MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF
EDWARD W. SPARROW HOSPITAL ASSOCIATION

MEDICAL STAFF ORGANIZATION MANUAL

Approvals
Medical Staff Executive Committee:  9/2/2014
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Board of Directors:  9/30/2014

Horty, Springer & Mattern, P.C.
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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.
ARTICLE 2

CLINICAL DEPARTMENTS AND SECTIONS

2.A. DEPARTMENTS AND SECTIONS

The Medical Staff shall be organized into the following departments and sections:

Anesthesiology
Emergency Medicine
Family Medicine
Laboratories
Medicine
Cardiology
Neurology
Obstetrics and Gynecology
Pediatrics
Psychiatry
Radiology
Surgery
Cardiothoracic Surgery
General Surgery
Neurosurgery
Ophthalmology
Oral/General Dentistry
Orthopedic Surgery
Otolaryngology (ENT)
Plastic Surgery
Podiatry
Urology
2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND DEPARTMENT CHAIRS

The functions and responsibilities of departments and department chairs and vice chairs are set forth in Article 4 of the Medical Staff Bylaws.

2.C. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS

(1) Clinical departments shall be created and may be consolidated or dissolved by the MEC upon approval by the Board as set forth below.

(2) The following factors shall be considered in determining whether a clinical department should be created:

(a) there exists a number of members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in the Bylaws);

(b) the level of clinical activity that will be affected by the new department is substantial enough to warrant imposing the responsibility to accomplish departmental functions on a routine basis;

(c) a majority of the voting members of the proposed department vote in favor of the creation of a new department;

(d) it has been determined by the Medical Staff leadership and the CEO that there is a clinical and administrative need for a new department; and

(e) the voting Medical Staff members of the proposed department have offered a reasonable proposal for how the new department will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.

(3) The following factors shall be considered in determining whether the dissolution of a clinical department is warranted:

(a) there is no longer an adequate number of members of the Medical Staff in the clinical department to enable it to accomplish the functions set forth in the Bylaws and related policies;

(b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department;
(c) the department fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;

(d) no qualified individual is willing to serve as chair of the department; or

(e) a majority of the voting members of the department vote for its dissolution.
ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

(2) Procedures for the appointment of committee chairs and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.

(3) This Article details the standing members of each Medical Staff committee. In addition to the standing members, other Medical Staff members or Hospital personnel may be invited to attend a particular Medical Staff committee meeting (as guests, without vote) in order to assist such committee in its discussions and deliberations regarding the issues on its agenda. All such individuals are an integral part of the credentialing, quality assurance, and peer review process and are bound by the same confidentiality requirements as the standing members of such committees.

3.B. MEETINGS, REPORTS, AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual shall meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely report after each meeting to the MEC and to other committees and individuals as may be indicated in this Manual.

3.C. BLOOD PRODUCT AND SAFETY UTILIZATION COMMITTEE

3.C.1. Composition:

(a) The Blood Product and Safety Utilization Committee is a multidisciplinary standing subcommittee of the Centralized Peer Review and Quality Committee, which shall consist of at least five members of the Active Staff as well as one ex officio resident member appointed to the committee by recommendation from the Graduate Medical Education Committee to the chair of the Blood Product and Safety Utilization Committee. A co-chair of the committee shall be elected by the members of the committee.

(b) Members will be appointed for three-year terms with the initial terms staggered such that approximately one-third of the members will be elected each year. The
chair shall also serve a three-year term. The chair and members may be reappointed for additional terms without limit.

3.C.2. Duties:

The Blood Product and Safety Utilization Committee shall:

(a) provide leadership to plan, initiate, monitor and respond to all blood and blood component administration activities;

(b) be responsible for maintaining institutional compliance with regulatory, accrediting and licensing agencies such as the American Association of Blood Banks (AABB) and The Joint Commission;

(c) coordinate the systematic and ongoing review of the appropriateness and quality of blood and blood products safety and utilization to promote the safe and effective use of blood, blood components and pharmaceutical blood substitutes;

(d) review and approve blood usage review plan;

(e) coordinate, prioritize, and monitor the Medical Staff blood and blood products safety and utilization data;

(f) develop an annual strategic blood and blood products safety and utilization plan to include:

   (i) development, implementation, and revision as needed of policies and procedures related to blood and blood products safety and utilization;

   (ii) providing training to all staff, including professionals involved in the transfusion of blood and blood products safety and utilization to established policies and procedures; and

   (iii) establishing a system for conducting annual competency and compliance assessment;

(g) supervise the maintenance of a quality review profile on each staff member related to blood and blood products safety and utilization, and transmit via the quality and risk management departments the same to be used in conjunction with the periodic reappraisal of each staff member;

(h) implement a system for screening of clinical risk management issues related to blood and blood products safety and utilization, including unexpected patient care management events and morbidity concerns; analyze aggregate data on significant high-risk events by identifying possible patterns and communicate same to the CPRQC and health system groups with related responsibilities; and
analyze trends of hazardous and risk management events reported regarding blood and blood products safety and utilization and attempt to determine effective solutions and implement appropriate systems or suggest action to enhance the quality and safety of patient care.

