MEDICAL STAFF BYLAWS
BAYSTATE WING HOSPITAL CORPORATION
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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 Hospital 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 Hospital. 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 account to the Board of Directors and to the Medical Staff for the overall quality and efficiency of patient care in the Hospital;

(c) 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 , including, but not limited to, recommendations to address identified issues concerning the quality and efficiency of medical care provided in the Hospital, and to receive and respond to other written or oral reports from time to time as necessary or appropriate;

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

(e) To implement the approved policies of the Medical Staff and the Hospital, including, but not limited to, polices related to medical records, or monitor that such policies are implemented by the departments, divisions, services, and other clinical subunits, and to make recommendations concerning such policies, as appropriate;

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

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

(h) 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;

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

(j) 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 Hospital bylaws, including the authority to report from time to time to the Hospital Quality Council, the Board of Directors, 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.

(k) To make recommendations on what categories of associate health professionals shall be permitted to practice in the Hospital and, for each category, the qualifications and description of services permitted, and to review and approve, subject to approval by the Board of Directors, 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 Hospital, which are part of the Patient Care Assessment Program at the Hospital, 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 Hospital;

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

(m) To oversee and coordinate, as necessary or appropriate, the education activities of the clinical departments;

(n) To inform the Medical Staff of the status of accreditation programs and accreditation status of the Hospital;

(o) To monitor and make recommendations concerning Medical Staff data-gathering and analysis components of the performance improvement program and coordinate Medical Staff activities in this area with those of other professional and support services;

(p) Assist in developing, periodically review, and participate as appropriate in the implementation of, in cooperation with Hospital Administration, one or more written plans for patient care in the event of a disaster in the Hospital or nearby communities that addresses, among other things, the care, reception, and evacuation of mass casualties, coordination of inpatient and outpatient services of the Hospital, and coordination between the Hospital and outside agencies regarding available resources;

(q) To assist in the evaluation of existing programs, services, and facilities of the Hospital and the Medical Staff and to recommend continuation, expansion, abridgment, or termination or closure of each;

(r) To assist in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment and to assess the relative priorities of services and the appropriate allocation of present and future resources; and

(s) To participate in developing, planning, implementing, and evaluating programs of and requirements for a continuing education program that is relevant to the type and scope of patient care services delivered in the Hospital and is designed to keep Members of the Medical Staff informed of significant developments and new skills in medicine and responds to the findings of the Hospital’s performance improvement activities.

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 thirteen (13) members, who shall include the following:

(a) Medical Staff President, as Chair;

(b) Medical Staff Vice President;

(c) All Department Chiefs;

(d) Division Clinical Leader of Hospital Medicine;

(e) Two (2) representatives from the Medical Staff to be elected at its annual meeting;

(f) Director of Medical Education;

(g) Director of Cardiology;

(h) Representative from the Risk Management Department, without vote;

(i) Representative from the Quality Department, without vote;

(j) Chief Nursing Officer, without vote;

(k) Chief Medical Officer, Baystate Health Eastern Region, without vote;

(l) Representative(s) from the Medical Staff Office, without vote; and

(m) Representative(s) from the Office of the CAO, without vote.

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

Each of the two (2) elected Medical Staff representative members 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 Chiefs 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 Directors, 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 CAO and, as appropriate or required, to the Board of Directors.

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, 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 Hospital 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 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, 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 Staff of the Hospital and whose primary site of practice is at the Hospital;

(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 BFMC, BNH, BMC, and the Hospital, without vote;

(f) Representatives from the Quality Departments of BFMC, BNH, BMC, and the Hospital, 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 MULTIDISCIPLINARY PEER REVIEW COMMITTEE

1.4.1 FUNCTIONS

The functions of the Multidisciplinary Peer Review Committee shall include the following:

(a) To provide a forum for open discussion of individual and system variables that affect patient care through review of selected multidisciplinary cases and collection of data pertinent to those cases;

(b) To focus on identifying cross-departmental root causes of unacceptable outcomes and to make recommendations for improvement in individual or Hospital systems;

