

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section N: Grievances and Appeals (Section § 13 of RFP)	25		
N-1	A, B, and C	<p>N.1 Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process, including your approach for meeting the general requirements and plan to:</p> <ul style="list-style-type: none"> o Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member’s primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal; o Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and o Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member’s health. As part of this process, explain how you will determine when the expedited process is necessary. <p>Include in the description how data resulting from the grievance system will be used to improve your operational performance.</p>	25		

Question N.1
Grievances and Appeals Process

Section N: Grievances and Appeals

N.1 Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process, including your approach for meeting the general requirements and plan to:

- Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal;
- Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and
- Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary.

Include in the description how data resulting from the grievance system will be used to improve your operational performance.

Louisiana Healthcare Connections (LHC) will establish, implement, and maintain a fully developed, member-centric grievance process that meets all DHH requirements. Our processes for identification, receipt, tracking, response, review, reporting, and resolution of Medicaid member inquiries, grievances and appeals comply with all State, federal and NCQA requirements. LHC will promote and maintain an internal function dedicated to the identification and prompt resolution of oral and written grievances, and member appeals. Our policies and procedures govern the resolution of inquiries, grievances and appeals, and encompass expedited review, external review, and access to the State's Fair Hearing system. LHC will maintain written policies and procedures clearly describing the grievance and appeals process and will provide the Member Grievance Policy and additional information to providers and subcontractors at the time of contracting, in the Provider Manual, Provider Newsletters and on the Provider Portal. We will educate members about the Member Grievance Policy through our Member Handbook, Member Newsletters, and Member Portal and during telephonic and face to face interactions with members.

Grievance System

Authority and Staffing. The Board of Directors (BOD) will have final authority and responsibility for the process, and will delegate operational oversight and implementation to LHC's Grievance and Appeal Committee (GAC). The GAC will review all appeals, complaints and grievances, including provider complaints handled by subcontractors under a delegated arrangement, to identify trends or issues requiring follow up or improvement. The Appeals and Grievance Coordinator (AGC) will be responsible for ensuring all aspects of the process are documented, routed, processed, tracked, resolved, and reported per DOM requirements. In addition, all LHC staff will be trained about the process and its importance; member and provider rights; and how to assist members and providers in filing complaints/grievances and appeals.

Educating Members, Providers and Subcontractors. We will educate members about grievance procedures in the Member Handbook and the Member Portal. This will include, but not be limited to, how to file a complaint or grievance, how the complaint or grievance will be addressed as well as how LHC will receive, track, review, and report all inquiries, grievances and appeals. It will also include the DHH Medicaid Fair Hearing process, including the rights of members and providers to access a fair hearing after exhausting LHC's internal appeal process, and the procedures involved. Information will be made available upon request; on our Member Portal; provided by staff when informing members of their rights; and verbally and/or in writing in applicable situations such as initiation of disenrollment by LHC and

decisions resulting in an adverse action. Providers and subcontractors will be educated about these procedures through applicable provider and subcontractor contracts; Provider Manuals; the Provider Portal; through interactions with Provider Relations and Contracting staff; in written notifications of adverse action; and upon request.

Reasonable Assistance to Members. LHC believes that members should have their concerns and issues heard and addressed as soon as possible. We educate our members about how to contact LHC' Member Services Department if they have an inquiry or concern, and about the grievance process, in the Member Handbook, on the LHC Member Portal, and at least annually in our Member Newsletters. All materials are written in easy-to-understand language equivalent to a 6th grade reading level. A member or member's authorized representative may contact LHC at any time with an inquiry on behalf of a member. They may contact LHC orally, in writing, by mail, facsimile, electronic mail, through the LHC Member Portal, or by dialing LHC' toll-free Member Services Helpline. We take pride in our responsive customer service, and attempt to resolve the issue or Inquiry for the caller at the time of the call. All LHC staff are trained to identify, document, and route verbal or written issues or inquiries to the appropriate personnel, although most individuals and members call the Member Services Helpline with their initial Inquiry. When responding to inquiries, MSRs utilize help screens and other system documentation to assist them in addressing issues or provide information to the member's satisfaction. LHC ensures that communication with designated representatives on behalf of members is HIPAA compliant, and that there is written consent from the member for a representative acting on behalf of the member. Our Grievance and Appeals Coordinator will confirm the member has given written consent. When appropriate, the Grievance and Appeals Coordinator will supply a consent form for the member to complete and return. In all cases the member has access to LHC assistance in filing member inquiries, grievances, appeals, or requests for State Fair Hearings. LHC will provide personal assistance to any member needing support in any stage of the complaint/grievance process; including communication assistance such as translation, TTY/TTD availability, interpreter services, or alternative formats for materials. We will make appeal forms available to members, providers, and other authorized representatives filing grievances on behalf of members, but submissions will be accepted regardless of format used. LHC will provide forms with all written adverse action notices, on the Member and Provider Portals, and upon request.

