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

Clinical Advisory Committee Meeting Minutes

Date April 4, 2025

Meeting Called By	Dr. Michael Smith, Chief Medical Officer
Type of Meeting	Web-Ex Meeting 1:00pm – 2:30pm

EXTERNAL ATTENDEES - VOTING MEMBERS/NON-VOTING MEMBERS

	Present	NAME	Present	NAME	Present
Hillary Faulk-Vaughn, MA, LPA, HSP-PA, Chair PAMH Clinical Director **Voting Member**	☒	Robby Adams, MD Vice-Chair Medical Director, Various **Voting Member**	☐	Ann Phelps Wilson, PharmD Clinical Pharmacist, Novant Health NHRMC **Voting Member**	☐
Terri Duncan, PhD Director of Bladen County DHHS **Voting Member**	☐	English Albertson Program Manager, Pride in NC Provider Council President **Voting Member**	☐	Ryan Estes, MBA, LCSW, LCAS, CCS Coastal Horizons, COO **Voting Member**	☐
Natasha Holley, MSW, LCSW, LCAS, CCS Integrated Family Services Clinical Director **Voting Member**	☐	Tracey Simmons-Kornegay, PharmD Public Health Director Duplin County Health Dept **Voting Member**	☐	Sharlena Thomas, LCMHC-S, LCAS, CCS RHA Clinical Director **Voting Member**	☒
Michael Martin, MSW, LCSW ABC Pediatrics **Voting Member**	☐	Ritesh Patel, PharmD PORT Health - Independent Contractor **Voting Member**	☐	Ian Bryan, MD ENC Pediatrics Owner/Director **Voting Member**	☐
Michael Lang, MD Chair of Psychiatry at ECU Health Brody School of Medicine **Voting Member**	☐	Hany Kaoud, MD PORT Health Medical Director **Voting Member**	☐	Carol Gibbs, MD Therapeutic Alternatives (Psychiatrist) **Voting Member**	☐
Johnnie Hamilton, Jr., PhD Clinical Director Dixon Social Interactive Services, Inc. **Voting Member**	☐	Beth Pekarek, MD Medical Director for Daymark (Eastern) **Voting Member**	☒	Robert McHale, MD Medical Director for Monarch **Voting Member**	☐
Laura McRae, MA, LCMHC TFC Senior Director Pinnacle Family Services **Voting Member**	☐	Erin Warlick, LCMHC-S Clinical Director Advantage Behavioral Healthcare, Inc. **Voting Member**	☐		☐
Amy Moore, MSW, LCSW Dixon Social Interactive Services, Inc. (Alternate for Dr. Hamilton) **Voting Member**	☐		☐		☐

INTERNAL TRILLIUM ATTENDEES, PRESENTERS, GUESTS - NON-VOTING MEMBERS

NAME	Present	NAME	Present	NAME	Present

Michael Smith, MD Chief Medical Officer Trillium - **Non-voting Member**	☒	Arthur Flores, MD Deputy Chief Medical Officer Trillium - **Non-voting Member**	☐	Jason Swartz, RPh Pharmacy Director Trillium – **Non-voting Member**	☐
Paul Garcia, MD VP of UM & Benefits (Alternate for Dr. Smith) Trillium - **Non-voting Member**	☒	Khristine Brewington , LCSW VP Network Management Trillium – **Non-voting Member**	☒	Julie Kokocha Director of Network Accountability (Alternate for Khristine) Trillium – **Non-voting Member**	☐
Olive Cyrus, RN, DNP Quality Manager Director Trillium – **Non-voting Member**	☒	LaDonna Battle Executive Vice President of Care Mgmt. & Population Health Trillium – **Non-voting Member**	☒	Amanda Morgan QM Coordinator Trillium – **Non-voting Member**	☐
Benita Hathaway, RN, LCMHC VP Population Health & Care Mgmt. Trillium – **Non-voting Member**	☒	Trudy Paramore Admin Asst – Medical Affairs Trillium – **Non-voting Member**	☐	Cham Trowell, LPA Director of UM BH & IDD Trillium – **Non-voting Member**	☒
Anthony G. Carraway, MD Medical Director Trillium – **Non-voting Member**	☒	Isa Cheren, MD Medical Director Trillium – **Non-voting Member**	☒	Taylor Goodnough, DO Medical Director Trillium – **Non-voting Member**	☒
Venkatalakshmi Doniparthi, MD Medical Director Trillium – **Non-voting Member**	☒	Tracy Snowden-Muller, RPh Administration Pharmacy Dir. Trillium – **Non-voting Member**	☐	Richard Peters, RPh Pharmacy Director Trillium – **Non-voting Member**	☒
Dr. Aloysius Gainey IDD/TBI Clinical Director Trillium – **Presenter – Non-voting**	☒				

