BHO Adverse Incident/Quality of Care Reporting Form for Providers (Non-MHC)

If Client is MEDICAID encrypt and send to:	CHP or FBHP ☐ FAX (719) 538-1456 erica.arnold-miller@valueoptions.com	NBHP: ☐ FAX (719) 538-1456 samatha.kommana@valueoptions.com

☐ **Adverse/Critical Incident –** Events that represent actual or potential serious harm to the well-being of a member or to others by the actions of a member, who is receiving services or has recently discharged from service in the last 12 months**.**

☐ **Quality of Care Issue -** Any action or failure to take action by a provider that **(1)** Could decrease the likelihood of a positive health outcome, **(2**) Inconsistent with current professional knowledge or **(3)** Puts the safety of the member at risk.
Examples of Quality of Care Concerns may include: Provider is prescribing medications inappropriately, abandons member, meets with member in an unsafe/inappropriate treatment setting, is 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

Reporting Timelines of Adverse/Critical Incidents: *Sentinel and Major Risk Events* are due to BHO or ValueOptions CO **within 24 Hours**. *Moderate and Minimal Risk Events* are due to BHO or ValueOptions CO **within 10 days**.

Provider Name:

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

Medicaid Number: ☐ **Not Medicaid**

Race / Ethnicity: ☐ **Caucasian** ☐ **Hispanic** ☐ **African American** ☐ **American Indian** ☐ **Asian/Pacific Islander** ☐ **Other:** ***(please specify)***

DSM Diagnostic Code(s): **Record all appropriate numeric and written nomenclature(s)**

Axis I:

Axis II:

Axis III:

Provider Name:		**Provider Telephone Number**	

Date of Incident: **Discovery Date:** ☐ **Male** ☐ **Female** **Was client enrolled in TX at the time of incident** ☐ **Yes** ☐ **No**

Incident Time: ☐ **AM** ☐ **PM**

Specific location of the incident: ☐ **Home** ☐ **RTU** ☐ **Drop-In Center/Clubhouse** ☐ **ATU** ☐ **Outpatient TX Setting** ☐ **Other (specify):**

What was client's alleged role in this incident: ☐ Victim ☐ Initiator/Perpetrator

Select appropriate response for any DEATH or if incident is a SELF-INJURY (requiring at least skilled care treatment intervention)

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

ANSWER ALL QUESTIONS IF THIS WAS A SUICIDE OR SUICIDE ATTEMPT:

Date of last contact with the client prior to this incident: (mm/dd/yyyy)

Were suicide issues addressed at this last contact? ☐ Yes ☐ No

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

Are there previous attempts documented? ☐ Yes ☐ No **How Many**? ☐ Date of last Attempt:

How many previous hospitalizations are documented in the client's chart?

Documented: Date of last hospitalization:

Was the client discharged from inpatient care or ATU within the last 7 days? ☐ Yes ☐ No

Was the client discharged from active treatment within the last 90 Days ☐ Yes ☐ No

As a result of the incident, was client or staff member admitted to a hospital for medical treatment ☐ Yes ☐ No

Was the client/staff treated in the ER for any injury or condition that could seriously jeopardize their life or health

☐Yes ☐ NO

Client has a HX of: ☐ Chronic Pain/Medical Condition ☐Substance Abuse ☐ Non-adherence to mental health TX

BHO Adverse Incident/Quality of Care Reporting Form (Continued)

Provider Name:

Client Name:	**Client Number:**	**DOB (mm/dd/yyyy)**

Other Reportable Adverse / Critical Incidents

☐ Allegation of Abuse/Neglect / Exploitation/Sexual Behavior involving staff

☐ Fall / Injury in a treatment setting

☐ Violent/Assaultive Behavior Required Urgent/Emergent Care

☐ Human/Civil Rights Violation

☐ Sexual Acting Out:

- ☐ *In a treatment setting*
- ☐ *Not in a treatment setting*

☐ Elopement ☐ *Client was a danger to self or others*

☐ Medication Error

☐ Adverse Drug Reaction

☐ Breach of Confidentiality

☐ Other (provide details in the text box provided).

Details of Adverse/Critical Incident OR Potential Quality of Care Concern: (include incident description, persons involved, staff actions, and incident outcome or disposition). Enter information in the text box below.

Client Injuries: ☐None ☐ Minimal ☐ Moderate ☐Severe

Staff Injuries: ☐ None ☐ Minimal ☐ Moderate ☐Severe

Print or Type Name and Title of Report Author	**Signature of Author**	**Date Signed by Author**
Print or Type Name of QM Director / Representative reviewing report	**Signature of QM director / Representative**	**Date Signed by QM Director / Representative**