Appropriate Expertise. Member Service Representatives (MSRs) and Case Management staff are typically the member's first point of contact regarding the filing of a grievance or appeal. All MSR and CM staff members are trained to document and resolve the member's concern during this first contact, if possible. This procedural training will also be extended to all LHC staff who works directly or indirectly with members. All staff will be trained to recognize any expression of dissatisfaction, and follow procedures to ensure the member's issue is appropriately captured and addressed, which includes emphasis on the importance of the grievance and appeals process and procedures, and the rights of both the member and provider. LHC's written policies will ensure that no punitive action will be taken against a provider who supports a member's complaint, grievance or appeal, or files a complaint, grievance or appeal on a member's behalf. Individual staff making decisions on the resolution of grievances and appeals will not have been involved in any prior level of review or decision-making, and will have authority to require corrective action as appropriate. Physicians involved in reviewing medically related grievances and appeals will have appropriate experience treating the member's condition or disease, and will not have been involved in any prior level of review or decision making. Members and providers will be allowed to present evidence to the individuals and/or committee making the decision.

Expedited Appeal Process. LHC will follow DHH's timeframes and processes for handling expedited and standard appeals, including extending time periods within guidelines, if the extension is in the best interest of the member. A member or provider may request an expedited appeal of an Action, while pursuing the standard appeals process if it could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The AGC will immediately gather supporting documentation for expedited appeal requests and forward all information to a Medical Director (MD).

The MD will consult with another physician, with the same or similar specialty, who was uninvolved in any previous level of review. Prior to issuing an adverse determination, the MD will also contact the requesting provider to obtain any additional information the provider or member wishes the MD to consider. For requests related to an ongoing emergency or denial of a continued hospitalization, the MD will render a decision within 24 hours or sooner as the member's condition requires. For other types of requests, the MD will render a decision within 72 hours of receiving the request or sooner as the member's condition requires. An oral expedited appeal request does not require written notification. The MD or CGC will provide prompt verbal notice of all decisions to the provider and member. The AGC will send written notification within two days of the expedited decision. If a request for an expedited appeal is denied, the appeal is transferred to the standard resolution process and reasonable efforts are made to provide the member with prompt oral notice of the denial of the expedited request and written notice within two days. Although a decision regarding the denial of a request for expedited resolution of an appeal does not constitute an Action or require a Notice of Action, LHC affords the member the right to file a grievance in response to the decision.

Member Grievance Process

A member grievance is any member expression of dissatisfaction about any matter other than an Action (described below). Possible concerns identified as grievances may include, but are not limited to, the quality of care or services provided to a member and aspects of interpersonal relationships such as the rudeness of a provider or employee, or failure to respect the member's rights. Members, authorized representatives acting on a member's behalf and providers (with the members' written consent) may file a grievance orally by using our toll-free or TTY/TDD number, in person, or in writing. Grievances will be logged and maintained within our Member Relationship Manager (MRM) system which provides a central location for documenting, tracking and reporting of member grievances by category, and facilitate monitoring of the grievance resolution process and timeframes. Please see the following attachments for the member grievance process: *Attachment N.1-A: Chart C1 Member Grievance Process* and *Attachment N.1-B: Chart C2 Standard Appeal Process*.

