MEDICAL STAFF BYLAWS
BAYSTATE FRANKLIN MEDICAL CENTER
APPENDIX 1 - MEDICAL STAFF ORGANIZATION

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PART ONE: STANDING COMMITTEES OF THE MEDICAL STAFF

1.1 GENERALLY

Consistent with Article VII of the Medical Staff Bylaws and the Medical Center bylaws, the purposes and responsibilities of the Medical Staff may be fulfilled through the functioning of standing and special committees of the Medical Staff, as well as committees of the Medical Center. The purposes and responsibilities of the Medical Staff include but are not limited to the following areas of operation: governance, administration, performance review and improvement, monitoring, evaluation, utilization review and management, clinical competence, patient care services, credentialing, corrective action, education, research, medical records, pharmacy and therapeutics, infection control, disaster preparedness, planning, Medical Staff Bylaws review and proposed amendment, nomination of Medical Staff officers, and patient care assessment program activities.

The current standing committees of the Medical Staff are set forth below in this Appendix 1, Medical Staff Organization.

1.2 MEDICAL STAFF EXECUTIVE COMMITTEE

1.2.1 FUNCTIONS

The functions of the Medical Staff Executive Committee shall include the following:

(a) To represent and act on behalf of the Medical Staff in all matters, including between meetings of the Medical Staff, except as may be otherwise provided in the Medical Staff Bylaws;

(b) To receive, coordinate, and act upon, as necessary or appropriate, the written reports and recommendations of the clinical departments and the standing and special committees directly responsible to it and to receive and respond to other written or oral reports from time to time as necessary or appropriate;

(c) To coordinate or oversee coordination of the activities of and policies adopted by the Medical Staff, departments, divisions, services, other clinical subunits, and committees;

(d) To implement the approved policies of the Medical Staff or monitor that such policies are implemented by the departments, divisions, services, and other clinical subunits;

(e) To review and report to the Medical Staff on proposals for amendments to the Medical Staff Bylaws;

(f) To recommend to the Board of Trustees, as required by the Medical Staff Bylaws, concerning matters relating to appointments, reappointments, Medical Staff category, department assignments, clinical privileges, and disciplinary actions;

(g) To take reasonable steps to assure professional and ethical conduct and competent clinical performance on the part of Medical Staff members, including recommendations concerning initiating investigations and initiating and pursuing corrective action or other disciplinary action and termination of Medical Staff membership and clinical privileges, when warranted, and requesting evaluation of a practitioner for appointment or reappointment, or of a Member who has requested additional clinical privileges, where there are questions about an individual's ability to perform the privileges requested;

(h) To account to the Board of Trustees at least quarterly, by written report, on the quality and efficiency of medical care provided to patients in the Medical Center, including a summary of findings and conclusions, recommendations or actions taken, and the effect of such recommendations or actions;

(i) To make recommendations on what categories of associate health professionals shall be permitted to practice in the Medical Center and, for each category, the qualifications and description of services permitted, and to review and approve, subject to approval by the Board of Trustees, the Associate Professional Staff Rules and Regulations, and the policies specific to any particular category of associate health professionals; and further, to oversee the quality assurance and peer review activities concerning Associate Professional Staff members, nursing, and other professional staff at the Medical Center, which are part of the Patient Care Assessment Program at the Medical Center, including but not limited to receiving periodic reports from committees established to perform such functions, which such committees shall operate at the direction, and as subcommittees, of the Patient Care Assessment Committee of the Medical Center;

(j) To make recommendations to the Office of the CAO on medico-administrative, Medical Center management, and planning matters; and

(k) To serve, together with the Hospital Quality Council, as the Patient Care Assessment Committee under the Patient Care Assessment Program ("PCAP") as required by the Qualified Patient Care Assessment Program regulations of the Massachusetts Board of Registration in Medicine as amended from time to time ("Regulations") in accordance with all the

duties and authority under the PCAP as set forth in the Regulations, the PCAP, the PCAP Plan, and the Medical Staff and Medical Center bylaws, including the authority to report from time to time to the Hospital Quality Council, the Board of Trustees, the Baystate Health, Inc. ("BH") Board of Trustees, the BH Board of Trustees Quality Committee, and any subcommittee or other designated committee of any such committee.

The Medical Staff delegates these responsibilities to the Medical Staff Executive Committee, consistent with the Standards of The Joint Commission and relevant law. The responsibilities and authority hereby delegated to the Medical Staff Executive Committee may be amended by the Medical Staff through amendment of this Section 1.2.1, by following the process for amendment of these Bylaws set forth in Article XII.

1.2.2 COMPOSITION

The composition of the Medical Staff Executive Committee shall include the following:

(a) The four (4) officers of the Medical Staff, of whom the President shall serve as Chair;

(b) The Chiefs of the Departments of Anesthesiology, Emergency Medicine, Medicine, Obstetrics, Pathology, Psychiatry, Radiology, and Surgery, and the Chair of the Department of Family Medicine;

(c) Five (5) members at-large elected from and by the voting Members of the Medical Staff, at least one of whom shall be a physician assistant, nurse practitioner, nurse anesthetist, or nurse midwife. Members at-large shall not serve more than two (2) consecutive two (2) year terms but may be re-elected after a one (1) year hiatus;

(d) Chair, Credentials Committee;

(e) Medical Director, Hospital Medicine Program;

(f) Chief Medical Officer of the Baystate Health Northern Region, without vote;

(g) Office of the CAO, without vote; and

(h) Vice President of Patient Care Services, without vote.

