Quality of Care Concern Notification

Please complete and email this form to Colorado Community Health Alliance (CCHA) at HealthTeam@CCHAcares.com. This form can also be faxed to 866-811-0319

Member name	
Member Medicaid ID	
Date of birth	
Region (6 or 7)	
Today's date	
Concern submitted by ☐ Provider ☐ CCHA staff ☐ Other (specify)	
Practitioner/facility under review	
Practitioner contact/phone	
Date(s) of QOC occurrence	
Dates of service for this episode of care	

Contact Information for Person Making Report	
Name/Title	
Organization	
Phone number	

Category of Concern (Please Check Main Issue)	
Treatment/Diagnosis Issue ☐ Delayed diagnosis ☐ Incorrect diagnosis ☐ Inadequate tests/assessment to obtain diagnosis ☐ Incorrect treatment ☐ Procedure error ☐ Unplanned return to surgery ☐ Inappropriate treatment plan ☐ Ineffectiveness of treatment ☐ Failure to seek consultation/second opinion ☐ Community or clinical standards discrepancy ☐ Poor coordination of care/services for high-risk members ☐ Poor follow-up/discharge planning for high-risk members	**Professional Conduct or Competence** ☐ Breach of confidentiality ☐ Provider noncompliance with regulations ☐ Egregious provider conduct ☐ Failure to communicate ☐ Patient abandonment ☐ Failure to treat ☐ Provider not qualified to perform service/procedure **Service Utilization Issue** ☐ Premature discharge ☐ Prolonged hospitalization/delay of discharge ☐ Denial of medically necessary treatment ☐ Inappropriate level of care

Patient Safety/Outcomes

☐ Unexpected death (not due to natural causes/accident)
☐ Substance overdose or death
☐ Suicide attempt requiring medical attention
☐ Preventable injury
☐ Preventable complication or infection
☐ Member missing from inpatient facility
☐ Elopement resulting in harm
☐ Lack of adequate supervision/monitoring
☐ Critical medical error (human or technological)
☐ Critical medical event resulting in death, permanent harm, or severe temporary harm
☐ Peer assaulted member
☐ Member assaulted peer
☐ Alleged abuse/neglect/exploitation of a member by provider or facility staff
☐ Illicit use of substances by member while in facility

Medication Issues

☐ Medication prescription error
☐ Medication dispensing error
☐ Failure to prescribe necessary medication
☐ Medication prescribed with known allergy

Delivery of Services

☐ Delay of care/services/equipment
☐ Denial of care/services/equipment
☐ After-hours care not available
☐ **Other type (please specify)**

Mandatory Reporting

Note: If mandatory reporting was completed as a part of this incident, please provide the following information if possible.

Date of reporting:

Type of reporting (familial or institutional abuse, neglect, exploitation, assault):

Reporting agency: (police department, adult protective services, child protective services, sep, ccb, other)

City or county jurisdiction:

Case#:

Report status:

Who reported incident?

Description of concern (please attach any pertinent additional documentation):