In the Colorado Access Provider Manual, you will find information about:

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Quality Management

The philosophy of the Colorado Access Quality Assessment and Performance Improvement (QAPI) program is to ensure that members receive access to high quality care and services in an appropriate, comprehensive, and coordinated manner that meets or exceeds community standards. Emphasis is placed on community-based, individualized, culturally sensitive services designed to enhance self-management and shared decision making between members, their families, and Providers. The Colorado Access QAPI program promotes objectives and systematic measurement, monitoring, and evaluation of services and work processes and implements quality improvement activities based upon the outcomes. The QAPI program uses a continuous measurement and feedback paradigm with equal emphasis on internal and external services affecting the access, appropriateness, and outcomes of care. Performance is measured against specific standards and analyzed to detect trends or patterns that indicate both successes and areas that may need improvement.

Activities associated with the QAPI program focus on the following:

- Accessibility and availability of services
- Overutilization and underutilization of services
- Member experience of care
- Quality, safety, and appropriateness of care
- Clinical outcomes and performance measurement
- Service monitoring
- Clinical practice guidelines and evidence-based practices
- Care management

The operation of a comprehensive, integrated program requires all participating primary care Providers, medical groups, specialty Providers, and other contracted ancillary Providers to actively monitor quality of care. The results of program initiatives and studies are used in planning improvements in operational systems and clinical services. Information about the QAPI program and summaries of activities and results are available to Providers and members upon request. Information is also published in provider and member bulletins/newsletters.

MEMBER SATISFACTION

We partner with the Colorado Department of Health Care Policy and Financing and the Health Services Advisory Group to administer several satisfaction surveys throughout the year, including:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey

- The Experience of Care and Health Outcomes (ECHO) survey for behavioral health services

Member satisfaction with quality of care and services is assessed utilizing a combination of approaches and data sources. This includes: member surveys, anecdotal information, call center data, and grievance and appeals data. The CAHPS survey, for CHP+ and RAE members, and the ECHO survey, for behavioral health, are conducted annually, and administered by the Colorado Department of Health Care Policy and Financing (HCPF). Both are designed to evaluate member perception of services received from the health plan and to evaluate performance of network physicians and providers in the delivery of care and service to the membership. Survey data is used for continuous quality improvement by establishing benchmarks and/or goals for performance and assessing overall levels of satisfaction as an indication of whether the plan is meeting member expectations. These surveys are typically administered January through April. Please encourage your clients/patients to complete any satisfaction surveys they receive, either by mail or phone.

ACCESSIBILITY AND AVAILABILITY OF SERVICES

Excessive wait time for appointments is a major cause of member dissatisfaction with the health care Provider and health plan; therefore it is crucial that all Colorado Access network Providers adhere to state and federal standards for appointment availability. If you are unable to provide an appointment within the required timeframes, please refer the member to the Colorado Access customer service department for assistance in finding member services within the required timeframes.

Physical Heath Appointment Standards	
Type of Care	**Standard**
Routine care (non-symptomatic, well care physical exam, preventive care)	Scheduled within 4 weeks of request
Non-urgent care (symptomatic)	Scheduled within 1 week of request
Urgent care	Scheduled within 24 hours of request
Behavioral Health Appointment Standards	
Type of Care	**Standard**
Routine care (non-urgent, symptomatic behavioral health services)	Within 7 days of member's request
Urgent care	Within 24 hours of initial contact by member
Emergency services (face-to-face)	Urban/suburban: within 1 hour of contact Rural/frontier: within 2 hours of contact
Emergency services (phone)	Within 15 minutes of initial contact
Outpatient follow-up appointments after hospital (behavioral health & physical health)	Within 7 days after discharge from a hospitalization

We monitor Provider compliance with appointment standards through a variety of mechanisms, including (but not limited to):

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

- Experience of Care and Health Outcomes (ECHO) survey
- Member grievance monitoring
- Secret shopper evaluation of appointment availability
- Provider self-reported appointment availability

PATIENT RECORD DOCUMENTATION

Providers are responsible for maintaining confidential medical records that are current, detailed, organized, and that promote continuity of care for each patient. Well-documented records facilitate communication, coordination, continuity of care, and effective treatment. Our patient records standards are based on state and federal requirements, Office of Behavioral Health standards, the Uniform Service Coding Standards Manual, and NCQA guidelines for medical record documentation. We may perform patient record audits/chart reviews to assure compliance with these standards.

At a minimum, providers must maintain records that shall include the following information:

1. The enrollee's name, identification number, date of birth, gender and place of residence;
2. Services delivered, including when, where and by whom services were provided; and
3. Medical diagnoses, treatments and therapies prescribed, medications administered or prescribed, referrals and follow-up arrangements.

