Resource Management Services
Q2 2025 Report

/Submitted to the Management Team on 7/21/2025 by
Angie Fontenot, Clinical/ Compliance Director

PERFORMANCE MEASUREMENT AND MANAGEMENT PLAN (2025)

OVERVIEW: PMMP addresses Effectiveness, Efficiency, Satisfaction, Accessibility, Resources and Business Function as it relates to member services. Data will be collected each month using spreadsheets and reports that gather and track the information needed to evaluate the domains. The data will be analyzed at least biannually by the Clinical/Compliance Director and summarized on this report which will be shared with members, employees, and stakeholders.

The analysis will be specific and list identifying markers such as a) sample size, b) Significant findings compared to performance target, c) method and subject of review, d) Extenuating/Influencing Factors/Trends, e) Performance Improvement Plan specific to which staff responsible, change in process, and dates of completion. Depending on the results, the PMMP may be revised/edited to improve the outcomes by year end.

I.EFFECTIVENESS AND EFFICIENCY

A. MEASURE RESULTS ACHIEVED FOR PERSONS SERVED

OBJECTIVE 1.: With Medication Knowledge/Compliance and licensed counseling, members will either have 0 hospitalizations or have only 1 hospitalization during length of stay.

PERFORMANCE INDICATOR: No repeat hospitalizations AEB monthly hospital tracker/spreadsheet.

THRESHOLD: No repeat hospitalizations for the year 2025.

METHOD OF REVIEW: Track number of psychiatric hospitalizations and Emergency Dept. visits using the Hospital Tracker.

SIGNIFICANT FUNCTIONS: To monitor number of psychiatric hospitalizations and emergency dept. visits and potentially reduce the number of hospitalizations and ED visits for members.

A. Sample size for 01/2025 – 6/2025: 44 members.
B. Utilized Hospital/ Emergency Department Tracker.
C. 5 repeat hospitalizations. Of the 5 repeat hospitalizations, 1 member had 1 repeat hospitalization, 4 members had 2 repeat hospitalizations.
D. The member with 1 repeat hospitalization was due to the member checking himself out of 1 facility, then entering another facility.
E. Of the 4 members with 2 repeat hospitalizations, 1 member is being evaluated for a higher level of care, 2 members were discharged to a higher level of care, with 1 of member returning to RMS and agreeing to comply with staff advice. 1 member chose to discharge.

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FINDINGS:
Lake Charles: 13-member hospitalizations or ED visits (13 in H2 2024); 10 members had no repeat visits (20 in H1).
Jennings: 9-member hospitalizations or ED visits (16 in H2 2024); 7 members had no repeat visits (15 in H1).
Lafayette: 22-member hospitalizations or ED visits (14 in H2 2024); 20 members had no repeat visits (15 in H1).
Agency-wide: 44-member hospitalizations or ED visits (43 in H2 2024); 37 members, had no repeat visits (50 in H1).

EXTENUATING/INFLUENCING FACTORS/TRENDS: Two MCO's, Amerihealth and United Healthcare, have a system for notifying behavioral health providers of emergency department & hospitalizations. The other MCO's have no notification system for providers. Therefore, these visits must be self-reported by members. Though the threshold was not met, the number of repeat hospitalizations has decreased over 1st half of 2025, from 15 in H1 2024 to 5 in H2 2024.

24 Crisis Intervention sessions (24 in H2 2024), totaling 47.32 CI hours (50.85 in H2 2024), were provided during H1 2025. 123.58 OPC Hours were provided during H1 2025 (185.63 in H2 2024), which is 62.05 hours less than H2 2024. 29 hospital follow-up appointments occurred during H1 2025 (31 in H1 2024)

Threshold not met.

