Annual Quality Management Program Evaluation

Fiscal Year 2018-2019

Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

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Executive Summary

FY2018-2019 Annual Quality Management Program Evaluation

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

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

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

After reviewing and evaluating overall performance and program effectiveness in all aspects of the 2018-2019 Quality Management Program, it has been determined that all the activities planned for the past year were completed. Twenty annual objectives were met, 1 was partially met and 2 were not met.

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

2018-2019 Highlights

- **Structural changes:** In fall of 2018, the Quality Management Department moved under the Chief Medical Officer, Dr. Michael Smith. In addition, a new Quality Management Director was hired, Fonda Gonzales. The Data Unit moved from the QM Department to the Informatics Department.
- **URAC reaccreditation:** Trillium's URAC onsite visit was held on January 16 and 17, 2019. Surveyors conducted interviews and file reviews at the Greenville and Wilmington office locations. Trillium was awarded a three year accreditation for the following three programs: Health Network, Health Utilization Management and Health Call Center.
- **NCQA accreditation:** NCQA accreditation is considered a "gold standard" in the industry. Trillium has continued the journey of pursuing NCQA accreditation in preparation for Medicaid Transformation and the transition to a Tailored Plan. Preparations include securing a consultant, training staff on NCQA processes and standards, revising existing procedures and creating new procedures in order to be in compliance with NCQA standards. In the fall of 2018, Trillium completed the Interactive Readiness Assessment (IRT) based on 2018 standards and will complete the IRT based on 2019 standards in the summer of 2019.
- **Incident Reporting:** Within the fiscal year 2017-2018 there was an increase of incidents reported. The Quality Management Department reviewed over 3,000 Incident Reports and provided technical assistance (TA) over 150 times to providers in the Network. This increase was due to the realignment of Nash and Columbus Counties into Trillium's geographical region and changes with restrictive intervention reporting.

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
Annual Policy and Procedure Review *The Quality Management Department is charged with maintenance of all Trillium Health Resources' policies and procedures. This includes ensuring all new and revised policies and procedures go through the appropriate approval process and are distributed to all employees. Additionally, QM is responsible for ensuring that the annual review of policies and procedures is completed by the Quality Improvement Committee.* ***Goal:** 100% of the Policies and Procedures will be reviewed.*	**OUTCOME ANALYSIS:** - Total # of policies reviewed-101 - Total # of procedures reviewed-148 - Total # of policies revised-9 (1-retired) - Total # of procedures revised-63 (2-retired) - The Quality Improvement Committee (QIC) reviewed and approved all policies and procedures on March 19, 2019. Due to upcoming changes with Medicaid Transformation including moving to NCQA accreditation, policies and procedures were again reviewed and updated in June 2019. Final approval was obtained from the CEO and the Governing Board (for policies). - An updated template and style guide were used during the annual review to ensure uniformity and consistency with all policies and procedures. - Implementation of policies and procedures was discussed during new employee orientation and throughout the year in Departmental meetings. - New and/or revised policies and procedures were reviewed by QIC and staff were notified via email of the revised policies and procedures. - Quality Management Staff ensured that the most current and up to date policies and procedures were posted to SharePoint for staff access. A hard copy is maintained and is located in the Quality Management Department (QM). - Quality Management staff were available for consultation/questions pertaining to all policies and procedures. - The requirement to maintain paper copy of manuals at each office site was assessed and determined not to be necessary. - The requirement of the QM department to track Receipt of Notification (RON) form(s) for all staff when new P & P are distributed was assessed and changes were made to the process.	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	NEXT STEPS: ♻ Policies and procedures will continue to be reviewed routinely and revisions will be made as needed to maintain compliance with laws, regulations and standards. The next annual review is scheduled for March 16, 2020.	
Over and Under Utilization of Services *Through the identification of potential fraud, waste and abuse within the provider network, potential trends are identified that may include over and underutilization of services rendered.* ***Goal:*** *Using retrospective analysis of claims data and other sources of information, members are identified who are potentially overutilizing crisis services and underutilizing more appropriate community based services* ***Goal:*** *To review and interpret 100% of Fraud and Abuse Management System (FAMS) allegation packages, data reports and complaints received.*	**OUTCOME ANALYSIS:** ♻ Using retrospective analysis of claims data and other sources of information, Trillium identified members who were overutilizing crisis services and underutilizing more appropriate community based services. Trillium used reports based on claims which are critical to utilization management. Over and underutilization outliers of high risk/high cost service utilizers were reviewed and through that process staff identified that the overutilizers were also the underutilizers of lower levels of care (LOC). The goal of Utilization Management in monitoring these identified priorities resulted in improved service utilization of high cost services and improved overall cost per member based on claims data. Once identified members were researched in other available internal and external databases for available/relevant information, healthcare trends were established for the member (i.e. past treatment, compliance, physical health status, medications, etc.). ♻ All of the above data was compiled into a clinical case staffing form and presented during the UM Team Clinical Care Staff meetings with the Chief Medical Officer and Integrated Care Nurse.	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met

	Recommendations from the UM team were collected for methods to improve member engagement with appropriate level services and adherence to treatment recommendations. The clinical case staffing form with recommendations was uploaded into the software platform utilized by Trillium.
	• Nine cases were staffed following the below guidelines:
	  ○ Reviewed over and underutilization report using data from the previous 12 months. Focused on members who utilized inpatient services and hospital emergency departments and ranked by # of visits.
	  ○ Identified members were researched in other available internal and external databases for trends (i.e. past treatment compliance, physical health status, medications, etc.).
	  ○ Assigned MH/SU Care Coordinator, if applicable, was notified regarding the identification of the member on this report and invited to contribute information.
	  ○ All data was compiled into a clinical case staffing form and presented during the UM Team Clinical Care Staff meetings.
	  ○ Recommendations from the UM team, the MH/SU Care Coordinator and the Chief Medical Officer were collected for methods to improve member engagement with services and adherence to treatment recommendations.
	  ○ The clinical case staffing form was uploaded into the Trillium's software platform
	• The Program Integrity Department reviewed and interpreted 19 out of 19 FAMS allegations packages received, analyzed data reports and identified outliers and trends.
	  ○ The Program Integrity Department staff responded to 78 allegations entered into EthicsPoint regarding fraud, waste and abuse.
	  ○ The Program Integrity Department reviewed data trends based on internal data reports during staff meetings.	

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	○ The Program Integrity Department conducted 92 program integrity related investigations. **OUTCOMES** • Substantiated-34 • Unsubstantiated-22 • Partially Substantiated and Partially Unsubstantiated-6 • Duplicate Report-2 • Outside of Scope-24 • Pending-3 **ACTIONS** • No Action Taken-29 • Sanctions-10 ○ Recoupment-12 ○ Contract Terminations-4 • Technical Assistance-12 • Contract Termination-1 • Referral to DHB for Potential Fraud-15 • Self-Audit Requested 7 • Case combined with another case-2 • Pending-3 *Some actions may still be in appeal timeframe and risk potential of being overturned. **Some investigations had more than one action taken against the provider	

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	NEXT STEPS: • Trillium Health Resources will continue with identification of potential fraud, waste and abuse through reviewing and interpreting FAMS allegations packages and analyzing data reports to identify outliers and trends. • Using retrospective analysis of claims data, Trillium will identify members that are overutilizing and underutilizing services.	

Clinical Practice Guidelines
 	
Trillium Health Resources is contractually mandated to select, communicate and evaluate the use of Clinical Practice Guidelines utilized by the Network. Trillium provides practitioners within the network with nationally recognized Clinical Practice Guidelines and ensures proper implementation. These clinical practices recommended for adoption must meet criteria including being evidence based, measurable and sustainable.
 	
