Provider QA Review Process by the Quality Assurance Unit

The Los Angeles County Department of Mental Health (LACDMH) Quality, Outcomes and Training Division's Quality Assurance (QA) Unit conducts reviews of its Directly Operated (DO) and contracted Legal Entity (LE) Providers. Once focused almost exclusively on monitoring adherence to Medi-Cal's technical regulations, the scope of the reviews will expand starting in January 2024 to include other important aspects of service provision including the efficient and effective use of services and timely access to care. This expansion will be incremental and is consistent with shifting priorities at the State level under California Advancing and Innovating Medi-Cal (CalAIM), namely a reinvigorated focus on clinical care in relation to administrative requirements (QA Bulletin 23-02). However, despite these changes, the goal of the reviews remains the same – to support the Department's mission to provide high quality Medi-Cal Specialty Mental Health Services (SMHS) to the residents of the County. And as before, the reviews are strongly oriented toward evaluating Providers for the purpose of determining the best areas in which to focus assistance. Although not the focus of the review, non-compliance with documentation or claiming requirements may result in the need to void claims.

Providers are reviewed according to a schedule set by the QA Unit. When deciding which providers to review, factors taken into consideration include: 1) time since last review, 2) performance in last review, and 3) data analysis and other issues brought to the attention of the QA Unit. The QA Unit reserves the right to adjust the review schedule as necessary. For DOs, all Provider Sites (i.e., individual Provider Numbers) under the identified program manager are reviewed. For LEs, all Provider Sites under the LE are reviewed. Those Providers selected for review are notified in advance, provided direction, and the review is coordinated between all participants.

Each review includes:
1. An analysis of data reports to determine service efficiency and effectiveness and adherence to Medi-Cal requirements. Data reviewed includes access to care timeliness, staffing adequacy, utilization of services, and service effectiveness as determined by certain outcome measures.
2. A pre-chart review data discussion to allow the QA Unit and Provider to share observations and information related to the data analysis (including the Provider's own internal data). Topics include service usage and pattern, workflow, care coordination, and screener and transition tool usage.
3. A chart review of clinical documentation to determine quality of services and adherence to Medi-Cal requirements. Documentation reviewed includes assessments and other evaluative tools (e.g., NET/CANS), progress notes, problem lists, and when needed medication consents, supplemental assessments (e.g., for IHBS, TBS, TFC), and other program/service-specific requirements.
4. A post-review discussion between the QA Unit and Provider on findings and observations from the data and chart reviews.
5. A Final Summary Report.
6. Follow up by the QA Unit to ensure all action items based on the review are completed and recommendations implemented as appropriate. The follow up may include an optional Plan of Support Meeting. This meeting provides an opportunity for the Provider and QA Unit to discuss the status of implementing the recommendations outlined in the Final Summary Report, coordinate details of any assistance to be provided by the QA Unit, and identify any needed additional support tailored to the Provider's needs. Topics of discussion may include consultation, training, and follow-up reviews.