

2019-2020 QUALITY MANAGEMENT PLAN



Trillium
HEALTH RESOURCES

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QUALITY MANAGEMENT PLAN OF TRILLIUM HEALTH RESOURCES

PROGRAM DESCRIPTION

OVERVIEW OF PROGRAM

The Quality Management (QM) Plan of Trillium Health Resources is designed to ensure that Local Management Entity (LME)/Managed Care Organization (MCO) core functions and qualified provider network services are delivered in a manner that is entirely consistent with the State Plan, our mission, philosophy, values, working principles, and in a manner that meets or exceeds the standards and statutory requirements under which the LME/MCO operates. The purpose of the Quality Management Plan is to establish a planned, systematic and comprehensive approach to measure, assess, and improve organization-wide performance. The quality improvement plan outlines the structure, processes and methods Trillium Health Resources uses to determine activities and measure outcomes related to the improvement of the care and treatment of members. The focus is on the continuous improvement of the quality and safety of clinical care, and quality of services. The Quality Management Plan promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement activities based upon the findings. The Quality Management Plan is designed to assess and analyze systems performance data that will subsequently guide performance improvement for better supporting the people we serve. The Quality Management Plan balances Quality Assurance and Quality Improvement activities in that Quality Assurance activities inform the Quality Improvement process. Quality Assurance activities yield data from multiple sources, which, after analysis, is integrated and utilized for planning and guiding administrative and managerial decision-making. The ultimate measure of the Quality Management Program's success is the achievement of desired individual outcomes by the people we serve.

The Quality Management Plan is reviewed at least annually. It is available for review by the various regulatory and accreditation entities (e.g. Centers for Medicare and Medicaid Services [CMS] and National Committee for Quality Assurance [NCQA]) upon request. It is also made available to our members and the network.

SCOPE

The scope of the Quality Improvement Plan is designed to promote and measure member safety, and the quality and appropriateness of behavioral health services. The improvement

program works in conjunction with the organization's utilization plan and the Network Adequacy and Accessibility Analysis.




Input and feedback into the QI process from members and various stakeholders across all catchment areas are valuable components of the Quality Improvement Plan.

The scope of the plan is cross functional and activities are focused on access, clinical quality, satisfaction, service, qualified providers and compliance. Activities are designed to address health care settings both physical and behavioral; evaluate the quality and appropriateness of care and services provided to members; pursue opportunities for improvement; and lastly, resolve identified problems.

Detailed processes and methodology are used to determine the overall efficacy of quality improvement activities. The monitoring of specific indicators is designed, measured and assessed by all appropriate departments to reveal trends and opportunities in an effort to improve organizational performance. These indicators are objective, measurable, based on current scientific literature, knowledge, and clinical experience, broadly recognized in the industry, and structured to produce statistically valid performance measures of care and services provided.

STATEMENT OF PURPOSE/OBJECTIVES:

The North Carolina Department of Health and Human Services identified as high priorities:

-  Advancing whole-person care so that all plans will include physical health, mental health, and substance use services for beneficiaries;
-  Addressing unmet health-related resource needs (sometimes called the "social determinants of health" or "healthy opportunities");
-  Enhancing local, community-based care management.

At the core of these efforts is the goal of improving the health of North Carolinians through an innovative, whole-person centered, well-coordinated system of care that addresses both medical and non-medical drivers of health.

These priorities are closely aligned with [CMS's Quality Strategy](#) which was adapted to address local priorities, challenges, and opportunities for North Carolina's Medicaid program.

The state's plan is based on the Institute of Healthcare Improvement's Triple Aim framework which includes: 1) Improving of the health of the population, 2) Improving the patient experience of care (including quality and satisfaction) and 3) Reducing or at least controlling the per capita cost of care.

In alignment with North Carolina's Quality Strategies, the overarching purpose of Trillium's Quality Management Plan is focused on:

-  Better Care Delivery

- ♻️ Healthier People, Healthier Communities
- ♻️ Smarter Spending

These strategies support Trillium's Mission Statement, which is "Transforming the lives of people in need by providing them with ready access to quality care."

Achieving these strategies will be a continuous commitment requiring on-going efforts such as:

- ♻️ ensuring that resources are directed toward agency priorities;
- ♻️ operational risks are immediately identified; staff and practitioners/providers are held accountable for meeting the agency's quality goals and desired outcomes;
- ♻️ regular, routine performance measurements and reporting;
- ♻️ staff a pervasive culture of respect, collaboration, and improvement among all participants;
- ♻️ administrative commitment to hear and consider input from all stakeholders and implement those recommendations for improvements that are reasonable, economically feasible and actionable; and
- ♻️ state leaders, policy makers and legislators who support member and staff empowerment and system improvements through enthusiastic, creative leadership over the long-term.

STRUCTURE OF THE QUALITY MANAGEMENT PROGRAM:

1. AUTHORITY AND RESPONSIBILITY

The organization's governing body, the Governing Board, is responsible for the oversight of the Quality Management Plan and the annual approval of the Plan. The approval of the Plan is documented in the minutes of the Quality Improvement (QI) Committee and the Board meeting. The Director of Quality Management leads and directs all quality management activities, which include:

- ♻️ Responsibility for the organization's compliance with contract requirements
- ♻️ Federal and State statutes
- ♻️ Performance standards
- ♻️ Supervising the implementation of the Quality Management Plan
- ♻️ Supporting the QI Committee in conducting activities
- ♻️ Tracking identified opportunities for improvement through the ongoing analysis of data.
- ♻️ Ongoing monitoring for compliance with national accreditation standards and providing leadership in accreditation reviews.
- ♻️ Providing quality related training to staff of Trillium Health Resources and to practitioners/providers in the network.
- ♻️ Reporting on the Quality Management Plan to the Governing Board.

2. CONTINUOUS QUALITY IMPROVEMENT (CQI) MODEL:

Trillium Health Resources quality improvement philosophy is based on the continuous quality improvement model which involves a process of design, discovery, remediation, and improvement.

There are three categories of requirements that provide the framework for these principles:

- 🌱 Organizational framework, policies and procedures = Design
- 🌱 Quality Assurance (QA) System = Discovery
- 🌱 Quality Improvement = Discovery, Remediation, and Improvement

A process for implementing appropriate remedial action for continuous quality improvement includes the following elements;

- 🌱 A structured and systematic approach to identify quality improvement opportunities;
- 🌱 A common language for problem solving techniques;
- 🌱 Facilitation of communication among groups;
- 🌱 Provides supports for the basis quality value of managing by data;
- 🌱 An increase in the credibility of data and reproducibility.

The design, discovery, remediation and improvement model is a process to identify and implement strategies and improvement activities.

- 🌱 **Design:** The designing and incorporation of quality and improvement strategies into the structures and processes of the organization.
- 🌱 **Discovery:** Evaluate data, identify opportunities to prevent/improve behavioral health problems or occurrences, and identify appropriate intervention strategies based on best practices and known barriers.
- 🌱 **Remediate:** Implement program(s) to address identified needs and barriers.
- 🌱 **Improvement:** Measure the effects of the improvement program and assess its effectiveness; continue intervention if effective; adjust as necessary to achieve goal targets; and repeat the cycle if the intervention does not achieve desired result.

Trillium's implementation and fulfillment of this model allows for an integrative approach that combines strategy, data, and communication to build a culture of excellence founded on quality principles.

3. RESOURCES

The philosophy of Trillium Health Resources is that all staff, contractors, and providers are "quality-driven." Quality improvement and quality management is integrated throughout the organization, and all staff have a role in the assurance of quality.

Trillium Health Resources has a full-time Director of Quality Management who has the authority and responsibility for the overall operation of the Quality Management Plan. The Director of Quality Management is supported by the Chief Medical Officer, with the Chief

Medical Officer co-chairing the Quality Improvement Committee along with the Director of Quality Management.

The Information Technology department provides a technology framework for increasing overall productivity, efficiency, and performance, all of which support the agency's mission and goals. The Business Informatics unit ensures that data is made available for timely, accurate reporting, and analysis.

This data is used by committees and management to make decisions regarding operations and the service system. Data enables the agency to monitor, coordinate and improve operations, and evaluate areas of need as well as potential areas for improvement.

The Performance Improvement Unit consists of a Performance Improvement Manager and Quality Management Coordinators. This Unit is responsible for monitoring incident reports, quality improvement activities, satisfaction/experience surveys, Trillium's Committee Structure, policy and procedure development, and various other tasks.

An organizational chart of Trillium Health Resources is available in Attachment A.

An organizational structure of the QIC is available in Attachment B.

Resources available to the Quality Management function include various Trillium departments, Medical Affairs, Utilization Management, Call Center, Customer Services, Care Coordination, Communications, Information Technology, Regional Operations, Program Integrity, Compliance, and Network. Organizational charts provide a more comprehensive description of the resources available within each department.

