QUALITY OF CARE CONCERN NOTIFICATION

Please save this form, complete it, and **email to:** qoc@coaccess.com.

Member name:	
Member ID:	
Today's date:	
Program: ☐ Child Health Plan Plus (CHP+) ☐ Medicaid	
Concern received from: ☐ Member ☐ Provider ☐ Colorado Access Staff ☐ Other:	
Practitioner/facility under investigation	
Date(s) of Occurrence:	

Contact information for person making report	
Name:	
Organization	
Phone Number:	

Category of concern (please check only primary category)

Treatment/diagnosis issue
- ☐ Delayed diagnosis
- ☐ Incorrect diagnosis
- ☐ Inadequate work up to obtain diagnosis
- ☐ Incorrect treatment
- ☐ Procedure error
- ☐ Unplanned return to surgery
- ☐ Unplanned readmission within 48 hours (for medical) or 7 days (for behavioral health)
- ☐ Inappropriate treatment plan
- ☐ Ineffectiveness of treatment
- ☐ Failure to seek consultation/2nd opinion
- ☐ Community standards discrepancy
- ☐ Poor coordination of care/services
- ☐ Poor follow up/discharge planning

Professional conduct or competence
- ☐ Breach of Confidentiality
- ☐ Abuse/neglect/exploitation of a member
- ☐ Provider non-compliance with regulations
- ☐ Egregious provider conduct
- ☐ Failure to communicate
- ☐ Patient abandonment
- ☐ Provider not qualified to perform service/procedure

Mis-utilization of services
- ☐ Premature Discharge
- ☐ Prolonged hospitalization/delay of discharge
- ☐ Denial of medically necessary treatment
- ☐ Inappropriate level of care
- ☐ Failure to recognize prescription drug abuse

Patient safety/outcomes
- ☐ Failure to treat
- ☐ Unexpected death
- ☐ Suicide attempt requiring medical attention
- ☐ Preventable injury
- ☐ Preventable complication or infection
- ☐ Member missing from facility
- ☐ Critical medical error (human or technological)
- ☐ Critical medical event resulting in death, permanent harm, or severe temporary harm

Medication issues
- ☐ Medication prescription error
- ☐ Medication dispensing error
- ☐ Medication prescribed with known allergy

Delivery of services
- ☐ Delay of care/services/equipment
- ☐ Denial of care/services/equipment
- ☐ After-hours care not available

Other (please specify):

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Description of incident/concern (please attach any additional documentation as available or necessary):

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