3.D. CANCER COMMITTEE

3.D.1. Composition:

The Cancer Committee is a multidisciplinary standing subcommittee of the Centralized Peer Review and Quality Committee with membership in accordance with the Commission on Cancer Standard 1.2. The committee shall also have one ex officio resident member appointed to the committee by recommendation from the Graduate Medical Education Committee to the chair of the Cancer Committee.

3.D.2. Duties:

The Cancer Committee shall:

(a) develop and evaluate annual goals and objectives for the clinical, educational, and programmatic activities related to cancer and the operations of the Cancer Center;

(b) organize, publicize, conduct, and evaluate regular educational and consultative cancer conferences that are multidisciplinary, institutionwide, and patient-oriented;

(c) ensure that consultative services from all major disciplines are available to all patients;

(d) supervise the Cancer Registry for quality control of abstracting, staging, and reporting;

(e) plan and complete a minimum of two patient care evaluation studies annually, one to include survival data and, if available, comparison data;

(f) ensure that cancer rehabilitation services are available and used; and

(g) encourage a supportive care system for all patients with cancer.

3.E. CENTRALIZED CREDENTIALS COMMITTEE

3.E.1. Composition:

(a) The Centralized Credentials Committee shall consist of at least five members of the Active Staff as well as one ex officio resident member appointed to the
committee by recommendation from the Graduate Medical Education Committee to the chair of the Centralized Credentials Committee.

(b) The chair and all members will be appointed for three-year terms with the initial terms staggered such that approximately one-third of the members will be elected each year. The chair and members may be reappointed for additional terms without limit.

3.E.2. Duties:

The Centralized Credentials Committee shall:

(a) in accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make reports of its findings and recommendations;

(b) in accordance with the Policy on Allied Health Professionals, review the credentials of all applicants seeking to practice as Category I and Category II practitioners, conduct a thorough review of the applications, interview such applicants as may be necessary, and make reports of its findings and recommendations;

(c) review, as may be requested by the MEC, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff and, as a result of such review, make a report of its findings and recommendations; and

(d) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including specifically as set forth in Section 4.A.3 (“Clinical Privileges for New Procedures”) and Section 4.A.4 (“Clinical Privileges That Cross Specialty Lines”) of the Credentials Policy.

3.F. CENTRALIZED PEER REVIEW AND QUALITY COMMITTEE (“CPRQC”)

3.F.1. Composition:

(a) The CPRQC shall consist of the Past Chief of Staff (who shall serve as the co-chair), the Medical Director of Performance Improvement (who shall serve as the second co-chair), the vice chairs of the clinical departments, the VPMA, and the Chief of Staff-Elect.

(b) The CPRQC includes two subcommittees: the Blood Product and Safety Utilization Committee and the Cancer Committee.
3.F.2. Duties:

The CPRQC shall:

(a) coordinate the systematic and ongoing review of the appropriateness and quality of: blood, drug use, surgery and invasive procedures, timeliness of completion of medical records, and physician-related infection data;

(b) review and approve blood usage review plan;

(c) coordinate, prioritize, and monitor the Medical Staff data gathering and analysis components of the health system’s quality review program and coordinate the Medical Staff’s activities in this area with those of the other professional and support services in the health system;

(d) serve as a liaison for quality review issues with the Medical Staff, the health system staff, and the committee(s) responsible for accreditation and licensure;

(e) develop an annual strategic plan, in coordination with the Medical Director of the Performance Improvement and Director of Risk Management services, for the staff’s performance improvement activities and annually review the effectiveness and cost efficiency of the staff’s process improvement activities;

(f) establish the following;

(i) formats for the aggregation, display and reporting of data and findings;

(ii) systems for follow up to determine that action taken results in problem resolution; and

(iii) format and schedule for submission of data and findings, committee minutes, and special reports;

