Cal Healthcare Compare Board of Directors Meeting

TUESDAY, SEPTEMBER 13, 2022

10:00AM PT

Proposed Agenda

- Welcome & introductions
- General updates
- Operations
- Cal Hospital Compare
- Cal Long Term Care Compare
- Wrap Up

Cal Healthcare Compare
Board of Directors Meeting Agenda
Tuesday, September 13, 2022, 10:00am PST
Virtual Meeting

Participant Dial In Information
Webinar link: https://zoom.us/j/4437895416 | Phone: 1-669-900-6833
Access code: Code: 443 789 5416 | Passcode: **cyno#**

Time	Agenda Item	Presenters
10:00 - 10:15 *15 min.*	Welcome and call to order - Introductions & welcome AIR Team - Approval of past meeting minutes - General Updates	- **Ken Stuart** Board Chair, Cal Healthcare Compare - **Alex Stack** - Director, Cal Healthcare Compare
10:15 –10:45 *30 min.*	Cal Healthcare Compare Operations - Board composition updates - Financials o 2023 Data Use Fees - HPI website o BOD approval for HPI subscription fees	- **Bruce Spurlock** Executive Director, Cal Healthcare Compare - **Alex Stack** Director, Cal Healthcare Compare
10:45 –11:25 *40 min.*	Cal Hospital Compare - Opioid Risk Score o Use case and strategy o Zip code data & trends o Potential straw proposal ▪ Insights & TAC feedback	- **Jack Jordan** Principal Researcher AIR
11:25 – 12:05 *40 min.*	Cal Long Term Care Compare - CLTCC website refresh - Current analyses - Exploring new SNF measure (HAI) - Website expansion and design o Timeline for future activities o Google analytics - BOD feedback	- **Deb Bakerjian** Clinical Professor, UC Davis Health
12:05 – close	Adjourn – Next virtual meeting: Tuesday, December 13, 2022 at 10:00am PT – 2023 Meeting Cadence	- **Ken Stuart** Board Chair

Introductions

Welcome AIR Data Analytic Partners
Jack Jordan & Shreya Shetty Atmakuri

Jack Jordan is a Principal Researcher in the Health Division at American Institutes for Research (AIR). His primary responsibilities include leading the analytics support for the Convergence HQIC contract including designing the process to deliver data to stakeholders in dashboards, perform analysis to find leverage points, and use that data to advise Convergence HQIC improvement advisors on strategy. Mr. Jordan also supports contracts to deliver partially adjudicated claims data to ACOs and direct contracting entities at CMS.

Jack Jordan has over 30 years' experience in quality improvement, analytics and patient safety in both the private sector and the Federal Government.

Welcome AIR Data Analytic Partners
Jack Jordan & Shreya Shetty Atmakuri

Shreya Shetty Atmakuri is a Data Analyst in the Health division at American Institutes for Research (AIR). Her responsibilities include providing analytics support for the Convergence HQIC team including processing the monthly data submissions, creating data validation reports and maintaining HQIC's data submission tool. Ms. Atmakuri also works for the NAEP Process data team where she uses her Python programming skills to prepare the data file for release. She performs various checks at block level for data accuracy, completeness, and abnormal events exploration. Previously, at AIR, she has helped various teams by identifying and automating the tasks that were manually done. She has also created dashboards for the Equity Evidence Academy conference.

Cal Healthcare Compare
Board of Directors Meeting Summary
Tuesday, June 21, 2022, 10:00am PST

Attendees: Gretchen Alkema Ash Amarnath, Debra Bakerjian, Richele Benevent, Kristen Bettega, Rachel Brodie, Jamie Chan, Tracy Fisk, Staci Gillespie, Terry Hill, David Hopkins, Libby Hoy, Chris Krawczyk, Helen Macfie, Joan Maxwell, Dominique Ritley, Patrick Romano, Mahil Senathirajah, Bruce Spurlock, Alex Stack, Kristof Stremikis, Ken Stuart, Kevin Worth

Summary of Discussion:

Agenda Items	Discussion
Welcome & call to order	• The meeting was called to order at 10:18am PST. • An amendment was made to the minutes to include language to complete an unfinished sentence. The amended minutes from the meeting on March 17, 2022 were moved, motioned, seconded and approved.
Announcements & Updates	• Rachel Brodie with Purchasers Business Group on Health has joined the Board of Directors. • CHC will transition data analytic partners from IBM Watson to AIR effective July 1, 2022.
Consent Agenda	• Board members were sent meeting materials to review in advance of the meeting.
Operations	Board Composition Bruce presented a history of the BOD composition. The CHC staff proposed to expand the size of the BOD and add the role of associate director, appointing David Hopkins. A BOD recommendation was made to include representation from the public health sector and local health departments and recruit new members with diverse perspectives. Action: CHC will develop a formal straw proposal and bring to the next BOD meeting on September 13th. 2023 Data Use Fees The data use fees will remain the same for 2023 with a proposed increase for 2024. The final 2023 document will be available for the September BOD meeting. Financials Bruce reviewed the financial statements from January – April 2022.
Cal Long Term Care Compare	The UC Davis team provided an overview of the bi-annual website data refresh including the addition of two new staffing measures. The BOD concurred with UC Davis and CHC to postpone scoring of staffing including nursing home "honor roll" recognition until the CMI data is available.

Cal Hospital Compare	Updates on the impact of COVID-19 on quality and Covered CA analysis will be communicated to the BOD members via email. Alex Stack gave a high level overview of the 2021 Opioid Care Honor Roll Program performance. A "most improved" category will be added to the honor roll recognition. The BOD consensus is to recognize the 25 hospitals with the most improvement ≥ 5 points from 2020 to 2021. Action: The BOD approved the development of a business plan for the HPI Mapping Tool.
Next Meeting/Meeting Adjournment	• Next meeting: Tuesday, September 13th at 10:00am PST via Zoom. • The meeting formally adjourned at 1:10pm PST

General Updates

Big News!

The California State Legislature approved $1M funding to the Department of Aging for expanding CLTCC website services to include:

- Home health agencies
- Hospices
- Adult residential care programs
- Adult day health centers
- Other licensed long term care providers

Press Release – Cal Hospital Compare & CHHS Announces Honor Roll Hospitals

A joint press release was issued on August 23rd recognizing all three hospital honor rolls!

- 108 hospitals met performance standards in maternity care
- 76 hospitals met performance standards in opioid stewardship
- 86 hospitals met performance standards in patient safety
- 9 hospital met performance standards for maternity care, opioid stewardship, and patient safety

Q2 2022 CHC Website Refresh

Updated maternity data reflects CY2021 – reports and data circulated to CA health plans & other data subscribers

Programs page features current honor rolls

- 2021 Opioid Care Honor Roll
- 2022 Maternity Care Honor Roll
- 2022 Patient Safety Honor Roll

Operations

Board Composition

EXPANDING THE BOARD

TERM LIMITS

Proposed BOD Changes (CY2023)

BOD Position	Current	Proposed	Composition
Voting Members			
Consumers	3	4	· Libby Hoy, PFCCpartners · Joan Maxwell, PFA · Kristof Stremikis, CHCF · Nicole Howell, Executive Director, Empowered Aging
County public health department	0	1	· Leslie Ray, Epidemiologist, San Diego County OR Rochelle Ereman, Epidemiologist, Marin County (retired)
Executive Director	1	1	· Bruce Spurlock, Cal Healthcare Compare
Hospitals	2	4	· Robert Imhoff, HQI · Helen Macfie, MemorialCare · Patty Atkins, Sharp (backfill Helen) · Adventist Health representative (rural) · Sutter Health representative
Health plans	2	2	· Jamie Chan, Blue Shield · Rick Krum, Anthem
Kaiser (hospital/health plan)	1	1	· Kevin Worth, Kaiser
LTC leadership	2	2	· Gretchen Alkema · Terry Hill
LTC facility	0	2	· Home health representative · Hospice representative
Purchasers	2	2	· Rachel Brodie, PBGH · Ken Stuart, CHCC
Non-Voting BOD Member			
State agencies	3	5	· Chris Krawczyk, HCAI · Ash Amarnath, Covered CA · Julia Logan, CalPERS · Julie Nagasako, Deputy Director, Office of Policy & Planning, CDPH · California Department of Aging Representative
Associate director	1	2	· David Hopkins, Stanford University · Helen Macfie, MemorialCare (pending retirement)
Total Voting Members	**13**	**19**	
Total Non-Voting Members	**4**	**7**	
TOTAL BOD Members	**17**	**26**	

Financials

BUSINESS PLAN

2023 DATA USE FEES

HPI WEBSITE SUBSCRIPTION

2023 & 2024 Data Use Fees

Data fee structure and pricing will remain the same for 2023

Fees will increase in 2024 with consideration to the:

- Expansion of the Cal Long Term Care Compare website
- Planned business development for health equity activities
- Additional data services e.g., HPI base package, nursing home information, etc.
- Interest and ability of plans to pay annual fee

Hospital Healthy Places Index (HPI) 3.0 Mapping Application

Site will officially launch on the Cal Healthcare Compare website by Jan 2023

Data will be available to hospitals via a paid annual subscription

HyperArts is currently building out landing page with initial content

Communication and marketing materials are forthcoming

Proposed HPI Subscription & Pricing Structure

Subscription Level	Access	Price
Standard	• Access to the full Hospital HPI Website for one year • Access includes 2 unique user logins • 15-minute introductory call with a member of the Cal Healthcare Compare Team	$1,800
Premium	• Standard access plus: • **Hospital REAL validation tool overlay, including but not limited to the American Community Survey and ARHQ Social Determinants of Health Survey. Using this information, we can help you to determine the accuracy of your REAL data and how that might inform your Community Health Needs Assessment and/or your Health Equity strategies.** • **30-minute coaching call with a member of the Cal Healthcare Compare Team on how to use the REAL validation tools in your work**	$2,250
Premium+	• Premium access plus: • **1 additional unique user login for a total of 3 accounts** • **Combine one data set of your choice with our data for an even more personalized view of social needs in your community; with interpretive guidance from the Cal Healthcare Compare Team** • ***Geocoding capabilities coming soon***	$2,700
Additional users	• Additional users may be added on to any plan for a nominal fee	$100/user

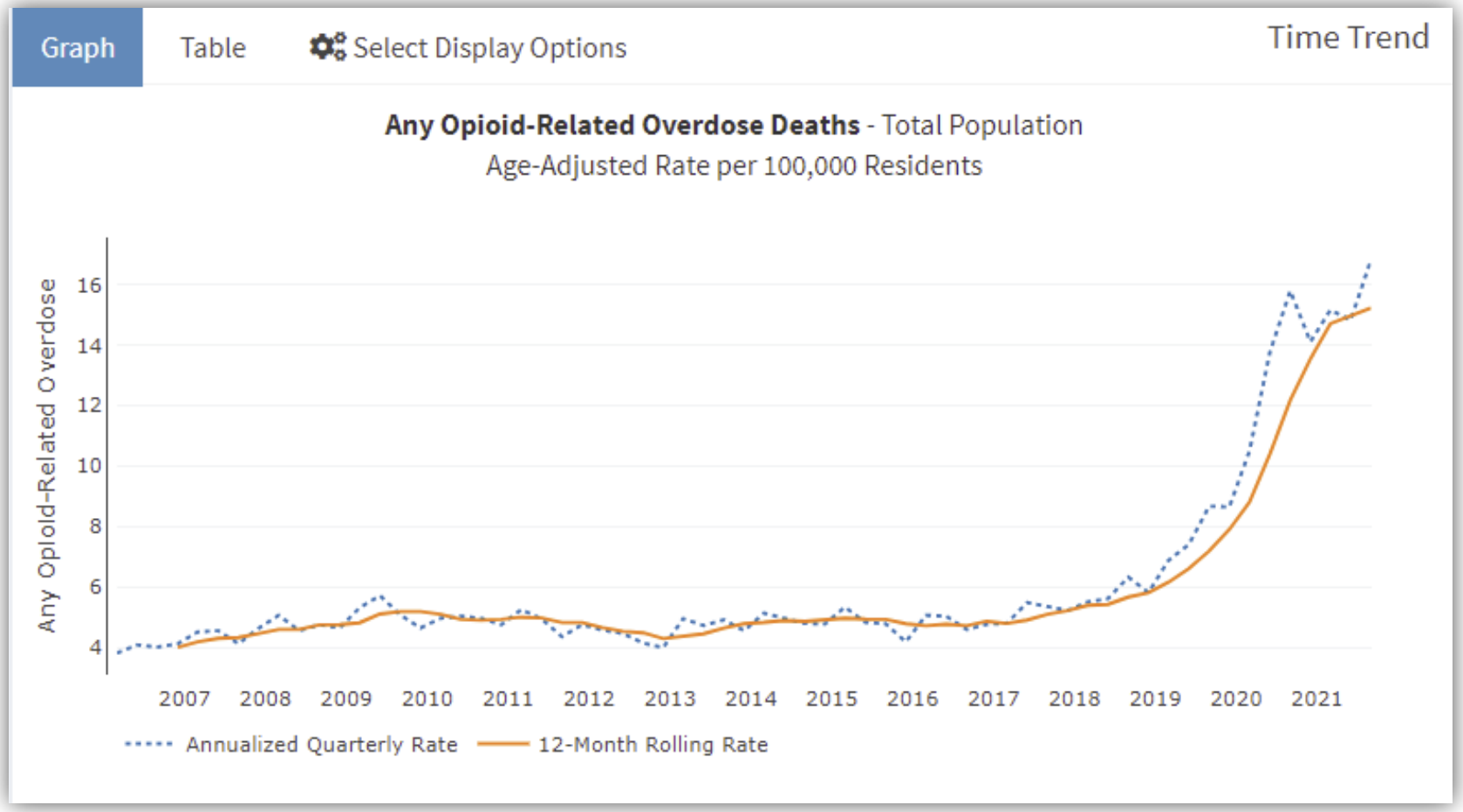
Cal Hospital Compare

Transition

Hand off meetings during June with contract start in July
Received historical files and programs.
Set up environment on AIR servers to run the programs
Fresh eyes observations:
Process involves nearly 50 working files to input and process data for reports.
Over time may one off edits have been made to the code to solve issues.
Some redesign of data processing may improve future processing.

