

# QUALITY OF CARE CONCERN NOTIFICATION

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

Member name:	
Member ID:	
Today's date:	
<b>Program:</b> <input type="checkbox"/> Access Advantage (AA) <input type="checkbox"/> Access Behavioral Care (ABC) <input type="checkbox"/> Access Health Colorado (AHC) <input type="checkbox"/> Child Health Plan Plus (CHP+) <input type="checkbox"/> Regional Collaborative Care Organization (RCCO)	
<b>Concern received from:</b> <input type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Colorado Access Staff <input type="checkbox"/> Other:	
Practitioner/facility under investigation	
Date(s) of Occurrence:	

<b>Contact information for person making report</b>	
Name:	
Organization	
Phone Number:	

<b>Category of concern (please check only primary category)</b>	
<b>Treatment/diagnosis issue</b> <input type="checkbox"/> Delayed diagnosis <input type="checkbox"/> Incorrect diagnosis <input type="checkbox"/> Inadequate work up to obtain diagnosis <input type="checkbox"/> Incorrect treatment <input type="checkbox"/> Procedure error <input type="checkbox"/> Unplanned return to surgery <input type="checkbox"/> Unplanned readmission within 48 hours (for medical) or 7 days (for behavioral health) <input type="checkbox"/> Inappropriate treatment plan <input type="checkbox"/> Ineffectiveness of treatment <input type="checkbox"/> Failure to seek consultation/2nd opinion <input type="checkbox"/> Community standards discrepancy <input type="checkbox"/> Poor coordination of care/services <input type="checkbox"/> Poor follow up/discharge planning	<b>Professional conduct or competence</b> <input type="checkbox"/> Breach of Confidentiality <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  <b>Mis-utilization of services</b> <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 <input type="checkbox"/> Failure to recognize prescription drug abuse
<b>Patient safety/outcomes</b> <input type="checkbox"/> Failure to treat <input type="checkbox"/> Unexpected death <input type="checkbox"/> Suicide attempt requiring medical attention <input type="checkbox"/> Preventable injury <input type="checkbox"/> Preventable complication or infection <input type="checkbox"/> Member missing from facility	<b>Medication issues</b> <input type="checkbox"/> Medication prescription error <input type="checkbox"/> Medication dispensing error <input type="checkbox"/> Medication prescribed with known allergy  <b>Delivery of services</b> <input type="checkbox"/> Delay of care/services/equipment <input type="checkbox"/> Denial of care/services/equipment <input type="checkbox"/> 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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