PERFORMANCE IMPROVEMENT PLAN INTERVENTION(S):

A. One clerical will be designated to enter hospitalizations on the hospital tracker upon learning of a hospitalization after initial admit to RMS. Any clerical learning of a hospitalization or ED visit is to contact the designated clerical. The Designated clerical to contact member that day to schedule appointment. To continue reaching out to member twice a day until able to reach the member. **3/14/25: protocol is being followed. 6/27/25: staffing change in designated clerical and training is ongoing. CCD monitors the tracker regularly and provides feedback to clerical & LMHPs.**
B. Clerical schedules an appointment with prescriber or licensed clinician within 7 days of hospital discharge. The designated clerical is to contact the CCD if the appointment has not been scheduled and kept within 7 days of the hospital discharge. **3/14/25: protocol is being followed. 6/27/25: staffing change with designated clerical and training is ongoing. CCD monitors the tracker regularly and provides feedback to clerical & LMHPs.**
C. Clerical schedules 3 consecutive licensed counseling appointments at 1- month apart post hospital stay. Designated clerical tracks these appointments on the tracker weekly and notifies the CCD if the appointments are not kept. **3/14/25: protocol is being followed. 6/27/25: staffing change with designated clerical and training is ongoing.**
D. CCD addresses missed appointments with LMHP who will then contact the member to discuss the matter and provide a CPST session accordingly all within the desired time frame. **3/14/25: protocol is being followed. 6/27/25: staffing change with designated clerical and training is ongoing. CCD is reviewing tracker regularly and providing directives for updates.**
E. LMHP addresses hospitalization cause, protocol for hospitalizations and crisis intervention services to prevent hospitalizations. LMHP directs member on steps to take in the event the member is considering

hospitalization again. TX plan to be updated to address prevention of hospitalization. PSR and CPST providers to follow TX plan. Commitment discussed. Hospital/ED tracker to include TX plan update by LMHP. **3/14/25: protocol is being followed. 6/27/25: Protocol is being followed.**

F. Administrative Support Personnel gather the data collected on the hospital tracker monthly and submits the report to the CEO and Clinical/Compliance Director at the start of the next month. **3/14/25: protocol is being followed. 6/27/25: protocol is being followed.**
G. AEGIS labs perform routine and ongoing ordered labs on members receiving medication management services.
H. Lab results are uploaded to the medical record and reported to the prescriber who then discusses the results with the member, educating the member on findings as they relate to symptom management. **3/14/25: protocol is being followed. 6/27/25: protocol is being followed.**
I. AEGIS labs collect data quarterly on medication adherence and provides a summary of findings to the CEO, and Clinical/Compliance Director. **3/14/25: protocol is being followed. 6/27/25: protocol is being followed.**
J. CCD to coordinate with MCOs in an effort to improve communication when a member is hospitalized. CCD to check the MCO portal on a daily basis, if applicable, to discover ED/hospitalizations then notify clerical accordingly. **3/14/25: protocol is being followed. 6/27/25: protocol is being followed. Amerihealth & UHC provide means of notification via their systems.**
K. CCD will generate a group message for all members by 3/2025 re-educating members on protocol to follow to prevent hospitalization and protocol post hospitalization. Message to be sent via text using on call or AVAYA. **3/14/25: CCD sent Broadcast message via On Call email. Message too large to send via SMS text.**
L. CCD will direct LMHPs to re-educate all staff in supervision meetings on protocol to prevent hospitalizations and ED visits; frequency of services important with attention to symptoms. All employees should be re-educated by 3/2025; all members should be re-educated by direct service staff by 4/2025. **3/14/25: CCD sent copy of Broadcast message to all staff. Directed LMHPs to review information during their next supervision sessions.**

STAFF RESPONSIBLE FOR INTERVENTION(S): Medical Director, Clinical / Compliance Director, LMHPs, Clerical Staff

DUE DATE FOR INTERVENTION(S): On-going

B.MEASURE EXPERIENCE OF SERVICES RECEIVED BY MEMBERS AND RESOURCES USED TO ACHIEVE RESULTS FOR MEMBERS

OBJECTIVE 1.: Members report satisfaction with the use of technology (email and links) to complete paperwork.

PERFORMANCE INDICATOR: 80% satisfied with use of information/communications technology AEB results of member surveys biannually

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THRESHOLD: 80% satisfaction with RMS technology

METHOD OF REVIEW: Distribute Satisfaction Surveys to adult and child/ adolescent members via electronic tablet and hard copy surveys at the time of service in all offices. Adult surveys are distributed twice per year, while child/ adolescent surveys are distributed once per year in H2.

SIGNIFICANT FUNCTIONS: To provide services deemed satisfactory by Members being served.