AGENDA

1. **Agenda topic: Welcome and Call to Order**
   Presenter(s): Dr. Michael Smith

Discussion	• Dr. Smith called the Clinical Advisory Committee (CAC) Meeting to order.
Conclusions	• There were no questions or concerns identified for follow-up or items recommended for corrective action.

Action Items	**Person(s) Responsible**	**Deadline**
• There were no items identified for follow-up		

2. **Agenda topic: Agenda Review and Approval**
   Presenter(s): Dr. Michael Smith

Discussion	• A quorum was not present for today's meeting. • There were no changes to the agenda. • The agenda was emailed to the membership for an electronic vote.
Conclusions	• The agenda for April 4, 2025, was approved via electronic vote on April 14, 2025.

	• There were no other questions or concerns identified for follow-up or items recommended for corrective action.

Action Items	Person(s) Responsible	Deadline
• There were no items identified for follow-up		

3. Agenda topic: Follow-up Items
Presenter(s): Dr. Michael Smith

Discussion	• Dr. Lang - F/u on ECU Dental School's wait time for appointments and if they have satellite dental offices. Open and moved to June meeting. • Jason - Email list of pharmacies participating in conducting injections to CAC members. Completed. The list of pharmacies participating in conducting injections was emailed to CAC membership on 04/14/25. • **Public Comment:** 8D-4 Clinically Managed Population Specific High Intensity Residential Program - Emailed to CAC 02/13/25. • **Public Comment:** TBI Waiver Expansion Paper - Emailed to CAC 02/24/25. • **Public Comment:** Value Based Payment Update: AMH Standardized Performance Incentive Program Draft Policy - Emailed to CAC 03/26/25.
Conclusions	• All open follow-up items will be carried forward to the next meeting until completion. • There were no other questions or concerns identified for follow-up or items recommended for corrective action.

Action Items	Person(s) Responsible	Deadline
• F/u on ECU Dental School's wait time for appointments and if they have satellite dental offices	Dr. Lang	Jun Mtg.

4. Agenda topic: Meeting Minutes Review and Approval
Presenter(s): Dr. Michael Smith

Discussion	• December 6, 2024 minutes were emailed to the membership for an electronic vote.
Conclusions	• December 6, 2024 minutes were approved via electronic vote on April 14, 2025 with a correction to Sharlena's agency title on Page 3. • There were no questions or concerns identified for follow-up or items recommended for corrective action.

Action Items	Person(s) Responsible	Deadline
• Post December 6, 2024 minutes to Trillium's SP site & forward to Communications to post to Trillium's Website	Susan	ASAP

5. Agenda topic: Performance Improvement Projects (PIP) Review
Presenter(s): Amanda Morgan

Discussion	• There is currently no data collected to present for the newly implemented PIPs.
Conclusions	• There were no questions or concerns identified for follow-up or items recommended for corrective action.

Action Items	Person(s) Responsible	Deadline
• There were no items identified for follow-up		

6. **Agenda topic: Trillium Updates and Information**
   Presenter(s): Dr. Michael Smith

