Ventura has a Population Health Management Strategy to address member needs across the continuum of care to promote high-quality, cost-effective health care delivery. VCHP offers programs, services, and activities to support our members to improve or maintain their health. The table below provides a summary of the programs/activities, indicates members eligible for participation, and how a member may choose to participate (opt-in) or ask to be removed from the program/service (opt-out). If you have any questions regarding these services or any other aspect of your care under Ventura, please do not hesitate to contact our **Health Services Department** at **(805) 981-5060 or call toll-free (800) 600-8247**. Members may also email questions or concerns to **VCHCP_HEDIS_QA8059815061@ventura.org**

Program/Service	Members eligible to participate	Program Activities	Member Opt-in or Opt-out
Influenza Vaccinations	Members enrolled in Ventura County Healthcare Plan with no risk factors Members enrolled in wellness programs	• Birthday Card Reminder • Notice in member newsletter • Information links on website • Reminders sent through County	Opt-out Members receive information unless a request is made to discontinue mailing
Breast Cancer Screening	Female Members (age 50-74) who have not had a mammogram in the prior year.	• Mammography postcard 2x/year • Member Newsletter Article directing member to website for information located in Member Preventive Health Guideline Brochure • Member Preventive Health Guidelines Brochure on website • Birthday Card Reminder • Mailing to members enrolled in disease management programs	Opt-out Members receive information unless a request is made to discontinue mailing
Colorectal Screening	Members (age 45 – 74) who have not had a colonoscopy or sigmoidoscopy in the past 10 years.	• Colorectal Screening postcard annually • Member Newsletter Article directing member to website for information located in Member Preventive Health Guideline Brochure	Opt-out Members receive information unless a request is made to discontinue mailing

Program/Service	Members eligible to participate	Program Activities	Member Opt-in or Opt-out
		• Member Preventive Health Guidelines Brochure on website • Birthday Card Reminder • Mailing to members enrolled in disease management programs	
Preventive Visits – Adults	All adults aged 20 years of age and older	• Member Newsletter Article directing member to website for information located in Member Preventive Health Guideline Brochure • Member Preventive Health Guidelines Brochure on website • Birthday Card Reminder	Opt-out Members receive information unless a request is made to discontinue mailing
Childhood Immunizations	Children from birth up to 2 years of age	• Member Newsletter Article directing member to website for information located in Member Preventive Health Guideline Brochure • Member Preventive Health Guidelines Brochure on website • Birthday Card Reminder	Opt-out Members receive information unless a request is made to discontinue mailing
Diabetes Condition Management	Members meeting one of the following criteria - At least two outpatient visits, observation visits, ER visits, or non-acute inpatient encounters with a diagnosis of diabetes • At least one inpatient encounter with a diagnosis of diabetes • Members dispensed insulin or hypoglycemic/ antihyperglycemics on an outpatient basis	• Program welcome letter • Annual mailing of education and resource materials • Health coaching calls (for Diabetic members at moderate or high-risk levels)Member • Members reminded to request eye exam results be sent to PCP	Opt-out Members automatically enrolled in the program if meet criteria

Program/Service	Members eligible to participate	Program Activities	Member Opt-in or Opt-out
Asthma Condition Management	Members identified with persistent asthma who meet one or more of the following criteria and were dispensed an asthma controller medication: - An emergency department visit with a diagnosis of asthma - One inpatient hospital discharge due to a diagnosis asthma - Four or more outpatient visits, observation visits, telephone visits, e-visits, or virtual check-ins with any diagnosis of asthma and prescribed two or more asthma medications - Four or more asthma medications	• Program welcome letter • Annual mailing of education and resource materials • Member website link to online local Lung support group as a community resource/ education • Health coaching calls (for Asthma members at high risk levels)	Opt-out Members automatically enrolled in the program if meet criteria
Hypertension Management	Members diagnosed with high blood pressure and placed on blood pressure medications	ESI Omada Hypertension Program • Welcome kit mailed to identified members • Digital application • Sent blood pressure monitor • Access to virtual healthy living/diet coaching ▪ Food tracking ▪ Community groups ▪ Learning modules • Expanded Screen Rx – Assessment of prescription gaps for hypertensive medication (uses claims data) o Call outs to discuss closing gaps in care if requested by member	Opt-in

Program/Service	Members eligible to participate	Program Activities	Member Opt-in or Opt-out
Inpatient Readmission Prevention	Members 18 – 64 years of age with an acute inpatient or observation stay	Reminder letter sent to members after discharge to encourage follow-up with primary care practitioner	Opt-out Members receive information unless a request is made to discontinue mailing
Prenatal Care	Females in child-bearing years	Member Newsletter – Prenatal Care in Your First Trimester - educating members of child-bearing years about importance of seeing their providers as early as possible once they know they are pregnant Newsletter article to inform members of the availability of doula services QA nurse outreach to identified members to inform of Doula services available to provide support during prenatal phase of pregnancy with physician referral.	Opt-out Members receive information unless a request is made to discontinue mailing Opt-in
Post partum Follow-up	Females who deliver	Reminder letter sent to member post-delivery to encourage follow-up with OB practitioner Newsletter article to inform members of the availability of doula services QA nurse outreach to identified members to inform of Doula services available to provide support during postpartum phase of pregnancy with physician referral.	Opt-out Members receive information unless a request is made to discontinue mailing Opt-in

Program/Service	Members eligible to participate	Program Activities	Member Opt-in or Opt-out
Follow-up for members with frequent ED visits	Members who frequently seek services through the ED	Educational mailings sent to members who frequently use ER	Opt-out Members receive information unless a request is made to discontinue mailing

Complex Case Management – Medical	Members identified at high risk such uncontrolled diabetes or asthma, multiple, complex disease issues, End Stage Renal Disease,
	- High-cost claims
	- Multiple ER visits
	- Multiple hospitalizations
	- High risk social needs (lack of caregiver/family support, financial issues)
	- Severe behavioral health or substance use issues as a co-morbidity
	- Traumatic brain injuries
	- Poly-pharmacy usage
		Calls from a Ventura Case Manager to:
		• Assess:
		  ○ Medical, psychosocial, and functional history
		  ○ Current disease/health issues
		• Develop a member specific care plan inclusive of self-management actions
		• Assist with care coordination including transitions of care and post inpatient care follow-up
		• Support coordination with behavioral health case managers
		• Evaluate and assist with community and support activities
		• Complete follow-up contacts to assess progress toward goals
		• Determine needed preventive health reminders
		• Assist with medication management
		
		Case Manager:
		• Mail applicable educational materials to members.
			Opt-out
			
			Members enrolled in the program based on identification criteria

Program/Service	Members eligible to participate	Program Activities	Member Opt-in or Opt-out
Behavioral Health Case Management (delegated to Optum Behavioral Health)	Members with behavioral or medical/behavioral risk who would benefit from behavioral health case management.	Outreach by telephone or mail, once contacted: • Screening and assessment of member is completed based identified issues • Assessment may consist of five (5) recovery domains including health, home, community, purpose, and resilience. • Identification of opportunities/gaps related to managing conditions/ symptoms • Development of member specific care plan in partnership with member • Services may be delivered electronically or telephonically • Follow-up monitoring/assessment of progress • Medication monitoring. BH Case Manager: • Mail applicable educational materials to members.	Opt-in Members receive BH case management services if member agrees