ANALYSIS:
Adult Surveys (Sample size: 7): Applicable domains include the following: 12) If you have utilized Telehealth Services, do feel comfortable using this mode of service delivery? 13) If you have received Telehealth Services, are you satisfied with the voice and video qualify of the session? 14) If you have received Telehealth Services, do you feel this is an acceptable way to receive your healthcare services? 16) I have used the RMS portal/ app; 17) I think the RMS portal/ app is easy to use; 18) I have used the email system to communicate with RMS; 19) I think the RMS email system is easy to use; 20) I have used faxing with RMS; 21) I think the RMS faxing system is easy to use and meets my needs.

FINDINGS: Regarding technology, 86% of members reported either satisfaction or neutral responses in areas surveyed, which is a 1% increase from H2 2025. The highest scores were related to the ease of use and satisfaction with telehealth services and the RMS portal/ app, with 100% of members agreeing to these domains. The lowest score was related to use of faxing with RMS, with 29% or members agreeing to using faxing. Of the 29% of members who used faxing with RMS, 90% agree to ease of faxing.

12. 100% + or neutral response (98% in H2 2024)
13. 100% + or neutral response (98% in H2 2024)
14. 100% + or neutral response (97% in H2 2024)
16. 86% + or neutral response (92% in H2 2024)
17. 100% + or neutral response (76% in H2 2024)
18. 100% + or neutral response (90% in H2 2024
19. 100% + or neutral response (89% in H2 2024)
20. 29% + or neutral response (62% in H2 2024
21. 57% + or neutral response (90% in H2 2024)

Comments from members include:
“Ive never used resource management therefor I can not really answer questions about what I think of their services.”

EXTENUATING/INFLUENCING FACTORS/TRENDS: CCD directed the distribution of surveys from 5/12/25 – 7/15/25. However, only 7 surveys were completed in H1. Some members require more assistance during initial set up. These members require more hands-on education from clerical, including clerical meeting members in their homes to assist with technology. On 6/25/25, the agency updated the Member Handbook to include educational information on technology members may utilize. Members of the older generation tended to not be open to change. Overall, members have responded more positively toward technology use.

Threshold met.

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PERFORMANCE IMPROVEMENT PLAN INTERVENTION(S):

A. Member Satisfaction Survey to highlight effectiveness and efficiency of technology.
B. Clerical educate members on admit and ongoing on the use of technology to complete documents. **3/14/25: ongoing. 7/18/25: CCD reeducated clerical re: the importance of distributing surveys to all members during the survey period.**
C. Designated Clerical send Member satisfaction surveys twice a year via texted link. **6/27/25: protocol is being followed. 7/18/25: CCD reeducated clerical re: the importance of distributing surveys to all members during the survey period.**
D. Member Satisfaction surveys to be readily available in each lobby and completed at member convenience. **3/13/25: Bethanie advises surveys are posted now. 6/27/25: Surveys are posted in both lobbies. 7/18/25: CCD reeducated clerical re: the importance of encouraging members to complete surveys to all members during the survey period.**
E. Results of the survey populate to a spreadsheet for analysis by Clinical/Compliance Director. **6/27/25: protocol is being followed.**

STAFF RESPONSIBLE FOR INTERVENTION(S): Clerical, PA, Clinical Compliance Director, LMHP, MHP, MHS

DUE DATE FOR INTERVENTION(S): ongoing

C.MEASURE EXPERIENCE OF SERVICES FROM STAKEHOLDERS

OBJECTIVE 1.: Referral Sources will report satisfaction with timeframe from referral to admission into the program.

PERFORMANCE INDICATOR: 80% satisfied with timeframe from referral to admission AEB stakeholder satisfaction survey twice a year.

THRESHOLD: 80% satisfaction

METHOD OF REVIEW: Bi-annual distribution of Stakeholder Surveys via emailed Google Drive form and hard copy forms in offices. SAMPLE SIZE: 36

SIGNIFICANT FUNCTIONS: To provide services which are deemed satisfactory by RMS Stakeholder.

ANAYLYSIS: Applicable domain includes the following: 1. I am satisfied with timeframe between the date of referral to the date of admission to Resource Management Services.

FINDINGS: 100% of Stakeholders report being satisfied with timeframe between the date of referral to the date of admission to Resource Management Services.