Opioid Risk Score by Zip Code

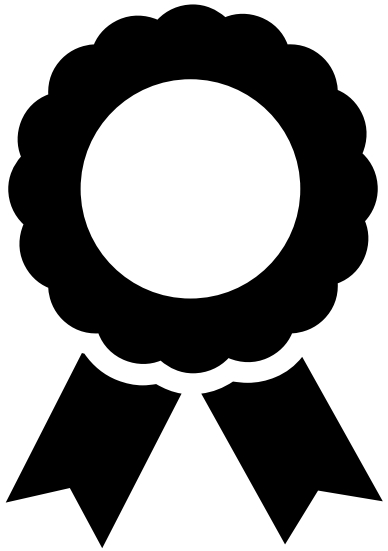
California is making progress but…



Source: California Overdose Surveillance Dashboard, accessed June 14, 2022

Opioid Care Honor Roll Program Programmatic Goals

- Activate hospitals to accelerate care redesign in service of reducing OUD related deaths
- Recognize hospitals for their performance & commitment to this effort
- Create the space for quality improvement & the sharing of best practices by connecting them to key resources



4 Domains of Care

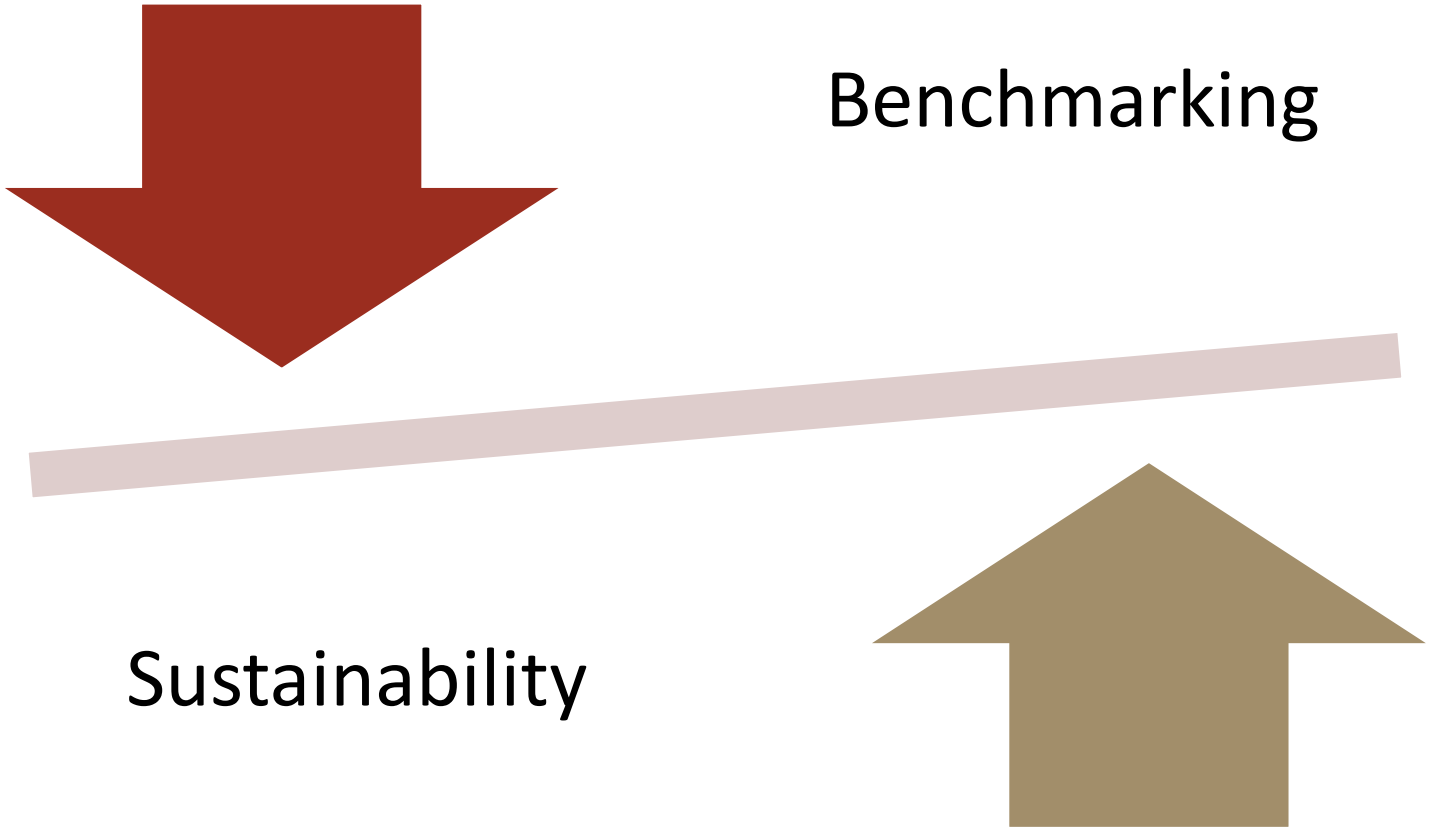
Safe & effective opioid use

Identification & treatment

Overdose prevention

Cross cutting organizational best practices

QI Gap



Introducing an Opioid Risk Score

- **Goal:** Allow hospitals to benchmark on prescribing practices in the communities that they serve and compare volumes opioid related encounters.
- Relation to Opioid Care Honor Roll
  - How do we envision the opioid risk score complimenting the work we are already doing?
    - Compare the opioid prescribing practices in a standard way

What Data are Available?

CA Overdose website have data from 2006 to 2021

Outcomes include Deaths, ED visits, Hospitalizations and Prescriptions at a county level

Filters include:

- County (drill to zip code in county)
- Age category
- Race

	Outcomes		
Filters	Deaths	ED Visists	Hospitalizations
All Drugs	x	x	x
Any Opioid	x	x	x
Any Opioid excluding Heroin		x	x
Prescription opioids	x		
Prescription opioids w/o synthetics	x		
Fentanyl	x		
Heroin	x	x	x
Natural or semisynthetics	x		
Methadone	x		
Synthetics excluding Methadone	x		
Any opioid and benzodiazepines	x	x	x
Any opioid and cocaine	x	x	x
Any opioid and psychostimulant with abuse potential	x		
Any opioid and amphetamine		x	x

