HSHS St. Vincent
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FACILITY: HSHS St. Vincent Hospital HSHS St. Mary's Hospital HSHS St. Nicholas Hospital HSHS St. Clare Hospital	**MANUAL(S):** Medical Staff
TITLE: Medical Staff Peer Review Policy	**ORIGINATING DEPARTMENT:** Medical Staff Services
SUPERCEDES: SVG 200-01-010 SMG C3167 SNS No policy number SCO No policy number	**POLICY NUMBER:** MS-011

I. POLICY: Medical Staff Peer Review Policy

II. PURPOSE:

- To ensure that HSHS hospitals, through the activities of its medical staff, assesses the Ongoing Professional Practice Evaluation of individuals granted clinical privileges and uses the results of such assessments to improve care and, when necessary, performs Focused Professional Practice Evaluation.

III. GOALS:

1. Monitor and evaluate the ongoing professional practice of individual practitioners with clinical privileges
2. Create a culture with a positive approach to peer review by recognizing practitioner excellence as well as identifying improvement opportunities
3. Perform focused professional practice evaluation when potential practitioner improvement opportunities are identified
4. Promote efficient use of practitioner and quality staff resources
5. Provide accurate and timely performance data for practitioner feedback, Ongoing and Focused Professional Practice Evaluation and reappointment
6. Support medical staff educational goals to improve patient care
7. Provide a link with the hospital performance improvement structure to assure responsiveness to system improvement opportunities identified by the medical staff
8. Assure that the process for peer review is clearly defined, fair, defensible, timely, and useful

IV. DEFINITIONS:

Peer Review: The evaluation of an individual practitioner's professional performance for all relevant competency categories using multiple sources of data and the identification of opportunities to improve care. Through this process, practitioners receive feedback for potential personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice in all practitioner competencies. During this process, the practitioner is not considered to be under investigation for the purposes of reporting requirements under the Healthcare Quality Improvement Act.

Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses in performance of an individual Medical Staff Member (MSM) or Advanced Practice Provider (APP), rather than appraising the quality of care rendered by a group of professionals or a system. The individual is evaluated consistently, compared to standards of care, and the review offers constructive criticism of the performance observed. Through this framework, a MSM or APP receives feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical and interpersonal skills in providing patient care.

Ongoing Professional Practice Evaluation (OPPE)
The routine monitoring and evaluation of current competency for practitioners with granted privileges. This is accomplished through the peer review process.

Focused Professional Practice Evaluation (FPPE)
The confirmation of current competency based on either 1) potential concerns from OPPE (i.e. focused review), 2) new medical staff members or new privileges, (e.g. proctoring), or 3) when concerns are raised about an individual's practice through a specialty-specific trigger, a reported concern, or other triggers (i.e., clinical trend or specific case that requires further review, patient complaint, corporate compliance issue, or sentinel event).

Peer Review Participants: All members of the medical staff are expected to participate as requested in the peer review process. This may include any individual medical staff member or APP, the Performance Monitoring Committee (PMC) as designated by the Medical Executive Committee or a specialty/department specific committee to conduct the review of individual practitioner performance for the Medical Staff. The Performance Monitoring Committee's purpose and oversight is described in the Performance Monitoring Committee Charter (Attachment A) unless otherwise designated for specific circumstances by the MEC. Members of the peer review body may render assessments of practitioner performance based on information provided by individual reviewers with appropriate subject matter expertise.

Peer: An individual practicing in the same profession and who has expertise to evaluate the subject matter under review. The level of subject matter expertise required will be determined on a case-by-case basis.

Practitioner: A Medical Staff Member (MSM) or an Advanced Practice Provider (APP).

Peer Review Data: Data sources may include case reviews and aggregate data based on review, rule and rate indicators in comparison with generally recognized standards, benchmarks or norms. The data may be objective or perception-based as appropriate for the competency under evaluation.

Practitioner Competencies: The General or Core practitioner competencies for evaluation are described below and further elaborated in the Medical Staff Expectations for Practitioners (Attachment B).

