Annual Quality Management Program Evaluation

Fiscal Year 2019-2020

Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

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ACCREDITED NCQA MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION 1 YEAR

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Trillium HEALTH RESOURCES
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Executive Summary

FY2019-2020 Annual Quality Management Program Evaluation

Trillium Health Resources maintains a comprehensive and proactive quality management program. This program provides the structure, process, resources, and expertise necessary to ensure that high-quality cost effective care and services are provided to its members. The Trillium Quality Management Program includes a continuous, objective, and systematic process for monitoring and evaluating key indicators of care and service; identifying opportunities for improvement; developing and implementing interventions to address the opportunities; and re-measuring to demonstrate effectiveness of program interventions.

This evaluation highlights Trillium's Quality Management Program activities and the organization's major accomplishments over the past year.

Through the annual Quality Management Program evaluation, Trillium is able to assess the strengths of the program and identify opportunities for improvement, thus enhancing our ability to improve care and service to members thereby meeting our goal of continuous quality improvement.

After reviewing and evaluating overall performance and program effectiveness in all aspects of the 2019-2020 Quality Management Program, it has been determined that all the activities planned for the past year were completed. Nineteen annual objectives were met, two were partially met, three were not met and one is on hold due to COVID-19.

2019-2020 Highlights

Structural changes: In preparation for future changes, the Quality Management Department created the position of Delegation Manager. In June 2020, the new Delegation Manager was hired, Kari Jester. In addition, there two additional positions that are budgeted for, Senior Data Analyst and Support Specialist. The Senior Data Analyst position is budgeted to begin July 1, 2020. The Support Specialist position is currently on hold due to Tailored Plan changes.

- **NCQA accreditation:** NCQA accreditation is considered a "gold standard" in the industry. Trillium completed the Interactive Readiness Tool (IRT) self-assessment in June 2020. Due to COVID-19, the onsite review scheduled for August 3rd and 4th was held virtually. Trillium is awaiting the final outcome of the survey.

- **Incident Reporting:** Within the fiscal year 2019-2020 the Quality Management Department reviewed over 3,000 Incident Reports and provided technical assistance (TA) over 150 times to providers in the Network. The Quality Management team is working with providers and various stakeholder committees to address late reporting related to Innovations Waiver providers, as this was an issue in 2019. Trillium's QM staff have updated and recorded the Incident Reporting training and the training available on Trillium's Learning Campus. The training includes detailed information about Incident Reporting and IRIS including standards and timelines for submission.

- **Member Experience and Annual Surveys:** An important aspect of our quality program and the services we provide to members are member experience surveys. The surveys covers topics such as:
  - Services provided and our network of behavioral health care practitioners and providers
  - Ease of accessibility to our staff and our network providers
  - Availability of appropriate types of behavioral health practitioners, providers and services
  - Acceptability (about cultural competence to meet member needs)
  - Claims processing
  - Utilization management process
  - Coordination of care

  The Quality Management Department, along with the Data Reporting Unit in the Informatics Department analyzed and reviewed annual data related to various member experience surveys.

The surveys contain feedback from members, stakeholders and providers related to a wide range of topics. This information was analyzed to identify improvement opportunities across departments, populations and services. Trillium has put an emphasis on addressing improvement opportunities identified as an outcome of these surveys.

- **Netsmart/HEDIS measures:** Trillium is working with Netsmart Technologies on a software platform that has provided Trillium with the capability to run HEDIS reports and measures. HEDIS, the acronym for Healthcare Effectiveness Data and Information Set, is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS is a performance measurement tool for health plans. The standard set of measures related to care and service is organized in categories including:
  - Effectiveness of care
  - Access/availability of care
  - Experience of care
  - Utilization and risk-adjusted utilization
  - Health plan descriptive information

HEDIS is a set of standardized performance measures designed to ensure that purchasers and members have the information they need to reliably compare the performance of managed health care plans.

The HEDIS performance measures are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. Trillium's software vendor uses measure-specific logic to automatically consolidate data from multiple data sources to determine a member's compliance with a measure or whether the member should be excluded from the denominator. Netsmart and Trillium have worked together to ensure all HEDIS reports are complete and valid.

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
Annual Policy and Procedure Review *The Quality Management Department is charged with maintenance of all Trillium Health Resources' policies and procedures. This includes ensuring all new and revised policies and procedures go through the appropriate approval process and are distributed to all employees. Additionally, QM is responsible for ensuring that the annual review of policies and procedures is completed by the Quality Improvement Committee.* *Goal: 100% of the Policies and Procedures will be reviewed.*	**Outcome Analysis:** • Total # of policies reviewed-99 • Total # of procedures reviewed-152 • Total # of policies revised-0 • Total # of procedures revised-3 • The Quality Improvement Committee (QIC) reviewed and approved all policies and procedures on March 17 and March 20, 2020. Final approval was obtained from the CEO and the Governing Board (for policies). • An updated template and style guide were used during the annual review to ensure uniformity and consistency with all policies and procedures. • Implementation of policies and procedures was discussed during new employee orientation and throughout the year in departmental meetings. • New and/or revised policies and procedures were reviewed by QIC and staff were notified via email of the revised policies and procedures. • Quality Management staff ensured that the most current and up to date policies and procedures were posted to SharePoint for staff access. A hard copy is maintained and is located within the Quality Management Department (QM). • Quality Management staff were available for consultation/questions pertaining to all policies and procedures. **Next steps:** • Policies and procedures will continue to be reviewed routinely and revisions will be made as needed to maintain compliance with laws, regulations and standards. The next annual review is scheduled for March 2021.	Met/ Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met

Over and Under Utilization of Services
 	
Through the identification of potential fraud, waste and abuse within the provider network, potential trends are identified that may include over and underutilization of services rendered.
 	
Under Utilization Goal: Using retrospective analysis of claims data and other sources of information, members are identified who are potentially underutilizing services.
 	
Over Utilization Goal: Using retrospective analysis of claims data, and other sources of information, members are identified who are potentially over utilizing crisis services and underutilizing more appropriate community based services.
Program Integrity Goal: To review 100% of Fraud and Abuse Management System (FAMS) allegation packages, data reports and complaints received.
	Outcome Analysis:
	
	- Using retrospective analysis of claims data and other sources of information, Trillium identified members who were over utilizing crisis services and underutilizing more appropriate community based services. Trillium used reports based on claims which are critical to utilization management. Over and underutilization outliers of high risk/high cost service utilizers were reviewed and through that process staff identified that the over utilizers were also the underutilizes of lower levels of care (LOC). The goal of Utilization Management in monitoring these identified priorities resulted in improved service utilization of high cost services and improved overall cost per member based on claims data. Once identified members were researched in other available internal and external databases for available/relevant information, healthcare trends were established for the member (i.e. past treatment, compliance, physical health status, medications, etc.).
	- All of the above data was compiled into a clinical case staffing form and presented during the UM Team Clinical Care Staff meetings with the Chief Medical Officer and Population Health Nurse. Recommendations from the UM team were collected for methods to improve member engagement with appropriate level of services and adherence to treatment recommendations. The clinical case staffing form with recommendations was uploaded into the software platform utilized by Trillium.
	- 12 cases were staffed following the below guidelines:
	  - Reviewed over and underutilization report using data from the previous 12 months. Focused on members who utilized inpatient services and hospital emergency departments and ranked by # of visits.
	  - Identified members were researched in other available
		Met/
		Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	internal and external databases for trends (i.e. past treatment compliance, physical health status, medications, etc.). ○ Assigned MH/SU Care Coordinator, if applicable, was notified regarding the identification of the member on this report and invited to contribute information. ○ All data was compiled into a clinical case staffing form and presented during the UM Team Clinical Care Staff meetings. ○ Recommendations from the UM team, the MH/SU Care Coordinator and the Chief Medical Officer were collected for methods to improve member engagement with services and adherence to treatment recommendations. ○ The clinical case staffing form was uploaded into the Trillium's software platform The Program Integrity Department received and reviewed 13 FAMS allegation packages from IBM 2019-2020 fiscal year. They also participated in 2 trainings from IBM on fraud, waste and abuse trending in medical services such as personal care. The team was able to complete investigations on 7 out of 13 FAMS allegations packages received. During this investigation data reports were analyzed to identify outliers and trends. ○ The Program Integrity Department staff responded to 61 allegations entered into EthicsPoint regarding fraud, waste and abuse. ○ The Program Integrity Department reviewed data trends based on internal data reports during staff meetings. ○ The Program Integrity Department conducted 68 program integrity related investigations.	

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met

	Outcomes
	• Substantiated-26
	• Unsubstantiated-19
	• Partially Substantiated and Partially Unsubstantiated-4
	• Duplicate Report-6
	• Outside of Scope-9
	• Pending-2
	• Insufficient information-2
	Actions
	• No Action Taken-25
	• Sanctions-11
	  ○ Recoupment-7
	  ○ Contract Terminations-7
	• Technical Assistance-11
	• Referral to DHB for Potential Fraud-8
	• Self-Audit Requested-8
	• Case combined with another case-5
	• Pending-2
	• Referred to Human Services Department Supervisor-2
	• Referred to Network Department-4
	*Some actions may still be in appeal timeframe and risk potential of being overturned
	**Some investigations had more than one action taken against the provider
	Next steps:
	• Trillium Health Resources will continue with identification of potential fraud, waste and abuse through reviewing and interpreting FAMS allegations packages and analyzing data reports to identify outliers and trends.	

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	♻ Trillium Health Resources will continue to respond to all allegations of fraud, waste and abuse entered into the Ethicspoint system. ♻ Using retrospective analysis of claims data, Trillium will identify members that are over utilizing and underutilizing services. ♻ Move to more of a population health/systematic monitoring of over and underutilization.	
Clinical Practice Guidelines *Trillium Health Resources is contractually mandated to select, communicate and evaluate the use of Clinical Practice Guidelines utilized by the Network. Trillium provides practitioners within the network with nationally recognized Clinical Practice Guidelines and ensures proper implementation. These clinical practices recommended for adoption must meet criteria including being evidence based, measurable and sustainable.* *Goal: Implement Netsmart system that will provide Trillium with the capability to run HEDIS reports and measures. Once Netsmart incorporates all needed data and HEDIS reports are validated, Trillium will measure performance against at least two important aspects of at least three clinical practice guidelines on an annual basis.*	**Outcome Analysis:** ♻ In 2019-2020, Trillium adopted the following clinical practice guidelines (CPG's) relevant to its members: Measures for Children ○ APC-Use of Concurrent Antipsychotics for Children and Adolescents ○ APM-Metabolic Monitoring for Children and Adolescents on Antipsychotics Measures for Adults: ○ AMM-Antidepressant Medication Management ○ SSD-Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are using Antipsychotic Medications ○ SAA-Adherence to Antipsychotic Medications for Individuals with Schizophrenia ○ COU-Risk of Continued Opioid Use ♻ A Communication Bulletin was shared with Trillium providers related to the adopted CPG's. CPG's are posted on Trillium's website for public access. ♻ Trillium IT staff have partnered with Netsmart for the development of HEDIS measure reports. ♻ Netsmart has collected needed value sets from Trillium in order to meet HEDIS standards. ♻ Validation for reports is in progress.	Partially Met/ Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	▲ The Data Unit created a draft HEDIS dashboard for monitoring of performance measures as set forth by NCQA. Once validated, the dashboard will be shared with various committees including QIC and CAC. **Next steps:** ▲ Annually, Trillium will measure performance against at least two important aspects of at least three clinical practice guidelines. ▲ Trillium will review guidelines against clinical evidence at least every two years, or more frequently if national guidelines change within the two year period. ▲ Trillium will compile data obtained from the annual measurement of adherence and will identify opportunities for improvement in care. Results will be shared with Clinical Advisory Committee and Quality Improvement Committee. ▲ Trillium Chief Medical Officer and the Clinical Advisory Committee will review the monitoring of adherence to selected elements of the guidelines and provide feedback and assistance to practitioners/providers as needed. ▲ The Trillium Chief Medical Officer, with the input from the Clinical Advisory Committee, may suggest additional or substitution guidelines to be monitored when appropriate. ▲ Per HEDIS specifications, measures are intended to be reviewed and analyzed on a calendar year. The next annual review of these measures and adherence to the guidelines will be in January-Feb of 2021. ▲ Trillium's Chief Medical Officer and the Clinical Advisory Committee will establish methods for review of practitioner's adherence to the established guidelines. ▲ Trillium will measure practitioner/provider adherence to clinical practice guidelines by identifying and measuring important points of care according to the chosen guidelines.	

