2020-2021- QUALITY MANAGEMENT PLAN

Trillium
HEALTH RESOURCES

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ACCREDITED NCQA MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION 1 YEAR

urac ACCREDITED Health Network Expires 03/01/2022

urac ACCREDITED Health Utilization Management Expires 03/01/2022

urac ACCREDITED Health Call Center Expires 03/01/2022

STATEMENT OF APPROVAL

This plan was approved by the CEO, Quality Improvement Committee, and/or Governing Board.

Leza Wainwright, CEO	**Date**
Mary Ann Furniss, Governing Board Chair	**Date**
Michael Smith, MD, CHCQM, **Chief Medical Officer**	**Date**
Fonda Gonzales, MS, LCMHC, NCC **Director of QM**	**Date**

NEXT ANNUAL REVIEW DATE: JUNE 2021

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 practitioner/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 statutory and national accreditation requirements under which the LME/MCO operates. The purpose of the Quality Management Plan (QM Plan) is to establish a planned, systematic and comprehensive approach to measure, assess, and improve organization-wide performance. The QM 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 in the provision of services in our Network. The QM Plan promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement projects and activities based upon the findings. The QM Plan is designed to assess and analyze systems performance data that will subsequently guide performance improvement for better supporting the people we serve. The QM Plan balances quality assurance and quality improvement activities such 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 Plan's success is the achievement of desired individual outcomes by the people we serve.

The QM 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 made available to our members and the network via the Trillium website, and can be provided in another format if so requested.

Scope

The scope of the QM Plan is designed to promote and measure member safety, and the quality and appropriateness of behavioral health services. The QM Work Plan works in conjunction with the organization's utilization management (UM) 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 QM 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 to, 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

Per North Carolina's Medicaid Managed Care Quality Strategy, April 18, 2019 document, "included within each of these three aims is a series of Goals and Objectives, intended to highlight key areas of expected progress and quality focus.

Together, as is shown in Figure 3 below, these Aims, Goals, and Objectives create a framework through which North Carolina defines and drives the overall vision for advancing the quality of care provided to Medicaid beneficiaries in the state."

Aims	Goals	Objectives
Aim 1: Better Care Delivery. *Make health care more person-centered, coordinated and accessible.*	**Goal 1: Ensure appropriate access to care**	Objective 1.1: Ensure timely access to care
		Objective 1.2: Maintain Medicaid provider engagement
	Goal 2: Drive patient-centered, whole person care	Objective 2.1: Promote patient engagement in care
		Objective 2.2: Link patients to appropriate care management and care coordination services
		Objective 2.3: Address behavioral and physical health comorbidities

Aims	Goals	Objectives
Aim 2: Healthier People, Healthier Communities. *Improve the health of North Carolinians through prevention, better treatment of chronic conditions, and better behavioral health care, working collaboratively with community partners.*	**Goal 3: Promote wellness and prevention**	Objective 3.1: Promote child health, development, and wellness
		Objective 3.2: Promote women's health
		Objective 3.3: Maximize long term services and supports (LTSS) populations' quality of life
	Goal 4: Improve chronic condition management	Objective 4.1: Improve behavioral health care
		Objective 4.2: Improve diabetes management
		Objective 4.3: Improve asthma management
		Objective 4.4: Improve hypertension management
	Goal 5: Work with communities to improve population health	Objective 5.1: Address unmet resource needs
		Objective 5.2: Address the opioid crisis
		Objective 5.3: Address tobacco use
		Objective 5.4: Reduce health disparities
		Objective 5.5: Address obesity
Aim 3: Smarter Spending *Pay for value rather than volume, incentivize innovation and ensure appropriate care.*	**Goal 6: Pay for value**	Objective 6.1: Ensure high-value, appropriate care

These strategies support Trillium's Mission Statement, which is "Transforming lives and building community well-being through partnership and proven solutions" and Trillium's Vision Statement, "For every community and individual we serve to reach their fullest potential."

Trillium's continuous commitment to achieving these strategies will require 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 measurement analyses and reporting;
- encouraging 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
- partnering with state leaders, policy makers and legislators who support member and staff empowerment and system improvements through enthusiastic, creative leadership over the long-term.

The formal process to develop and review Trillium's Quality Strategies occurs annually, unless there is a significant change. Significant changes include events such as a change to the delivery system model; addition of new populations or services; or significant changes to the federal regulations and/or contract contents governing quality.

The effectiveness of the quality strategy is assessed through the recommendations provided by the External Quality Review Organization (EQRO), a review of our performance on HEDIS measures, and survey results. Additional information is gleaned from reviews of complaints/grievances, appeal logs, member experience, out of network request and utilization, and quality improvement activities (QIAs) to determine opportunities.

STRUCTURE OF THE QUALITY MANAGEMENT PROGRAM:

1. Authority, Responsibility, and Functional areas

The Trillium Health Resources 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 functional areas and responsibilities, which include:

- The organization's compliance with contract requirements including Federal and State statutes, reporting, and outcome measures
- Policy & Procedure Oversight
- Delegation Management

- Adverse Events/ Incident Reporting Oversight
- Performance standards such as Clinical Practice Guidelines, HEDIS and key performance indicators (KPIs)
- Analysis of Member Experience using survey results, complaint/grievance and appeal data, and out-of-network service requests and utilization
- Tracking of overutilization and underutilization of high risk/high cost services
- Management of the Network Accessibility and Adequacy Analysis report
- Completion of the organization's Cultural Competency Plan
- Supervising the implementation of the Quality Management Plan, QM Work Plan, and the QM Annual Plan Evaluation
- Supporting the QI Committee and related committees such as the Human Rights Committee, Global Quality Improvement Committee, and the Sentinel Events Review Group in conducting activities
- Identification and Initiation of Quality Improvement Activities (QIAs)
- Tracking identified opportunities for improvement through the ongoing analysis of data, dashboards, and data analytics.
- Sharing provider performance data regularly with practitioners/ providers
- Providing members with information on self-management tools
- 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:

According to the World Health Organization, CQI is incorporated into the management of the organization so that it has a built in mechanism for identifying and addressing problems. That is, quality management and improvement attempt to anticipate and prevent problems; managers and supervisors are proactive; and the organizational culture is one of responsiveness and empowerment of staff to participate and assume responsibility for problem identification and solutions.

Trillium Health Resources quality improvement philosophy is based on the continuous quality improvement model which involves a process of design, discovery, remediation, and improvement. NCQA states that quality improvement is implementing corrective actions based on assessment results, aimed at addressing identified deficiencies and improving outcome(s).

The Health Resources & Services Administration (HRSA) defines QI as systematic and continuous actions that lead to measurable improvement and identifies 4 key QI principles:

1. Work on the system(s) and its processes
2. Focus on patients
3. Focus on being part of the team
4. Focus on use of the data

While HRSA uses the term patient, this is applicable to Trillium's members. How these principles are demonstrated at Trillium includes:

- understanding our delivery system and the associated key processes.
- measure of the extent to which member's needs and expectations are met.
- being a part of a team
- focusing on the data

