2021-2022 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) PLAN

Completed By
Fonda Gonzales,
QM Director, May 2021

Reviewed by
QIC June 2021

Approved by
Governing Board June 2021

Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

Table of Contents

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

ACCREDITED NCQA MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION
1 YEAR

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 2022

***TRILLIUM'S QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PLAN WILL BE REVISED AND UPDATED TO INCORPORATE TAILORED PLAN REQUIREMENTS AS REQUIRED PRIOR TO THE NEXT ANNUAL REVIEW IN JUNE 2022.**

INTRODUCTION

Trillium Health Resources (Trillium) is a Local Management Entity/Managed Care Organization (LME/MCO) that manages mental health (MH), substance use (SU), and intellectual/developmental (I/DD) disability services for people with Medicaid and for those uninsured or underinsured in eastern North Carolina.

Trillium Health Resources is the largest public Medicaid managed care organization in North Carolina in terms of geographic size covering 17,000 square miles and 31% of land mass. Trillium's 26 counties include a total population of 1.5 million and in FY 19-20 we were responsible for services to 404,532 people who had Medicaid or were uninsured. Trillium actually provided services to 58,452 individuals. (Source Trillium 2020 Annual Report). Trillium's regions vary widely by population density. Most of the catchment area is rural, including North Carolina's two least populated counties: Hyde and Tyrrell counties. The most populated cities include Wilmington, the eighth largest city in North Carolina and Greenville, the tenth largest city.

TRILLIUM MISSION AND VISION STATEMENTS

MISSION:
Transforming lives and building community well-being through partnership and proven solutions.

VISION:
For every community and individual we serve to reach their fullest potential.

Trillium Values Statement developed in 2020:

We want all our member families, staff, providers, and partners to know what we will NOT stand for. Trillium has always believed in encouraging inclusive environments and reducing stigma for those we serve with mental health, substance use, or I/DD conditions. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. A person's worth and dignity should not be diminished by any of these characteristics; our differences make us stronger. We do not stand for racism, in all its forms. We do not stand for exclusion, whether against people of different abilities or different races. We do not stand for limiting anyone's potential, through restrictive practices or beliefs. We do stand together, united and unapologetically, in the true spirit of partnership to collectively transform. We invite you to join us.

PROGRAM OVERVIEW

Trillium's Quality Assessment and Performance Improvement (QAPI) Plan has been developed to align with the critical needs of our population and meet the requirements as set forth by North Carolina Department of Health and Human Services (NCDHHS). The QAPI Plan of Trillium Health Resources is designed to ensure that the organization's 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 Trillium operates.

Trillium seeks to improve health outcomes for Medicaid Members/State-funded Recipients (Members) by focusing on rigorous and well-defined outcomes measurement, promoting health outcomes for all of the diverse populations we serve through reduction or elimination of health disparities, and rewarding providers for advancing quality goals.

Trillium's mission, values, and working principles provide vision for how we meet NCDHHS standards and statutory requirements. In alignment with North Carolina's quality strategies, the overarching purpose of the Trillium Quality Assessment and Performance Improvement (QAPI) Plan is focused on whole person-centered care that supports:

- Better care delivery and improved Member experience
- Healthier people, healthier communities
- Improved provider experience
- Smarter spending

Quality Assessment and Performance Improvement (QAPI) Plan

The purpose of the Quality Assessment and Performance Improvement (QAPI) Plan is to establish a planned, systematic and comprehensive approach to measure, assess, and improve organization-wide performance. The QAPI 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 QAPI Plan promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement projects and activities based upon the findings. The QAPI Plan is designed to assess and analyze systems performance data that will subsequently guide performance improvement for better supporting the people we serve. The QAPI 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 Assessment and Performance Improvement (QAPI) Plan's success is the achievement of desired individual outcomes by the people we serve.

The QAPI Plan is reviewed at least annually. It is available for review by the various regulatory and accreditation entities (i.e. 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.

The scope of the QAPI Plan is designed to promote and measure member safety, and the quality and appropriateness of services. The QAPI Plan and 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 process and documents

The scope of the QAPI Plan is cross functional. Activities are focused on access, clinical quality, satisfaction, service, qualified practitioners/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.

Quality Assessment and Performance Improvement (QAPI) 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 work plan is a mechanism for tracking quality management activities and objectives for improving quality and safety of clinical care, quality of service, and members' experience. 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 QAPI 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.

