**PERFORMANCE MEASUREMENT AND MANAGEMENT PLAN**

**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 2024.

**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.

**ANALYSIS**:

1. Sample size for 07/2024 – 12/2024: 43 members.
2. Utilized Hospital/ Emergency Department Tracker.
3. Of the 15 repeat hospitalizations, 4 members had 1 repeat hospitalization, 9 members had 2 repeat hospitalizations (1 of whom was hospitalized twice in H2 2024) and 1 had 3 repeat hospitalizations, including 2 hospitalizations in H2 2024.
4. Of the 4 members with 1 repeat hospitalization, 1 moved to a group home and 1 moved to a higher level of care.
5. Of the 9 members with 2 repeat hospitalizations, 5 members were non-compliant with follow-up appointments and chose to discharge.
6. The member with 3 hospitalizations was moved to a 30-day facility on 12/27/24.

**FINDINGS**:

Lake Charles: 13-member hospitalizations or ED visits (23 in H1); 7 members had no repeat visits (20 in H1).

Jennings: 16-member hospitalizations or ED visits (18 in H1); 10 members had no repeat visits (15 in H1).

Lafayette: 14-member hospitalizations or ED visits (20 in H1); 11 members had no repeat visits (15 in H1).

Agency-wide: 43**-**member hospitalizations or ED visits (61 in H1); 28 members, had no repeat visits (50 in H1).

**EXTENUATING/INFLUENCING FACTORS/TRENDS:** With the exception of Amerihealth, and now United Healthcare, MCO’s do not have a system of notifying behavioral health providers of emergency department & hospitalizations. Therefore, these visits must be self-reported by members.

24 Crisis Intervention sessions (20 in H1), totaling 50.85 CI hours (45.65 in H1), were provided during H2 2024. 185.63 OPC Hours were provided during H2 2024, which is 71.50 hours less than H1 2024. 31 hospital follow-up appointments occurred during H2 2024.

**Threshold not met.**

**PERFORMANCE IMPROVEMENT PLAN INTERVENTION(S):**

1. Clerical enter hospitalizations on the hospital tracker upon learning of a hospitalization after initial admit to RMS. 7/23/24: Hospital tracker has been revised to include number of hospital visits in 2024. **1/30/25: Intervention is followed consistently; no changes to system needed.**
2. Clerical schedules an appointment with prescriber or licensed clinician within 7 days of hospital discharge. 7/23/24: Intervention is followed consistently; no changes to system needed. **1/30/25: This duty was reassigned to a new clerical staff member in September 2024. Re-education occurred in December 2024 to ensure initial follow-up appointments are scheduled within 7 days of discharge consistently.**
3. Clerical schedules 3 consecutive licensed counseling appointments at 1- month apart post hospital stay. 7/23/24: Intervention is followed consistently; no changes to system needed**. 1/30/25: Intervention is followed consistently; no changes to system needed.**
4. Clerical track missed appointments and provide information to LMHP. 7/23/24 PIP: C/CD has re-educated Clerical Designee on the importance of notifying LMHP & C/CD of missed appointments weekly for proper follow-up to occur. **1/30/25: This duty was reassigned to a new clerical staff member in September 2024. Re-education occurred in December 2024 to ensure proper follow-up and member compliance with hospital follow-up appointments.**
5. LMHP addresses missed appointments with member. Commitment discussed. 7/23/24: By 7/26/24, C/CD to re-educated LMHPs to follow-up on clerical notifications. **1/30/25: LMHPs and CCD consistently follow-up as notified.**
6. 7/24/24 (added): C/CD will direct Clinical staff to re-educate all members on the importance of hospital follow-up appointments by 8/26/24. **1/30/25: PIP was met and re-education in ongoing.**
7. 7/24/24 (added): By 8/2/24, C/CD will re-educate clerical in each office to reinforce with members the importance of keeping hospital follow-up appointments. **1/30/25: PIP was met and re-education in ongoing.**
8. 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. Monthly LHC/Quartet reports and Amerihealth reports are also used to track hospitalizations and community tenure. 7/23/24: C/CD has begun gathering data for monthly reports. **1/30/25: United Healthcare reports are now being utilized to track hospitalizations for UHC members.**
9. AEGIS labs perform routine and ongoing ordered labs on members receiving medication management services.
10. 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.
11. AEGIS labs collect data quarterly on medication adherence and provides a summary of findings to the CEO, and Clinical/Compliance Director.