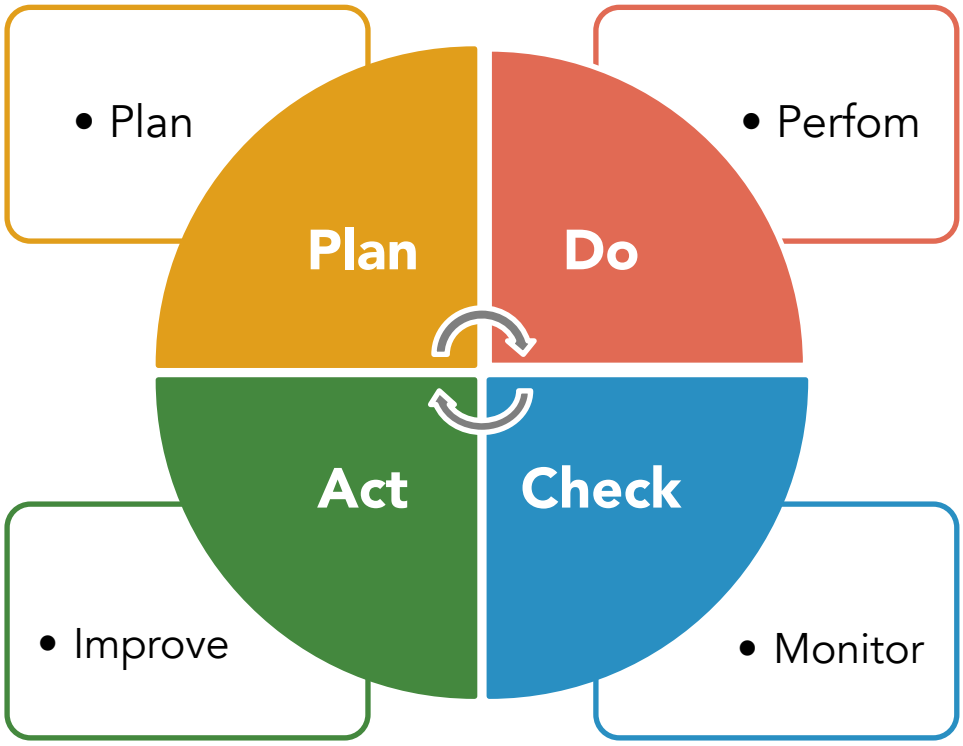
At its core, QI is a team process. Trillium staff have the knowledge, skills, experience, and perspectives to make lasting improvements. It is the responsibility of each individual to be an active and contributing member of the team. Each staff member participating on a workgroup, committee, or as part of a team, brings a unique perspective to the process; i.e., how things work; what happens when changes are made, and how to sustain improvements during daily work. Focus is on the team component of the principles because as an organization we are all interdependent. The Quality Improvement Committee members play a big role in the CQI process.

Data is an important cornerstone of quality improvement. Data is used to describe how well current systems are working; what happens when changes are applied, and to document successful performance.

The Plan-Do-Check-Act (PDCA) cycle is a four-step model for carrying out change. This is the model utilized in the QM Department. Just as a circle has no end, the PDCA cycle should be repeated again and again for continuous improvement.

The Plan-Do-Check-Act Procedure:

1. **Plan:** Recognize an opportunity and plan a change.
2. **Do:** Test the change. Carry out a small-scale study.
3. **Check:** Review the test, analyze the results, and identify what you've learned.
4. **Act:** Take action based on what you learned in the study step. If the change did not work, go through the cycle again with a different plan. If you were successful, incorporate what you learned from the test into wider changes. Use what you learned to plan new improvements, beginning the cycle again.



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 supervised 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/ adverse events, national accreditation, quality improvement activities, including the QM Work Plan,

satisfaction/experience surveys, Trillium's Committee Structure, policy and procedure development, new employee orientation, and various other tasks.

The Delegations Manager oversees and manages the evaluation of the adequacy and effectiveness of Delegation Oversight activities. This activity includes the identification and escalation of issues and risks along with the development and tracking of action plans to address needed changes and improvements. This position monitors and evaluates the performance of local and national delegated vendors according to contractual requirements, national accreditation standards, Federal, and State requirements.

The Senior Data Analyst is responsible for assuring compliance with the DMH and DHB contract requirements such as Super Measures/ Performance Measures, NCQA accreditation, HEDIS reporting, as well as other external and internal reporting needs. This position develops analytical reports, including conducting analysis, information synthesis, summarizing and interpretation of results, to include the identification of patterns and trends in data. The Data Analyst makes recommendations for actionable areas to intervene and identifies matters of significance that could impact the agency.

The QM Administrative Assistant provides confidential administrative support to Quality Management Department by completing meeting minutes, ensuring Policy and Procedures are kept up to date, and assisting with any other tasks and duties necessary.

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

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

Resources available to the Quality Management function include various Trillium departments, Medical Affairs, Utilization Management, Call Center, Customer Services, Care Management, 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
- TBS Application for STR and UM
- TBS Provider Monitoring Database
- TBS Complaints / Grievances 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, , outcomes and overall effectiveness. These data sources include, but are not limited to:

- HEDIS reports
- Population Health Assessment
- 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

4. Data Governance

Trillium utilizes a methodology of Data Governance (DG) that governs the process of managing the availability, usability, integrity and security of the data in enterprise systems, based on internal data standards and policies that also control data usage. Effective data governance ensures that data is consistent and trustworthy and doesn't get misused. For Data Governance to work effectively, it must be embraced by everyone in the organization. While certain roles and departments within Trillium are responsible for maintaining and reporting on the data, it is the responsibility of every staff member to use the data and the information it provides responsibility. No one department or person can possibly

govern the data alone; it must be a concerted effort by all following a set of guidelines, standards and protocols that promotes a responsible use of data.

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.

5. Committee Structure

Trillium manages a consortium of committees that report up to one main committee, the Quality Improvement Committee (QIC). A Communication flow between committees is available in Attachment K. Trillium supports the following committees that report up to the QIC on a scheduled basis:

- Global Quality Improvement Committee
- Human Rights Committee
- Sentinel Events Review Group
- Compliance Committee
- Sanctions Committee
- Clinical Advisory Committee
- Provider Council
- Credentialing Committee

As stated previously, Trillium's Governing Board is responsible for the oversight of the Quality Management Plan. The Director of Quality Management leads and directs all quality management functional areas and responsibilities which includes co-chairing the QIC along with Trillium's Chief Medical Officer (CMO). The Chief Medical Officer's role is to supervise the QM Program and provide medical leadership in the development of clinical procedures. As such, the CMO 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. The CMO collaborates with and provides medical representation to the community and is able to articulate best practices and quality outcomes.

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 B 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 results, and demographics. Once integrated, data is analyzed, interpreted and opportunities for improvement are identified. When interventions are implemented, the effectiveness of interventions is measured to assess progress. 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 member experience 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 purpose and charge of the Compliance Committee is to provide oversight of the prevention and/or detection of operational non-compliance, and/or inappropriate behavior within the workplace and within the provider network. In addition, the compliance committee supports the compliance program in providing oversight and guidance to ensure Trillium is in compliance with all applicable laws, regulations, and agency policies/procedures as well as enhances the culture of compliance through education and open lines of communication. 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. Trillium strives to foster an environment of ethical decision making and is dedicated to the principles of honesty and integrity within the workplace. The Chief Compliance Officer delegates attendance, participation, and reporting from the Compliance Committee to the Quality Improvement Committee to the Internal Compliance Manager. The Internal Compliance Manager serves as liaison to the QIC.

The Compliance Committee reviews the following information during the course of routine meetings:

- Program Integrity Activities, such as provider issues and risks identified
- Analyze fraud, waste, and abuse data for Trillium and Practitioners/Providers
- Internal Compliance Reviews-Risks Identified
- Grievances/Complaints against Trillium and Practitioners/Providers
- Security Incidents
- HIPAA Incidents
- Human Resources Issues (Code of Conduct/Ethics issues)
- Rules/Regulations and what is on the horizon
- Review of Conflict of Interest/Dual Employment/Managed Care situations
- Information about Industry wide risks (information from HCCA/News articles)

Trillium collects data from all sources of member complaints/grievances and appeals and aggregates and analyzes the data using the following categories:

- Quality of Care.
- Access.
- Attitude and Service.
- Billing and Financial Issues.
- Quality of Practitioner Office Site.

The Compliance Committee evaluates the data and relays any noticeable trends to the QIC as necessary for appropriate review, discussion and identification of opportunities for improvement.

The Compliance Committee:

- Meets at minimum quarterly 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 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 and act as administrative support to the committee. The Human Rights Committee liaison regularly makes reports to the QIC.