In any event, the majority of the members of the Medical Staff Executive Committee shall be physicians.

1.2.3 MEETINGS AND REPORTING

The Medical Staff Executive Committee shall meet once a month at least eleven (11) times per year. Fifty percent (50%) of the voting members present in person at any meeting of the Medical Staff Executive Committee constitutes a quorum.

The Medical Staff Executive Committee shall report as necessary or appropriate to the Board of Trustees and to the Performance Improvement Council at the Medical Center.

1.3 CREDENTIALS COMMITTEE

1.3.1 FUNCTIONS

The functions of the Credentials Committee shall include the following:

(a) To coordinate the Medical Staff credentialing process;

(b) To analyze applications and recommendations for appointment, focused professional practice evaluation conclusion or extension, reappointment, changes in Medical Staff and Associate Professional Staff membership, and clinical privileges and changes therein, as well as applications and recommendations for appointment, reappointment, and clinical privileges for crisis clinicians and crisis supervisors, and to make recommendations thereon;

(c) To integrate quality and utilization assessment and review, monitoring, membership, and other relevant information into individual credentials files, including records of participation in Medical Staff and Associate Professional Staff and education activities, and records of results of quality assessment, review, monitoring, and utilization activities;;

(d) To review and recommend to the Medical Staff Executive Committee for approval the defined criteria for delineating clinical privileges for practitioners within each department, including the recommendation of and criteria for any clinical privileges that may be granted to be performed via telemedicine link, in compliance with Medical Staff and Medical Center bylaws, policies, procedures, standards, rules, and regulations, standards of The Joint Commission, and relevant law;

(e) To develop or coordinate, periodically review, and make recommendations on the procedures and forms used in connection with each component of the credentialing process and to oversee maintenance of the individual credentials files; and

(f) To design and oversee implementation of the credentialing procedures for associate health professionals and crisis clinicians/crisis supervisors

functioning under the supervision of the Medical Staff or a Medical Staff member.

1.3.2 COMPOSITION

The composition of the Credentials Committee shall be representative of the clinical departments and shall include the following, with two (2) of the physician members to be appointed to serve as Co-Chairs:

(a) At least three (3) and up to five (5) members of the Active Staff of the Medical Center ("BFMC") and whose primary site of practice is at the Medical Center;

(b) At least three (3) and up to five (5) members of the Active, Courtesy, or Affiliated Staff who are also members of the Active Staff of Baystate Noble Hospital ("BNH") and whose primary site of practice is at BNH;

(c) At least three (3) and up to five (5) members of the Active, Courtesy, or Affiliated Staff who are also members of the Active Staff of Baystate Wing Hospital ("BWH") and whose primary site of practice is at BWH;

(d) At least six (6) and up to eight (8) members of the Active, Courtesy, or Affiliated Staff who are also members of the Active Staff of Baystate Medical Center ("BMC") and whose primary site of practice is at BMC;

(e) Representatives from the Risk Management Departments of the Medical Center, BNH, BWH, and BMC, without vote;

(f) Representatives from the Quality Departments of the Medical Center, BNH, BWH, and BMC, without vote; and

(g) Representative(s) from the Medical Staff Office, without vote.

A designee of the Office of the CAO, without vote, also shall be available to attend meetings of the Credentials Committee as needed or appropriate and shall routinely receive copies of Credentials Committee materials, such as agendas, minutes, and reports.

Each physician member of the Credentials Committee shall serve no more than a total of six (6) consecutive terms.

1.3.3 MEETINGS AND REPORTING

The Credentials Committee shall meet monthly and shall report to the Medical Staff Executive Committee.

1.4 BLOOD TRANSFUSION COMMITTEE

1.4.1 FUNCTIONS

The functions of the Blood Transfusion Committee shall include the following:

(a) To monitor and evaluate the use of all blood and blood products for their appropriateness, safety, and effectiveness;

(b) To review the use of blood products and the appropriateness of blood transfusions;

(c) To review transfusion reactions;

(d) To review all incidents of blood borne hepatitis, AIDS, and other blood borne diseases;

(e) To review lab quality improvement in the blood bank; and

(f) To review nursing blood administration policies and procedures.

1.4.2 COMPOSITION

The composition of the Blood Transfusion Committee shall include the following:

(a) Physician members of the Medical Staff representing major clinical departments;

(b) Laboratory Manager;

(c) Representative from Blood Bank; and

(d) Representative from Patient Care Division.

1.4.3 MEETINGS AND REPORTING

The Blood Transfusion Committee shall meet at least quarterly and shall report as appropriate to the Medical Staff Executive Committee.

1.5 BYLAWS, RULES AND REGULATIONS COMMITTEE

1.5.1 FUNCTIONS

The functions of the Bylaws, Rules and Regulations Committee shall include the following:

(a) To review the Medical Staff Bylaws and the Medical Staff Rules and Regulations at least annually and to make recommendations to the

Medical Staff Executive Committee concerning proposed amendments, if any; and

(b) To review proposed amendments to the Medical Staff Bylaws and to the Medical Staff Rules and Regulations for compatibility with existing Medical Staff Bylaws and Medical Staff Rules and Regulations.