EXTENUATING/INFLUENCING FACTORS/TRENDS: Improved response from Stakeholders.

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Threshold of 80% satisfaction was met.

PERFORMANCE IMPROVEMENT PLAN INTERVENTION(S):

A. Stakeholder Satisfaction Survey to highlight timeliness of access to services. **3/14/25: completed**
B. Designated clerical sends Stakeholder Satisfaction Survey to a random sample of referral sources twice a year via fax/mail. Designated clerical to phone a sample of referral sources for each office to conduct survey via phone specific to member being referred.
C. Stakeholder satisfaction surveys to be readily available in the lobby of each office for parents and other stakeholders to complete at their convenience.
D. Surveys are to be completed biannually by random sample of parents of child/adolescent members who are also stakeholders.
E. Results of the survey are given to the Clinical/Compliance Director for analysis.

STAFF RESPONSIBLE FOR INTERVENTION(S): Clinical Compliance Director, Clerical Designee, LMHPs, Clerical

DUE DATE FOR INTERVENTION(S): Biannual Review – Ongoing. **Distribution completed in April 2025.**

OBJECTIVE 2: Stakeholders (Parents of child/adolescent members) report satisfaction with use of technology (text links/email/patient portal) to complete documents and sessions.

PERFORMANCE INDICATOR: 80% satisfied with use of information/communications technology AEB results of stakeholder surveys biannually.

THRESHOLD: 80% satisfaction

METHOD OF REVIEW: Bi-annual distribution of Stakeholder Surveys via emailed Google Drive form and hard copy forms in offices. SAMPLE SIZE: 36

SIGNIFICANT FUNCTIONS: 80% satisfaction with RMS technology

ANAYLYSIS:
Stakeholder Surveys: Applicable domains include the following: 14) I have used the RMS portal/ app; 15) I think the RMS portal/ app is easy to use and meets my need. 16) I have used the telehealth video system. 17) I think the telehealth video system is easy to use and meets my need. 18) I have used email to communicate with RMS staff. 19) I think the RMS email system is easy to use and meets my need. 20) I have used faxing with RMS. 21) I think the RMS faxing system is easy to use and meets my need.

FINDINGS: Regarding technology, 90% of members reported either satisfaction or neutral responses in areas surveyed. The highest scores were related to the ease of use and satisfaction both with the RMS portal/ app and telehealth services, with 100% of members agreeing to these domains. The lowest score was related to use of faxing with RMS, with 58% or members agreeing to using faxing. Of the 58% of members who used faxing with RMS, 86% agree to ease of faxing.

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14. 100% + or neutral response
15. 100% + or neutral response
16. 94% + or neutral response
17. 100% + or neutral response
18. 81% + or neutral response
19. 97% + or neutral response
20. 58% + or neutral response
21. 86% + or neutral response

EXTENUATING/INFLUENCING FACTORS/TRENDS: Surveys were distributed in April 2025. On 6/25/25, the agency updated the Member Handbook to include educational information on technology members may utilize. Overall, members have responded more positively toward technology use.

Threshold of 80% satisfaction was met.

PERFORMANCE IMPROVEMENT PLAN INTERVENTION(S):

A. CCD to revise stakeholder satisfaction survey to highlight effectiveness and efficiency of technology. **3/14/25: completed. 6/27/25: will survey again in August 2025.**
B. Clerical to educate parents of child/adolescent members initially and on going on the use of technology to complete documents and sessions.
C. Designated clerical to send stakeholder satisfaction surveys to parents of child/adolescent members biannually and encourage parents to complete surveys anytime when in office. **3/14/25: completed. 6/27/25: will survey again in August 2025.**
D. Results of the surveys to populate to a spreadsheet which is then analyzed by the CCD.

STAFF RESPONSIBLE FOR INTERVENTION(S): Clinical Compliance Director, Clerical Designee, LMHPs, Clerical

DUE DATE FOR INTERVENTION(S): Biannual Review – Ongoing. Next survey to be distributed in August 2025.

II.ACCESSIBILITY

A.MEASURE SERVICE ACCESS

OBJECTIVE 1.: Nonemergent Referrals will be scheduled timely

PERFORMANCE INDICATOR: 80% of Nonemergent referrals' appointments are scheduled to occur within 30 days of referral AEB referral tracking spreadsheet.

