a goal to exercise more, but on my own time. The only time I really exercise is during P.E. I would like to change that.

– Severance Middle School student

I love this program. It coincides with everything I am teaching during the semester. It reinforces all of the information they are learning about body systems and helps them understand more, with hands-on lessons and props to see and feel. Kids love it as well.

– North Valley teacher

This is such a valuable class, especially with the health screening in the end.

– Harris Elementary School teacher

The HH&M lessons go over many important topics that our fifth graders don't learn about elsewhere.

– Bennett Elementary School teacher

Showing up to class each week made me think more about my health and choices.

– Family Program participant

It was a great time with my kiddos to think and focus on health.

– Family Program participant

This program was definitely beneficial for improving my family's health and raising awareness.

– Family Program participant



BStrongBFit:

333 4th-8th 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:

20,388 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.

3,475 kids and their families attend community events like our Run Series, lung demonstrations, hands-only CPR at community events and community benefit adult screenings.

1,598 first graders participated in Healthy Kids, Healthy Start. This health education curriculum is designed to start students off with knowledge to make healthy choices, resulting in improved math, reading and writing scores; better grades; higher levels of self-esteem; reduced disruptive behaviors; and lower levels of anxiety and stress.

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.

In the fall of 2025, UCHealth Medical Center of the Rockies (MCR) became the first hospital in northern Colorado to be designated a Thrombectomy-Capable Stroke Center by The Joint Commission. This advanced designation recognizes MCR's commitment to providing high-quality stroke care, including mechanical thrombectomy procedures and post-procedural care.

Stroke Education/Prevention program impact statistics (FY 2025):

168 visits to currently hospitalized stroke patients by our Stroke Survivors Taking Aim at Recovery (SSTARs) volunteers to provide empathetic listening, personal connection and information on Stroke Support Group.

262 phone calls to discharged stroke patients via the Stroke Survivor to Survivor (SS2S) program by our stroke-survivor volunteers to provide additional emotional support to patients who have transitioned back into the community.

364 attendees of the region's four stroke support groups across the Fort Collins, Loveland, Greeley and Johnstown communities.

Community outreach events:

6,656 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:

280+ fire and EMS personnel attending stroke-education sessions upon hire and as part of annual competencies focused on stroke detection and timely transport to treatment facilities.

Clinical education—Nursing:

393 registered nurses attended NIHSS certification classes focusing on assessment and classification of stroke severity.

Practice sharing:

2,000 additional clinical providers provided education about new best practices, treatment options and transport recommendations during clinical outreach.

TESTIMONIALS

I was so impressed with everyone and the medical team there. I keep telling everyone that I got the absolute best care available. In follow up, we read through all of my discharge instructions thoroughly and that outlines when to take my medications and what all of them are for.

Stroke is traumatic for the survivor and family. We feel like no one knows what we go through. Support groups let us get together with others that know all the hardships, pain and bewilderment from stroke. I wouldn't be where I am today without the groups and the support we get from each other.

Family education:

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

Family-education impact statistics:

Participants reported:

100% feel more prepared to give birth.

99% had the information they needed to make decisions about labor-pain-management strategies.

100% of labor partners feel more prepared to support the laboring person.

99% are aware of postpartum mood disorder symptoms and when to seek treatment.

100% felt prepared to breastfeed.

100% can recognize infant hunger cues.

100% feel more prepared to care for their newborn.

100% have a better understanding of infant safe-sleep practices.

100% believe they will be able to keep their infant safer while traveling in a car because of the car-seat education.

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.

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.

I loved the facts and science behind everything and the hands-on activities for infant CPR and car seats.

This was the best class we have taken from UCHealth—so informative and helpful. I wish everyone would take this class. (Breastfeeding Basics)

This is the best pre-baby class we have taken yet! I can't recommend it enough. Thank you, thank you, thank you!

I loved the class. It's easy to feel overwhelmed as a new parent. This class helped reduce a lot of anxiety.

This was super informative and a great crash course for first-time parents. I learned a lot. It was very helpful practicing what we learned in class as well with the dummies. I feel more confident now trying out the information we learned.

This class was more helpful than I thought it would be. I was expecting more of a "basics" class. My husband and I also really liked the time spent on the support person's roles.

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 2025):

232 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, 66% of them were using their car seat incorrectly before the educational session.