Prescribing Data Available

Prescription filters

Opioid prescriptions by patient location

Opioid prescriptions by prescriber location

Opioid prescriptions by pharmacy location

MME by patient location

MME by prescriber location

MME by pharmacy location

Residents on > 90 MME opioids

Prescription filters

Residents with 5 + prescribers or pharmacies

Opioid naïve residents prescribed LA/ER opioids

Residents with overlapping opioids

Residents with overlapping opioid / benzodiazepines

Buprenorphine prescriptions by patient location

Buprenorphine prescriptions by prescriber location

Buprenorphine prescriptions by pharmacy location

Additional Data

Hospital Emergency Room Visits by Zip Code

Hospital Admissions by Zip Code

Hospital Admissions via Emergency Room by Zip Code

HPI Data by Zip Code

Demographics by Zip Code

Opioid Related ED visits and Deaths are Highly Variable by Location

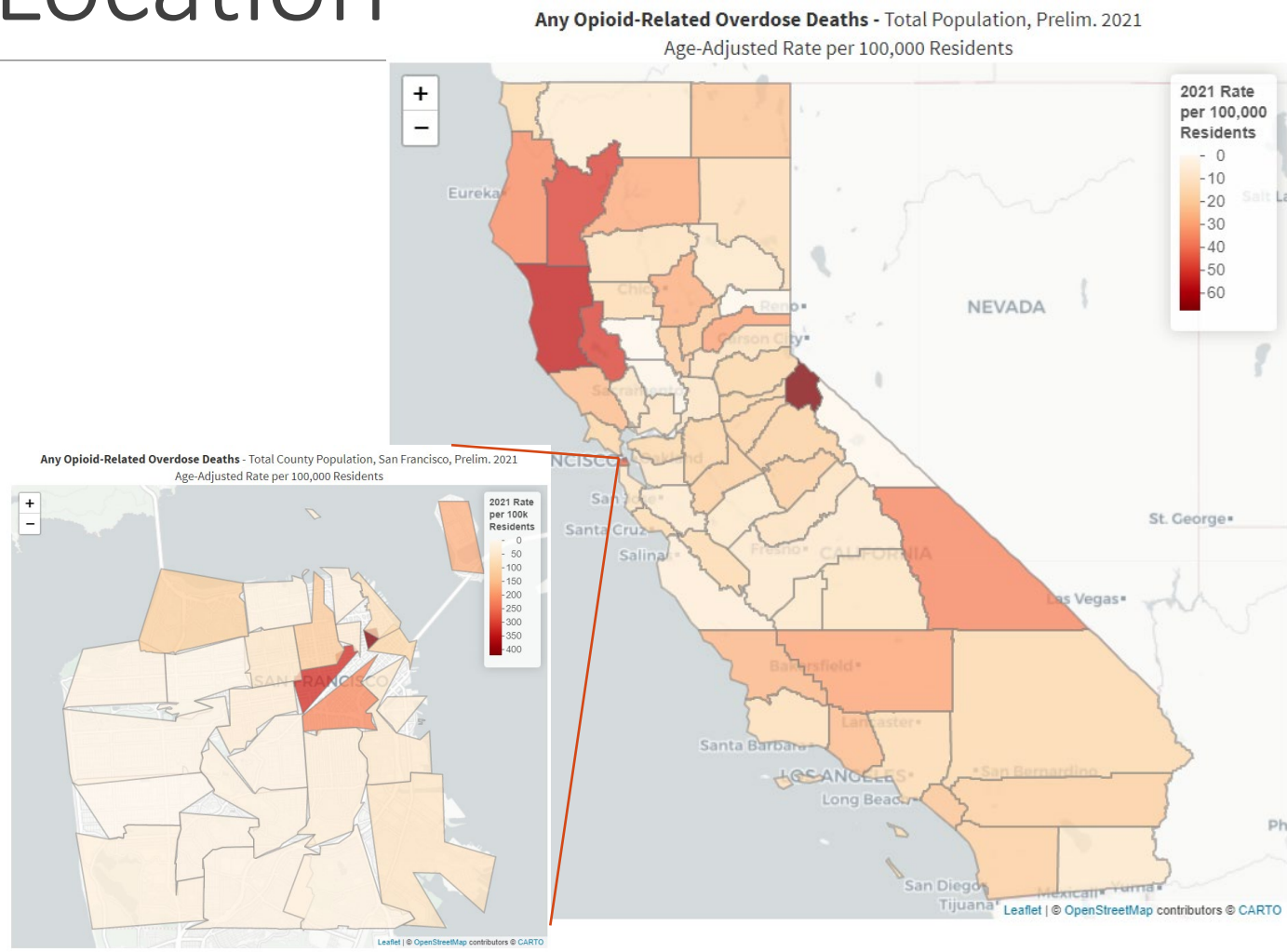
Large differences between counties

Also, large differences between zip codes within counties

Hospitals have very different exposure based on the catchment area for patients

330 zip codes have 0 opioid ED visits registered in 2017-2019

11 zip codes have extreme levels of ED visits for opioids

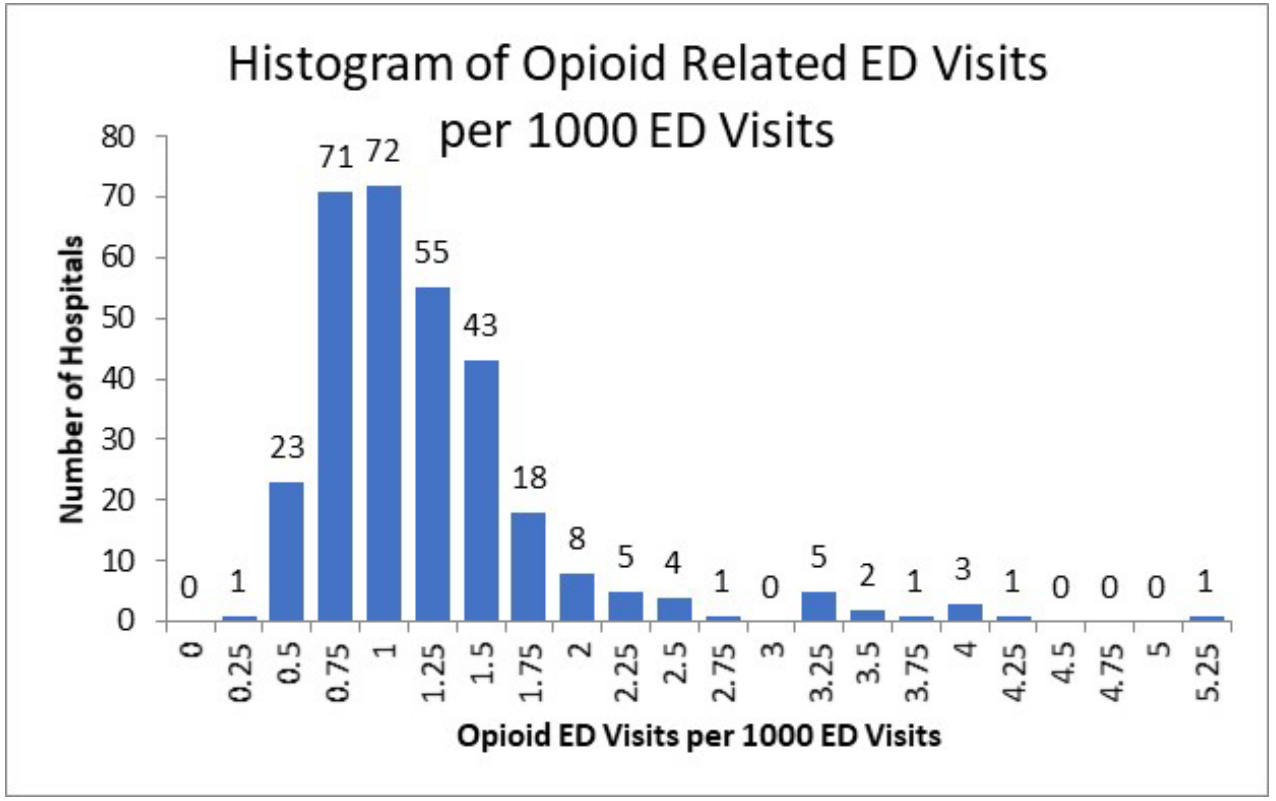


Graphics are from California Overdose Surveillance Dashboard

Strategy

Encourage Desirable Practices

- Continue opioid stewardship for acute pain
- Improve support for patients with Opioid Use Disorder
  - Track best practices
  - Target areas with largest populations
- Make exposure level of hospitals transparent
  - Identify hospitals with largest challenges in patient population
  - Adjust data to account for exposure levels



Would Standardized Exposure Level Be of Value?

Emergency Rooms experience very different mix of patients and diagnosis

Opioid related emergency department visits show more than 10-fold difference in rates

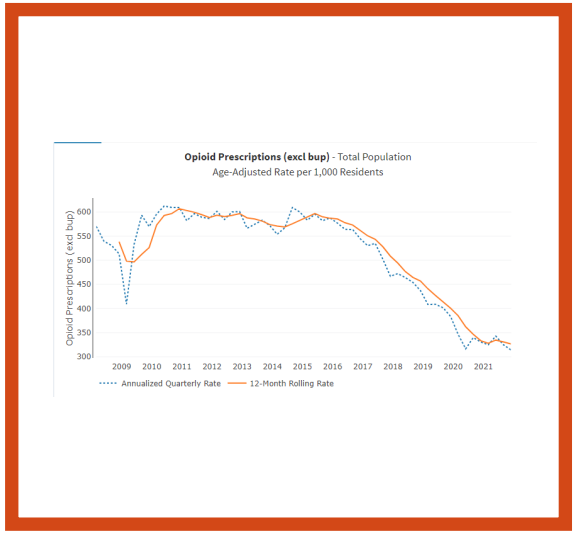
Exposure level can help target highest leverage hospital to develop excellence

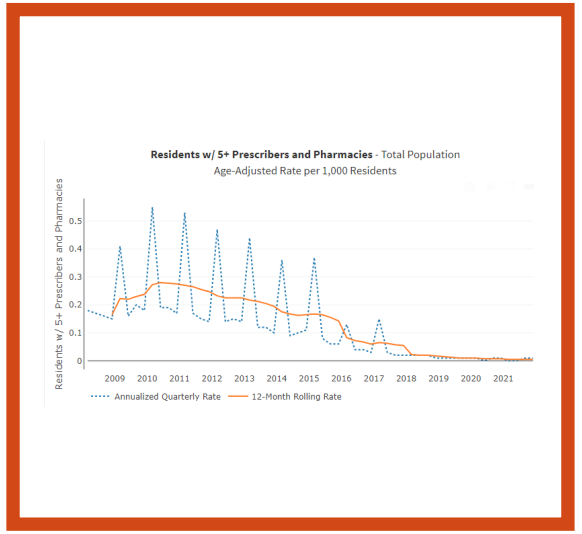
Exposure level may improve data by scaling results

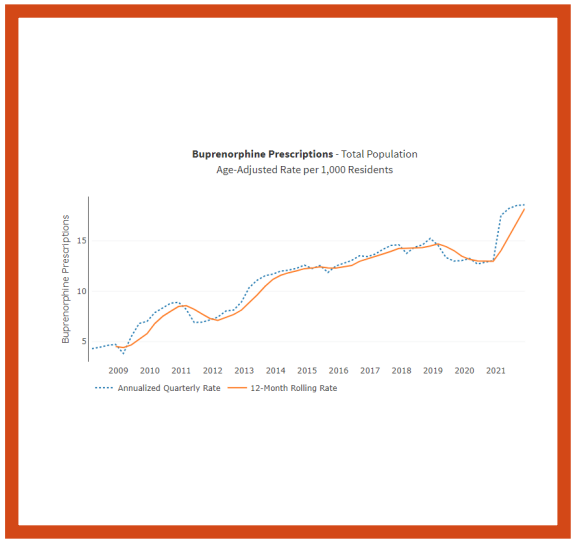
Zip Code Data and Trends

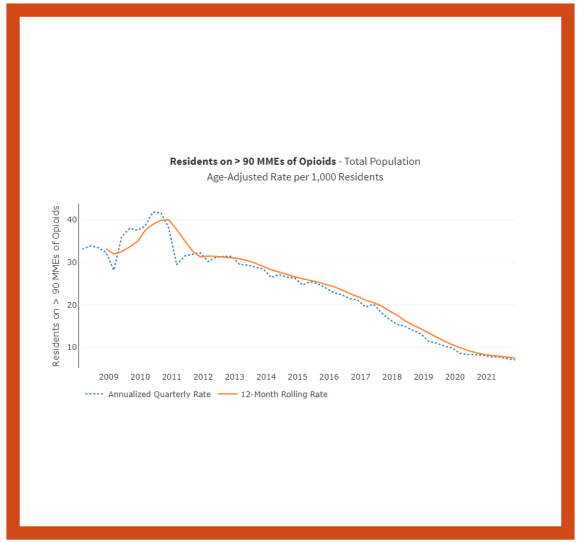
Hospital Actions

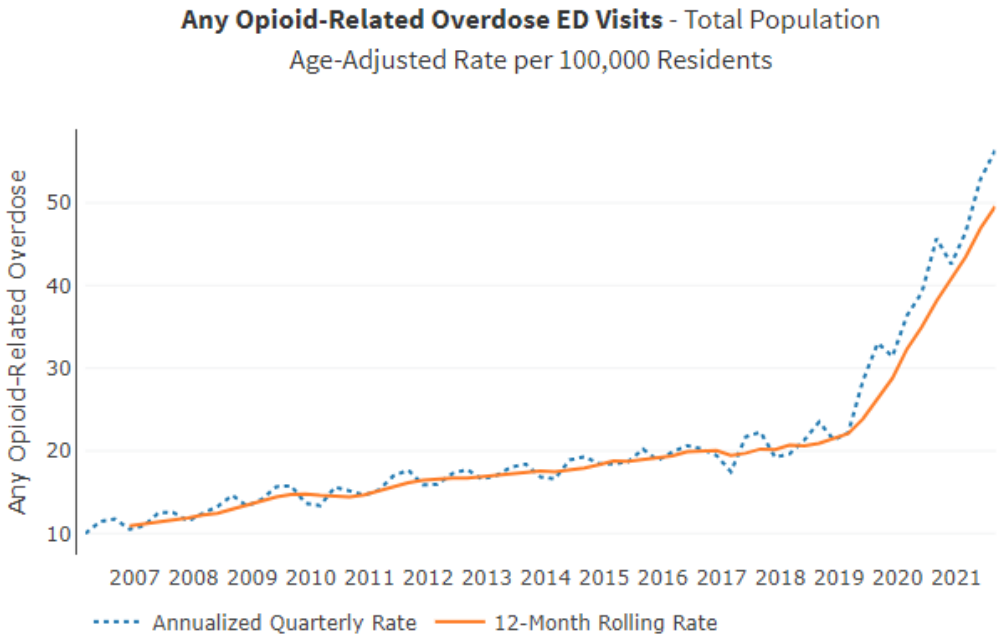
- Slow pipeline of patients with future opioid abuse by conservative treatment of acute pain
- Reduce high dose patient exposure
- Highly reliable post-overdose care and rapid start of Buprenorphine
- Reduce patients using multiple pharmacies and physicians for opioid prescriptions