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	♣ Trillium will compile data obtained from the annual measurement of adherence and will identify opportunities for improvement in care. These results will be shared with CAC and QIC. ♣ Trillium will share the results of the annual measurement with practitioners/providers by posting on the Trillium website and through Network communications.	
Network Adequacy and Accessibility *The Network Adequacy Accessibility Report is an annual study of our catchment area and the people who live there. It also looks at where services are available and how people use them. Ultimately, the analysis serves as a roadmap for determining future growth based on current capacity.* *Goal: To complete the Network Adequacy and Accessibility Report according to the requirements published by DHHS by the due date.*	**Outcome Analysis:** ♣ In March of 2020, Trillium began the annual process of surveying and assessing gaps and needs identified by members, families and stakeholders. Due to COVID-19, this task and the requirement was put on hold and postponed until after the COVID restrictions are lifted. Please see Trillium's waiver log for more information. **Next steps:** ♣ Trillium will complete the Network Adequacy and Accessibility Report according to the requirements published by DHHS by the due date once the state of emergency related to COVID ends. ♣ The Network Development Plan will incorporate areas of need identified in the process and offer solutions to fill those needs or gaps. ♣ A copy of the final document will be shared with the Governing Board, Regional Boards, and CFAC. ♣ Once completed the Network Adequacy and Accessibility Report will be made available on Trillium's website for full detail and next steps. ♣ The Final Report and the Network Development Plan will be reviewed with Trillium's QIC to assess any necessary interventions.	On hold due to COVID-19/ Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
Provider Satisfaction *Annually, a provider satisfaction survey is conducted by DHB to determine areas that need improvement within the network and to assess provider satisfaction with Trillium Health Resources, its practices and processes.* *Goal: To obtain a positive response on overall satisfaction of equal to or greater than 90 % and share results.* **See Complete Provider Survey Analysis for additional information*	**Outcome Analysis:** - Trillium participated in DHB's 2019 Provider Satisfaction Survey. - There was a 24.2% increase in the number of survey respondents from 2018 to 2019 surveys. There were 308 respondents for Trillium this year, and 248 respondents for the previous year. Our response percentage from all surveys sent was 72.0%, which was the third highest rank of completed usable surveys among all the LME/MCOs. - Trillium received an overall satisfaction rating of 88.5% from respondents. This was an increase of 4.2% from the previous year - There has been a steady increase in overall satisfaction from previous years at 84.3 (2017-2018) and 81.9% (2016-2017). Trillium was slightly under the goal of having a positive response equal to or greater than 90% for overall satisfaction, but the trend continues to move in an upward direction. This goal will continue next year. The state average was 88.89% which was slightly above Trillium's score of 88.49%. Many of Trillium's functional areas maintained a positive satisfaction score, pointing to the efforts and strategies implemented throughout the agency to improve processes based on the survey results and feedback from the previous year. - Trillium implemented several strategies and interventions over the fiscal year in an effort to impact satisfaction. Trillium continued utilizing CMS (an internal database) which allows the provider directory and TBS systems to "talk." This has alleviated the issue of having to keep two systems current. Additionally, each time a change is made directly into TBS it automatically populates over into the directory. Trillium has continued to do a random sample of 42 providers per month that the Network Department contacts to verify their information and records are accurate and up to date.	Not Met/ Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	Trillium continued to offer more technical assistance than punitive strategies. The Trillium Network department uses a ticket system which streamlined the processes to obtain quicker responses to questions for providers. Network Communication Bulletins were utilized as a source of communication for providers. Finally, a continued strategy implemented in 2018 was to reach out to every individual provider to request specific contact information for anyone that would be providing feedback and answering the survey. This was done in an effort to minimize bounce back of emails and to get the most current and accurate points of contact at each provider. Network now has those provider survey contacts on file in TBS. Network also sent out reminders in the Network Communication bulletins and stressed the importance of having a voice and responding to the survey ♻ Trillium conducted an analysis of the survey results. All results were reviewed by the Global Quality Improvement Committee, Trillium's CFAC, Executive Team and QIC to identify any systemic issues to be addressed by Trillium Health Resources through corrective actions or quality improvement projects. **Next steps:** ♻ QIC will continue to discuss possible ways for improving overall satisfaction of providers. ♻ QIC will discuss interventions to increase overall satisfaction in all areas surveyed. ♻ Trillium will continue to participate in the annual survey, analyze data and implement improvement efforts when deemed necessary.	

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
Member Satisfaction *Annually, a member satisfaction survey is conducted by DHB who contracts with an EQRO to determine areas that need improvement and to assess members satisfaction with areas to include, but not limited to, satisfaction with UM processes, providers, timely access to services and availability of services* *Goal: To obtain a positive response equal to or greater than 85% for overall satisfaction and share results.* **See Complete Adult and Child ECHO Survey Analysis for additional information*	**Outcome Analysis:** Trillium participated in the 2019 ECHO Survey for Adults and Children. Of the 571 surveys sent out, 64 adult surveys and 94 child surveys were returned and used in calculations. Trillium had an overall response rate of 16.5% for the child survey, which was a slight decrease from last year's response rate of 16.8%. For the adult survey, the response rate was 11.7% which was a decrease from last year at 14.7%. Overall satisfaction rating for child was 65.71%, which was a slight increase from last year's rating of 65.3% and slightly below the state average which was 65.80%. The goal of 85% overall satisfaction was not achieved, therefore, this goal will continue for next year. Overall satisfaction rating for adult was 65% which was a significant decrease from last year's results of 75% and below the state average of 68.4%. Trillium conducted an analysis of the survey results. All results were reviewed by the Global Quality Improvement Committee, Trillium's CFAC, Trillium's Executive Team and QIC to identify any systemic issues that would need to be addressed by Trillium Health Resources through corrective actions or quality improvement projects. As a result of the analysis, "Opportunities for Improvement" related to the Adult ECHO were discussed as identified below: Opportunities for Improvement Question / Satisfaction Score / Correlation with Q28 Q3. Usually or always got help by telephone — 8.3 — 0.66 Q27. Care responsive to cultural needs — 40.0 — 0.99 Q41. Getting help from customer service was not a problem — 57.1 — 0.87 Q18. Usually or always involved as much as you wanted in treatment — 76.4 — 0.70 Q22. Given as much information as wanted to manage condition — 79.6 — 0.66	Not Met/ Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met

- Q3- Response:
  - The current pandemic has expanded member's access to services via phone, video conference, etc. No additional interventions necessary at this time.
- Q27- Response:
  - There are numerous interventions implemented to address the topic of cultural needs such as: updates to Trillium's Cultural Competency Plan that incorporates National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards), organization wide town hall meetings, organization wide focus groups to open the lines of communication and to help advance and sustain culturally and linguistically appropriate practices and services within Trillium and the provider network.
- Q41- Response:
  - Call Center staff created a more formal quality monitoring form to monitor staff on a monthly basis. Call Center statistics will be shared with the staff to inform staff on various metrics.
  - Desktop protocols are in place
  - There is future planning to implement a member experience survey at the end of each call. This item is currently on hold.
- As a result of the analysis, "Opportunities for Improvement" related to the Child ECHO were discussed as identified below:

Opportunities for Improvement

Question	Satisfaction Score	Correlation w/ Q29
Q28. Care responsive to cultural needs	50.0	1.00
Q35. Much better or a little better able to deal with symptoms and problems compared to 1 year ago	63.6	0.66
Q30. A lot or somewhat helped by treatment	80.9	0.71
Q20. Usually or always got professional help wanted for child	84.5	0.63
Q18. Usually or always involved as much as you wanted in treatment	87.3	0.65

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	▲ Q28- Response: ○ There are numerous interventions implemented to address the topic of cultural needs such as: updates to Trillium's Cultural Competency Plan that incorporates National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards), organization wide town hall meetings, organization wide focus groups to open the lines of communication and to help advance and sustain culturally and linguistically appropriate practices and services within Trillium and the provider network. ▲ As a result of the 2018 EQRO review and a part of Trilliums Corrective Action Plan the areas contained in the December 2018 Trillium ECHO-Child and ECHO-Adult Survey Analyses under "Opportunities for Improvement" were discussed and reviewed in detail during the August 2019 Quality Improvement Committee (QIC) meeting. ▲ Due to the correlation between performances in particular areas of member experience and overall satisfaction with counseling or treatment, the committee decided to focus on the specific performance-related items from Q28 and Q29, which is the rating question in the survey instrument measuring overall satisfaction with counseling or treatment. ▲ Based on the discussion, the following strategies and interventions were implemented and responses/outcomes shared during QIC: ○ Focused Satisfaction results for both the Adult & Child ECHO surveys were shared with providers in the Network Bulletin, Global Quality Improvement Committee, Clinical Advisory Committee, and internally with staff via the employee newsletter. Information shared included identified items correlated with overall satisfaction along with lower scoring questions on both the Adult & Child surveys. ○ Feedback was requested from Trillium's Provider Council,	

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	Global Quality Improvement Committee, and Clinical Advisory Committee. Any feedback was brought to QIC for review and evaluation of action. ○ Trillium established an internal workgroup to focus on the detailed contents of the Cultural Competency Plan, training efforts (internal and external), process for enhancing cultural and linguistic competencies and lastly, ensuring Trillium is assessing all needs in the network. **Next steps:** ▲ The QIC will continue to discuss possible ways for increasing participation and improving the overall satisfaction of members. ▲ QIC will discuss interventions to increase overall satisfaction in all areas surveyed. ▲ Trillium will continue to participate in the annual survey, analyze data and implement improvement efforts when deemed necessary.	
Perception of Care *The NC Division of MH/DD/SAS conducted a Perception of Care survey to assess members perception of care of services received from network providers.* *Goal: To obtain 100% of the surveys required of Trillium Health Resources within the timeframe given by NC DMH/DD/SAS (2019 administration period).* *Goal: To obtain a positive response equal to or greater than 95% on overall satisfaction for Youth, Adult, and Parent surveys and share results (2019 results).*	**Outcome Analysis:** ▲ Trillium QM staff, reached out to applicable providers and assisted with the administration of the 2019 Perception of Care Survey. ▲ The survey administration period was 5/6/2019-6/4/2019. ▲ 2019 Required Survey Numbers for Trillium: ○ Adult-525 ○ Youth-125 ○ Parent-150 ○ Total-800 ▲ Actual Number of Surveys completed and submitted to the state for analysis: ○ Adult-565 ○ Youth-120 ○ Family/Parent-128	Partially Met/ Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
**See Complete Perception of Care Survey Analysis for additional information*	○ Total- 813 ▲ Overall satisfaction ratings were as follows: Adult-92.7%, Youth-83.8%, and Family/Parent-92.0%. ▲ The goal of obtaining a positive response of equal to or greater than 95% on overall satisfaction was not met for the Adult, Youth or Family/Parent surveys. ▲ Trillium conducted an analysis of the survey results. As a result of the analysis, "Opportunities for Improvement" related to the Perception of Care Surveys were discussed as identified below: ○ Smoking – Trillium's members report a much higher smoking rate than North Carolina's general population. In addition, there was a statistically significant increase in the number of members who reported smoking from 2018 to 2019. Trillium staff are researching smoking cessation interventions to decrease Trillium's smoking rate to prevent future increases. Interventions such as Clickotine, Incentive Programs, Prescription medications used for smoking cessation, Share information from the American Lung Association related to smoking cessation. ○ Overall Health – It is routine practice for Care Coordinators to discuss health and wellbeing during the risk assessment with members. During on-going communication with the members, conversation regarding preventive care will be incorporated. A script will be used to evaluate the members overall health. ○ Member Handbook- Interventions to increase distribution or awareness of Trillium's handbook is necessary in an effort to increase satisfaction across multiple domains and populations. The following interventions are in place: ➢ Care Coordinators ask or remind members as appropriate to access and/or obtain a copy of the handbook and follow through with assisting members in obtaining the handbook. ➢ The Communications Department enhanced	

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	materials distributed to the members that include the link to the handbook and instructions for access to the handbook. ➢ Information was shared with providers regarding the upcoming annual survey implementation will be included in a future bulletin. ♻ QM submitted information in the Network Bulletin reminding providers of the upcoming Perception of Care (POC) survey implementation to increase participation in the surveys. ♻ All results were reviewed by the Global Quality Improvement Committee, Trillium's CFAC, Executive Team and QIC to identify any systemic issues that would need to be addressed by Trillium Health Resources through corrective actions or quality improvement projects. **Next steps:** ♻ Trillium Health Resources will continue to participate in the annual survey, analyze data and implement improvement efforts when deemed necessary. ♻ Trillium plans to obtain 100% of the surveys required of Trillium within the timeframe given for the next survey administration period. ♻ Due to COVID-19, the 2020 administration period was been moved to August 2020, the minimum requirement of surveys has been reduced and there is an online/electronic version of the survey.	

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met

Delegation Oversight
 	
Initial and Annual reviews were completed on all delegated entities and prior to any new contracts to ensure each delegated entity meets all requirements of the delegation agreement.
 	
Goal: 100% of the annual delegation reviews are completed within the 12 month timeframe.
	Outcome Analysis:
	
	- 100% of the annual delegation reviews were completed within the 12-month timeframe. All delegated entities maintained compliance with items on their monitoring tool throughout the year at 100%.
	- The Delegation Review Tool was reviewed for completeness and accuracy. The Delegation Work Flow process was reviewed, updated, and shared with Trillium Leadership Team to assure that all departments were aware of the requirements.
	- Delegated entities:
	  - Language/Interpreting: Language Line/Fluent, Integrated Language Services
	  - Records Management/Shredding: Iron Mountain
	  - Peer Reviews/Appeals: BHM
	  - TCLI In-reach: Recovery Innovations/Recovery International
	- All entities were approved for continued delegation by the respective content experts/committees for 2020-2021 fiscal year. Results of each delegation oversight review are submitted to QIC and the Credentialing Committee (as applicable for credentialing delegations) annually for review.
	
