Foothills Behavioral Health Partners Quality of Care Report Form

*Routing: *Please Fax to Kari Snelson, FBHPartners: (303) 432-5970 or email: ksnelson@fbhpartners.com*

Client Name:

Client Number: ____________________ **DOB:** ________________

Provider: ____

MH Center Name: ______________________________________

Provider Telephone Number: ____________________________

Medicaid Number: ___________________________

DSM Treating Diagnosis Code(s):

Date Reported:	**Time Reported:** ☐ AM ☐ PM	**Discovery Date:**	**Was client enrolled at the time of incident:** ☐ Yes ☐ No	☐ Male ☐ Female

Persons Involved Names:

☐ **Clinician/Staff** ________________________________

☐ **Other** ________________________________

Specific Location of the Incident:

- ☐ **Home**
- ☐ **ATU**
- ☐ **RTC**
- ☐ **Hospital**
- ☐ **Outpatient Treatment Setting**

Quality of Care Issue - Any action or failure to take action on the part of a provider that has the potential to decrease the likelihood of a positive health outcome and/or is inconsistent with current professional knowledge and/or puts the safety of the member at risk. **Any issue that places members at risk of possible immediate harm should be reported immediately (Those items in bold below). Please be sure a critical/adverse incident form is provided as appropriate.**

Type of Issue (please check) – The categories noted below pertain to Provider Behavior:

Access to Care	Professional/Legal Standards	Clinical Practice	Provider Behavior
☐ Failure to provide appropriate appointment access	☐ **Failure to maintain confidentiality**	☐ **Treatment setting not safe**	☐ **Sexual relationship with Client**
☐ Lack of timely response to telephone calls	☐ Suspected fraud & abuse	☐ **Treatment doesn't meet acceptable standard of care**	☐ **Seductive, inappr. phys. contact**
☐ Prolonged in-office wait time	☐ **Abandoned client**	☐ **Medication prescribing that does not meet standard of care**	☐ **Threats of/and or aggressive behavior**
☐ Inpatient or residential psychiatric assessment does not meet timeliness standards (within 24 hrs for inpt and 72 hrs residential)	☐ Poor/lack of medical record documentation	☐ **Medication delivery/administration errors**	☐ **Exploitive Behavior with Client**
☐ other __________	☐ Poor communication skills	☐ Inaccurate/poorly documented diagnosis	☐ **other** __________
	☐ Failure to release medical records	☐ Failure to properly document dangerous to self and others	
	☐ **Provider impairment**	☐ Failure to coordinate care/inadequate hospital/residential discharge planning	
	☐ **Illegal prescribing**	☐ Inadequate or failure to appropriately refer	
	☐ other __________	☐ Documentation fails to support appropriate use of restraints/seclusion	
		☐ Other __________	

Summary of Quality of Care/Service Issue **(Use section on page 2 of this form for additional information if necessary).**

Additional Summary Continued From Page 1:

Over→

Are there any potential urgent patient safety issues: ☐ Yes ☐ No

Has member been contacted to assess for healthcare needs or safety: ☐ Yes ☐ No

Print Name of Person Submitting Report	Signature	Title	Date & Time Report Completed

Preliminary Investigation Information/Recommendations/Actions Taken (Completed by FBHP Director of Compliance and Clinical Integrity or Medical Director)

Was medical record requested: ☐ Yes ☐ No If YES, date received:

Is there a potential need for urgent provider sanction: ☐ Yes ☐ No

Has any known legal action been initiated by or on behalf of the involved member: ☐ Yes ☐ No

FOLLOW UP/Action Taken ***This Report Will Be Reviewed by the Person(s) and Committee(s) Responsible for Quality of Care and Others as Designated***

Initial Reviewer: ____________________

Print Name	Signature	Title	Date

Second Reviewer: ____________________

Print Name	Signature	Title	Date

Third Reviewer: ____________________

Print Name	Signature	Title	Date

Summary of Follow-Up Activity: ☐ Referred to QOC ☐ Provider Education ☐ Monitor Provider ☐ Corrective Action Plan

☐ Other – explain: ____________________

Print Name of Follow Up Coordinator	Signature of Follow Up Coordinator	Title	Date

*Collection and processing of quality of care information administered through Beacon Health Options® Colorado