Quality Assessment and Performance Improvement (QAPI) Plan Evaluation

Trillium Health Resources completes an evaluation of the agency's Quality Assessment and Performance Improvement (QAPI) Plan annually. The written evaluation is an assessment of the effectiveness of the components of the program, completed and on-going activities that addresses the quality and safety of clinical care and quality of service(s). 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 QAPI Plan 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 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 evaluation, the prior year's QAPI Work Plan is revised, and a new QAPI Work Plan for the coming year is developed to guide and focus the work for the next year. The QAPI Plan Evaluation is presented to the QIC annually.

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.

The state's Quality Strategy is built with the desire to construct an innovative, whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and an enhanced focus on promoting health equity.

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 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

Per North Carolina's Medicaid Managed Care Quality Strategy, April 5, 2021 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." These strategies support Trillium's Mission, Vision, and Values Statement.

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
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 and community inclusion
	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
		Objective 5.1: Address unmet health-related resource needs

Aims	Goals	Objectives
	Goal 5: Work with communities to improve population health	Objective 5.2: Address the opioid crisis
		Objective 5.3: Address tobacco use
		Objective 5.4: Promoting health equity
		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

**Source North Carolina's Medicaid Managed Care Quality Strategy, April 5, 2021*

Trillium's QM strategy is based on continuous quality improvement including constantly working to identify targets for improvement and responding quickly to gaps. Our data analytics capabilities provide the insights and opportunities to discover and address disparities in quality metrics. They enable us to understand variations in quality across multiple performance

venues. Critical success factors to achieve our QM goals require continuous effort and commitment to:

- Ensure that resources are directed toward priorities such as opioid response, access to care, addressing health-related needs and services for children with complex needs as well as care needs specific to individuals with Intellectual and/or Developmental Disability (I/DD) and Traumatic Brain Injury (TBI)
- Hold staff and providers accountable for meeting quality goals and desired outcomes
- Review performance measurements and monitor key metrics through dashboards and regular reporting
- Hear and consider input from all stakeholders and implement recommendations for improvements that are Member focused, reasonable, economically feasible, actionable, and measureable
- Align with the NCDHHS Quality Strategy to support Members as well as design and implement system improvements

Trillium's continuous quality improvement activities are designed to promote the highest quality integrated care. Our Quality Assessment Performance Improvement (QAPI) Plan takes a data-driven, outcomes-based approach to quality.

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.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) STRUCTURE

The Trillium Health Resources Governing Board, is responsible for the oversight of the Quality Assessment and Performance Improvement (QAPI) Plan and the annual approval of the Plan. The approval of the Plan is documented in the minutes of the Quality Improvement Committee (QIC) 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 Adequacy and Accessibility Analysis report
- Completion of the organization's Cultural Competency Plan
- Supervising the implementation of the Quality Assessment and Performance Improvement (QAPI) Plan, QAPI Work Plan, and the QAPI Annual 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 Assessment and Performance Improvement (QAPI) Plan to the Governing Board

PLAN-DO-STUDY-ACT (PDSA)

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 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 model utilized in the QM department is the "Plan-Do-Study-Act" (PDSA), a four-step model for carrying out change. PDSA is a quality management tool used as a framework for problem solving and continuous quality improvement. Just as a circle has no end, the PDSA cycle should be repeated again and again for continuous improvement.

RESOURCES

The philosophy of Trillium Health Resources is that all staff, sub-contractors, and practitioners/providers are “quality-driven”. Quality improvement and quality management are 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 Assessment and Performance Improvement (QAPI) Plan. The Director of Quality Management is supervised by the CMO, with the CMO co-chairing the Quality Improvement Committee along with the Director of Quality Management. The clinical operation of the QAPI Plan is overseen by the CMO, who is a board-certified psychiatrist with active, current, and unrestricted medical license in the state of North Carolina. The CMO has a minimum of five years post-graduate experience in direct patient care and possesses the qualifications to perform clinical oversight.

The Information Technology (IT) 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 Data Reporting unit within the IT department ensures that data is made available for timely, accurate reporting, and analysis. Trillium’s QM staff work closely with the IT Business Informatics Data Reporting Unit to develop and apply critical data analytics necessary to build and manage our QM activities. QM analytics support the continuous QI efforts required to ensure program expectations and outcomes are identified and realized. Trillium’s core business platform, Trillium Business System (TBS) is the cornerstone of Trillium’s IT solution. This proprietary platform houses a multitude of business rules and logic developed over the years to address the critical needs of the behavioral health (BH) and I/DD population served by Trillium. Our IT platforms are built and designed to be both scalable and flexible allowing for the identification of new populations, programs and solutions to emerging community gaps and needs.