***Goal:** Trillium will initiate actions to increase adherence within the network, focusing on monitoring metabolic indicators during use of antipsychotic medications.*
	OUTCOME ANALYSIS:
	• Trillium Health Resources adopted and disseminated clinical practice guidelines relevant to its members.
	• In 2016, Trillium's Clinical Advisory Committee (CAC) approved two guidelines to monitor:
	  ○ Use of rating scales to monitor treatment effectiveness and outcomes in the treatment of major depression.
	  ○ Adherence to metabolic monitoring guidelines for members being treated with antipsychotic medication, with specific focus on lipid panels and serum glucose/Hemoglobin A1C.
	• In 2018, the monitoring of Adherence to use depression rating scales to monitor treatment effectiveness and outcomes in the treatment of major depression was discontinued.
	• The use of rating scales for depression project was discontinued for the following reasons:
	  1. The use of rating scales for depression monitoring was not being used for all members with depression within the clinic
		Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	2. The scores from the depression rating scales collected did not reflect an alteration in treatment plan 3. The data was unable to be externally validated 4. The project was unable to be expanded to all network providers given the inability to collect and validate the data via an automated process. ♻ The metabolic monitoring during the use of antipsychotic medications is underway and is continuing to be modified. Discussions occur periodically within Medical Affairs and with the Clinical Advisory Committee and are reflected in the Annual QM plan. ♻ There have been data extracts on our individual network prescribers' adherence to the guideline about monitoring metabolic indicators in patients being prescribed antipsychotic medications, specifically serum lipids and either serum glucose or Hemoglobin A1C. The data extracts revealed that a relatively small group of clinicians are responsible for caring for the majority of the patients taking an antipsychotic medication, and that the current adherence scores for our clinicians are similar to the results reported in the literature. **NEXT STEPS:** ♻ Trillium is working towards obtaining NCQA accreditation. The NCQA accreditation standards on Clinical Practice Guidelines, QI 10, require Trillium to identify evidence based Clinical Practice Guidelines to be established, implemented, evaluated annually, and updated every two years. Trillium, along with the Clinical Advisory Committee, chose the following HEDIS measures: **Measures for Children** ○ APC-Use of Concurrent Antipsychotics for Children and Adolescents ○ APM-Metabolic Monitoring for Children and Adolescents on Antipsychotics	

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	Measures for Adults: ○ AMM-Antidepressant Medication Management ○ SSD-Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are using Antipsychotic Medications ○ SAA-Adherence to Antipsychotic Medications for Individuals with Schizophrenia ○ UOD-Use of Opioids at high Dosages ○ COU-Risk of Continued Opioid Use ♻ Trillium's Chief Medical Officer and the Clinical Advisory Committee will establish methods for review of practitioner's adherence to the established guidelines. ♻ Trillium will measure practitioner/provider adherence to clinical practice guidelines by identifying and measuring important points of care according to the chosen guidelines. ♻ Trillium will compile data obtained from the annual measurement of adherence and will identify opportunities for improvement in care. These results will be shared with CAC and QIC. ♻ Trillium will share the results of the annual measurement with practitioners/providers by posting on the Trillium website and through Network communications.	
Network Adequacy and Accessibility *The Network Adequacy Accessibility Report is an annual study of our catchment area and the people who live there. It also looks at where services are available and how people use them.*	**OUTCOME ANALYSIS:** ♻ Trillium completed the Network Adequacy and Accessibility Report according to the requirements published by DHHS by the due date of July 2019. ♻ Review of the final report reflects: ○ 1,310 stakeholders responded to the survey, which is a 2.10% increase from last year's survey participants. Of 231 staff completing the survey, 70.13% identified as Care Coordination.	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
Ultimately, the analysis serves as a roadmap for determining future growth based on current capacity. ***Goal:*** *To complete the Network Adequacy and Accessibility Report according to the requirements published by DHHS by the due date.*	○ The Member/Family Survey was completed by 1,921 individuals, a 21.20% increase from last year. ○ Five (5) teams were assigned to specific counties to reach out to Members/Family, Stakeholders and Providers. Trillium Contract Managers contacted providers on their caseloads for input as well. ♣ A Network Development Plan incorporates areas of need and solutions. **NEXT STEPS:** ♣ A copy of the final document was shared with the Governing Board, Regional Boards, and CFAC. ♣ The Network Adequacy and Accessibility Report will be made available on Trillium's website for full detail and next steps. ♣ The Final Report will be reviewed in the August QIC meeting along with the Network Development Plan to assess any necessary interventions.	
Provider Satisfaction *Annually, a provider satisfaction survey is conducted by DHB to determine areas that need improvement within the network and to assess provider satisfaction with Trillium Health Resources, its practices and processes.* ***Goal:*** *To obtain a positive response equal to or greater than the state average for overall satisfaction and share results.*	**OUTCOME ANALYSIS:** ♣ Trillium participated in DHB's 2018 Provider Satisfaction Survey. ♣ Trillium had a response rate of 77.7%, which was a significant increase from the previous year's response rate of 56.8%. ♣ At the close of the survey period, 248 surveys were returned and analyzed out of the 319 surveys sent out. ♣ Providers reported overall satisfaction was 84.3%, which was an increase from the previous year at 81.9%. Trillium was slightly under the goal of having a positive response equal or greater than the state average for overall satisfaction. The state average was 86.6% which was slightly above Trillium's score of 84.3%.	Not Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	Many of Trillium's functional areas maintained a positive satisfaction score, pointing to the efforts and strategies implemented throughout the agency to improve processes based on the survey results and feedback from the previous year. ♻ Trillium conducted an analysis of the survey results. All results were reviewed by the Global Quality Improvement Committee, Trillium's CFAC, Executive Team and QIC to identify any systemic issues to be addressed by Trillium Health Resources through corrective actions or quality improvement projects. **NEXT STEPS:** ♻ The low response rate for this survey makes it difficult to generalize results and identify areas for needed improvement. The QIC will continue to discuss possible ways for improving the overall satisfaction of members. ♻ QIC will discuss interventions to increase overall satisfaction in all areas surveyed. ♻ Trillium will continue to participate in the annual survey, analyze data and implement improvement efforts when deemed necessary. ♻ QIC will evaluate the goal for the survey and adjust the goal percentage to a fixed target and work to achieve that target. Currently the goal is set for the "state average" which will be different each year.	
Member Satisfaction *Annually, a member satisfaction survey is conducted by DHB who contracts with an EQRO to determine areas that need improvement and to assess members satisfaction with areas to include, but not limited to, satisfaction with UM processes, providers, timely access to services and availability of services*	**OUTCOME ANALYSIS:** ♻ Trillium participated in the ECHO Survey for Adults and Children. ♻ Of the 571 surveys sent out, 84 adult surveys and 96 child surveys were returned and used in calculations. Trillium had an overall response rate of 16.8% for the child survey, which was a decrease from last year's response rate of 34.1%. For the adult survey, the response rate was 14.7%, which was a decrease from last year at 21.4%.	Partially Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
Goal: To obtain a positive response equal to or greater than the state average for overall satisfaction and share results.	▲ Overall satisfaction rating for child was 65.3%, which was an 11.3% decrease from last year's rating of 73.6% and below the state average which was 71.1%. ▲ Overall satisfaction rating for adult was 75% which was in line with last year's results of 75.8% and above the state average of 69.7%. ▲ Trillium conducted an analysis of the survey results. All results were reviewed by the Global Quality Improvement Committee, Trillium's CFAC, Trillium's Executive Team and QIC to identify any systemic issues that would need to be addressed by Trillium Health Resources through corrective actions or quality improvement projects. **NEXT STEPS:** ▲ The low response rate for these surveys makes it difficult to generalize results and identify areas for needed improvement. The QIC will continue to discuss possible ways for improving the overall satisfaction of members. ▲ QIC will discuss interventions to increase overall satisfaction in all areas surveyed. ▲ Trillium will continue to participate in the annual survey, analyze data and implement improvement efforts when deemed necessary. ▲ As a result of the annual EQRO review and recommendation suggested, Trillium will adjust the survey goal percentage for "overall satisfaction" to a fixed target and work to achieve that target instead of using the "state" average" as the goal. Once the goal is determined by QIC, it will be documented on the QM Work plan and monitored accordingly.	

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met

Perception of Care
 	
The NC Division of MH/DD/SAS conducted a Perception of Care survey to assess members perception of care of services received from network providers.
 	
***Goal:** To obtain 100% of the surveys required of Trillium Health Resources within the timeframe given by NC DMH/DD/SAS (2018 administration period).*
 	
