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

Search Tip:
You can search quickly and easily by clicking on the binoculars icon on your toolbar, or by using the command Control+Shift+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
- Member satisfaction
- Quality, safety, and appropriateness of clinical care
- Clinical outcomes
- Performance improvement projects
- Service monitoring
- Clinical practice guidelines and evidence-based practices

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 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Centered Medical Home survey
- The Experience of Care and Health Outcomes (ECHO) survey for behavioral health services

Member feedback about their health care services is a critical component to the overall success of the health care system. 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	Within 7 business days of initial contact
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
Follow-up care after discharge from a hospital or ATU	Scheduled within 7 day after an inpatient discharge

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, and organized, and that promote continuity of care for each patient. Well-documented records facilitate communication, coordination and continuity of care, and effective treatment. Our patient records standards are based on state and federal requirements, 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.

Medical/Physical Health Record Requirements	
Administrative/Demographic Requirements	**Source**
Each page contains client name/ID number.	NCQA
Each record includes client address, employer/school, telephone number (including emergency contact), marital and legal status, guardian information (if relevant).	NCQA
All entries are dated and include author's identification.	NCQA
Record is legible to someone other than the writer.	NCQA
Clinical Information	**Source**
Significant illnesses and medical conditions are indicated on the problem list.	NCQA
Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is noted.	NCQA
Past medical history is easily identified and includes: serious accidents, operations, and illnesses. For children and adolescents (ages 0 – 18), past medical history relates to prenatal care, birth, operations, and childhood illnesses.	NCQA
For patients age 12+, there is appropriate notation concerning the history and current use of cigarettes, alcohol, and substances.	NCQA
The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.	NCQA
Laboratory and other studies are ordered, as appropriate.	NCQA
Working diagnoses are consistent with findings	NCQA
Treatment plans are consistent with diagnoses	NCQA
Encounter forms or notes have a notation regarding follow-up care, calls, or visits when indicated. The specific time of return is noted in weeks, months, or as needed.	NCQA
Unresolved problems from previous office visits are addressed in subsequent visits.	NCQA
If a consultation is requested, there is a note from the consultant in the record.	NCQA
Consultation, laboratory, and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. Review and signature by professionals other than the ordering practitioner do not meet this	NCQA

requirement. If the reports are presented electronically or by some other method, there is also presentation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging results have an explicit notation in the record of follow-up plans.	
An immunization record (for children) is up-to-date or an appropriate history has been made in the medical records (for adults)	NCQA
There is evidence that preventive screening and services are offered in accordance with Colorado Access practice guidelines.	NCQA
Behavioral Health Record Requirements	
Administrative/Demographic Requirements	**Source**
Each page contains client name/ID number	NCQA
Each record includes client address, employer/school, phone number (including emergency contact), marital and legal status, guardian information (if relevant)	NCQA
All entries are dated and include responsible clinician's name and professional degree	USCS Manual
Record is legible to someone other than the writer	NCQA
Informed consent forms are signed by client or guardian	NCQA
Professional disclosure statement (for primary clinician, at minimum) is signed by client or guardian; includes clear explanation of practitioner's name, highest degree, state license (if applicable), supervisor (if applicable), and the provider agency/institution. Not applicable to MDs and nurses.	CRS 12-43-214
Client is provided information on member rights, grievances and appeals, available services.	HCPF Contract
Any information about the client's advance directive, or evidence of provider advice on advance directives (for clients 18+).	CRS 15-14-505(2)
Intake and Assessment	**Source**
Chief complaint/presenting problem and the history/duration of the problem.	NCQA
Complete psychosocial history, including: interpersonal/family relationships, cultural and linguistic factors, educational/employment history, and developmental needs.	42 CFS 438.208(c)(2)
Complete psychiatric/mental health history, including: screening for mental illness, screening for trauma, any previous diagnoses, previous treatment episodes and response to treatment, family history of mental health issues.	NCQA, 42 CFR 438.208(c)(2)
Medical history, including: current medical issues, medical history, allergies, and/or one or more of the following: ROI for PCP, referral to PCP, request for EPSDT services.	42 CFR 441.50 - 441.62
Complete mental status exam, including: presentation/appearance/speech, mood and affect, intellectual functioning, thought processes and content, attention/concentration, memory, impulse control, judgement and insight (not required for codes H0001 or H0031).	NCQA