In addition to QM staff, the following systems support the QM Department:

- ▲ Microsoft Office Software, including Excel and Microsoft Project
- ▲ CIE Application for STR and UM
- ▲ CIE Provider Monitoring Database
- ▲ CIE Complaints Database
- ▲ Outlook
- ▲ CISCO
- ▲ MS SQL Reporting Services
- ▲ SPSS (Analytic Software)
- ▲ SharePoint
- ▲ Smart sheet
- ▲ Incedo
- ▲ RStudio
- ▲ Netsmart

Trillium collects, stores, groups, analyzes and uses the following data in order to identify opportunities for improvement, and track and measure process, outcomes and overall effectiveness. These data sources include, but are not limited to:

- 🌱 HEDIS reports
- 🌱 Quality Rating System (QRS)
- 🌱 Member Experience Surveys (CAHPS)/ ECHO
- 🌱 Provider satisfaction surveys
- 🌱 Access and availability data (GeoAccess)
- 🌱 Continuity and coordination of care processes and data
- 🌱 Credentialing and re-credentialing data and files
- 🌱 Member quality-of-care complaints
- 🌱 Member complaints and appeals
- 🌱 Provider complaints and appeals
- 🌱 Utilization Management data and files
- 🌱 Delegated entities' performance data
- 🌱 Internal audits of Quality Improvement processes, data and reports
- 🌱 Online interactive tools/HRA data and reports
- 🌱 Feedback from external regulatory and accrediting agencies

All data is stored in Trillium's electronic systems. Utilization and member/provider data is stored, updated and maintained in an Enterprise Data Warehouse that is backed up daily. Data resulting from surveys, interaction with members, mandatory reporting and specific analysis and monitoring are stored in independent databases supported by the IT Department which in turn ensures data confidentiality in compliance with HIPAA regulations. Data accuracy is assessed through periodic audits such as medical record reviews for performance monitoring and reporting, sharing of performance data with providers and other internal audit processes. Data collection, management and analysis is carried out by Trillium's staff with the appropriate background and qualifications required by the task, such as data management, computer programming, data analysis and clinical expertise.

A comprehensive data recovery process is in place to ensure continuity of business in the event of a major adverse event. All data is backed up daily and stored in an outside location. Trillium has an established tele-work procedure and several locations that contribute to a fast restoration of services in the event of a major adverse event.

All data, documents, reports, materials, files and committee minutes are kept for a period of years (according to various regulatory, state and federal requirements), whether on site or achieved in a secured site. Trillium has organizational procedures related to data and records that are reviewed annually and that clearly describes processes.

4. COMMITTEE STRUCTURE

A. Quality Improvement Committee:

The Quality Improvement Committee (QIC) is granted authority for quality management by the Governing Board and therefore provides on-going reporting to the Board. The QIC consists of a cross functional team including members from various departments across the organization, in addition to the Trillium Health Resources Chief Medical Officer (See Attachment C Job Description) Trillium's Chief Medical Officer has full responsibility and

authority for the quality of care provided to members. The QIC has been established as the method by which the annual Quality Management Plan is brought to life. The QIC is designed to support Trillium Health Resources' goal of providing care of the highest caliber possible within the constraints of available resources. The QIC's ongoing goal is to ensure that the LME/MCO meets, at minimum, state and national accreditation standards for quality.

In addition, Trillium uses measurements of quality in clinical care and drives continuing improvement that positively affects member care. Its primary purpose is to collect and integrate various data sources such as outpatient, inpatient, pharmacy, lab, and demographics. Once integrated, data is analyzed, interpreted and opportunities for improvement are identified. The Committee is charged with working cross-functionally to accomplish the Quality Improvement Activities of the organization. The QIC conducts a more focused review of any topics that it deems is warranted and as measured by tracking and trending performance indicators.

The QIC meets, at minimum, on a monthly basis and maintains approved minutes of all Committee meetings. The QIC is co-chaired by the Chief Medical Officer and the Director of Quality Management. A quorum must be present in order for voting to occur. A quorum shall exist when there is a simple majority of voting members present at an official committee meeting or during an expedited approval process.

The primary responsibilities of the QIC are to:

- ▲ Provide guidance to staff on quality management priorities and projects
- ▲ Consult on quality improvement activities to undertake
- ▲ Monitor progress in meeting quality improvement goals
- ▲ Monitor adherence to key performance indicators (KPI) internally and externally
- ▲ Review and approve the Quality Management Plan and QM Work Plan
- ▲ Evaluate the effectiveness of the Quality Management Plan annually
- ▲ Approve and maintain policies and procedures
- ▲ Evaluate survey results and determine opportunities for improvement

B. Compliance Committee

The purpose of the Compliance Program is to prevent and/or detect operational non-compliance within the organization. The Compliance Committee has the primary responsibility for ensuring that the organization's compliance policies and procedures are accurate and, as appropriate, integrated into the operations of the organization.

The Compliance Committee:

- ▲ Meets on a monthly basis, in order to identify opportunities for reducing risks within the organization by identifying and reviewing any potential conflicts of interest. The Compliance Committee consists of member representation from various departments, including the Chief Medical Officer.
- ▲ Reviews results/risks identified from Internal Compliance Monitoring of each Department/functional area throughout the year.

- 🌱 Reviews the Compliance Plan and the evaluation of the Compliance Program, at minimum, on an annual basis.
- 🌱 Arranges for responses to all staff questions concerning Compliance that may or may not be readily answered from policies or procedures.
- 🌱 Receives, documents, and acts in response to any complaints made by staff regarding Trillium Health Resources' Compliance practices and procedures.
- 🌱 Maintains the accuracy of the organization's Compliance policies and procedures. This includes a review of federal and state laws and regulations and modifying policies and procedures, as necessary and appropriate, to comply with changes in the law.
- 🌱 Detects and prevents fraud and abuse within the provider network through reviewing reports, complaints, and current investigations on fraud and abuse.

C. Human Rights Committee

The Human Rights Committee is comprised of board representation, member/family members and practitioners/providers representing all disability groups. Trillium staff serve as liaisons to the committee.

The primary responsibility of the committee is to ensure the protection of members' rights by:

- 🌱 Reviewing complaints and grievances regarding potential client rights violations
- 🌱 Reviewing member appeals (monthly and quarterly data)
- 🌱 Reviewing concerns regarding the use of restrictive interventions by providers
- 🌱 Reviewing concerns regarding confidentiality
- 🌱 Reviewing concerns regarding member incident reports

D. Global Quality Improvement Committee

The Global Quality Improvement Committee serves as a fair and impartial committee representing practitioners/providers to discuss and explore ideas related to quality improvement issues. In addition to practitioner/provider representatives, the committee membership also includes representatives from the Regional Consumer and Family Advisory Committees (CFAC). Trillium's QM plan provides opportunities for practitioners/providers, members, and families to provide input and feedback on QM issues and projects through their representation on the GQIC. The CFAC representatives serve as liaisons for members and families while participating in the selection of quality improvement activities, the formulation of project strategies or interventions, and other QM topics.

The objectives of this Committee are to:

- 🌱 Review developing quality concerns
- 🌱 Assess practitioner/provider training needs related to quality
- 🌱 Collaborate with Trillium Health Resources QM staff regarding quality issues
- 🌱 Collaborate with Trillium QM staff regarding quality issues, which includes providing feedback on the MCO's QI activities
- 🌱 Review current standards and recommend minimum standards for network QA/QI systems

- 🌱 Allow for avenues in which practitioners/providers can learn from each other

E. Sentinel Events Review Group

The Sentinel Events Review Group completes internal review of sentinel events of members, such as deaths, and/or other serious incidents. This group serves to identify any unexpected occurrence involving a member's death, serious psychological injury or the risk thereof.

The group also ensures that any recommended changes be implemented and monitored in a timely manner to ensure the health and safety of members. Events may trigger a more in-depth review of practitioner/provider processes and action may be requested of a practitioner/provider (i.e., Root Cause Analysis, Plan of Correction, etc.). Committee membership includes the Chief Medical Officer, staff psychologist, UM Director, QM Director, and other QM staff.

F. Clinical Advisory Committee

The Clinical Advisory Committee meets on a bimonthly basis. The goal of the Clinical Advisory Committee is to identify clinical practices that improve outcomes for people. This group serves to promote evidence-based practices for all populations served within the network. The Clinical Advisory Committee facilitates an open exchange of ideas, shared values, goals, a vision, and promotes collaboration and mutual accountability among practitioners/providers. The Clinical Advisory Committee strives to achieve best practices to empower members within our community to achieve their personal goals. Committee membership consists of licensed physicians and clinicians (practitioners), including the Chief Medical Officer of Trillium Health Resources.

G. Credentialing Committee

The Credentialing Committee meets monthly and serves as a fair and impartial representation of all practitioners/providers within the Network. The objectives of this committee are:

- 🌱 To review a list of practitioners and/or providers approved by the Chief Medical Officer
- 🌱 To review all "red-flagged" applications and decide what action is to be taken
- 🌱 To review and approve all procedures related to practitioner/provider credentialing
- 🌱 To provide oversight of delegated credentialing by reviewing annual reports, delegation tools and having final approval of credentialing decisions made by the delegated entity.
- 🌱 To evaluate and report on the effectiveness of the credentialing program

Committee Members include the Chief Medical Officer (Chair), Credentialing Specialists, and at least three practitioners from within the Trillium Health Resources network representing different NC clinical licensing boards. The Credentialing Committee is a peer-review body comprised of a diverse group with members that range multiple specialties across the network. The Trillium Network Director participates as an ad hoc member.

H. Provider Council

The Trillium Provider Council (PC) strives to be knowledgeable of all aspects of Trillium operations that impact practitioners/providers, including network capacity, stability and the quality of care that its members provide. The Council relies on an exchange of information from its membership and input from other committees. The Provider Council meets quarterly and represents the practitioner/provider community. The Council represents the interests and needs of the network and identifies strategic issues that affect the performance of the network.