***Goal:** To obtain a positive response equal to or greater than the state average on overall satisfaction for Youth, Adult, and Parent surveys and share results (2017 results).*
	OUTCOME ANALYSIS:
	• Trillium QM staff, reached out to applicable providers and assisted with the administration of the 2018 Perception of Care Survey.
	• The survey administration period was 5/7/2018-6/8/2018.
	• 2018 Required Survey Numbers for Trillium:
	  ○ Adult-525
	  ○ Youth-125
	  ○ Parent-150
	  ○ Total-800
	• Actual Number of Surveys completed and submitted to the state for analysis:
	  ○ Adult-910
	  ○ Youth-327
	  ○ Parent-271
	  ○ Total-1508
	• Overall satisfaction ratings were as follows: Adult-93.2% (state average 93.3%), Youth-88% (state average 85.5%), and Parent-93.6% (state average 93.1%).
	• Trillium either met the goal of equal to or greater than the state average or was within a few tenths of a point away.
	• Trillium conducted an analysis of the survey results. All results were reviewed by the Global Quality Improvement Committee, Trillium's CFAC, Executive Team and QIC to identify any systemic issues that would need to be addressed by Trillium Health Resources through corrective actions or quality improvement projects.
		Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	NEXT STEPS: • Trillium Health Resources will continue to participate in the annual survey, analyze data and implement improvement efforts when deemed necessary. • Trillium plans to obtain 100% of the surveys required of Trillium within the timeframe given for the next survey administration period. • Trillium will evaluate an appropriate goal and adjust as necessary for "overall satisfaction".	
Delegation Oversight *Initial and Annual reviews were completed on all delegated entities and prior to any new contracts to ensure each delegated entity meets all requirements of the delegation agreement.* ***Goal:** 100% of the annual delegation reviews are completed within the 12 month timeframe.*	**OUTCOME ANALYSIS:** • 100% of the annual delegation reviews were completed within the 12-month timeframe. All delegated entities maintained compliance with items on their monitoring tool throughout the year at 100%. • The Delegation Review Tool was reviewed for completeness and accuracy and minor adjustments made to the content. • The Delegation Work Flow process was reviewed, updated, and shared with Trillium Leadership Team to assure that all departments were aware of the requirements. • CCME recommended that Trillium revise its Delegation Procedure and the Delegation Assessment Tool, to include Primary Source Verification of the State Exclusion List, to comply with NC Medicaid Contract, Section 7.6.4, and Exclusions. Trillium completed those revisions. • Per 2019 External Quality Review Final Report, Trillium met 100% of the Delegation standards for this year's EQR. • Delegated entities: ○ Language/Interpreting: Clear Messaging, Language Line/Fluent, Integrated Language Services	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	○ Shredding: Cintas/Shred It ○ Records Management: Iron Mountain ○ Peer Reviews/Appeals: BHM ○ TCLI In-reach: Recovery Innovations/Recovery International ♻ All entities were approved for continued delegation by the respective content experts/committees for 2019-2020 fiscal year. Trillium added a new interpretation delegation in June 2019, Integrated Language Services, and ended delegations with both Cintas/Shred-It and Clear Messaging. ♻ Results of each delegation oversight review are submitted to QIC and the Credentialing Committee (as applicable for credentialing delegations) annually for review. **NEXT STEPS:** ♻ Trillium will continue to conduct pre-assessments and annual oversight reviews of all delegated entities. Trillium will provide technical assistance and may request Plans of Correction for any items that are "not met" on the delegation review tools. ♻ Trillium will complete 100% of the annual oversight reviews that are required to be completed within the 12 month timeframe.	
QM Workplan *The QM Workplan outlines quality improvement activities for the year* ***Goal:** 100% of all tasks in the QM Work Plan will be completed.*	**OUTCOME ANALYSIS:** ♻ The Quality Management Work Plan specified quality improvement activities for Trillium in FY 18-19. ♻ The plan included goals, objectives, and initiatives identified for the year. ♻ The work plan was utilized as a mechanism for tracking quality improvement activities cross-functionally for the organization.	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	▲ Trillium continues to use its QM Work Plan as a tool to identify specific quality improvement activities for the organization. The plan is reviewed routinely and updated accordingly with any status updates. ▲ Trillium's QM Work Plan was reviewed by CCME as a part of their annual review. ▲ All tasks in the QM Work Plan were completed. **NEXT STEPS:** ▲ 2019-2020 Work Plan has been developed and was reviewed in June 2019 by QIC. ▲ A goal of 100% of the tasks listed on the QM Work Plan will be completed and the Work Plan will be updated routinely throughout the year to reflect progress.	
QM Plan/Program Description *Trillium's Quality Management Plan/Program Description lays out Trillium's overall plan for organization wide quality management/improvement.* ***Goal:** To fully comply (100%) with contract requirements and accreditation standards.*	**OUTCOME ANALYSIS:** ▲ The Quality Management Plan/Program Description is created at the beginning of the fiscal year to outline Trillium's Quality Management Plan for the year. ▲ The 2018-2019 Quality Management Plan/Program Description was reviewed and approved by QIC and the Governing Board in June 2018. ▲ Trillium Health Resources continues to use its Quality Management Plan/Program Description as a tool to identify organization wide quality management plans/initiatives for the year. The plan is reviewed annually in QIC. ▲ The Quality Management Plan/Program Description is posted on Trillium's website for public access. ▲ Trillium's Quality Management Plan/Program Description was reviewed by CCME as a part of their annual review. ▲ The Quality Management Plan/Program Description was submitted annually to DMH/DHB during the month of August.	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	NEXT STEPS: • The 2019-2020 QM Plan was reviewed and approved by QIC and the Governing Board in June 2019. • Trillium will fully comply (100%) with contract requirements and accreditation standards as outlined in the QM Plan/Program Description. • The Quality Management Plan/Program Description will be submitted to DMH/DHB during the month of August.	
National Accreditation *Trillium's QM department is responsible for ensuring Trillium maintains ongoing compliance with accreditation standards relevant to accredited programs.* ***Goal:** Maintain Full Accreditation status with a 93% or above.*	**OUTCOME ANALYSIS:** • The QM Department continued to work with various departments to ensure Trillium maintained compliance with standards for all accredited programs by coordinating and facilitating a review of the standards with each department. • Trillium successfully completed the URAC desktop review in the fall of 2018. • The URAC onsite visit was January 16 and 17, 2019. Surveyors conducted interviews and file reviews at both the Greenville and Wilmington office locations. Upon completion of the review, Trillium was awarded a three year accreditation for the following three programs: Health Network, Health Utilization Management and Health Call Center. • Trillium has continued to pursue NCQA accreditation. Preparations have included securing a consultant, training staff on NCQA processes and standards, revising existing procedures and creating new procedures in order to be in compliance with NCQA standards and completed an Interactive Readiness Assessment (IRT). • Trillium began working with a NCQA Consultant in the fall of 2018 and completed the first Interactive Review Tool (IRT) based on 2018 standards at that time.	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	♣ Numerous consultation meetings were held to review and discuss specific topics that were not clear based on interpretation of the standards. ♣ Staff were provided multiple opportunities to participate in training on NCQA standards. ♣ Relevant procedures have been revised and/or new procedures were drafted and these were approved and effective July 1, 2019. **NEXT STEPS:** ♣ **URAC:** Trillium will maintain full accreditation status with a 93% or above by continuing monitoring of each department over the next year. ♣ **NCQA accreditation:** Trillium will continue to pursue NCQA accreditation by continuing all efforts previously mentioned and reassessing Trillium's readiness with the IRT based on 2019 standards in August 2019. In addition, new processes are being implemented for Trillium to be in compliance with NCQA standards. Trillium will begin completing the NCQA application in fall 2019 and plans to submit the application for NCQA accreditation in the fall or winter of 2019 with a projected onsite date of June 2020. Trillium's goal will be to obtain full accreditation indicated by a score of 100%-84% at the accreditation review.	
Key Performance Indicators (KPI) *Trillium conducts monthly monitoring of designated key performance indicators to ensure benchmarks are being met and to detect any trends related to the effectiveness of the whole organization*	**OUTCOME ANALYSIS:** ♣ Trillium included DHB and DMH Supermeasures in the KPI list and monitored them throughout the year which brought the number of measures monitored on the KPI from 15 to 20. ♣ Of the 20 KPI's, 14 met their benchmarks each month which indicates that 80% of the key performance indicators met benchmarks for the year. ♣ Data was presented to QIC for review each month.	Not Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
Goal: 100% of the key performance indicators will meet benchmarks. *For detailed information on the KPI's, see the KPI spreadsheet included as Attachment B, KPI Report.*	**NEXT STEPS:** • Trillium will continue to monitor KPI's on a monthly basis to efficiently identify any trends or patterns in the data. • Data will continue to be presented to QIC for review. If any issues or trends are identified, QIC will discuss further action needed. • Corrective actions may be requested for any key performance indicators not meeting the established benchmark. • Trillium's goal is to meet 100% of the benchmarks set for the KPI's over the next year.	
State Reporting *Trillium ensures all state reports are developed according to specifications provided, are validated, reviewed and submitted on time to the appropriate agencies.* *Goal: 100% of reports will be accurate, complete, and submitted on time.*	**OUTCOME ANALYSIS:** • The Data Reporting Unit in the Informatics Department is the hub of reporting for Trillium. The Data Reporting Unit is responsible for tracking and submitting all state reports to ensure compliance. A tracking mechanism is used for all reports indicating when reports are due, whom they are submitted to, along with any other information around submission of reports to the state. • 100% of state reports were accurate, complete, and submitted on time to the appropriate agencies. • During Trillium's annual CCME review, 20 DHB performance measures (including 10 Innovations Waiver measures) were validated and no concerns were noted. **NEXT STEPS:** • Trillium will continue to complete reports, validate, review and submit to the Department of Health and Human Services on time. • Reports will continue to be analyzed to determine any areas of deficiencies that need improvement.	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	♣ All reports will continue to be reviewed with appropriate departments, QIC, and Executive Team as deemed necessary.	
Dashboards *Trillium ensures all dashboards are developed as requested, validated, reviewed, and submitted on time to the appropriate committees.* ***Goal:** 100% of dashboards will be accurate, complete, and submitted on time.*	**OUTCOME ANALYSIS:** ♣ The Data Reporting Unit is responsible for creating dashboards and sharing data with various committees to analyze for trends, outliers and red flags. ♣ Any trends, outliers or red flags identified are referred to QIC to determine any needed action. ♣ 100% of committee dashboards created were accurate, complete, and submitted on time. ♣ Committee dashboards are produced on a routine basis for the following committees: 1. Global Quality Improvement Committee 2. Sentinel Events Review Group 3. Human Rights Committee 4. Quality Improvement Committee **NEXT STEPS:** ♣ Trillium will continue to ensure 100% of dashboards are accurate, complete, and submitted on time. ♣ Reports will be submitted and reviewed with appropriate committees.	Met
Quality Improvement Projects *During FY 2018-2019, Trillium maintained Quality Improvement Projects (QIP's) as indicated by the state contracts and accreditation standards.*	**CURRENT QUALITY IMPROVEMENT PROJECTS:** ♣ Increasing DHB and DMH Mental Health 7 day follow up: ○ Goal is to increase the percentage of individuals receiving a follow-up appointment within 1 to 7 days of being discharged from a community hospital, facility based crisis, or state psychiatric hospital to 45% for both DHB and DMH populations.	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
Goal: *100% of QIP's will be accurate and complete, and in compliance with regulatory guidelines and accreditation standards.* *For detailed information on each QIP including all measurements, barriers and interventions, see Attachment A, Annual QIP Report.*	○ Baseline from January-March 2018 was DHB=42%; DMH=20.2% ○ Most recent measurement- January-March 2019 was DHB 48.9%; DMH 19.3% ♻ Increasing DHB and DMH Substance Use 7 day follow up: : ○ Goal is to increase the percentage of individuals receiving a follow-up appointment within 1 to 7 days of being discharged from a community hospital, facility based crisis, or state psychiatric hospital to 45% for both DHB and DMH populations. ○ Baseline from January-March 2018 was DHB=29.1% and DMH 31.1% ○ Most recent measurement – January-March 2019: DHB=41.7%; DMH=33.6% ♻ Increasing Provider Satisfaction Related to the Appeals Process for Denial, Reductions or Suspensions of Service(s): ○ Goal is to increase the provider satisfaction percentage related to the appeals process for denial, reductions or suspension of service(s) to the state average, which is 77.5%. ○ Baseline from the 2017 DHHS Provider Satisfaction Survey results was 71.56% ○ Most recent measurement-2018 Annual DHHS Provider Satisfaction Survey results for question #26=80.9%. This goal was met and is in maintenance until the next survey results are shared in early 2020. ♻ Improving the percentage of timely contacts with TCLI individuals in In-Reach status: ○ Goal is to have 98% of TCLI In-Reach individuals to have received a documented contact using identified method/software system at least once every 90 days. ○ Baseline for January 2019 was 88.5% ○ Most recent measurement in June 2019 was 97.7%	