	Next steps:
	
	- Trillium will continue to conduct pre-assessments and annual oversight reviews of all delegated entities. Trillium will provide technical assistance and may request Plans of Correction for any items that are "not met" on the delegation review tools.
	- Trillium will complete 100% of the annual oversight reviews that are required to be completed within the 12 month timeframe.
		Met/
		Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
QM Workplan *The QM Workplan outlines quality improvement activities for the year* *Goal: 100% of all tasks in the QM Work Plan will be completed.*	**Outcome Analysis:** • The Quality Management Work Plan specified quality improvement activities for Trillium in FY 19-20. • The work plan included goals, objectives, and initiatives identified for the year. • The work plan was utilized as a mechanism for tracking quality improvement activities cross-functionally for the organization. • Trillium continues to use its QM Work Plan as a tool to identify specific quality improvement activities for the organization. The plan is reviewed routinely and updated accordingly with any status updates. • All tasks in the QM Work Plan were completed. **Next steps:** • 2020-2021 Work Plan has been developed and will be reviewed by QIC in September 2020. 100% of the tasks listed on the QM Work Plan will be completed and the Work Plan will be updated routinely throughout the year to reflect progress.	Met/ Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
QM Plan/Program Description *Trillium's Quality Management Plan/Program Description lays out Trillium's overall plan for organization wide quality management/improvement .* *Goal: To fully comply (100%) with contract requirements and accreditation standards.*	**Outcome Analysis:** ▲ The Quality Management Plan/Program Description is created at the beginning of the fiscal year to outline Trillium's Quality Management Plan for the year. ▲ The 2019-2020 Quality Management Plan/Program Description was reviewed and approved by QIC and the Governing Board in June 2019. The 2020-2021 Quality Management Plan/Program Description was reviewed and approved by QIC and the Governing Board in August 2020—delayed due to COVID-19. ▲ Trillium continues to use its Quality Management Plan/Program Description as a tool to identify organization wide quality management plans/initiatives for the year. The plan is reviewed annually in QIC. ▲ The Quality Management Plan/Program Description is posted on Trillium's website for public access. ▲ The Quality Management Plan/Program Description is submitted annually to DMH/DHB during the month of August. **Next steps:** ▲ Trillium will fully comply (100%) with contract requirements and accreditation standards as outlined in the QM Plan/Program Description. ▲ Due to COVID-19, an extension was granted for the annual submission of QM documents to DMH/DHB. Trillium's QM documentation will be submitted to DMH/DHB on or before September 11, 2020.	Met/ Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
National Accreditation *Trillium's QM department is responsible for ensuring Trillium maintains ongoing compliance with accreditation standards.* *Goal: Maintain Full Accreditation status with a 93% or above (URAC) or 84% or above (NCQA).*	**Outcome Analysis:** • The QM Department continued to work with various departments to ensure Trillium maintained compliance with standards for all accredited programs by coordinating and facilitating a review of the standards with each department. • Trillium has continued to pursue NCQA accreditation. Preparations have included training staff on NCQA processes and standards, revising existing procedures and creating new procedures in order to be in compliance with NCQA standards and completing the Interactive Readiness Assessment (IRT). • Trillium continued working with a NCQA Consultant throughout the year • Numerous consultation meetings were held to gather, review and cite documentation for the survey. • All necessary documentation was cited and uploaded into the IRT. The IRT was submitted in June 2020. • A virtual file review was conducted on August 3rd and 4th, 2020. • Trillium is awaiting the final results of the review. **Next steps:** • Next steps related to national accreditation are pending at this time until the final results of the NCQA survey are shared with Trillium.	Met/ Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
Key Performance Indicators (KPI) *Trillium conducts monthly monitoring of designated key performance indicators to ensure benchmarks are being met and to detect any trends related to the effectiveness of the whole organization* *Goal: 100% of the key performance indicators will meet benchmarks.* *For detailed information on the KPI's, see the KPI spreadsheet included as Attachment A, KPI Report.*	**Outcome Analysis:** - Trillium included DHB and DMH Supermeasures in the KPI list and monitored them throughout the year which brought the number of measures monitored on the KPI from 15 to 20. - Of the 20 KPI's, 15 met their benchmarks each month which indicates that 75% of the key performance indicators met benchmarks for the year. - Data was presented to QIC for review. Data was reviewed monthly and specific areas of concern were discussed as they are also Quality Improvement Projects. Please see QIP templates for specific interventions discussed related to items of concern on the KPI. **Next steps:** - Trillium will continue to monitor KPI's on a monthly basis to efficiently identify any trends or patterns in the data. - Data will continue to be presented to QIC for review. If any issues or trends are identified, QIC will discuss further action needed. - Corrective actions may be requested for any key performance indicators not meeting the established benchmark. - Trillium's goal is to meet 100% of the benchmarks set for the KPI's over the next year.	Not Met/ Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
State Reporting *Trillium ensures all state reports are developed according to specifications provided, are validated, reviewed and submitted on time to the appropriate agencies.* *Goal: 100% of reports will be accurate, complete, and submitted on time.*	**Outcome Analysis:** • The Data Reporting Unit in the Informatics Department is the hub of reporting for Trillium. The Data Reporting Unit is responsible for tracking and submitting all state reports to ensure compliance. A tracking mechanism is used for all reports indicating when reports are due, whom they are submitted to, along with any other information around submission of reports to the state. • 100% of state reports were accurate, complete, and submitted on time to the appropriate agencies. **Next steps:** • Trillium will continue to complete reports, validate, review and submit to the Department of Health and Human Services on time. • Reports will continue to be analyzed to determine any areas of deficiencies that need improvement. • All reports will continue to be reviewed with appropriate departments, QIC, and Executive Team as deemed necessary.	Met/ Continue next year
Dashboards *Trillium ensures all dashboards are developed as requested, validated, reviewed, and submitted on time to the appropriate committees.* *Goal: 100% of dashboards will be accurate, complete, and submitted on time.*	**Outcome Analysis:** • The Data Reporting Unit is responsible for creating dashboards and sharing data with various committees to analyze for trends, outliers and red flags. • Any trends, outliers or red flags identified are referred to QIC to determine any needed action. • 100% of committee dashboards created were accurate, complete, and submitted on time. • Committee dashboards are produced on a routine basis for the following committees: 1. Global Quality Improvement Committee 2. Sentinel Events Review Group	Met/ Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	3. Human Rights Committee **4.** Quality Improvement Committee **Next steps:** ▲ Trillium will continue to ensure 100% of dashboards are accurate, complete, and submitted on time. ▲ Reports will be submitted and reviewed with appropriate committees.	
Quality Improvement Projects *During FY 2018-2019, Trillium maintained Quality Improvement Projects (QIP's) as indicated by the state contracts and accreditation standards.* *Goal: 100% of QIP's will be accurate and complete, and in compliance with regulatory guidelines and accreditation standards.* *For detailed information on each QIP including all measurements, analysis, barriers, interventions and next steps, see Attachment B, Annual QIP Report.*	**Current Quality Improvement Projects:** ▲ Increasing DHB and DMH Mental Health 7 day follow up: ○ Goal is to increase the percentage of individuals receiving a follow-up appointment within 1 to 7 days of being discharged from a community hospital, facility based crisis, or state psychiatric hospital to 45% for both DHB and DMH populations. ○ Baseline from January-March 2018 was DHB=42%; DMH=20.2% ○ Most recent measurement- Q4 April 2020-June 2020: DHB 46.1%; DMH 22.1% ▲ Increasing DHB and DMH Substance Use 7 day follow up: ○ Goal is to increase the percentage of individuals receiving a follow-up appointment within 1 to 7 days of being discharged from a community hospital, facility based crisis, or state psychiatric hospital to 45% for both DHB and DMH populations. ○ Baseline from January-March 2018 was DHB=29.1% and DMH 31.1% ○ Most recent measurement –Q4 April 2020-June 2020 DHB=50.0%; DMH=36.4% ▲ Improving the percentage of timely contacts with TCLI individuals in In-Reach status: ○ Goal is to have 98% of TCLI In-Reach individuals to have received a documented contact using identified method/software system at least once every 90 days. ○ Baseline for January 2019 was 88.5%	Met/ Continue next year

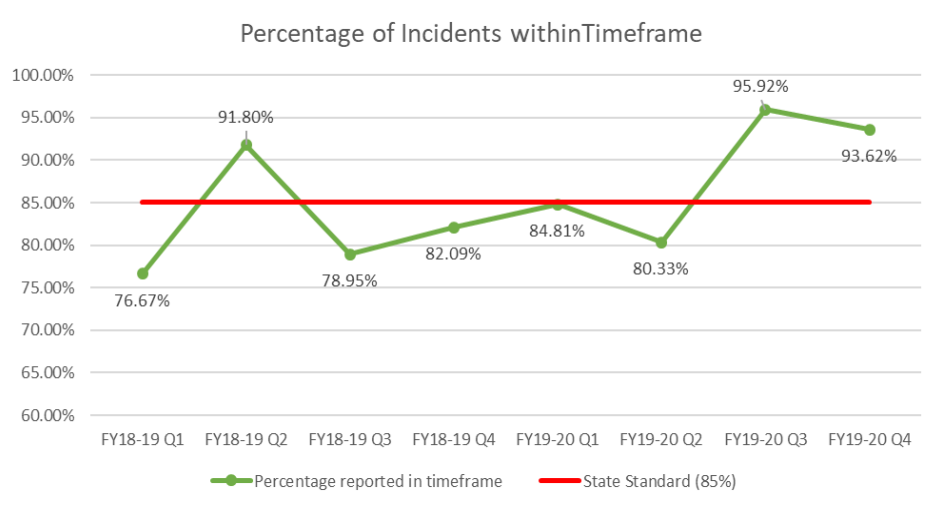
Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	○ Most recent measurement—July 2020 98.47% ♣ *NEW-Decrease inappropriate utilization of Emergency Department for members ○ Goal- measure #1-Reduce the number of ED visits to 0.66% or below. ○ Goal-measure #2-Increase follow-up treatment percentage after ED visits to 80% or above. ○ Goal-measure #3-Decrease number of IIH and ACTT members utilizing the ED to 7.79% or below. ○ Baseline: July – Sept 2019 ➢ Measure #1: 0.67% ➢ Measure #2: 76.72% ➢ Measure #3: 8.36% ○ Most recent measurement: January – March 2020 ➢ Measure #1: 0.69% ➢ Measure #2: 77.16% ➢ Measure #3: 9.36% ♣ *NEW- Increase utilization of MST services for members between the ages of 12-17 with Conduct Disorder Diagnosis ○ Goal is to increase the utilization rate of MST services for members diagnosed with Conduct Disorder to 14.7% or above ○ Baseline: July-Sept 2019 was 9.04% ○ Most recent measurement: January-March 2020-4.67% **Closed Quality Improvement Projects for FY 19-20:** ♣ Increasing Provider Satisfaction Related to the Appeals Process for Denial, Reductions or Suspensions of Service(s) **Outcome Analysis:** ♣ All QIP's were reviewed and discussed at monthly QIC meetings. ♣ QM staff reviewed all QIP's as a part of the peer review to ensure compliance with all regulatory and accreditation standards.	