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

- Reviewing complaints and grievances regarding potential member 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 (GQIC) 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 involvement of representatives of relevant medical systems and other health care practitioners, 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 goal of the GQIC is to represent collaboration and strengthen the relationship between practitioners/providers and Trillium Health Resources. The GQIC discusses and monitors the quality needs of the network and identifies recommendations from the committee members to the QIC as appropriate and necessary. The QIC has ultimate decision making authority regarding recommendations and initiatives. Trillium staff serve as liaisons to the committee and act as administrative support to the committee. The GQIC liaison regularly makes reports to the QIC.

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 (SERG) completes internal review of sentinel events of members, such as deaths, and/or other serious incidents. The SERG includes member incident reports and adverse events tracking and monitoring. 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. Trillium initiates prompt action and implements interventions based on established procedures when there is evidence of poor quality that could affect the health and safety of members. Such 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.). The SERG monitors adverse events on a monthly basis, including provider/practitioner specific member complaints using a monthly and cumulative report. If it is determined at the time of receipt of a grievance, that there is a potential health and safety component, the Chief Medical Officer (CMO) and Executive Vice President (EVP) of Clinical Operations will be notified promptly via email and/or telephone. After consultation with the CMO or EVP of Clinical Operations occurs, any recommended actions are undertaken to resolve the issue.

Committee membership includes the Chief Medical Officer, Medical Director of UM, Staff Psychologist, Head of Program Integrity, Head of Network Development, Head of UM, QM Director, Network Monitoring Manager, Population Health Nurse, and other QM staff. The Chief Medical Officer functions as the facilitator of the virtual group.

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 are likely to improve clinical quality outcomes and enhance member experience. 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. The Clinical Advisory Committee reviews and provides input into the selection of evidenced-based clinical practice guidelines relevant to members and based on literature review. 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. All voting members of the committee must be licensed physicians and clinicians (practitioners), including the Chief Medical Officer of Trillium Health Resources with the exception of qualified Intellectual and Developmental Disabilities professionals. The Clinical Advisory Committee offers an opportunity for involvement of representatives of relevant medical systems and

other health care practitioners in the quality improvement program The Chief Medical Officer functions as the liaison to QIC and makes regular reports on activity.

G. Credentialing Committee

The Credentialing Committee meets monthly and serves as a fair and impartial representation of all practitioners/providers within the Network. Trillium guidelines dictate that the credentialing committee members adhere to Trillium's non-discriminatory policy. Trillium's process requires signature of an attestation statement from those on the committee. 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), Head of Network Development, Credentialing Specialists, and at least three practitioners from within the Trillium Health Resources network representing different NC clinical licensing boards. The Head of Network Development functions as the liaison to QIC and makes regular reports of Credentialing Committee activity. The Credentialing Committee is a peer-review body comprised of a diverse group with members that range multiple specialties across the network. The credentialing committee membership are heterogeneous. The Trillium Vice President of Network Operations 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. The Provider Council offers an opportunity for involvement of representatives of relevant behavioral health medical systems and other health care practitioners into Trillium's quality improvement program.

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/practitioners. 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 members to achieve their personal goals

I. Sanctions Committee

Trillium implements ongoing practitioner/ provider monitoring and takes appropriate interventions by implementing appropriate interventions when it identifies instances of poor quality related to Medicaid sanctions, sanctions or limitations on licensure, complaints/ grievances, and identified adverse events. Trillium subscribes to the NPDB continuous query sanction reporting. Trillium initiates appropriate action immediately upon receipt of its release by the reporting entity. If it is determined at the time of receipt of a complaint/ grievance, that there is a potential health and safety component, the Chief Medical Officer (CMO) and Executive Vice President (EVP) of Clinical Operations will be notified promptly via email and/or telephone. After consultation with the CMO or EVP of Clinical Operations occurs, any recommended actions are undertaken to resolve the issue.

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. The Head of Network Development functions as the liaison to QIC and makes regular routine reports on committee activity.

RESPONSIBILITIES OF QUALITY MANAGEMENT

A. 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.

B. Clinical Practice Guidelines

Trillium Health Resources is contractually mandated and in accordance with national accreditation requirements, must 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's selected behavioral health guidelines are based on nationally recognized recommendations and peer-reviewed medical literature. Recognized professional practice societies, such as the American Psychiatric Association, the American Academy of Pediatrics, and the National Institute on Alcohol Abuse and Alcoholism, publish recommended guidelines.

The purpose of adopting and encouraging the use of CPGs is to help practitioners/providers in screening, assessing and treating common disorders. The adopted guidelines are intended to support, not replace, sound clinical judgment. Before a guideline is adopted, Trillium reviews relevant scientific literature and obtains practitioner/provider input through the Clinical Advisory Committee (CAC). These clinical practices recommended for adoption must meet criteria including being evidence based, measurable and sustainable. 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 uses scientific evidence or professional standards when determining which clinical practice guidelines to adopt. Once implemented, Trillium reviews each guideline at least every two years for continued applicability and update them as needed, or more frequently if national guidelines change within the two-year period. Any changes to guidelines are communicated to practitioners/providers via bulletins and are posted on Trillium's website.

When used in clinical decision making, adherence to these recognized guidelines helps to ensure that care authorized for acute and chronic behavioral health conditions meets national standards for excellence. Adherence to the guidelines is measured through use of the Healthcare Effectiveness Data and Information Set (HEDIS®*) measures.

Trillium has selected the following HEDIS measures as Clinical Practice Guidelines:

- SSD – Diabetes Screening for Adults with Schizophrenia/Bipolar
- SAA – Adherence to Antipsychotics for Adults with Schizophrenia
- COU – Risk of Continued Opioid Use

- APM – Metabolic Monitoring for Children/Adolescents on Antipsychotics
- APC – Use of Multiple Concurrent Antipsychotics in Children/Adolescents
- AMM – Antidepressant Medication Management

C. Self-management tools

Data indicate that persons with disabilities do not participate in wellness programs or health screening activities at the same level as do persons without disabilities. Yet, health promotion efforts can be of critical importance to persons with disabilities due to their higher-than-average risk for preventable chronic conditions including cardiovascular disease, obesity, diabetes and heart disease. Wellness programs have proved to be an effective tool to use in reining in health care costs. Trillium offers self-management tools, derived from available evidence, that provide members with information on wellness and health promotion. Trillium provides tools to help members determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk or maintaining low risk. Tools are interactive resources that allow members to enter personal information and results are based on individual information. Members can access these tools directly from Trillium's website or through other methods (e.g. printed material). Trillium evaluates its self-management tools for usefulness to members at least every 36 months with consideration of the following:

- Language is easy to understand.
- Members' special needs, including vision and hearing.

D. 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 under-utilizers 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. A random sample of identified members may be 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 Medical Director of 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 TBS platform. Outcomes and findings are discussed during departmental staff meetings as well as the Sanctions Committee and Compliance Committee. Sanctions Committee members and Compliance Committee members are asked to use their unique perspectives/experiences to provide recommendations for actions taken and actions to be considered based on the information shared.

Practice Management:

- The Practice Management department of Trillium Health Resources assists in the review of over / under utilization by driving best practices and industry standards using the following strategies:
- Implementation of pilot projects to drive provider performance and quality of care
- Evaluation and identification of improvement efforts of current programs (all populations served)
- Recommending clinical and operational improvements to provider practices and performance metrics
- Providing training, remediation and technical assistance on value-based purchasing and performance metrics
- Educating providers on value-based purchasing
- Oversight of quality of care goals and regulatory requirements
- Recruitment and retention of high performing providers
- Offering alternative payment arrangements in the delivery of care across all populations served

E. Member Experience

An important aspect of our quality program and the services we provide to members is the member experience survey. We obtain feedback from our members at least annually. The survey covers the following areas:

- 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

Trillium also collects data from all sources of member complaints/grievances and appeals and aggregates them into the following categories:

- Quality of Care.
- Access.
- Attitude and Service.
- Billing and Financial Issues.
- Quality of Practitioner Office Site.