CLOSED QUALITY IMPROVEMENT PROJECTS FOR FY 18-19:

- Increasing access to adequate admission, discharge and transfer data from hospitals in the Trillium geographical area.
- Improving the percentage of Timely contacts with TCLI individuals in In-Reach status

OUTCOME ANALYSIS:

- All QIP's were reviewed and discussed at monthly QIC meetings.
- QM staff reviewed all QIP's as a part of the peer review to ensure compliance with all regulatory and accreditation standards.
- All QIP's were shared with the Global Quality Improvement Committee and Clinical Advisory Committee for feedback and input.
- A QIP annual report was created and submitted to QIC, the Governing Board and DHHS.
- Articles on QIP's were developed and shared with employees in the Trillium newsletter.
- All completed QIP templates and summary QIP grids were posted on Trillium's SharePoint page for staff access.
- During the annual CCME review, QIP's were reviewed, validated and feedback provided. Trillium scored "High Confidence" on each QIP reviewed by CCME.

NEXT STEPS:

- Trillium will continue to maintain the required number of projects per the DMH and DHB contracts as well as accreditation standards.
- QM staff will review QIP's with QIC on a monthly basis to discuss progress, measurements and needed interventions.
- The QIP peer review will continue to be conducted annually.
- The QIP Grid will be continuously updated and shared on the QM SharePoint site for staff access.
- As Trillium moves towards NCQA accreditation, additional "Quality Improvement Activities" (QIA's) will be added.

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met

Provider Performance Data
 	
To share data with providers on various measures, at least annually. This data provides a snapshot into how they are performing compared to similar providers.
 	
***Goal:** 100% of Provider Performance Reports will be accurate, complete, and submitted on time.*
	OUTCOME ANALYSIS:
	• Trillium's Data Reporting Unit compiled reports for Licensed Independent Practitioner's (LIP's), LIP groups and provider agencies that included performance data related to:
	  ○ Claims denials
	  ○ Claims denial reasons
	  ○ Authorization denials
	  ○ Authorization denial reasons
	  ○ QIP scores
	  ○ Accessibility
	• In July 2018, 418 reports were distributed to provider agencies, LIP groups and LIP's.
	NEXT STEPS:
	• Reports will be sent out annually. The next round of reports will be released in July 2019.
	• Quality Improvement Committee will discuss how to use these reports in a valuable manner to enhance performance improvement for the provider network and Trillium staff.
	• Future performance measures may be identified for the Network as Trillium progresses toward Tailored Plan implementation.
		Met

Incident Reporting *To ensure the health and safety of all members.* ***Goal:** 100% of Incident Reports submitted by will be reviewed.*	**OUTCOME ANALYSIS:** • 100 % of incident reports submitted were reviewed. • Over the past year, the Quality Management Department has reviewed over 3,000 Incident Reports (IR's) and provided technical assistance (TA) over 150 times to providers in the Network. In FY 17-18, 1830 incident reports were reviewed and TA was provided	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	over 62 times. This is an increase of 1,192 reports reviewed and an increase of TA provided by 92 contacts. ♻ The increase in IR's reviewed and TA provided was related to two factors: additional counties being added to Trillium's catchment area, Nash and Columbus and changes at the state level related to restrictive intervention reporting that impacted the number of IR's. ♻ QM Coordinators conducted daily reviews of incident reporting and compiled a daily report of incidents that may pose a threat to member health and safety. Detailed information about the incidents was sent out to a select group of staff within Trillium, including the Chief Medical Officer, for review and discussion on possible follow-up required or immediate action needed. ♻ Data was reviewed monthly with the Sentinel Events Review Group and updates were submitted to QIC. The Sentinel Events Review Group corresponded monthly for internal review of sentinel events of members, such as deaths, and/or other serious incidents and served to identify any unexpected occurrence involving a member's death, serious psychological injury or the risk thereof. The committee also ensured that any recommended changes were implemented and monitored in a timely manner to ensure the health and safety of members. ♻ Data was reviewed to identify any patterns, trends or concerns that may need to be addressed. **NEXT STEPS:** ♻ Trillium will continue to review 100% of the incident reports submitted and provide TA as needed.	

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	❖ Performance Improvement Manager and QM Coordinators will continue with the daily report and monthly SERG meetings to review reports and data in order to identify trends, patterns or areas of concern that need investigation or follow up.	
State Contracted Provider QIP Review *To improve the quality of MH/DD/SA services for Trillium Health Resources members, providers with state-funded contracts are required to complete 3 Quality Improvement Projects (QIP's) that demonstrate evidence of performance improvement related to some aspect of organizational processes/structure, member outcomes or other Provider Improvement activities.* *Goal: 100% of QI projects submitted by state-funded contracted network providers will be reviewed.* *Goal: Trillium will provide QIP Technical Assistance and Training to providers who score below a 60% on their QIP's and any providers who request additional assistance.*	**OUTCOME ANALYSIS:** ❖ 100% of the QI projects submitted by state-funded fully contracted providers were reviewed and scored using a standardized tool. ❖ Over 200 QIP's were reviewed and scored. 94% of the providers received scores considered to be positive. Four providers scored 60% or below on one or more QIP's. ❖ Check-in and technical assistance were provided during the year for providers who scored 60% or less on their projects. Technical Assistance was offered to all providers throughout the year. ❖ Letters with results and feedback were sent out to providers in December 2018. In addition, scores and feedback were included in the Provider Performance Reports distributed by the Data Reporting Unit. ❖ A Blinded Peer Review was offered to all providers to offer suggestions on methods to improve the projects to any providers who chose to participate in the review. ❖ No providers participated in the Blinded Peer Review offered by Global Quality Improvement Committee. **NEXT STEPS:** ❖ Trillium has discontinued the requirement that state funded providers submit 3 QIP's by 7/31 of each year. ❖ Per Trillium's Provider Manual, Trillium continues to require all providers demonstrate a Continuous Quality Improvement (CQI) process by identifying and implementing Quality Improvement Projects at their organization.	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	♣ Trillium may, at its discretion, contact a provider to request submission of Quality Improvement Projects for review/feedback related to overall provider quality/service delivery improvement. ♣ Evaluation of potential methods for review of compliance with QIPs will occur and a determination made regarding the need to implement monitoring activity. ♣ If a provider submits QIP's for review, 100% of the projects submitted will be reviewed, scored and returned to the provider in a timely manner using the scoring tool. ♣ Technical Assistance will be provided during the year if requested by a provider. ♣ Blinded Peer Reviews will be offered to providers annually.	
Internal Compliance Quality Improvement Initiatives ***Goal:*** *100% of the Internal Compliance quality initiatives will be completed on time.*	**OUTCOME ANALYSIS:** Effectiveness Assessment of Internal Compliance: ♣ Conducted departmental self-assessment of activities performed during first three years of operation and developed activities for FY18-19 based on lessons-learned, areas of greatest risk and strategies with biggest impact. Ensured initiatives were value added and resonated with work plan goals for the year. Department Information Sheets: ♣ Constructed Department-specific information/education/ self-assessment sheets based on best-practice healthcare compliance guidance. ♣ Provided education, compliance culture development and department self-evaluation practices. DHB Contract Addendum Implementation	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	♣ Conducted organization wide education and assessment regarding new elements outlined in the DHB Contract. ♣ Ensured organization is aware of new requirements and took action to implement new requirements. Assessment of Compliance specific and organization-wide written documentation ♣ Evaluated internal documents and provided recommendations for revisions, additions, restructuring and alignment with other written materials. ♣ Ensured written materials reflect required language, met contractual requirements and accurately provided information to the intended audience. EQR Corrective Actions and Recommendations ♣ Assessed implementation of corrective action items and recommendations outlined during the 2018 External Quality Review. ♣ Provided a measurement of the organization's compliance with CAP/recommendation item implementation. **NEXT STEPS:** ♣ Measure organizational impact, and assess next steps to continue evolving the role of Internal Compliance organization-wide. ♣ Development of on-going Department Support initiatives. ♣ Implement strategies to provide on-going/behind the scenes support to certain functional areas. ♣ Ensure Departments/Functional areas receive real-time, on-going information necessary to make operational adjustments.	