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	♻ All QIP's were shared with the Global Quality Improvement Committee and Clinical Advisory Committee for feedback and input. ♻ A QIP annual report was created and submitted to QIC, the Governing Board and DHHS. ♻ Articles on QIP's were developed and shared with employees in the Trillium newsletter. ♻ All completed QIP templates and summary QIP grids were posted on Trillium's SharePoint page for staff access. **Next steps:** ♻ Trillium will continue to maintain the required number of projects per the DMH and DHB contracts as well as accreditation standards. ♻ QM staff will review QIP's with QIC on a monthly basis to discuss progress, measurements and needed interventions. ♻ The QIP peer review will continue to be conducted annually. ♻ The QIP Grid will be continuously updated and shared on the QM SharePoint site for staff access.	
Provider Performance Data *To share data with providers on various measures, at least annually. This data provides a snapshot into how they are performing compared to similar providers.* *Goal: 100% of Provider Performance Reports will be accurate, complete, and submitted on time.*	**Outcome Analysis:** ♻ Trillium's Data Reporting Unit compiled reports for Licensed Independent Practitioner's (LIP's), LIP groups and provider agencies that included performance data related to: ○ Claims denials ○ Claims denial reasons ○ Authorization denials ○ Authorization denial reasons ○ QIP scores ○ Accessibility/Access to Care ♻ In July 2020, 391 reports were distributed to provider agencies, LIP groups and LIP's. ♻ This year, 24 additional documents were distributed with	Met/ Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	data and information related to access to care standards. This information was for facilities that provide community-based inpatient hospital services, state psychiatric hospitals, state ADATC, detox, or facility based crisis services for mental health and substance abuse. Of those individuals ages 3 through 64 who were admitted for treatment, 40% or more of these individuals are required to receive a follow-up visit within 1-7 days after discharge with a behavioral health practitioner. This information was shared with providers. **Next steps:** - Reports will continue to be distributed annually. The next round of reports will be released in July 2021. - Future performance measures may be identified for the Network as Trillium progresses toward Tailored Plan implementation.	
Incident Reporting *To ensure the health and safety of all members.* *Goal: 100% of Incident Reports submitted by will be reviewed.*	**Outcome Analysis:** - 100 % of incident reports submitted were reviewed. - Over the past year, the Quality Management Department has reviewed over 3,000 Incident Reports (IR's) and provided technical assistance (TA) over 450 times to providers in the Network. In FY 18-19, over 3,000 incident reports were reviewed and TA was provided over 150 times. The number of reports remains relatively the same while there was an increase in the number of times technical assistance was provided. The increase in TA could be due to the increased use of this tab within the platform. Each time contact was made with providers for incomplete reports, this was documented as TA. - QM Coordinators conducted daily reviews of incident reporting and compiled a daily report of incidents that may pose a threat to member health and safety. Detailed information about the incidents was sent out to a select group of staff within Trillium, including the Chief Medical	Met/ Continue next year

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	Officer, for review and discussion on possible follow-up required or immediate action needed. • Data was reviewed monthly with the Sentinel Events Review Group and updates were submitted to QIC. The Sentinel Events Review Group corresponded monthly for internal review of sentinel events of members, such as deaths, and/or other serious incidents and served to identify any unexpected occurrence involving a member's death, serious psychological injury or the risk thereof. The committee also ensured that any recommended changes were implemented and monitored in a timely manner to ensure the health and safety of members. • Data was reviewed to identify any patterns, trends or concerns that may need to be addressed. • After review of data throughout the year, an item of concern has been late incident reporting among Innovations Waiver providers. Trillium is responsible for reporting to the state routinely and one of the measures reported is related to timeliness of IW incident reporting. ○ Measurement Item: What was the proportion of the level 2/3 incidents that were reported within required timeframes—(required timeframe for these are 72 hours) • The goal for timely submission of IW incident reports is 85%. The below graph shows the percentages since FY 18-19 in relation to the 85% target.	

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met



- For the entire year of 2019, the measurement was below the target goal of 85%.
- Trillium has attempted various interventions such as updating the IRIS Incident Report Training. The training has been recorded and is available on My Learning Campus. Communicating with providers on late reporting through the IRIS system and providing technical assistance (TA) when needed. There is a statement in the IRIS system reminding providers of reporting timeframes and training is provided as well. Reminders are also included in the Network Communication Bulletin.
- GQIC members and providers will discuss late incident reporting at their perspective agencies to gain feedback and suggestions to share at the GQIC meeting in October 2020.

Next steps:

- Trillium will continue to review 100% of the incident reports submitted and provide TA as needed.
- Follow up with Global Quality Improvement Committee will be conducted on the topic of IW late incident for feedback and suggestions on how to encourage compliance with the requirement of submitting timely incident reports.
- Quality Management will continue with the daily report and

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	monthly SERG meetings to review reports and data in order to identify trends, patterns or areas of concern that need investigation or follow up.	
Internal Compliance Quality Improvement Initiatives *Goal: 100% of the Internal Compliance quality initiatives will be completed on time.*	**Outcome Analysis:** DHB Contract Addendum Implementation - Completed a full review of DHB contract amendment - Conducted organization wide education and assessment regarding new elements outlined in the DHB Contract. - Ensured organization is aware of new requirements and took action to implement new requirements. EQR Corrective Actions and Recommendations Follow-Up - Assessed implementation of corrective action items and recommendations outlined during the 2019 External Quality Review. - Provided a measurement of the organization's compliance with CAP/recommendation item implementation. - Completed analysis of reoccurring items 2017-2019 (review for similar items on CAP and recommendations lists from year to year) **Next steps:** - Goal was met, therefore, was discontinued. No additional goals at this time.	Met/ Discontin ue

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
Transitions to Community Living Quality Improvement Initiatives *Goal: 100% of the Transitions to Community Living quality initiatives will be completed on time.*	**Outcome Analysis:** Staff Efficiency - Implemented the use of Surface Pro's for Transition Coordinators and Housing Navigators. - Implemented automated forwarding service from FTP server for information coming in from the state (IT to set up a report to automatically detect when a new file comes in and that file is automatically assigned) - Automated folder creation on the P drive Reporting Efficiency - Created ACCESS database to enhance efficiency and organization of RSVP tracking and data/ease of reporting/decrease errors - Created distribution groups and rules for email - Created fixed naming conventions in Incedo and the P drive - Implemented designators in Incedo to identify In-Reach, Transition, Post Transition and Diversion - Created more specific reports in Incedo-Tracking of data for TCLI **Next steps:** Goal was met, therefore, was discontinued. No additional goals at this time.	Met/ Discontinue
Human Resources Quality Improvement Initiatives *Goal: 100% of the Human Resources quality initiatives will be completed on time.*	**Outcome Analysis:** Staff Recruitment and Onboarding - Implemented ADP's Workforce Now-Implementation of a more efficient recruitment and onboarding process, which will provide a better system for tracking and managing activities. Electronic Personnel Files	Met/ Discontinue

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	♻ Implemented ADP's Workforce Now-Move from paper to electronic personnel files as well as allow access to employee files from different locations as needed. **Next steps:** Goal was met, therefore, was discontinued. No additional goals at this time.	
Communications Quality Improvement Initiatives *Goal: 100% of the Communications quality initiatives will be completed on time.*	**Outcome Analysis:** Online ordering portal ♻ Created an online ordering portal with current vendors so staff in each location can order brochures and give-away items (pens and stress balls) to be mailed directly to their office. Monthly awareness videos ♻ Created PowerPoint videos with captioning and music. Videos typically have much higher engagement rates than text or social media, so we hope to increase viewership through the videos **Next steps:** ♻ Goal was met, therefore, was discontinued. No additional goals at this time.	Met/ Discontin ue
Program Integrity Quality Improvement Initiatives *Goal: 100% of the Program Integrity quality initiatives will be completed on time.*	**Outcome Analysis:** Streamline Processes ♻ In an effort to streamline processes and increase efficiency, created a more efficient process for medical releases and gun permits. **Next steps:** ♻ Goal was met, therefore, was discontinued. No additional goals at this time.	Met/ Discontin ue

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
Finance Quality Improvement Initiatives *Goal: 100% of the Finance quality initiatives will be completed on time.*	**Outcome Analysis:** Implement Great Plains Version 2018 (Accounting Software upgrade) ♻ Improved financial efficiencies through comprehensive document attachment, improved workflow processes, less paperwork and filing by implementing Great Plains Version 2018. **Next steps:** ♻ Goal was met, therefore, was discontinued. No additional goals at this time.	Met/ Discontinue
Network/Credentialing Quality Improvement Initiatives *Goal: 100% of the Credentialing quality initiatives will be completed on time.*	**Outcome Analysis:** Report Accuracy ♻ Submitted IT request to add Credentialing Expiration dates in TBS to track agency/group expiration dates. ♻ Created the ability to run accurate reports and avoid lapses in credentialing. **Next steps:** ♻ Goal was met, therefore, was discontinued. No additional goals at this time.	Met/ Discontinue
Information Technology/Informatics Quality Improvement Initiatives *Goal: 100% of the Information Technology/Informatics quality initiatives will be completed on time.*	**Outcome Analysis:** Data Warehouse Restructuring ♻ Aligned business rules to Trillium and made platform more stable, scalable and exhibit faster replication. Redesigned data warehouse ETL processes and business rules. ♻ Given the complexities of this project, we've divided it into 4 phases. The scope of this QM Work Plan item is Phase 1 (Queue Manager), originally aiming for completion by June 30, 2020. Given current COVID-19 priorities, we are delaying the completion of this phase to be completed by 8/31/2020 (tentatively). To date, we are 80% done with mapping and	Partially Met/ Continue next year and monitored by the IT department

Compliance Element	FY 2019-2020 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	dependency testing and will begin the Unit Testing soon thereafter. We have also begun preliminary work on the Report Management Tool (RMT) / Data Dictionary (Phase 2). Data Dictionary phase is currently underway to develop a common language for reporting and aligning code to business rules. Warehouse designs work expected to begin Q1/Q2 of calendar year 2020. Full deployment of next warehouse solution expected late 2020 to early 2021 prior to Tailored Plan launch. ♻ Moving forward, this item will be monitored by IT and no longer in the QM Workplan. NCQA / HEDIS Reporting ♻ Ensured compliance, leverage expertise of software vendor, and reduced Trillium admin/support overhead via SaaS. Installed new reporting platform that will meet the needs for NCQA and HEDIS reporting. ♻ Trillium worked through testing and validation of the 15 HEDIS measures. Set-up, training and deployment of the KPI dashboards has begun with IT. Training for Core Validation Team. Enhanced End User Reporting Capability ♻ Enhanced end user reporting capabilities by providing a platform that will allow more flexible reporting, improved governance, and better visualization. Installed new reporting platform that will enhance end user reporting capabilities. ♻ Moving forward, this item will be monitored by IT and no longer in the QM Workplan.	

Summary

Based on the review and evaluation of performance in all aspects of the Quality Management program, the overall effectiveness of Trillium's 2019-2020 goals, proved to be strong and evolving.

Items to note are progress towards influencing system-wide safety and member-centered clinical practices, as well as the implementation of new software platforms and completion of the NCQA survey.

Overall, the quality improvement initiatives were well received and resulted in significant internal and external growth. Resources were adequately allocated to include programs that address member-focused care of our network, access and availability, quality clinical reviews, education and outreach to members and the community at large, and the development of refined internal processes to aid in the management of and adherence to performance measures/guidelines/contractual obligations.

Trillium's quality management activities demonstrated a commitment to efficient and effective care for our members, and to a global system of care dedicated to excellence.

Attachment A-Key Performance Indicators Report

TRILLIUM HEALTH RESOURCES KEY PERFORMANCE INDICATORS

July 1, 2019 - June 30, 2020

Listed below are the Trillium Health Resources Key Performance Indicators that are monitored on an ongoing basis. Green highlight signifies the indicator met the standard. Red highlight signifies the indicator has not met the standard. A corrective action plan will be implemented when a measure has not been met for a period of three months. Results will be compared against the State Monthly Monitoring Report for accuracy.

INDICATOR	DATA MEASUREMENT	STANDARD	COLOR KEY	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	June 2020	NOTES
% of Community Inpatient Readmits assigned to Care Coord.	N: Number of readmits assigned to a Care Coordinator D: Total number of readmits	85%	Green: 85% and above Red: 84% and below	94.7%	94.6%	90.5%	97.6%	93.3%	94.1%	96.2%	100.0%	88.6%	100.0%	92.0%	91.7%	
Total % of Auth Requests Processed in Required Timeframes	N: # Standard Auth Requests Processed in 14 Days PLUS # Expedited and Inpatient Auth Requests Processed in 3 Days D: Total Number of Auth Requests Received	95%	Green: 95% and above Red: 94% and below	99.8%	100.0%	99.9%	99.9%	99.9%	100.0%	100.0%	99.5%	99.6%	99.8%	99.6%	100.0%	
% Routine Auths Processed in 14 Days	N: # Standard Auth. Requests Processed in 14 days D: # of Standard Auth. Request Decisions	95%	Green: 95% and above Red: 94% and below	99.8%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	99.9%	100.0%	

INDICATOR	DATA MEASUREMENT	STANDARD	COLOR KEY	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	June 2020	NOTES
% Expedited/Inpt Auths Processed in 3 Days	N: # of Expedited and Inpatient Auth. Requests Processed in 3 days D: # of Auth. Requests requiring Expedited Decisions, inclusive of inpatient	95%	Green: 95% and above Red: 94% and below	99.8%	100.0%	100.0%	99.7%	99.9%	99.9%	99.9%	98.4%	98.5%	99.0%	98.8%	100.0%	
% of Claims Processed within 30 Days	N: # of Claims Paid or Denied within 30 Days D: Total # of Clean Claims Received during the Month	90%	Green: 90% and above Red: 89% and below	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	
% of Complaints resolved in 30 days	N: # of complaints being reported in this Report Period, that were either resolved in 30 days or referred to other entities for investigation within 30 days. D: Total # of Complaints received (1 month prior)	90%	Green: 90% and above Red: 89% and below	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		

INDICATOR	DATA MEASUREMENT	STANDARD	COLOR KEY	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	June 2020	NOTES
% of Denied Medicaid Encounter Claims	N: # of Denied Upstream Medicaid Encounter Claims D: Total # of Upstream Medicaid Encounter Claims Adjudicated	<5%	Green: 4% and below Red: 5% and above	0.3%	0.3%	0.7%	0.4%	0.6%	0.3%	0.3%	0.3%	0.3%	0.4%	0.6%	0.6%	
% 7 Day Follow Up-MH	N: # of follow-up visits with a mental health practitioner within 1-7 days after discharge. D: # of discharges from a community-based hospital, state psychiatric hospital, or a facility based crisis service with a principal mental health diagnosis	40%	Green: 40% and above Red: 39% and below	39.4%	37.5%	37.7%	40.6%	38.9%	43.1%	45.0%	48.7%	43.0%	46.5%	43.9%		There is currently a QIP for this super measure and the agency is coming up with/implementing interventions.