Substance use history, including: screening for substance use/abuse/dependence of cigarettes, alcohol, illicit and over-the-counter drugs, previous treatment episodes, and response to treatment.	NCQA, 42 CFR 438.208(c)(2)
Safety and risk assessment, including: suicide/self-harm, violence/homicide, and the resulting crisis plan (or documentation that crisis plan not needed).	NCQA
Complete diagnoses are documented and are consistent with data from the assessment	NCQA
Treatment Plan	**Source**
A current treatment plan based on information gathered in the client's assessment.	42 CFR 438.208
Treatment plan is individualized, strength-based, and culturally sensitive	42 CFR 438.208
Treatment plan goals are specific, objective, and measurable.	42 CFR 438.208
Treatment plan includes specific strategies/service types and frequency of services planned. All treatment services being received are included in the treatment plan.	42 CFR 438.208(c)(3)
Treatment plan includes process for monitoring and revising plan as appropriate. Treatment plans are reviewed/revised annually or if there is a change in needs or functioning.	42 CFR 438.208(c)(3)
Treatment plan is developed by the member/guardian and the provider/treatment team. Treatment plan is signed by member and the reviewing professional (or includes documentation of the member's reason for not signing treatment plan).	42 CFR 438.208(c)(3)

Behavioral Health Record Documentation in an Integrated Care Setting

Seeing members in an integrated care setting may present specific challenges in chart documentation efforts. All behavioral health record requirements listed above still apply. It is both anticipated and expected that documentation may be briefer and that requirements given for the intake and assessment may be noted as "not applicable" if the issue or history is not relevant to the issue being addressed in the integrated care setting. However, it should be noted that all requirements must still be present in the documentation and completed, even if completed with "not applicable" or a very brief summary. The treatment plan portion of the above listed requirements may also look different in an integrated care setting. If the client is not seeking ongoing services, then a treatment plan is not required. If the client is seeking ongoing services, the treatment plan may be included in the overall assessment in narrative format, or can be completed at the following session.

For example, it may be presented in the narrative as follows:

- **Treatment goals:** Brief clinical assessment and therapy to address <insert primary issues>
- **Patient strengths and cultural needs:** <insert patient strengths and cultural considerations or state that there are none that the patient reports>

- **Treatment objectives:** <insert brief personalized, specific and measurable objectives>
- **Planned frequency of contact:** <insert how often therapy will occur>
- **Estimated length of treatment:** six sessions
- **Individual coordinating care:** <insert PCP or other coordinating staff in the integrated care setting>
- **Comments:** <list all services being provided, services patient has declined, or other clinical impressions, treatment strategies, etc.>
- **Patient agrees to plan:** <insert patient's agreement with plan>
- **Next scheduled session (treatment plan to be reviewed):** <insert next scheduled session with the patient>

QUALITY OF CARE CONCERNS AND CRITICAL INCIDENTS

A quality of care concern is any concern regarding the professional competence and/or conduct of a Provider, which could adversely affect the health or welfare of a member. Any potential quality of care concerns that you identify during a course of treatment of a member must be reported to us by you as the Provider. The identity of any Provider reporting a potential quality of care concern is confidential. Quality of care concerns can be reported by filling out the Quality of Care Notification form located online at coaccess.com/frequently-used-forms and emailing it to qoc@coaccess.com. Please note that the reporting of any potential qualify of care concerns is in addition to any mandatory reporting of critical incidents (defined below) or child abuse as required by law or applicable rules and regulations.

Critical Incidents and Critical Errors are subject to mandatory reporting under Colorado law as well as your Provider Agreement. "Critical Incident" is 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. The Quality of Care Notification form is the mechanism for the Provider or Colorado Access staff member to complete an event report for critical incidents. "Critical Error" means a failure of a planned action to be completed as intended. Errors are unintended, undesirable, and result from a defect or failure of a diagnostic, therapeutic, or supportive process, at any point in the continuum of care. Errors may be either human or technological. An error may or may not have a negative outcome. Errors may be acts of commission or omission. Errors shall be reported by using the Quality of Care Notification form if they:

- Require a significant change in further diagnosis or treatment;
- Lead to initial or prolonged hospitalization;
- Are life threatening;
- Result in disability, death, significant cognitive impairment, or congenital abnormality.

CLINICAL PRACTICE GUIDELINES

We use current, evidence-based, nationally recognized resources for standards of care when evaluating and adopting clinical practice guidelines. The Colorado Access Quality and Performance Advisory Committee (QPAC), comprised of network Providers and community partners, reviews the clinical practice guidelines on an annual basis for possible updates and revisions. 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.