Responsibilities include efforts to promote standardization and consistency throughout the system and to advise Trillium Health Resources on the impact that changes in the system have on members and providers. The Council membership includes practitioners/providers representing various services, member/family members and Trillium Health Resources staff.

The Trillium Provider Council:

- 🌱 Serves as a fair and impartial representative of all service providers within the network
- 🌱 Identifies strategic issues that impact network performance
- 🌱 Facilitates an open exchange of ideas
- 🌱 Shares values, goals and vision
- 🌱 Promotes collaboration and mutual accountability among the network
- 🌱 Recommends best practices that empower consumers to achieve their personal goals

I. Sanctions Committee

The Sanctions Committee meets, at a minimum, monthly or as needed to consistently and fairly review recommended sanctions for practitioners/providers. These reviews are in response to investigated and identified violations related to contractual obligations, state and federal laws, rules, regulations and policies set to protect the health and safety of members. The Sanctions Committee is charged with responding to suspicious practices that would expose Trillium Health Resources to liability. The committee is dedicated to maintaining professional conduct and integrity in support of the agency's Mission, Vision, and Values. The committee will assist in protecting against fraud and abuse within the catchment area, which in turn will assist in assuring the quality of the service delivery system.

RESPONSIBILITIES OF QUALITY MANAGEMENT

1. ANNUAL POLICY AND PROCEDURE REVIEW

The Quality Management Department is charged with the maintenance of all Trillium Health Resources' policies and procedures. This includes ensuring that all new and revised policies and procedures go through the appropriate approval process and are distributed to all staff. Additionally, QM is responsible for ensuring that the annual review of policies and procedures is completed by the Quality Improvement Committee.

2. CLINICAL PRACTICE GUIDELINES

Trillium Health Resources is contractually mandated to select, communicate and evaluate the use of Clinical Practice Guidelines utilized by Practitioners/Providers within the Network. Trillium is accountable for adopting and disseminating clinical practice guidelines relevant to its members for the provision of acute and chronic behavioral healthcare services. Trillium uses clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. Trillium provides nationally recognized Clinical Practice Guidelines and encourages proper implementation.

These clinical practices recommended for adoption must meet criteria including being evidence based, measurable and sustainable. Trillium Health Resources reviews, selects and then disseminates clinical practice guidelines relevant to its members based on literature review, input from the Clinical Advisory Committee and the Trillium Chief Medical Officer. Specifically defined elements from a minimum of at least three behavioral conditions (preventive or non-preventive), with at least one guideline addressing children and adolescents will be monitored at any one time to evaluate the extent of adherence. Trillium annually measures performance against at least two important aspects of each of the three clinical practice guidelines. 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. Trillium generally uses scientific evidence or professional standards when determining which clinical practice guidelines to adopt. Trillium reviews its guidelines against clinical evidence at least every two years, or more frequently if national guidelines change within the two-year period.

3. OVER AND UNDER UTILIZATION

Utilization Management:

The Utilization Management department of Trillium Health Resources is consistent with the federal regulations which includes mechanisms used to detect underutilization of services as well as overutilization. The data driven reports based on claims are critical to managing utilization management. Trillium tracks for over and underutilization outliers of high risk/high cost utilizers and through this process have identified the over utilizers are also the underutilizes of lower levels of care. The goal of Utilization Management in monitoring these identified priorities will result in further reducing service utilization of high cost services and reducing overall cost per member based on claims data. Identified members are researched in other available internal and external databases for other available/relevant information and healthcare trends (i.e. past treatment, compliance, physical health status, medications, etc.). This pattern may point to areas of fraud, waste and/or abuse, and more accurately can highlight risk to members who may not be receiving the level of care required to maintain

stability and functionality. Trends in over and underutilization of services are monitored by the Chief Medical Officer and the UM Director monthly.

Program Integrity:

The Program Integrity department of Trillium Health Resources monitors over and underutilization of services through identifying patterns and outliers in data. These utilization trends are detected through comprehensive reviews of data identified using the IBM software platform, Fraud and Abuse Management System ("FAMS") as well as internal reports developed using the CIE platform. Outcomes and findings are discussed during departmental staff meetings as well as Sanctions Committee and Compliance Committee.

4. SATISFACTION SURVEYS

Provider Satisfaction Survey:

An annual Provider Satisfaction Survey is conducted by the Division of Health Benefits (DHB). DHB contracts with an External Quality Review Organization (EQRO) to conduct this survey each year to assess provider satisfaction.

Member Satisfaction Survey (ECHO- Experience of Care and Health Outcomes):

DMA also conducts an annual satisfaction survey for all Medicaid members. DMA contracts with an External Quality Review Organization (EQRO) to conduct this survey each year to assess member satisfaction with services. CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a member satisfaction survey as well as a major component of HEDIS. The CAHPS survey is a measurement tool, used for all products, which ask members to report and evaluate their experiences with health care in areas of customer service, access to care, claims processing and provider interactions.

Perception of Care Survey:

The NC Division of MH/DD/SAS conducts a Perception of Care survey on an annual basis to assess members perception of care of services received from network providers. A designated number of members are selected to participate in the survey. Once the designated number of surveys are completed, the surveys are returned to NC DMH/DD/SAS for analysis.

Survey Analysis

Once complete, results of the surveys are returned to Trillium. Trillium conducts an analysis of survey results and completes a comparison to previous annual survey data. All results are reviewed by QIC and other appropriate committees to identify any systemic issues that would need to be addressed by Trillium through corrective actions or quality improvement activities. Details of discussions, conclusions and any action needed are documented in meeting minutes.

Communication of Survey Results:

Trillium's Quality Management department is committed to sharing information with our members, families and network about our quality assurance initiatives. Trillium shares results of Satisfaction Surveys with members, families, and the network by posting results on our website and sharing with various committees including the Global Quality Improvement, Consumer Family Advisory Committee (CFAC), and the Provider Council.

5. DELEGATION OVERSIGHT

The QM Department oversees the delegation process. Trillium maintains oversight responsibility of delegated activities and retains the right to modify or withdraw the nature of the contractual relationship, including the termination of the contract and/or the delegation of activities as specified in the relevant contract or delegation agreement. The QM delegation review process seeks to ensure that the vendor or delegate's activities adhere to Trillium's policies and procedures, regulatory and accreditation standards and/or meet performance goals as required in the relevant contract or delegation agreement. In the event of not meeting performance goals, the QI Committee may require improvement and would be responsible for monitoring any corrective action plans.

Monitoring includes the review of both the delegated vendor's policies/procedures/practices and performance standards. The delegated activity objectives are:

- 🌱 Pre-evaluate potential delegated entities prior to delegation
- 🌱 Complete an annual assessment of delegated activities
- 🌱 Monitor oversight of delegated activities
- 🌱 Ensure delegated entities meet or exceed established performance and operational measures
- 🌱 Ensure delegated entities meet or exceed accreditation standards
- 🌱 Establish corrective action plans if performance measures are not met

6. QUALITY MANAGEMENT WORK PLAN

An annual work plan is developed and reviewed by the QI Committee. The purpose of the Work Plan is to focus on the specific activities that Trillium will undertake to meet established goals planned for the year. The annual work plan includes time frames for monitoring and completing quality improvement activities, has clearly defined and measurable objectives for the year, identifies individuals responsible for those activities, has time frames for monitoring and completing each activity and serves as an action plan for previously identified issues. The work plan is a mechanism for tracking quality management activities. The QM Work Plan is monitored throughout the year to assess the progress of activities. Any necessary updates to the plan are presented quarterly or as needed.

7. QUALITY MANAGEMENT PLAN/PROGRAM DESCRIPTION

The purpose of the Quality Management Plan/Program Description is to ensure the continual assessment and improvement of Trillium Health Resources' operations with an emphasis on open communication, interdepartmental cooperation, and total agency teamwork. The QM Plan/Program Description details the objectives and structure of the QM program and describes Trillium Health Resources philosophy based on the Continuous Quality Improvement model. Resources used to support quality management efforts are also identified.

This plan is reviewed and revised, at minimum, on an annual basis for the purpose of evaluating its effectiveness. In addition, the plan is reviewed and approved by QIC and the Governing Board annually.

8. QUALITY MANAGEMENT PROGRAM EVALUATION

Trillium Health Resources completes an evaluation of the agency's Quality Management Program annually. The written evaluation is an assessment of the effectiveness of the components of the program. The evaluation outlines accomplishments, documents limitations or barriers to meeting objectives, and identifies recommendations for the following year. The evaluation addresses the structure and functioning of the overall QM program, the processes in place, and the outcomes or results of QI activities. The QM Evaluation includes information about the following:

- ▲ Review of progress and status of annual goals
- ▲ Monitoring of previously identified issues
- ▲ Evaluation of the effectiveness of each quality improvement activity
- ▲ Review of trends of clinical and service quality indicators
- ▲ Evaluation of the improvements occurring as a result of quality improvement efforts
- ▲ Evaluation of the overall effectiveness of QI Activities
- ▲ Evaluation of adequacy of staff resources
- ▲ Evaluation of program structure and processes
- ▲ Goals and recommendations for the work plan for the following year

Based on the annual program evaluation, the prior year's QM Work Plan is revised, and a new QM Work Plan for the coming year is developed to guide and focus the work for the next year. The QM Evaluation is presented to the QIC and Governing Board annually.

9. ACCREDITATION

Trillium Health Resources is currently URAC accredited for the following programs:

1. Health Utilization Management
2. Health Call Center
3. Health Network

The Quality Management Department is responsible for ensuring that Trillium Health Resources maintains ongoing compliance with all accreditation standards relevant to these programs. The Quality Management Department is also responsible for conducting all accreditation activities, including the completion of the reaccreditation application every 3 years, ensuring monitoring reviews are conducted by the Internal Compliance Unit, and completing all relevant URAC documentation.

Trillium began exploring Managed Behavioral Healthcare Organization (MBHO) accreditation through NCQA in 2018. Trillium has participated in NCQA accreditation training, has acquired the services of a consultant to assist with the accreditation process, and completed an initial self-assessment of compliance with the MBHO accreditation standards.

NCQA is considered the “gold standard” of managed care industry. NCQA believes that its accreditation is aligned with a “rigorous, comprehensive review” and that “for consumers and employers, the (NCQA accreditation) seal is a reliable indicator that an organization is well-managed and delivers high quality care and service”.

10. DATA ANALYTICS

The Quality Management Team, in collaboration with the Informatics Data Reporting Team, leads the analytic function for support of the continuous quality improvement efforts of the agency and for discerning opportunities for identifying and responding to areas of operational need. Included in this is the implementation of drill down analytics, which provides the opportunity to discover disparities in quality metrics and to understand variation in quality across various venues of performance. These investigative analytics lead to an understanding of what is driving gaps in services and aid in identifying areas for improvements in order to enhance the overall quality of care for Trillium Health Resources members. Trillium Health Resources uses the information discovered to guide policy decisions and annual improvement goals.

11. KEY PERFORMANCE INDICATORS (KPIs)

Trillium Health Resources conducts ongoing monitoring of KPIs to assure that the organization is meeting and maintaining identified performance benchmarks. KPIs are chosen by the Quality Improvement Committee on an annual basis. Monitoring of the designated key performance indicators is conducted on a monthly basis by the Quality Improvement Committee. Performance issues identified may require corrective action.

12. STATE REPORTING

The Informatics Data Reporting Team is responsible for ensuring that Trillium Health Resources follows the reporting requirements outlined within the NC DMH/DD/SAS and DHB contracts. The Informatics Data Reporting Team ensures that all state reports are developed according to specifications provided, validated, reviewed to determine any areas of

deficiencies that need improvement, and are submitted in a timely manner to the appropriate agencies.

13. DASHBOARDS

The Informatics Data Reporting Teams responsible for internal reporting requirements for the purposes of analysis, pattern and trend identification, compliance, and tracking and monitoring of service provision. Data Analysts, develop dashboards that highlight strengths and help determine any areas that need improvement. Dashboards are reviewed with various committees, including Quality Improvement Committee, Sentinel Events Review Group, Global Quality Improvement Committee, Human Rights Committee, etc. Areas needing attention will be submitted to the Quality Improvement Committee for possible corrective action.

14. QUALITY IMPROVEMENT ACTIVITIES (QIAS):

Trillium Health Resources develops Quality Improvement Activities (QIAs) as part of its assessment and implementation of continuous quality improvement. QIAs are created in response to identified problems, gaps, performance issues, accreditation requirements, or other performance initiatives. QIA selection can be based on the analysis of administrative data and/or input from system stakeholders. Trillium assesses the demographic characteristics and health risks of its covered population and available integrated data and uses its analysis results to prioritize opportunities. Trillium chooses at least three and up to nine relevant clinical issues that reflect the health needs of significant groups within the organization's population. One of the clinical issues may be a preventive health issue.

The Quality Improvement Committee oversees the initiation and development of Quality Improvement Activities. Each QIA will include Activity Selection and Methodology, Data Results/Tables, Analysis Cycle, Interventions Table, and Charts or Graphs as outlined on the QIA template. The Quality Improvement Committee regularly and routinely monitors the progress of QIAs to ensure that interventions are appropriate and data indicates the project is on target with reaching its goal. In addition, Trillium Health Resources shares updated information with DHB on the implementation and closure of all quality improvement activities. Trillium Health Resources' Chief Medical Officer provides oversight of all quality improvement activities. Members, families and guardians review and provide input for Quality Improvement Activities through Global Quality Committee and CFAC.

Per the DMH and DHB contracts, Trillium Health Resources will maintain at least four Quality Improvement Activities and one of the QIAs shall be related to the Transitions to Community Living Initiative. At least one of the QIAs shall focus on a clinical area and one shall focus on a non-clinical area. Where possible, QIAs will track measurements for Medicaid and state-funded populations separately. Trillium Health Resources will sustain any observed performance improvements for at least one year after the goal is achieved.

Per accreditation standards, Trillium will identify at least three relevant clinical issues. For those issues identified, data will be collected and analyzed in order to identify opportunities for improvement. Opportunities for improvement will be formally documented, interventions will be

implemented to improve performance and Trillium will measure the effectiveness of those interventions.

15. PROVIDER PERFORMANCE DATA

Provider Performance Reports are created by the Informatics Data Reporting Team. These reports are sent out to providers on an annual basis. The purpose of the Provider Performance Report is to offer providers a snapshot into how they are performing in certain areas compared to similar network providers.

These reports may include performance data related to Claim Denials and Claim Denial Reasons, Authorization Denials and Authorization Denial Reasons, Accessibility, and Quality Improvement Activities, among other measures. This data is for informational purposes and can assist the providers in making internal improvements such as validating data or possible development of Quality Improvement initiatives.

16. INCIDENT REPORTING

Providers of publicly funded services licensed under NC General Statutes 122C (Category A providers-except hospitals), AND providers of publicly funded non-licensed, periodic services (Category B providers) are required to complete and report incidents for members receiving mental health, developmental disabilities and substance abuse services.

QM staff review all incidents for completeness, appropriateness of interventions, and achievement of short and long term follow up, both for the member, as well as the provider's service system. If questions/concerns are noted when reviewing the incident report the QM staff work with the provider to resolve any identified issues/concerns. If issues/concerns are raised related to member care, services, or the provider's response to an incident, the QM staff may elect to refer the concerns to the Network Department to further investigate. On a daily basis, QM staff track specific category types of Level II and III incidents. This information is used to create a daily report that is distributed to all Sentinel Events Review Group members and other identified persons within Trillium to assess if there is any immediate action needed due to health and safety concerns. Trillium Health Resources will provide incident report training to the provider network, as needed, and when changes are made by the Division of MH/DD/SAS.

17. PROCESS AND OUTCOME MEASURES

The following process and outcome measures are collected and reported with various frequencies from monthly to annually depending on the nature of the indicator, what it measures and the availability of data. These measures are collected, analyzed and reported by a team of professionals with knowledge in data management, analysis and clinical expertise. Benchmarks and/or goals are developed for all measures. For those publicly reported measures, national and regional benchmarks are utilized and then goals set based on differences between the Plan's performance and benchmarks. For internal developed measures or measures with no benchmarks available, goals are set based on the Plan's

trends and objectives. Results are presented at various committees and shared with members and practitioners/providers as appropriate via newsletter and the member and provider portals.

HEDIS (Healthcare Effectiveness Data & Information Set) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. HEDIS is sponsored, supported and maintained by the National Committee for Quality Assurance (NCQA). 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.

18. SERVING A CULTURALLY DIVERSE MEMBERSHIP

A primary focus of the Quality Management Plan is to develop, implement and monitor processes that promote culturally competent and responsive care to members. It is imperative that Trillium assure network awareness of cultural competency into the quality of care delivered to members. Trillium's Executive and Leadership Teams have oversight for the implementation of Cultural Competence throughout the organization and the network. Trillium maintains a Cultural Competence Plan that includes internal and external initiatives as mechanisms for meeting needs of population(s) served.

TRILLIUM HEALTH RESOURCES

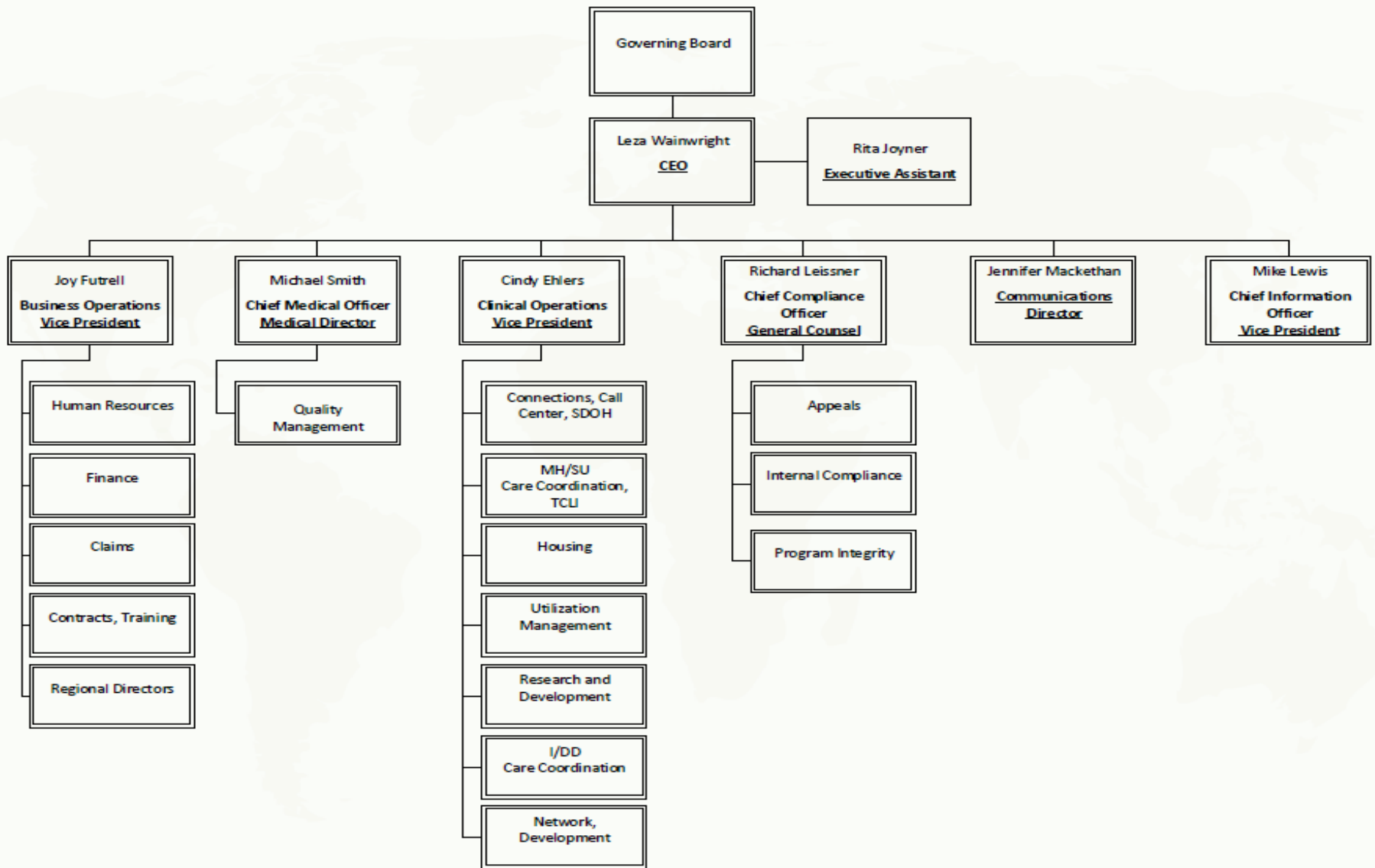
KEY PERFORMANCE INDICATORS

FY 2019-2020

INDICATOR	TARGET	RATIONALE
TELEPHONE STANDARDS		
% answered within 30 seconds	95%	Monitoring call center telephone data is one of the most efficient and effective methods for evaluating the ease of member access.
Blockage Rate	5% or less	
Abandonment Rate	5% or less	
TIMELINESS OF UM PROCESSING		
Total % of TAR's processed in required timeframe (Medicaid and State funded)	95%	Responding timely to requests for authorizations facilitates member access to care.
% of routine authorizations processed in 14 days (Medicaid and State funded)	95%	<ul style="list-style-type: none"> ▲ Prospective-Urgent: 72 hours ▲ Prospective-Non-Urgent: 14 calendar days ▲ Concurrent-Urgent: 72 hours ▲ Concurrent-Non-Urgent: 14 calendar days ▲ Retrospective-Urgent: N/A ▲ Retrospective-Non-Urgent: 30 calendar days
% of expedited inpatient authorizations processed in 3 days (Medicaid and State funded)	95%	
CARE COORDINATION AND TRANSITIONS TO COMMUNITY LIVING INITIATIVE		
% of community inpatient readmissions assigned to Care Coordination	85%	Ensuring those who are readmitted to a Community Psychiatric Inpatient Facility within 30 days of a previous admission are Care Coordinated.
% of annual allotted TCLI housing slots for whom eligible individuals have transitioned to supportive housing.	100%	Ensuring that the TCLI population transitions into supportive housing.
COMPLAINT RESOLUTION		
% of complaints resolved within 30 days (Medicaid and State funded)	90%	Ensuring complaints being reported to the MCO are either resolved in 30 days or referred to other entities for investigation within 30 days

INDICATOR	TARGET	RATIONALE
TIMELINESS OF CLAIMS PAYMENT/ENCOUNTER PROCESSING IN NCTRACKS		
% of claims processed within 30 days (Medicaid and State funded)	90%	Ensuring clean claims received during the month were processed (paid or denied) within 30 days.
% of denied Medicaid encounter claims	<5%	Ensuring less than a 5% denial rate for encounter claims on a monthly basis.
RECEIPT OF FOLLOW-UP SERVICES AFTER DISCHARGE FROM HOSPITALIZATION		
% of those discharged from Community Hospitals, State Psychiatric Hospitals, and Facility-Based Crisis Services for Mental Health Treatment who received a Follow-Up service within 7 days(Medicaid)	40%	Ensuring that those discharged after hospitalization for mental health treatment receive an appropriate follow-up.
% of those discharged from Community Hospitals, State Psychiatric Hospitals, and Facility-Based Crisis Services for Substance Use Treatment who received a Follow-Up service within 7 days(Medicaid)	40%	Ensuring that those discharged after hospitalization for substance use treatment receive an appropriate follow-up.
% of those discharged from Community Hospitals, State Psychiatric Hospitals, and Facility-Based Crisis Services for Mental Health Treatment who received a Follow-Up service within 7 days(Non-Medicaid)	40%	Ensuring that those discharged after hospitalization for mental health treatment receive an appropriate follow-up.
% of those discharged from Community Hospitals, State Psychiatric Hospitals, and Facility-Based Crisis Services for Substance Use Treatment who received a Follow-Up service within 7 days(Non-Medicaid)	40%	Ensuring that those discharged after hospitalization for substance use treatment receive an appropriate follow-up.
INTEGRATED CARE		
% of Innovations Waiver enrollees who received at least one primary or preventive health service	90%	Ensuring that Innovations Waiver enrollees receive a primary/preventive health visit during each year.

ATTACHMENT A: TRILLIUM ORGANIZATIONAL CHART



ATTACHMENT B: STRUCTURE OF THE QUALITY IMPROVEMENT COMMITTEE








ATTACHMENT C: CHIEF MEDICAL OFFICER JOB DESCRIPTION

Job Title: Medical Director
Working Title: Chief Medical Director
FLSA Status: Exempt
Employee Name: Michael E. Smith, MD
Position Number: 32000

Summary Description:

The Chief Medical Officer is a management position and reports to the CEO.

The Chief Medical Officer provides medical leadership to Trillium Health Resources and the community. The Chief Medical Officer provides executive leadership in the area of Medical Affairs. Specific responsibilities include:

-  Provide medical oversight to the activities of Trillium Health Resources.
-  Provides direct supervision to the Quality Management Department and the Medical Affairs Department.
-  Ensure that services provided are medically necessary and that they are provided by qualified providers.
-  Provide oversight of the Performance Improvement and credentialing programs, the clinical functions of Utilization Management, Care Coordination, and the Call Center, as well as monitoring of subcontractors.
-  Ensure that qualified clinicians are accountable to the organization for decisions affecting members.

Essential Duties and Responsibilities:

1. Provides medical leadership to Trillium Health Resources in the development of clinical procedures.
2. Participates as a member of the Trillium Executive Committee, Corporate Compliance Committee, and other clinical committees.
3. Co-chairs the Quality Improvement Committee, which assures quality and risk management outcome studies, service monitoring and evaluation.
4. Chairs the Trillium Credentialing Committee.
5. Analyzes data on a variety of indicators and uses this data to assess and improve the process and outcomes of care while looking for opportunities for growth, integration, reduced cost of care and quality improvement.
6. Collaborates with and provides Trillium Health Resources' medical representation to the community and is able to articulate best practices and quality outcomes.

7. Provides medical leadership for Utilization Review/Utilization Management.
8. Coordinates with DMH Medical Director (or similar position), Medical Directors of state hospitals, other state facilities, non-state hospitals, and other organizations. This includes promoting coordination of services and policies with such organizations.
9. Acts as liaison to universities, medical schools, and other academic organizations.
10. Collaborates with and supports the Chair and Vice Chair of the Trillium Health Resources Clinical Advisory Committee so as to optimize the contributions of the Committee and its value to the organization.
11. Assists with provider network development, network operations, credentialing and coordination of care among providers.
12. Provides consultation and guidance as needed for handling complaints, appeals, and grievances.
13. Provides clinical support, advice, and consultation to the call center (Screening, Triage and Referral) and to Care Coordination.
14. Provides consultation to Trillium Health Resources clinicians and participating providers in determining medical necessity and interpreting guidelines and criteria.
15. Conducts clinical peer reviews and appeal clinical reviews.
16. Other duties as assigned.

Supervisory Responsibilities:

This is a self-directed position. The employee must be able to access needed information independently in order to research questions and problems and develop strategies to address these. Employee must independently establish work priorities and determine necessary activities in order to address issues and to respond to crisis situations.

Provides supervision of the Staff Psychologist and the Medical Affairs administrative assistant, along with the Integrated Care Nurse, and oversight of the Medical Affairs department.

Requirements:

Must be a physician, board certified in psychiatry, with an unrestricted NC medical license and 2 years post-graduate experience in direct patient care. Must operate within the scope of practice. Must have at least two years of executive experience in a managed care organization/environment.

Knowledge, Skills and Abilities:

Experience with public community mental health services and consumers with serious mental illness, co-occurring mental illness and substance abuse, children who are emotionally disturbed, as well as experience with developmental disabilities populations is very important. The employee must have a wide knowledge of medical, pharmacological, and service related supports needs of these populations in order to make decisions about need for care as well as to provide consultation and advice to other community physicians. The employee must be able to work collaboratively and effectively with other team members in order to develop processes, protocols, analyze data and solve problems.

This is a high profile leadership position and it is important for this employee be able to establish positive relationships with both the medical community and other key stakeholders. Excellent verbal and written communication skills are essential.

Decision Making/Consequences of Error:

A high level of accuracy is required in all areas, but in particular to decisions related to authorization or denial of care. All decisions must be well founded and within the scope of Medical practice. Diplomacy and sensitivity is required for public relations work in order to establish positive relationships and support the role of Trillium Health Resources in the community. Consideration of complex data, feedback and information is required for decision-making and for the development of clinical processes and protocols, and for pro-active planning.

Errors may result in risk to consumers who do not receive needed services and treatment. It is critical that public relations activities be handled in an appropriate manner in order to maintain public understanding and enlist support for Trillium Health Resources' efforts to manage a local/regional system of care. Failure to follow personnel, risk management, staff training and other requirements could also result in an event resulting in liability to the agency.

Nature and Purpose of Public Contacts:

This position requires the employee to establish and maintain effective working relationships with others. Personal contacts are a significant factor in the employee's effective performance of job duties. The employee must be able to communicate effectively, both verbally and in written form, with staff of Trillium Health Resources, professionals and other physicians, local agencies and officials, advocates, consumers, and family members.

The employee must be well educated in cultural diversity issues and sensitive in interactions with various and diverse members of the staff and community. The employee must be able to communicate in a positive and caring manner.

Mental/Physical Demands:

Employee must have excellent mental and physical stamina due to the constantly changing demands of the position and the developmental stages of this position and its role in Trillium Health Resources. Employee must be able to operate a motor vehicle. The employee must be able to travel independently throughout the 19 catchment areas. Travel throughout the state may be required.

Certifications: Must be a physician, board certified in psychiatry, with an unrestricted NC medical license.

SUPERVISOR CERTIFICATION: I certify that (a) I am the Immediate Supervisor for this position, that (b) I have provided a complete and accurate description of responsibilities and duties, and (c) have verified (and reconciled as needed) its accuracy and completeness with the employee.

Signature: _____ Title: _____

Date: _____

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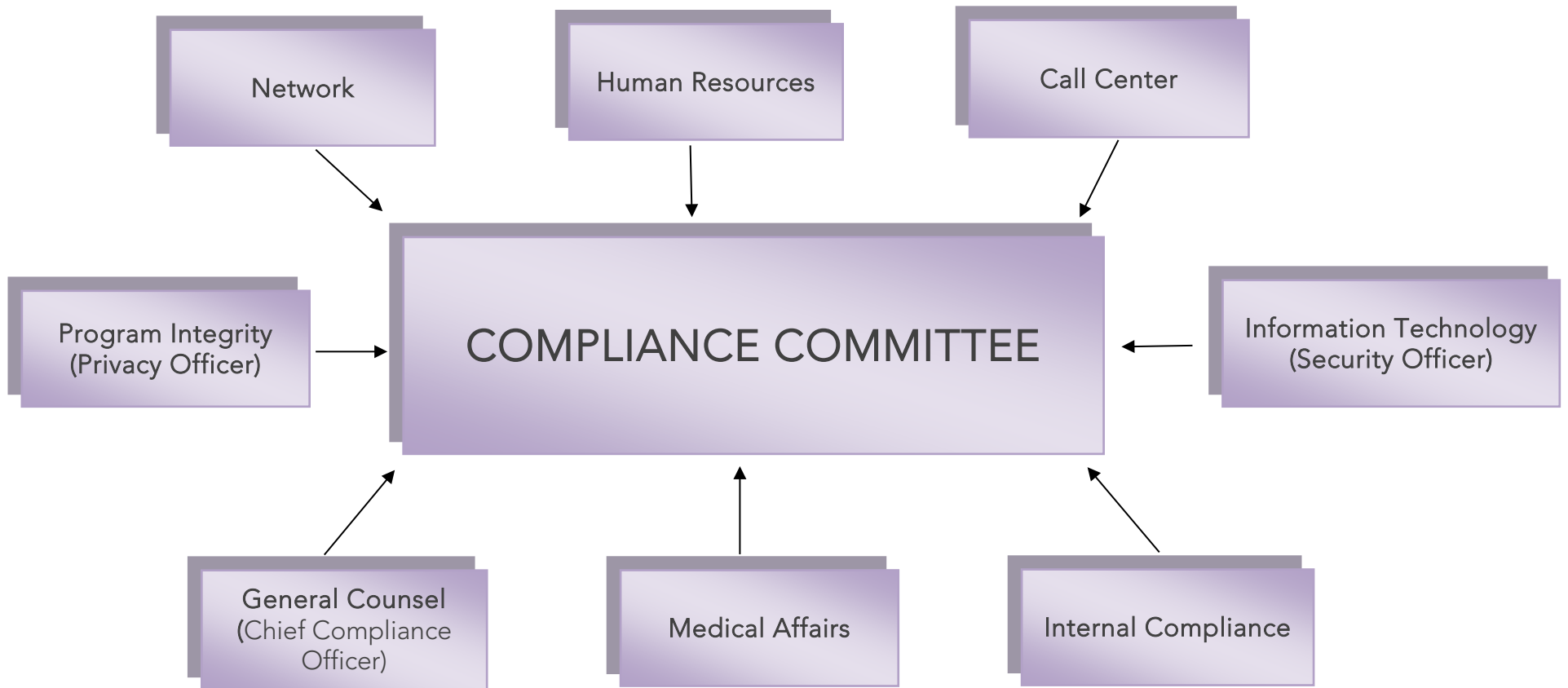
Employees' Certification: I certify that I have reviewed the position description and that it is a complete and accurate description of my responsibilities and duties.

Signature: _____ Title: _____

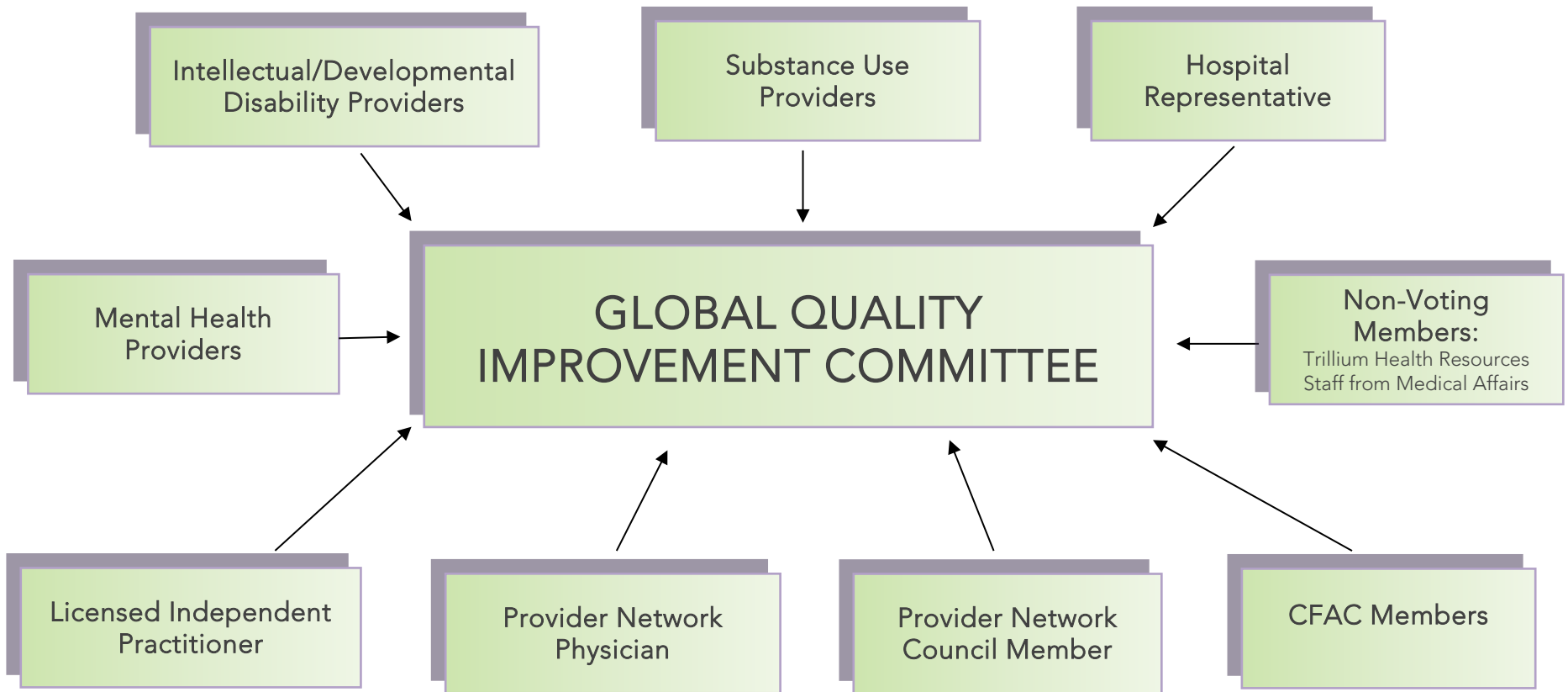
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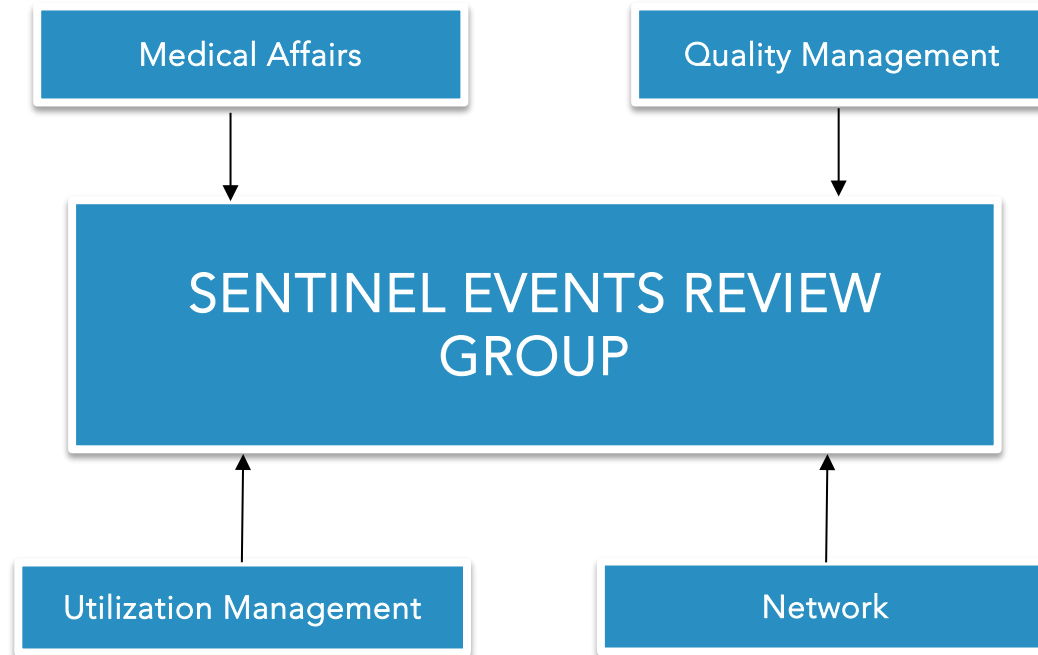
ATTACHMENT D: STRUCTURE OF THE COMPLIANCE COMMITTEE