- Patient Care
- Medical Knowledge
- Interpersonal and Communication Skills
- Professionalism
- Systems Based Practice
- Practice Based Learning and Improvement

V. GUIDELINES/PROCEDURES

A. Information Management

1. All peer review information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws, regulations and accreditation requirements pertaining to confidentiality and non-discoverability.
2. The involved practitioner will receive written provider-specific feedback.
3. The medical staff will use the provider-specific peer review results in making its recommendations to the hospital regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.

4. Any written documents that the medical staff determines should be retained related to provider-specific peer review information will be kept by the hospital in a secure, locked file. Provider-specific peer review information may include:
   - Individual case review findings
   - Aggregate performance data for all of the general competencies measured for that practitioner
   - Any written correspondence with the practitioner deemed necessary regarding commendations, improvement opportunities, or corrective action and working notes of the peer review process. Any written or electronic documents related to the review process other than the final committee decisions shall be considered working notes of the committee and shall be destroyed by policy after the committee decision has been made. Working notes include potential issues identified by hospital staff, preliminary case rating, questions and notes of the practitioner reviewers.
   - Peer review data will be retained according to the HSHS document retention policy.
5. Peer review information in a practitioner's quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities. The Chief Physician Executive (CPE) will assure that only authorized individuals have access to individual provider quality files and that files are reviewed under the supervision of the Director of Medical Staff Office or designee for the following individuals:
   - The specific provider being reviewed (after contacting the Medical Staff President, Chief Physician Executive or Director of Medical Staff Services, may have read only access to his/her file(s) of written reports and action/resolution summaries as approved by the hospital's legal counsel)
   - Members of the MEC and/or department chairs, credentials committee
   - CPE, medical staff services professionals supporting the peer review process
   - Individuals surveying for accrediting bodies with appropriate jurisdiction e.g. The Joint Commission, HFAP, DNV or state/federal regulatory bodies
   - Individuals with a legitimate purpose for access as determined by the hospital's legal counsel and/or the Board of Directors
   - The hospital CEO for purposes of any potential professional review action as defined by the medical staff bylaws
6. No copies of peer review documents will be created and distributed unless authorized by medical staff policy or bylaws, the hospital's legal counsel, the MEC, or the Board.

B. Internal Peer Review

1. ***Circumstances:*** Internal Peer Review is conducted by the medical staff using its own members as the evaluation source of practitioner performance. It is performed as an OPPE and reported to the appropriate committee for review and action as appropriate. The procedures for conducting Internal Peer Review for an individual case and for aggregate performance measures are described below.
   a. New hospital procedure/technology and review is recommended by a medical staff committee, and/or by a board requirement; or
   b. A sentinel event or "near-miss" identified by Risk Management during concurrent or retrospective review; or
   c. Special circumstances requiring focused review (e.g. unusual clinical pattern of care, limited license, DEA, malpractice, number of management inappropriate, etc.). The Department Chair, Credentials Committee, and/or Medical Executive Committee can determine a need for reviews and evaluation of focused review.
   d. Measures for review are determined by both hospital-wide and department/specialty-specific indicators. Indicators are reviewed and evaluated for their ability to provide objective screening measures regarding the clinical knowledge, clinical competence, clinical judgment and skill of a peer.

2. ***Participants:*** Participants in the review process will be selected according to the medical staff policies and procedures and based on granted privileges. All participants will sign a statement of confidentiality prior upon

initial appointment and then biannually with recredentialing/reappointment. It is expected that members of the medical staff avail themselves to participate in the peer review process.

3. ***Conflict of Interest Procedure:*** It is the obligation of the reviewer to disclose to the Medical Staff Services personnel assigning a peer review case or to the Performance Monitoring Committee a potential conflict. It is the responsibility of the peer review assigner to determine on a case by case basis if a relative conflict is substantial enough to prevent the individual from participating.
    - When a potential conflict is identified, the Department Chair or Performance Monitoring Committee chair will be informed in advance and make the determination if a substantial conflict exists.
    - When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during peer review body discussions or decisions other than to provide specific information requested as described in the peer review process.