The Chair of the Bylaws, Rules and Regulations Committee shall act as parliamentarian at any Medical Staff meeting when so requested by the Medical Staff President.

1.5.2 COMPOSITION

The composition of the Bylaws, Rules and Regulations Committee shall include the Immediate Past President of the Medical Staff and at least three (3) Medical Staff members, one of whom shall serve as Chair.

1.5.3 MEETINGS AND REPORTING

The Bylaws, Rules and Regulations Committee shall meet at least annually or otherwise at the call of the Chair and shall report to the Medical Staff Executive Committee.

1.6 NOMINATING COMMITTEE

1.6.1 FUNCTIONS

The functions of the Nominating Committee shall be to nominate one or more qualified candidates for each of the Medical Staff offices.

1.6.2 COMPOSITION

The composition of the Nominating Committee shall include the following:

(a) Immediate past President of the Medical Staff, as Chair; and

(b) At least three (3) other members of the Medical Staff appointed by the President of the Medical Staff.

1.6.3 MEETINGS AND REPORTING

The Nominating Committee shall meet in or about September of each even-numbered year and more often as necessary or appropriate to fulfill its responsibilities. The Nominating Committee shall report to the Medical Staff Executive Committee.

1.7 PEER LEADERSHIP COUNCIL

1.7.1 FUNCTIONS

The functions of the Peer Leadership Council shall include the following:

(a) To receive, evaluate, and act upon as appropriate reports and referrals concerning alleged incidents regarding the clinical performance and professional conduct of Members and members of the Medical Center's Associate Professional Staff ("APS") (*e.g.*, reports and referrals that call into question whether healthcare services were performed in compliance with applicable standards of care or call into question the Member's or APS member's fitness to provide healthcare services, including, but not limited to, reports of conduct that undermines a culture of safety at the Medical Center);

(b) To serve as a collegial, non-disciplinary committee with the goal of helping Members and APS members to identify issues regarding and improve their clinical performance and professional conduct;

(c) To refer, with or without recommendation, to the Professional Practice Evaluation Committee ("PPEC"), for its consideration and appropriate recommendation or action, those reports or referrals deemed appropriate for PPEC review consistent with Medical Center and Medical Staff policies;

(d) To refer, with or without recommendation, to the Medical Staff Executive Committee, for its consideration and appropriate recommendation or action, situations involving questions related to the clinical performance or professional conduct of any Member, including, but not limited to, situations involving violations of Baystate Health, Inc. ("BH"), Medical Center or Medical Staff Bylaws, policies, procedures, standards, rules, and regulations;

(e) To submit written reports, at least semi-annually, to the Medical Staff Executive Committee and to department chiefs (with regard to Members and APS members in their respective departments) concerning reports received, reviewed, and resolved by the Committee; and

(f) To submit written reports to the Medical Staff Office to be used in the evaluation of applications by Members and APS members for reappointment, changes in Medical Staff membership, and changes in clinical privileges, as applicable.

1.7.2 COMPOSITION

The composition of the Peer Leadership Council shall include the following, one of whom shall be appointed to serve as Chair:

(a) The Chief Medical Officer for the Baystate Health Northern Region;

(b) A representative from Quality and Performance Improvement at the Medical Center;

(c) The President of the Medical Staff; and

(d) The Chair of the Professional Practice Evaluation Committee; and

(e) Based on the particular case under review, on an *ad hoc* basis for purposes of that case, the Department Chief of the Member whose conduct or performance is under review or another appropriate representative from among the Department Chiefs.

1.7.3 MEETINGS AND REPORTING

The Peer Leadership Council shall meet as often as necessary or appropriate to fulfill its responsibilities, but, in any event, at least one (1) time per year, and shall report to the Medical Staff Executive Committee.

1.8 PROFESSIONAL PRACTICE EVALUATION COMMITTEE

1.8.1 FUNCTIONS

The functions of the Professional Practice Evaluation Committee shall include the following:

(a) To receive, evaluate, and take appropriate action concerning alleged incidents regarding the clinical performance and professional conduct of Members and members of the Medical Center's Associate Professional Staff ("APS") (*e.g.*, reports that call into question whether healthcare services were performed in compliance with applicable standards of care or call into question the Member's or APS member's fitness to provide healthcare services, including, but not limited to, reports of conduct that undermines a culture of safety at the Medical Center);

(b) To refer, with or without recommendation, to the Medical Staff Executive Committee, for its consideration and appropriate recommendation or action, situations involving questions related to the clinical performance or professional conduct of any Member, including, but not limited to, situations involving violations of Baystate Health, Inc. ("BH"), Medical Center or Medical Staff Bylaws, policies, procedures, standards, rules, and regulations;

(c) To refer, with or without recommendation, to the appropriate department chief or supervisor, for consideration and appropriate recommendation or action, situations involving questions related to the clinical performance or professional conduct of any APS member, including, but not limited to,

situations involving violations of BH, Medical Center or Medical Staff Bylaws, policies, procedures, standards, rules, and regulations;

(d) To refer, with or without recommendation, to the appropriate BH Human Resources Department manager, for consideration and appropriate recommendation or action, situations involving questions related to the clinical performance or professional conduct of any Member or APS member who is employed by a BH-affiliated entity, including, but not limited to, situations involving violations of BH policies, procedures, and standards;