**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.

**THRESHOLD:** 80%

**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.

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

**ANALYSIS**

**Adult Surveys (Sample size: 63):** 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, 85% of members reported either satisfaction or neutral responses in areas surveyed, which is the same percentage as H1. The highest scores were related to the ease of use and satisfaction with telehealth services, with 98% of members agreeing to these domains. The lowest score was related to use of faxing with RMS, with 62% or members agreeing with this domain. Of the 62% of members who used faxing with RMS, 90% agree to ease of faxing.

12. 98% + or neutral response

13. 98% + or neutral response

14. 97% + or neutral response

16. 92% + or neutral response

17. 76% + or neutral response

18. 90% + or neutral response

19. 89% + or neutral response

20. 62% + or neutral response

21. 90% + or neutral response

Comments from members include: “None of these apply to me”, “First time using it”, “I love resource management and their staff”.

**EXTENUATING/INFLUENCING FACTORS/TRENDS:** Distribution of surveys began 07/05/2024. Some members required more assistance during initial set up. These members required more hands-on education from clerical. Members of the older generation tended to not be open to change. Overall, members have responded more positively toward technology use.

**Child/ Youth Surveys (Sample size: 100)**: Applicable domains include the following: 9) I have used the RMS portal/ app with my guardian. 10) I think the RMS portal / app is easy to use and meets my need. 11) I have used the telehealth video system with my guardian. 12) I think the telehealth video system is easy to use and meets my need. 13) I have used email with my guardian to communicate with RMS staff. 14) I think the RMS email system is easy to use and meets my need. 15) I have used faxing with my guardian and RMS. 16) I think the RMS faxing system is easy to use and meets my need.

**FINDINGS:** Regarding technology, 86% of members reported either satisfaction or neutral responses in areas surveyed. The highest scores were related to the ease of use and satisfaction with On Call patient portal and telehealth services, with 97% of members agreeing to these domains. The lowest score was related to use of faxing with RMS, with 60% or members agreeing with this domain.

9. 91% + or neutral response

10. 97% + or neutral response

11. 89% + or neutral response

12. 97% + or neutral response

13. 80% + or neutral response

14. 91% + or neutral response

15. 60% + or neutral response

16. 81% + or neutral response

Comments from members include: “Not much to agree or disagree because we have not been seen yet by a doctor.” “I haven’t had any visits yet so I couldn’t answer basically all of those questions because I’ve never been through them.” “We haven’t been to a visit nor have we seen a doctor yet. So I can’t really answer these questions truthfully. Thank you.”

**EXTENUATING/INFLUENCING FACTORS/TRENDS:** Distribution of surveys began 07/05/2024. Some members required more assistance during initial set up. These members required more hands-on education from clerical. Overall, members have responded more positively toward technology use.

**Threshold of 80% satisfaction was met.** 85% of adult members and 86% of child / adolescent members reported either satisfaction or neutral responses in areas surveyed.

**PERFORMANCE IMPROVEMENT PLAN INTERVENTION(S):**

1. Clinical/Compliance Director to revise Member Satisfaction Survey to highlight effectiveness and efficiency of technology. 7/23/24: Survey was revised on 3/21/2024.
2. Clerical to continue to educate members on admit and ongoing on the use of technology to complete documents.
3. Clerical to send Member satisfaction surveys twice a year via texted link. 7/23/24: Next survey to be conducted September 2024. **1/30/25: The Child/ Youth Satisfaction Survey is distributed once per year and was utilized in July 2024. The 2nd Adult Satisfaction Survey sent 9/23/24.**
4. Member Satisfaction surveys to be readily available in each lobby and completed at member convenience. 7/23/24: Completed 3/25/2024.
5. Results of the survey populate to a spreadsheet for analysis by Clinical/Compliance Director.