Acknowledgement. Staff receiving grievances orally will acknowledge the grievance and attempt to resolve them immediately. Staff will document the substance of the grievance. For informal grievances, defined as those received orally and resolved immediately to the satisfaction of the member, representative or provider, the staff will document the resolution details. The GAC will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within five business days of receipt.

Investigation. The G&A Coordinator, under the direction of the Quality Management (QM) Director, will conduct an initial review, which may include contacting the member for additional information or clarification of the issue and gathering applicable documentation from other LHC departments. For example, the investigation may include the assistance or input of the member's Case Manager, or the Provider Services Department if the matter involves a LHC provider. Clinical issues, including grievances filed as a result of a service denial or a decision to deny a request for an expedited appeal resolution, are forwarded to the Medical Management Department for investigation or review by a physician or other appropriate clinician. If the grievance involves a quality of care issue, it is forwarded to the QM Department for review, resolution and inclusion in the quality of care investigation process. Matters involving privacy concerns or potential fraud and abuse are forwarded to the Compliance Officer for resolution. The Compliance Officer will also determine whether the issue should be forwarded to DHH, and accordingly will report suspected concerns related to fraud, abuse, waste, neglect and overpayment issues to DHH immediately upon discovery. .

Resolution Time Frame. Once the resolution is determined, the AGC will draft a resolution letter which is reviewed and approved by the QM Director, then sent via certified mail to the member. Although LHC is allowed up to 90 days to resolve a grievance, the health plan makes every effort to resolve member

grievances at the point of contact. If the matter requires additional follow up such as the involvement of different departments, or requires follow up with a provider regarding accessibility issues, then we will strive to resolve within 10 business days with an internal benchmark of 30 days but will not exceed the 90 day timeframe.

Notice of Resolution. LHC will consider a member grievance resolved when the member is satisfied with the resolution and then will follow up with a written letter to the member outlining the grievance and the resolution as well as the member's right to seek a State Fair Hearing if they are not satisfied with the resolution. Regardless of the outcome, LHC will not discriminate or retaliate against a member for filing a grievance, appeal or requesting a State fair hearing.

Tracking Grievances. Grievances will be categorized within MRM under standard categories outlined in LHC's contract or DHH's reporting guide. Some examples of effective and efficient categories for detailed reporting by our affiliates include Bridgeway Health Solutions (Bridgeway) in Arizona. Bridgeway utilizes a tiered grievance classification process consisting of broad categories including: Transportation, Medical Service Provision, Contractor Service Level, Access to Care, and Wheelchairs. These categories are further defined by sub categories to delineate and trend issues while monitoring and tracking resolution timeframes. On at least a monthly basis, all grievance data will be compiled into one Enrollee Grievance Report, which the G&A Manager will review for identification of trends. Any trends that are discovered which are specific to a department or service are submitted to the appropriate department for review and corrective action. This data is also submitted monthly to DHH as required, and a report is presented at the quarterly Quality Assessment Performance Improvement Committee (QAPIC) meeting for further review and recommendations as needed. LHC recognizes that trending of member expressions of dissatisfaction provides valuable information about what may be problematic for a member and what changes need to occur to provide optimal service to members.

Appeal of Adverse Action

An appeal is defined as a request for the review of an Action taken by a health plan. The definition of an Action includes: the denial or limited authorization of a requested service, including the type or level of service; reduction, suspension or termination of a previously authorized service; denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner including failure of LHC to act within the required timeframes. LHC's parent company, Centene, and its affiliate health plans maintain an excellent record of meeting grievance and appeal resolution timeframes, and we recognize that failure to provide services in a timely manner also constitutes an action. LHC also recognizes that failure to issue a determination for standard and expedited appeals will be deemed as an approval as of the date upon which the final determination should have been made. Members will have 30 calendar days from the date of the receipt of the *Notice of Action* to request an appeal. Members, the legal representative of a deceased member's estate, or a member's authorized representative (with written consent from the member) acting on behalf of the member, may file an appeal orally or in writing. Providers filing an appeal on behalf of a member will require the member's written consent, other than in the case of an expedited appeal request. Oral inquiries regarding an appeal of an action will be treated as an appeal. An oral appeal request must be followed by a written, signed appeal; however, if the appeal request is received orally, the oral receipt date will be considered the initial receipt date of the appeal. Expedited requests do not require written follow up. Please see ***Attachment N.1-C: Chart C3 Expedited Appeal Process.***