(e) To refer, with or without recommendation, to the Committee on Practitioner Health, for consideration and appropriate recommendation or action, situations involving questions of physical or mental impairments, including alcohol or substance abuse by a Member or APS member;

(f) To implement, facilitate, and monitor a Medical Staff process to identify and manage matters related to the clinical performance and professional conduct of Members and APS members that is separate from the Medical Staff and APS disciplinary functions, that includes a purpose of assistance and rehabilitation, and that is designed to educate Members; APS members; and BMC employees, volunteer, and other personnel regarding matters of clinical performance and professional conduct, including, but not limited to, behaviors that undermine a culture of safety;

(g) To serve as a resource to the Medical Staff, its committees and Members, and to APS members with regard to issues concerning clinical performance and professional conduct;

(h) To serve as a resource to the Medical Staff, its committees and Members, and APS members with regard to behavioral or health issues that undermine the safe exercise of clinical privileges and the culture of safety at the Medical Center;

(i) To review and approve specialty-specific data elements for Ongoing Professional Practice Evaluation and specialty-specific triggers for Focused Professional Practice Evaluation that are identified by each department;

(j) To develop, in conjunction with the Member or the APS member, Focused Professional Practice Evaluation plans that are intended to assist in the evaluation and improvement of identified areas of the clinical performance or professional conduct of Members and APS Members, in the best interests of patient care;

(k) To submit written reports, at least semi-annually, to the Medical Staff Executive Committee and to department chiefs (with regard to

practitioners in their respective departments) concerning reports received, reviewed, and resolved by the Committee; and

(l) To submit written reports to the Medical Staff Office to be used in the evaluation of applications by Members and APS members for reappointment, changes in Medical Staff membership, and changes in clinical privileges, as applicable.

1.8.2 COMPOSITION

The composition of the Professional Practice Evaluation Committee shall include the following, one of whom shall be appointed to serve as Chair:

(a) The Chief Medical Officer for the Baystate Health Northern Region;

(b) A representative from Quality and Performance Improvement at the Medical Center;

(c) The most recent past President of the Medical Staff; and

(d) Four (4) representatives from among the Department Chiefs; and

(e) Based on the particular case under review, on an *ad hoc* basis for purposes of that case, the Department Chief of the Member whose conduct or performance is under review or another appropriate representative from among the Department Chiefs.

1.8.3 MEETINGS AND REPORTING

The Professional Practice Evaluation Committee shall meet at least four (4) times per year and more often as necessary or appropriate to fulfill its responsibilities and shall report to the Medical Staff Executive Committee.

1.9 HOSPITAL QUALITY COUNCIL

1.9.1 FUNCTIONS

The functions of the Hospital Quality Council shall include the following:

(a) To be responsible for the overall direction, coordination, and integration of the quality assessment and quality improvement activities at the Medical Center;

(b) To establish, implement, and modify, subject to the approval of the Board of Trustees and where appropriate the Medical Staff Executive Committee, a performance improvement and patient safety plan for the Medical Center;

(c) To serve, together with the Medical Staff Executive Committee, as the Patient Care Assessment Committee under the Patient Care Assessment Program ("PCAP") as required by the Qualified Patient Care Assessment Program regulations of the Massachusetts Board of Registration in Medicine as amended from time to time ("Regulations") in accordance with all the duties and authority under the PCAP as set forth in the Regulations, the PCAP, the PCAP Plan, and the Medical Staff and Medical Center bylaws, including the authority to report from time to time to the Medical Staff Executive Committee, the Board of Trustees, the Baystate Health, Inc. ("BH") Board of Trustees, the BH Board of Trustees Quality Committee, and any subcommittee or other designated committee of any such committee;

(d) To develop and communicate organizational priorities for performance improvement and patient safety based on the Medical Center's mission and strategic goals; data, including but not limited to ORYX/CORE Measure data, other comparative data, and nationally recognized evidence-based best practices; and recommendations received from the committees and teams which comprise the performance improvement infrastructure;

(e) To advise clinical departments and services with regard to continuous improvement activities and opportunities;

(f) To allocate organizational resources in support of improvement initiatives and provide recognition for team achievement;

(g) To assess and continuously improve the effectiveness of the Medical Center's performance improvement process;

(h) To receive reports from the Hospital Quality Coordinating Council;

(i) To receive reports from the Safety Committee relative to the safety and maintenance of facilities and equipment; and

(j) To review the utilization management plan and to monitor that it is in effect, known to Medical Staff Members, and functioning at all times.

1.9.2 COMPOSITION

The composition of the Hospital Quality Council shall include the following, one of whom shall serve as Chair:

(a) Medical Center President;

(b) Chief Medical Officer of the Baystate Health Northern Region;

(c) Vice President of Patient Care Services;

(d) Senior Vice President of Quality and Population Health of Baystate Health, Inc.;

(e) Medical Staff President;

(f) Director of Finance;

(g) Quality Director;

(h) Up to five (5) other members of the Medical Staff appointed by the President of the Medical Staff, and

(i) Medical Director of Hospitalist Services.

1.9.3 MEETINGS AND REPORTING

The Hospital Quality Council shall meet approximately monthly and at least nine (9) times per year and shall report as appropriate to the Medical Staff Executive Committee and to the Board of Trustees. The Hospital Quality Council shall transmit as appropriate its findings for information or follow-up to clinical units, Departments, the Medical Staff, or Medical Center Administration.

