

**MEDICAL STAFF BYLAWS
BAYSTATE MEDICAL CENTER, INC.
APPENDIX 1 - MEDICAL STAFF ORGANIZATION**

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**MEDICAL STAFF BYLAWS
BAYSTATE MEDICAL CENTER, INC.
APPENDIX 1 - MEDICAL STAFF ORGANIZATION**

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 be consistent with standards of The Joint Commission and 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 CEO on medico-administrative, Medical Center management, and planning matters; and
- (k) To serve, together with the Hospital Quality Council and the Physician Leadership Team, as the Patient Care Assessment Committee and Coordinator pursuant to 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 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 Physician Leadership Team, the Board of Trustees, the Baystate Health, Inc. (“BH”) Board of Trustees, the BH Quality Committee, and any other 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 be broadly representative of the Medical Staff and shall include at least eleven (11) members, who shall include the following:

- (a) Medical Staff President, as Chair;
- (b) Medical Staff Vice President;
- (c) Medical Staff Secretary;
- (d) Medical Staff Treasurer;
- (e) Immediate past President of the Medical Staff;
- (f) Representatives from among the Department Chairs and the Medical Staff Committee Chairs appointed by the Medical Staff President;
- (g) Representatives from the Medical Staff appointed by the Medical Staff President, at least one of whom shall be a physician assistant, nurse practitioner, nurse anesthetist, or nurse midwife;
- (h) Senior Vice President, Chief Quality Officer, BH, without vote;
- (i) Chief Medical Officer, BMC, without vote; and
- (j) Representative(s) from the Office of the CEO, without vote.

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

Each member of the Medical Staff Executive Committee shall serve no more than a total of six (6) consecutive terms; however, this six (6)-year limitation shall not apply to any individual serving ex officio on the Medical Staff Executive Committee.

1.2.3 MEETINGS AND REPORTING

The Medical Staff Executive Committee shall meet once a month at least eleven (11) times per year.

The Medical Staff Executive Committee shall communicate its discussions, recommendations, and actions as appropriate that affect or define Medical Staff policies, rules, regulations, or positions by monthly or other regular, periodic written summary reports made available to all members of the Medical Staff. In this regard, it is the responsibility of the Department Chairs to report at the department meetings on such discussions, recommendations, and actions. The Medical Staff Executive Committee also reports its discussions, recommendations, and actions to the Board of Trustees, as appropriate, and fulfills other reporting obligations as may be set forth in the Medical Staff Bylaws. Copies of the minutes or other reports of the Medical Staff Executive Committee are forwarded to the Office of the CEO and, as appropriate or required, to the Board of Trustees.

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 appointed to serve as Co-Chairs:

- (a) 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 Franklin Medical Center (“BFMC”) and whose primary site of practice is at BFMC;
- (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 Staff of the Medical Center whose primary site of practice is at the Medical Center;
- (e) Representatives from the Risk Management Departments of BFMC, BNH, BWH, and the Medical Center, without vote;
- (f) Representatives from the Quality Departments of BFMC, BNH, BWH, and the Medical Center, without vote; and
- (g) Representative(s) from the Medical Staff Office, without vote.

A designee of the Office of the CEO, 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 ADMINISTRATIVE AFFAIRS COMMITTEE

1.4.1 FUNCTIONS

The functions of the Administrative Affairs Committee shall include to review at least annually and propose amendments, if any, to the Medical Staff Bylaws and Medical Staff rules and regulations and to investigate and provide recommendations on such other administrative policy making and planning matters and activities of concern to the Medical Staff as are referred by the Medical Staff Executive Committee. The Administrative Affairs Committee also shall serve as the nominating committee for general officers of the Medical Staff and other Medical Staff elected positions.

1.4.2 COMPOSITION

The composition of the Administrative Affairs Committee shall include the following:

- (a) Immediate past President of the Medical Staff, as Chair;
- (b) Four (4) to six (6) additional members of the Active Staff;
- (c) Medical Staff Secretary; and
- (d) Office of the CEO, without vote.