INDICATOR	DATA MEASUREMENT	STANDARD	COLOR KEY	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	June 2020	NOTES
% 7 Day Follow Up-SA	N: # of follow-up visits with a substance use practitioner within 1-7 days after discharge. D: # of discharges from a community-based hospital, state psychiatric hospital, ADATC or a detox/facility based crisis service with a principal substance use disorder diagnosis.	40%	Green: 40% and above Red: 39% and below	34.8%	43.6%	43.4%	41.2%	40.8%	42.1%	53.5%	57.1%	52.8%	41.7%	38.6%		There is currently a QIP for this super measure and the agency is coming up with/implementing interventions.
% With Primary Care/Preventative Visit	N: # of Individuals Under the Innovations Waiver with a primary or preventative care visit.D: # of Individuals Under the Innovations Waiver	90%	Green: 90% and above Red: 89% and below	94.7%	94.5%	94.8%	94.5%	94.5%	94.2%	93.1%	93.5%	93.7%	92.7%	91.5%		

INDICATOR	DATA MEASUREMENT	STANDARD	COLOR KEY	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	June 2020	NOTES
Total % of Auth Requests Processed in Required Timeframes	N: # Standard Auth Requests Processed in 14 Days PLUS # Expedited and Inpatient Auth Requests Processed in 3 Days D: Total Number of Auth Requests Received	95%	Green: 95% and above Red: 94% and below	100.0%	100.0%	99.6%	99.9%	100.0%	99.7%	98.6%	99.8%	100.0%	99.7%	100.0%	100.0%	
% Routine Auths Processed in 14 Days	N: # Standard Auth. Requests Processed in 14 days D: # of Standard Auth. Request Decisions	95%	Green: 95% and above Red: 94% and below	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%	99.9%	100.0%	100.0%	100.0%	100.0%	
% Expedited/Inpt Auths Processed in 3 Days	N: # of Expedited and Inpatient Auth. Requests Processed in 3 days D: # of Auth. Requests requiring Expedited Decisions, inclusive of inpatient	95%	Green: 95% and above Red: 94% and below	100.0%	100.0%	99.3%	99.8%	100.0%	99.5%	98.0%	98.4%	100.0%	98.0%	100.0%	100.0%	

INDICATOR	DATA MEASUREMENT	STANDARD	COLOR KEY	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	June 2020	NOTES
% of Claims Processed within 30 Days	N: # of Claims Paid or Denied within 30 Days D: Total # of Clean Claims Received during the Month	90%	Green: 90% and above Red: 89% and below	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
% of Complaints resolved in 30 days	N: # of complaints being reported in this Report Period, that were either resolved in 30 days or referred to other entities for investigation within 30 days. D: Total # of Complaints received (1 month prior)	90%	Green: 90% and above Red: 89% and below	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
% 7 Day Follow Up-MH	N: # of follow-up visits with a mental health practitioner within 1-7 days after discharge. D: # of discharges from a community-based hospital, state psychiatric hospital, or a facility based crisis service with a principal mental health	40%	Green: 40% and above Red: 39% and below	23.5%	16.8%	29.0%	22.3%	26.3%	19.9%	21.8%	17.9%	26.8%	24.3%	25.6%		There is currently a QIP for this super measure and the agency is coming up with/implementing interventions.

INDICATOR	DATA MEASUREMENT	STANDARD	COLOR KEY	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	June 2020	NOTES
	diagnosis															
% 7 Day Follow Up-SA	N: # of follow-up visits with a substance use practitioner within 1-7 days after discharge. D: # of discharges from a community-based hospital, state psychiatric hospital, ADATC or a detox/facility based crisis service with a principal substance use disorder diagnosis.	40%	Green: 40% and above Red: 39% and below	45.5%	36.5%	38.9%	37.3%	43.5%	33.3%	35.7%	34.6%	32.1%	43.2%	28.6%		There is currently a QIP for this super measure and the agency is coming up with/implementing interventions.
Number of Individuals transitioned into supportive housing.	N: # of N.C.-U.S. DOJ priority population group members with SMI/SPMI who transition into supportive housing via a TCLI housing slot during the month. D: # of annual housing slots	8%	Green: 8% and above Red: 7% and below													

INDICATOR	DATA MEASUREMENT	STANDARD	COLOR KEY	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	June 2020	NOTES
	allotted to LME-MCO by DHHS.															
% of calls Abandoned	N: # of Calls Abandoned D: Total # of Calls (re: Services for consumers)	≤5%	Green: 5% and below Red: 6% and higher	2.3%	1.9%	2.6%	1.9%	1.7%	2.3%	1.7%	1.9%	1.9%	1.7%	2.1%	2.1%	
% Answered within 30 seconds	N: # of calls answered within 30 seconds D: Total # Calls (re: Services for consumers)	95%	Green: 95% and above Red: 94% and below	96.3%	97.6%	95.8%	97.4%	96.8%	96.9%	97.8%	97.0%	97.3%	96.8%	95.9%	96.4%	
Blockage Rate	N: Total # of blocked calls D: Total # Calls presented	≤5%	Green: 5% and below Red: 6% and above	0.14%	0.20%	0.22%	0.05%	0.19%	0.06%	0.10%	0.06%	0.28%	0.20%	0.22%	0.18%	

Attachment B-

Quality Improvement Projects/Activities Annual Report

Quality Improvement Projects/Activities

Trillium
HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

CURRENT PROJECTS

INCREASING DHB AND DMH MENTAL HEALTH 7 DAY FOLLOW-UP

A. Goal:

The goal of this project is to increase the percentage of individuals receiving a follow-up appointment within 1 to 7 days (excluding same day appointments) of being discharged from a community hospital, facility based crisis, or state psychiatric hospital to 45% or more for both DHB and DMH populations (separate funding sources). **It should be noted that the goal for this measure for DHB and DMH penalties is 40%.*

B. Baseline:

The baseline measurement for this project was taken from January – March 2018. The numerator is the number of individuals discharged from a hospital, facility based crisis, or state psychiatric hospital who received a follow-up appointment within 1 to 7 days of discharge. The denominator is the total number of individuals discharged.

Numerator – Members receiving a follow-up appointment within 1 to 7 days of discharge

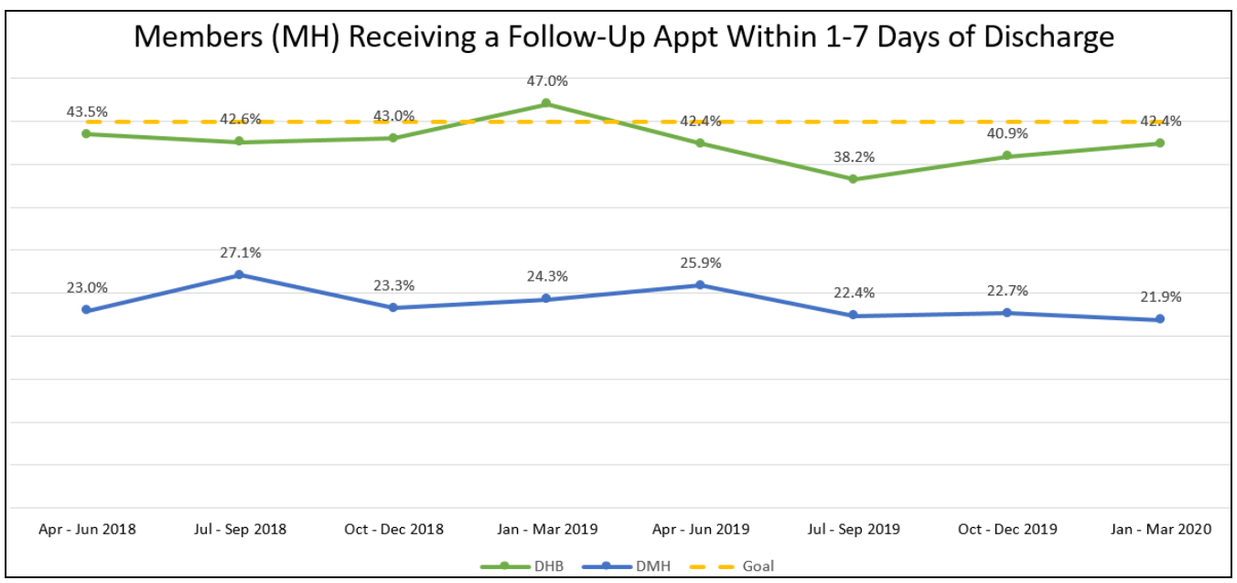
Denominator – All members discharged

Baseline – DHB = **42.0%** (N = 224; D = 533); DMH = **20.2%** (N = 73; D = 362)

C. Measurements:

Measurements are taken quarterly, accounting for a 90 day claims lag, and previous months' data is revised retroactively as new claims are processed.

- Measurement #1 – April – June 2018 – *DHB* 226/520 = **43.5%**; *DMH* 46/200 = **23.0%**
- Measurement #2 – July – Sept 2018 – *DHB* 215/505 = **42.6%**; *DMH* 124/457 = **27.1%**
- Measurement #3 – Oct – Dec 2018 – *DHB* 214/498 = **43.0%**; *DMH* 102/437 = **23.3%**
- Measurement #4 – Jan – March 2019 – *DHB* 240/511 = **47.0%**; *DMH* 89/367 = **24.3%**
- Measurement #5 – April – June 2019 – *DHB* 252/594 = **42.4%**; *DMH* 70/270 = **25.9%**
- Measurement #6 – July – Sept 2019 – *DHB* 221/579 = **38.2%**; *DMH* 110/490 = **22.4%**
- Measurement #7 – Oct – Dec 2019 – *DHB* 310/758 = **40.9%**; *DMH* 109/480 = **22.7%**
- Measurement #8 – Jan – March 2020 – *DHB* 314/741 = **42.4%**; *DMH* 110/503 = **21.9%**



D. Barriers:

Barriers to this project have included the following:

1. Trillium occasionally does not get credit for applicable paid claims due to upstream denials in NCTRACKS.
2. HEARTS data is sent only quarterly but measurements are obtained monthly.
3. Some hospitals outperform other hospitals in terms of scheduling follow-up appointments.
4. Members may not receive adequate support/reminders to attend their follow-up appointments post discharge.
5. Providers schedule follow-up appointments in varying ways. For example, to reduce no show rates some larger providers schedule all post discharge follow-up appointments at 8am on a particular weekday, which can result in a long wait if many appointments are made for that same day.
6. There are multiple systems that need to be linked so data is shared in real time – TBS (formerly CIE)/Billing, and Incedo.
7. The Harbor, a facility-based crisis/detox center in New Hanover County will be closing in the near future. Due to the closing of that facility a nearby crisis center – Dix Crisis Intervention Center in neighboring Onslow County – is anticipating a sharp increase in admissions from the New Hanover area. In addition to increasing the already large number of referrals/admissions from the New Hanover area and causing concern over availability/capacity, those members who travel from areas previously served by The Harbor to Dix Crisis will have further to travel once discharged which could impact successful scheduling/attendance of follow-up appointments.
8. Providers may not be aware that this measure is being tracked state-wide and that large monetary penalties are being implemented by the State for not meeting this measure.
9. There are no claims for members who go to long term care (TROSA, Healing Transitions, WB Jones, etc.) following an inpatient hospitalization.
10. Undetermined how to address members sent to TCLI RSVP database who do not qualify for TCLI.
11. State-funded includes dual eligibility, Medicaid does not include dual eligibility. For State-funded we may pay for the inpatient stay/treatment and private insurance could pay for follow-up, which we would not see since we do not get those claims.

E. Interventions:

- Trillium Claims' Department is identifying technical fixes to resolve and focus on upstream denials and works on claims related to this measure weekly to include revisions and resubmissions.
- Trillium Claims' Department is aligning all current and future edits (taxonomy, etc.) to NCTRACKS edits so that discrepancies are decreased.
- Trillium Data Unit created a report to send to the Claims Department weekly that identifies the provider claims denied by Trillium, along with the denial reason, and broken down by provider specific level, so Claims staff and Network Contract Managers can assist providers with resubmission of claims.
- Network Contract Managers are making contact with their designated provider caseloads to review and discuss denied claims submission errors/issues.
- Ongoing discussion between Trillium and DHB/DMH regarding discrepancies in Trillium's local data and the data sets sent by the State.
- The Data Reporting Team developed an interactive dashboard that tracks all Super Measures in R/RStudio, which has real time data which is updated daily.