1.10 HOSPITAL QUALITY COORDINATING COMMITTEE

1.10.1 FUNCTIONS

The functions of the Hospital Quality Coordinating Committee shall include:

(a) To conduct, coordinate, prioritize, and monitor the data-gathering and analysis components of the Medical Center's performance improvement program and coordinate the Medical Staff's activities in this area with those of other professional and support services in the Medical Center; and

(b) To prioritize performance improvement activities, establish formats for the reporting of data and findings, establish a system for follow-up to determine that action taken results in problem resolution, and establish formats and schedules for submission of data and findings, committee minutes, and special reports.

1.10.2 COMPOSITION

The composition of the Hospital Quality Coordinating Committee shall include the following, one of whom shall serve as Chair:

(a) Quality Manager and/or Process Improvement Manager;

(b) Director of Patient Care Services;

(c) One (1) member of the Medical Staff appointed by the President of the Medical Staff from among those members currently serving on the Hospital Quality Council; and

(d) One or more members of Medical Center leadership appointed by the President of the Medical Staff.

1.10.3 MEETINGS AND REPORTING

The Hospital Quality Coordinating Committee shall meet approximately monthly and at least nine (9) times per year and shall report as appropriate to the Hospital Quality Council.

1.11 PHARMACY AND THERAPEUTICS COMMITTEE

1.11.1 FUNCTIONS

The functions of the Pharmacy and Therapeutics Committee shall include fulfilling Medical Staff responsibilities and functions relating to pharmacy and therapeutics policies and practices and shall include the following:

(a) To assist in the formulation of broad and professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs for Baystate Health, including in the Medical Center;

(b) To advise Baystate Health, including the Pharmacy at the Medical Center, on matters pertaining to the choice of available drugs;

(c) To educate Members concerning the safe and effective use of pharmaceuticals;

(d) To make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(e) To develop and review periodically a drug list for use by Baystate Health, including in the Medical Center, determine the necessary operating rules for its use, and assure that said rules are available to and observed by all Medical Staff members;

(f) To evaluate clinical data concerning new drugs or preparations requested for use at Baystate Health, including in the Medical Center;

(g) To establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs and, where appropriate, to collaborate with the Institutional Review Board; and

(h) To submit written reports, at least semi-annually, to the Performance Improvement Council and to the Medical Staff Executive Committee concerning drug utilization policies and practices in the Medical Center.

1.11.2 COMPOSITION

The composition of the Pharmacy and Therapeutics Committee shall include the following, with one (1) of the physician members appointed to serve as Chair:

(a) Three (3) to five (5) members from the Active Staffs of each of the Medical Center, BNH, and BWH, and eight (8) to twelve (12) members of the Active Staff of BMC, representative of the major clinical areas;

(b) Senior Director of Acute Care Pharmacy Services, BH;

(c) Representative of Pharmacy from across the health system, including from each of the BH-affiliated hospitals;

(d) Representatives of the BH Division of Healthcare Quality and the Quality Departments of each of the BH-affiliated hospitals;

(e) Representative of Nursing from across the health system, including from each of the BH-affiliated hospitals ; and

(f) Office of the CEO, BMC.

1.11.3 MEETINGS AND REPORTING

The Pharmacy and Therapeutics Committee shall meet at least ten (10) times annually and shall report semi-annually to the Performance Improvement Coordinating Council and monthly to the Medical Staff Executive Committee.

1.12 MEDICATION MANAGEMENT QUALITY IMPROVEMENT COMMITTEE

1.12.1 FUNCTIONS

The functions of the Medication Management Quality Improvement Committee shall include the following:

(a) To receive updates concerning the formulary for the Medical Center;

(b) To review and analyze the safety, quality, timeliness, and effectiveness of the Medical Center’s medication use processes and make recommendations for improvement;;

(c) To receive and review reports concerning unexpected drug reactions; and

(d) To coordinate and oversee the development and implementation of education and other initiatives related to medication safety.

1.12.2 COMPOSITION

The composition of the Medication Management Quality Improvement Committee shall include the following:

(a) Three (3) to five (5) physician members representative of the clinical departments, one of whom shall serve as Chair;

(b) Pharmacy Manager;

(c) Representatives from Food and Nutrition Services;

(d) Representatives of Nursing, including Nursing Education; and

(e) Chief Nursing Officer.

1.12.3 MEETINGS AND REPORTING

The Medication Management Quality Improvement Committee shall meet at least quarterly and otherwise as necessary or appropriate to fulfill its responsibilities and shall report to the Hospital Quality Coordinating Council.