1.4.3 MEETINGS AND REPORTING

The Administrative Affairs Committee shall meet at least annually and more often as necessary or appropriate to fulfill its responsibilities. The Administrative Affairs Committee shall report to the Medical Staff Executive Committee.

1.5 HOSPITAL QUALITY COUNCIL

1.5.1 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 improvement activities at the Medical Center;

- (b) To adopt and modify, subject to the approval of the Medical Staff Executive Committee, the Physician Leadership Team, and the Board of Trustees, and to supervise and collaborate in the performance of, specific programs and procedures for assessing and improving the quality and efficiency of medical care provided in the Medical Center;
- (c) To serve, together with the Medical Staff Executive Committee and the Physician Leadership Team, as the Patient Care Assessment Committee and Coordinator pursuant to 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 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 Physician Leadership Team, 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;
- (d) To receive reports from the Safety Committee relative to the safety and maintenance of facilities and equipment;
- (e) To receive reports from the Performance Improvement Coordinating Council;
- (f) To review the utilization review and management plan and monitor that it is in effect, known to the Medical Staff members, and functioning at all times;
- (g) To monitor enforcement of bylaws, policies, rules and regulations relating to all aspects of medical records, including documentation, completion, maintenance, and retention; and
- (h) To participate in developing the Medical Center’s written plan for its performance improvement activities and annually review the effectiveness of such activities.

1.5.2 COMPOSITION

The composition of the Hospital Quality Council shall be consistent with the PCAP and the performance improvement program of the Medical Center and shall include the following:

- (a) Chief Nursing Officer, as Co-Chair;
- (b) Senior Vice President and Chief Quality Officer, BH, as Co-Chair;

- (c) Chief Operating Officer;
- (d) Medical Staff President;
- (e) Medical Staff Vice President;
- (f) All Operational Vice Presidents; and
- (g) All Department Chairs.

1.5.3 MEETINGS AND REPORTING

The Hospital Quality Council shall meet once a month at least ten (10) times per year and shall report as appropriate to the Board of Trustees, the Medical Staff Executive Committee, and the Physician Leadership Team. As appropriate, it shall transmit its findings for information or follow-up to the Credentials Committee, Administrative Affairs Committee, relevant clinical units of the Medical Staff, and to the Administration of the Medical Center when other professional, technical, or administrative services are involved.

1.6 PHYSICIAN LEADERSHIP TEAM

1.6.1 FUNCTIONS

The functions of the Physician Leadership Team shall include the following:

- (a) To review cases, including the following: (i) cases involving a sentinel event; and (ii) cases considered for reporting to the Massachusetts Board of Registration in Medicine or other regulatory or accrediting body;
- (b) To report, with or without recommendation, to the Medical Staff Executive Committee for its consideration and appropriate recommendation or action, situations involving a question of clinical competence, patient care and treatment management, case management, professional ethics, unprofessional or disruptive behavior by any Medical Staff Member, and violations of Medical Center or Medical Staff bylaws, policies, procedures, standards, rules and regulations; and
- (c) To serve, together with the Hospital Quality Council and the Medical Staff Executive Committee, as the Patient Care Assessment Committee and Coordinator pursuant to 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 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 Hospital Quality Council, 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.

1.6.2 COMPOSITION

The composition of the Physician Leadership Team shall include the following:

- (a) Chief Physician Executive, BH, as Chair;
- (b) All Department Chairs;
- (c) Medical Staff President;
- (d) Vice President, Medical Affairs, BMC; and
- (e) Senior Vice President, Quality and Population Health, BH.

1.6.3 MEETINGS AND REPORTING

The Physician Leadership team shall meet once a month at least ten (10) times per year. The Physician Leadership Team shall report as necessary and appropriate to the Medical Staff Executive Committee, the Hospital Quality Council, the Board of Trustees, the Baystate Health, Inc. (“BH”) Board of Trustees, and the BH Quality Committee. As appropriate, it shall transmit its findings for information or follow-up to the Credentials Committee, Administrative Affairs Committee, relevant clinical units of the Medical Staff, and to the Administration of the Medical Center when other professional, technical, or administrative services are involved.