- Trillium's Chief Medical Officer is continuing to discuss this measure with other MCO Medical Directors for collaboration when possible.
- Providers identified by data to have high volume of served members and follow-up appointments encouraged to send a staff member from their office to the hospital to communicate directly with members during the discharge process, in hopes of increasing motivation/effort of the individual to attend follow-up appointments.
- Trillium's Chief Medical Officer had discussions with providers (indicated by data) that have high volume of served members and follow-up appointments. These meetings include provider/facility Executives/Medical Directors.
- Care Coordination staff routinely contact members when they are aware of a member's hospitalization to discuss follow-up appointments and any issues surrounding attending those appointments.
- Inpatient Report is ran daily in Incedo by Care Coordination Managers and follow-up tasks are created/assigned by Mangers to Care Coordinators.
- Call Center staff give daily reminder phone calls to members identified as having follow-up appointments post hospital discharge for those members who are scheduled with providers who do not conduct appointment reminders themselves.
- Call Center staff contact members for all providers, regardless of if a provider will contact member themselves.
- Trillium hired 3 new Care Coordinator positions in Greenville to assist with discharge planning for both State/Medicaid members who are ED/Inpatient.
- A workgroup in place currently to address possibility of alternative service definition of Assertive Engagement being added for State-funded only. This would be used in 2 hour blocks, 8 hours max a month.
- An addendum was added to contract with PORT and Coastal Horizons for Opioid services to include incentives for meeting the measure(s).
- An addendum was added to contract with PORT and Coastal Horizons for Peer Support Services as a method to try and improve member follow-up/access.
- Health Connex, a system still in development, may assist in the future. The first batch of data have been received and daily feeds of 2500-3500/day are entered. Member IDs from CIE will be matched to Incedo. The final ADT report will be compared to State Hospital report and Auth Report in TBS (Trillium Business System, formerly CIE) to ensure members are not being missed.
- Dr. Smith and Dr. Garcia obtained data on Dix Crisis related to follow-up appointment percentage and scheduled a visit to the facility to discuss that data with Dix's executive management/staff.
- Trillium Health Resources awarded 3 State contracts for opioid treatment centers in Rocky Mount, Jacksonville, and Morehead City. These centers will divert members from the EDs in their area to the treatment center and are averaging one diversion per week currently.
- Data pertaining to follow-up rate to be shared with providers so they are aware of their individual follow-up rate(s). Education to be provided network wide via newsletters on the Super Measure requirements/penalties.
- Workgroup formed to discuss in detail and to develop a work flow. Member Engagement is reaching out to members in the RSVP database that do not qualify for TCLI. If there is a provider agency currently working with the member, Member Engagement also tries to reach out to them.

- New in lieu of/alternative service for both Medicaid and State funded – Rapid Response Team. Will link to follow-up services within 24 hours of discharge. This was developed due to COVID-19 but could impact data for this project and Trillium could advocate for its' continuation. Will start in Greenville, NC at Vidant Health as a pilot program.

F. Outcome Analysis:

- Measurement data for this project extended over eight quarters; however, Trillium only achieved the goal of this project for one quarter (Jan-March 2019) for DHB members.
- The goal for DHB and DMH penalties is 40%; however, during initial project development, Trillium chose to increase the project goal to 45%. During the eight quarters measured, Trillium achieved 40% or more for seven quarters for DHB members; however, for DMH members, all eight quarters reflect percentages below 40%. Trillium may suffer large financial penalties on a monthly basis if performance is not improved to a level that meets the standard.
- The total number of members (DHB and DMH) discharged from a community hospital, facility based crisis, or state psychiatric hospital fluctuate each quarter. For DHB members, this number fluctuates from 498 (lowest) to 758 (highest). For DMH members, this number fluctuates from 200 (lowest) to 503 (highest). There appears to be no correlation between the number of members discharged for the quarter and the rate at which they receive follow up care.
- Eleven concrete barriers have been identified as obstacles to achieving this goal for twelve consecutive months.
- At this time, focused interventions (working upstream denials, increased focus on claims related to Super Measures, increased communication between Trillium and the State/Other MCOs/Providers/Members, etc.) have not consistently increased the percentage of individuals receiving a follow-up appointment within 1 to 7 days of being discharged from a community hospital, facility based crisis, or state psychiatric hospital.

G. Next Steps:

- Since Trillium is not meeting the expected standard that has been established by DHB and DHM for follow-up appointments after discharge, Trillium will continue this project into FY 2020-2021.
- Trillium will continue with the identified interventions and work to detect any unidentified barriers and potential new interventions that will support the achievement of the project goal.

INCREASING DHB AND DMH SUBSTANCE USE 7 DAY FOLLOW-UP

A. Goal:

The goal of this project is to increase the percentage of individuals receiving a follow-up appointment within 1 to 7 days (excluding same day appointments) of being discharged from a community hospital, facility based crisis, or state psychiatric hospital to 45% or more for both DHB and DMH populations (separate funding sources). **It should be noted that the goal for this measure for DHB and DMH penalties is 40%.*

B. Baseline:

The baseline measurement for this project was taken from January – March 2018. The numerator is the number of individuals discharged from a hospital, facility based crisis, or

state psychiatric hospital who received a follow-up appointment within 1 to 7 days of discharge. The denominator is the total number of individuals discharged.

Numerator – Members receiving a follow-up appointment within 1 to 7 days of discharge

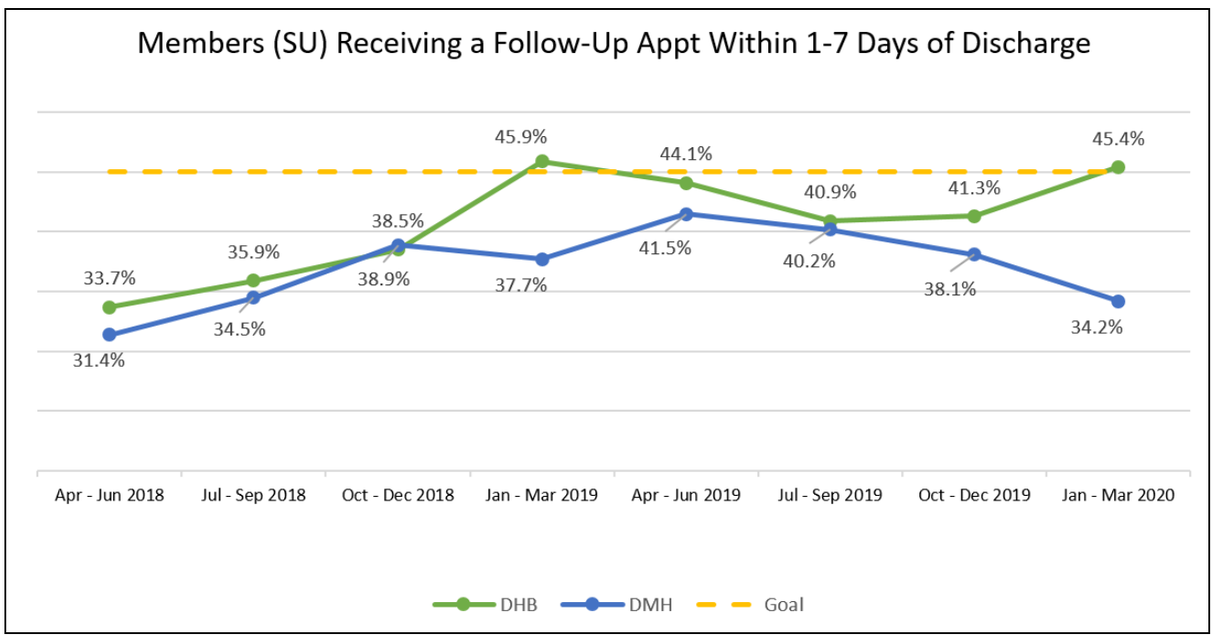
Denominator – All members discharged

Baseline – DHB = 29.1% (N = 25; D = 86); DMH = 31.1% (N = 192; D = 618)

C. Measurements:

Measurements are taken quarterly, accounting for a 90 day claims lag, and previous months' data is revised retroactively as new claims are processed.

- Measurement #1 – April – June 2018 – *DHB* 28/83 = **33.7%**; *DMH* 183/583 = **31.4%**
- Measurement #2 – July – Sept 2018 – *DHB* 28/78 = **35.9%**; *DMH* 205/594 = **34.5%**
- Measurement #3 – Oct – Dec 2018 – *DHB* 42/109 = **38.5%**; *DMH* 243/625 = **38.9%**
- Measurement #4 – Jan – March 2019 – *DHB* 50/109 = **45.9%**; *DMH* 231/612 = **37.7%**
- Measurement #5 – April – June 2019 – *DHB* 49/111 = **44.1%**; *DMH* 257/620 = **41.5%**
- Measurement #6 – July – Sept 2019 – *DHB* 63/154 = **40.9%**; *DMH* 288/717 = **40.2%**
- Measurement #7 – Oct – Dec 2019 – *DHB* 57/138 = **41.3%**; *DMH* 295/775 = **38.1%**
- Measurement #8 – Jan – March 2020 – *DHB* 59/130 = **45.4%**; *DMH* 270/789 = **34.2%**



D. Barriers:

Barriers to this project have included the following:

1. Trillium occasionally does not get credit for applicable paid claims due to upstream denials in NCTRACKS.
2. HEARTS data is sent only quarterly but measurements are obtained monthly.
3. Some hospitals outperform other hospitals in terms of scheduling follow-up appointments.
4. Members may not receive adequate support/reminders to attend their follow-up appointments post discharge.
5. Providers schedule follow-up appointments in varying ways. For example, to reduce no show rates some larger providers schedule all post discharge follow-up appointments

at 8am on a particular weekday, which can result in a long wait if many appointments are made for that same day.

6. There are multiple systems that need to be linked so data is shared in real time – TBS (formerly CIE)/Billing, and Incedo.
7. The Harbor, a facility-based crisis/detox center in New Hanover County will be closing in the near future. Due to the closing of that facility a nearby crisis center – Dix Crisis Intervention Center in neighboring Onslow County – is anticipating a sharp increase in admissions from the New Hanover area. In addition to increasing the already large number of referrals/admissions from the New Hanover area and causing concern over availability/capacity, those members who travel from areas previously served by The Harbor to Dix Crisis will have further to travel once discharged which could impact successful scheduling/attendance of follow-up appointments.
8. Providers may not be aware that this measure is being tracked state-wide and that large monetary penalties are being implemented by the State for not meeting this measure.
9. There are no claims for members who go to long term care (TROSA, Healing Transitions, WB Jones, etc.) following an inpatient hospitalization.
10. Undetermined how to address members sent to TCLI RSVP database who do not qualify for TCLI.
11. State-funded includes dual eligibility, Medicaid does not include dual eligibility. For State-funded we may pay for the inpatient stay/treatment and private insurance could pay for follow-up, which we would not see since we do not get those claims.

E. Interventions:

- Trillium Claims' Department is identifying technical fixes to resolve and focus on upstream denials and works on claims related to this measure weekly to include revisions and resubmissions. Trillium Claims' Department is aligning all current and future edits (taxonomy, etc.) to NCTRACKS edits so that discrepancies are decreased.
- Trillium's Data Reporting Unit created a report to send to the Claims Department weekly that identifies the provider claims denied by Trillium, along with the denial reason, and broken down by provider specific level, so Claims staff and Network Contract Managers can assist providers with resubmission of claims.
- Network Contract Managers are making contact with their designated provider caseloads to review and discuss denied claims submission errors/issues.
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- The Data Reporting Unit developed an interactive dashboard that tracks all Super Measures in R/RStudio, which has real time data which is updated daily.
- Trillium's Chief Medical Officer is continuing to discuss this measure with other MCO Medical Directors for collaboration when possible.
- Providers identified by data to have high volume of served members and follow-up appointments encouraged to send a staff member from their office to the hospital to communicate directly with members during the discharge process, in hopes of increasing motivation/effort of the individual to attend follow-up appointments.
- Trillium's Chief Medical Officer had discussions with providers (indicated by data) that have high volume of served members and follow-up appointments. These meetings include provider/facility Executives/Medical Directors.

- Care Coordination staff routinely contact members when they are aware of a member's hospitalization to discuss follow-up appointments and any issues surrounding attending those appointments.
- Inpatient Reports are ran daily in Incedo by Care Coordination Managers and follow-up tasks are created/assigned by Mangers to Care Coordinators.
- Call Center staff give daily reminder phone calls to members identified as having follow-up appointments post hospital discharge for those members who are scheduled with providers who do not conduct appointment reminders themselves.
- Call Center staff contact members for all providers, regardless of if a provider will contact member themselves.
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- A workgroup in place currently to address possibility of alternative service definition of Assertive Engagement being added for State-funded only. This would be used in 2 hour blocks, 8 hours max a month.
- An addendum was added to contract with PORT and Coastal Horizons for Opioid services to include incentives for meeting the measure(s).
- An addendum was added to contract with PORT and Coastal Horizons for Peer Support Services as a method to try and improve member follow-up/access.
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- Data pertaining to follow-up rate to be shared with providers so they are aware of their individual follow-up rate(s). Education to be provided network wide via newsletters on the Super Measure requirements/penalties.
- Workgroup formed to discuss in detail and to develop a work flow. Member Engagement is reaching out to members in the RSVP database that do not qualify for TCLI. If there is a provider agency currently working with the member, Member Engagement also tries to reach out to them.
- New in lieu of/alternative service for both Medicaid and State funded – Rapid Response Team. Will link to follow-up services within 24 hours of discharge. This was developed due to COVID-19 but could impact data for this project and Trillium could advocate for its' continuation. Will start in Greenville, NC at Vidant Health as a pilot program.

