## **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: ☐ HealthEdge GuidingCare ☐ State ID Today's date: Program: ☐ RAE 3 ☐ CHP+ HMO ☐ Other ☐ RAE 5 ☐ DH MCO Concern received from: ☐ Provider ☐ Colorado Access Staff ☐ Other:

Please note a concern received from a member should be submitted as a Grievance
Practitioner/facility under investigation:
Date(s) of occurrence:
Contact information for person making report
Name:
Organization:
Email address or phone number:
<u> </u>

Category of concern (please check only <u>ONE</u> 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: <a href="mailto:compliance@coaccess.com">compliance@coaccess.com</a>

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.

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