Our teams work together to develop dashboards and reports to support the analysis, pattern and trend identification, compliance, tracking and monitoring of Trillium’s service provision. The dashboards provide insights on provider performance, Member outcomes, improvement opportunities, and trends. Our dashboard and reporting systems are modern information systems based on globally recognized platforms and standards such as Microsoft Power BI. The platforms are customizable to deliver information needs identified by our clinical and care coordination or care management teams to improve Member outcomes. Dashboards and reports are available to Trillium team members in real time and as needed to support our Members. 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 the Head of Performance Improvement and Quality Management Coordinators. This Unit is responsible for monitoring incident reports/ adverse events, national accreditation, quality improvement activities, including the QAPI Work

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

The Delegation and Accreditation Unit is responsible for assuring the agency's compliance with delegated activities and national accreditation standards. The Head of Accreditation oversees and manages the evaluation of the adequacy and effectiveness of Delegation Oversight activities and includes Accreditation Consultants as well as Delegation Coordinators. These activities include 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 QM Performance Measures Unit 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. The Data Analyst Supervisor, along with HEDIS & Performance Specialists develop analytical reports, including conducting analysis, information synthesis, summarizing and interpretation of results, to include the identification of patterns and trends in data. The staff in this unit make recommendations for actionable areas to intervene and identifies matters of significance that could impact the agency.

Head of Health Plan Development is responsible for supporting the Director of Quality Management with the organization's achievement and on-going maintenance of NCQA Health Plan national accreditation. This position evaluates each functional area or department's readiness to design and implement NCQA or HEDIS oriented quality improvement activities and also drafts narrative reports to interpret regulatory specifications, explain programs and results of programs, and document findings and limitations of department interventions. The Head of Health Plan Development ensures maintenance of programs for members in accordance with prescribed Health Plan quality standards; conducts data collection, reporting and monitoring for key performance measurement activities; and provides direction and implementation of NCQA accreditation surveys. These activities are designed to provide organizational support to functional area leaders including streamlining status reports, drafting, editing letters/brochures, as they relate to QAPI activities and HEDIS.

The QM Administrative Assistant provides confidential administrative support to the 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.

Resources available to the Quality Management function include various Trillium departments, Medical Affairs, Utilization Management/Appeals, Call Center, Customer Services, Care Management/Population Health, Communications, Information Technology, Regional Operations, Program Integrity, Legal / 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 (not to be considered an exhaustive list):

- 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/Health Risk Assessment data and reports
- Feedback from external regulatory and accrediting agencies

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 responsibly. 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.

Data Analytics

The Quality Management Team, in collaboration with the Business 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. Trillium ingests all of the available data (claims, pharmacy, labs, and demographic) into a centralized data warehouse solution. Upgrades and on-going enhancements to the system will be important as Trillium transitions into a Tailored Plan and will then be responsible for additional lines of business.

Dashboards

The Business Informatics Data Reporting Team is 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.

DELEGATION OVERSIGHT

The Delegation and Accreditation unit 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

COMMITTEE STRUCTURE

Trillium manages a consortium of committees that includes the Quality Improvement Committee (QIC). Trillium embeds practitioners (clinicians)/providers in many of the established committees to ensure a strong clinical perspective is a consistent and active part of its quality improvement initiatives. Each practitioner/provider, Board member, and/or Consumer and Family Advisory Committee (CFAC) member serving on a Committee agrees to comply with all state and federal rules, guidelines, and mandates related to conflicts of interest and confidentiality. Each committee member upon appointment and as changes occur, completes a disclosure statement. Disclosure statements are maintained by the Chief Compliance Officer (or designee). Each Committee maintains By-Laws and/or Charters that provides additional

detailed information related to the committee including its purpose, structure, meeting schedule, membership, and responsibilities.

QIC is comprised of representatives from each of the following committees who assist in the quality oversight of the agency:

- 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 Assessment and Performance Improvement (QAPI) 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 QAPI Plan 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.