Acknowledgement. The AGC will document written or oral appeals requests within one business day of receipt. The content of the appeal, including all clinical aspects involved and any actions taken, will be documented. The AGC will send the member or authorized representative an acknowledgement letter within 5 working days of receiving the request that will include the subject of the appeal; explanation of the appeal process; the member's rights, including the right to submit comments, documents, or other

evidence relevant to the appeal in person or in writing; notice of the member's right to request a State Fair Hearing at any time during the appeal process; and the procedures involved.

Resolution Time Frame. LHC will resolve appeals as quickly as the member's condition requires. Standard appeals will be resolved and the member and provider notified within 30 calendar days of receipt and expedited appeals within 72 hours of receipt. The resolution time frame will be extended for up to 14 calendar days if the member requests the extension, or if the delay is in the best interest of the member and the member agrees to the extension. We also will provide the member with written notification of the reason for the delay for extensions not requested by the member.

Expedited Review. The expedited process is described above. We will conduct an expedited review if we or the provider determine the standard time frame for resolution could seriously jeopardize the member's life or health, or the ability to attain, maintain or regain maximum function, including when a practitioner with knowledge of the member's medical condition determines the appeal to be urgent. Denied expedited appeal requests will be handled in the standard time frame. The AGC will provide prompt oral notice of the denial of expedited resolution to the member, and written notice within two calendar days.

Reviewers. A physician with appropriate clinical expertise will review appeals involving clinical issues or any medical necessity decisions. The individual will be a clinical peer of the same or similar specialty, who is not a subordinate of the individual who made the initial adverse determination and who was not involved in the initial determination or any prior decision-making. Members are encouraged to submit additional documentation, in person or in writing, to support their case and are reminded of the limited time available for expedited appeals. When received, any additional documentation related to the appeal is date-stamped and included in the file for review.

Notice of Resolution. The AGC will provide written notice of the appeal resolution to the member and the provider within two business days of the decision, not to exceed 30 days following receipt of the appeal. Adverse appeal resolution notices will include, but are not limited to, the appeal decision and reasons for the decision in easily understood language; reference to the protocol or criterion on which the decision was based; notification of the member's rights; or to request a State Fair Hearing and the procedure for doing so. This letter also includes instructions on how to request a hearing, that the member may ask for the continuance of previously authorized benefits until the matter is resolved and how to make a service continuance request. If the member (or his/her designated representative) requests a State fair hearing, LHC ensures all supporting documentation is forwarded to Louisiana Division of Administrative Law, within seven calendar days from the date LHC receives the written hearing request.

Continuation of Benefits. We will continue a member's benefits through the appeal resolution process (until the final decision by LHC or the State Fair Hearing decision is issued) if the appeal was filed within 10 days of the Notice of Action or the intended effective date of a proposed action and the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired and the member request an extension of benefits. If these conditions are met, benefits are continued throughout the appeal process. The services will remain in place until at least one of the following occurs: the member withdraws the appeal, the appeal decision is rendered and the member does not request a continuance within the designated timeframe pending a hearing, filed hearing results in an adverse decision for the member, or the original authorization time period expires or authorization service limits are met.

Using Data to Improve Processes and Performance

Complaint, grievance and appeals data will be reviewed by appropriate staff and committees for action as needed. The GAC will review monthly reports of complaints, grievances and appeals to identify trends and areas of concern, including whether LHC and DHH standards for timeliness and other processing issues are being met; to identify patterns related to specific issues, providers or LHC departments; and to

target any needed corrective actions. The Utilization Management Committee (UMC) will review appeals data to identify trends that indicate that specific utilization guidelines should be updated, developed or clarified; or that there is a provider education need. Complaint, grievance and appeal data as well as data relating to processing standards (such as timeliness) will also be submitted monthly to our cross-departmental Performance Improvement Team and quarterly to the Quality Assessment Performance Improvement Committee (QAPIC) for trending and analysis. LHC will incorporate aggregate data in member and provider satisfaction analysis for the annual QI Program Evaluation.