(g) receive and synthesize information submitted by the infection control nurse, pharmacy and therapeutics, critical care, radiation safety and cancer areas, on a routine basis;

(h) supervise the peer review process pertinent to each staff member, incorporating ongoing professional practice evaluations, focused professional evaluations and reports to MEC via the centralized peer review report, the same to be used in connection with the periodic reappraisal of each staff member;

(i) implement a system for screening of clinical risk management issues, including unexpected patient care management events and morbidity concerns; analyze aggregate data on significant high-risk events by identifying possible patterns and
communicate same to the MEC and health system groups with related responsibilities; and

(j) analyze trends of hazardous and risk management events reported and attempt to determine effective solutions and implement appropriate systems or suggest action to enhance the quality and safety of patient care.

3.G. CONTINUING MEDICAL EDUCATION/LIBRARY COMMITTEE

3.G.1. Composition:

(a) The Continuing Medical Education/Library Committee is a standing subcommittee of the Graduate Medical Education Committee and shall consist of at least three Medical Staff members who will serve in one of two categories: (i) those interested in serving as long-standing core members, and (ii) those who will serve on a rotational basis consisting of three-year terms. The committee will also include the Medical Library Manager, Operations Manager of Medical Education, Medical Education Director, and one ex officio resident member.

(b) Each member of the committee will carry one vote on events seeking CME credit.

3.G.2. Duties:

The Continuing Medical Education/Library Committee shall:

(a) identify the educational needs of the Medical Staff, and suggest educational programs that will improve patient care based on evaluation of quality assurance activities and defined needs;

(b) assist the Medical Staff in planning, implementing, coordinating, promoting, and assessing programs of continuing education that are designed to keep the Medical Staff informed of significant new developments and new skills in medicine; and

(c) make recommendations regarding the library needs of the Medical Staff.

3.H. DEPARTMENT LEADERSHIP COMMITTEES

3.H.1. Composition:

Any clinical department may opt to elect and utilize a Department Leadership Committee. Such committees shall consist of at least five members of the Active Staff who have been elected by the voting members of the relevant department and confirmed by the MEC and Board.
3.H.2. Duties:

The Department Leadership Committees shall:

(a) develop, review, and recommend updates to criteria for clinical privileges within the relevant clinical department;
(b) provide leadership in the development of clinical protocols and order sets within the relevant clinical specialty area;
(c) review new policies that have been developed by Hospital administration and/or Medical Staff leadership that affect the provision of patient care services within the relevant department, participate in the communication of such policies to members of the department, and provide leadership in the development of the same, when necessary;
(d) agree, as individual members, to serve as initial reviewers when clinical specialty expertise is requested by the Centralized Peer Review and Quality Committee (“CPRQC”);
(e) develop and review, on an ongoing basis, relevant specialty-specific quality indicators utilized in the ongoing professional practice evaluation process and make recommendations for updates when indicators are being met;
(f) develop and recommend to the CPRQC baseline focused professional practice evaluation recommendations to confirm competence for new members of the relevant department in relevant specialty areas;
(g) provide oversight and assistance as may be necessary to effectuate the focused professional practice evaluation process to confirm competence for new members of the relevant department;
(h) perform any other tasks as may be directed by the CPRQC, MEC, or the Board; and
(i) meet as often as necessary to accomplish their functions, maintain a permanent record of their findings, proceedings, and actions which shall be forwarded to the CPRQC and to the MEC.

3.I. GRADUATE MEDICAL EDUCATION COMMITTEE (“GMEC”)

3.I.1. Composition:

(a) The GMEC shall consist of at least one representative from both the Michigan State Colleges of Human Medicine and Osteopathic Medicine, the Operations Manager for Medical Education, six resident representatives, and the Director of
Medical Education, who shall serve as the chair of the committee. Residency Program Directors or their alternate from all residency programs who use Sparrow Hospital as their primary training site will also be members of the GMEC.

(b) The six voting resident members shall be selected by nomination from the following groupings: one resident from the Family Practice and Sports Medicine programs; one resident from the Neonatology and Pediatrics programs; one resident from the Internal Medicine and Cardiology programs; one resident from the Osteopathic Internship, Neurology, OB/GYN, and Urology programs; one resident from the Emergency Medicine program; and one resident from the General Surgery program.

(c) Each member of the committee shall have one vote.

3.1.2. Duties:

The GMEC shall advise the MEC and Board regarding the following:

(a) institutional policies regarding the functioning and supervision of all graduate medical education trainee activities within the institution;

(b) evaluation of clinical activities, patient safety issues, quality of patient care provided by the participants in the residency program and educational and supervisory needs of graduate medical education trainees; and

(c) the scope of practice and credentialing of trainees, both for educational and professional activities defined by the residency curriculum and for those outside the scope of residency curriculum.