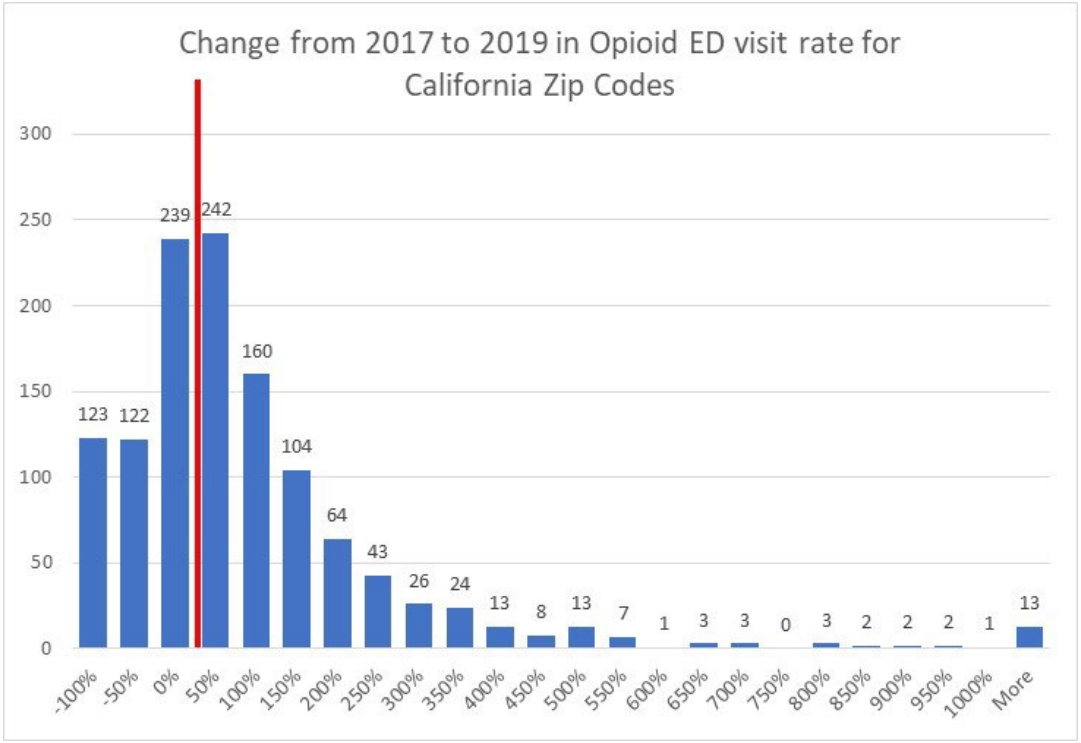






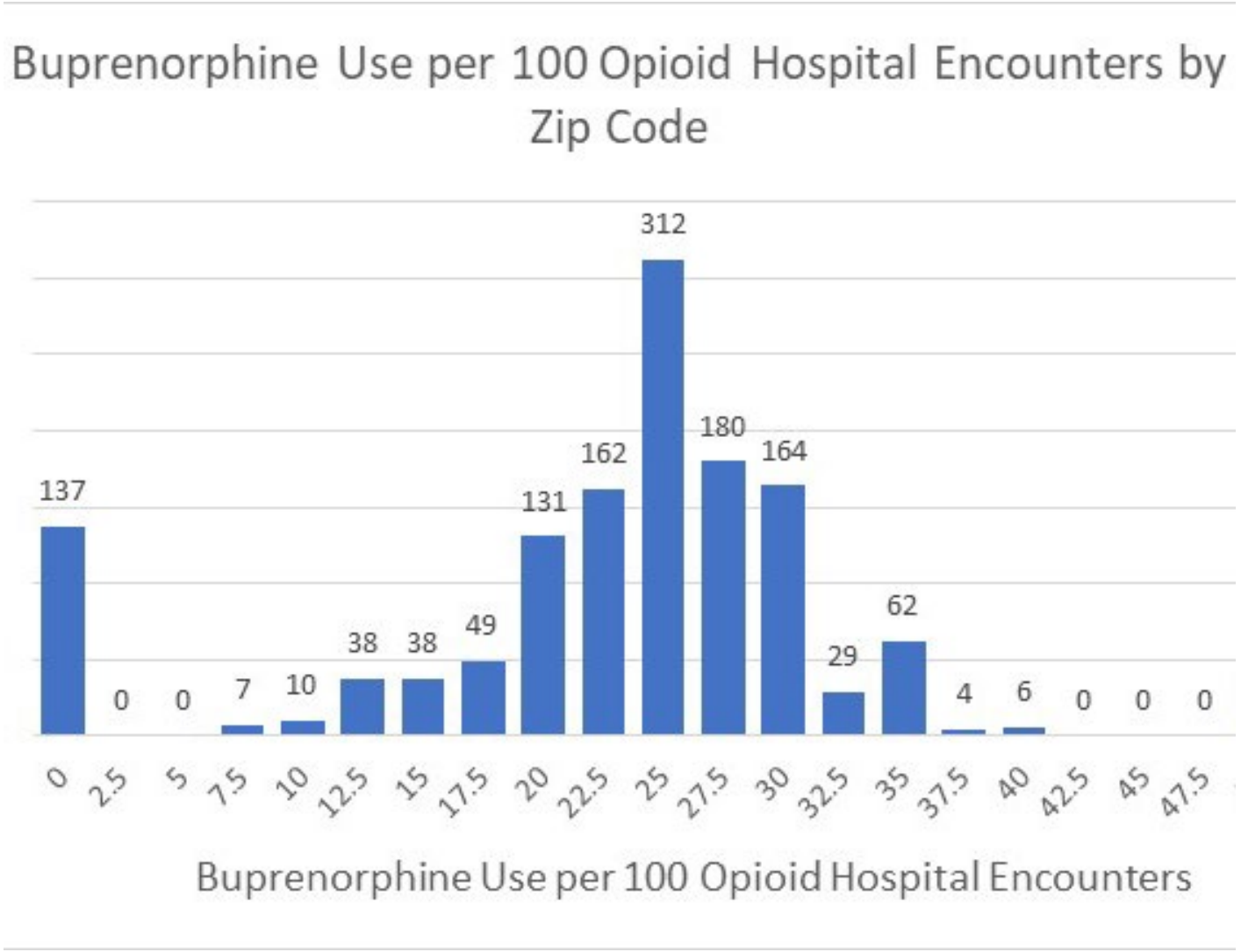






Emergency Room Visits Increasing

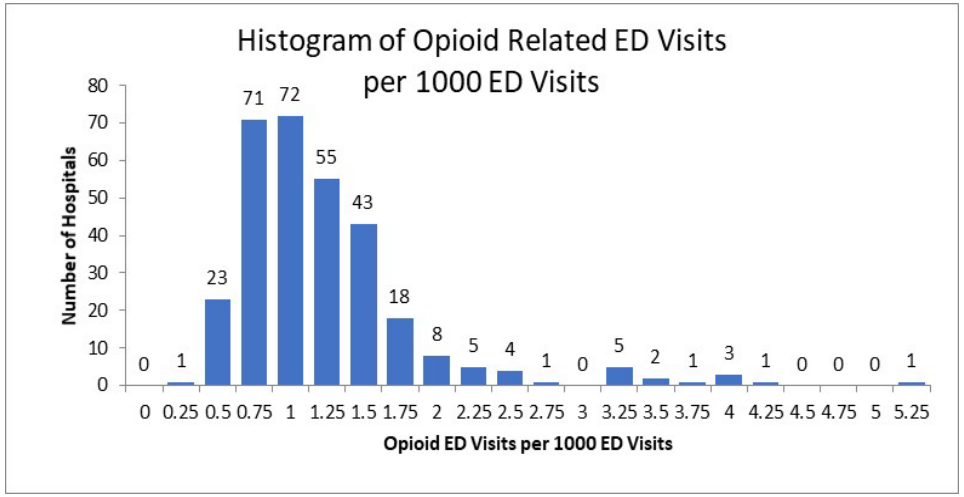
STRONG TREND BUT WIDE VARIATION IN IMPACT BY ZIP CODE

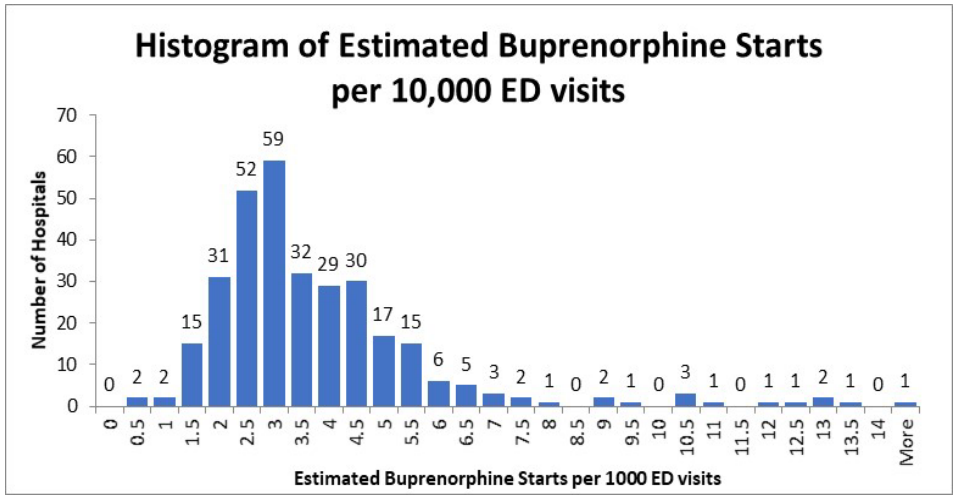


Buprenorphine Use per 100 Opioid Hospital Encounters

- Are practices different in treatment by location?
- Many zip codes have limited number of residents and no exposure

Potential Straw Proposal





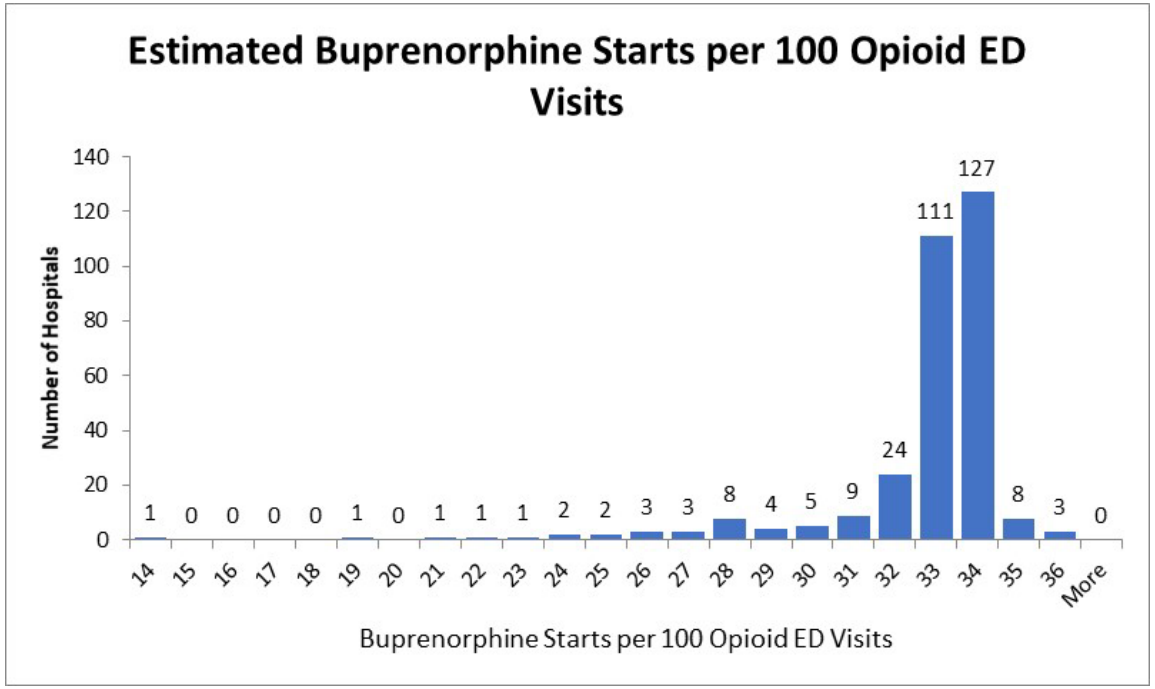
Buprenorphine Use Benchmarking

Hospitals have very different amounts of opioid related encounters

Hospitals also have very different amounts of Buprenorphine use in their catchment areas

Proposed Method

Weighting Buprenorphine use in hospital catchment area by the opioid related emergency room visits



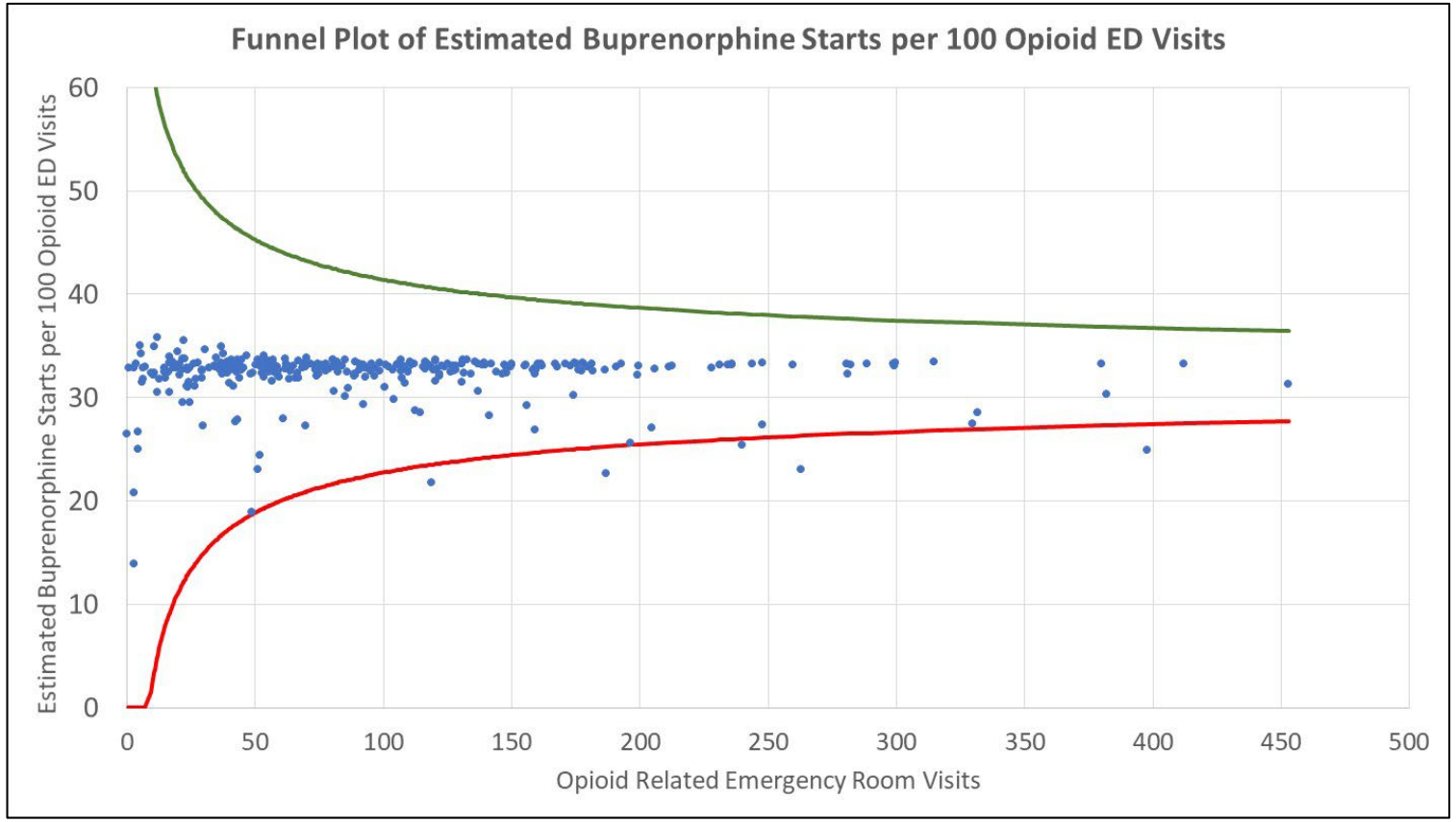
Reweighting Changes the Picture

Most hospitals have very similar rates with a few outliers

Opioid visits seems to better capture exposure for the hospital

Funnel Plots can Identify Opportunities

Funnel plots are a graphical method to display statistical test for hospitals that are different than the mean.