1.13 COMMITTEE ON PRACTITIONER HEALTH

1.13.1 FUNCTIONS

For the purposes of this Section 1.10.1 only, the term practitioner as is defined in the Medical Staff Bylaws also shall include members of the Medical Center's Associate Professional Staff. The functions of the Committee on Practitioner Health shall include the following:

(a) To help identify those Medical Staff members and members of the Medical Center's Associate Professional Staff with physical or behavioral impairments, including alcohol or substance abuse and conduct that undermines a culture of safety;

(b) To facilitate the handling of matters associated with such impairments by making recommendations to the Medical Staff Executive Committee;

(c) To develop and implement intervention guidelines for the Committee on Practitioner Health, which shall be consistent with any bylaws, policies, procedures, standards, rules, and regulations of the Medical Staff or Medical Center with respect to Members with physical or behavioral impairments, including alcohol or substance abuse; and

(d) To implement, facilitate, and monitor a Medical Staff process to identify and manage matters of individual practitioner health that is separate from the Medical Staff disciplinary function, that includes a purpose of

assistance and rehabilitation, and that is designed to include mechanisms for the following:

(1) Educating practitioners regarding illness and impairment recognition issues unique to practitioners;

(2) Encouraging self-referrals by practitioners and referrals of practitioners;

(3) Making referrals of practitioners to appropriate professional internal or external resources for diagnosis and treatment;

(4) Maintaining the confidentiality of referred or self-referred practitioners to the extent consistent with patient safety, the Medical Staff Bylaws, and relevant law;

(5) Evaluating complaints, allegations, and concerns regarding issues of practitioner impairment;

(6) Monitoring the affected practitioner, and any related patient safety issues, until the practitioner's rehabilitation or any corrective action or other disciplinary process is complete;

(7) Reporting to the Medical Staff Executive Committee instances where the performance of a practitioner is a threat to patient safety or otherwise is inconsistent with the Medical Staff Bylaws; and

(8) Initiating appropriate recommendations or actions when a practitioner violates or fails to complete a required rehabilitation program or other requirement of the Committee on Practitioner Health.

The Medical Center is required to and shall comply with all federal and state reporting requirements, including those pursuant to the federal Health Care Quality Improvement Act and the Massachusetts Board of Registration in Medicine regulations, or otherwise. Issues with respect to physical or behavioral impairment, including alcohol or substance abuse, also may be the subject of policies developed by the Medical Staff or Medical Center.

1.13.2 COMPOSITION

The composition of the Committee on Practitioner Health shall include at least four (4) Medical Staff members, one (1) of whom must be a mental health professional. Members will be selected on the basis of their experience or interest in the area of professional impairment.

1.13.3 MEETINGS AND REPORTING

The Committee on Practitioner Health shall meet at least annually and more often as necessary at the call of the Chair to fulfill its responsibilities and shall report to the Medical Staff Executive Committee.

1.14 LABORATORY AND RADIOLOGY UTILIZATION MANAGEMENT COMMITTEE

1.14.1 FUNCTIONS

The functions of the Laboratory and Radiology Utilization Committee shall include the following:

(a) To implement an oversight process to provide a multidisciplinary rigorous review, prioritization, and approval process for new and emerging U.S. Food and Drug Administration (FDA) approved laboratory tests not previously utilized at the Medical Center;

(b) To monitor the use and misuse of select laboratory tests;

(c) To provide for strategic planning of utilization and quality initiatives;

(d) To provide input to care process models;

(e) To emphasize *Choosing Wisely* initiatives; and

(f) To serve as partners to other clinical areas to improve their processes..

1.14.2 COMPOSITION

The Laboratory and Radiology Utilization Management Committee shall include the following, which its members appointed by the co-chairs of the committee in consultation with the Office of the CEO and the President of the Medical Staff::

(a) Director of Pathology Quality and Process Improvement, Department of Pathology, as Co-Chair;

(b) Chair, Department of Radiology, as Co-Chair ;

(c) Director Quality Assessment, Division of Health Care Quality as Co-Chair;

(d) Physicians and administrative staff from the Department of Pathology;

(e) Physicians and administrative staff from the Department of Radiology;

(f) Members of the Active Staff of Baystate Medical Center;

(g) Members of the Active Staffs of Baystate Noble Hospital, Baystate Franklin Medical Center, and Baystate Wing Hospital, with one to two members from each hospital.

(h) Representatives from the Associate Professional Staff;

(i) Representatives of Nursing;

(j) Representatives of Pharmacy;

(k) Representatives of the Graduate Medical Education Program, which may include residents and program leaders;

(l) Representatives of BH administration;

(m) Representatives of other Medical Center constituencies, such as Medical Support Services or Patient Care Services;

(n) Representatives from Information and Technology; and

(o) Representatives from Operations Excellence

1.14.3 MEETINGS AND REPORTING

The Laboratory and Radiology Utilization Management Committee shall meet once a month at least ten (10) times per year and shall report to the Medical Staff Executive Committee of each Baystate hospital.

PART TWO: PATIENT CARE ASSESSMENT PROGRAM

2.1 GENERALLY

The Medical Center shall establish and review annually a Qualified Patient Care Assessment Program ("Program"), which shall be described in a written plan (the "Plan"), and shall adopt such policies, procedures, standards, rules, and regulations in accordance with the Medical Staff and Medical Center bylaws as may be required in order to comply with the regulations of the Massachusetts Board of Registration in Medicine, as set forth in 243 C.M.R. § 3.00, as may be amended from time to time ("Regulations"). The Program is intended to and shall at all times comply with the Medical Center and Medical Staff bylaws and with the Regulations and other applicable law.