Discussion	• **Tailored Plan (TP) Update** Currently, Trillium has an Interim Health Plan Accreditation and we are in the process of moving from interim accreditation to full Health Plan Accreditation. This is one of the necessary elements for our contract with the state for being a health plan. The other TPs are not as far along in the process as Trillium. NCQA does a two part survey, the first part is documentation review and we must submit all of our documents on May 6, 2025. Our NCQA Consultants and our staff are very busy with this work as there are hundreds of pages of documents required for submission. The second phase of our survey will be a virtual on-site file review and is scheduled for June 23rd and June 24th. On June 10th we will be notified of which files NCQA wants to review. These files will be from our Population Health Management Program and UM appeals and denials. From each of these areas we will have to pull files for a total of 30 and present them to the reviewers. Some of these files, especially UM appeals and denials are with our PBM vendor and our Standard Plan vendor. It will be quite an effort to pull these files together, review them and be ready to present them. If we review the first 8 of each of those categories and they have no deficiencies then the file review for that section will be done. We are hoping this will be the case, but will be prepared to review all 30 files. We will be notified in July of our standing. We may have a report ready for the August meeting. This is a huge undertaking and has affected just about every department in Trillium. We have a new Governing Board and in two weeks we will be having our third Governing Board meeting. Previously, we had a Consolidation Board that was meant to be an interim board until a permanent board was established. We have a really good Governing Board consisting of men and women throughout our catchment area who are very motivated and have experience in the healthcare industry. In March, it was announced that the federal government was cutting some funding to North Carolina DHHS, which would result in 80 jobs being cut and $100 million dollars in funding cuts. That will affect us, but not sure quite how and they're not sure what positions are being cut. Some of the jobs they are cutting are temporary positions or positions that have been filled with time limited contract employees. There are more cuts forthcoming and they haven't announced to us what or who that will be. We have received a letter regarding funding cuts from certain programs that really aren't through us. They are funded straight from the General Assembly and work has ceased on those. As of right now, our payments are continuing and the payments from the federal government to the department have continued. This is a time of a lot of uncertainty, but we are staying by our mission to take care of our members. There hasn't been any update on these cuts. Dr. Smith opened the floor for comments or questions. **Discussion** Hillary asked if Trillium had a contingency plan in place on how Trillium will address cuts if the payments become less from the federal government and

	how that will be navigated. Dr. Smith responded that it is hard to implement a contingency plan when we have limited knowledge about upcoming budget cuts, but yes we are talking about contingency plans on how we can continue funding. This will be more reactive instead of proactive. Dr. Battle said that she had that conversation yesterday about building contingencies upon contingencies and as • **Staffing and Consolidation Updates** We are fully consolidated with staff and are moving forward in that area. The provider network still has some areas that we continue to address. Our DSS liaisons have reached out to every county DSS office and our Regional Vice Presidents are at just about every meeting they can be in their regions. They are out meeting with our CFACs, hospitals as well as DSS offices and anyone else they can find to introduce Trillium. We are still hiring even with consolidation and still have positions available. We did have a change in the Executive Team structure. The Executive Team had remained the same for many years, but due to increasing our catchment area and members we felt a change was needed. Dr. Battle joined our team about a year ago as our Chief Clinical Operations Officer and brings that representation to our Team. We have added a Chief Strategy and Innovations Officer which is Cindy Ehlers. Christie Edwards is our new Chief Operations Officer. Melissa Owens will be our new Human Resources Officer and we are in the process of recruiting her current position of Chief Financial Officer. We felt these changes were needed to cover all the different areas that our plan is moving into.
Conclusions	• There were no questions or concerns identified for follow-up or items recommended for corrective action.

Action Items	**Person(s) Responsible**	**Deadline**
• There were no items identified for follow-up		

7. Agenda topic: CAC Business
Presenter(s): Dr. Garcia, Fonda, Jason, Cham

	• **Drug Utilization Review (DUR)/Pharmacy & Therapeutic (P&T) Subcommittee– Tracy Snowden-Muller for Jason Swartz** We had the flexibilities that started with TP back in July and our pharmacy flexibilities ended at the end of February. We are working on some of the expired PAs and rejections that are now occurring for our members and making sure they are getting continuation of therapy through that. We are working on GLP-1 coverage. As of August 1st, the state began covering weight loss on the GLP-1s that they would cover. So, we have seen an increase as of August on the GLP-1s being used for weight loss. We went from a monthly spend of about $700,000.00 on GLP-1s for Diabetes Mellitus versus last month spending $2,000,000.00 on GLP-1s monthly. We also continue to see an increase in prior authorizations being processed for weight loss, which is not a surprise in our patient population because the medications they are on for behavioral health do cause weight gain. We are hoping to see a benefit in weight loss for our members and a decrease in other co-morbidities. We are also focused on cell gene therapies that

Medicaid is covering. We have not seen any of these requests come through yet; however, other plans have seen these with the first being a gene therapy for Sickle Cell and those are multi-million dollar therapies for approximately eight to ten million dollars on Sickle Cell. Those are processed differently to the state. We are prepared to take on any of these, but we have not seen any as of yet. We continue to work with Care Management and UM on the medical records process per the TOC requirements.

