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

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Section 3. Quality Management

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You can search quickly and easily by using the command Control+F. This will display a search box for you to enter what you want to find.

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.

The scope of the QAPI program includes but is not limited to the following elements of care and service:

- Accessibility and availability of services
- Over- and under-utilization of services
- Member satisfaction and experience of care
- Quality, safety, and appropriateness of clinical care
- Clinical outcomes and performance measurement
- Service monitoring
- Clinical practice guidelines and evidence-based practices
- Care management
- Performance improvement projects

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 (HCPF) and the Health Services Advisory Group (HSAG) to administer several satisfaction surveys throughout the year, including:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey for CHP+
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Centered Medical Home (PCMDH) 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, including: member surveys, anecdotal information, call center data, and grievance and appeals data. The CAHPS and ECHO surveys are conducted annually by HCPF and HSAG, who work with a third-party survey vendor, DataStat, to administer the survey and collect the data. Both are designed to evaluate member perception of services received from the health plan and evaluate performance of network physicians and providers in the delivery of care to members. 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 May. These surveys provide valuable information on member experience of health care. If inquired, please educate members on the importance of completing this survey and reiterate the value of getting members voices heard.

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.

ACCESS TO CARE STANDARDS

Physical and Behavioral Health	
Type of Care	**Timeliness Standard**
Urgent	Within 24 hours of initial contact/request* **Exception for CHP+ when member is temporarily absent from service area*
Outpatient follow-up after hospitalization	Within 7 days after discharge
Non-urgent, symptomatic* **For behavioral health, cannot consider administrative or group intake processes as a treatment appointment or place members on waiting lists for initial requests*	Within 7 days of request
Physical Health Only	
Type of Care	**Timeliness Standard**
Emergency	24/7

Routine (non-symptomatic well-care physical examinations, preventive care)* **For CHP+, also applies to "non-emergent, non-urgent medical problems" except for regularly scheduled visits to monitor a chronic medical condition if schedule calls for visits less frequently than once every 30 days*	Within 1 month of request*, unless required sooner by AAP Bright Futures schedule **30 calendar days for CHP+*
Behavioral Health Only	
Type of Care	**Timeliness Standard**
Emergency (by phone)	Within 15 minutes after initial contact
Emergency (in-person)	Urban/suburban areas: within 1 hour of contact Rural/frontier areas: within 2 hours of contact

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

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 (OBH) standards, the Uniform Service Coding Standards (USCS) Manual, and National Committee for Quality Assurance (NCQA) guidelines for medical record documentation. We may perform patient record audits/chart reviews to assure compliance with these standards.

Providers billing behavioral health service codes need to review the USCS Manual for technical documentation requirements and information on correct billing guidelines. Providers are subject to behavioral health documentation audits.

Behavioral Health Documentation Standards
General Documentation Requirements
Each page contains client name/ID number.
Identification and demographic data shall be documented including, but not limited to: address, phone number, emergency contact, school, employment, ethnicity, race, gender, language preference, marital status, legal status, guardianship if relevant
Medical record is legible

Each entry must be signed, credentialed, and dated
Authorizations signed as applicable
Assessment Requirements (90791 & 90792)
Date of service
Start and end time of service
Place of service
Mode of treatment (i.e. face-to-face, telehealth, etc)
Provider's dated signature and relevant qualifying credential. A title should be included where no credential is held.
Assessment timeliness: A comprehensive evidence-based or best practices assessment shall be completed as soon as is reasonable upon admission and no later than seven business days of admission into services
Assessment updates: Assessment is reviewed and updated when there is a change in the person's level of care or functioning, or at minimum, every 6 months
Chief complaint/problem statement
Client strengths, skills, abilities, interests
Barriers to treatment
Complete psychosocial history (social history) including but not limited to: Interpersonal/family relationships, current risk areas, educational/employment history, developmental needs for child members, legal issues, trauma (for children/adolescents, additional requirement includes an evaluation of family/social/environmental challenges that may pertain to the youth's treatment)
Psychiatric/mental health history including but not limited to: Screening for mental illness, screening for trauma, previous diagnoses, previous treatment/response to treatment, family history of mental illness, special health care needs
History of psychiatric hospitalization including but not limited to: Any prior psychiatric hospitalizations, including involuntary treatment/hospitalization
Medical history
Complete mental status evaluation (MSE)
Substance abuse history, including current and previous substance use/abuse/dependence and previous treatment/response to treatment
Suicide question
Homicide question
Formal risk assessment/screen
Safety plan/crisis plan
Behavioral health diagnoses supported by evidence in the assessment, prove medical necessity, and reflect a currently approved ICD and/or DSM diagnosis
Readiness for treatment /admissions summary statement including a final summary statement next steps for treatment/referral