(c) To review cases, including any of the following: (i) multidisciplinary cases involving a sentinel event; (ii) multidisciplinary cases considered for reporting to the Massachusetts Board of Registration in Medicine or other regulatory or accrediting body; (iii) cases originally reviewed by individual service committees that, or individuals responsible for quality improvement who, consider the case to go beyond the scope of the original committee or review; and (iv) cases identified by a Medical Staff Member or other healthcare provider or individual responsible for quality improvement as having educational merit in light of the multidisciplinary complexity or issues involved;

(d) 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 Hospital or Medical Staff bylaws, policies, procedures, standards, rules and regulations;

(e) To afford, when appropriate and reasonably practicable, Medical Staff Members who are the subject of such reports the opportunity to meet with the Multidisciplinary Peer Review Committee prior to its submission of such reports to the Medical Staff Executive Committee; and

(f) To report information or recommendations to other Medical Staff committees or to Hospital Administration, as appropriate.

1.4.2 COMPOSITION

The composition of the Multidisciplinary Peer Review Committee shall include the following, with one of the physician members to be appointed Chair:

(a) All Department Chiefs;

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

(c) Division Clinical Leader of Hospital Medicine;

(d) One or more Members of the Active Staff;

(e) Chief Nursing Officer, or designee; and

(f) On an ad hoc basis as necessary or appropriate for consultation, a representative from Pharmacy, participating without vote.

Any Medical Staff Member may attend and participate in discussion at meetings of the Multidisciplinary Peer Review Committee regarding cases that have educational merit in light of the multidisciplinary complexity or issues involved. Attendance at and participation in meetings of the Multidisciplinary Committee will be restricted to members of the Committee set forth in this Section when the discussion concerns the clinical performance or professional conduct of an particular Member, or otherwise as may be determined by the Chair.

Consistent with individual obligations of Medical Staff membership, an individual Medical Staff Member whose case is scheduled for discussion by the Multidisciplinary Peer Review Committee and who receives notice of such meeting is required to attend and participate in such meeting for the purpose of case presentation and discussion.

1.4.3 MEETINGS AND REPORTING

The Multidisciplinary Peer Review Committee shall meet at least quarterly and otherwise as needed upon the call of the Chair or the Medical Staff President. The Multidisciplinary Peer Review 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 quality improvement activities at the Hospital;

(b) To establish, implement, and modify, subject to the approval of the Board of Directors and where appropriate the Medical Staff Executive

Committee, a performance improvement and patient safety plan for the Hospital;

(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 Hospital bylaws, including the authority to report from time to time to the Medical Staff Executive Committee, the Board of Directors, 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 Hospital'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 Hospital'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.

1.5.2 COMPOSITION

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

(a) Chief Medical Officer of the Baystate Health Eastern Region, as Co-Chair;

(b) Chief Nursing Officer, as Co-Chair;

(c) All Department Chiefs;

(d) Division Clinical Leader of Hospital Medicine;

(e) Senior Vice President, Quality and Population Health, Baystate Health, Inc., or designee;

(f) The Vice Chair and up to two (2) additional members of the Board of Directors, at least one (1) of whom shall be the Medical Staff President;

(g) Regional Director of Emergency Services;

(h) Regional Manager of Quality;

(i) Representative of the Office of the CAO, without vote;

(j) On an ad hoc basis as necessary or appropriate for consultation, one (1) or more of the Division Clinical Leaders, without vote; and

(k) On an ad hoc basis as necessary or appropriate for consultation, a representative from Pharmacy, without vote.

1.5.3 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, to the Board of Directors, and to the Baystate Health, Inc. Board of Trustees Quality Committee. The Hospital Quality Council shall transmit as appropriate its findings for information or follow-up to clinical units, Departments, the Medical Staff, or Hospital Administration.

1.6 HOSPITAL QUALITY COORDINATING COMMITTEE

1.6.1 FUNCTIONS

The functions of the Hospital Quality Coordinating Committee shall include:

(a) To receive reports from the clinical departments and hospital and Medical Staff committees related to quality and safety at the Hospital;

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

(c) 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.