1.7 PERFORMANCE IMPROVEMENT COORDINATING COUNCIL

1.7.1 FUNCTIONS

The functions of the Performance Improvement Coordinating Counsel 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;
- (b) To conduct ongoing surgical and other invasive-procedure review, including evaluation of the selection, appropriateness, performance, and effectiveness of surgical and other invasive procedures, tissue review, and evaluation and comparison of preoperative and postoperative diagnosis, indications, actual diagnosis of tissue removed, and situations in which no tissue was removed;

- (c) To conduct ongoing blood usage review, including evaluation of the selection, appropriateness, performance, and effectiveness with which all categories of blood and blood components are used, review of confirmed transfusion reactions, and review of ordering practices for blood and blood products;
- (d) To analyze utilization profiles on a periodic basis and prepare written evaluations of the utilization review and management activities on a continuous basis, including a determination of their effectiveness in allocating resources;
- (e) To conduct studies, take actions, submit reports, and make recommendations as required by the utilization review and management plan;
- (f) To review and evaluate medical records to determine that they:
 - (1) Properly describe the condition and progress of the patient, the therapy and tests provided, the results thereof, and the identification of responsibility for all actions taken; and
 - (2) Are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the Medical Center;
- (g) To develop a utilization review and management plan for approval by the Medical Staff Executive Committee, Physician Leadership Team, Medical Center management, and the Board of Trustees. The plan must apply to all patients regardless of payment source, outline the confidentiality and conflict of interest policy, and include provision for, at least:
 - (1) Review of the appropriateness and medical necessity of admissions, continued hospital stays, and the use of clinical support services,
 - (2) Discharge planning,
 - (3) Data collection and reporting requirements, and
 - (4) Use of written, objective, and measurable criteria in conducting the reviews; and
- (h) 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.

1.7.2 COMPOSITION

The composition of the Performance Improvement Coordinating Council shall include the following:

- (a) Vice President of Nursing, as Co-Chair;
- (b) Medical Staff Vice President, as Co-Chair;
- (c) Senior Vice President, Quality and Population Health, BH;
- (d) A representative from among the Department Chairs;
- (e) A representative from among the Clinical Vice Presidents;
- (f) A representative of the Joint Commission Leadership Team;
- (g) Medical Director, Healthcare Quality; and
- (h) Director of Performance Improvement.

1.7.3 MEETINGS AND REPORTING

The Performance Improvement Coordinating Council shall meet once a month at least ten (10) times per year and shall report as appropriate to the Hospital Quality Council.

1.8 PHARMACY AND THERAPEUTICS COMMITTEE

1.8.1 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.

1.8.2 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 BFMC, BNH, and BWH, and eight (8) to twelve (12) members of the Active Staff of the Medical Center, 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.

1.8.3 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.

1.9 MEDICATION MANAGEMENT QUALITY IMPROVEMENT COMMITTEE

1.9.1 FUNCTIONS

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

- (a) To receive updates concerning the formulary of 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.

1.9.2 COMPOSITION

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

- (a) The Medical Center physician members of the Pharmacy and Therapeutics Committee, one of whom serve as Chair;
- (b) The BH and Medical Center Pharmacy members of the Pharmacy and Therapeutics Committee;
- (c) The BH and Medical Center Quality members of the Pharmacy and Therapeutics Committee; and
- (d) The BH and Medical Center Nursing members of the Pharmacy and Therapeutics Committee

1.9.3 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 Performance Improvement Coordinating Council.

1.10 BEHAVIORAL EVENT REVIEW COMMITTEE

1.10.1 FUNCTIONS

The functions of the Behavioral Event Review Committee shall include the following:

- (a) To receive reports concerning and evaluate alleged incidents of behavior by Members and by members of the Medical Center's Associate Professional Staff ("APS") 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 of such behavior by 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 chair or supervisor, for consideration and appropriate recommendation or action, situations involving questions of such behavior by 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 of such behavior by 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 of individual practitioner behavior 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 behaviors that undermine a culture of safety;
- (g) 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;
- (h) To submit written reports, at least semi-annually, to the Performance Improvement Coordinating Council, to the Medical Staff Executive Committee, and to department chairs (with regard to practitioners in their

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

- (i) 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.