3.J. MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the MEC are set forth in Section 5.D of the Medical Staff Bylaws.

3.K. NOMINATING/LEADERSHIP DEVELOPMENT COMMITTEE

3.K.1. Composition:

The Nominating/Leadership Development Committee shall consist of the Chief of Staff (who shall serve as Chair), the Immediate Past Chief of Staff, the Chief of Staff-Elect, and two additional members of the Medical Staff appointed by the MEC in specialty areas that will enable the Committee to be as broadly representative of the Medical Staff as possible. The VPMA and the President shall also be members of the Committee, ex officio, without vote.
3.K.2. Duties:

The Nominating/Leadership Development Committee shall be responsible for the following:

(a) identifying and recommending to the MEC a slate of qualified individuals to serve as Medical Staff Officers in accordance with Article 3 of the Medical Staff Bylaws; and

(b) cultivating a physician leadership identification, development, and education process to promote effective and successful Medical Staff Leaders at present and in the future.

3.L. OSTEOPATHIC METHODS COMMITTEE

3.L.1. Composition:

The Osteopathic Methods Committee shall consist of at least three members of the Medical Staff who are doctors of osteopathic medicine and one ex officio osteopathic resident member appointed to the committee by recommendation from the GMEC to the chair of the Osteopathic Methods Committee.

3.L.2. Duties:

The Osteopathic Methods Committee shall:

(a) promote the effective use of distinctive osteopathic procedures;

(b) approve the recording of distinctive osteopathic findings, diagnosis, and therapy;

(c) provide an effective vehicle for continuing education of distinctive osteopathic principles and methods;

(d) conduct studies on and promote the effective methods for osteopathic diagnosis and treatment for comprehensive care, including such parameters as:

(i) recording of musculoskeletal findings, diagnosis, and management on patient charts;

(ii) the need for continuing education in osteopathic principles and practice;

(iii) defining the clinical environment for osteopathic diagnosis and treatment; and

(iv) promoting the use of osteopathic principles and practice in the recording of findings and of osteopathic manipulative treatment and the application
of such modalities as part of the comprehensive care rendered to/received by patients;

(e) conduct any other special studies of the inputs, processes or outcomes of the care that may be required to determine the appropriateness of clinical performance; and

(f) be responsible under paragraphs (i) and (ii) above to send written reports as required or requested on the progress and results of such studies directly to the MEC and to the Board.

3.M. TRIAGE COMMITTEE

3.M.1. Composition:

(a) The Triage Committee shall be comprised of the following voting members:

(1) Chief of Staff, who shall serve as the Chair;
(2) Immediate Past Chief of Staff;
(3) Chief of Staff-Elect;
(4) Chair, Centralized Credentials Committee; and
(5) VPMA.

(b) Medical Staff Services representatives shall serve as ex officio members, without vote, to facilitate the Triage Committee’s activities.

(c) Other Medical Staff members or Hospital personnel may be invited to attend a particular Triage Committee meeting (as guests, without vote) in order to assist the Triage Committee in its discussions and deliberations regarding an issue(s) on its agenda. These individuals shall be present only for the relevant agenda item(s) and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the Triage Committee.

3.M.2. Duties:

The Triage Committee shall perform the following functions:

(a) review and address concerns about practitioners’ professional conduct as outlined in the Medical Staff Professionalism Policy;
(b) review and address concerns about practitioners’ health status and the ability to provide safe and competent care as outlined in the Practitioner Health Policy;

(c) meet, as necessary, to consider and address any situation that may require immediate action;

(d) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any or all facilities within the Hospital; and

(e) perform any additional functions as may be outlined in the peer review policy or as may be requested by the CPRQC, the MEC, or the Board.
ARTICLE 4

AMENDMENTS

(a) An amendment to this Manual may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists.

(b) Notice of all proposed amendments shall be provided to each voting staff member at least 14 days prior to the MEC meeting when the vote is to take place, and any voting member may submit written comments on the amendments to the MEC.

(c) No amendment shall be effective unless and until it has been approved by the Board.
ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein.

Adopted by the Medical Staff: September 2, 2014
Approved by the Board: September 30, 2014

REVIEW AND UPDATES

Change: Add Triage Committee
Adopted by the Medical Staff: July 7, 2015
Approved by the Board: July 28, 2015