Trillium assesses complaints/grievances, appeals, member experience, out-of-network request and utilization to determine opportunities for improvement. When opportunities are identified and interventions implemented, Trillium measures the effectiveness of previous interventions and discusses the information in QIC meetings.

a) 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. Provider Satisfaction surveys are administered to providers to allow the Division of Health Benefits (DHB) to assess Trillium's ability in the following three areas:

- Interacting with network providers
- Providing training and support to providers
- Providing Medicaid Waiver materials to help providers strengthen their practice

Active providers are surveyed for their opinions of satisfaction with Trillium. An active provider is defined as a Medicaid provider that has at least five 1915(b)/(c) waiver encounters within the previous six months. The survey is administered over a six-week period using a web survey protocol. The state provides raw data to Trillium for review and analysis annually.

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

DHB also conducts an annual satisfaction survey for all Medicaid members. DHB contracts with an External Quality Review Organization (EQRO) to conduct this survey each year to assess member satisfaction with services. DataStat, Inc., conducted the survey on behalf of North Carolina Medicaid (NC Medicaid) and the Carolinas Center for Medical Excellence (CCME) in 2019. The instrument selected for the survey was the Adult and Child Experience of Care and Health Outcomes (ECHO®) Survey 3.0 (which is the CAHPS® behavioral health survey) for use in assessing the performance of the

health plans. 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. Results from the Consumer (Member) Satisfaction Survey for North Carolina Adult and Child /Family Medicaid members provide a comprehensive tool for assessing member's experiences with their health care.

The survey sample includes adult Medicaid recipients over the age 18 and parents or guardians of child Medicaid recipients between the ages of 12 to 17 who received mental health, substance abuse, or intellectual and developmental disability services through the LME/MCO within the last year. The survey is administered over a 12-week period using a mixed-mode (mail and telephone) protocol.

The three-wave protocol consists of an initial survey mailing and reminder postcard to all respondents, followed by a second survey mailing to non-respondents, and finally a phone follow-up to non-respondents for whom a valid telephone number is available. The state provides raw data to Trillium for review and analysis annually.

c) Perception of Care Survey:

The Federal Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant include requirements for the collection of performance measures. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) oversees the administration of the annual Consumer Perception of Care Survey to comply with some of these requirements. Survey results are also used to inform state policy decisions designed to improve the system.

The survey is to be administered to individuals participating in treatment for a mental health or substance use disorder, selecting as representative a sample as possible of our provider community and service mix. The number of completed surveys we are required to return is based on the number of individuals served.

Required survey numbers and the recommended sampling method are sent to Trillium by DMH/DD/SAS including instructions with a separate survey form mailing. DMH/DD/SAS sends a memo to Trillium that we can share with our Community Behavioral Health Providers to encourage the participation of all LME-MCO Network providers in our survey sample. Trillium is asked to include a copy of the memo with the Consumer Perception of Care Survey materials we send to each provider in our sample.

The Survey Administration Guidelines for Providers are communicated to Trillium by DMH/DD/SAS to promote the use of standard survey procedures statewide. The Guidelines are provided in an editable format so that we may adapt the document to include our LME-MCO contact information. Trillium is

not allowed to modify the content of the guidelines. Trillium is asked to distribute the guidelines to all providers in our sample.

Trillium returns all completed surveys to DMH/DD/SAS so that they can be scanned (using scantron) and analyzed. The state provides raw data to Trillium for review and analysis annually.

d) Network Adequacy and Accessibility Assessment Survey

Gaps and Needs Assessment (formally called the Network Adequacy and Accessibility Assessment) is an annual study of our area and the people who live here as well as where services are available and how people use them. Surveys that incorporate questions from the state and CFAC are completed by members, families and stakeholders to gather information for the assessment. Ultimately, the assessment serves as a roadmap for determining future growth based on current capacity and identified needs.

e) National Core Indicator (NCI)

National Core Indicator (NCI) surveys are administered annually by the NC Division of MH/DD/SAS with assistance from the Carolina Institute for Developmental Disabilities (CIDD) and the University of NC at Chapel Hill. NCI collects information from people with disabilities and their families and guardians to find out what service areas are working well and those that need improvement in North Carolina and nationally. Each MCO is responsible for drawing a random sample of members to be interviewed both in person and via mail.

f) Home and Community Base Supports-My Individual Experience Survey

Home and Community Base Supports-My Individual Experience Survey:

Conducted quarterly, this is a survey from the NC Department of Health and Human Services (DHHS) for members on a Medicaid waiver. The survey was developed to measure participant's satisfaction, level of awareness of and access to their rights, privacy requirements and member experience expectations, as outlined in the HCBS requirements.

g) Survey Analysis

Once complete, and the results of the surveys are returned to Trillium, we conduct an analysis of the results and complete 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. The timeframe for survey analysis is dependent upon receipt of the raw data from the state for many of the identified surveys.

h) 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 Member Experience 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.

F. Delegation Oversight

The QM Department oversees the delegation process. Trillium currently does not delegate any QI functions. However, we do have an established detailed procedure and process for delegating the activity if needed. 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

G. 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.

H. 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.

I. 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. Trillium collects HEDIS and other performance measure data and compares our performance to national benchmarks, state program performance, and prior organizational performance. The evaluation also 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 annually.

J. Accreditation

Trillium Health Resources is currently URAC accredited through 3/2022 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, and completing all relevant URAC documentation.

Trillium began exploring Managed Behavioral Healthcare Organization (MBHO) accreditation through NCQA in 2018. 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". Trillium has completed the survey process and is awaiting results from that review as of the writing of this plan.

K. 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.

L. 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 by the Quality Improvement Committee. Performance issues identified may require corrective action. A list of the identified key performance indicators is included as Attachment A.

M. 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.

N. 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.

O. 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. The Global Quality Improvement Committee, Provider Council, and Clinical Advisory Committee provide an opportunity for involvement of practitioners/providers and representatives of relevant medical systems or other behavioral health care practitioners to review and provide input on Quality Improvement Activities.

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.

P. Provider Performance Data

Trillium provides a report to practitioners/ providers including interpretation of their QI performance data and feedback regarding QI activities. The Provider Performance Reports (PPRs) 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 practitioners/providers.

These reports may include performance data related to 1-7 day follow-up percentages, 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.

The Practice Management Department may engage in focused clinical and operational improvements with practitioner/provider practices related to performance metrics as a part of alternative payment arrangements in the delivery of care across populations served. Performance data is routinely shared. This activity could also include training, remediation and technical assistance on value-based purchasing and performance metrics. Trillium's goal is to decrease gaps in treatment and develop improvement opportunities which result in the recruitment and retention of high performing practitioners/providers.

Q. 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.

R. 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, 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 (Healthcare Effectiveness Data & Information Set) 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 performance measures in HEDIS 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.

S. Network Adequacy & Accessibility Analysis

In accordance with the information published by the state regarding Network Adequacy and Accessibility requirements, Trillium conducts an annual analysis of its provider network that incorporates data analysis of practitioners/providers for language, access to and choice of providers, as well as input from members, family members, practitioners/providers and other stakeholders. Trillium reviews all services, including crisis services, and identifies service needs and will prioritize strategies to address any network needs identified. The assessment takes into consideration the characteristics of the population in the entire catchment area and includes input from individuals receiving services and their family members, the practitioner/provider community, local public agencies, and other local system stakeholders. The state requirements include quantifiable and measurable standards for the number of each type of behavioral healthcare practitioner and provider.

