QUALITY OF CARE & CRITICAL INCIDENT NOTIFICATION

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

Member name:	
Date of birth:	
Member ID: ☐ Altruista ☐ State ID	
Today's date:	
Program: ☐ RAE 3 ☐ CHP+ HMO ☐ Other ☐ RAE 5 ☐ CHP+ SMCN	
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:	
Email address or phone number:	

Category of concern (please check only ONE primary category)

Treatment/diagnosis issue
- ☐ Delayed diagnosis
- ☐ Incorrect/inadequate/ineffective/denial/delay of treatment diagnosis
- ☐ Procedure error
- ☐ Unplanned/preventable complication/infection or readmission to hospital within 48 hours (PH)
- ☐ Unplanned readmission within 7 days (BH)
- ☐ Failure to seek consultation/2nd opinion
- ☐ Community standards discrepancy
- ☐ Lack of coordination of care/services
- ☐ Lack of follow-up/discharge planning
- ☐ Inappropriate treatment plan
- ☐ Failure to treat
- ☐ Delay/denial of care/services/equipment

Professional conduct or competence
- ☐ 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

Patient safety/outcomes
- ☐ Unexpected death (other than natural or due to long-term health issues)
- ☐ Suicide attempt requiring medical attention
- ☐ Preventable injury
- ☐ Member missing from facility
- ☐ Aggression related to under-treated mental health issue (actual unsafe behaviors, not threats)

Medication issues
- ☐ Medication prescription error
- ☐ Medication dispensing error
- ☐ Medication error related to known allergy
- ☐ Failure to recognize prescription drug abuse

Access to care
- ☐ After-hours care not available
- ☐ Unable to offer follow-up appointment within timeliness standards

Other (please specify):

QUALITY OF CARE CONCERN NOTIFICATION

Description of incident/concern

Please attach any additional documentation as available or necessary.

Minimum information needed: background (ex: time member has been in treatment, general history, etc.); location, time of day, context of the incident; individuals involved, if applicable; status/outcome of the incident.

Please complete and **email to**: QOC@coaccess.com and include any relevant documentation.

For HIPAA/Confidentiality concerns, please send to: compliance@coaccess.com

This form does not replace mandatory reporting.

Your partnership in assuring quality services is appreciated.

If you need this document in large print, Braille, other formats, or languages, or read aloud, or need another copy, call 800-511-5010. For TDD/TTY, call 888-803-4494. Call Monday to Friday, 8 a.m. to 5 p.m. The call is free.

Si necesita este documento en letra grande, Braille, otros formatos o idiomas, o se lea en voz alta, o necesita otra copia, llame al 800-511-5010. Para TDD/TTY, llame al 888-803-4494. Llame de lunes a viernes, de 8 a.m. a 5 p.m. La llamada es gratis.