Challenges with the Methodology

- Opioid emergency department visits are estimated by assigning visits in a zip code based on a hospital's emergency room market share
  - *Method assumes zip codes for opioid visits align with overall visits*
- Buprenorphine prescriptions in zip codes are assigned to hospitals based on a hospital's market share of patients in the zip code
- Strong trends in opioid overdoses can make data change drastically from year to year
- Special causes like rash of fentanyl overdoses in a zip code can skew results for a period

Cal Long Term Care Compare

- WEBSITE REFRESH
- CURRENT ANALYSES
- EXPLORING NEW SNF MEASURE
- WEBSITE EXPANSION &DESIGN

Website Refresh

Website Refresh

Changes to Staffing Domain

- Updated HPRD to 0.xx to improve specificity
- Added weekend staffing hours

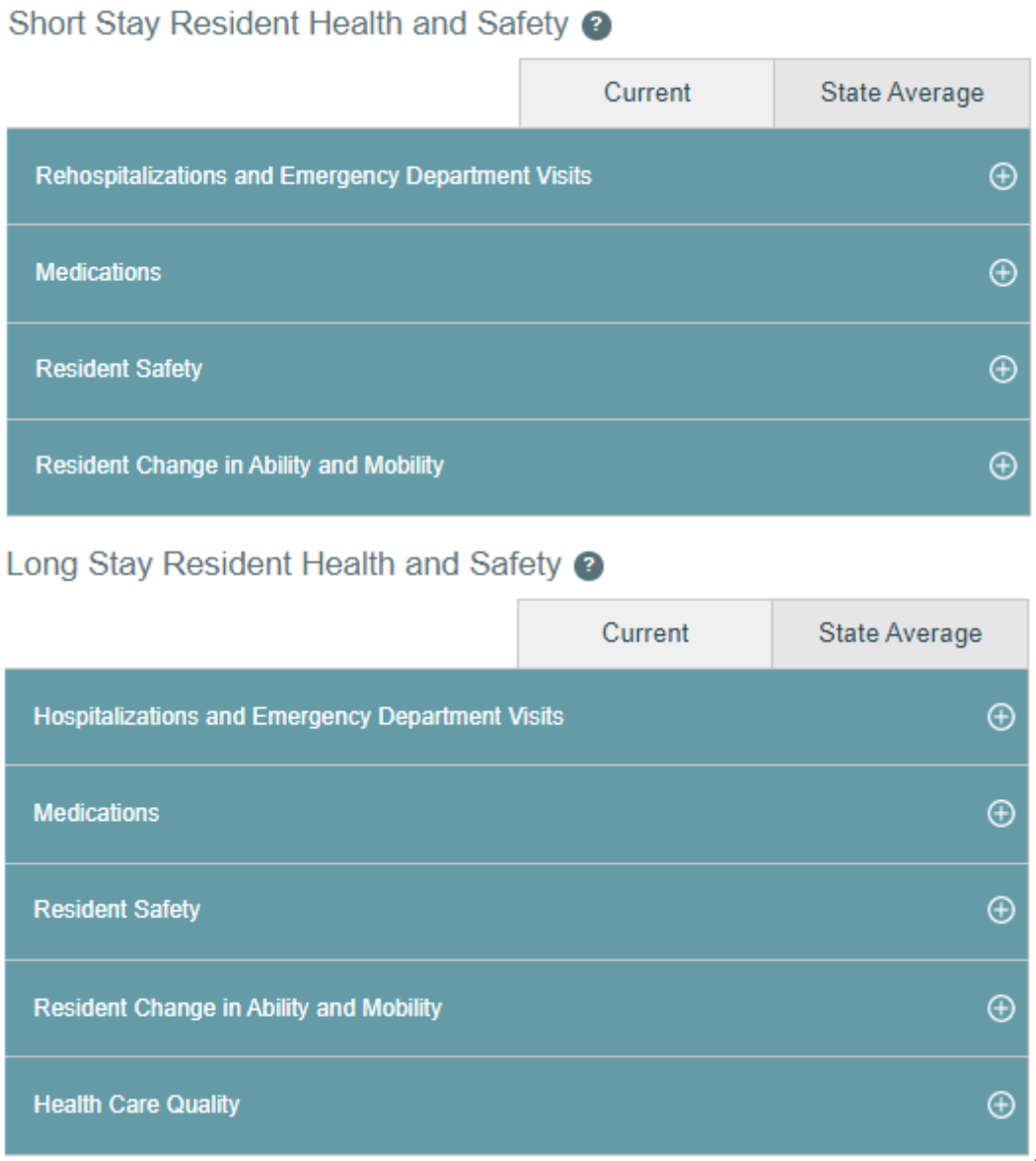
Staffing

	Current	State Average
Nursing Hours per Resident per Day		
Registered nurse (RN) hours per resident per day	0.38 (higher is better)	0.56 (higher is better)
Licensed vocational/practical nurse (LVN/LPN) hours per resident per day	1.18 (higher is better)	1.09 (higher is better)
Nursing assistant (NA) hours per resident per day	2.31 (higher is better)	2.48 (higher is better)
Total number of nurse staff hours per resident per day	3.88 (higher is better)	4.12 (higher is better)
Total number of nurse staff hours per resident per weekend day	3.69 (higher is better)	3.70 (higher is better)
Nursing staff turnover	AVERAGE 67.2% (lower is better)	57.2% (lower is better)
Nursing staff retention	POOR 39.4% (higher is better)	67.0% (higher is better)
Physical therapist staff minutes per resident per day	5.55 (higher is better)	5.22 (higher is better)

Website Refresh

Changes to Quality of Care Domain

- July ‘22 data release used for QOC domain update
- Added subgroups to Short Stay and Long Stay resident measures to reduce consumer cognitive load



Website Refresh

Changes to Quality of Care Domain

Vaccinations: added a separate section

- COVID-19*
  - Weighted Staff Vaccination + Booster Rating
- Influenza
- Pneumococcal

Vaccinations

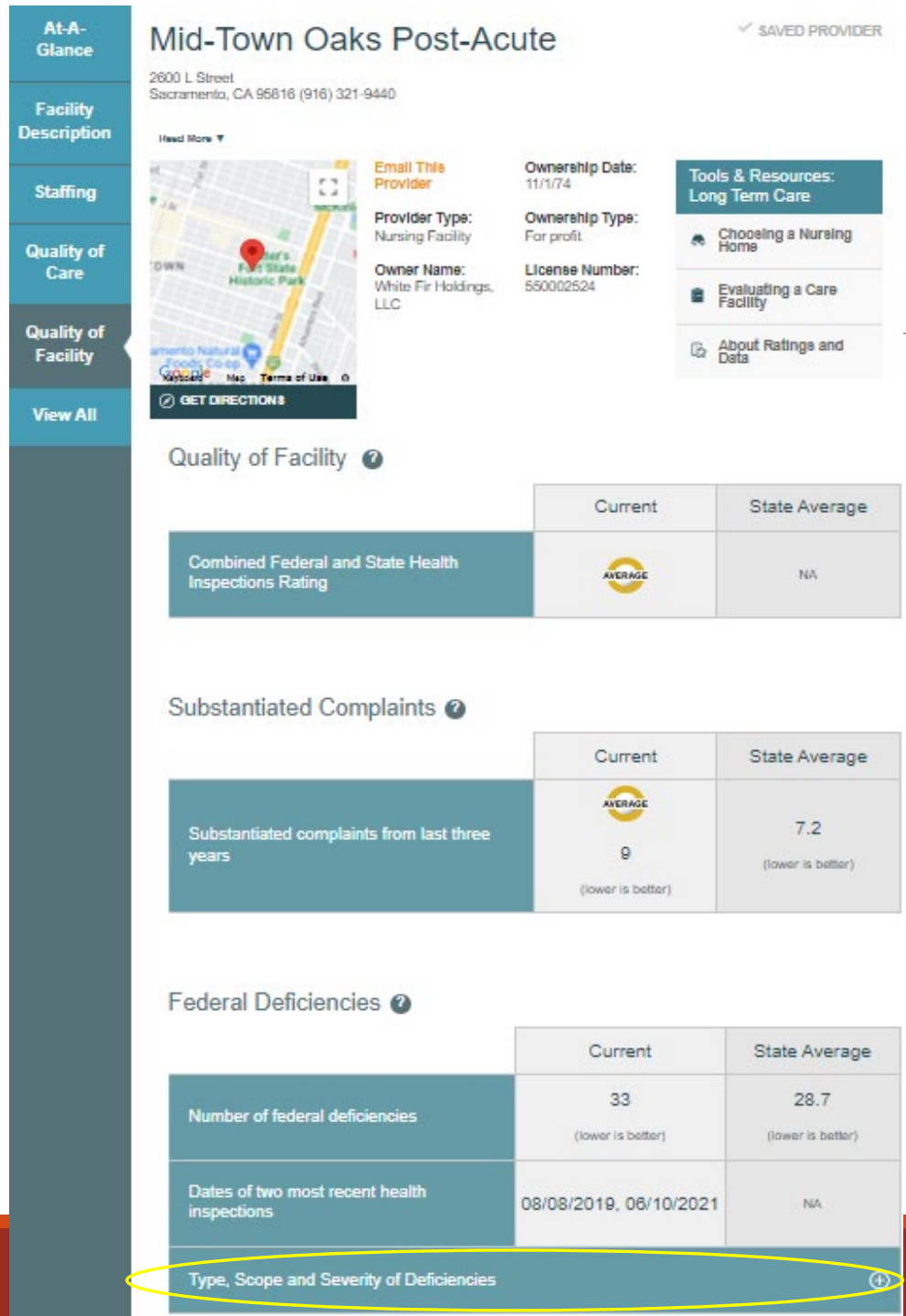
	Current	State Average
COVID-19 Vaccination Rates		
Weighted staff COVID-19 vaccination + booster	AVERAGE 93.75% (higher is better)	91.51% (higher is better)
Resident COVID-19 vaccination + booster	69.88% (higher is better)	83.56% (higher is better)
Influenza Vaccination		
Percentage of short-stay residents who were assessed and appropriately given the seasonal influenza vaccine	89.00% (higher is better)	91.92% (higher is better)
Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine	94.09% (higher is better)	98.47% (higher is better)
Pneumonia Vaccination		
Percentage of short-stay residents assessed and appropriately given the pneumococcal vaccine	75.93% (higher is better)	93.18% (higher is better)
Percentage of long-stay residents assessed and appropriately given the pneumococcal vaccine	93.56% (higher is better)	98.02% (higher is better)

Website Refresh

Added new domain: Quality of Facility

- Composite Overall Health Inspection Rating
- Substantiated Complaints
- Federal Deficiencies
- State Citations (AA,A,B, Total)
- Federal and State Financial Penalties for Violations ($)

Quality of Facility Domain



At-A-Glance
Facility Description
Staffing
Quality of Care
Quality of Facility
View All

Mid-Town Oaks Post-Acute

SAVED PROVIDER

2600 L Street
Sacramento, CA 95816 (916) 321-9440

Read More

Email This Provider

Provider Type: Nursing Facility

Owner Name: White Fir Holdings, LLC

Ownership Date: 11/1/74

Ownership Type: For profit

License Number: 550002524

Tools & Resources: Long Term Care
- Choosing a Nursing Home
- Evaluating a Care Facility
- About Ratings and Data

Quality of Facility

	Current	State Average
Combined Federal and State Health Inspections Rating	AVERAGE	NA

Substantiated Complaints

	Current	State Average
Substantiated complaints from last three years	AVERAGE 9 (lower is better)	7.2 (lower is better)

Federal Deficiencies

	Current	State Average
Number of federal deficiencies	33 (lower is better)	28.7 (lower is better)
Dates of two most recent health inspections	08/08/2019, 06/10/2021	NA
Type, Scope and Severity of Deficiencies		

State Citations

	Current	State Average
Number of class AA citations (resident death)	0 (lower is better)	0.0 (lower is better)
Number of class A citations (resident danger)	0 (lower is better)	0.3 (lower is better)
Number of class B citations (resident care)	0 (lower is better)	0.9 (lower is better)
Total number of state citations	0 (lower is better)	1.2 (lower is better)

Federal and State Financial Penalties for Violations

	Current	State Average
Federal fines issued for violations from the last three years ($)	$0 (lower is better)	$17,963 (lower is better)
State fines issued for violations ($)	$0 (lower is better)	$11,572 (lower is better)
Total federal and state fines ($)	$0 (lower is better)	$29,281 (lower is better)
Number of days the facility was denied payment due to unresolved violations	0 (lower is better)	2.3 (lower is better)

