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If you have any questions, call us at 800-511-5010 (toll free).

colorado access

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, behavioral health providers, substance use 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 on the Colorado Access website. Information is also published in provider and member bulletins/newsletters.

Providers with results from activities in the QAPI program that are found to not meet Colorado Access quality standards will receive further communication from the quality department about areas of deficiency and remediation opportunities.

Colorado Access quality department supports and promotes correcting any deficiencies using SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) interventions. Colorado Access will review provider materials submitted through a remediation process and give feedback on interventions based on how likely the actions are to offer long-term solutions to the deficient areas. The Colorado Access quality department may conduct additional QAPI program activities after remediation actions and discussion to assess improvement effectiveness and ensure enhancements have been sustained.

MEMBER SATISFACTION

In addition to administering an internal member satisfaction survey in collaboration with the customer service department, Colorado Access also partners 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+ members
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey for Health First Colorado members

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 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. Results from these surveys shared with providers are intended to promote quality improvement within provider practices. CAHPS survey results can be found at hcpf.colorado.gov/client-satisfaction-surveys-cahps.

If inquired, please educate members on the importance of completing member satisfaction surveys and reiterate the value of getting members' voices heard. These surveys provide valuable information on member experience of health care. Colorado Access uses member satisfaction survey results to identify and implement improvement projects within the network.

In addition to the CAHPS survey, Colorado Access also conducts a member satisfaction survey to solicit actionable member feedback on their experience of care. Survey results provide Colorado Access with a valuable opportunity to hear feedback from members and understand their experience in a timely manner. Survey responses are used to improve how Colorado Access interacts with and advocates for members by understanding their experience and satisfaction of care. Member satisfaction survey results are published in the provider newsletter.

ACCESSIBILITY AND AVAILABILITY OF SERVICES

Excessive wait time for appointments is a major cause of member dissatisfaction with health care providers; therefore, it is crucial that all Colorado Access network providers follow contractual 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 at 800-511-5010 for assistance in finding member services within the required timeframes.

Providers must have an adequate phone system that allows members to connect with live representatives for treatment inquiries.

- Members must not wait on hold for longer than 15 minutes to speak with a representative at a provider's office.
- Providers must also have a voicemail system or another method to track calls received so that members are getting the communication needed to secure appointments. Calls must be returned to members within one to two business days.
- Voicemails for provider practices must clearly identify the provider reached and provide the member with information on after-hours coverage. Providers' voicemails should also provide information on how members can seek emergency services.
- Providers who serve Health First Colorado or CHP+ members shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees.

Providers are encouraged to offer flexible appointment times or after regular business hours' appointments to members whenever possible. Federal regulations prohibit discrimination against Health First Colorado and CHP+ beneficiaries. Any practice which selectively excludes members from available treatment services and/or appointments may be in violation of those regulations.

ACCESS TO CARE STANDARDS

Physical Health, Behavioral Health and Substance Use	
Type of Care	**Timeliness Standard**
Urgent	Within 24 hours of initial identification of need *Urgent is defined as the existence of conditions that are not life-threatening but require expeditious treatment because of the prospect of the condition worsening without clinical intervention.*
Outpatient follow-up after hospitalization or residential treatment	Within seven days after discharge
Non-urgent, symptomatic*	Within seven days after request

**For behavioral health/substance use disorder (SUD), cannot consider administrative or group intake processes as a treatment appointment for non-urgent, symptomatic care or place members on waiting lists for initial requests*	Behavioral health/SUD **ongoing** outpatient visits: Frequency varies as the member progresses and the type of visit (e.g., therapy session versus medication visit) changes. This should be based on member's acuity and medical necessity.
Physical Health only	
Type of Care	**Timeliness Standard**
Emergency	24 hours a day availability of information, referral, and treatment of emergency medical conditions
Routine (non-symptomatic well-care physical examinations, preventive care)	Within one month after request* **Unless required sooner by AAP Bright Futures schedule*
Behavioral Health (BH) and Substance Use Disorder (SUD) only	
Type of Care	**Timeliness Standard**
Emergency (by phone)	Within 15 minutes after initial contact, including TTY accessibility
Emergency (in-person)	Urban/suburban areas: within one hour of contact Rural/frontier areas: within two hours of contact
Psychiatry/psychiatric medication management- urgent	Within seven days after request
Psychiatry/psychiatric medication management- ongoing	Within 30 days after request
SUD Residential for Priority populations as identified by Office of Behavioral Health in order: • Women who are pregnant and using drugs by injection; • Women who are pregnant; • Persons who use drugs by injection; • Women with dependent children; • Persons who are involuntarily committed to treatment	Screen a member for level of care needs within two days of request. If admission to the needed residential level of care is not available, refer the individual to interim services, which can include outpatient counseling and psychoeducation, as well as early intervention clinical services (through referral or internal services) no later than two days after making the request for admission. These interim outpatient services are intended to provide additional support while waiting for a residential admission.
SUD Residential	Screen a member for level of care needs within seven days of request.

	If admission to the needed residential level of care is not available, refer the individual to interim services, which can include outpatient counseling and psychoeducation, as well as early intervention clinical services (through referral or internal services) no later than seven days after making the request for admission. These interim outpatient services are intended to provide additional support while waiting for a residential admission.