The table below summarizes how Grievance and Appeal data will be used to identify performance issues and develop performance improvement initiatives and which department will be involved in developing and implementing the initiatives.

Performance Issue	How Data Will Be Used	Department
Access/Availability Deficiencies	Identifying Network Gaps; Provider Wait Times, Compliance, and Training	Provider Relations
Quality of Care, Member Safety, Abuse of Member –Adult and Child	Training/Recredentialing/Peer Review	Medical Director, QI
Benefit Questions	Improvements to Written Materials	Member and Provider Services, QI
Service Levels	Staffing Adjustments/Training Technology Enhancements	Member/Provider Services
Customer Service Deficiencies	Business Process Improvement	Applicable Functional Area
Inappropriate Billing Practices	Fraud and Abuse	Compliance/Special Investigations Unit

The table below depicts examples of how our Arizona affiliate, Bridgeway Health Solutions, utilized the process reflected above for analysis of Grievances throughout the course of the contract cycle.

Plan Year Trending	Identified Areas	Actions Taken	Outcomes
Contract Year '07	Received 72 grievances, with a majority of the matters related to transportation issues in Maricopa County all applied to the same provider.	Through coordination with the Provider Relations and Quality Management Departments, Bridgeway increased the oversight and monitoring of the transportation provider to ensure improved customer service and adherence to policies and procedures.	Review of CYE '08 grievance data shows a significant reduction in the number of issues received related to transportation, which is attributed to Bridgeway's interventions following the identified trend from the previous year.
Contract Year '08	Received 94 of 116 grievances for Providers Billing Members.	Continued to trend, including documentation of efforts provided by Member Services to assist members and providers with appropriate billing/claims submissions	Outcomes identified in subsequent Contract Year Grievance System reporting.
Contract Year '08	Identified three network adequacy related issues where members were experiencing difficulty in securing attendant care services.	We were able to promptly address the needs of the members through assistance of our locally based Case Manager and Provider Relations Representative and resolve the issue by securing attendant care services for the members.	The network adequacy issues were collectively resolved within five days to the satisfaction of the members and there were no additional reported grievances in this category through the remainder of the plan year.
Contract year '09	Received 55 grievances, with continued low reporting of transportation issues, and continued trending Providers Billing Members issues.	Review of grievance data in early CYE '09 in conjunction with '08 grievance data revealed in a majority of these instances, the issues were not related to a dissatisfaction or frustration, but rather a need for assistance with ensuring the provider's records were updated with the member's current eligibility/enrollment information.	Bridgeway responded to this trend by utilizing the Member Services Department to develop a tracking database, and work closely with the Provider Relations and Case Management Departments to either (1) ensure the provider has the appropriate member eligibility/enrollment information, and/or (2) utilize the database as a recruitment tool, contacting out of network providers seeing our members to contract with Bridgeway.
Contract Year '10	Received 36 grievances, showing a reduction in the category, Providers Billing Members, which was attributed to the intervention efforts from the previous plan year.	Continued Tracking of issues, and analysis of previously implemented interventions.	Bridgeway continues to report a low number of grievances as well as a consistent prompt resolution of issues and attributes the increased reporting in various other categories in 2010 to trainings provided to staff by the Compliance/G&A Department on identifying and reporting grievances.

Over a 24 month period (Jan. 2009-Dec. 2010), Superior, our affiliate serving the CHIP population in Texas with approximately 115,000 current enrollees, captured a total of 1384 CHIP member complaints. The majority of these complaints are categorized into the three groups below which represent approximately 96% of the total number of complaints.