Discussion

Dr. Garcia asked if North Carolina required step therapy for weight loss. Tracy responded that there is no requirement for step therapy and there is no time limit set on those therapies. Dr. Garcia stated that this may be a recommendation to the state because you can put someone on a GLP for weight loss, but if they don't learn the different modifications then they can't come off of it. Dr. Garcia recommended discussing this more at the next DUR meeting.

- **UM Parity – Dr. Garcia, Cham Trowell**

  The Mental Health Parity and Addiction Act has been around a while, but the final ruling was this past September and is based on the coverages of services (inpatient services, out of network inpatient services, outpatient services, out of network outpatient services, pharmacy and emergency services). As of January 1st, we removed quantitative treatment limits and we also removed our NCQLs and our non-quantitative treatment limits creating clinical pathways designed to be diagnostic specific. Our goal is to incorporate some of our HEDIS measures into our pathways and then get them out into the community. Our clinical pathways are posted on our website. You can access the website by entering Trilliumhealthresources.org, type mental parity and it will take you to three sections (substance use disorders, adult behavioral health disorders and child /adolescents' behavioral health disorders. We are starting with 30 diagnoses for now and may expand those. We want to make sure people are familiar with them, know how to utilize them and are comfortable with them. A lot of indications seen on the pathways are things that people are doing anyway. Dr. Garcia shared an example pathway titled Clinical Pathways for Treatment of Depression and reviewed it in detail. He noted that the HEDIS measure is in paratheses that is associated with that particular action. We will implement this in October and then have a year where we provide technical assistance to providers out in the community to make sure we are making a difference and ensuring HEDIS measures are being followed.

  Discussion

  Sharlena said that she appreciates the pathways and utilizing them would be much easier than sifting through 30 to 50 pages of research white paper information to find the evidence based practices. The pathways have evidence based practices listed which is great. Sharlena said that she was planning to recommend that this committee come up with a meaningful use grid for our services, but thinks these pathways are going to help. She inquired if someone was dually diagnosed then would we look at the primary diagnosis or all the diagnoses. Dr. Garcia stated that that was a good

question and we should focus on the primary diagnosis. Dr. Garcia said that the vast majority of questions received have been regarding our quality assurance tool. He reviewed the quality assurance review tool with the group. Cham shared that the quality assurance tool is really to encourage, make strong suggestions and push in the direction of clinical pathways. Dr. Pekarek said she really likes the emphasis on making sure the diagnosis is correct. If somebody is not getting better then you have to rethink what you are treating. Khristine asked the providers in the meeting how they teach mental health parity to their practitioners, therapists and prescribers. How does this type of information get to your folks who are doing the referrals and the work. Sharlena responded that for her agency the Clinical Department, Clinical Leadership across the state provides the information, explains the information during their consultations and provides the same information to their Operational Team Leaders meetings. So, they are receiving information from operations, clinical and QA. We had to explain what parity was and that it kind of put us in the same situation as medical providers. We explained the good and the bad of it, not having to submit authorizations, but you're in charge of your own authorizations. There is a risk there, just because you don't have to submit doesn't mean you don't have to do it right. We really wanted to educate folks on the risks as well as not creating our own guidelines, grids and amounts as considerations versus a sealing limit or any limit at all. We created consideration grids, like if you are considering providing anything over an amount, we want to make sure we're staffing it and assuring we are looking at it from a high risk high needs perspective. Sharlena stated that clinical coverage policy doesn't outline a requirement for an annual CCA and now its benefited and part of entitlement that a person can get an annual CCA. She asked if Trillium requires an annual CCA and if so requested it in writing along with some type of logic as to that expectation. Cham said the best answer is to go by whatever your agency's policies and procedures say and according to client need. Nothing has changed with parity; providers should have been ensuring medical necessity during COVID. Cham said she loved that Sharlena's agency is doing their due diligence to make sure that is occurring. She also stated from a UM perspective she is glad to be able to talk with providers because we certainly are seeing questions around what is needed in the records and again as reminder this has been the same as it has all along. We are going to look for exactly what the policies say. Hillary followed up on Khristine's question and shared they are a much smaller agency so we're going to have a little bit of a different process than Sharlena's agency. We have all of our team leads actually get together mostly weekly to discuss those cases where we are clinically stuck and we all look at these through different perspectives and ensuring we have followed the right pathway of clinical recommendations for each person. Having multiple clinicians involved and some who do not have any experience with a client gives a fresh perspective,. We also have been under no prior authorizations for a long time, but we still follow the guidelines internally that we had when we were submitting authorizations. We still have internal reviews and a person dedicated to review assessments,