    In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, the Performance Monitoring Committee, the Department Chair or MEC will replace, appoint or determine who will participate in the process so that bias does not interfere in the decision-making process.

4. ***Performance Measurement and OPPE/FPPE***

    a. Selection of Practitioner Performance Measures
    Measures of practitioner performance will be selected to reflect the six General Competencies and will utilize multiple sources of data.

    b. Individual Case Review
    Case review will be conducted based on review indicators determined by the medical staff. Case review will be conducted in a timely manner with the goal for routine cases to be completed within 90 days from the date the chart is reviewed by the quality management staff and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability.

    c. Indicator Data Evaluation for Ongoing Professional Practice Evaluation (OPPE)
    The evaluation of practitioner performance measures from either the results of single or multiple case reviews, or rate or rule indicators will be conducted on an ongoing basis as described in the OPPE/FPPE policy.

    d. Thresholds for Focused Professional Practice Evaluation (FPPE)
    If the results of an OPPE indicate a potential issue with practitioner performance, the Department Chair, the Performance Monitoring Committee or MEC may initiate a FPPE as described in the OPPE/FPPE policy. Additionally, a single egregious case may initiate a focused review by the Department Chair, the PMC or MEC.

C. External Peer Review

1. **Circumstances:** Circumstances for External Peer Review may include but are not limited to the following:
    - Lack of internal expertise: when no one on the medical staff has adequate expertise in the specialty under review; including new procedures or technology or the only practitioners on the medical staff with that expertise are determined to have a significant conflict of interest.
    - Ambiguity: when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees.
    - Legal concerns: When dealing with the potential for lawsuits, or when the medical staff needs confirmation of internal findings or an expert witness for potential litigation or fair hearing.

- Credibility: when or if the medical staff or Board needs to verify the overall credibility of the internal peer review process typically as an audit of internal peer review findings.
- Benchmarking: when an organization is concerned about the care provided by its physicians relative to best practices and wishes to better define its expectations and as future quality monitoring to determine whether improvement has been achieved.
- Lack of internal resources: when the medical staff has the expertise but lacks sufficient time or resources to perform external peer review, or when the only practitioners on the medical staff with expertise are determined to have a conflict of interest regarding the practitioner under review.
- In addition, the MEC or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies.

2. Authorization

Either the Director of Medical Staff Services or designee, Chief Physician Executive, Department Chair, Performance Monitoring Committee, MEC or the Board of Directors will make determinations on the need for external peer review. No practitioner can require the hospital to obtain external peer review if it is not deemed appropriate by the determining bodies indicated above. The authorizing body will define how the external results will be evaluated and considered regarding the quality and appropriateness of care. This will be based on the nature of the review, the expertise of the reviewer, and the issues under review.

3. Review

Once the results of external peer review are obtained, unless the reason for external peer review was due to legal concerns or credibility, the report will be reviewed to determine if any potential improvement opportunities are present. If improvement opportunities exist, they will be handled through the same mechanism as internal peer review unless the issue is already being addressed in the corrective action process. If external peer review is requested directly by MEC or the Board for legal concerns or credibility, the requesting body will determine which body should perform the initial review of the report.

4. Practitioner Involvement

The authorizing body will prospectively determine the nature of the involvement for the practitioner under review. If issues are identified, the practitioner will be given a copy of the report and an opportunity to provide input regarding its findings in the same timeframes as for internal peer review prior to the committee's final decision. The identity of the external peer reviewer will be blinded from the practitioner.

D. Oversight and Reporting

The oversight of the peer review process is described in the Performance Monitoring Committee charter (Attachment A). Ongoing peer review is conducted in a consistent manner and reported to the appropriate medical staff committee for action with information reported to the Medical Executive Committee, Board Quality Care and the Board of Directors on a quarterly basis.

E. Statutory Authority

Peer review information is considered privileged and confidential in accordance with Wisconsin Statutes §146.37 and §146.38 and federal laws and regulations covering peer review protection. Protected information includes information in the Medical Staff Confidential Peer Review summary executive minute, practitioner's reappointment/reauthorization profile, OPPE and FPPE, confidential emails and other documented practitioner communication created by the medical staff specialist or designee.