Quality of Facility: Inspection Categories- Type, Severity, & Scope

Type, Scope and Severity of Deficiencies		
Freedom from abuse, neglect, and exploitation	0 (lower is better)	1.3 (lower is better)
Quality of life and care	6 (lower is better)	6.0 (lower is better)
Infection control	2 (lower is better)	3.3 (lower is better)
Resident assessment and care planning	7 (lower is better)	4.3 (lower is better)
Nursing and physician services	1 (lower is better)	0.8 (lower is better)
Resident rights	6 (lower is better)	3.9 (lower is better)
Nutrition and dietary	4 (lower is better)	2.8 (lower is better)
Pharmacy service	7 (lower is better)	3.7 (lower is better)
Environmental	0 (lower is better)	1.2 (lower is better)
Administration	0 (lower is better)	0.7 (lower is better)
Total health inspection deficiencies	33 (lower is better)	27.9 (lower is better)

Severity		
Immediate jeopardy to resident health or safety	0 (lower is better)	0.3 (lower is better)
Actual harm	0 (lower is better)	0.4 (lower is better)
Minimal harm or the potential for actual harm	33 (lower is better)	26.2 (lower is better)
No harm with the potential for minimal harm	0 (lower is better)	1.1 (lower is better)
Scope		
Many residents (potentially) affected	0 (lower is better)	1.4 (lower is better)
Some residents (potentially) affected	12 (lower is better)	8.5 (lower is better)
Few residents (potentially) affected	21 (lower is better)	18.1 (lower is better)

Current Analyses

PDPM: ENABLING CASE MIX ADJUSTMENT

CMS ABUSE ICON

PDPM Data

PDPM data can be used to:

1. Score staffing HRPD
2. Score long term stay quality of care measures (if we can calculate the denominators)
3. Create fair Skilled Nursing Facility Staffing Recognition Award

Status update

- CMS reports that California did not request Medicaid data reported as PDPM; therefore, no prepared data set exists currently
- Re-requesting RUGS-III data from CMS; UCD will convert to PDPM

CMS Abuse Citations

LTAC requested analysis of reasons for CMS abuse icon assignment; October LTAC will make recommendation to Board about the icon

79 California facilities had an abuse icon assigned by CMS. Of those:

0 = CMS overall rating of 5 stars (superior)

8 = CMS overall rating of 4 stars (above average)

20 = CMS overall rating of 3 stars (average)

34 = CMS overall rating of 2 stars (below average)

17= CMS overall rating of 1 star (poor)

Notes:

- Some abuse violations are more minor than others (.e.g., resident pulling another resident's hair vs. staff not allowing resident to wear oxygen when going to the bathroom) are at Level D-F

- The Challenge: a repeat D citation ("no actual harm, isolated") is not as serious as a single J/K/L citation ("immediate jeopardy")

Exploring a New SNF Measure

SNF HEALTHCARE ACQUIRED INFECTIONS RESULTING IN HOSPITALIZATION

New CMS Measures: *Healthcare-Associated Infections (*HAI)

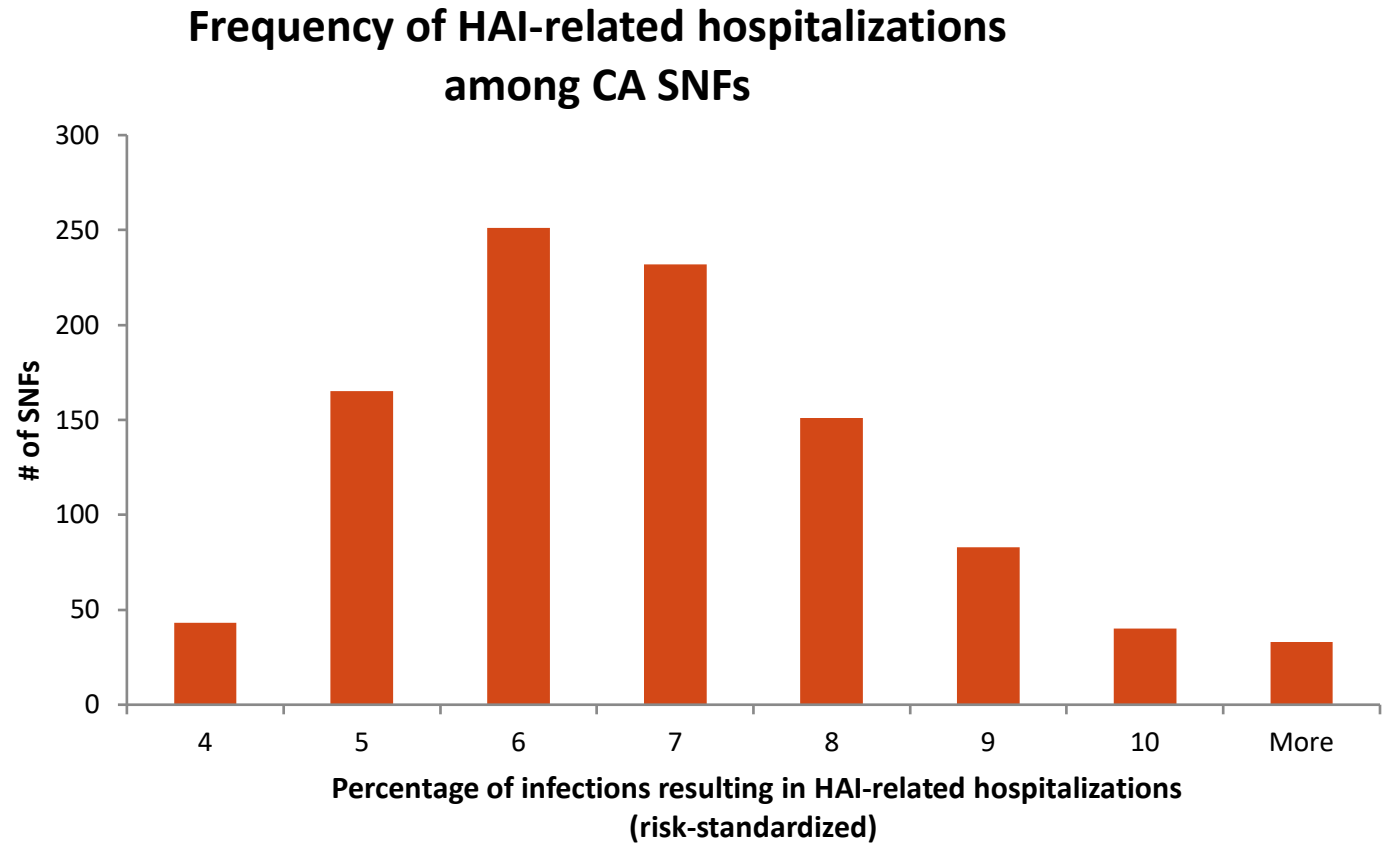
Measure: *"Percentage of infections short-stay patients got during their SNF stay that resulted in hospitalization"*

California SNFs:

- 168 → better than the national rate
- 744 → no different than the national rate
- 86 → worse than the national rate

	Observed rate	Risk-standardized rate
Average	7.65	6.37
Minimum	0	2.71
Maximum	40	12.23
Count	998	998

CMS Measure: SNF HAIs requiring hospitalization



Website Expansion & Design

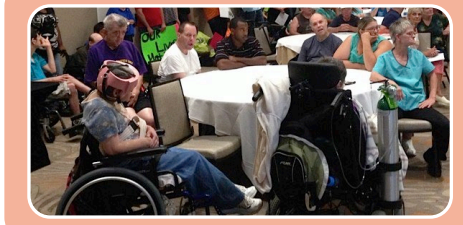
New LTC Providers

Home Health and Hospice

- 2,505/1,820 providers
- Biannual website update

Adult Residential Care Programs*/Adult Day Health Care Ctrs

- 14,048/313 providers
- Annual website update



Other LTC Providers

- ~13,000
- Annual website update

Tentative Reporting Schedule

	Meeting Schedule	Website Refresh
2023		
January	Board	
February		SNF/LTCH/IRF
March	LTAC	
April	Board	
May		Hospice/Home Health*
June	LTAC	
July	Board	
August		SNF/LTCH/IRF
September	LTAC	
October	Board	
November		Hospice/Home Health
December	LTAC	
2024		
January	Board	
February		SNF
March	LTAC	
April	Board	
May		Hospice/Home Health
June	LTAC	
July	Board	
August		SNF
September	LTAC	
October	Board	
November		Hospice/Home Health
December	LTAC	

Potential Public Reporting Challenges

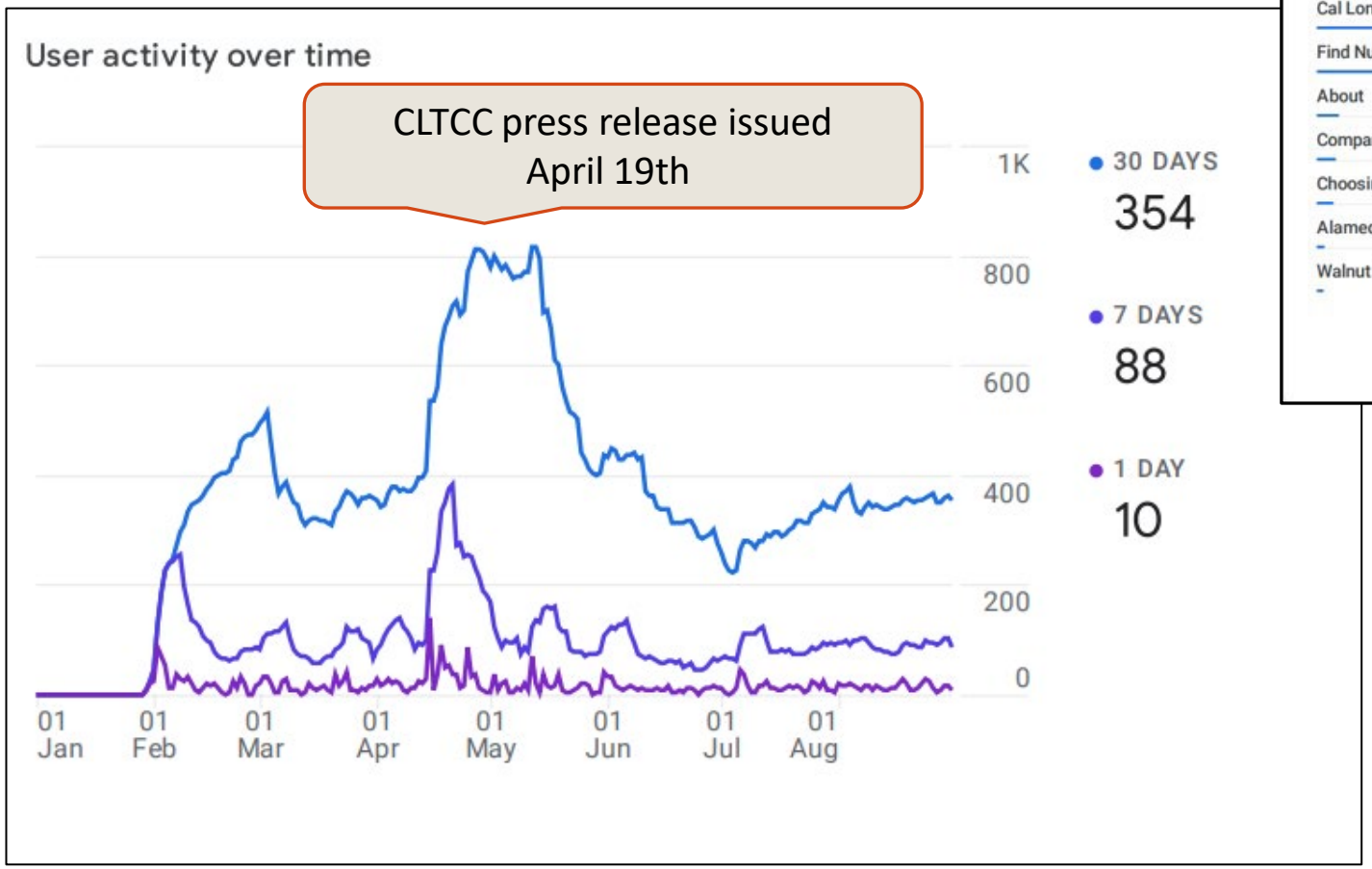
- Clearly defining differences among various providers
  - Educating public about types and differences
- Availability of quality of care measures will vary dramatically among provider types
  - Fall/Winter 2022, UC Davis investigating QoC measure sources
    - Anticipate few or none for Adult Day Health Care Centers, Residential Care Programs, Congregate Care (report complaints/citations and accreditation information when available)