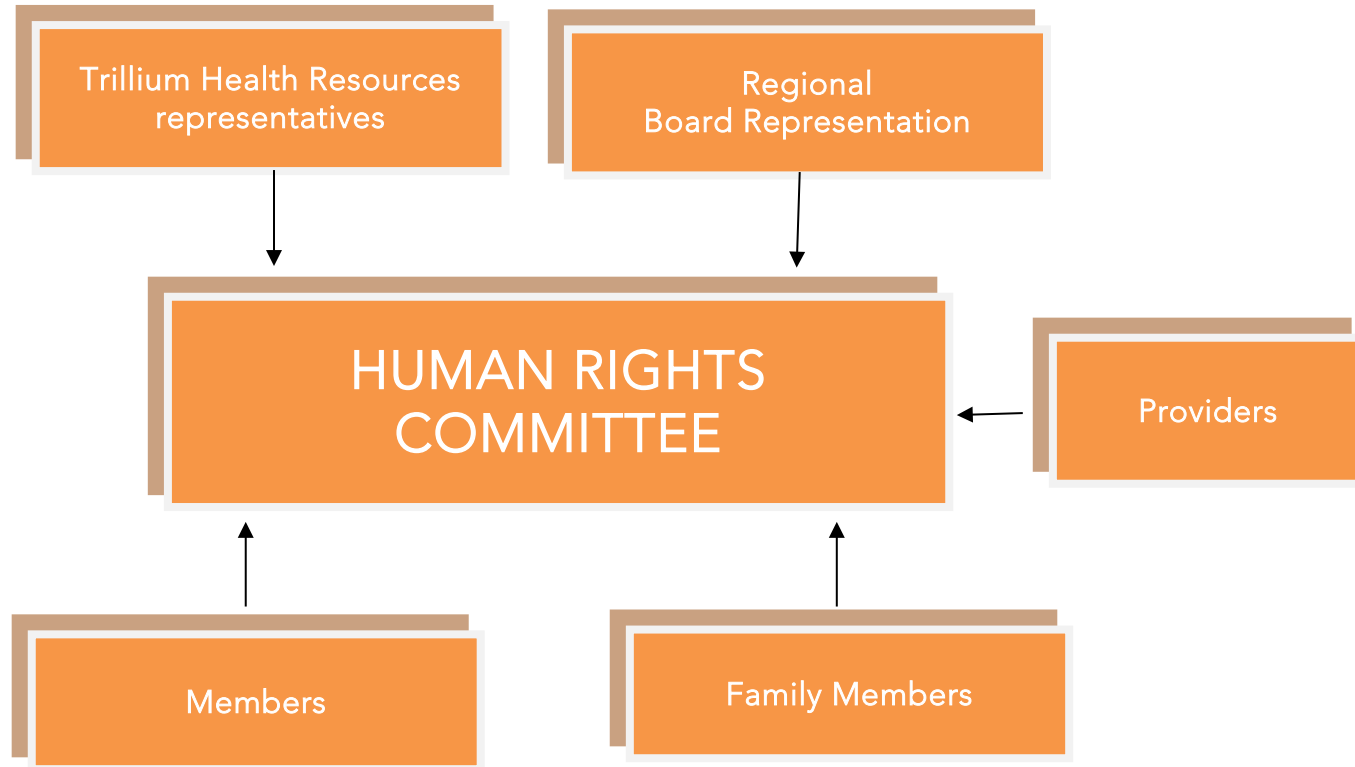
ATTACHMENT E: STRUCTURE OF THE GLOBAL QUALITY IMPROVEMENT COMMITTEE



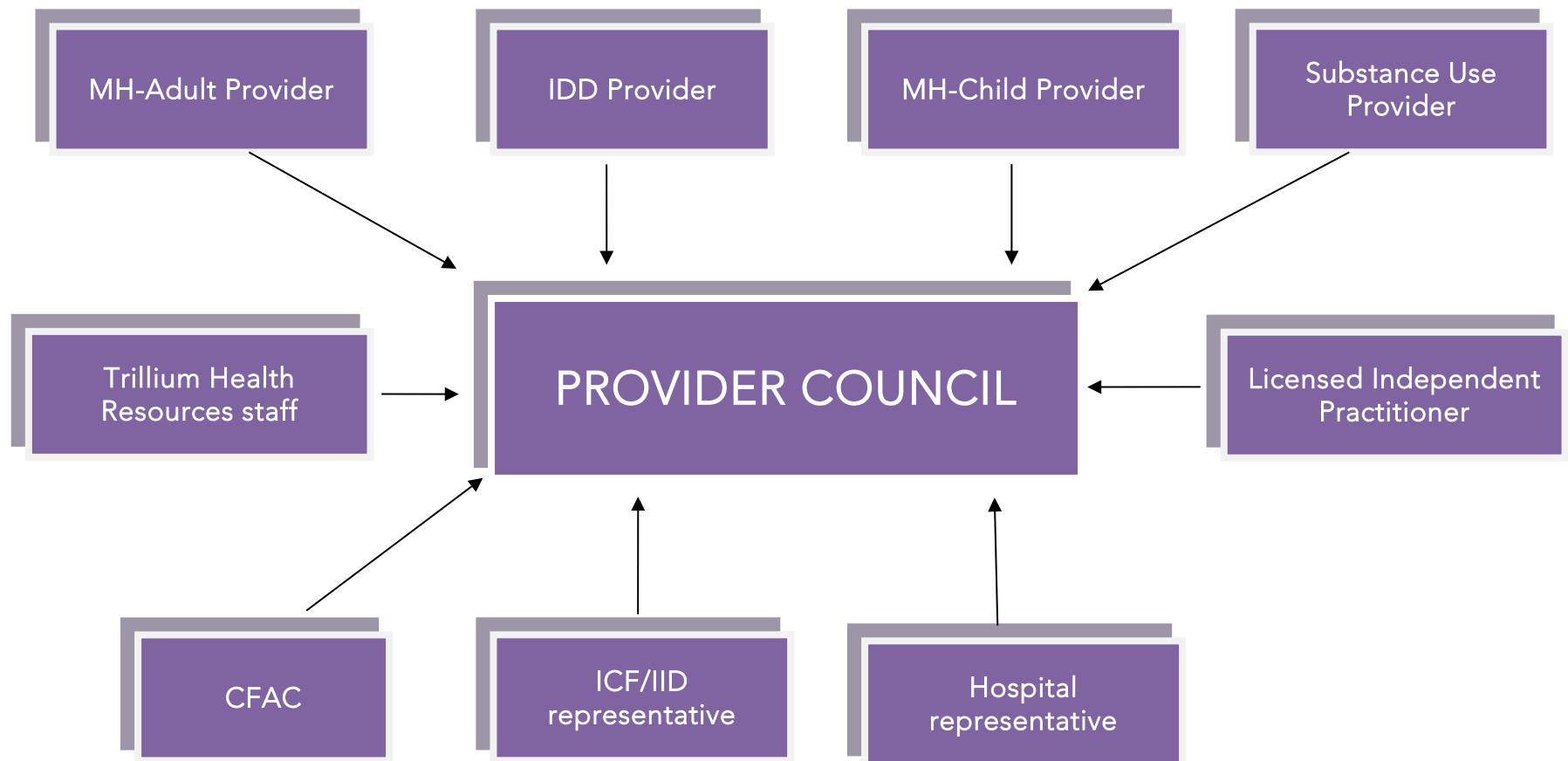
ATTACHMENT F: STRUCTURE OF THE SENTINEL EVENTS REVIEW GROUP