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
Information Technology/Informatics Quality Improvement Initiatives *Goal: 100% of the Information Technology/Informatics quality initiatives will be completed on time.*	**OUTCOME ANALYSIS:** Business Solutions/Applications ♻ Increased speed to market for delivery of business needs/solutions by adopting Agile methodology within the Business Systems Department for maintaining and enhancing the core business applications. Electronic Personnel Files ♻ Ensured IT resources were optimized and aligned with Enterprise Strategy by adopting Enterprise level governance mechanism. Report Consolidation ♻ Reduce support need and make reporting platform more efficient. Audit and streamline reports, including merging to one platform. **NEXT STEPS:** Data Warehouse Restructuring ♻ Align business rules to Trillium and make platform more stable, scalable and exhibit faster replication. Redesign data warehouse ETL processes and business rules. NCQA / HEDIS Reporting ♻ Ensure compliance, leverage expertise of software vendor, and reduce Trillium admin/support overhead via SaaS. Install new reporting platform that will meet the needs for NCQA and HEDIS reporting. Enhanced End User Reporting Capability ♻ Enhance end user reporting capabilities by providing a platform that will allow more flexible reporting, improved governance, and better visualization. Install new reporting platform that will enhance end user reporting capabilities.	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
Communications Quality Improvement Initiatives *Goal: 100% of the Communications quality initiatives will be completed on time.*	**OUTCOME ANALYSIS:** Provider Directory export to print feature ♻ Web developer created an "export to print' feature so any visitor to the website can either print the full directory or query using filters and then print. **NEXT STEPS:** ♻ Create an online portal with current vendor so staff in each location can order brochures and give-away items (pens and stress balls to start with) to be mailed directly to their office. ♻ Create PowerPoint videos with captioning and music. Videos typically have much higher engagement rates than text on social media, so we hope to increase viewership though the videos.	Met
Contracts and Training Quality Improvement Initiatives *Goal: 100% of the Contracts and Training quality initiatives will be completed on time.*	**OUTCOME ANALYSIS:** Contract Management System ♻ Implemented the use of e-signature in order to improve the return rate of contracts. Contract Ticket System ♻ Implemented Contract Ticket System to manage staff resources and use as a supervisory tool based on available reports. **NEXT STEPS:** ♻ Monitor and evaluate implementation of the systems above to assure desired outcomes are maintained.	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
Network/Credentialing Quality Improvement Initiatives *Goal: 100% of the Network/Credentialing quality initiatives will be completed on time.*	**OUTCOME ANALYSIS:** **Network** Productivity Tracker/Recruitment ♻ Implemented tracking system to use when determining if additional staff resources are needed. Implemented a simple system (Veri-Clock) that tracks all tasks assigned to employees as well as employee time on a task. **Customer Service** ♻ Implemented Network Support Services Ticket System and improved turnaround times and resolution quality by maintaining a knowledge base of advanced technical solutions exclusively for, and limited to, staff. **Communication** ♻ Created one avenue to share vital information in writing with our provider network and implemented FAQ's to go along with the Network Communication Bulletin's where any provider can ask questions regarding the bulletin and the FAQ will be sent out with the answers to share with the network. **Streamline Processes/Compliance** ♻ Streamlined the routine monitoring process. ♻ Streamlined the COI process to improve staff resources/time spent on tasks. ♻ Streamlined the Non-UCR contract process and obtained more information related to progress from providers on how the funds were used and the providers status (i.e. self-sustaining) **Credentialing** Revision of documents to reduce processing time and errors	Met

Compliance Element	FY 2018-2019 Trillium Health Resources Standards and Accomplishments	Met/ Not Met
	♻ Revised Credentialing Application--Review Practitioner Application for updated standards. ♻ Revised Credentialing Check-Sheet-to ensure Network staff reviewed all necessary requirements on the application. ♻ Revise SSR form-update form to clarify types of requests. ♻ Implemented the use of e-signature in order to improve the return rate of contracts. **Increase efficiency** ♻ DHB contract does not require site visits--eliminate site visit requirement from process. ♻ Revise internal process to eliminate CAQH requirement for credentialing. ♻ Update workflow to send approvals to Chief Medical Officer weekly. **Update recredentialing expiration protocol** ♻ Develop protocol to notify providers and Contracts department when credentialing expires to eliminate ability to bill once credentialing expires. **NEXT STEPS:** Report accuracy ♻ Submit IT request to add Credentialing Expiration dates in CIE to track agency/group expiration dates. Enhance the ability to run accurate reports and avoid lapses in credentialing.	

Summary

Based on the comprehensive review and evaluation of performance in all aspects of the Quality Management program, the overall effectiveness of Trillium's 2018-2019 goals, including progress towards influencing system-wide safety, and member-centered clinical practices, proved strong and evolving.

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

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

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

Attachment A-Quality Improvement Projects

CURRENT PROJECTS

A. INCREASING DHB AND DMH MENTAL HEALTH 7 DAY FOLLOW-UP

Goal:

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

Baseline:

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

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

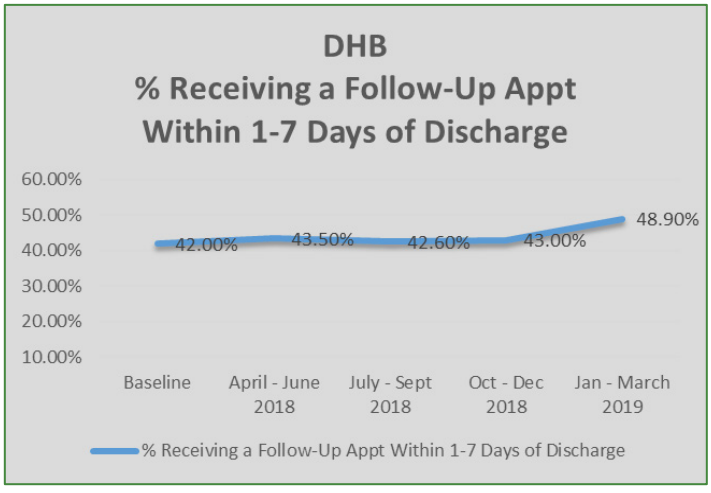
Denominator – All members discharged

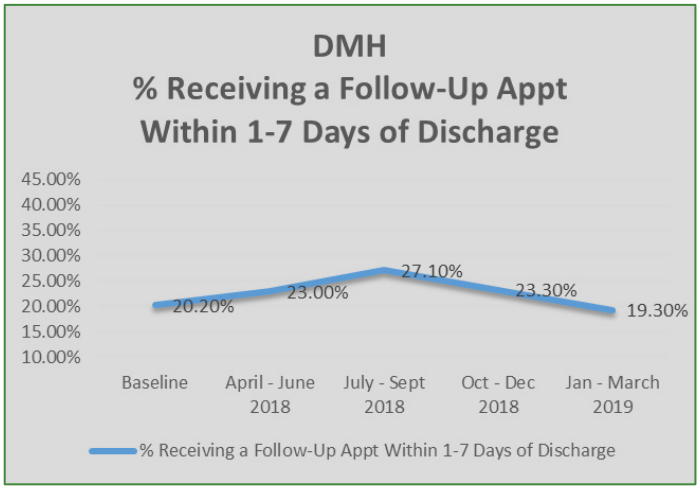
Baseline – *DHB* **= 42.0%** (N = 224; D = 533); *DMH* **= 20.2%** (N = 73; D = 362)

Measurements:

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

- Measurement #1 – April – June 2018 – *DHB* 226/520 = **43.5%**; *DMH* 46/200 = **23.0%**
- Measurement #2 – July – Sept 2018 – *DHB* 215/501 = **42.6%**; *DMH* 124/457 = **27.1%**
- Measurement #3 – Oct – Dec 2018 – *DHB* 214/498 = **43.0%**; *DMH* 102/437 = **23.3%**
- Measurement #4 – Jan – March 2019 – *DHB* 320/655 = **48.9%**; *DMH* 81/419 = **19.3%**





Barriers:

Barriers to this project have included the following:

1. Trillium occasionally does not get credit for applicable paid claims due to upstream denials in NCTRACKS.
2. HEARTS data is sent only quarterly but measurements are obtained monthly.
3. Some hospitals outperforming other hospitals in terms of scheduling follow-up appointments.
4. Members may not receive adequate support/reminders to attend their follow-up appointments post discharge.
5. Providers schedule follow-up appointments in varying ways. For example, to reduce no show rates some larger providers schedule all post discharge follow-up appointments at 8am on a particular weekday, which can result in a long wait if many appointments are made for that same day.