Upon completion of the assessment, Trillium creates a Network Development Plan to meet identified community needs. The Network Development Plan includes identification and analyses of gaps and requests for approval of exceptions Trillium is contractually required to meet the exception process as identified in the annual requirements document, which provides instructions for conducting each year's "LME/MCO Network Adequacy and Accessibility Analysis". Trillium may utilize existing approved statewide alternative service definitions or develop and request approval for new alternative service definitions to fill network adequacy and accessibility service needs not met with current service definitions. Services reported under alternative service definitions may be used to support performance measures, while non-UCR services cannot.

T. 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 recognizes the cultural diversities woven through the communities we serve and that our communities are only as strong as their people. Trillium strives to ensure that all members have equal access to services provided by a network of culturally competent providers and Trillium staff. Accordingly, Trillium endeavors to contract with providers who recognize that efficacious MH/SU/IDD services requires meeting the unique cultural needs of our communities and the individuals who reside within them. Trillium is committed to the well-being of these communities and our number one focus is helping every person we serve obtain the culturally appropriate services needed to improve well-being and live a fulfilling life.

Trillium has established and implemented procedures to monitor the adequacy, accessibility, and availability of its Provider Network to meet the needs of all members, including those with limited proficiency in English.

Trillium's Executive and Leadership Teams have oversight responsibility for the implementation of Cultural Competence throughout the organization and the network. Trillium maintains a Cultural Competence Plan that includes objectives for serving a culturally and linguistically diverse membership as mechanisms for meeting the needs of population(s) served.

Annually, as a component of the Network Adequacy and Accessibility Analysis, Trillium evaluates the language needs of members in comparison to the network and makes adjustments to the network accordingly. Trillium practitioners/providers have access to cultural competency and health literacy training via our on-line learning portal. The credentialing and re-credentialing application asks a practitioner/ provider to indicate if they have completed the available cultural competency training. Trillium makes this information available in the advanced search option in the network directory.

ATTACHMENT A: KEY PERFORMANCE INDICATORS

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. • 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 routine authorizations processed in 14 days (Medicaid and State funded)	95%	
% 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
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.

INDICATOR	TARGET	RATIONALE
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 B: CHIEF MEDICAL OFFICER JOB DESCRIPTION

Trillium Health Resources
Job Description

Job (Pay Plan) Title: Medical Director
Working Title: Chief Medical Director
Name of Employee: Michael E. Smith, MD
FLSA Status: Exempt
Position Number: 32000
Cost Center/Department: 41/Governance

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 NC DHHS BH/IDD 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 Medical Director of Utilization Management, Staff Psychologist, Integrated Care Nurse and the Medical Affairs administrative assistant, , and oversight of the Medical Affairs department.

Provides supervision of the Director of Quality Management along with oversight of the Quality Management Department.

Requirements:

Education: Must be a physician, board certified in psychiatry, with an unrestricted NC medical license.
Experience: Two (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.
License: Must be a physician, board certified in psychiatry, with an unrestricted NC medical license.

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.

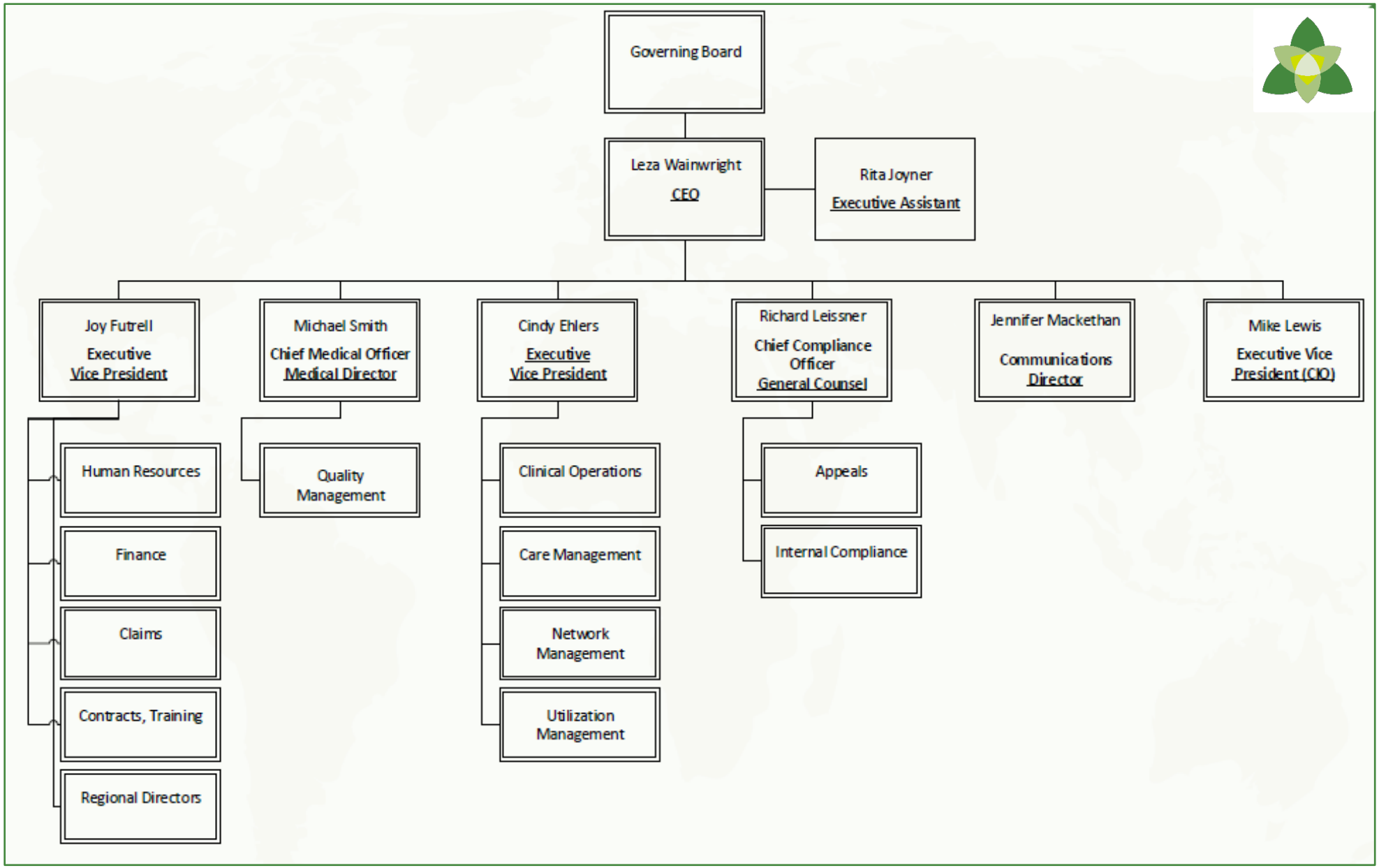
SUPERVISOR CERTIFICATION: I certify that (a) I am the Immediate Supervisor for this position, that (b) I have provided a complete and accurate description of responsibilities and duties, and (c) have verified (and reconciled as needed) its accuracy and completeness with the employee.

Signature:_____ **Title:**_____

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.