then we have regular internal audits to see if we are tying the thread all the way through. We like having those internal checks and balances so that when it comes time for an audit we know that we have been able to check what it would have been should an authorization have been in place. Dr. Garcia said that parity should make entry into services a lot easier. You don't have to wait for prior authorizations for most services and members can go ahead and get treated. Dr. Garcia stated he had an idea of developing a pathway (protocol) for patients that go to the ED, facility based crisis or hospital setting for when they get discharged. Dr. Smith stated if the group has thoughts about how Trillium can assist with training on parity and pathways for your staff please let us know.

- **Screening Tools Review – Dr. Garcia**
  Trillium has an array of screening tools available for our providers. These can be accessed by going to Trillium's website and typing in Screening Tools. All screening tools are non-proprietary. Dr. Garcia shared his screen and did a walk through on our Substance Use and Mental Health screening tools that are available. He said if there were other non-proprietary screening tools the group would like us to consider adding then to please let him know.
- **TBI Waiver – Dr. Gainey**
  Dr. Gainey stated that we don't have an implementation date for the state-wide TBI Waiver roll out as of yet. This will probably be impacted by what's going on with Medicaid so we'll have to wait and see. In anticipation of that approval DHHS sent out the TBI Waiver expansion paper back in February. The paper provides an overview of DHHS' plan to expand the Waiver statewide. It is currently available for TBI individuals in the Alliance region which has been operating as a pilot program since 2018. The paper outlines an array of services that will be included in the Waiver, discusses the overall goal of addressing individual needs and promoting physical and cognitive rehabilitation. It also discussed the importance of establishing a specialized TBI provider network which is critical going forward because we don't have a lot of providers currently trained to work with that population. DHHS is considering expanding the Waiver eligibility to include adults with an acquired brain injury or those who have a non-traumatic brain injury, individuals who sustained brain damage due to internal factors such as a lack of oxygen, heart attack, stroke, etc. Another critical point is that DHHS also plans to expand eligibility criteria to individuals whose TBI occurred at or after their 18th birthday, previously it was age 20. The paper also emphasized that expanding the Waiver statewide would provide a coordinated TBI specific pathway for those who are in need of rehabilitative treatment. Currently, outside of Alliance, TBI programs are funded with state dollars. With the Waiver it is believed that the services would be more coordinated and that will certainly help with providing those services. After reviewing the concept paper, we followed up with our questions and comments on the plan for the Waiver. The North Carolina Brain Injury Association Conference will be taking place on April 13th and 14th at Wrightsville Beach. Dr. Smith said if anyone in the group did not have access to the paper to let him know and he would forward the link.

Conclusions	• There were no questions or concerns identified for follow-up or items recommended for corrective action.

Action Items	Person(s) Responsible	Deadline
• There were no items identified for follow-up		

8. Agenda topic: Open Agenda Discussion
Presenter(s): All Members

Discussion	• There were no open agenda items discussed.
Conclusions	• There were no questions or concerns identified for follow-up or items recommended for corrective action.

• There were no items identified for follow-up		

Next Meeting Date: June 6, 2025
(All meetings convene from 1pm – 2:30pm)

Supporting Document/Attachment for Minutes:
Agenda - Apr 2025
Meeting Minutes – Dec 2024
Public Comment: 8D-4 Clinically Managed Population Specific High Intensity Residential Program
Public Comment – TBI Waiver Expansion Paper
Public Comment – Value Based Payment Update: AMH Standardized Performance Incentive Program Draft Policy

Submitted by Susan Massey