Interventions:

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

- Care Coordination staff routinely contact members when they are aware of a member's hospitalization to discuss follow-up appointments and any issues surrounding attending those appointments.
- Inpatient Report is ran daily in Incedo by Care Coordination Managers and follow-up tasks are created/assigned by Mangers to Care Coordinators.
- Call Center staff give daily reminder phone calls to members identified as having follow-up appointments post hospital discharge for those members who are scheduled with providers who do not conduct appointment reminders themselves.
- Call Center staff contact members for all providers, regardless of if a provider will contact member themselves.

B. Increasing DHB and DMH Substance use 7 day follow-up

Goal:

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

Baseline:

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

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

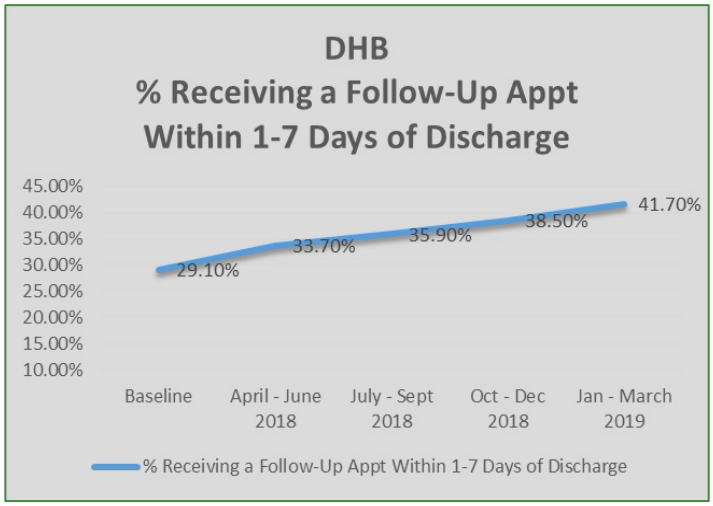
Denominator – All members discharged

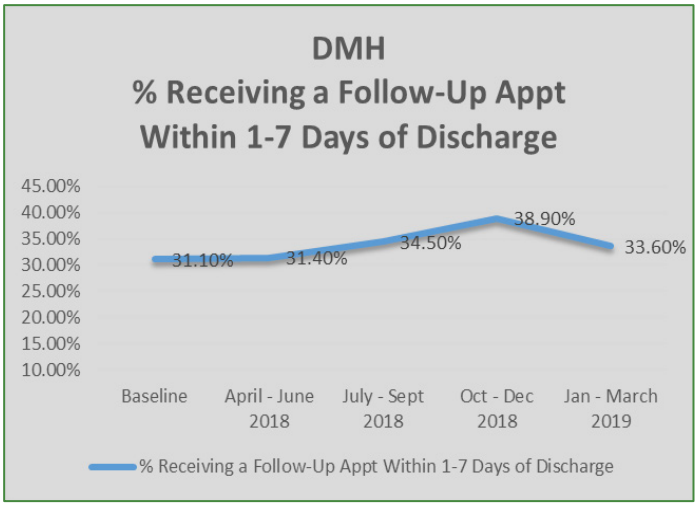
Baseline – *DHB* **= 29.1%** (N = 25; D = 86); *DMH* **= 31.1%** (N = 192; D = 618)

Measurements:

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

- Measurement #1 – April – June 2018 – *DHB* 28/83 = **33.7%**; *DMH* 183/583 = **31.4%**
- Measurement #2 – July – Sept 2018 – *DHB* 28/78 = **35.9%**; *DMH* 205/594 = **34.5%**
- Measurement #3 – Oct – Dec 2018 – *DHB* 42/109 = **38.5%**; *DMH* 243/625 = **38.9%**
- Measurement #4 – Jan – March 2019 – *DHB* 53/127 = **41.7%**; *DMH* 212/631 = **33.6%**





Barriers:

Barriers to this project have included the following:

1. Trillium occasionally does not get credit for applicable paid claims due to upstream denials in NCTRACKS.
2. HEARTS data is sent only quarterly but measurements are obtained monthly.
3. Some hospitals outperforming other hospitals in terms of scheduling follow-up appointments.
4. Members may not receive adequate support/reminders to attend their follow-up appointments post discharge.
5. Providers schedule follow-up appointments in varying ways. For example, to reduce no show rates some larger providers schedule all post discharge follow-up appointments at 8am on a particular weekday, which can result in a long wait if many appointments are made for that same day.

Interventions:

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

- Care Coordination staff routinely contact members when they are aware of a member's hospitalization to discuss follow-up appointments and any issues surrounding attending those appointments.
- Inpatient Reports are ran daily in Incedo by Care Coordination Managers and follow-up tasks are created/assigned by Mangers to Care Coordinators.
- Call Center staff give daily reminder phone calls to members identified as having follow-up appointments post hospital discharge for those members who are scheduled with providers who do not conduct appointment reminders themselves.
- Call Center staff contact members for all providers, regardless of if a provider will contact member themselves.

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

Goal:

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

Baseline:

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

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

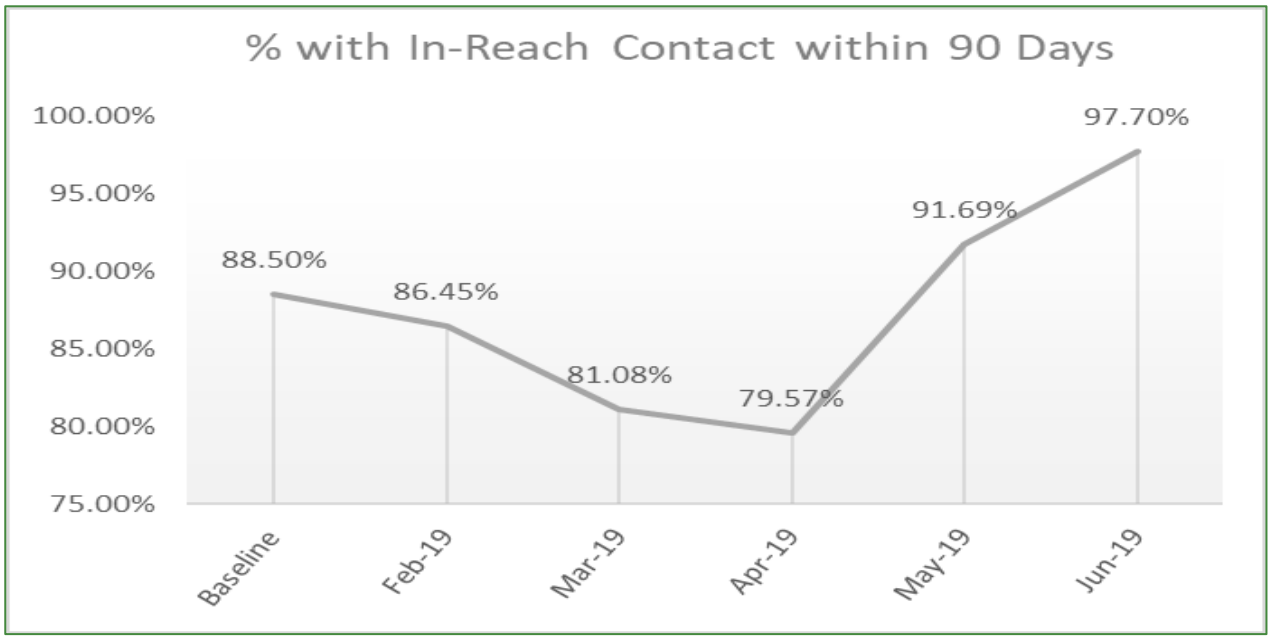
Denominator - # of all members currently in In-Reach status at the time of measurement (a monthly "snapshot")

Baseline – 88.5% (N = 956; D = 1080)

Measurements:

Measurements are taken monthly, and are as follows:

- Measurement #1 – February 2019, **86.45%** (N = 919; D = 1063)
- Measurement #2 – March 2019, **81.08%** (N = 780; D = 962)
- Measurement #3 – April 2019, **79.57%** (N = 771; D = 969)
- Measurement #4 – May 2019, **91.69%** (N = 938; D = 1023)
- Measurement #5 – June 2019, **97.7%** (N = 918; D = 940)



Barriers:

Barriers to this project have included the following:

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

Interventions:

- The In-Reach report was edited so that most recently updated "In-Reach Task" date for any duplicate In-Reach Task members is used. This ensures the percentage is not affected by having members with both overdue and on time reports being generated. TCLI will continue to work with RI to ensure they close out any extra In-Reach tasks on members. Currently a weekly report is sent to RI on Monday mornings, which contains a list of members with more than one In-Reach task open. RI has been able to resolve a majority of these since the reports inception. Resolution is ongoing.
- Weekly report of In-Reach members lacking a contact within 90 days sent to RI.