Complaint Type:	Actions Taken	Outcomes
<p>Complaints categorized as "Balance Billing" (577 Complaints, 42% of total Complaints): Describe any occurrence in which a member receives a bill from a provider. The vast majority of these complaints originate from miscommunication between the member and provider upon the date of service. It has been determined that members receive bills most often as a result of not presenting their Superior CHIP ID card when the service is rendered. Superior's investigation of these concerns usually results in the billing provider agreeing to either submit the claim to Superior or adjust the member's account to a zero balance. 76% of the complaints investigated resulted in the member not being responsible. The 24% of complaints that resulted in member responsibility were the due to receipt of non-covered benefits, receipt of non-emergent ER services and co-payments.</p>	<p>1) Provider outreach - Superior reminded billing providers of their contractual obligation to hold CHIP members harmless for covered benefits.</p> <p>2) Member outreach - Superior advised members of their responsibility to present their Superior CHIP ID card at the time of service. Members were also educated on the importance of notifying Superior immediately upon receipt of a billing statement. Members had previously been disregarding statements and only notifying Superior once their account had been placed with a collection agency. By notifying Superior of statements timely, the billing concerns can be addressed quickly and easily.</p>	<p>As a result of provider and member education, Superior has seen a decrease in the number of balance billing complaints received from CHIP members.</p>
<p>Complaints categorized as "Health Plan Administrative ID Cards" (602 Complaints, 44% of total Complaints): Superior considers Members' non-receipt of Health Plan ID cards to be a complaint in certain circumstances.</p>	<p>Issue One: Superior identified the Plan eligibility error issue through the recording, tracking and trending of Member complaints. A thorough investigation of the increase in calls and related complaints from Members not in receipt of their New Member ID Card led to the discovery of the eligibility file error for certain CHIP Member groups. The error was promptly resolved, and the number of calls and complaints as result of this Plan Administration error eliminated.</p>	<p>Issue One Outcome: Superior modified its procedures to include the name of the 'head of household' on the Member ID card envelopes sent through the US mail, if provided from the State in the Member eligibility file. This practice, together with Superior's use of the national code of addresses to validate addresses with residents at those addresses has decreased our receipt of calls and complaints related to Member ID cards not received during this reporting period.</p>

Complaint Type:	Actions Taken	Outcomes
<p>During this reporting period, two issues resulted in a significant number of complaints from Members who did not receive their ID card timely. One issue was the result of Plan error in the generation of eligibility records for certain CHIP member categories; the second issue was the result of the US Postal service not delivering the ID cards if the CHIP Member Last name did not match the resident address Sir name.</p>	<p>Issue Two: The non-receipt of ID cards as result of the non-delivery of ID cards by the US Postal Service (USPS) resulted in several consultations with USPS management. Superior learned that Postal Delivery personnel may have some liability if protected health information, or other personal information is delivered to the wrong party.</p>	<p>Issue Two Outcome: As a result, the US Postal service allows postal workers to use their discretion in the delivery of mail, if they do not believe the intended addressee resides at the address to which protected information is sent.</p>
<p>Complaints categorized as "Quality of Care / Quality of Service" (149 Complaints, 11% of total Complaints):Of the Quality of Care/Quality of Service complaints, 38% reference the attitude/customer service received from the practitioner's office staff. 37% of the complaints are about the general care received from the provider. The members are typically dissatisfied with either the level of care or the length of time the provider spent examining the patient. 5% are complaints about providers declining requests for referrals. Other issues relate to appointment availability, copays, dirty office sites, etc.</p>	<p>Superior has implemented a new process of monitoring complaints and quality issues between re-credentialing cycles in order to maintain a network of direct and delegated participating practitioners who meet or exceed Superior Health Plan's (SHP) standards for delivery of high-quality and safe care to members. Quarterly, a collaborative report is generated by the QI Department and Complaint Unit to monitor potential practitioner concerns.</p>	<p>Superior reviews complaints on an ongoing basis during the intervals between formal re-verification of credentials. The credentialing staff will refer any incidences of potentially poor quality of care or recent sanction to the Quality Improvement Department (QI) so that important quality or safety issues may be identified and, when appropriate, acted on in a timely manner. If the result of the review indicates that any practitioner has exceeded the thresholds defined the Complaint Unit and QI, they are referred to the (Quality Improvement Committee) QIC. The QIC may determine additional action regarding practitioners who have met the threshold of complaints as follows: 1) continued monitoring, 2) corrective action plans or 3) referral to SHP's Peer Review Committee.</p>