THRESHOLD: 80% of Nonemergent referrals' appointments scheduled within 30 days of referral.

METHOD OF REVIEW:

A. Review of "Report of Services Provided Within 10 Days of Authorization Report".
B. SAMPLE SIZE: 359

SIGNIFICANT FUNCTIONS: Decrease waiting time between Referral and Initial Intake.

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ANALYSIS: This Indicator is affected by the large volume of referrals in comparison to the agency's ability to serve members and training. "Centralized Scheduling" has proven effective.

FINDINGS:
LC: 52 members waited over 30 days during H1 2025 (17 members in H2 2024)
Jennings: 24 members waited over 30 days during H1 2025 (3 members in H2 2024)
Lafayette: 30 members waited over 30 days during H1 2025 (17 members in H2 2024)
Overall, 106 members, an average of 70%, waited less than 30 days between Referral and Initial Intake in H1 2025. (H2 2024 avg: 88%)

EXTENUATING/INFLUENCING FACTORS/TRENDS: Those members who declined services were not included in totals. Due to difficulties in receiving Magellan PA's in the St. Landry area, intake appointments for members involved with Eckerd Connects must be put on hold until the agency receives with either a signed Freedom of Choice or Plan of Care with CPST/ PSR services listed. staff failing to request services in timely manner. Other extenuating factors include delay in assessment due to members being initially unreachable, hospitalized, out of town, cancellations, no calls/ no shows, etc.

Threshold of 80% was not met.

PERFORMANCE IMPROVEMENT PLAN INTERVENTION(S):

A. Referrals received electronically are streamlined to one clerical who is to enter all referrals received that day on the spreadsheet by end of each day. The designated clerical is to initiate contact via phone/text with the referral within 48 hours of receipt of the referral and document every attempt to make contact. **3/14/25: Protocol is being followed. 6/27/25: Protocol is being followed.**
B. Referrals received via phone can be immediately scheduled by ANY clerical taking the call pending verification of Medicaid eligibility. **6/27/25: Issues noted with clerical not immediately scheduling when calls are received. CCD sent email clarification to clerical on 6/20/25.**
E. Hospital discharge Referrals are to be scheduled by the designated clerical upon receipt of the electronic referral or by ANY clerical taking the call at the time of the phone referral. Appointment Must be scheduled to occur within 7 days of hospital discharge. **3/14/25: Protocol is being followed. 3/14/25: completed. 6/27/25: Protocol is being followed.**
C. Designated clerical schedules referrals with two tentative dates; second date is "on call" meaning if the current scheduled referral doesn't show then the referral is willing to have telehealth intake on short notice on the "on call" date. **3/14/25: Having some cancellations & trouble filling slots. CCD continues to direct clerical to double book slots. 6/27/25: Referrals are resistant to scheduling an "on call" date, stating they are taking off of work, cancelling plans, etc. only for appointments to not occur.**
D. Designated clerical to double book referrals until confirmation received from referral 2 days prior to intake. Calls, texts should occur to gain confirmation. Communication with referring PCP or other referral source should occur to notify of communication barriers in scheduling intake. **3/14/25: Confirming appointments 1 day prior to Intake. Avaya texting has been disabled. Having some cancellations & trouble filling slots. CCD continues to direct clerical to double book slots. 6/27/25: Referrals are resistant to double-booking, stating they are taking off of work, cancelling plans, etc.**

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only for appointments to not occur. Avaya texting is operational again, and clerical is utilizing the SMS system.

E. **6/27/25: Designated clerical staff confirms assessments and completion of Intake paperwork on 1 business day prior to scheduled appointment. Referrals are provided with deadlines to confirm and complete paperwork; assessments are rescheduled if deadlines are not met. Designated clerical confirms appointments on the day off assessments.**
F. Assigned LMHP scheduled for sole purpose of initial intake. **6/27/25: 2 LMHPs are now assigned to complete intakes. 7/18/25: Due to decrease in referrals, 1 LMHP is assigned to complete intakes.**
G. Referral Spreadsheet and LMHP schedule/intake schedule will be monitored by CCD to track timeliness of scheduling and intake. **6/27/25: ongoing**
H. CCD to monitor weekly the receipts of referrals and timeliness of contact and scheduling. **3/14/25: ongoing. 6/27/25: ongoing.**

STAFF RESPONSIBLE FOR INTERVENTION(S): Clinical / Compliance Director, Medical Director, Clerical Staff, LMHPs

DUE DATE FOR INTERVENTION(S): Ongoing

III.MEASURE BUSINESS FUNCTION

A.COLLECTIONS AND DENIALS OF SERVICES BILLED

OBJECTIVE 1: Clean claims are submitted and paid within 60 days; Denials are aged no more than 120 days and are resolved and paid within 60 days of resubmit date.