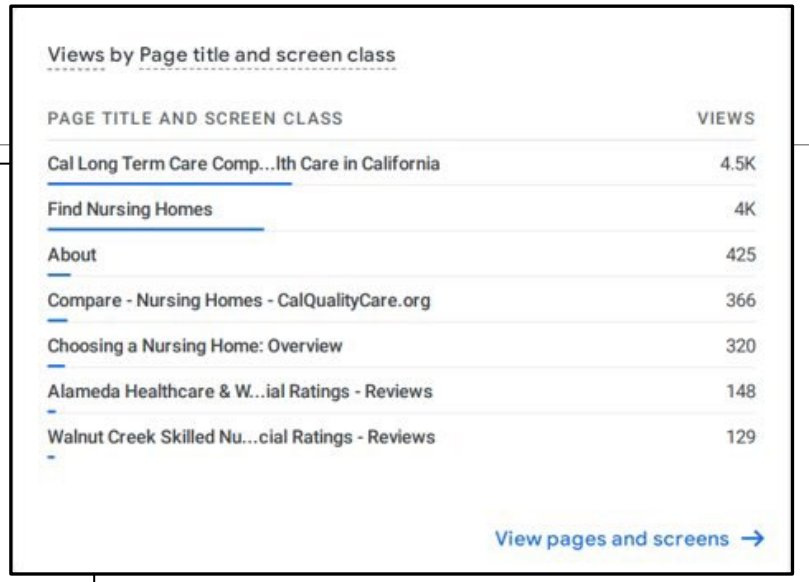
Google Analytics – CLTCC

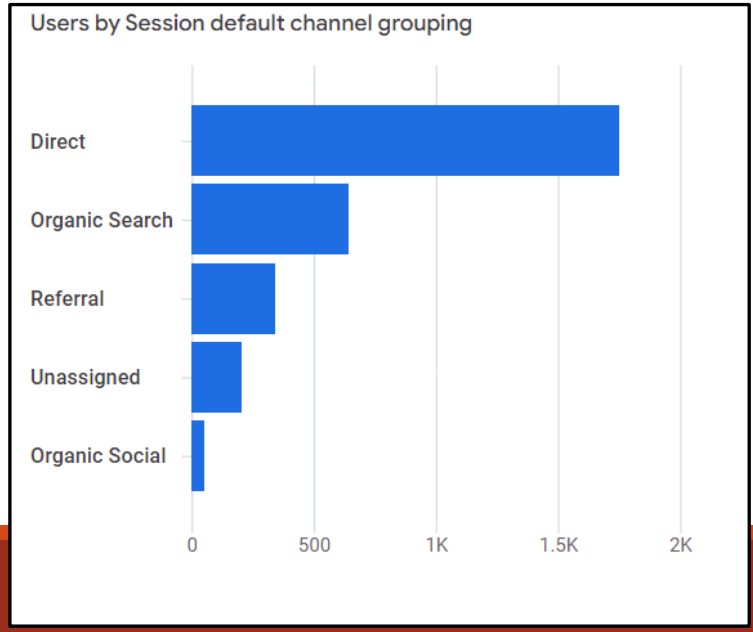
Website Visitor Stats: Jan – Aug 2022

Cal Long Term Care Compare	Cal Hospital Compare
Total website users: 2.9K Total new website users: 2.8k Average engagement time: 2 minutes, 9 seconds	Total website users: 18,869 Total new website users: 18,588 Average engagement time: 1 minute, 59 seconds

CLTCC: Jan – Aug 2022







Wrap Up

Cal Healthcare Compare BOD Schedule

- Next BOD meeting: **Tuesday, December 13 at 10am**. This meeting is subject to change.
- Calendar invitations for the 2023 quarterly TAC and BOD meetings will be sent in late September.

2022 Meeting Cadence (Quarterly)

Meeting	CY 2022											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
Cal Long Term Care Compare Technical Advisory Committee (2 hrs)		Feb 24		Apr 14				Aug 25			Nov 30	
Cal Hospital Compare Technical Advisory Committee (2 hrs)		Feb 15			May 10			Aug 16			Nov 15	
Board of Directors Virtual = 3 hrs In person = 4 hrs			Mar 17 virtual			Jun 21 virtual			Sep 13 virtual			Dec 13 subject to change

Thank you!

Appendix

Proposed BOD Changes (CY2023)

BOD Position	Current	Proposed	Composition
Voting Members			
Consumers	3	4	· Libby Hoy, PFCCpartners · Joan Maxwell, PFA · Kristof Stremikis, CHCF · Nicole Howell, Executive Director, Empowered Aging
County public health department	0	1	· Leslie Ray, Epidemiologist, San Diego County OR Rochelle Ereman, Epidemiologist, Marin County (retired)
Executive Director	1	1	· Bruce Spurlock, Cal Healthcare Compare
Hospitals	2	4	· Robert Imhoff, HQI · Helen Macfie, MemorialCare · Patty Atkins, Sharp (backfill Helen) · Adventist Health representative (rural) · Sutter Health representative
Health plans	2	2	· Jamie Chan, Blue Shield · Rick Krum, Anthem
Kaiser (hospital/health plan)	1	1	· Kevin Worth, Kaiser
LTC leadership	2	2	· Gretchen Alkema · Terry Hill
LTC facility	0	2	· Home health representative · Hospice representative
Purchasers	2	2	· Rachel Brodie, PBGH · Ken Stuart, CHCC
Non-Voting BOD Member			
State agencies	3	5	· Chris Krawczyk, HCAI · Ash Amarnath, Covered CA · Julia Logan, CalPERS · Julie Nagasako, Deputy Director, Office of Policy & Planning, CDPH · California Department of Aging Representative
Associate director	1	2	· David Hopkins, Stanford University · Helen Macfie, MemorialCare (pending retirement)
Total Voting Members	**13**	**19**	
Total Non-Voting Members	**4**	**7**	
TOTAL BOD Members	**17**	**26**	

Potential BOD Members (w/ TAC Training)			
Equity	0	1	Neil Maizlish, Research Scientist, Public Health Alliance of Southern California; Pat Powers, Initiative Management Team, Laura Hogan, Initiative Management Team, Barbara Masters, Initiative Director, California Accountable Communities for Health Initiative
Community based/facing organizations	0	1	Carmen Rita Nevarez, Director, California Opioid Prevention Network; Serena Clayton, Executive Director, CA Bridge
Case management association	0	1	Representative from the American Case Management Association - Southern CA Chapter, CALA staff
Providers	0	1	Bill Barcelona, EVP Government Affairs, America's Physician Group

CAL HEALTHCARE COMPARE

HOSPITAL & NURSING HOME PERFORMANCE DATA FEES (2023)

Cal Healthcare Compare is a non-profit organization that is governed by a multi-stakeholder board, with representatives from hospitals, nursing homes, purchasers, consumer groups, and health plans. In 2022, Cal Healthcare Compare was rebranded to encompass Cal Hospital Compare and Cal Long Term Care Compare. Cal Healthcare Compare provides quality data and ratings on California hospitals and nursing home providers. We use an open and collaborative process to aggregate multiple sources of public data, and to establish relevant measures and scoring. Cal Hospital Compare and Cal Long Term Compare each have their own Technical Advisory Committee, with support from American Institutes for Research (AIR) and UC Davis Health respectively, that report up to the Cal Healthcare Compare Board of Directors. The Cal Hospital Compare website is updated quarterly and the Cal Long Term Compare website is updated bi-annually.

Industry Collaboration

- California Department of Public Health
- California Health Care Foundation
- California Maternal Quality Care Collaborative
- California Medical Association
- California Department of Health Care Access and Information
- Centers for Medicare and Medicaid Services
- Covered California
- Health Net
- Hospital Quality Institute
- Kaiser Foundation Health Plan & Hospitals
- Leapfrog Hospital Safety Grades
- The SCAN Foundation
- Yelp

Trusted Data

- The websites are always free to use and offers fully open access
- The information is objective, unbiased and relevant to consumers and other stakeholders
- Users will never see advertising or promotion of one hospital over others
- Our partnership with AIR and UC Davis Health provides rich analytics and reliable data

Contact

Alex Stack, MPH
Director, Programs & Strategic Initiatives, Cal Healthcare Compare
Improvement Advisor, Hospital Quality Improvement Collaborative
Cynosure Health
714-351-5982 (c) | astack@cynosurehealth.org
All In Saves Lives. www.cynosurehealth.org

Option 1: Cal Healthcare Compare Sponsorship

Unlimited data access, organizational leadership, and performance intelligence.

- Participation in Cal Healthcare Compare governance via Technical Advisory Committees and Board of Directors; operational decision making, establish priorities, and strategic planning.
- Quarterly hospital data files and bi-annual nursing home data files that include all publicly reporting measures in a usable format; memos outlining measurement updates, trends, and implications.
- Annual hospital (patient safety, maternity, opioid) and nursing home honor roll reports, including list of patient safety poor performing outlier hospitals not publicly available.
- Honor roll methods are aligned with and useful for assessing Covered California network requirements.
- Access to all Technical Advisory Committee exploratory analyses produced with AIR and UC Davis Health.
- Sponsors can submit custom query requests for Technical Advisory Committee review (pending resource availability).
- Up to 15 hours annually of clinical and technical assistance provided by Bruce Spurlock, MD, Cal Healthcare Compare's Executive Director.

$125,000/year

Option 2: Performance Intelligence Subscription

Includes all performance metrics and scores along with reports and performance insights.

- Participation in Cal Healthcare Compare governance via Technical Advisory Committees; review measures, reports, trends and provides input to the Board of Directors.
- Quarterly hospital data files and bi-annual nursing home data files that include all publicly reporting measures in a usable format; memos outlining measurement updates, trends, and implications.
- Annual hospital (patient safety, maternity, opioid) and nursing home honor roll reports, including patient safety poor performing outlier hospitals not publicly available.
- Up to 10 hours annually of clinical and technical assistance provided by Bruce Spurlock, MD, Cal Healthcare Compare's Executive Director.

$65,000/year

Option 3: Purchaser Related Performance Data

Includes all Cal Healthcare Compare Honor Roll reports and related metrics for ALL hospitals and nursing homes; with expanded hospital maternity measures and list of patient safety poor performing outlier hospitals not publicly available.

- Annual hospital (patient safety, maternity, opioid) and nursing home honor roll reports, including list of patient safety poor performing outlier hospitals not publicly available.
- Data files includes relevant measures in an easy-to-use analytic file.
- Hospital patient safety and poor performers data set includes healthcare associated infections, AHRQ PSI 90, Sepsis Management, HCAHPS, and Leapfrog Hospital Safety Grade.
- Hospital maternity data set includes NTSV c-section, VBAC, breastfeeding, episiotomy rates and deliveries by certified nurse midwife
- Hospital opioid care data set includes self-assessment results and related analyses for hospitals participating in the Opioid Care Honor Roll program.
- Nursing home honor roll data set. Exact measures to be determined.

$45,000/year

Option 4: Select Purchaser Related Performance Data

Includes Cal Healthcare Compare Honor Roll reports and related metrics for ALL or SELECT hospitals and nursing homes; with list of patient safety poor performing outlier hospitals not publicly available. See report details below.

- Annual hospital (patient safety, maternity, opioid) and nursing home honor roll reports, including list of patient safety poor performing outlier hospitals not publicly available.
- Data files includes relevant measures in an easy-to-use analytic file.
- Hospital patient safety and poor performers data set includes healthcare associated infections, AHRQ PSI 90, Sepsis Management, HCAHPS, and Leapfrog Hospital Safety Grade for only those hospitals included in the report.
- Hospital maternity data set includes NTSV c-section rate for all hospitals.
- Opioid care data set includes self-assessment results and related analyses for hospitals achieving Superior Performance and Excellent Progress.
- Nursing home honor roll data set for all nursing homes. Exact measures to be determined.

$35,000/year

Option 5: Custom data request

Customized data request for measures not included in data subscription options 3 and 4.

- Initial consultation with Cal Healthcare Compare, AIR, and/or UC Davis Health team members to optimize request design.
- Analytic-ready data file(s) designed to meet your specifications.
- Example data request may include hospital wide readmission rate, sepsis management, death rate, surgical site infections, etc.

Starting at $5,000

Appendix

2023 Cal Healthcare Compare Data Reporting Timeline				
Report	**Expected Deliverable Date**	**Measures**	**Source**	**Measurement Period**
Hospital Patient Safety Honor Roll and **Poor Performer Report**	Mar 2023	Healthcare Associated Infections *(CLABSI, CAUTI, SSI Colon Surgery, MRSA, CDI)*	CMS Hospital Compare	4/1/2021– 03/30/2022
		AHRQ PSI 90	CMS Hospital Compare	1/1/2020 –12/31/2021
		Sepsis Management	CMS Hospital Compare	4/1/2021 – 3/30/2022
		Patient Experience *(RN communication, MD communication, Help received when wanted, Staff explained medication, Patients understood their care when they left the hospital)*	CMS Hospital Compare	4/1/2021 – 3/30/2022
		Hospital Letter Grade	Leapfrog Hospital Safety Grades	Fall 2021, Spring 2022, Fall 2022
Hospital Maternity Honor Roll	July 2023	NTSV C-Section Rate	California Maternal Quality Care Collaborative	CY 2022
Hospital Opioid Care Honor Roll	July 2023	• Safe & Effective Opioid Use • Identification & Treatment • Overdose Prevention • Cross Cutting Opioid Management Best Practices	Opioid Management Hospital Self-Assessment	CY 2022
Nursing Home Honor Roll/Better Staffing Recognition	TBD	• Exact measures and methodology to be determined	TBD	TBD

BYLAWS

OF

CALIFORNIA HOSPITAL ASSESSMENT AND

REPORTING TASK FORCE (CHART)

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Page

BYLAWS
OF
CALIFORNIA HOSPITAL ASSESSMENT AND REPORTING TASK FORCE (CHART)

ARTICLE I
Purposes

The corporation is organized for the public and educational purposes as specified in its Articles of Incorporation.