2.2 PATIENT CARE ASSESSMENT PROGRAM ELEMENTS

The Program shall contain such elements as required by the Regulations, which shall include the following:

(a) Designation by the Board of Trustees of a committee or committees to serve as the Patient Care Assessment Committee consistent with and as required by the Regulations and delineation of policies governing responsibilities of the Patient

Care Assessment Committee; such Patient Care Assessment Committee shall have the authority to report from time to time to the Board of Trustees, the Baystate Health, Inc. ("BH") Board of Trustees, the BH Quality Committee, and any subcommittee or other designated committee of any such committee;

(b) Designation by the Board of Trustees of an individual or committee to serve as the Patient Care Assessment Coordinator, consistent with and as required by the Regulations, to implement the Program and ensure compliance with the Regulations;

(c) Procedures for risk identification and analysis, including, but not limited to, internal incident reporting and auditing, and incident reporting to the Massachusetts Board of Registration in Medicine;

(d) Procedures for loss prevention and risk reduction, including, but not limited to, policies and procedures pertaining to medication errors, prescription practices, credentialing, identification of and counseling of impaired health care providers, and the establishment of guidelines and standards for clinical specialties;

(e) Procedures and policies for patient communications and documentation activities, including, but not limited to, informed consent, maintenance of medical records, and the central collection of, investigation of, analysis of, and timely response to patient complaints that relate to patient care and the quality of medical services, consistent with and as required by the Regulations and relevant law;

(f) Procedures for reporting conduct of a health care provider that indicates incompetency in his or her specialty or conduct that might be inconsistent with or harmful to good patient care and safety, based on an affirmative duty of all health care providers to report injuries and incidents in writing to the Patient Care Assessment Coordinator;

(1) With respect to Medical Staff members, such reports shall be reported, investigated, reviewed, and resolved as described in and in accordance with the Program, the Plan, the Medical Staff Bylaws, or other applicable policies, procedures, standards, rules, and regulations;

(2) With respect to Medical Center employees, agents, or other individual health care providers who are not a members of the Medical Staff, such reports shall be reported, investigated, reviewed, and resolved as may be recommended by the Office of the CAO or as described in and in accordance with the Program, the Plan, or other applicable bylaws, manuals, policies, procedures, standards, rules, and regulations;

(3) Whenever a recommendation is made that a health care provider should be subject to disciplinary action, such recommendation shall be forwarded to the Medical Staff Executive Committee, Office of CAO, Board of Trustees or otherwise as consistent with and described in the Program, the

Plan, the Medical Staff Bylaws, or other applicable bylaws, manuals, policies, procedures, standards, rules, and regulations.

(g) Instruction, orientation, and training of employees with respect to such issues as incident reporting, quality assurance, performance improvement, patient care assessment, and patients rights, consistent with and as required by the Regulations and other relevant law;

(h) Generation of internal incident reports in accordance with focused occurrence reporting criteria, occurrence screening criteria, and random chart audits, and the filing of focused occurrence reporting criteria and occurrence screening criteria with the Massachusetts Board of Registration in Medicine as required by the Regulations;

(i) Procedures for central collection of, review, investigation, analysis, resolution and follow-up of incident reports and patient complaints, as appropriate;

(j) Identification of patterns and trends of incident reports and patient complaints and development of recommendations for corrective action, as appropriate;

(k) Reports to the Massachusetts Board of Registration in Medicine of major incidents, disciplinary actions, and other matters required to be reported to the Massachusetts Board of Registration in Medicine by applicable law;

(l) Policies governing the responsibilities of the Patient Care Assessment Coordinator consistent with and as required by the Regulations, including policies requiring the Patient Care Assessment Coordinator to provide biannual summary reports to the Board of Trustees, with a copy to be filed simultaneously with the Massachusetts Board of Registration in Medicine, policies requiring that such reports contain recommendations for quality assurance, performance improvement, risk management, patient care assessment and education, and a requirement that all incident reports, summary reports, and written recommendations to and from Patient Care Assessment Coordinator shall be maintained for three years;

(m) Procedures for documentation of disciplinary actions;

(n) Procedures to implement ongoing review and counseling, or to arrange for and monitor participation in review and counseling, of health care providers impaired by drugs or alcohol, procedures to ensure compliance with Massachusetts General Laws, Chapter 112, § 5F with regard to reporting impaired licensees to the Massachusetts Board of Registration in Medicine, and procedures to ensure that the Patient Care Assessment Coordinator is kept apprised of any review or monitoring of such impaired providers;

(o) Provisions to require evaluation of a licensee's clinical skills, competence, and judgment upon request of the Massachusetts Board of Registration in Medicine, to the extent legally permissible;

(p) Provisions for granting the Massachusetts Board of Registration in Medicine and the Department of Public Health access to appropriate books and records, to the extent legally permissible;

(q) Provisions requiring the establishment of a committee charged with overseeing the safety and maintenance of facilities and equipment, to render periodic reports to the Patient Care Assessment Coordinator;

(r) Procedures for reporting and responding to allegations of noncompliance with policies, procedures, and protocols governing research and scholarly activities occurring at or under the auspices of the Medical Center, the Institutional Review Board at Baystate Medical Center, Inc., or Baystate Health, Inc., as applicable;

(s) Procedures and policies for evaluating the quality and safety of care provided by participants in graduate medical education programs, *e.g.*, medical residents and fellows, at the Medical Center, if any, including quality and patient safety trainee-focused training and education programs for such participants;

(t) Processes to collect, investigate, and trend patient outcome data in order to assure that participants in graduate medical education programs, *e.g.*, medical residents and fellows, at the Medical Center, if any, are practicing in an environment that allows them to provide safe and competent care;

(u) Procedures for reporting and responding to allegations concerning the conduct or competence of participants in graduate medical education programs, *e.g.,* medical residents and fellows, and faculty members, at the Medical Center, if any, that calls into question the individual's competence or fitness to provide health care services or to participate, as a trainee or faculty member in a graduate medical education program;

(v) Development and operation of a Peer Support Program to assist providers coping with the impact of adverse events, with such assistance including providing emotional support to affected providers to reduce psychological distress and the subsequent incidence of errors; and

(w) Such other Program elements and provisions as may be required by law, including the requirements of 243 C.M.R. § 3.12 and other Regulations, or as the Board of Trustees may authorize from time to time.

