The JCMC Population Health Program is an innovative self-management program which provides the opportunity of rewards to patients of the Hudson County who have been diagnosed with one or more chronic disease that are most sensitive to coordinated outpatient and acute care.

**Program Objectives:**
- Uncontrolled/poorly managed conditions
- Multiple chronic conditions
- Non-compliance with medications or medical appointments
- Challenging social and economic barriers to health
- Stalled barriers to care
- Frequent inpatient hospitalization/ER visits
- High risk complex needs
- Individuals in need of care coordination and care management

**Program Expansion:**
- Employees
- Uninsured
- Insurers
- Community Health events
- Supermarkets
- Barbershops
- Physicians offices
- Pharmacies
- Healthcare/Warehouse
- Partner FQHCs
- Health departments
- Schools and program websites

**Home Evaluation:**
An in home review of hazards including CO levels, fire and fall hazards, lead paint, mold/mildew, etc. especially for asthmatic members in the community. Essential supplies, such as mattress/pillow covers and anti-allergen spray are delivered to the member at no cost to them.

**Caregiver Support:**
An at home program for caretakers of family members with multiple chronic diseases. Includes survey tools to identify caregiver strain as well as barriers to good outcomes (e.g. fall potential, hearing and vision problems, cognitive and tolerating concerns) and attaches next steps/solutions to identified barriers. Lets caretakers earn reward points for their participation.

**Shared Decision Support:**
The informed-patient program that uses videos (EmmiSolutions®) and targeted efforts to provide education and to generate questions to clinicians prior to procedures and care plans. Works on the principle that fully informed patients often choose the more conservative option.

**Rapid Cycle Performance Improvement:**
Methodology is comprehensively utilized. This process ensures continuous opportunity for improvement and identifying weakness while program threats are mitigated. The use of 2013 PDSA cycles facilitates multiple initiatives to be process mapped and ongoing workflow efficiencies to be sustained.

**A Risk Stratification Tool**
That scores social determinants to help focus resources. Common determinants such as health literacy, insurance status, financial assets, transportation needs, and language barriers, examining cultural backgrounds as they pertain to health and disease, belief in one’s ability to affect change, family support, access to and desire for fruits and vegetables, etc. are reviewed.

**Community Health Trust Partnership**
An innovative idea to engage key community organizations across several industries, whether it is a school, bank, or hospital to allocate resources to effectively and efficiently manage the care of community members.

Fifteen different Monthly Patient & Family Support groups (behavioral health, oncology, asthma, caregiver, job training, etc. for the patients to interact with others who may be in the same situation)

- Strong FQHC Partnerships
- 15+ Monthly Patient/Family Support Groups
- Healthcare Leadership & Innovation Institute
- 75+ Local Vendor Discount Pools
- Social Media Co-branding Events
- Chronic Disease Management
- 9-12+ Inpatient/Outpatient Care Redesign Programs
- Community Resource Inventory
- Primary Practices Transformation
- Monthly Patient Calendar
- Community Health Trust -150+
- Lunch & Learn Sessions

**Overview**

**Methods and Interventions**

**Results**

**Improvement**

- Identifying patients at high risk or with complex health problems
- Utilizing nurses and non-clinical navigators to support, advocate for, and motivate chronically ill patients using an innovative points-driven financial rewards system
- Deploying a risk stratification tool that incorporates social determinants of health, cultural beliefs and disease burden
- Establishing a Community Health Trust of local businesses, local DOH, schools, banks, gyms, and advocacy groups
- Risk stratification is conducted upon initial enrollment and every six months thereafter as a basis for navigation, resource prioritization and graduation status

**Sustainability**

**Population Health Village: New**

**Contact**

Candice Pimentel  
Asthma Educator  
Email: Candice.Pimentel@rwjbh.org  
Phone: 201-434-3266  

Raushanah Ali  
Asthma Educator  
Email: Raushanah.Ali@rwjbh.org  
Phone: 201-434-4536