1.10.2 COMPOSITION

The composition of the Behavioral Event Review Committee shall include the following:

- (a) The President of the Medical Staff, who shall serve as Chair;
- (b) The Chair of the Credentials Committee;
- (c) A physician from the Department of Psychiatry;
- (d) Vice President, Medical Affairs, BMC, without vote;
- (e) A representative of the Medical Staff Office, without vote; and
- (f) The Director of Performance Improvement, without vote.

1.10.3 MEETINGS AND REPORTING

The Behavioral Event Review Committee shall meet as necessary or appropriate to fulfill its responsibilities and shall report to the Medical Staff Executive Committee.

1.11 COMMITTEE ON PRACTITIONER HEALTH

1.11.1 FUNCTIONS

The functions of the Committee on Practitioner Health shall include to support the Medical Center commitment to providing quality patient care for the members of the community and a safe working environment for Medical Center employees and staff. To this end, the Committee on Practitioner Health shall help identify those Medical Staff members and members of the Medical Center's Associate Professional Staff with physical or mental impairments, including alcohol or substance abuse, and to facilitate the handling of matters associated with such impairments by making recommendations to the Medical Staff Executive Committee.

For the purposes of this Section 1.9.1 only, the term practitioner as is defined in the Medical Staff Bylaws also shall include residents and fellows at the Medical Center and members of the Medical Center's Associate Professional Staff. The functions of the Committee on Practitioner Health also shall include the following:

- (a) To develop policies and procedures for education, identification, including self-identification and self-referral, intervention, monitoring, reviewing cases, and assessing the ongoing health status of identified impaired practitioners;
- (b) To assist and counsel individual practitioners on the need to obtain professional evaluation, guidance, or services, and provide such support to a practitioner as deemed appropriate, including assisting the practitioner in obtaining said services;
- (c) To receive information and complaints regarding any physical or mental impairment, including alcohol or substance abuse, concerning any practitioner, and to investigate and make recommendations to the Medical Staff Executive Committee and to the appropriate departmental chairs;
- (d) To monitor the participation of a practitioner in evaluation and treatment programs and to receive regular reports of follow-up regarding the compliance of the practitioner with the program. In most cases, monitoring will be managed through a referral to the physician health service of the Massachusetts Medical Society;
- (e) To develop recommendations to other appropriate committees, residency programs, or officers of the Medical Staff regarding reasonable safeguards, which will address:
 - (1) The continued practice of a practitioner at the Medical Center during the course of and subsequent to completion of evaluation and treatment;
 - (2) Monitoring procedures; and
 - (3) Relapse or failure to complete treatment program;
- (f) 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 mental impairment, including alcohol or substance abuse, also may be the subject of policies developed by the Medical Staff or Medical Center.

1.11.2 COMPOSITION

The composition of the Committee on Practitioner Health shall include the following:

- (a) Medical Staff members from various departments of the Medical Staff or other Medical Center personnel appointed on the basis of their expertise or interest in the area of professional impairment; and
- (b) Office of the CEO.

1.11.3 MEETINGS AND REPORTING

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

1.12 PATIENT EXPERIENCE COMMITTEE

1.12.1 FUNCTIONS

The functions of the Patient Experience Committee shall include the following:

- (a) To act within the existing Performance Improvement structure at the Medical Center to provide leadership, accountability, and resources to improve and enhance the patient experience at the Medical Center, in the best interests of delivery of quality, effective, efficient, and patient-centered care;
- (b) To coordinate, prioritize, and monitor the gathering and analysis of data concerning the patient experience and to coordinate the clinical and operational activities of the Medical Center to improve accountability concerning such data;
- (c) To receive reports from the Patient & Family Advisory Council;
- (d) To conduct pilot studies concerning potential changes, take actions, submit reports, and make recommendations as appropriate concerning the patient experience at the Medical Center;
- (e) To refer, with or without recommendation, to a Member's Department Chair, the peer review committee of the relevant department, or the Medical Staff Executive Committee, for consideration and appropriate recommendation or action, situations involving concerns regarding the performance 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; and
- (f) To refer, with or without recommendation, to the appropriate supervisor, peer review committee, or BH Human Resources Department manager, for consideration and appropriate recommendation or action, concerns regarding the performance of any individual employed by a BH-affiliated entity, including, but not limited to, situations involving violations of BH policies, procedures, and standards.