**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:** 85% satisfaction

**METHOD OF REVIEW:** Bi-annual distribution of Stakeholder Surveys via emailed Google Drive form and hard copy forms in offices. SAMPLE SIZE: 48

**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 Stakeholder; responses went from 6 to 48.

**Threshold of 85% satisfaction was met.**

**PERFORMANCE IMPROVEMENT PLAN INTERVENTION(S):**

1. Clinical/Compliance Director to revise Stakeholder Satisfaction Survey to highlight timeliness of access to services. Results to be calculated in H2 2024. 7/23/24: Google survey and hard copy surveys have been revised.
2. Administrative Support Person sends Stakeholder Satisfaction Survey to a random sample of referral sources twice a year via fax. 7/23/24: Clerical Designee to send Stakeholder survey twice per year via fax or email; next distribution is scheduled for August 2024. **1/30/25: Distribution of Stakeholder surveys began 8/19/24.**
3. Stakeholder satisfaction surveys are readily available in the lobby of each office for parents and other stakeholders to complete at their convenience. 7/23/24: Completed 03/25/2024.
4. Results of the survey are given to the Clinical/Compliance Director for analysis.
5. 7/24/24 (added): In August 2024, clerical designee to call select number of referral sources each month to question the referral coordinator, specific to the member referred. **1/30/25: completed**
6. 7/24/24: Clerical to request parents also complete surveys; ongoing.

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

**DUE DATE FOR INTERVENTION(S):** Biannual Review – Ongoing - C/CD and LMHPs to continue to focus on the domains of dysfunction mentioned within the survey, using “Best Practice Guidelines.” 7/23/24: Ongoing. April 2024 completed; next distribution will occur in August 2024. **1/30/25: August distribution completed.**

**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:**

1. Reviewed “Report of Services Provided Within 10 Days of Authorization Report”.
2. SAMPLE SIZE: 302

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

**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: 17 members waiting over 30 days during H2 2024 (24 members in H1)

Jennings: 3 members waiting over 30 days during H1 2024 (20 members in H1)

Lafayette: 17 members waiting over 30 days during H1 2024 (34 members in H1)

Overall, 265 members, an average of 88%, waited less than 30 days between Referral and Initial Intake in H1 2024. (H1 avg 70%)

**Threshold of 80% was met.**

**EXTENUATING/INFLUENCING FACTORS/TRENDS:** Those members who declined services were not included in totals. 1 intake appointment in Jennings was delayed due to Eckerd Connects 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.

**PERFORMANCE IMPROVEMENT PLAN INTERVENTION(S):**

1. 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.
2. Referrals received via phone can be immediately scheduled by clerical taking the call pending verification of Medicaid eligibility.
3. Hospital discharge Referrals are to be scheduled by clerical upon receipt of the electronic referral or at the time of the phone referral. Appointment Must be scheduled to occur within 7 days of hospital discharge.
4. 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. 7/24/24: C/CD to re-educate clerical on the “on call” process by 8/2/24.
5. 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. 7/24/24: C/CD to re-educate clerical on the “on call” process by 8/2/24.
6. **1/31/25 (Added): Designated clerical contacts all referrals scheduled the following day to confirm appointments. Clerical ensures all paperwork is completed at this time.**
7. **Appointments with confirmed with complete paperwork are kept.**
8. **Appointments not confirmed, with incomplete paperwork, are cancelled and the slot is filled.**
9. **Appointments not confirmed with complete paperwork are given until 3:00 pm to confirm. If not confirmed, appointment is rescheduled.**
10. **Appointments confirmed with incomplete paperwork are given until 3:00 pm to complete unless the member commits to going to the office to complete paperwork 30 minutes before scheduled appointment. If not complete, appointment is rescheduled.**
11. MHP schedules should reflect at least 5 routine, consistent slots ongoing for intakes. Schedules are not to be edited unless approval received from C/CD. **1/31/25: Designated LMHP completes 3 assessments per day, 15 assessments per week via telehealth. 2 LMHPs are available to complete in-person assessments each week per member request.**
12. Referral Spreadsheet and LMHP schedules will be monitored to track this procedure.
13. 7/23/24: C/CD will re-educate clerical on procedures and problem-solve barriers to meeting the goal; 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 July 1,2024-December 31,2024.  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 H2 2024

**FINDINGS:**

From July 1, 2024 – December 31, 2024

Number of claims- 20,329 (18,916 in H1)

Of the 20,329 claims, 19,253 were clean claims (H1: 12,519). 1076 claims were denied (H1 : 6,397).