PERFORMANCE INDICATOR: 80% of submitted claims are clean and paid within 60 days. 80% of aged claims are less than 120 days old.

THRESHOLD: 80% of submitted claims are clean and paid within 60 days. 80% of aged claims are less than 120 days old.

METHOD OF REVIEW: Utilized reports from EHR: "All Claims by Payor" and "Aging (as of date)" for period of January 1,2025 – June 30, 2025. Also used "Outstanding balances" spreadsheet as well as "MCO deposits" spreadsheet. Utilized Quarterly Claims Sample Review Report as well.

SIGNIFICANT FUNCTIONS: Produce consistent steady cash flow and ensure reimbursement of services provided.

ANALYSIS: Review of All Claims by Payor Reports for H1 2025.

FINDINGS:
Total # of claims: 20,582
Total # of denied claims: 1251

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Total # of denied claims older than 120 days: 131

EXTENUATING/INFLUENCING FACTORS/TRENDS: 6% denied claims; 94% clean claims
10% denied claims older than 120 days. For H1 2025, the majority of claims are clean and paid within 60 days of initial submission. Billing team has been able to resolve majority of denied claims timely resulting in payment within 120 days of initial submission.

Threshold was met.

PERFORMANCE IMPROVEMENT PLAN INTERVENTION(S):

A. Work necessary OT to catch up denials to 120 days old.
B. 1 Billing assistant to dedicate all time to MCO denials, documenting interventions and dates to resolve claim issues.
C. No write offs unless approved by CEO. All avenues to be exhausted to receive reimbursement.
D. 1 Billing assistant to work commercial and private claims, documenting interventions and dates to resolve claim issues.
E. Both billing assistants to hold monthly meetings with MCO liaisons, Carelogic and commercial insurances to communicate barriers to getting paid. Request open tickets and written correspondence to ensure adequate follow through on the parts of all parties. **7/8/25: Monthly meetings are no longer required for some of the MCOs as a result of fewer issues thus creating denials. Project tickets are opened when all possible corrections have been made and a claim continues to deny. Matters are escalated to higher authority and provider relations when RMS exhausted all measures to reverse a denied claim. Meetings with liaisons, Carelogic and commercial insurances are arranged when new matters arise.**
All other interventions remain in place. At this point, plan is working very well.
F. Billing assistants to generate daily report to CEO who will provide day to day directives.
G. CEO and billing team to meet weekly to devise action plans and proper follow through.
H. Outstanding Balances, Daily billing report, and year to date service type billing to be generated by Billing Assistant every Friday and sent to CEO.
I. Billing team coordinates with clerical and employees regularly to re-educate on systems in place to promote clean claims, proper coding and timeliness of documentation

STAFF RESPONSIBLE FOR INTERVENTION(S): CEO, Billing Staff

DUE DATE FOR INTERVENTION(S): Ongoing

IV.MEASURE PERSONNEL TRAINED ON THEIR ROLES THAT IMPACT PERFORMANCE MEASUREMENT AND MANAGEMENT

OBJECTIVE 1.: Clerical and direct service staff will receive the education and support on an ongoing basis by the CCD/LMHPs to combat weak performance which negatively impacts business function and quality services.

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PERFORMANCE INDICATOR: CPST Expired Services report show an decrease in service units not provided; utilization report indicates an increase in frequency of services overall compared to 2024 year. CPST services will be delivered at least once a month to each member.

THRESHOLD: Increase in CPST frequency provided to members in 2025 compared to 2024.

METHOD OF REVIEW: Reviewed "Monthly Expired Units" and "Monthly Utilization" reports.

SIGNIFICANT FUNCTIONS: Decrease in expired CPST services.