Trillium leverages the clinical expertise of committee members to assist with a variety of clinical functions including, but not limited to the following:

- Examine and provide input on clinical decision support tools and corresponding clinical policy criteria.
- Review of, and agreement with clinical content published to stakeholders.
- Evaluation of trended member adverse events and/or potential quality of care concerns.
- Evaluate Trillium's QAPI plan including Quality Improvement Activities (QIAs)/ Performance Improvement Projects.

Quality Improvement Committee:

The Quality Improvement Committee (QIC) is granted authority for quality management by the Chief Executive Officer and the QAPI Plan is approved by the Governing 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 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 Assessment and Performance Improvement (QAPI) 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 (as available), lab results (as available), 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. 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 activities and performance goals
- Monitor adherence to key performance indicators (KPIs) internally and externally
- Review and approve the Quality Assessment and Performance Improvement (QAPI) Plan and QAPI Work Plan
- Evaluate the effectiveness of the Quality Assessment and Performance Improvement (QAPI) Plan annually
- Approve and maintain policies and procedures
- Evaluate member experience survey results and determine opportunities for improvement

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 and Medicaid Contract Manager. The Internal Compliance and Medicaid Contract 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 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.

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
- Reviewing concerns regarding access to services

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 QAPI 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

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) will be notified promptly via email and/or telephone. After consultation with the CMO occurs, any recommended actions are undertaken to resolve the issue.

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

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. The objectives of this committee are:

- To provide feedback and recommendations to Trillium about its clinical initiatives and clinical performance.
- To recommend new service initiatives to address service gaps and provide insight into the annual gaps and needs analysis.
- To make recommendations for clinical training and clinical education for the Trillium clinical network.
- To evaluate and recommend clinical practice guidelines, along with approaches for monitoring their implementation in Trillium network practices.
- To review and advise Trillium Health Resources regarding the annual QAPI Plan, and to review the goals, and objectives of the Trillium Health Resources QM department.
- To review and advise Trillium Health Resources regarding the annual Utilization Management (UM) plan, and to review the goals, and objectives of the Trillium Health Resources UM department.

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 is heterogeneous. The Trillium Vice President of Network Management participates as an ad hoc member.

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

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 National Practitioner Data Bank (NPDB) continuous query sanction reporting. Trillium initiates appropriate action within 30 days of notification to determine if action is needed. 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) or designee, will be notified promptly via email and/or telephone. After consultation with the CMO/ designee 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. The objectives of this committee are:

- Ensure the use of objective evidence and patient-care considerations when a practitioner/ provider does not meet quality standards.

- Determine if recommended sanction(s) are appropriate for the identified violations and in accordance with established procedure(s).
- Identify, review, and discuss areas of weakness and vulnerability to Trillium Health Resources.
- Provide insight and questions concerning any investigations.
- Maintain communication between departments about sanctions, their findings, and dispute resolutions.

QUALITY MANAGEMENT ACTIVITIES

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.

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 ensures that all adopted clinical practice guidelines are based on valid and reliable clinical evidence, a consensus of practitioners in the particular field, professional standards, nationally recognized recommendations, peer-reviewed medical literature, and/or the best available scientific evidence. Recognized professional practice societies such as the American Psychiatric Association, the American Academy of Pediatrics, and the National Institute on Alcohol Abuse and Alcoholism, etc. publish recommended guidelines that are used by Trillium. 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). Trillium must adopt evidence-based clinical practice guidelines for at least three behavioral health conditions (with at least one guideline addressing children and adolescents) and annually measure performance against at least two important aspects of each of the three clinical practice guidelines. Trillium has chosen the following behavioral health conditions for this activity:

a. Schizophrenia

b. ADHD (addresses children/adolescents)

c. Opioid Use Disorder

Providers are responsible for adhering to and following the Clinical Practice Guidelines adopted by Trillium. Trillium provides notification to practitioners/ providers regarding the compliance expectations and requirements for these guidelines in a variety of methods including Communication Bulletins, Provider Manual, and Trillium's website. Adherence to these guidelines may be monitored in the following ways:

- Focused audits completed via Utilization Reviewer and others as appropriate and applicable.
- Routine review of Service Authorization Requests (identifying any areas of concern)
- Peer Review activities
- Quality of Care Referrals/ Member Complaints & Grievances
- Clinical Advisory Committee activities
- Special Investigations Unit/ Program Integrity monitoring, if indicated
- Trillium's Committee reporting structure supports the general oversight and management of practitioner/provider adherence to established Clinical Practice Guidelines.