2.3 INFORMATION SHARING AND COORDINATED CREDENTIALING AND PEER REVIEW ACTIVITIES

The Medical Center is a licensed hospital affiliated with Baystate Health, Inc., an integrated health system whose mission is "To improve the health of the people in our communities every day, with quality and compassion." In furtherance of this mission and of the system-affiliated hospitals' patient care assessment, quality assurance, and quality improvement programs, the system will maintain comparably high and consistent profressional standards among its affiliated hospitals and provide efficient patient care and support services. To

facilitate this, information sharing and coordinated and cooperative credentialing and peer review activities are hereby authorized. All such intereactions and activities between system-affiliated hospitals shall be conducted in a manner consistent with the purpose and intent of the Health Care Quality Improvement Act, 42 U.S.C. § 11101 *et seq.*, and applicable Massachusetts peer review, quality assurance, and quality improvement laws and regulations. The Medical Staff, through the Medical Staff committees, shall implement policies and provedures for information sharing and coordinated and cooperative credentialing and peer review activities with other affiliated hospitals within the system.

2.4 EXTERNAL MEDICAL PEER REVIEW PARTICIPANTS

Health care providers who are not Members of the Medical Staff may participate from time to time in Program activities and medical peer review proceedings at the Medical Center, including but not limited to participation in the procedures set forth in these Medical Staff Bylaws, Appendix 1 (Medical Staff Organization), Appendix 2 (Credentialing Procedures), and Appendix 3 (Corrective Actions and Fair Hearings). Such external medical peer review participation may be authorized in the discretion of the Office of the CAO in situations including but not limited to the following: (a) when there are insufficient Members of the Medical Staff in the practitioner's specialty or subspecialty who are not in direct economic competition with the practitioner and who have no direct, personal interest in the outcome of the Program activity or medical peer review proceeding; or (b) when specialized knowledge, experience, or expertise not readily available among Members of the Medical Staff is necessary or appropriate in the context of a Program activity or medical peer review proceeding.

External medical peer review participants in Program activities and medical peer review proceedings at the Medical Center are governed by the same confidentiality, immunity, and privilege obligations and protections afforded other participants in Program activities and medical peer review proceedings under relevant law. The proceedings, reports, and records concerning the participation of any external medical peer review participant in any Program activity or medical peer review proceeding, including all information, testimony, exhibits, and documents presented to or generated by such participant, shall be confidential and privileged to the extent provided by relevant law.

2.5 CONFIDENTIALITY, IMMUNITIES, AND PRIVILEGE

The proceedings, reports, records, findings, recommendations, evaluations, opinions, deliberations or other actions of any individual or committee operating pursuant to the Program or the bylaws of the Medical Staff, the Medical Center, or any organization within Baystate Health, including but not limited to a medical peer review committee as that term is defined in the Regulations and controlling statutes, in the discharge of its functions concerning the Program, as well as all such activities of all individuals and committees that may provide information, carry out any activity, undertake any function, in whole or in part, that is within the meaning and furtherance of the responsibilities associated with the Program, and all other responsibilities by statutes, regulations, and as guidelines applicable to Medical Center facilities and the health care providers employed, privileged, or associated in connection therewith,

particularly the Regulations, shall be deemed generated by and activities of a committee of the Medical Staff and shall be subject to the confidentiality requirements, and shall be afforded the protections and immunities, set forth in federal and Massachusetts law, including the Regulations, to the full extent permissible under such laws. Accordingly, information and records necessary to comply with risk management and quality assurance programs established pursuant to the Regulations and necessary to the work product of any medical peer review committee, including but not limited to incident reports and credentialing information generated pursuant to the Regulations, and any root cause analyses or periodic performance reviews generated pursuant to standards of The Joint Commission, and all information and records otherwise generated pursuant to the Regulations and related to the functions of a medical peer review committee, shall be deemed to be proceedings, reports, and records of a medical peer review committee and shall be and hereby are so designated by the Patient Care Assessment Coordinator. The foregoing principles, however, shall not prevent the transmission of appropriate information among committees of or to the Board of Trustees of the Medical Center or any organization within Baystate Health, or to Medical Center regulators or surveyors including but not limited to the Massachusetts Board of Registration in Medicine, the Massachusetts Department of Public Health, or The Joint Commission, to enable such committees and boards and regulators and surveyors to comply with their legal duties and responsibilities; and further, any such transmissions of information are consistent with the Regulations, pursuant to the Program, and shall be subject to the confidentiality requirements, and shall be afforded the protections and immunities, set forth in federal and Massachusetts law, including the Regulations, to the full extent permissible under such laws.

February 14, 2023