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
- Member satisfaction surveys
- Member grievance monitoring
- Quality of care concerns
- Access to care evaluation of appointment availability, including requests to provide Third Next Available Appointment (TNAA) data, Secret Shopper calls, and required quality improvement opportunities
- Behavioral health and substance use disorder medical record reviews
- Provider access to care and medical record review trainings

SUPPORT FOR TIMELINESS STANDARDS

If you are unable to provide an appointment within the required timeframes, please refer the member to the Colorado Access customer service department at 800-511-5010 for assistance in finding services within the required timeframes. Providers must contact the provider network services department at ProviderNetworkServices@coaccess.com or 800-511-5010 if changes are needed for member panel size, closing panels, or acceptance of new patients. Providers must give a 60-day advance written notice for closing the panel to new members. Please contact your provider network services representative for additional details.

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. Colorado Access patient records standards are based on state and federal requirements, Office of Behavioral Health (OBH) standards, Behavioral Health Administration (BHA) standards, the State Behavioral Health Services (SBHS) Billing Manual, National Committee for Quality

Assurance (NCQA) guidelines for medical record documentation, and clinical best-practices. We may perform patient record audits/chart reviews to ensure compliance with these standards.

Providers billing behavioral health and substance use disorder service codes need to review the SBHS Billing Manual for technical documentation requirements and information on correct billing guidelines. Providers are subject to behavioral health and substance use disorder documentation audits and subsequent training and/or remediation based on audit results.

Integrated care practices (defined by the Agency for Healthcare Research and Quality as "the care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.") are not required to construct a formal, free-standing treatment plan separate from the treatment plans noted in an assessment or therapy note. Because interventions/treatment episodes are brief and solution-focused, integrated practices need to incorporate treatment needs/plans into the body of the documentation (i.e., in the "P" section of a DAP note).

Behavioral Health and Substance Use Disorder Documentation Standards
General Documentation Requirements
Name or Medicaid ID is listed on each document within the record
Identification and demographic information are documented
Documentation is legible
Documentation of consent to participate in services noted by member/guardian
Interpretation, when needed, is documented
Assessment Documentation Requirements
Date of service
Start and end time of service or service duration
Place of service
Provider's dated signature and relevant qualifying credential. A title should be included where no credential is held. Assessment is countersigned by the licensed supervisor of a non-credentialed provider.
Assessment is completed timely (outpatient—as soon as is reasonable upon admission and no later than seven (7) business days of admission into services)
Chief complaint/problem statement
Client strengths, skills, abilities, interests
Complete psychosocial history (social history)
Developmental history for clients younger than 18 years old
Cultural/spiritual factors that may impact treatment
Psychiatric/mental health history

Medical history and medical necessity
Prescribed medication(s)
Complete mental status evaluation (MSE)
Substance use/abuse history
Formal risk assessment/screen, including questions about suicide **and** homicide risk; Associated safety plan/crisis plan, if applicable
Behavioral health or SUD diagnoses with supporting evidence
Readiness for treatment/admissions summary
Plan for next contact/care coordination
Treatment Plan Documentation Requirements
Treatment plan is completed timely (outpatient—14 business days after assessment)
Treatment plan is updated/current (outpatient—when there is a change in the client's level of functioning or service needs, and no later than every six months)
Treatment plan is individualized and culturally sensitive
Treatment plan is strength-based
Treatment goals are measurable, specific, objective, and realistic
Treatment interventions include specific types and frequency of services
Risk/harm/SI/HI concerns are addressed in the treatment plan
Discharge criteria is established and discharge summary is present when client is absent from services for more than 30 days
Treatment plan identifies agencies/other providers involved in client's care along with the services they are providing
Child's treatment plan includes how family/guardian(s) will be involved in treatment to address child's issues or reason why their involvement is inappropriate
Client participation in treatment plan
Provider's dated signature and relevant qualifying credential. A title should be included where no credential is held. Treatment plan is countersigned by the licensed supervisor of a non-credentialed provider.
Progress Summary Documentation Requirements
Date of service
Start and end time of service or service duration
Place of service
CPT service code
Provider's dated signature and relevant qualifying credential. A title should be included where no credential is held. Progress summary is countersigned by the licensed supervisory of a non-credentialed provider.
Progress summary refers to the goals and objectives from the treatment plan
Includes the clinical intervention/treatment modality
Client's response to intervention
Progress towards goal(s)
Plan for next contact/care coordination
Notes address risk/harm/SI/HI, as needed, until risk is resolved
Evidence of documentation of no-show appointments or drop out of services

Coordination of Care Documentation Requirements
For clients 18 years old and older, evidence that provider asked if client has advanced directive and offered educational information (see Health First Colorado Right and Responsibilities form).
Provider assessed for health/services needs other than mental health and made appropriate referrals. Documents follow-up on referrals made.

QUALITY OF CARE CONCERNS AND CRITICAL INCIDENTS

A quality of care concern (QOC) is a concern that care provided did not meet a professionally recognized standard of health care. A general quality of care review or a beneficiary complaint review may cover a single or multiple concerns (See 42 CFR §476.1). QOCs can include complaints 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 letter about the incident that includes education about best practices, remediation opportunities, a formal corrective action plan, referral to a licensing or regulatory agency or could be terminated from our network based on findings from the QOC. Quality of care concerns and critical incidents can be reported by filling out the Quality of Care & Critical Incident Notification form and emailing it to qoc@coaccess.com.

Please note that the reporting of any potential quality of care concerns or critical incidents is required 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.

CLINICAL PRACTICE GUIDELINES

Colorado Access uses 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 to ensure relevance. Copies of the approved clinical practice guidelines are also available upon request, free of charge.