ADDITIONAL BEHAVIORAL HEALTH DOCUMENTATION STANDARDS AUDIT MEASURES

Providers billing behavioral health service codes, including fee for service, need to review the Uniform Service Coding Standards Manual for information on billing practices and are subject to behavioral health documentation audits.

General Documentation	
	Client full name listed on each document within record
	Identification and demographic data shall be documented
	Medical record is legible
	Authorizations are signed as applicable
Assessment Components	
	Date of services is included in the chart
	Place of service is present
	Mode of treatment is present (mode of delivery of service)
	Provider’s signature, degree, and position/title are present for each service
	Assessment timeliness
	Assessment updates are present when there is a change in the person’s level of care or functioning, or every six months
	Chief complaint/Problem statement and readiness for treatment are documented

	Client strengths, skills, abilities, and interests are documented
	Barriers to treatment are present
	Complete psychosocial history is documented (social history)
	Psychiatric/Mental health history is documented
	History of psychiatric hospitalization is documented (if applicable)
	Medical history is documented
	Complete mental status evaluation is documented
	Substance abuse history is documented
	Suicide question is documented
	Formal risk assessment/screen is present
	Safety plan/Crisis plan is present if applicable
	Behavioral health diagnoses with supporting evidence is documented
	Readiness for treatment/Admissions summary statement is present
	Plan for next contact(s) including any follow up or coordination needed with third parties and disposition to prevent a duplication of activities
Treatment Plan Components	
	Timeliness of treatment plan documentation/completion
	Treatment plan includes mechanism for monitoring or revising the treatment plan annually or as needed
	Treatment plan is individualized
	Treatment plan is culturally sensitive
	Treatment plan is strength based
	Treatment goals are specific, objective, and realistic
	Treatment goals are measurable
	Treatment interventions include specific types and frequency of services
	Evidence that the client participated in the treatment plan development
	Provider's signature, degree, and position are present
	Date of services is included in the chart
	Start and end time/duration of service is included
	Place of service is present
	Mode of treatment is present
Progress Summary	
	Medical record is legible
	Dates of service are present
	Start/end time and duration of session is present
	Place of service is present
	Mode of treatment is present
	Provider's signature is present with their credentials, title, and position
	All individual progress summary forms from the current clinician are saved final
	Note refers to the goals and objectives from the current treatment plan being address in that session

	Includes the clinical intervention (modality that supports service provided)
	Client's response to intervention
	Progress toward goal is described in each note
	Notes address needs such as medical, dental or substance use disorder with referral to additional services as needed
	Notes address suicide risk as needed until risk is resolved
	Interpretation when needed is documented in session note
	Evidence present of outreach to clients who no show for appointments or drop out of services
Case Management Note	
	Client full name listed in record
	Medical record is legible
	Dates of service are present
	Start/End time and duration of session is present
	Place of service is present
	Mode of treatment is present
	Provider's signature is present with their credentials, title, and position
	The reason for the visit/call is listed
	Description of services provided is present
	Individual's response to the services is present
	Notes indicate how the service impacted the individual's progress toward goals/objectives
	Notes indicate plan for next contact(s), including any follow up or coordination needed with third parties

QUALITY OF CARE CONCERNS AND CRITICAL INCIDENTS

A quality of care concern is a complaint made regarding a provider's competence or care that could adversely affect the health or welfare of a member. Examples include prescribing a member the wrong medication or discharging them prematurely.

A critical incident is defined as a patient safety event not primarily related to the natural course of the patient's illness or condition that reaches a patient, and results in death, permanent harm, or severe temporary harm. Examples include a suicide attempt requiring prolonged and exceptional medical intervention, and being operated on the wrong side or the wrong site.

You must report any potential quality of care concerns and critical incidents that you identify during a course of treatment of a member. The identity of any provider reporting a potential concern or incident is confidential.

A Colorado Access medical director will review each concern/incident and score them based on the level of risk/harm to the patient. A facility might receive a call or letter about the incident that includes education about best practices; a formal corrective action plan; or could be terminated from our network. To report a quality of care concern or critical incident, fill out the form located online at coaccess.com/providers/forms and email it to qoc@coaccess.com.

Please note that reporting any potential quality of care concerns or critical incidents is in addition to any mandatory reporting of critical incidents or child abuse reporting as required by law or applicable rules and regulations. Please refer to your provider agreement for details. If you have any questions, please email goc@coaccess.com.

CLINICAL PRACTICE GUIDELINES

We use current, evidence-based, nationally recognized resources for standards of care when evaluating and adopting clinical practice guidelines. All approved clinical practice guidelines are available to Providers and members on our website at coaccess.com. Copies of the approved clinical practice guidelines are also available upon request.