1.12.2 COMPOSITION

The composition of the Patient Experience Committee shall include the following:

- (a) Chief Operating Officer, BH, as Co-Chair;
- (b) Senior Vice President, Quality and Population Health, BH, as Co-Chair;
- (c) The President of the Medical Staff;

- (d) The Chair of the Department of Medicine;
- (e) The Vice President of Nursing;
- (f) The Director of Performance Improvement;
- (g) The Director of Quality/Medical Management;
- (h) Representatives of the Division of Healthcare Quality;
- (i) Members of the Medical Staff, including representatives from the Hospitalists Program and Physician Informatics, appointed by the Co-Chairs;
- (j) Representatives from Nursing;
- (k) Representatives from among the Clinical Directors;
- (l) Representatives from among the Operational Vice Presidents; and
- (m) On an ad hoc basis as necessary or appropriate, other clinical representatives and professional, technical, and administrative support staff participating as consultants in relevant areas of expertise, without vote.

1.12.3 MEETINGS AND REPORTING

The Patient Experience Committee shall meet monthly or otherwise as necessary or appropriate to fulfill its responsibilities and shall report to the Performance Improvement Coordinating Council and the Hospital Quality Council.

1.13 TECHNOLOGY AND THERAPEUTICS COMMITTEE

1.13.1 FUNCTIONS

The functions of the Technology and Therapeutics 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 clinical technologies, clinical interventions, and therapeutics not previously utilized at the Medical Center;
- (b) To ensure that the acquisition of new and emerging clinical technologies and interventions is linked to clinical, academic, and financial priorities at the Medical Center, is formally approved by clinical departmental and administrative leadership, and is financially feasible;

- (c) To serve as the primary, multidisciplinary forum for the discussion of the acquisition of new clinical technologies and interventions, including related clinical, academic, and financial issues;
- (d) To develop an application process for new technologies, interventions, and therapeutics at the Medical Center, which shall include the receipt and review of data concerning requested new technologies, interventions, and therapeutics, such as the purpose, the defined improved outcomes and clinical benefits, the documented outcomes from medical literature, the resource requirements, and related educational, marketing, and reimbursement issues;
- (e) To review where appropriate applications concerning the acquisition of new technologies, interventions, and therapeutics and make recommendations concerning such requested acquisitions;
- (f) To develop related policy, procedure, and criteria at the Medical Center to implement such a clinical technologies, interventions, and therapeutics application review and recommendation process; and
- (g) To work collaboratively and cooperatively where appropriate with the Institutional Review Board at the Medical Center, whose responsibilities include review of clinical technologies, interventions, and therapeutics not yet FDA-approved, and with the Pharmacy and Therapeutics Committee, whose responsibilities include review of FDA-approved drugs.

1.13.2 COMPOSITION

The Technology and Therapeutics Committee shall be co-chaired by a Medical Staff member appointed by the Medical Staff President and a Medical Center administrator appointed by the Office of the CEO; its members shall be appointed by the co-chairs, in consultation with the Office of the CEO and the President of the Medical Staff, and its composition shall include the following:

- (a) Members of the Active Staff;
- (b) Representatives of Medical Center administration and finance; and
- (c) Representatives of other Medical Center constituencies, such as Medical Support Services or Patient Care Services.

1.13.3 MEETINGS AND REPORTING

The Technology and Therapeutics Committee shall meet as necessary or appropriate 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 the 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 CEO 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 CEO, 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, including its Institutional Review Board, or Baystate Health, Inc.;
- (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, 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, 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, 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 clinicians coping with the impact of adverse events, with such assistance including providing emotional support to affected clinicians 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 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 CEO 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.

2.4 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