Plan for next contact(s) including any follow-up or coordination needed with 3rd parties and disposition to prevent a duplication of activities
Treatment Plan Requirements
Timeliness of treatment plan completion: As soon as is reasonable after admission and no later than 14 business days after the assessment (for outpatient)
Treatment plan updates: Treatment plan is reviewed and updated when there is a change in the person's level of care or functioning, or at minimum, every 6 months
Treatment plan is individualized
Treatment plan culturally sensitive and reflect findings of a cultural assessment, including but not limited to: Gender appropriate, sexual, orientation, socio-economic status, ethnicity, personal values, level of acculturation and/or assimilation, spirituality, linguistics, age, family systems, interpretation of trauma, coping skills
Treatment plan is strength-based and includes individualized interventions that utilize the clients' interests, abilities, and supports to improve or maintain their level of functioning
Treatment goals are specific, objective, and realistic
Treatment goals are measurable and articulate a measure in time, symptom, severity, duration, and/or frequency
Treatment interventions include specific types and frequency of services
Client participation in treatment plan: All parties (the individual, legal guardian, interdisciplinary team members, etc.) who participate in the development shall sign the treatment plan
Provider's dated signature and relevant qualifying credential. A title should be included where no credential is held
Case Management Requirements (T1017, H0006)
Client name/ID number
Medical record is legible
Date of service
Start and end time of service
Mode of treatment (i.e. face-to-face, telehealth, etc.)
Provider's dated signature and relevant qualifying credential. A title should be included where no credential is held.
The reason for the visit/call
Description of services provided
Individual's response to the services
Notes indicate how the service impacted the individual's progress towards goals/objectives
Notes indicate plan for next contact(s), including any follow-up or coordination needed with third parties
Progress Summary Requirements (90832-90838)

Date of service
Start and end time of service
Place of service
Mode of treatment (i.e. face-to-face, telehealth, etc.)
Provider's dated signature and relevant qualifying credential. A title should be included where no credential is held.
All individual progress summary forms from current clinician are saved final and completed timely no later than seven business days after the therapy
Note refers to the goals and objectives from the current treatment plan being addressed in that session
Includes the clinical intervention (modality that supports service provided)
Client's response to intervention
Progress towards goal is described in each note
Notes address needs such as medical, dental or SUD prn 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 service

QUALITY OF CARE CONCERNS AND CRITICAL INCIDENTS

A quality of care concern is a complaint made regarding a provider's competence, conduct, and/or care provided that could adversely affect the health or welfare of a member. Examples include, but are not limited to, 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. Critical incidents are subject to mandatory reporting under Colorado law as well as your Provider Agreement. Examples include, but are not limited to, a suicide attempt requiring prolonged and exceptional medical intervention and being operated on the wrong side or 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. Quality of care concerns and critical incidents can be reported by filling out the form located online at coaccess.com/providers/forms/ and emailing it to qoc@coaccess.com.

Please note that the reporting of 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 you provider agreement for details. If you have additional questions, please email qoc@coaccess.com.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/providers/resources/quality/. Clinical practice guidelines are identified and reviewed by medical professionals. Copies of the approved clinical practice guidelines are also available upon request, free of charge.