- Small table added to documentation sent to RI staff that has a total count of overdue member by coach.
- Education provided to RI.
- TCLI Data Analyst working with Informatics to develop further TCLI Data Validation Reports.

D. Increasing Provider Satisfaction Related to the Appeals Process for Denial, Reductions, or Suspension of Service(s)

Goal:

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

Baseline:

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

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

Denominator – Total Responses = 334

Baseline – 71.56% (N = 239/D = 334)

Measurements:

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

- Measurement #1 – 2018 Annual Results – 80.9%
- Measurement #2 – 2019 Annual Results – *Available early 2020*

Barriers:

Barriers to this project have included the following:

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

Interventions:

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

**ALL CURRENT FY 2018-2019 PROJECTS WILL CONTINUE INTO FY 2019-2020

CLOSED PROJECTS FY 2018-2019

I. Increasing Access to Adequate Admission, Discharge, and Transfer Data from Hospitals in the Trillium Catchment Area.

Goal:

The goal of this project was to increase the percentage of hospital Emergency Departments within the Trillium Health Resources catchment area that participate in the Admission, Discharge, and Transfer (ADT) data feeds to the CCNC Case Management Information System (CMIS) to 80%.

Baseline:

The baseline measurement for this project was collected in January 2017 and was based on the number of hospitals currently participating in ADT data feeds into the CMIS system at that time. The numerator is the number of hospitals participating in ADT data feeds, and the denominator is the total number of hospitals within Trillium catchment area.

Numerator – Hospitals participating in ADT data feeds to CMIS

Denominator – Total number of hospitals within the Trillium catchment area

Baseline - 47% (N = 8; D = 17)

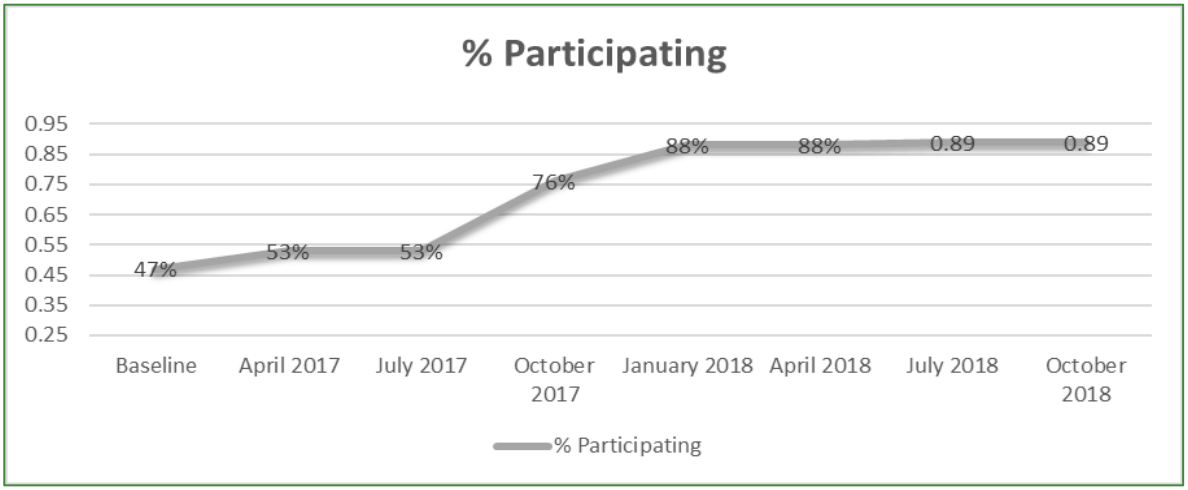
Measurements:

Measurements were taken quarterly, and are as follows:

- Measurement #1 – April 2017, **53%** (N = 9; D = 17)
- Measurement #2 – July 2017, **53%** (N = 9; D = 17)
- Measurement #3 – October 2017, **76%** (N = 13; D = 17)
- Measurement #4 – January 2018, **88%** (N = 15; D = 17)

*Goal Met. 12 month maintenance period began.

- Measurement #5 – April 2018, **88%** (N = 15; D = 17)
- Measurement #6 – July 2018, **89%** (N = 16; D = 18)
- Measurement #7 – October 2018, **89%** (N = 16; D = 18)



Barriers:

Barriers to this project have included the following:

1. Difficulty that has come from changing contracts between hospitals and the NC Hospital Association,
2. The uncertainty of hospitals around sharing information and maintaining HIPAA compliance,
3. A lack of awareness by hospital Executives of the ADT data feed and its' benefits,
4. Concern from hospitals around the benefits of participating in comparison to the perceived increased work load for hospital staff,
5. One hospital's (Washington County Hospital) CEO no longer being employed by the hospital and the gap in time until a new CEO was recruited.

Interventions:

- The NC Hospital Association incorporated participation in the ADT feed into the annual hospital contract renewal, which eliminated the barrier of changing contracts.
- Trillium's Chief Medical Officer provided Novant Brunswick Executives a list of bulleted items/facts related to the benefits of participating in ADT feeds.
- Education has been provided by the NC Hospital Association and its' members, including Trillium Chief Medical Officer, as well as their attorneys, to hospitals on how information sharing within ADT data feeds is protected under HIPAA law. Assistance has also been provided to hospitals as they negotiate their contracts.
- A team consisting of Trillium Regional Directors, Clinical VP of Operations, and the Chief Medical Officer developed a communication plan and stakeholder engagement plan, which included specific talking points to share when engaging hospital staff in discussion on participation in ADT data feeds. Many of the hospitals that do not participate currently have been contacted directly and education has been provided about the benefits of ADT data sharing.
- Onsite visits between Trillium staff and hospital staff occurred, with the purpose of education on the benefits of ADT data feeds.
- Trillium Chief Medical Officers maintained close communication with Washington County Hospital staff throughout the process of hiring a new CEO.

*This project was closed successfully on November 20, 2018

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

Goal:

The goal of this project was for 95% of TCLI In-Reach individuals to have received a contact within the last 90 day period.

Baseline:

The baseline measurement was taken from June 2017. The baseline and subsequent measurements were taken from TCLI Monthly Performance Dashboard, and the specific benchmark metric "Percentage of Individuals in In-reach Status during the Month with In-reach Contact in the Last 90 Days".