"Statement of confidentiality"

All information, interviews, reports, statements, memoranda, recommendations, letters of reference or other third party confidential assessments of a health care practitioner's professional competence used in the course of evaluation and

improvement of quality care is privileged, strictly confidential, non-discoverable and inadmissible in accordance with the Wisconsin Statutes §146.37 and §146.38 and federal laws and regulations covering peer review protection."

F. Peer Review Liability Immunity

The ongoing work of MSMs granted privileges and APPs with an approved scope of practice are only reviewed in the Executive session of medical staff meetings, acting through the peer review process and governed by the bylaws of the Medical Staff. Hospital and clinical support staff participate in the review process if deemed appropriate.

In the event there is an action against a peer review committee member, the corporate bylaws stipulate indemnity for committee members of the hospital against damages and expenses actually and incurred in connection with any suit or proceeding arising from the fact that the person is or as the agent of the hospital. Excluded from indemnity are actions that are determined to involve conflict or interest or willful or want on misconduct.

VI. ATTACHMENT LIST

Attachment A: Peer Review Committee Charter
Attachment B: Medical Staff Competency Expectations and Implementation Policy (Joint Commission Framework)

Attachment A

St. Vincent Hospital/St. Mary's Hospital and St. Nicholas Hospital Performance Monitoring Committee Charter

PURPOSE

The purpose of the Performance Monitoring Committee is to establish a committee to monitor and improve physician and Advanced Practice Provider performance on an individual and aggregate level.

GOALS

1. Improve patient outcomes by pursuing and maintaining excellence in physician and APP performance.
2. Create a culture with a positive approach to physician and APP peer evaluation by recognizing physician/APP excellence as well as identifying improvement opportunities.
3. Promote efficient use of physician/APP and clinical review resources.
4. Provide accurate and timely performance data for physician feedback, ongoing and focused professional practice evaluation for use in the appointment of physicians to Medical Staff membership and APPs, granting of clinical privileges and reappointment.
5. Provide a link with the hospital performance improvement structure to assure responsiveness to system improvement opportunities identified by the Medical Staff.

SCOPE
AUTHORITY AND RESPONSIBILITY

The Performance Monitoring Committee (PMC) will have oversight for evaluating and improving physician/APP performance through:

- Evaluate performance of individual cases of physicians and/or Advanced Practice Providers with clinical privileges
- Identify potential hospital performance improvement (PI) opportunities resulting from case review and confidentially relay such information and/or recommendations to the appropriate hospital or allied health professional quality improvement department committee or designee
- Approve additions or deletions to indicators, criteria, or focused studies for the evaluation of physician/APP performance
- Review the indicators, screening tools, and referral systems for effectiveness, in collaboration with the Medical Staff Department Chairs, and recommend changes to the Medical Executive Committee (MEC)
- Assure that all Medical Staff departments participate in the development of specialty-specific indicators. If a department fails to provide recommendations, the PMC will assist the Department Chair to develop and implement specialty-specific indicators
- Define the appropriate content and format for physician performance feedback reports

The following quality and peer evaluation activities have been delegated by the PMC as described:

- Blood Use: Policies requiring medical staff approval for blood use will be referred to the Department of Pathology Committee to report to the Medical Executive Committee for approval.
- Medication Use: Formulary and medication policy issues requiring Medical Staff approval will be addressed by the Pharmacy & Therapeutics Committee and reported to the MEC for approval.
- Quality Review: Routine concurrent aspects of Quality measures including Core/SCIP measures, Institute for Healthcare Improvement (IHI) initiatives, National Patient Safety Goals, and other state and national quality initiatives will be managed through the Quality and CPI department and the Chief Physician Executive. Patterns and trends data will be addressed by the PMC as needed.