Trillium compiles an Annual Report depicting the quantitative and qualitative analysis of the results of each of the measured aspects of the clinical practice guidelines. This report is shared and reviewed by the Quality Improvement Committee (QIC). QIC works to identify any systemic issues and/or opportunities for improvement that can be addressed by Trillium through corrective action or quality improvement activities. Details of discussions, conclusions and any action needed are documented in meeting minutes. This report will also be shared with the Clinical Advisory Committee (CAC) for review and discussion.

Behavioral Health Screening Programs

Trillium Health Resources has established and implemented behavioral health screening programs to assist practitioners/providers in determining the likelihood that a member has a coexisting substance use and mental health disorder or that presenting signs and symptoms may be influenced by co-occurring issues.

These screening tools are based on evidence from research studies that have been shown to be effective in the detection of positive screening for behavioral health symptoms and can be used as part of the general assessment of a member to determine if further evaluation is needed for formal diagnostic identification and treatment planning.

The screening tools have been reviewed by Trillium's Clinical Advisory Committee and are recommended for use by Trillium Health Resources' Network. As a member of the Trillium network, providers and practitioners may select one or more of the identified screening instruments to add to their existing array of tools. Trillium distributes information on the screening programs to practitioners and providers at least every two years via Communication

Bulletins, email, and on its website. Notifications will also be provided when there are revisions and/or additions to the screening programs. If any technical assistance is needed regarding these instruments, providers/practitioners may contact Trillium. Trillium welcomes feedback and recommendations from practitioners/providers about other screening tools they use in their current treatment setting.

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 (i.e. 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.

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 monitoring these identified priorities is to evaluate service utilization of high cost services and reduce 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 Deputy Chief Medical Officer monthly. TBS data may be used to detect under and over utilization of services and for demographic-based initiatives to address health disparities based upon age, race, ethnicity, sex, language, geography and by key population group (i.e. LTSS).

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

MEMBER EXPERIENCE

Ensuring a positive experience from the moment a member connects with Trillium is a critical component to effective health care delivery. Member experience encompasses many interactions such as getting timely appointments, accessing information and resources from Trillium staff and network providers easily and receiving provider services with minimal disruption. Trillium monitors member experiences (how the members feel about their interactions with Trillium) to identify areas for improvement. Annually, Trillium works to improve the member's experience by evaluating members' access to services using out of network service request/ utilization data, data from grievances, Utilization Management /appeals processes, member experience / member satisfaction surveys to identify areas for improvement.

Survey data contributing to the overall member experience at Trillium and reviewed routinely during Committee meetings includes the following areas (not to be considered an exhaustive list):

- 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

As described in the Compliance Committee section, Trillium collects data from all sources of member complaints/grievances and aggregates them based on total and rate per 1,000 members into the following categories as a method of evaluating member experience:

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

A Member Experience Report is compiled including data regarding members' access to services (out of network service request/ utilization data), data from grievances, Utilization Management /appeals data, experience / satisfaction survey data. The report is reviewed by QIC and other committees, as appropriate, to identify any systemic issues to be addressed by Trillium through corrective actions or quality improvement measures. When opportunities are identified and interventions implemented, Trillium measures the effectiveness of previous interventions and discusses the information in QIC meetings.

SURVEYS

Provider Satisfaction Survey:

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

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. 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 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.

Perceptions 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 Perceptions 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 for distribution. DMH/DD/SAS sends a memo to Trillium that Trillium can share with 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 Perceptions of Care Survey materials sent to each provider in the 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 to adapt the document with trillium specific contact information. Trillium is not allowed to modify the content of the guidelines. Trillium is asked to distribute the guidelines to all providers in the sample.

Trillium returns all completed surveys to DMH/DD/SAS for scanning (using scantron) and analysis. The state provides raw data to Trillium for review and analysis annually.

Network Adequacy and Accessibility Assessment Survey

The Network Adequacy and Accessibility Assessment is an annual study of Trillium's catchment 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.

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.

Home and Community Base Supports-My Individual Experience Survey

Home and Community Base Supports-My Individual Experience Survey is 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 members' satisfaction, level of awareness of and access to their rights, privacy requirements and member experience expectations, as outlined in the HCBS requirements.

Survey Analysis

Once complete, and the results of the surveys are returned to Trillium, where an analysis of the results is conducted including 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.