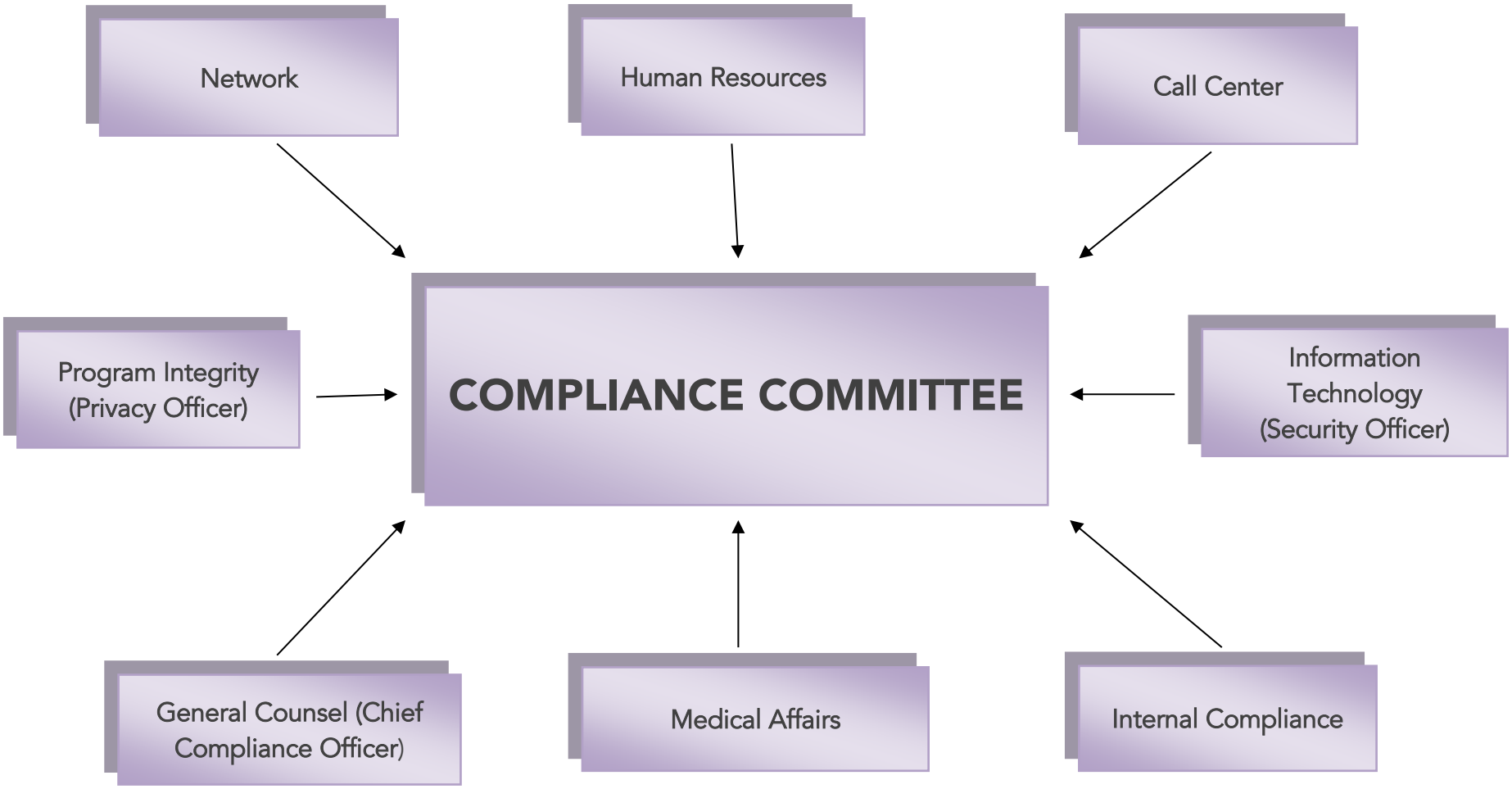
Signature:_____ **Title:**_____

ATTACHMENT C: TRILLIUM ORGANIZATIONAL CHART

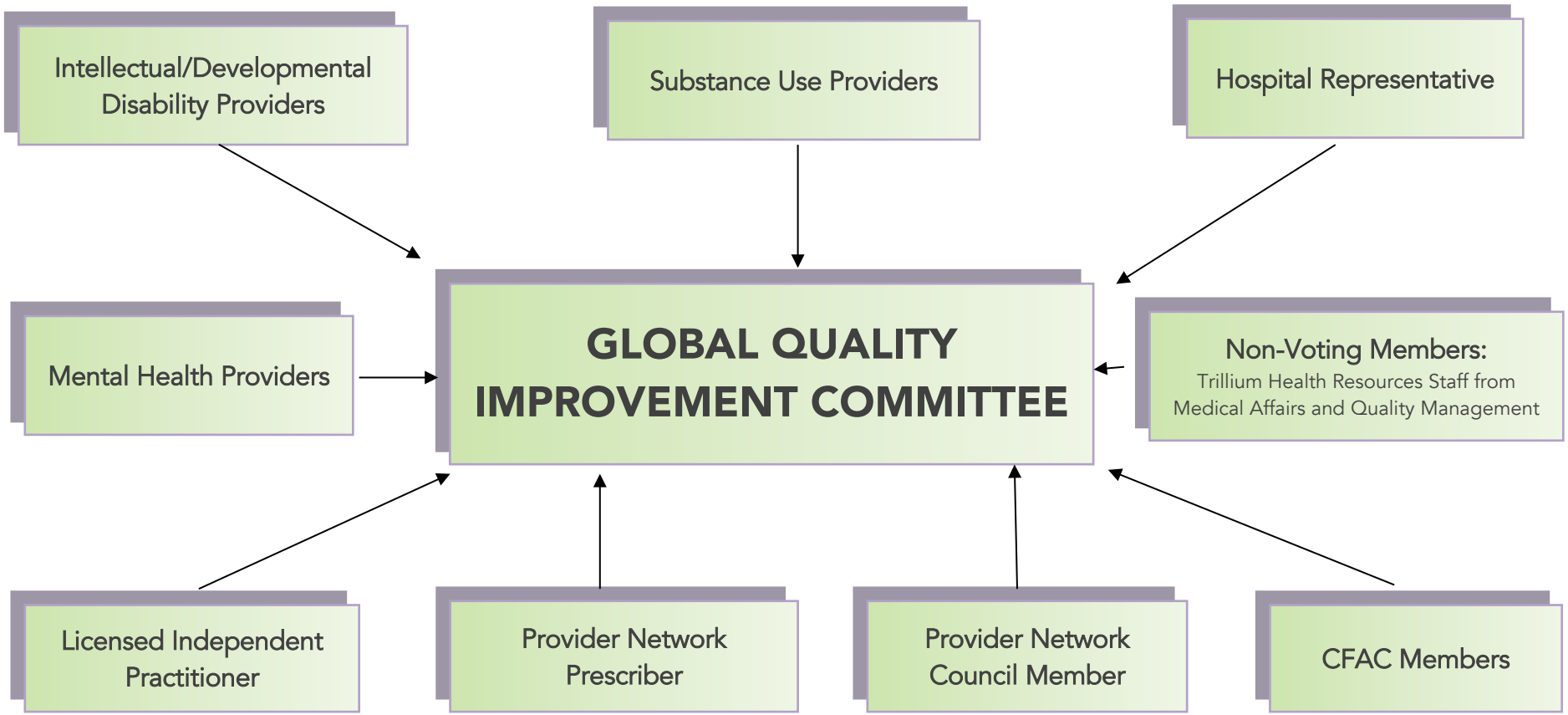


ATTACHMENT D: STRUCTURE OF THE QUALITY IMPROVEMENT COMMITTEE

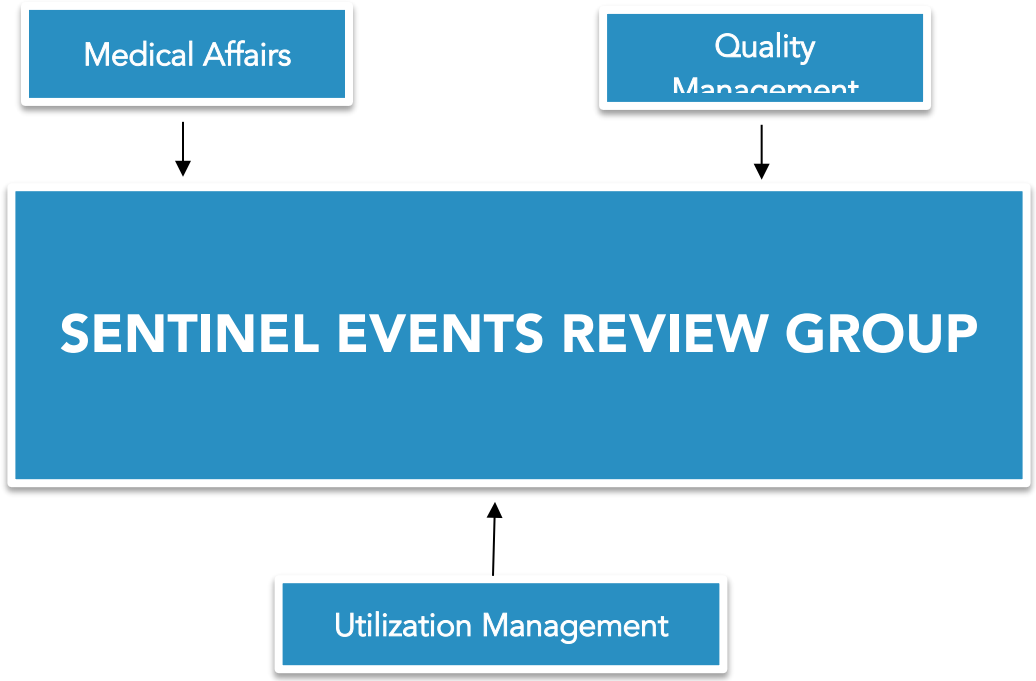
ATTACHMENT E: STRUCTURE OF THE COMPLIANCE COMMITTEE