1.6.2 COMPOSITION

The composition of the Hospital Quality Coordinating Committee shall include the following:

(a) Regional Manager of Quality, as Co-Chair;

(b) Chief Nursing Officer, as Co-Chair;

(c) Chief Medical Officer of the Baystate Health Eastern Region;

(d) Performance Improvement Coordinator;

(e) Chief Safety Officer;

(f) Two (2) or more representatives from among the Department Chiefs and Division Clinical Leaders; and

(g) One (1) or more members of Hospital leadership appointed by the President of the Medical Staff.

1.6.3 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.

1.7 NOMINATING COMMITTEE

1.7.1 FUNCTIONS

The functions of the Nominating Committee shall include identifying nominees for Medical Staff officers and members at-large for the Medical Staff Executive Committee after consultation with Members of the Medical Staff concerning the qualifications and acceptability of prospective nominees.

1.7.2 COMPOSITION

The composition of the Nominating Committee shall include the following:

(a) The three (3) most recent former consecutive Medical Staff Presidents who are currently on the Active Staff, with the member with the most consecutive years of service on the Committee to serve as Chair; and

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

1.7.3 MEETINGS AND REPORTING

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

1.8 BYLAWS COMMITTEE

1.8.1 FUNCTIONS

The functions of the Bylaws 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 a referred to the committee by the Medical Staff Executive Committee.

1.8.2 COMPOSITION

The composition of the Bylaws Committee shall include at least five (5) members of the Medical Staff appointed by the Medical Staff President, one of whom shall serve as Chair.

1.8.3 MEETINGS AND REPORTING

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

1.9 INFECTION PREVENTION COMMITTEE

1.9.1 FUNCTIONS

The Infection Prevention Committee shall be responsible for establishing and directing a Hospital-wide infection prevention and control program, and its functions shall include the following:

(a) To maintain surveillance over the Hospital's Infection Prevention Program, formulating and implementing Hospital-wide infection reporting, analysis, and record-keeping criteria and procedures;

(b) To develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic, isolation, and sanitation techniques and make recommendations for improved compliance and for modifying techniques;

(c) To recommend, as appropriate and to the extent practicable under the circumstances, measures to respond to specific infection occurrences;

(d) To develop, evaluate, and review preventive infection surveillance and control policies and procedures relating to all aspects of the Hospital's activities, including, but not limited to, operating rooms, patient care units, CSR, Environmental Services, sterilization and disinfection procedures (by heat, chemicals, or otherwise), isolation procedures, prevention of cross-infections by anesthesia apparatus or inhalation therapy equipment, testing of Hospital personnel for carrier status, disposal of infectious material, food sanitation, and waste management;

(e) To evaluate infection data and report to the Performance Improvement Committee, nursing administration, and relevant departments regarding infection prevention and control; and

(f) To coordinate with the Office of Employee Health for matters relevant to infection prevention and control.

1.9.2 COMPOSITION

The composition of the Infection Prevention Committee shall include the following:

(a) One (1) member of the Active Staff, appointed to serve as Chair;

(b) Up to three (3) Members of the Active Staff selected to be representative of major clinical areas;

(c) Infection Control Coordinator;

(d) Representative from the Risk Management Department;

(e) Representative from the Quality Department;

(f) Representative from Visiting Nurse and Hospice Services;

(g) Performance Improvement Coordinator;

(h) Representative from Microbiology;

(i) Representative from Hospital Administration;

(j) Chief Nursing Officer, or designee;

(k) On an ad hoc basis as necessary or appropriate for consultation, representatives from Environmental Services, Pharmacy, Plant Operations/Maintenance, Central Supply, and the Operating Room, participating without vote; and

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

1.9.3 MEETINGS AND REPORTING

The Infection Prevention Committee shall meet at least quarterly and otherwise as necessary or appropriate to fulfill its responsibilities and shall report to the Medical Staff Executive Committee.