Communication of Survey Results:

Trillium's Quality Management department is committed to sharing information with members, families and the network about quality assurance initiatives. Trillium shares results of Member

Experience Surveys with members, families, and the network by posting results on Trillium's website and sharing results with various committees including the Global Quality Improvement Committee, Consumer Family Advisory Committee (CFAC), and the Provider Council.

Accreditation

Trillium Health Resources is currently URAC accredited through 3/2022 for the following programs:

- Health Utilization Management
- Health Call Center
- 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.

In September 2020, Trillium earned accreditation from the National Committee for Quality Assurance (NCQA) for Managed Behavioral Healthcare Organization (MBHO). Trillium was granted a full one-year accreditation, indicating that Trillium's quality improvement and member protection programs are well established and meet NCQA standards.

Trillium is preparing for re-survey in September 2021 with the goal of achieving full accreditation status that would expire in December 2023.

State Reporting

The Business 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 Business 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.

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 issues that reflect the health needs of significant groups within the organization's population, including 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 QIAs. 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 state contracts and accreditation standards, Trillium Health Resources is required to maintain at least four Quality Improvement Activities and one of the QIAs shall be related to the Transitions to Community Living Initiative (TCLI).

QIAs shall focus on relevant clinical and non-clinical issues. Where possible, QIAs will track measurements for Medicaid and state-funded populations separately. 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. Trillium Health Resources will sustain any observed performance improvements for at least one year after the goal is achieved before closing / terminating the activity.

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 Business 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.

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.

Key Performance Indicators (KPIs)/ Outcome Measures

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 in the QAPI Work Plan.

Healthcare Effectiveness Data and Information Set

HEDIS, the acronym for Healthcare Effectiveness Data and Information Set, is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS is a performance measurement tool for health plans. The standard set of measures related to care and service is organized in categories including:

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization and risk-adjusted utilization
- Health plan descriptive information

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

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

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. Measures are collected, analyzed and reported by a team of professionals with knowledge in data management, analysis and clinical expertise. As appropriate, benchmarks and/or goals are developed for measures. For HEDIS measures, national and regional benchmarks are utilized for comparison and goals set based on differences between Trillium's performance and benchmarks. For internal developed measures or measures with no benchmarks available, goals are set based on trends and objectives. Results are presented at various committees and shared with members and practitioners/providers as appropriate via newsletter.

Coordination of Behavioral Healthcare

Annually, Trillium identifies opportunities to improve coordination across the continuum of services by analyzing the collected data with the goal of evaluating the continuity and coordination of care that members received and takes action (as necessary), to improve and measure the effectiveness of actions/interventions implemented as a result.

Trillium selects at least one opportunity to improve coordination of behavioral healthcare in each of the following categories:

- Exchange of information across the continuum of behavioral healthcare services.
- Access and follow-up with appropriate behavioral healthcare practitioners in the network.
- Appropriate use of psychotropic medications.
- Special needs of members with severe and persistent mental illness (SPMI).

The Care Coordination Program at Trillium will monitor the deliberate activities related to coordinating and organizing patient care for specific designated populations against benchmarks defined yearly, which may include state requirement targets.

Care Coordination activities will outline interventions and how data will be collected and monitored for conformity to the benchmarks or to measure improvement in Care Coordination improvement activities.

Complex Case Management

Trillium Health Resources assists members with multiple or complex conditions to obtain access to care and services, and coordinates their care, through its complex case management program. The overall goals of Trillium's' complex case management program are to:

- To proactively identify members who have multiple or complex medical and/or social determinants of health needs, or who are at risk of developing complex needs during an acute episode of illness
- To provide early intervention and intensive support for members appropriate for complex case management to prevent recurrent crises or unnecessary hospitalizations and to regain optimum health or improved functional capability.
- To ensure delivery of the right services/supports, in the right amount, at the right time, in a cost-effective manner.

Annually specific program objectives are formulated to help achieve these overall goals. The complex case management program works in collaboration with other Trillium departments, treating providers, family/external supports, and community resources, to meet members' needs. Trillium considers complex case management to be an opt-out program: all eligible members have the right to participate or to decline to participate. Additional detailed information can be found in the Complex Case Management Program Description and Procedure.