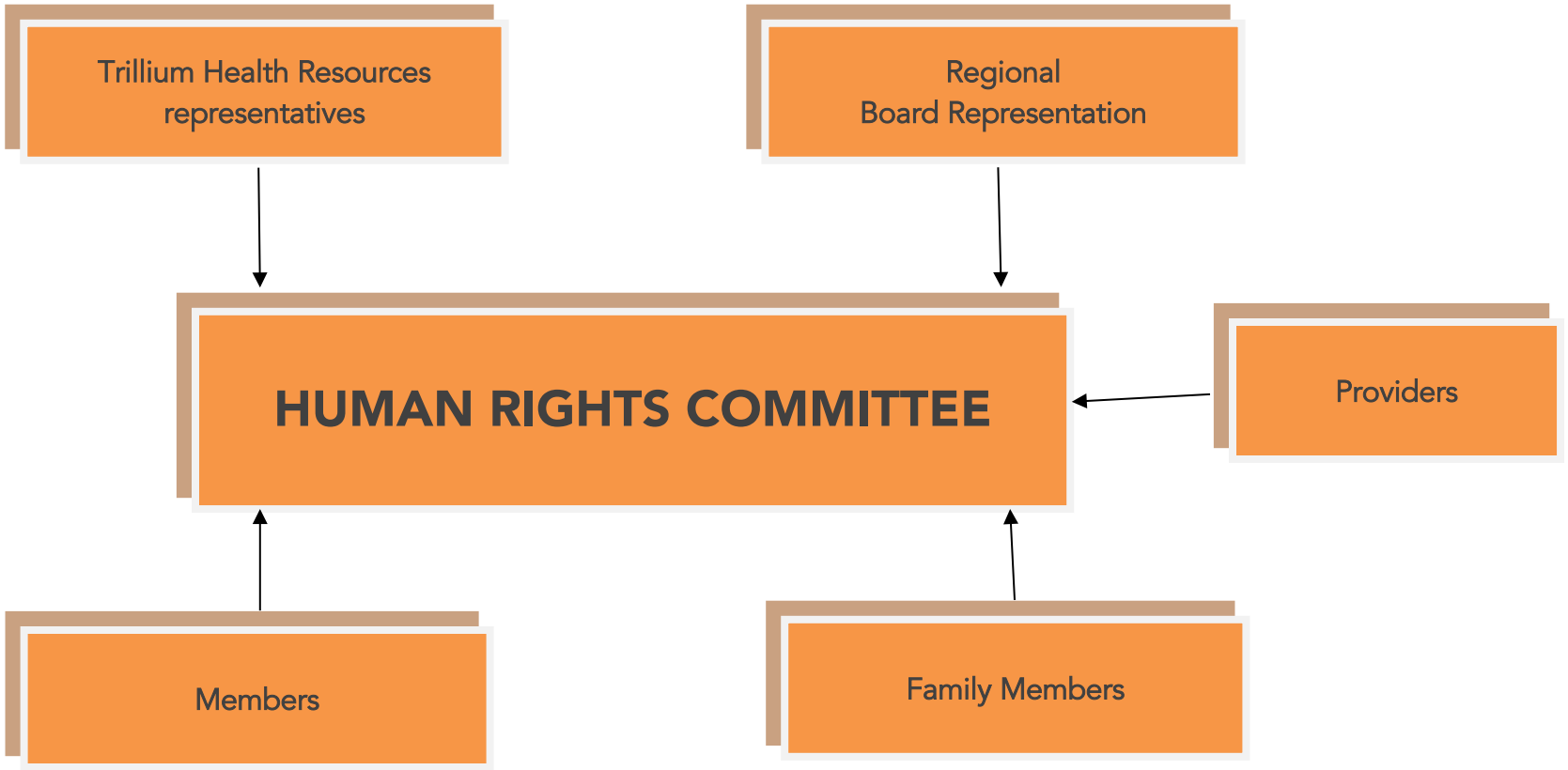
ATTACHMENT F: STRUCTURE OF THE GLOBAL QUALITY IMPROVEMENT COMMITTEE



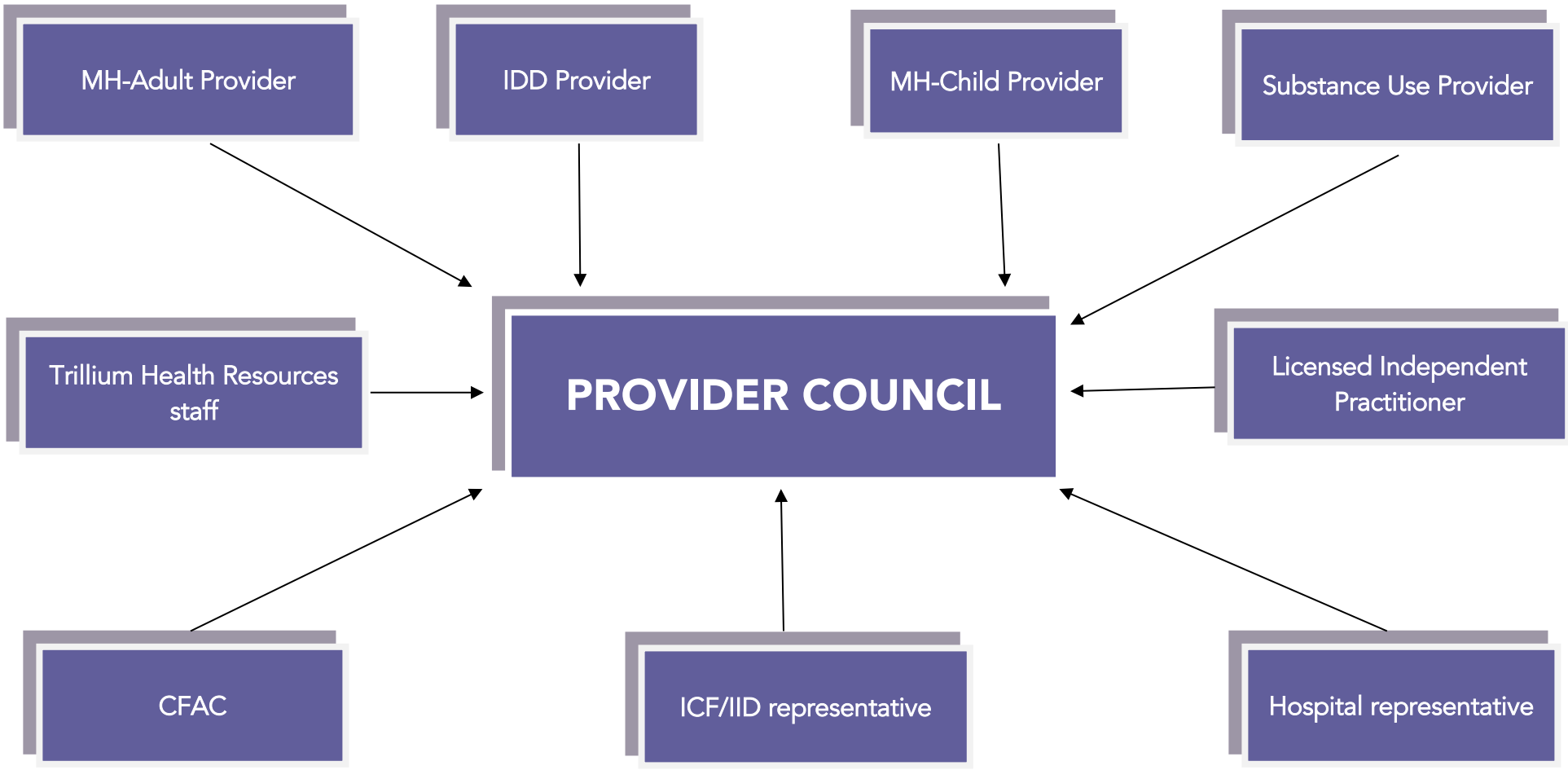
ATTACHMENT G: STRUCTURE OF THE SENTINEL EVENTS REVIEW GROUP



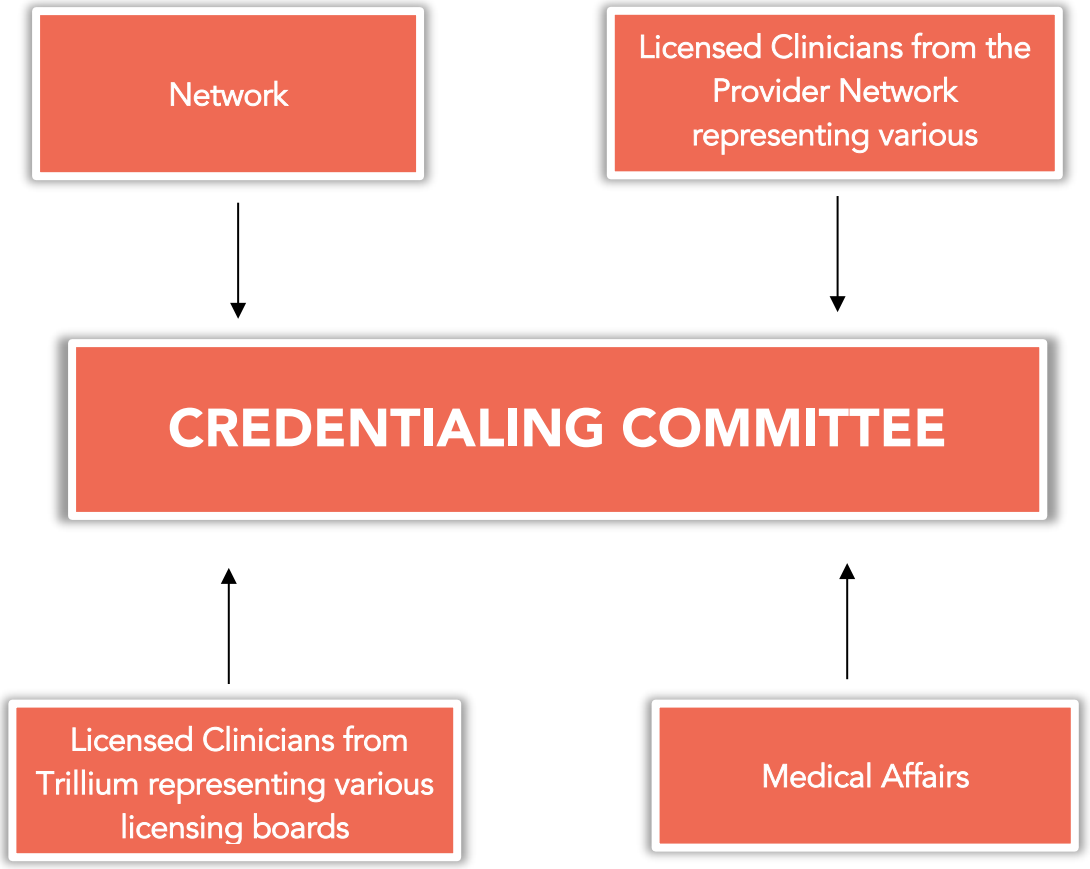
ATTACHMENT H: STRUCTURE OF THE HUMAN RIGHTS COMMITTEE