F. Outcome Analysis:

- Measurement data for this project extended over eight quarters; however, Trillium only achieved the goal of this project for two quarters (Jan-March 2019 & Jan-March 2020) for DHB members.

- The goal for DHB and DMH penalties is 40%; however, during initial project development, Trillium chose to increase the project goal to 45%. During the eight quarters measured, Trillium achieved 40% or more for five quarters for DHB members; however, for DMH members, only two quarters reflect percentages above 40%. Trillium may suffer large financial penalties on a monthly basis if performance is not improved to a level that meets the standard.
- The total number of members (DHB and DMH) discharged from a community hospital, facility based crisis, or state psychiatric hospital fluctuate each quarter. For DHB members, this number fluctuates from 78 (lowest) to 154 (highest). For DMH members, this number fluctuates from 583 (lowest) to 789 (highest). There appears to be no correlation between the number of members discharged for the quarter and the rate at which they receive follow up care.
- Eleven concrete barriers have been identified as obstacles to achieving this goal for twelve consecutive months.
- At this time, focused interventions (working upstream denials, increased focus on claims related to Super Measures, increased communication between Trillium and the State/Other MCOs/Providers/Members, etc.) have not consistently increased the percentage of individuals receiving a follow-up appointment within 1 to 7 days of being discharged from a community hospital, facility based crisis, or state psychiatric hospital.

G. Next Steps:

- Since Trillium is not meeting the expected standard that has been established by DHB and DHM for follow-up appointments after discharge, Trillium will continue this project into FY 2020-2021.
- Trillium will continue with the identified interventions and work to detect any unidentified barriers and potential new interventions that will support the achievement of the project goal.

Improving the Percentage of Timely Contacts with TCLI Individuals in In-Reach Status

A. Goal:

The goal of this project is for 98% of TCLI In-Reach individuals to have received a documented contact using identified method/software system at least once every 90 days.

B. Baseline:

The baseline measurement was taken from January 2019. The baseline and subsequent measurements are taken from Incedo.

Numerator - # of members contacted at least once within a rolling 90 day period.

Denominator - # of all members currently in In-Reach status at the time of measurement (a monthly "snapshot")

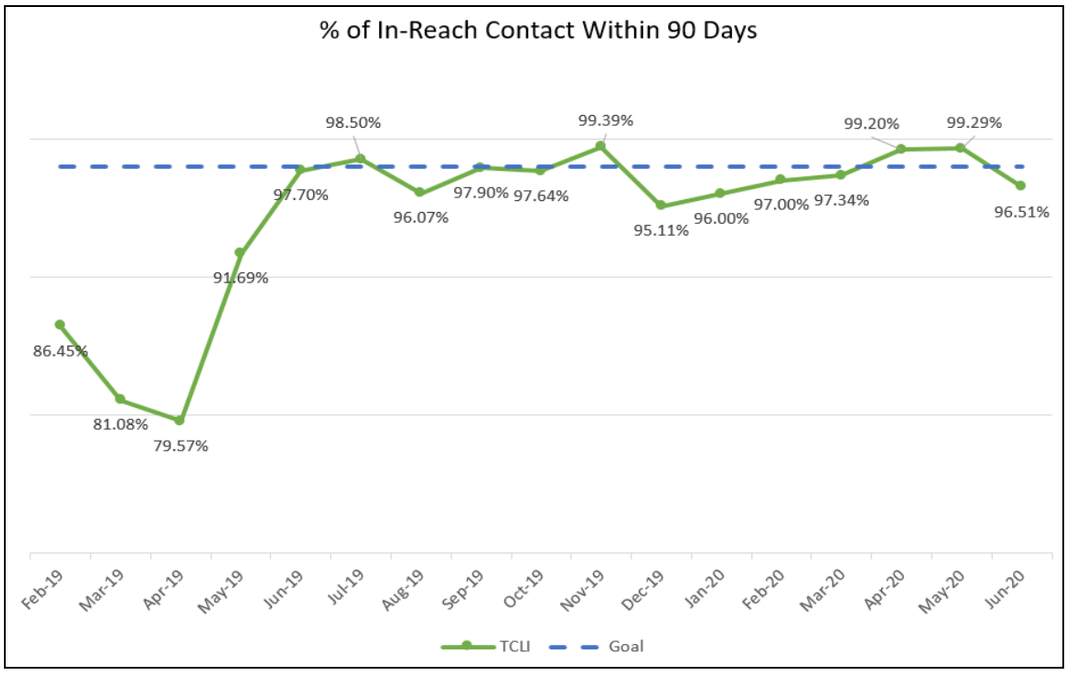
Baseline – 88.5% (N = 956; D = 1080)

C. Measurements:

Measurements are taken monthly, and are as follows:

- Measurement #1 – February 2019, **86.45%** (N = 919; D = 1063)
- Measurement #2 – March 2019, **81.08%** (N = 780; D = 962)

- Measurement #3 – April 2019, **79.57%** (N = 771; D = 969)
- Measurement #4 – May 2019, **91.69%** (N = 938; D = 1023)
- Measurement #5 – June 2019, **97.7%** (N = 918; D = 940)
- Measurement #6 – July 2019, **98.5%** (N = 899; D = 913)
- Measurement #7 – August 2019, **96.07%** (N = 954; D = 993)
- Measurement #8 – September 2019, **97.90%** (N = 994; D = 1015)
- Measurement #9 – October 2019, **97.64%** (N = 994; D = 1018)
- Measurement #10 – November 2019, **99.39%** (N = 976; D = 982)
- Measurement #11 – December 2019, **95.11%** (N = 934; D = 982)
- Measurement #12 – January 2020, **96.0%** (N = 955; D = 995)
- Measurement #13 – February 2020, **97.0%** (N = 985; D = 1015)
- Measurement #14 – March 2020, **97.34%** (N = 952; D = 978)
- Measurement #15 – April 2020, **99.20%** (N = 998; D = 1006)
- Measurement #16 – May 2020, **99.29%** (N = 974; D = 981)
- Measurement #17 – June 2020, 96.51% (N = 940; D = 974)



D. Barriers:

Barriers to this project have included the following:

1. Some TCLI members in Incedo have multiple In-Reach tasks open which may cause duplication in the reports.
2. RI, who the task of In-Reach is delegated to, does not use a uniform naming convention for "In Reach" tasks and may not consistently close out old tasks when a new care manager is assigned.
3. Some RI staff were marking tasks complete instead of leaving open which made TCLI's reports miss these members within search criteria since the search is for "open," not closed.
4. TCLI data analyst added the TCLI Designators to Incedo and modified the final Informatics report which was published in early May 2019 to work off those designators. This affected the percentage a bit as TCLI staff had been missing a few members due to the nature of how the initial report was written. Additionally, with the

new designators came an easier way to query for missing tasks and "unassigned" In Reach members that is allowing reconciliation of TCLI database and Incedo.

E. Interventions:

- The In-Reach report was edited so that most recently updated "In-Reach Task" date for any duplicate In-Reach Task members is used. This ensures the percentage is not affected by having members with both overdue and on time reports being generated. TCLI will continue to work with RI to ensure they close out any extra In-Reach tasks on members. Currently a weekly report is sent to RI on Monday mornings, which contains a list of members with more than one In-Reach task open. RI has been able to resolve a majority of these since the reports inception. Resolution is ongoing.
- Weekly report of In-Reach members lacking a contact within 90 days sent to RI.
- Small table added to documentation sent to RI staff that has a total count of overdue member by coach.
- Education provided to RI.
- TCLI Data Analyst working with Informatics to develop further TCLI Data Validation Reports.
- Addendum to contract with RI International includes penalty language for not meeting In-Reach goals.

F. Outcome Analysis:

- Measurement data for this project extended seventeen months; however, Trillium only achieved the goal of this project for four months (July 2019, Nov 2019, April 2020, and May 2020).
- The total number of members in In-Reach status at the time of the measurement fluctuate each month; this ranges from 913 (lowest) to 1063 (highest). There appears to be no correlation between the number of members in In-Reach status and the rate at which they are contacted in a rolling 90 day period.
- Four concrete barriers have been identified as obstacles to achieving this goal for twelve consecutive months.
- At this time, targeted interventions (weekly reports to RI, report filtering, etc.) have not consistently increased compliance with In-Reach contacts once every 90 days by RI staff.

G. Next Steps:

- Since Trillium has not yet met performance targets for twelve consecutive months, Trillium will continue this project into FY 2020-2021.
- Trillium will continue with the identified interventions and work to detect any unidentified barriers and potential new interventions that will support the achievement of the project goal.

DECREASE INAPPROPRIATE UTILIZATION OF EMERGENCY DEPARTMENT FOR MEMBERS

A. Goal:

The goals of this project are: Measure 1) To reduce the number of ED visits to 0.66% or below; Measure 2) Increase follow-up treatment percentage after ED visits to 80% or

above; Measure 3) Decrease number of IIH and ACTT members utilizing the ED to 7.79% or below.

B. Baselines:

Numerators

Measure 1) # of ED visits
Measure 2) # of ED discharges with a follow-up within 30 days, excluding ED and MCM
Measure 3) IIH and ACTT recipients having an ED visit within 30 days of IIH or ACTT service

Denominators

Measure 1) Eligible population
Measure 2) # of ED discharges
Measure 3) Members receiving IIH or ACTT within the timeframe

Baselines

Measure 1) 0.67% (N = 1,661; D = 248,179)
Measure 2) 76.72% (N = 1,269; D = 1,654)
Measure 3) 8.36% (N = 129; D = 1,543)

C. Measurements:

Measurements will be taken quarterly via report developed/shared by the Informatics Unit.

- Measurement #1 – Oct-Dec 2019

  #1) **0.68%** (N = 1,654; D = 243,580)

  #2) **78.55%** (N = 1,296; D = 1,650)

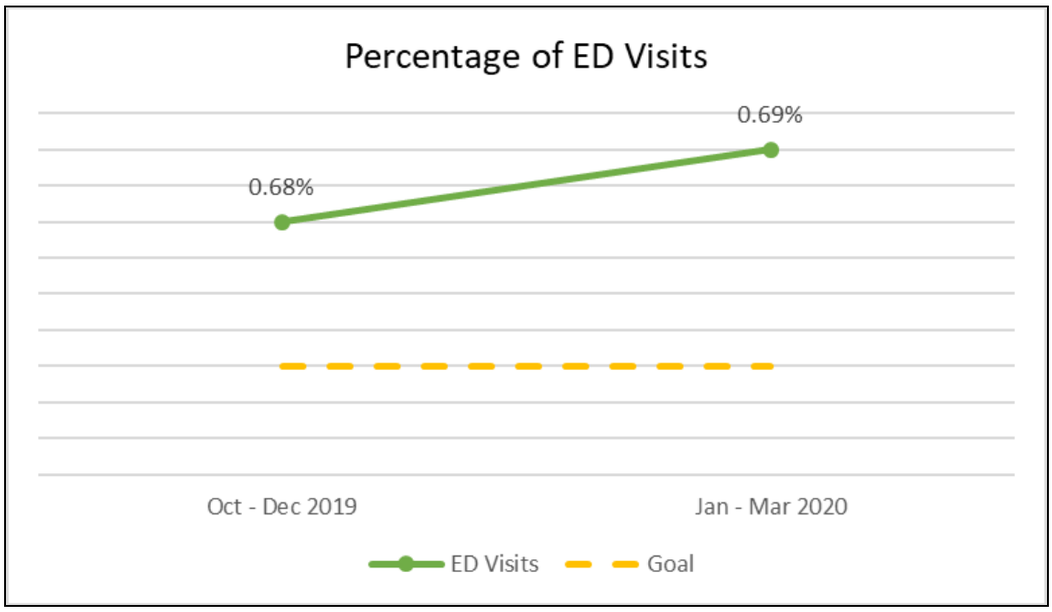
  #3) **8.91%** (N = 151; D = 1,695)