ANALYSIS: The average expired CPST services per month in H1 2025 was $73,162.43 (average expired CPST services per month in H2 2024 $72,197.77)

FINDINGS: The average monthly CPST frequency met was 71% for H1 2025 (65% in H2 2024), while expired CPST services for H1 2025 were $441,162.43 ($433,4186.63 in H2 2024).

Threshold was partially met.

EXTENUATING/INFLUENCING FACTORS/TRENDS: While the amount of expired CPST services increased in H1 2025, the average monthly frequency of CPST services provided to members increased. The agency has been more successful in hiring and retaining qualified CPST providers.

PERFORMANCE IMPROVEMENT PLAN INTERVENTION(S):

A. CPST providers will attend supervision sessions at least monthly to discuss caseloads and barriers to providing services to all members at least once a month. These meetings are to be conducted by CCD/LMHPs. Any CPST provider not consistently providing CPST or working the desired number of hours hired to work are to meet with the CCD in the weekly supervision meeting for new hires. **3/14/25: ongoing. 6/27/25: ongoing. All CPST providers met on 6/5/25 to share ideas to improve access and CPST frequency to all members. Provider feedback was positive.**
B. All members on a caseload are to have received CPST at least once a month before CPST provider can provide CPST more than 2x/month on any given member.
C. CCD to conduct a training to all CPST providers and LMHPs on CPST protocol and steps to take to alleviate any barriers to providing CPST services at least monthly on each member assigned. CPST providers are to contact CCD or LMHP assigned to the case to discuss unresolved barriers. The CCD/LMHP to then speak with the PSR provider and follow through until PSR provider facilitates the connection of the CPST provider with the member. **3/14/25: Protocol is being followed. 6/27/25: Protocol is being followed.**
D. The week of the 15th of each month, a designated clerical will run a report for each CPST provider which reflects those assigned members on the caseload who have yet to receive CPST services at least once that month. The designated clerical in each office will then forward the list to the CPST provider and cc the CCD. Communication/supervision provided by CCD at that time to determine if the PSR provider interventions are needed to make the connection occur. Plan is devised and then put into

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motion to ensure members receive the CPST at least monthly. **3/14/25: Protocol is being followed. 6/27/25: Protocol is being followed.**

E. Monthly clinical spreadsheets resulting data specific to assigned duties and services are to be collected and provided to CEO and Clinical/Compliance Director by first week of the following month. **3/14/25: ongoing. 6/27/25: Protocol is being followed.**

STAFF RESPONSIBLE FOR INTERVENTION(S): Clinical / Compliance Director, Medical Director, Clerical Staff, LMHPs, CPST providers

DUE DATE FOR INTERVENTION(S): Ongoing

RISK FACTORS

Critical Incidents

Critical Incidents are reported throughout the year. RMS is required to report any incident which may adversely affect the health and well-being of a member or staff. Some incidents are required to be reported to Department of Children and Family Services, Adult Protective Services, or Elderly Protective Services. Some incidents are required to be reported to the insurance company (MCO), while others are only reported internally, based on CARF and MCO standards.

In H1 2025, a total of 49 critical incidents were reported (22 in H2 2024), which was an increase of 27 over the H2 2024. The greatest number of reported incidents was mental health hospitalizations; 23 hospitalizations were reported in (4 in H2 2024). Clinical Compliance Director and LMHPs continue to educate staff on identifying possible triggers to crises and hospitalizations. Staff continue to educate member on the use of the crisis line for afterhours crises. LMHP continue to meet with members within 7 days post hospitalization. In H1 2025, 4 reported communicable diseases were due to the COVID-19 (7 in H2 2024) which is a decrease of 3; also included were other communicable diseases (1) such lice, scabies, etc. Staff continued to educate members and families regarding disease prevention, especially COVID-19, such as signs and symptoms, wearing masks, handwashing, use of hand sanitizer, and social distancing. Other frequently reported incidents included abuse and neglect issues, all of which were reported to MCO's. In H1 2025,

Health and Safety

Upon change of ownership, the agency underwent, and passed with minor corrections, health and safety surveys and inspections by the Office of Public Health and Louisiana Office of State Fire Marshall. In H1 2025, the agency passed a 2-day audit conducted by the Louisiana Department of Health, Health Standards Section. The agency has since enhanced evacuation routes and emergency response. Policy and procedures have been updated accordingly.