1.10 PHARMACY AND THERAPEUTICS COMMITTEE

1.10.1 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 professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, and use of, and safety procedures and other matters related to, drugs for Baystate Health, including in the Hospital;

(b) To advise Baystate Health, including the Pharmacy at the Hospital, 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 periodically review a drug list for use by Baystate Health, including in the Hospital, 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 Hospital;

(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 Hospital.

1.10.2 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 the Hospital, 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 of BMC.

1.10.3 MEETINGS AND REPORTING

The Pharmacy and Therapeutics Committee shall meet at least ten (10) times annually and shall report monthly to the Medical Staff Executive Committee.

1.11 MEDICATION MANAGEMENT AND QUALITY IMPROVEMENT COMMITTEE

1.11.1 FUNCTIONS

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

(a) To receive updates concerning the formulary for the Hospital;

(b) To review and analyze the safety, quality, timeliness, and effectiveness of the Hospital'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.

1.11.2 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) Representative of the Quality Department; and

(d) Director of Patient Care Services.

1.11.3 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 Medical Staff Executive Committee.

1.12 BEHAVIORAL EVENT REVIEW COMMITTEE

1.12.1 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 Hospital's Associate Professional Staff ("APS") that undermines a culture of safety at the Hospital;

(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"), Hospital 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 of such behavior by any APS member, including, but not limited to, situations involving violations of BH, Hospital 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 Hospital employees, volunteers, 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 Hospital;

(h) To submit written reports, at least semi-annually, to the Joint Conference Committee, 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

(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.

1.12.2 COMPOSITION

The composition of the Behavioral Event Review Committee shall include the following, one of whom shall be appointed to serve as Chair:

(a) Medical Staff President, as Chair;

(b) A representative of the Credentials Committee;

(c) Chief Medical Officer, Baystate Health Eastern Region, without vote;

(d) A physician from the Department of Psychiatry;

(e) Representative from the Risk Management Department, without vote; and

(f) Representative from the Quality Department, without vote.

1.12.3 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.

1.13 COMMITTEE ON PRACTITIONER HEALTH

1.13.1 FUNCTIONS

The functions of the Committee on Practitioner Health shall include to support the Hospital commitment to providing quality patient care for the members of the community and a safe working environment for Hospital employees and staff. To this end, the Committee on Practitioner Health shall help identify those Medical Staff members and members of the Hospital'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 1.10.1 only, the term practitioner as is defined in the Medical Staff Bylaws also shall include residents and fellows at the Hospital and members of the Hospital'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 Hospital 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 Hospital 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 Hospital.

1.13.2 COMPOSITION

The composition of the Committee on Practitioner Health shall include at least four (4) Members of the Medical Staff appointed by the Medical Staff President, one (1) of whom shall be appointed to serve as Chair. One (1) of the members of the Committee

shall be a representative from the Department of Psychiatry. One (1) shall be a senior Member of the Medical Staff, and another shall be an individual who is not a current member of either the Medical Staff Executive Committee or the Credentialing Committee. Members of this Committee shall have an interest and, when possible, an expertise, in chemical dependency, mental illness, and/or aging and cognitive problems.

1.13.3 MEETINGS AND REPORTING

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

PART TWO: PATIENT CARE ASSESSMENT PROGRAM

2.1 GENERALLY

The Hospital 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 Hospital 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 Hospital 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 Directors 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 Directors, the Baystate Health, Inc. ("BH") Board of Directors, the BH Quality Committee, and any subcommittee or other designated committee of any such committee;

(b) Designation by the Board of Directors 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 Hospital 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 Directors 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 Directors, 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 Hospital, 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 Hospital, 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 Hospital, 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 Hospital, 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; and

(v) 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 Directors 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 Hospital, 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 Hospital 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 Hospital, or any organization within Baystate Health, Inc., 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 Hospital 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 Directors of the Hospital or any organization within Baystate Health, Inc., or to Hospital 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.

January 8, 2019