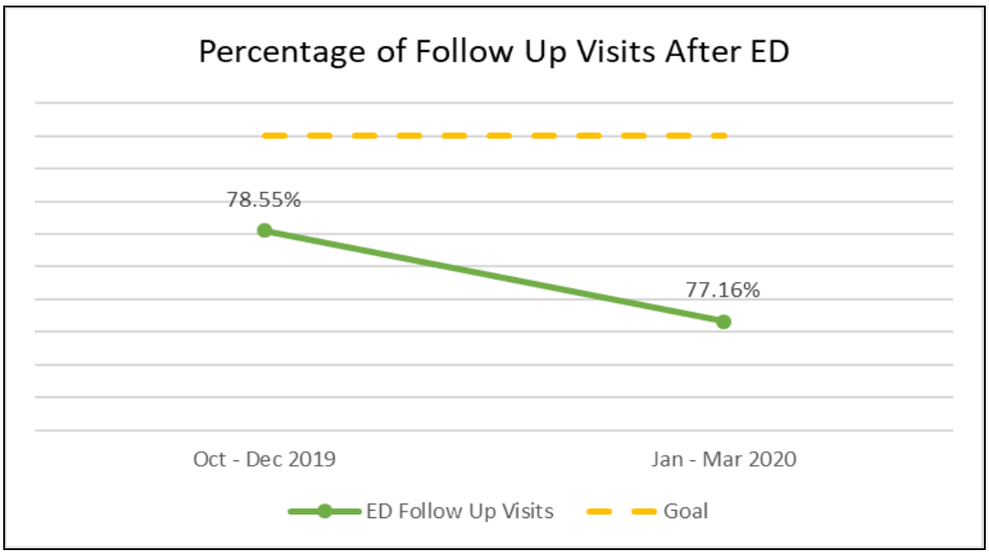
- Measurement #2 – Jan-March 2020

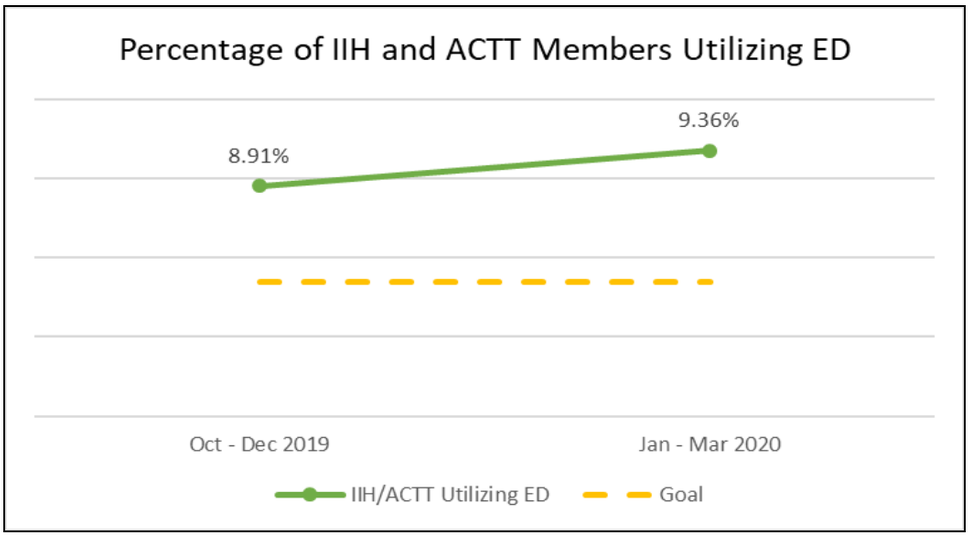
  #1) **0.69%** (N = 1,652; D = 239,563)

  #2) **77.16%** (N = 1,284; D = 1,664)

  #3) **9.36%** (N = 159; D = 1,698)







D. Barriers:

Barriers to this project have included the following:

1. CC/CCM dept. is changing to a new software platform summer of 2020.
2. Not all facilities participate in the feed.
3. Access to care in rural communities.
4. Lack of adequate staff to address new or additional work.
5. Lack of funded alternatives for Emergency Departments.
6. Insufficient core Medicaid benefits.
7. Inconsistent ED performance.
8. Senate Bill 630 changed the IVC law for North Carolina. The changes involved are unfunded mandates and could have impact on the crisis system state wide.

E. Interventions:

- Transition period of additional data validation from previous to new system.
- CC/CCM staff to compare member data from authorization report and State hospital report to ensure members are being linked to appropriate resources and/or Care Coordination.
- The East Carolina University/Brody School of Medicine Department of Family Medicine is applying for a federal grant in regards to increasing Telehealth in rural counties and has requested Trillium Health Resources provide a letter of support.
- Three clinicians hired within the CC department to focus on ED/Inpatient admissions of members and to link with follow-up and resources.

- Trillium Health Resources awarded 3 State contracts for opioid treatment centers in Rocky Mount, Jacksonville, and Morehead City. These centers will divert members from the EDs in their area to the treatment center and are averaging one diversion per week currently.
- "Life Transitions" is an In Lieu Of service for SPMI members meant to decrease inpatient admissions in New Hanover county by providing apartments specifically ran for the SPMI population. Based on a model from provider in Tennessee with successful outcomes.
- Recruitment of Family Centered treatment providers via an RFP. Will be incentive based with identified outcome measures. Applications received and reviewed, recommendations made for 3 providers but on hold until November 2020. These providers would not provide IIH services on the In Lieu Of service.
- Will identify data specific to each Emergency Department in catchment to rank according to which might need most assistance.
- RFI posted for development of Behavioral Health Urgent Care (BHUC) sites within 9 identified regions of Trillium's 26 county catchment area. Sites would be either open 12 or 24 hours a day, 7 days a week, and 365 days a year and would provide crisis related/identified services. Trillium has not as of yet received any responses to this RFI.
- Creation of a Community Crisis Plan by region that addresses potential issues that may arise due to changing IVC law.
- Trillium is in stage 1 of the ACTT plus Pilot. The pilot aims to deter and decrease ED visits through increased utilization of ACTT services.

F. Outcome Analysis:

- Measurement data for this project extended over two quarters. At this time, achievement has not been obtained for either quarter for the three measures/goals of this project.
- Based on the measurement data received, the total number of ED discharges and the total number of members receiving IIH or ACTT do not fluctuate drastically over the two quarters (differences of 14 discharges and 3 members, respectively). However, the total eligible population decreased from 243,580 (Oct-Dec 2019) to 239,563 (Jan-March 2020). At this time, with measurement data obtained for only two quarters, no conclusion can be made regarding the correlation of the population sample and the project measure/goal.
- Eight concrete barriers have been identified as obstacles to achieving the project goals.
- At this time, targeted interventions have not consistently reduced the number of ED visits, increased follow up treatment percentage after ED visits, nor decreased the number of IIH and ACTT members utilizing the ED.

G. Next Steps:

- Since Trillium has not yet met performance targets for twelve consecutive months, Trillium will continue this project into FY 2020-2021.
- Trillium will continue with the identified interventions and work to detect any unidentified barriers and potential new interventions that will support the achievement of the project goals.

INCREASE UTILIZATION OF MST SERVICES FOR MEMBERS BETWEEN THE AGES OF 12-17 WITH CONDUCT DISORDER DIAGNOSIS

A. Goal:

The goal of this project is to increase current utilization rate of MST services for members diagnosed with Conduct Disorder to 14.7% or above.

B. Baseline:

Numerator – # of members who received MST

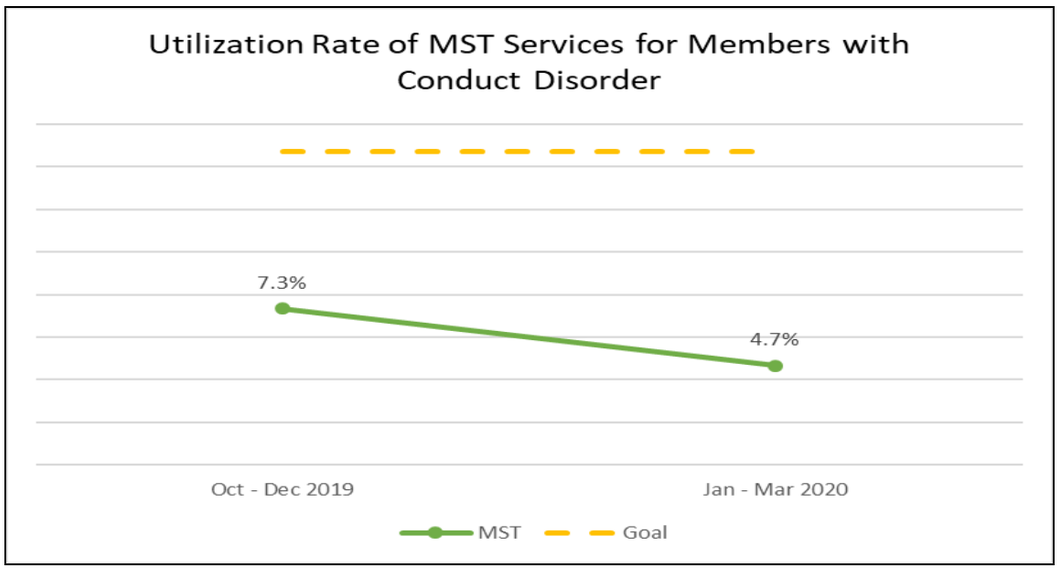
Denominator – Any member age 12-17 with a primary diagnosis of Conduct Disorder on a claim

Baseline – 9.04% (N = 16; D = 177)

C. Measurements:

Measurements will be taken quarterly via report developed/shared by the Informatics Unit.

- Measurement #1 – Oct-Dec 2019 – **7.33%** (N = 14; D = 191)
- Measurement #2 – Jan-March 2020 – **4.67%** (N = 10; D = 214)



D. Barriers:

Barriers to this project have included the following:

1. Insufficient access to MST Services
2. Low utilization of MST Services
3. Lack of education on MST Services

E. Interventions:

- Expansion of MST into Onslow county and Columbus county via 2 providers - Easter Seals UCP in Onslow and Alexander Youth Network in Columbus. Both Alexander Youth Network and Easter Seals UCP began taking referrals effective the end of June 2020.
- UM/Dr. Garcia continue to conduct over/under utilization reviews and make recommendation of MST when appropriate to providers.
- Care Coordination and Call Center staff to educate families on MST service.
- Trillium staff – Lauren Swain – to educate county providers/DJJ staff on MST service utilization.
- Ongoing training with all 26 county Department of Social Services on MST service utilization conducted/facilitated by Trillium staff (Sean Kenny and Regional Directors).

- School systems (i.e., alternative schools) will receive education on MST services.
- Due to Child Care Coordinator turnover and limited MST referrals from Care Coordination, education/training on MST services will be provided to Child Care Coordinators.

F. Outcome Analysis:

- Measurement data for this project extended over two quarters. At this time, achievement has not been obtained for either quarter for the goal of this project.
- Based on the measurement data received, the total number of members age 12-17 with a primary Conduct Disorder diagnosis on a claim fluctuate each quarter. There appears to be a correlation between the population sample and the utilization rate of MST services; the higher the population sample, the lower the utilization rate of MST services.
- Three concrete barriers have been identified as obstacles to achieving the project goal.
- At this time, targeted interventions have not consistently increased the utilization rate of MST services for members between the ages of 12-17 with Conduct Disorder diagnosis.

G. Next Steps:

- Since Trillium has not yet met performance targets for twelve consecutive months, Trillium will continue this project into FY 2020-2021.
- Trillium will continue with the identified interventions and work to detect any unidentified barriers and potential new interventions that will support the achievement of the project goal.

CLOSED PROJECTS FY 2019-2020

INCREASING PROVIDER SATISFACTION RELATED TO THE APPEALS PROCESS FOR DENIAL, REDUCTIONS, OR SUSPENSION OF SERVICE(S)

A. Goal:

The goal of this project was to increase the satisfaction percentage related to the appeals process for denial, reduction, or suspension of service(s) of network providers who responded to Question #26 of the Annual DHHS Provider Satisfaction Survey to the 2017 state average of all MCOs, which is 77.5%.

B. Baseline:

The baseline measurement for this project was taken from Question #26 of the 2017 DHHS Provider Satisfaction Survey results – "My agency is satisfied with the appeals process for denial, reduction, or suspension of service(s)." The numerator is the number of responses that were "Strongly Agree" and "Agree" to Question #26, and the denominator is the number of total responses to Question #26.

Numerator – 34 "Strongly Agree" + 205 "Agree" = 239

Denominator – Total Responses = 334

Baseline – 71.56% (N = 239; D = 334)

C. Measurements:

Measurements will be taken annually from the Annual DHHS Provider Satisfaction Survey Results Report.

- Measurement #1 – 2018 Annual Results – 80.9% (N = 131; D = 162)
- Measurement #2 – 2019 Annual Results – 83.2% (N = 163; D = 196)

D. Barriers:

Barriers to this project have included the following:

1. Providers may be uncertain or experience confusion surrounding the different appeal processes Trillium offers (UM appeals, Peer to Peer reviews, Sanctions) and may be basing their satisfaction on a process other than appeals related to the denial, reduction, or suspension of services.
2. It is unknown as to the specific reasons providers may not be satisfied with the appeals process in order to design and implement specific interventions to improve satisfaction.
3. In 2017 there was an increase in appeals related to Innovations Waiver services for Nash County members who were transitioned from another MCO to Trillium's catchment area/benefit plan.
4. Data will be impacted by changes occurring in November 2019 (Standard Plan implemented in initial regions which includes Nash County) and February 2020 (Standard Plan implemented in remaining regions).

E. Interventions:

- Education provided to the provider network on the different Trillium appeal processes.
- The Trillium QM and Appeals Department conducted quarterly post-appeal process surveys to determine what the providers experience was and their reasons for dissatisfaction, if any.
- With the transition of Columbus County occurring July 2018, Trillium staff increased communication with Columbus County providers surrounding differences in benefit plans and increased overall interpersonal interaction with provider staff.

F. Outcome Analysis:

- Measurement data for this project extended over three years. As of January 2020, achievement of the project goal was met and maintained for twelve consecutive months, therefore, this project was closed successfully.

G. Next Steps:

- Trillium will continue to monitor and review annual survey data to assess for trends or outliers that may require action or interventions.