95% of the claims were clean claims, which is 29% more claims than the H1 average of 66%.

**Threshold was met.**

Of the 951 claims listed on the Aging (by date) report, 681 claims (H1: 6,397), or 72%, were less than 120 days old. This is down from the H1 average of 91%. Target of 80% was not met.

**EXTENUATING/INFLUENCING FACTORS/TRENDS:** Change Healthcare Cyber-attack created significant problems leading to halt in accounts receivable as well as halt in successful processing of claims through a clearing house.  To resolve these barriers to successful claims submission, RMS was forced to change clearing houses.  This process took greater than 6 weeks to resolve.  During this time period from February to April, there were numerous challenges with rejected batches and claim errors.  CEO conducted a thorough review of the billing department which led to the changes in the billing team.

**Threshold not met.**

**PERFORMANCE IMPROVEMENT PLAN INTERVENTION(S**):

1. Work necessary OT to catch up denials to 120 days old. Tag team denials with billing coordinator, billing assistant and administrative support staff to accomplish this task. 7/23/24: Billing Coordinator position eliminated; billing team is working on this task. **1/31/25: Billing team, lead by CEO, has been successful in working claims timely.**
2. Billing assistant to dedicate 6 hours a day to denials documenting interventions and dates to resolve claim issues. 7/25/24: Changes to the billing team occurred. Billing coordinator position eliminated. CEO taking active role in billing department. Change in responsibilities occurred.  Two billing team members make up the billing team and their sole purpose is to work denied claims.
3. No write offs unless approved by CEO. All avenues to be exhausted to receive reimbursement.
4. Billing coordinator to work with Carelogic staff, commercial and MCO liaisons to resolve any barriers to clean claims. 7/25/24: Billing Coordinator position eliminated; billing team designee is working on this task. CEO and Administrative Manager have met with all liaisons of MCOs to bring rosters up to date. All MCOs have been notified of change in staff and contact information.
5. Outstanding Balances spreadsheet to be generated by Billing Coordinator every Friday and sent to CEO. 7/25/24: Billing Coordinator position eliminated; billing team designee is working on this task. Outstanding balances spreadsheet was not accurate as a result of former Billing Coordinator failing to post payments. CEO has re-educated billing team staff on procedure to rectify the issue and will be followed during the next half of year. CEO educated Billing team on reports.
6. Billing Coordinator to run end of month reports such as All Claims by Payor Report which depicts aged claims and % of billed claims that were paid versus denied; to be sent to CEO by week 1 of the following month. 7/25/24: Billing Coordinator position eliminated; billing team designee is working on this task. This was not being done but will be followed during second half of year. CEO educated Billing team on reports.
7. 7/25/24 (added): CEO to conduct weekly billing team meeting and issue assignments.
8. 7/25/24 (added): Billing team to generate a daily productivity report to CEO.

**STAFF RESPONSIBLE FOR INTERVENTION(S):** CEO, Billing team

**DUE DATE FOR INTERVENTION(S):** Ongoing

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

***A. LEAD MENTORSHIP PROGRAM***

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

**PERFORMANCE INDICATOR:** Expired Services report show a decrease in service units not provided and utilization report indicates an increase in frequency of services overall compared to 2023 year.

**THRESHOLD**: Expired Services report show a decrease in service units not provided and utilization report indicates an increase in frequency of services overall compared to 2023 year.

**METHOD OF REVIEW:** Review of Expired Services Report and Utilization Report.

**SIGNIFICANT FUNCTIONS:** Improve quality of care and promote mental stability with consistent delivery of PSR/CPST services.