Hospital fit-station impact statistics:

951 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:

1,500 students educated, and more than

350 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

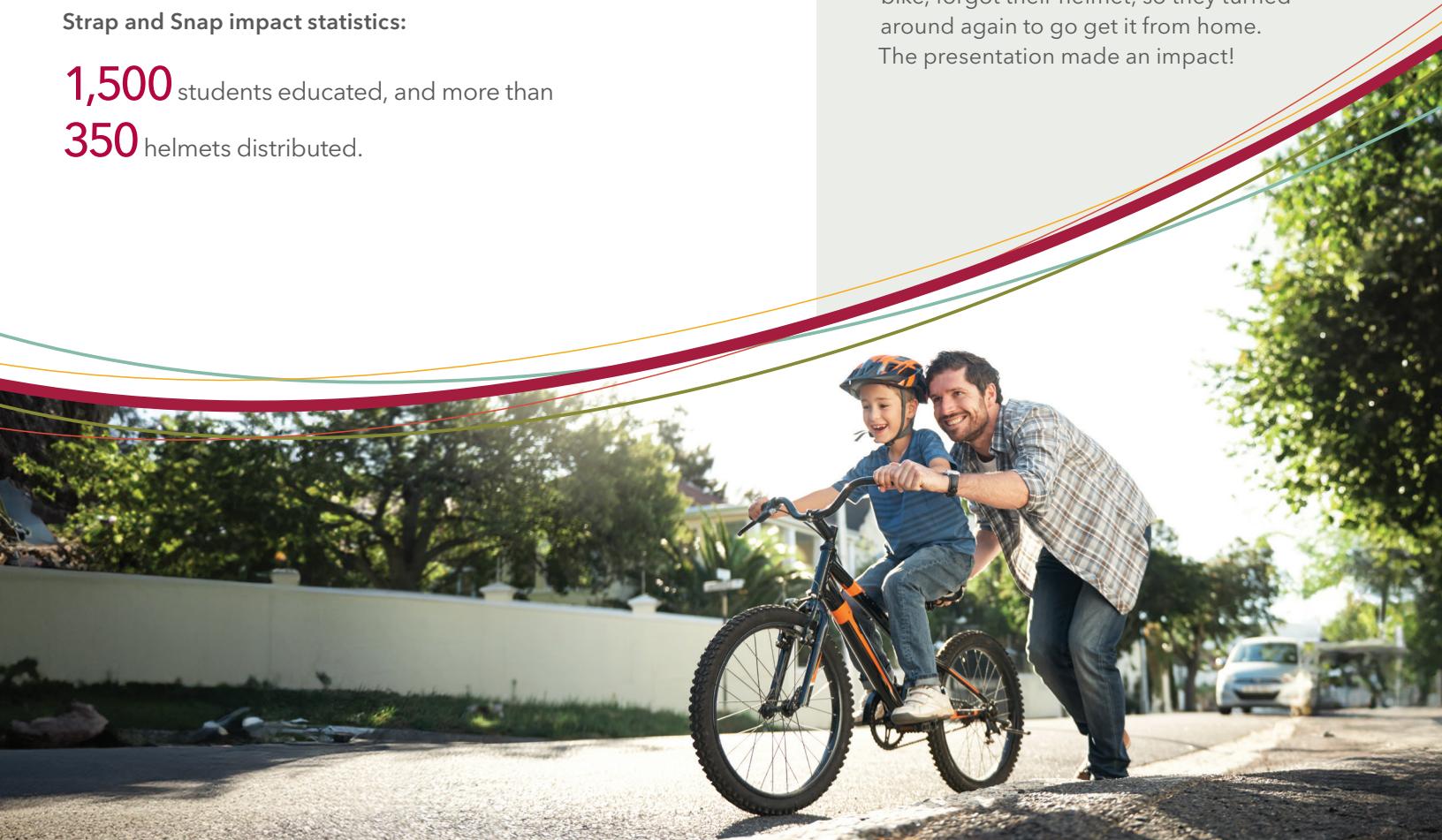
Our educator was amazing. So knowledgeable. Helped ensure the correct fit for our newborn and toddler car seats. What an amazing program this is! Thank you!

TESTIMONIAL

Thank you very much for these programs that help our community, which allow us to keep our children safe and have more peace of mind.

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!





Community Benefits
2026-2028 Programs Update
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