Numerator - # of individuals with In-reach contact within 90 days

Denominator - # of all individuals in In-reach status during that month

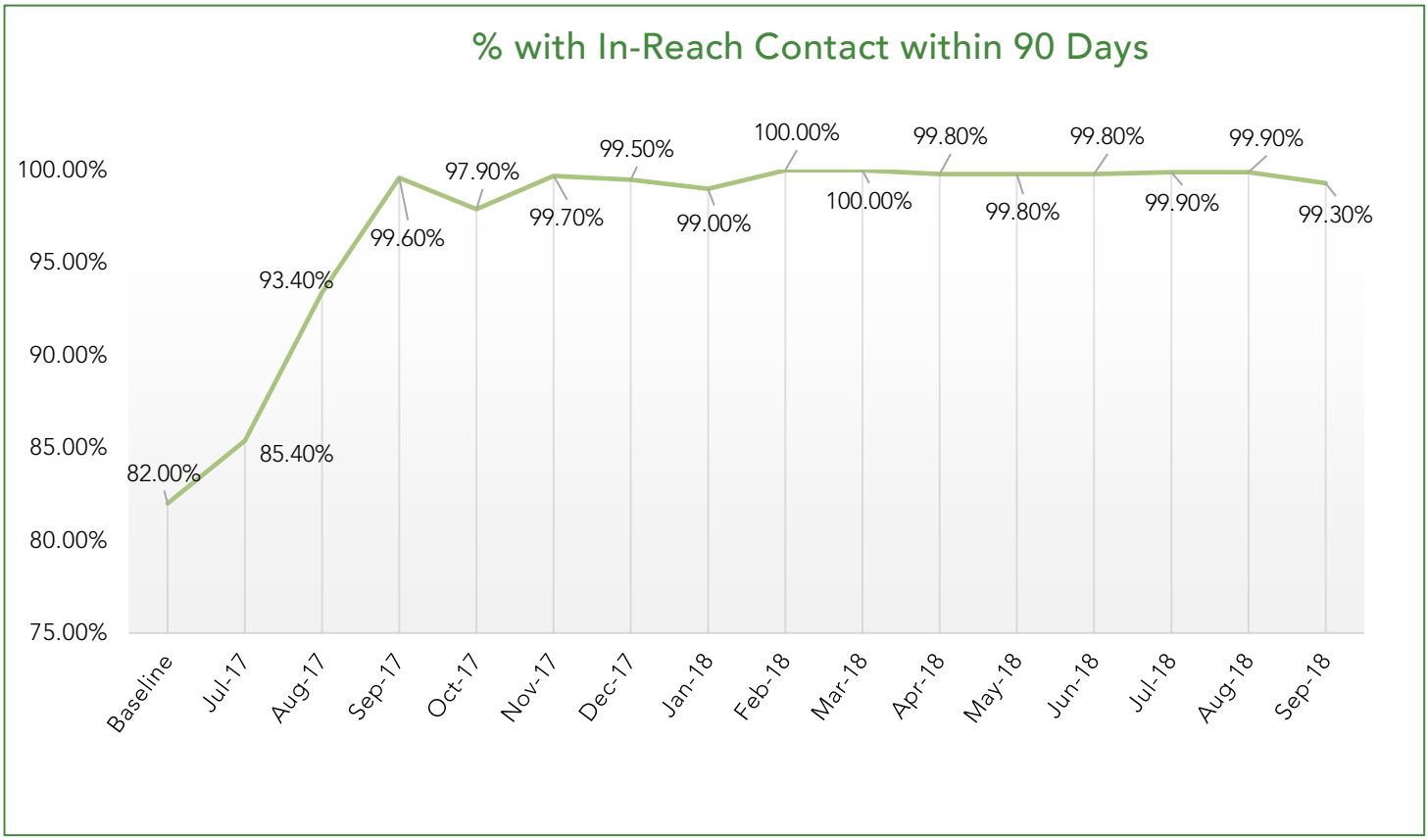
Baseline - 82.0% (N = 574; D = 700)

Measurements:

Measurements are taken monthly, and are as follows:

- Measurement #1 – July 2017, 85.4% (N = 670; D = 785)
- Measurement #2 – August 2017, 93.4% (N = 699; D = 748)
- Measurement #3 – September 2017, **99.6%** (N = 731; D = 734)

  *Goal Met. 12 month maintenance period began.
- Measurement #4 – October 2017, **97.9%** (N = 736; D = 752)
- Measurement #5 – November 2017, **99.7%** (N = 752; D = 754)
- Measurement #6 – December 2017, **99.5%** (N = 767; D = 771)
- Measurement #7 – January 2018, **99.0%** (N = 773; D = 781)
- Measurement #8 – February 2018, **100.0%** (N = 796; D = 796)
- Measurement #9 – March 2018, **100%** (N = 834; D = 834)
- Measurement #10 – April 2018, **99.8%** (N = 837; D = 839)
- Measurement #11 – May 2018, **99.8%** (N = 838; D = 840)
- Measurement #12 – June 2018, **99.8%** (N = 902; D = 904)
- Measurement #13 – July 2018, **99.9%** (N = 918; D = 919)
- Measurement #14 – August 2018, **99.9%** (N = 932; D = 933)
- Measurement #15 – September 2018, **99.3%** (N = 943; D = 950)



Barriers:

Barriers to this project have included the following:

1. Previous TCLI databases have had no available report to generate for monitoring 90 day follow up contacts,
2. The In-reach service for Trillium members is contracted out which means that Trillium staff will be relying on the In-reach Manager to provide effective supervision and hiring,
3. Data validation and accuracy are a concern due to 3 different databases currently used to track TCLI information,
4. Effective July 1, 2017 Nash County was incorporated into Trillium's data and effective July 1, 2018 Columbus County was incorporated into Trillium's data.

Interventions:

- A new report was developed by DHHS that pulls information directly from the new TCLI database. In addition, a report was created in CIE to validate data and compare to the TCLI database to ensure accurate 90 day follow up.
- Training and technical assistance was provided initially to In-Reach staff, then as needs are identified. Training such as motivational interviewing, Medicaid 101, NC ABLE, communication skills, and chronic disease self-management are provided on an as needed basis – in addition to training on the In-Reach Tool.

- TCLI staff cleaned up and validated data in the 3 databases by comparing reports from databases with data in CIE. TCLI staff developed desktop procedures to streamline the data entry process in an effort to reduce errors. In addition, TCLI staff maintained a separate spreadsheet that houses all TCLI information.

  This spreadsheet is used as another level of data validation and accuracy verification. TCLI has a Data Analyst that monitors all of these databases and the spreadsheet and is assisting in creating processes to ensure data accuracy.
- Reconciliation of data in all databases will be ongoing.

***This project was closed successfully on December 18, 2018**

18-19 KPI Report

INDICATOR	DATA MEASUREMENT	STANDARD	July 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	June 2019	NOTES
% of Community Inpatient Readmits assigned to Care Coord.	N: Number of readmits assigned to a Care Coordinator D: Total number of readmits	85%	100.0%	97.1%	93.3%	87.1%	96.0%	100.0%	96.9%	96.0%	89.3%	91.9%	92.1%	89.2%	
Total % of Auth Requests Processed in Required Timeframes	N: # Standard Auth Requests Processed in 14 Days PLUS # Expedited and Inpatient Auth Requests Processed in 3 Days D: Total Number of Auth Requests Received	95%	100.0%	99.5%	99.5%	99.8%	99.8%	100.0%	99.9%	99.9%	100.0%	99.9%	99.9%	100.0%	
% Routine Auths Processed in 14 Days	N: # Standard Auth. Requests Processed in 14 days D: # of Standard Auth. Request Decisions	95%	100.0%	99.7%	99.6%	100.0%	99.9%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%	100.0%	
% Expedited/Inpt Auths Processed in 3 Days	N: # of Expedited and Inpatient Auth. Requests Processed in 3 days D: # of Auth. Requests requiring Expedited Decisions, inclusive of Inpatient	95%	100.0%	99.1%	99.5%	99.3%	99.6%	100.0%	99.7%	100.0%	100.0%	99.7%	99.9%	100.0%	
% of Claims Processed within 30 Days	N: # of Claims Paid or Denied within 30 Days D: Total # of Clean Claims Received during the Month	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
% of Complaints resolved in 30 days	N: # of complaints being reported in this Report Period, that were either resolved in 30 days or referred to other entities for investigation within 30 days. D: Total # of Complaints received (1 month prior)	90%	100.0%	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		Two grievances in September were resolved outside of 30 days due to damage and issues from Hurricane Florence delaying responses from providers.
% of Denied Medicaid Encounter Claims	N: # of Denied Upstream Medicaid Encounter Claims D: Total # of Upstream Medicaid Encounter Claims Adjudicated	<5%	0.9%	0.5%	0.5%	0.4%	0.5%	0.4%	0.3%	0.3%	0.6%	0.5%	0.5%	0.4%	
% 7 Day Follow Up-MH	N: # of follow-up visits with a mental health practitioner within 1-7 days after discharge. D: # of discharges from a community-based hospital, state psychiatric hospital, or a facility based crisis service with a principal mental health diagnosis	40%	46.5%	48.5%	29.5%	38.7%	54.4%	35.5%	48.1%	48.3%	50.2%	41.9%	43.6%		There is currently a QIP for this super measure and the agency is coming up with/implementing interventions.
% 7 Day Follow Up-SA	N: # of follow-up visits with a substance use practitioner within 1-7 days after discharge. D: # of discharges from a community-based hospital, state psychiatric hospital, ADATC or a detox/facility based crisis service with a principal substance use disorder diagnosis	40%	23.1%	45.2%	38.1%	34.9%	43.6%	37.0%	36.6%	44.4%	43.9%	42.9%	42.5%		There is currently a QIP for this super measure and the agency is coming up with/implementing interventions.
% With Primary Care/Preventative Visit	N: # of Individuals Under the Innovations Waiver with a primary or preventative care visit. D: # of Individuals Under the Innovations Waiver	90%	96.5%	96.4%	96.5%	96.6%	96.6%	97.1%	94.0%	92.6%	91.2%	90.0%	88.3%		
Total % of Auth Requests Processed in Required Timeframes	N: # Standard Auth Requests Processed in 14 Days PLUS # Expedited and Inpatient Auth Requests Processed in 3 Days D: Total Number of Auth Requests Received	95%	100.0%	99.9%	99.8%	99.9%	99.9%	100.0%	99.8%	99.9%	100.0%	99.7%	100.0%	100.0%	
% Routine Auths Processed in 14 Days	N: # Standard Auth. Requests Processed in 14 days D: # of Standard Auth. Request Decisions	95%	100.0%	100.0%	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	100.0%	99.6%	100.0%	100.0%	