**ANALYSIS**: Members are not receiving all approved services; RMS is losing revenue due to expired services. Problem-solving strategies listed in “Interventions” should be monitored weekly by LMHPs and C/CD. Employees are not working hours hired to work; employees are not serving members at expected frequency; understaff of CPST Providers.

**FINDINGS:**

**Expired Services**

**Lake Charles**: H2 2024 expired services = $163,171.43 (H1 = $150,008.62)

**Jennings:** H2 2024 expired services = $194,554.57 (H1 = $103,012.75)

**Lafayette:** H2 2024 expired services = $ 151,439.52 (H1= $72,193.81)

**Agency-wide:** H2 2024 expired services = $509,165.52 (H1 = $325,215.18), average of $84,860.92 (H1= $54,202.53) per month (2023 expired services = $1,295.987.41, average of $107,991.45 per month), which is a decrease in average expired services compared to 2023.

**Utilization**

**Lake Charles**: An average of 60% of members (H1: 82%) received services at the expected frequency, failing to meet the expectation of 70%.

**Jennings:** An average of 58% of members (H1: 76%) received services at the expected frequency, failing to meet the expectation of 70%.

**Lafayette:** An average of 66% of members (H1: 78%) received services at the expected frequency, failing to meet the expectation of 70%.

**Agency**-**wide**: H2 2024 Utilization Reports indicate an average of 61% of members (H1: 93%) received services at the expected frequency, which is a decrease in frequency of services to members compared to the 2023 average frequency of 68%.

**EXTENUATING/INFLUENCING FACTORS/TRENDS:** Staff not utilizing all authorized services, causing members to not receive all services requested and authorized; and causing RMS to lose revenue due to expired services. CPST provider turnover and staff shortages continued in the 2nd half of 2024 and resulted in large CPST caseloads for members who were receiving PSR services. Expected CPST frequency is below expectations due to workforce shortage as well as members’ reluctancy to engage with her CPST providers. **1/31/25: Clerical turnover and lack of knowledge of reports has likely lead to skewed frequency.**

**Expired Services threshold was met, while Utilization threshold was not met.**

**PERFORMANCE IMPROVEMENT PLAN INTERVENTION(S**):

1. Direct service team lead will monitor daily the service delivery tools/spreadsheets like time sheets, expired services report, utilization of services report, etc to identify employees with challenges hindering positive outcomes. Lead will reach out to those employees and provide the additional training and support to resolve matter and enhance performance. **7/23/24: Direct service team lead position has been eliminated. C/CD monitors reports and reaches out to staff as needed. Peer Mentor continues to work with new staff members. 1/31/25: Peer Mentor position eliminated; C/CD & LMHPs monitor reports and coordinate with staff re: frequency and expired units.**
2. Clerical lead will monitor daily the clinical spreadsheets like referrals, 10-day report, hospital tracker, PA tracker etc to identify breakdown in established systems and protocols. Lead will reach out to clerical or clinical staff upon findings to provide the additional education, guidance, and support to accomplish deadlines and promote improved communication. 7/23/24: Direct service team lead position has been eliminated. C/CD monitors reports and reaches out to staff as needed. C/CD provides monthly supervision to Lafayette and Jennings staff; Lake Charles LMHP provides supervision to Lake Charles staff. Clerical designees monitor trackers and report breakdowns in systems and protocols. C/CD and LMHP reach out to staff to provide support and guidance as needed. **1/31/25: Clerical designee position eliminated. Clerical re-education is ongoing in order to ensure understanding and accuracy of reports.**
3. 7/24/24: C/CD has begun weekly meetings with new CPST providers. **1/31/25: CCD meets weekly with those staff who have a frequency not met of 8 or more members for the month.**
4. Any resistance or continued poor performance should be reported to the CD for immediate follow up and counsel.
5. 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.

**STAFF RESPONSIBLE FOR INTERVENTION(S):** Medical Director, Clinical / Compliance Director, LMHPs, Peer Mentor, MHS/MHPs

**DUE DATE FOR INTERVENTION(S):** Ongoing