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 individuals receiving services and their family members, the practitioner/provider community, local public agencies, and other local system 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. The state requirements include quantifiable and measurable standards for the number of each type of behavioral healthcare practitioner and provider as well as standards for the geographic distribution of each type of practitioner/ provider. Trillium has also established practitioner to member ratios by practitioner type in addition to the state established parameters for assessing network adequacy.

As a component of the annual analysis, Trillium evaluates the language needs of members in comparison to the network (Language Diversity Report) and makes adjustments to the network accordingly.

Upon completion of the assessment, the results are analyzed to determine performance against the established standards. Based on the opportunities for improvement, 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. While services paid and reported under alternative service definitions may be used to support performance measures, services paid on an expenditure basis, rather than filed claims, do not. . As an additional component to the evaluation of the adequacy of Trillium's Network, annually a Timely Appointment Report for Medicaid Members is compiled to ensure appropriate access to appointments based on triage categories of urgent, emergent, and routine.

Serving a Culturally Diverse Membership

A primary focus of the Quality Assessment and Performance Improvement (QAPI) 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/DD/SAS 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 Competency 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 (Language Diversity Report) and makes adjustments to services offered to diverse speaking people in 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.

Trillium's Non-Discrimination Policy and Cultural Competency Plan aims to guide our approach, programs, and services and also support the creation of a culturally competent behavioral and physical health system of care that embraces and supports individual differences to achieve the best possible outcomes for members receiving services. Research indicates that how individuals experience health and define their well-being is greatly informed by their cultural identity. Trillium chose to implement the use of national Culturally and Linguistically Appropriate Standards (CLAS) standards in 2020. It is our desire to promote equity, reduce health disparities, and improve quality of care. See our Cultural Competency Plan for evaluation of CLAS standards within Trillium Health Resources.

Population Assessment

Annually, Trillium uses available data (i.e., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics) to assess members and relevant sub-populations, the characteristics and needs, including social determinants of health (SDoH), so that appropriate programs can be developed. Particular attention is given to the needs of children/ adolescents (age 3 to age 22), Members with disabilities, and Members with serious and persistent mental illness (SPMI).

Inter-rater Reliability

Trillium Health Resources Utilization Management department evaluates the consistency with which licensed clinicians/behavioral healthcare professionals involved in UM apply criteria in decision making. The Utilization Management department monitors this data to ensure adherence to established performance goals. A report is provided to the QIC quarterly for assessment of compliance with established performance goals. The annual UM Plan describes this process in more detail.

Utilization Timeliness Report

Requests for mental health (MH), substance use (SU) or intellectual and developmental disability (IDD) services are made by the completion and submission of a Treatment Authorization Request (TAR). Staff have up to 14 calendar days to process routine (non-urgent/preservice) requests or 72 hours for an expedited (urgent pre-service/urgent concurrent) request. All time frames for review are inclusive of decision and the peer review and mailing of Notice of Adverse Benefit Determination letter to the member/legally responsible person if there is a denial of all or part of the request. The Utilization Management department and Appeals department monitor this data to ensure adherence to established performance goals. The annual UM Plan describes this process in more detail.

Accessibility of Services

Trillium evaluates access to appointments using the Timeliness of Appointments Report. Data for this report is collected continuously by Call Center Agents when assisting members that are requesting MH/IDD/SU services to schedule an appointment. When the Call Center Agent completes a screening, triage, and referral (STR) and the member is determined as meeting clinical threshold and eligibility criteria to receive Medicaid emergent, urgent, or routine care the associated data is included in the report. The data is not secret shopper data or practitioner self-reported data. The data represented is collected from actual appointments and entered in the Trillium Business System (TBS) as they are scheduled. Appointments are scheduled with providers who offer an array of behavioral health services including medication management.

The Timeliness of Appointments Reports are run quarterly using a calendar year time frame. The quarterly report results are summarized to produce the annual report. The completed annual report is presented to the Quality Improvement Committee to analyze the data and address areas for improvement, as necessary. When interventions are required, the effectiveness of the interventions are evaluated during the quarterly departmental review and during the annual report evaluation.

CLOSING

Trillium's Quality Assessment and Performance Improvement (QAPI) Plan promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement activities based upon findings. The QAPI Plan is designed to continually and consistently assess and analyze system performance data which will subsequently guide performance improvement to better support Trillium's members. All of the committees, along with the numerous activities, staff, and processes described in the QAPI Plan seamlessly combine to ensure the highest quality across the Trillium system.