The PMC may delegate some aspects of peer evaluation to individual Medical Staff departments or department sub-committees. The designation of such review/evaluation and investigation is considered peer review. The following quality

review activities have been delegated by the PMC as described. Cases with misinterpretations or missed findings resulting in significant change in treatment, or significant adverse outcomes potentially related to physician care, as defined by Review Indicators, will be referred to the Medical Staff Services Office to initiate the designated case review process.

- Image Based Specialties (Pathology, Radiology): Image Based Specialties will perform routine quality improvement and patient safety review and peer reviews of diagnostic image interpretation by physicians (e.g., surgical pathology or cytology slides, radiological images).
- Trauma: The Trauma Committee will perform its quality review function under the required American College of Surgeons guidelines.
- Departmental and Specialty Morbidity and Mortality Functions (Case Reviews): Departments and sections of the Medical Staff may on a routine or an ad-hoc basis conduct M&M meetings or discussions for the purpose of quality improvement, patient safety, and education.
- Sentinel Events: Sentinel events and "near misses" are reported and investigated in a non-punitive environment by the Risk Manager in accordance with the Sentinel Event directive #100-01-056.

The following aspects of physician performance will NOT be addressed by the Performance Monitoring Committee:

- Physician/APP Behavior: Individual physician and Advanced Practice Providers colleague behavior incidents will be addressed by the Director of Medical Staff Services, Medical Staff Department Chairs, Chief Physician Executive and/or the Physician Health Committee.
- Health Information Management: Issues related to individual physician compliance with documentation criteria and record completion will be addressed by the Medical Executive Committee. However, general patterns of noncompliance with medical record documentation and record completion will be presented periodically to the PMC.
- Credentialing: Each Medical Staff department is responsible for evaluating the qualification of its members for membership and clinical privileges. Department recommendations are reviewed by the Medical Staff Credentials Committee, Medical Executive Committee and the Hospital Board of Trustees, as set forth in the Bylaws.

MEMBERSHIP

The Performance Monitoring Committee shall consist of eight members of the Medical Staff, one of whom shall serve as chairperson, with an option of at least one Advanced Practice Provider; members are appointed by the PMC Chairperson based on the recommendations of the Medical Staff Department Chairpersons and PMC members. The appointments are subject to approval by the MEC. An effort will be made to be reflective of the Medical Staff as a whole in specialties and medical groups represented.

Members will serve for a 3-year term with the option of renewal.

The Chair of the PMC will be appointed by the PMC with subject to approval by the MEC.

PMC members will be expected to attend at least two thirds of the PMC meetings over a twelve-month period to maintain membership. PMC members will be expected to participate in appropriate educational programs provided by the hospital or Medical Staff to increase their knowledge and skills in performing the PMC's responsibilities.

MEETINGS

The PMC will meet monthly as required. A quorum for purposes of making case determinations will be based on the presence of 50% of the voting members at a regularly scheduled meeting. Action will be by a simple majority, with a majority consisting of a majority of voting members present.

REPORTING

The PMC reports directly to the Medical Executive Committee (MEC) and will provide quarterly reports regarding actions recommended by the PMC to be taken to improve the quality of patient care. No changes can be made to the PMC charter and policies without approval of the MEC.

Attachment B

Medical Staff Competency Expectations and Implementation Policy (Joint Commission Framework)

Expectations of Attending Physicians Granted Privileges at HSHS St. Vincent Hospital, St. Mary's Hospital, St. Nicholas Hospital and St. Clare Hospital

Outlined below are the expectations that physicians have of each other as members of our medical staff. These expectations reflect current medical staff bylaws, policies and procedures and organizational policies to bring together the most important issues found in those documents and key concepts reflecting our medical staff's culture and vision. While these expectations will provide a guide for the medical staff in selecting measures of physician competency, not every expectation will be directly measured.

Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease and at the end of life as evidenced by the following:

1. Provide effective patient care that consistently meets or exceeds medical staff or appropriate external standards of care as defined by comparative outcome data, medical literature and results of peer review activities.
2. Plan and provide appropriate patient management based on accurate patient information, patient preferences, current indications and available scientific evidence using sound clinical judgment.
3. Assure that each patient is evaluated by a physician as defined in the bylaws, rules and regulations and document findings in the medical record at that time.
4. Demonstrate caring and respectful behaviors when interacting with patients and their families.
5. Provide for patient comfort by managing acute and chronic pain according to medically appropriate standards.
6. Counsel and educate patients and their families.
7. Cooperate with hospital efforts to implement methods to systematically enhance disease prevention.
8. If applicable, supervise residents, students and allied health professionals to assure patients receive high quality of care.

Medical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, Clinical and social sciences, and the application of their knowledge to patient care and the education of others as evidenced by the following:

1. Use evidence-based guidelines when available, as recommended by the appropriate specialty, in selecting the most effective and appropriate approaches to diagnosis and treatment.
2. Maintain ongoing medical education and board certification as appropriate for each specialty.
3. Demonstrate appropriate technical skills and medical knowledge.

Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams as evidenced by the following:

1. Communicate effectively with physicians, other caregivers, patients and families to ensure accurate transfer of information through appropriate oral and written methods according to hospital policies.
2. Request inpatient consultations by providing adequate communication with the consultant including a

clear reason for consultation and direct physician-to-physician contact for urgent or emergent requests.

3. Maintain medical records consistent with the medical staff bylaws, rules, regulations and policies.
4. Work effectively with others as a member the health care team.
5. Maintain patient satisfaction with physician care.

Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society as evidenced by the following:

1. Act in a professional, respectful manner at all times and adhere to the Medical Staff Bylaws, Rules and Regulations, and Hospital policies.
2. Respond promptly to requests for patient care needs.
3. Address disagreements in a constructive, respectful manner away from patients or non-involved caregivers.
4. Participate in emergency call as defined in the bylaws, rules and regulations.
5. Follow ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and discussion of unanticipated adverse outcomes.
6. Utilize sensitivity and responsiveness to culture, age, gender, and disabilities for patients and staff.
7. Make positive contributions to the medical staff by participating actively in medical staff functions, serving when requested and by responding in a timely manner when input is requested.

Systems Based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize healthcare as evidenced by the following:

1. Comply with hospital efforts and policies to maintain a patient safety culture, reduce medical errors, and meet national patient safety goals.
2. Follow nationally recognized recommendations regarding infection control procedures and precautions when participating in patient care.
3. Ensure timely and continuous care of patients by clear identification of covering physicians and by availability through appropriate and timely electronic communication systems.
4. Provide quality patient care that is cost effective by cooperating with efforts to appropriately manage the use of valuable patient care resources.
5. Cooperate with guidelines for appropriate hospital admission, level of care transfer, and timely discharge to outpatient management when medically appropriate.

Practice Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care as evidenced by the following:

1. Regularly review your individual and specialty data for all general competencies and use the data for self-improvement of patient care.
2. Respond in a constructive manner when contacted regarding concerns about patient care.
3. Use hospital information technology to manage information and access on-line medical information.
4. Facilitate the learning of students, trainees and other health care professionals.

Policy for Communication and Use of Physician Competency Expectations

The medical staff competency expectations of physician performance provided in the above document have been approved by the MEC and the Medical Staff of St. Vincent Hospital, St. Mary's Hospital, St. Nicholas Hospital and St. Clare Hospital. The goal of communicating these expectations is to create a fair process for physicians on our medical staff to hold each other mutually accountable for physician performance. The communication of these expectations will occur through the following mechanisms:

New Applicants/Appointees:

- All providers requesting medical staff membership will be provided with a copy of the competency expectations with the application materials.
- All new appointees will sign a copy of the expectations to acknowledge receiving and reading it as part of their appointment documents. The appointment application will not be considered complete without the signed expectations document.

Current Members

- At the time of individual reappointment, medical staff members undergoing reappointment will receive a copy of the current version of the expectations with their reappointment documents.
- All members seeking reappointment will return a signed copy of the expectations to acknowledge receiving and reading it. The reappointment application will not be considered complete without the current signed expectations document.
- Members undergoing performance improvement or corrective action activities will receive a copy of the current expectations as part of the process.