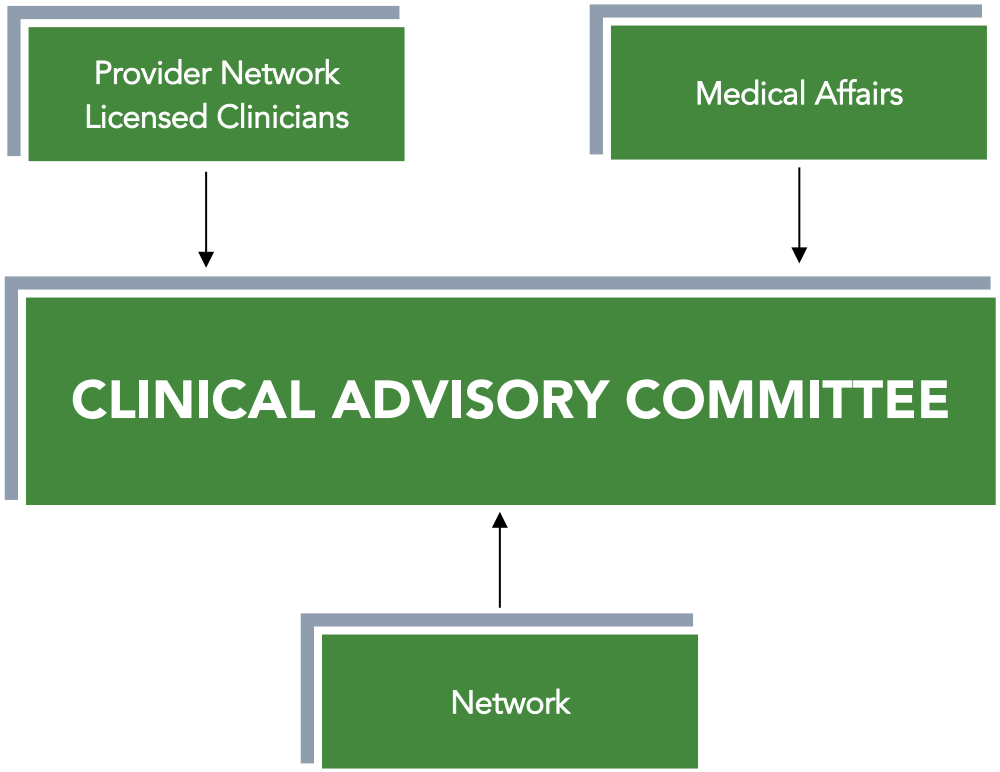
ATTACHMENT I: STRUCTURE OF THE PROVIDER COUNCIL



ATTACHMENT J: STRUCTURE OF THE CREDENTIALING COMMITTEE



ATTACHMENT K: STRUCTURE OF THE CLINICAL ADVISORY COMMITTEE



ATTACHMENT L: STRUCTURE OF THE SANCTIONS COMMITTEE

ATTACHMENT M: COMMUNICATION FLOW BETWEEN COMMITTEES