NHP Quality of Care Concern Notification

Instructions to submit:

- Use this form to report all quality of care (QOC) concerns to NHP within 24 hours of discovery or observation
- Submit the form via secure email to Quality_Management@nhpllc.org
- Submit with this form all documentation relevant to the concern, such as the following: Treatment plans, discharge plans, medical records, assessments, medical orders, clinician orders, clinician notes, progress notes (inpatient claim), nursing notes, ancillary department notes, medication administration records, surgical/procedure reports, history and physical reports, discharge summary, narrative reports, radiology reports, diagnostic reports and laboratory reports

Contact Information		
Contact name:	Contact phone:	Contact email:
Concern received from: ☐ Member ☐ Provider/non-clinical staff ☐ NHP Staff ☐ Other (DHS, community partner) :		
Today's date:		
Facility Provider Information		
Facility/provider name:	Facility/provider address:	
Member Information		
Member Name (last, first):	DOB (mm/dd/yyyy):	
Medicaid ID Number:		
Diagnostic Information		
Primary diagnosis code (Dx):	Dx name:	
Quality of care concern information		
QOC issue date(s):	QOC issue time: ☐ AM ☐ PM	Discovery Date:
Location of incident: ☐ Member home ☐ Public place ☐ Facility ☐Other		
Category of concern (please check only primary category)		
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	**Mis-utilization of services** ☐ Premature Discharge ☐ Prolonged hospitalization/delay of discharge ☐ Denial of medically necessary treatment ☐ Inappropriate level of care ☐ Failure to recognize prescription drug abuse	

☐ 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	**Delivery of services** ☐ Delay of care/services/equipment ☐ Denial of care/services/equipment ☐ After-hours care not available
Treatment/diagnosis issue ☐ Delayed diagnosis ☐ Incorrect diagnosis ☐ Inadequate work up to obtain diagnosis ☐ Incorrect treatment ☐ Procedure error ☐ Unplanned return to surgery ☐ Unplanned readmission within 48 hours (for medical) or 7 days (for behavioral health) ☐ Inappropriate treatment plan ☐ Ineffectiveness of treatment ☐ Failure to seek consultation/2nd opinion ☐ Community standards discrepancy ☐ Poor coordination of care/services ☐ Poor follow up/discharge planning	**Medication issues** ☐ Medication prescription error ☐ Medication dispensing error ☐ Medication prescribed with known allergy **Professional conduct or competence** ☐ Breach of Confidentiality ☐ Provider non-compliance with regulations ☐ Egregious provider conduct ☐ Failure to communicate ☐ Patient abandonment ☐ Provider not qualified to perform service/procedure
Other (please specify):	
Mandatory Reporting Note: If mandatory reporting was completed as a part of this incident, please provide the following information if possible.	
Type of reporting (familial or institutional abuse, neglect, exploitation, assault):	
Reporting agency (police department, adult protective services, child protective services, sep, ccb, other):	
Date of reporting:	Case #:	City or county jurisdiction:
Who reported incident?	Report status:
Description of incident/concern (please attach any additional documentation as available or necessary):	

Description of incident/concern, continued: