Adverse Incident/Quality of Care Reporting Form

If Client is Medicaid fax to: *Do not email forms*	FAX (719) 538-1456 For questions contact Tom.Dahlberg@valueoptions.com or Rhonda.Borders@valueoptions.com

☐ Adverse/Critical Incident ☐ Quality of Care Issue

Examples of Quality of Care Concerns may include: Prescribing medications inappropriately, abandoning member, meets with member in an unsafe/inappropriate treatment setting, not responding to a member in a timely manner, does not conduct an adequate or timely assessment, does not refer member appropriately to services, does not coordinate care, does not plan a member's discharge appropriately, does not respond to a member in an emergency situation.

Incident Reporting Timelines: *Sentinel Events* are due to BHO or ValueOptions CO within 24 Hours. *Major Events* are due within 48 hours. *Moderate and Minimal Risk Events* are due within 10 days. Incident review or investigation must be completed within 120 days.

MH Center/Facility Name: Choose an item. If other, specify:

Client Name: Client#: DOB (mm/dd/yyyy):

Medicaid ID Number: ☐ Not Medicaid ☐ Male ☐ Female

Race/Ethnicity: Choose an item. If other, please specify:

DSM V and ICD_10 Diagnostic Code(s): Record dx code and written description

Provider Name: Provider Phone Number:

Date of Incident: Incident Time: ☐ AM ☐ PM Discovery Date:

Specific location of the incident: Choose an item. If other, specify:

At time of incident, client was Choose an item.

Client's role in this incident: ☐ Victim ☐ Initiator/Perpetrator

Select appropriate response for any DEATH or SELF-INJURY (requiring at least skilled treatment intervention)

☐ Natural Causes ☐ Homicide ☐ Unknown ☐ Suicide ☐ Suicide Attempt-Serious ☐ Self-Injury

ANSWER ALL QUESTIONS **ONLY** IF THIS WAS A SUICIDE, SUICIDE ATTEMPT, OR UNKNOWN DEATH:

Date of last contact with client prior to death: Click here to enter a date.

Rating of suicide risk at last contact: ☐ Not addressed ☐None ☐ Low ☐ Moderate ☐ High

Safety plan or instructions documented if necessary? ☐ Yes ☐ No

What means were used? ☐ Gunshot ☐ Hanging ☐ Overdose ☐ Cutting ☐ Other:

Number of previous attempts known: Date of last Attempt:

Number of previous hospitalizations: Date of last hospitalization:

Were there cancelled or no show appointments just prior to suicide or unknown death? ☐ Yes ☐ No

If so, number of outreach attempts to client since date of last visit:

Client Injuries: ☐None ☐ Minimal ☐ Moderate ☐Severe Staff Injuries: ☐ None ☐ Minimal ☐ Moderate ☐Severe

As a result of the incident, was client or staff member ☐ evaluated or treated at ER and released ☐ Treated at ER for injury or condition that could seriously jeopardize life or health ☐ admitted to hospital for medical treatment

Client has a HX of: ☐ Chronic Pain/Medical Condition ☐Substance Abuse ☐ Non-adherence to MH treatment

Other Reportable Adverse/Critical Incidents-If none, move to the next section

Choose an item.
Choose an item.
Choose an item.
Choose an item.

If other, specify:

Details of Adverse/Critical Incident OR Potential Quality of Care Concern: (include incident description, persons involved, staff response or actions).

Outcome, Disposition and/or Follow Up		
Name and Title of Report Author	Signature of Author	Date Signed by Author
QM Director / Representative reviewing report	Signature of QM director / Representative	Date Signed by QM Director / Representative