

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: <input type="checkbox"/> Altruista <input type="checkbox"/> State ID	
Today's date:	
Program: <input type="checkbox"/> RAE 3 <input type="checkbox"/> CHP+ HMO <input type="checkbox"/> Other <input type="checkbox"/> RAE 5 <input type="checkbox"/> CHP+ SMCN	
Concern received from: <input type="checkbox"/> Provider <input type="checkbox"/> Colorado Access Staff <input type="checkbox"/> Other: <i>Please note a concern received from a member should be submitted as a Grievance</i>	
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 <u>ONE</u> primary category)	
<p>Treatment/diagnosis issue</p> <input type="checkbox"/> Delayed diagnosis <input type="checkbox"/> Incorrect/inadequate/ineffective/denial/delay of treatment diagnosis <input type="checkbox"/> Procedure error <input type="checkbox"/> Unplanned/preventable complication/infection or readmission to hospital within 48 hours (PH) <input type="checkbox"/> Unplanned readmission within 7 days (BH) <input type="checkbox"/> Failure to seek consultation/2nd opinion <input type="checkbox"/> Community standards discrepancy <input type="checkbox"/> Lack of coordination of care/services <input type="checkbox"/> Lack of follow-up/discharge planning <input type="checkbox"/> Inappropriate treatment plan <input type="checkbox"/> Failure to treat <input type="checkbox"/> Delay/denial of care/services/equipment	<p>Professional conduct or competence</p> <input type="checkbox"/> Abuse/neglect/exploitation of a member <input type="checkbox"/> Provider non-compliance with regulations <input type="checkbox"/> Egregious provider conduct <input type="checkbox"/> Failure to communicate <input type="checkbox"/> Patient abandonment <input type="checkbox"/> Provider not qualified to perform service/procedure
<p>Patient safety/outcomes</p> <input type="checkbox"/> Unexpected death (other than natural or due to long-term health issues) <input type="checkbox"/> Suicide attempt requiring medical attention <input type="checkbox"/> Preventable injury <input type="checkbox"/> Member missing from facility <input type="checkbox"/> Aggression related to under-treated mental health issue (actual unsafe behaviors, not threats)	<p>Mis-utilization of services</p> <input type="checkbox"/> Premature discharge <input type="checkbox"/> Prolonged hospitalization/delay of discharge <input type="checkbox"/> Denial of medically necessary treatment <input type="checkbox"/> Inappropriate level of care
	<p>Medication issues</p> <input type="checkbox"/> Medication prescription error <input type="checkbox"/> Medication dispensing error <input type="checkbox"/> Medication error related to known allergy <input type="checkbox"/> Failure to recognize prescription drug abuse
	<p>Access to care</p> <input type="checkbox"/> After-hours care not available <input type="checkbox"/> Unable to offer follow-up appointment within timeliness standards

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.