Member Grievances / Formal Complaints

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Any member who feels he/she is being treated in an unfair or inappropriate manner or believes that his/her privacy and confidentiality has been breached shall have the opportunity to informally voice his/her grievance. If the grievance cannot be informally resolved, the member can submit a formal, written grievance. Members are be given the freedom to file a grievance with Resource Management Services, its services, and/or its staff. 0 grievances of formal complaints were filed in H1 2025.

QUARTER QUALITY RECORD REVIEW SUMMARY

Subject of Review: Record Review of open and closed cases

Sample Size: 18 records

METHOD OF REVIEW: Review random sample of 18 records from each clinic quarterly.

SIGNIFICANT FUNCTIONS: To improve quality of agency-wide General and Clinical Practice Guideline; to provide services in an effective and efficient manner to all members.

EXTENUATING/INFLUENCING FACTORS/TRENDS: In Q1 2025, PSR hours increased to 10,381.65 (10,257.83 in Q4 2024), while CPST service hours decreased to 2537.43 (2992.40 in Q4 2024). Outpatient counseling hours decreased to 74.83 (90.08 in Q4 2024), while med management hours increased to 230.85 (228.72 in Q4 2024).

THRESHOLD: 85%

ANALYSIS: Q1 2025 Record Review indicates continued progress in uploading Initial Intake packets to Document Library in Carelogic EHR. For the most part, completed packets are automatically uploaded to member Document Libraries. The highest average scores were related to member rights, cultural competency, continuity of care, and medication management. Discharge planning continued to be the lowest score.

FINDINGS: 96% overall for Q1 2025 which exceeds threshold (Q4 2024: 94%)

PERFORMANCE IMPROVEMENT PLAN

INTERVENTION(S): 1) “Checks and Balances” plan in place to ensure intake packets are thoroughly completed with all signatures and documents present/uploaded into EHR. 2) OnCall patient portal/ app continues to greatly improve efficiency and improved quality. 3) CCD sent Quality Record Review results to LMHPs and clerical, with a deadline for updates 6/20/2025. 4) Clinical / Compliance Director provides ongoing feedback to LMHPs regarding assessment documents, treatment planning and discharge planning.

STAFF RESPONSIBLE FOR INTERVENTION(S): CEO**,** Clerical, CCD, PA, LMHPs

Lake Charles:

Resource Management Services
Q2 2025 Report

Submitted to the Management Team on 7/21/2025 by
Angie Fontenot, Clinical/ Compliance Director

General Requirements: 97% (Q4 2024: 94%)
Member Rights: 100% (Q4 2024: 84%)
Initial Evaluation: 78% (Q4 2024: 87%)
Cultural Competency: 100% (Q4 2024: 100%)
Continuity and Coordination of Care: 99% (Q4 2024: 100%)
Treatment Plan: 97% (Q4 2024: 99%)
Medication Management: 100% (Q4 2024: 100%)
Adverse Incident: 100% (Q4 2024: 100%)
Discharge Summary: 80% (Q4 2024: 100%)

Jennings:
General Requirements: 98% (Q4 2024: 96%)
Member Rights: 100% (Q4 2024: 100%)
Initial Evaluation: 93% (Q4 2024: 95%)
Cultural Competency: 100% (Q4 2024: 100%)
Continuity and Coordination of Care: 97% (Q4 2024: 100%)
Treatment Plan: 95% (Q4 2024: 98%)
Medication Management: 100% (Q4 2024: 100%)
Adverse Incident: 100% (Q4 2024: 100%)
Discharge Summary: 89% (Q4 2024: 56%)

Lafayette:
General Requirements: 96% (Q4 2024: 88%)
Member Rights: 100% (Q4 2024: 100%)
Initial Evaluation: 95% (Q4 2024: 95%)
Cultural Competency: 94% (Q4 2024: 100%)
Continuity and Coordination of Care: 97% (Q4 2024: 100%)
Treatment Plan: 95% (Q4 2024: 100%)
Medication Management: 100% (Q4 2024: 100%)
Adverse Incident: 100% (Q4 2024: 100%)
Discharge Summary: 93% (Q4 2024: 44%)