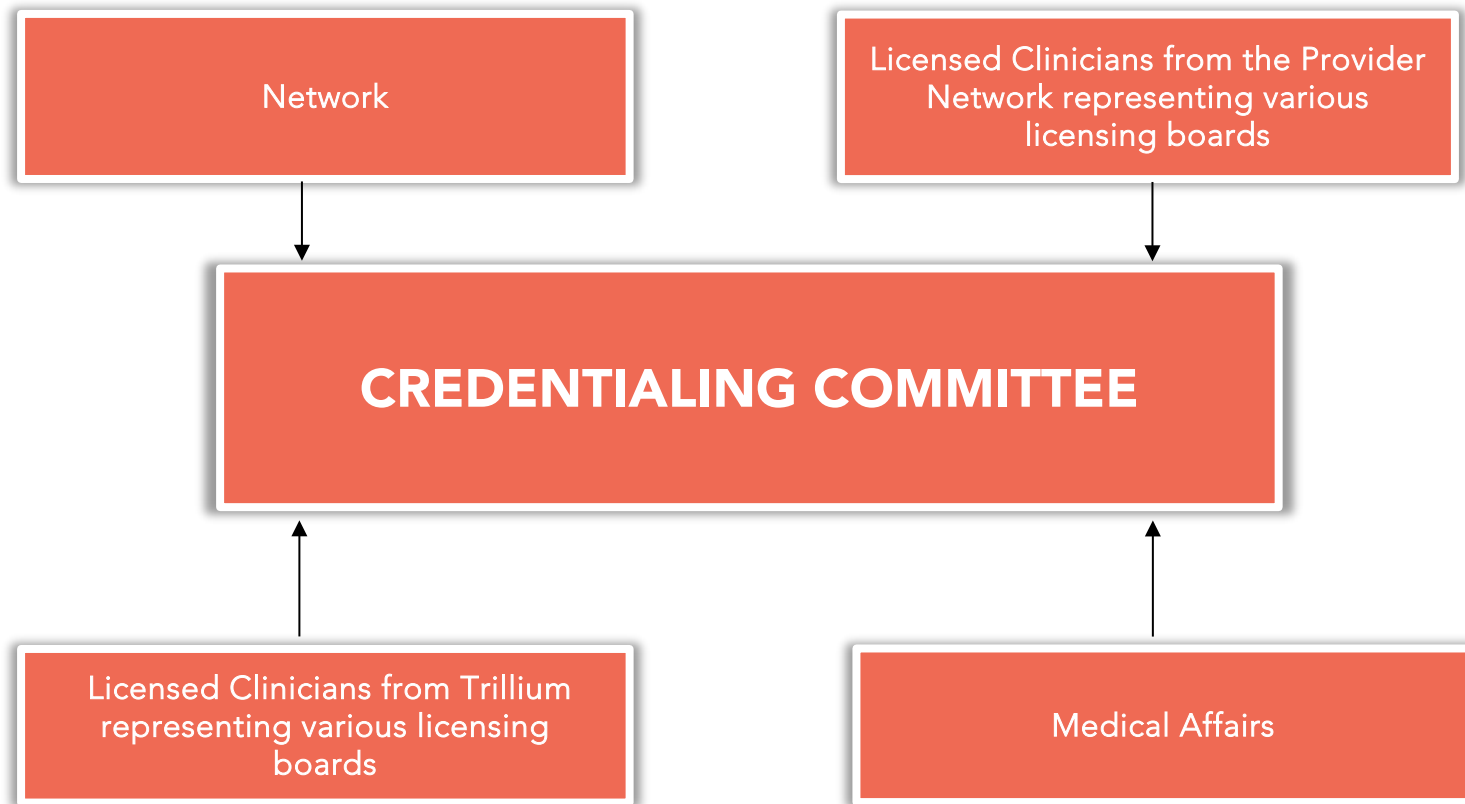
ATTACHMENT G: STRUCTURE OF THE HUMAN RIGHTS COMMITTEE



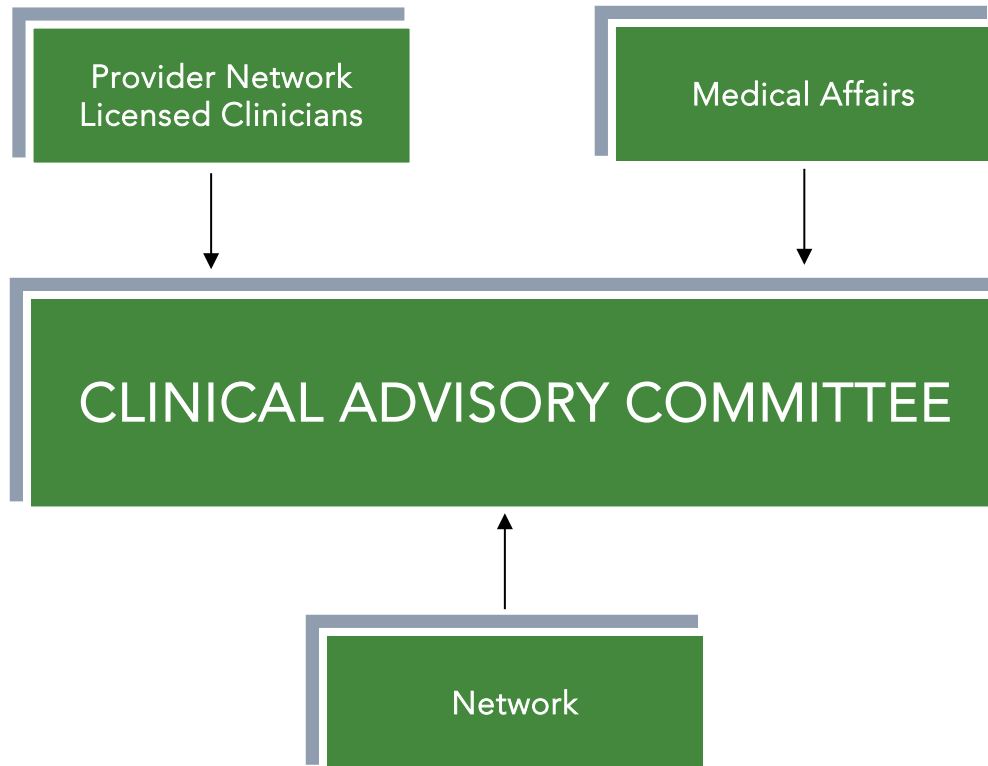
ATTACHMENT H: STRUCTURE OF THE PROVIDER COUNCIL



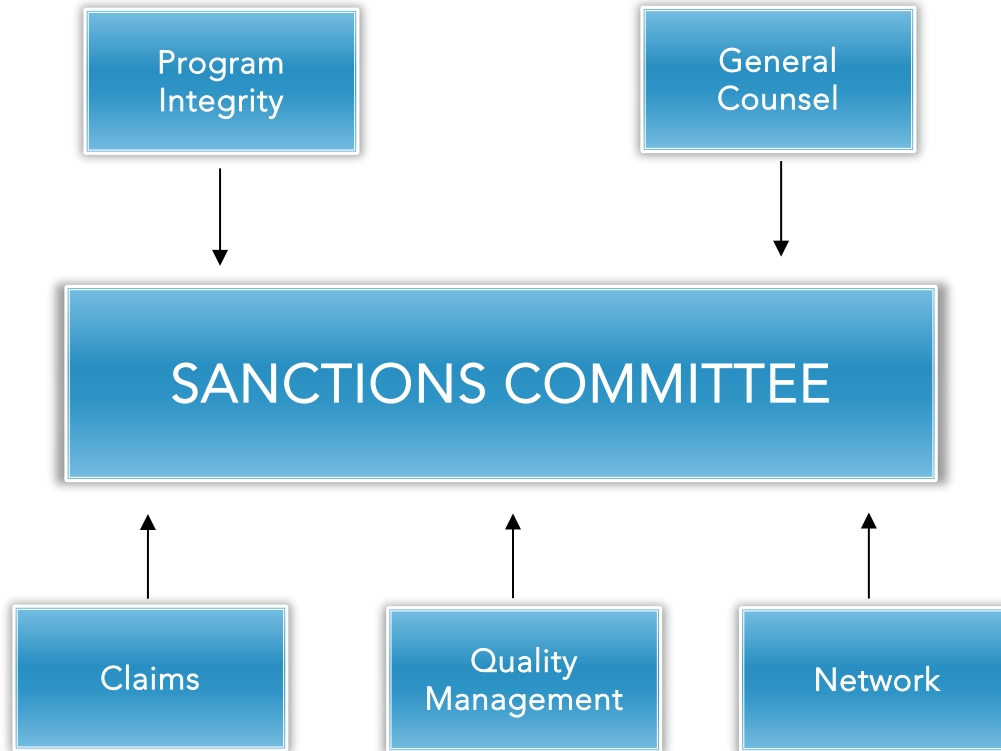
ATTACHMENT I: STRUCTURE OF THE CREDENTIALING COMMITTEE



ATTACHMENT J: STRUCTURE OF THE CLINICAL ADVISORY COMMITTEE



ATTACHMENT K: STRUCTURE OF THE SANCTIONS COMMITTEE



ATTACHMENT L: COMMUNICATION FLOW BETWEEN COMMITTEES