ARTICLE II
Offices

Section 1. Principal Office.

The Board of Trustees ("Board" or "Governing Board") is granted full power and authority to change the principal office from one location to another within California.

Section 2. Other Offices.

Branch or subordinate offices may at any time be established by the Board at any place or places where the corporation is qualified to do business.

ARTICLE III
Membership

Section 1. No Members.

Unless and until these Bylaws are amended to provide otherwise, this corporation shall have no statutory members, as the term "member" is defined in Section 5056 of the California Nonprofit Corporation Law. Any action which would otherwise by law require approval by a majority of all members or approval by the members shall require only approval of the Board. All rights which would otherwise by law vest in the members shall rest in the Board.

Section 2. Associates.

Nothing in this Article shall be construed to limit the corporation's right to refer to persons associated with it as "members" even though such persons are not members, and no such reference by the corporation shall render anyone a member within the meaning of Section 5056 of the California Nonprofit Corporation Law. Such individuals may originate and take part in the discussion of any subject that may properly come before any meeting of the Board, but may not vote. The corporation may confer, by amendment of its Articles of Incorporation or of these Bylaws, some or all of a member's rights, set forth in the California Nonprofit Corporation Law, upon any person who does not have the right to vote for the election of trustees/directors, on a disposition of substantially all of the assets of the corporation, on a

merger, on a dissolution, or on changes to the corporation's Articles of Incorporation or Bylaws, but no such person shall be a member within the meaning of said Section 5056.

ARTICLE IV
Board of Trustees

Section 1. Powers.

Subject to the limitations of the California Nonprofit Public Benefit Corporation Law, the corporation's Articles of Incorporation and these Bylaws, the activities and affairs of the corporation shall be conducted and all corporate powers shall be exercised by or under the direction of the Board. The Board may delegate the management of the corporation's activities to any person(s), management company or committees, however composed, provided that the activities and affairs of the corporation shall be managed and all corporate powers shall be exercised under the ultimate direction of the Board. No assignment, referral or delegation of authority by the Board or anyone acting under such delegation shall preclude the Board from exercising full authority over the conduct of the corporation's activities, and the Board may rescind any such assignment, referral or delegation at any time.

Without prejudice to its general powers, but subject to the same limitations set forth above, the Board shall have the following powers in addition to any other powers enumerated in these Bylaws and permitted by law:

To select and remove all of the officers, agents and employees of the corporation; to prescribe powers and duties for them which are not inconsistent with law, the corporation's Articles of Incorporation or these Bylaws; to fix their compensation; and to require security from them for faithful service;

To conduct, manage and control the affairs and activities of the corporation and to make such rules and regulations therefore which are not inconsistent with law, the corporation's Articles of Incorporation or these Bylaws;

To adopt, make and use a corporate seal and to alter the form of the seal from time to time;

To borrow money and incur indebtedness for the purposes of the corporation, and to cause to be executed and delivered therefore, in the corporate name, promissory notes, bonds, debentures, deeds of trust, mortgages, pledges, hypothecations and other evidences of debt and securities therefore;

To carry on a business and apply any revenues in excess of expenses that results from the business activity to any activity in which it may lawfully engage;

To act as trustee under any trust incidental to the principal object of the corporation, and receive, hold, administer, exchange and expend funds and property subject to such trust;

To acquire by purchase, exchange, lease, gift, devise, bequest, or otherwise, and to hold, improve, lease, sublease, mortgage, transfer in trust, encumber, convey or otherwise dispose of real and personal property; and

To assume any obligations, enter into any contracts or other instruments, and do any and all other things incidental or expedient to the attainment of any corporate purpose.

Section 2. Number and Qualifications of Trustees.

i. The authorized number of trustees shall be not less than three (3) or more than twenty-one (21), unless changed by a duly adopted amendment to this provision. The exact number of trustees shall be fixed within these limits by a resolution of the Board.

ii. The initial Board of Trustees shall be appointed by the incorporator. Of the nineteen (19) initial Board members, four (4) shall be representatives of health plans providing healthcare coverage to subscribers or enrollees, four (4) shall be representatives of acute care hospitals licensed under Section 1250(a) or (b) of the California Health and Safety Code, four (4) shall represent consumers of health care, four (4) shall represent purchasers of healthcare, i.e., employees or organizations representing employers, one (1) representative of the Association of California Nurse Leaders ("ACNL"), one (1) representative from the California Medical Association ("CMA"), and one representative from the California Healthcare Foundation ("CHCF"). The ratio of four health plans, four hospital, four consumers, four purchasers, one ACNL, one CMA and one CHCF member shall remain after appointment of the initial Board until changed by the Board.

Section 3. Appointment and Term of Office.

Trustees shall be selected at an annual meeting of the Board by the trustees holding office as of the date of such meeting. Representatives from the participating health plans, hospitals, purchasers and consumers will nominate candidates for selection for their specific stakeholder group prior to the annual meeting.

Trustees shall hold office for a term of three (3) years, or until a successor has been elected. The members of the Board shall stagger their terms by dividing the number of members of the Board into three groups of unequal or equal number and then labeling the groups 1, 2, and 3. Thereafter, by lot, the name of a trustee shall be assigned to one of the three groups. The terms for each of the trustees in Group 1 shall expire after one year; the terms for each of the trustees in Group 2 shall expire after the second year; and, the terms for each of the trustees in Group 3 shall expire after the third year. After these initial terms, each trustee shall hold office for three (3) years. The trustees representing health plans, hospitals, consumers and purchasers should be staggered within their respective groups to assure that all members of the group are not up for election at the same time.

Section 4. Trustee Approval of Certain Corporate Actions.

The Board must approve the following actions:

i. the annual budget of the corporation;

ii. any non-budgeted expenditures of the corporation over $25,000;

iii. the removal of trustees/directors without cause pursuant to Section 5222 of the California Corporations Code;

iv. the approval of the sale, lease, conveyance, exchange, transfer, or other disposition of all or substantially all of the assets of the corporation;

v. the approval of the principal terms of a merger of the corporation with another organization;

vi. the approval of the filing of a petition for the involuntary dissolution of the corporation if statutory grounds for such a dissolution exist;

vii. the approval of the voluntary dissolution of the corporation or the revocation of such an election to dissolve it; and

viii. the approval of any borrowing of money.

Section 5. Resignation and Removal.

Subject to the provisions of Section 5226 of the California Nonprofit Public Benefit Corporation Law, any trustee may resign effective upon giving written notice to the president, the secretary, or the Board, unless the notice specifies a later effective time. If the resignation is effective at a future time, a successor may be selected before such time, to take office when the resignation becomes effective.

Section 6. Vacancies.

A Board vacancy or vacancies shall be deemed to exist if any trustee dies, resigns, or is removed, or if the authorized number of trustees is increased.

Notwithstanding Section 5 of this Article, the Board may declare vacant the office of any trustee who has been convicted of a felony, or has been found to have breached any duty arising under Article 3 of Chapter 2 of the California Nonprofit Public Benefit Corporation Law or to be of unsound mind by any court of competent jurisdiction.

A vacancy on the Board shall be filled only by resolution of the Board. Each trustee so elected, appointed, or designated shall hold office until the expiration of the term of the replaced trustee and continue to hold office until a qualified successor has been elected, appointed, or designated.

No reduction of the authorized number of trustees shall have the effect of removing any trustee prior to the expiration of the trustee's term of office.

Section 7. Place of Meeting.

Meetings of the Board shall be held at the principal office of the corporation or at any other place within or without the State of California which has been designated in the notice of the meeting or, if there is no notice, by resolution of the Board.

Section 8. Annual Meeting.

Annually the Board shall meet for the purpose of organization, appointment of officers and the transaction of such other business as may properly be brought before the meeting. This meeting shall be held at a time, date and place as may be specified and noticed by resolution of the Board.

Section 9. Regular Meetings.

Regular meetings of the Board, including annual meetings, shall be held without call or notice at such times and places as may from time to time be fixed by the Board.

Section 10. Special Meetings.

Special meetings of the Board for any purpose may be called at any time by the president, the secretary or any two trustees. The party calling such special meeting shall determine the place, date and time thereof.

Section 11. Notice of Special Meetings.

Special meetings of the Board may be held only after each trustee has received four (4) days' prior notice by first-class mail or forty-eight (48) hours' notice given personally or by telephone, including a voice messaging system or other system or technology designed to record and communicate messages, telegraph, facsimile, electronic mail, or other electronic means.

Any such notice shall be addressed or delivered to each trustee at the trustee's address as it is shown on the records of the corporation or as may have been given to the corporation by the trustee for purposes of notice or, if an address is not shown on the corporation's records or is not readily ascertainable, at the place at which the meetings of the trustees are regularly held.

Notice by mail shall be deemed received at the time a properly addressed written notice is deposited in the United States mail, postage prepaid. Any other written notice shall be deemed received at the time it is personally delivered to the recipient or is delivered to a common carrier for transmission, or is actually transmitted by the person giving the notice by electronic means to the recipient. Oral notice shall be deemed received at the time it is communicated, in person or by telephone or wireless, to the recipient or to a person at the office

of the recipient whom the person giving the notice has reason to believe will promptly communicate it to the receiver.

The notice of special meeting shall state the time of the meeting, and the place if the place is other than the principal office of the corporation, and the general nature of the business proposed to be transacted at the meeting. No business, other than the business the general nature of which was set forth in the notice of the meeting, may be transacted at a special meeting.

Section 12. Quorum.

A majority of the trustees then in office shall constitute a quorum. Every act or decision done or made by a majority of the trustees present at a meeting duly held at which a quorum is present is an act of the Board. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of trustees, if any action taken is approved by at least a majority of the required quorum for such meeting. trustees may not vote by proxy.

Section 13. Consent to Meetings.

The transactions of the Board at any meeting, however called and noticed or wherever held, shall be as valid as though done at a meeting duly held after regular call and notice if a quorum be present, and if, either before or after the meeting, each trustee entitled to vote, not present in person signs a written waiver of notice, or a consent to the holding of such meeting, or approval of the minutes thereof. All such waivers, consents or approvals shall be filed with the corporate records and made a part of the minutes of the meeting. Notice of a meeting need not be given to any trustee who attends the meeting without protesting prior to or at the commencement of the meeting, the lack of notice to such trustee.

Section 14. Action Without Meeting.

Any action required or permitted to be taken by the Board under any provision of the Nonprofit Public Benefit Corporation Law may be taken without a meeting if all members of the Board shall individually or collectively consent in writing to such action. Such consent(s) shall be filed with the minutes of the proceedings of the Board and shall have the same force and effect as a unanimous vote of such trustees.

Section 15. Telephonic and Electronic Video Meetings.

Members of the Board may participate in a meeting through the use of conference telephone, electronic video screen communication, or other communications equipment. Participation in a meeting through use of conference telephone constitutes presence in person at that meeting as long as all members participating in the meeting are able to hear one another. Participation in a meeting through use of electronic video screen communication or other communications equipment (other than conference telephone) constitutes presence in person at that meeting if (i) each member participating can communicate with all other members concurrently, (ii) each member is provided the means of participating in all matters before the Board including, without limitation, the capacity to propose, or to interpose an objection to,

specific action to be taken, and (iii) the corporation has adopted and implemented some means of verifying both that the person participating in the meeting is a trustee or other person entitled to participate in the meeting and that all actions of, or votes by, the Board are taken or cast only by the trustees and not by persons who are not trustees.

Section 16. Adjournment.

A majority of the trustees present, whether or not a quorum is present, may adjourn any trustees meeting to another time or place. If a meeting is adjourned for more than twenty-four (24) hours, notice of such adjournment to another time or place shall be given, prior to the time schedule for the continuation of the meeting, to the trustees who were not present at the time of the adjournment.

Section 17. Rights of Inspection.

Subject to applicable federal and state laws regarding pupil confidentiality, every trustee has the absolute right at any reasonable time to inspect and copy all books, records, and documents of every kind and to inspect the physical properties of the corporation.

Section 18. Board Committees.

(i) Board may appoint an executive committee and one or more other committees each consisting of two (2) or more trustees to serve at the pleasure of the Board, and delegate to such committee any of the authority of the Board, except with respect to:

a. The filling of vacancies on the Board or on any committee which has the authority of the Board;

b. The fixing of compensation of the trustees for serving on the Board or on any committee;

c. The amendment or repeal of Bylaws or the adoption of new Bylaws;

d. The amendment or repeal of any resolution of the Board which by its express terms is not so amendable or repealable;

e. The appointment of other committees having the authority of the Board;

f. The expenditure of corporate funds to support a nominee for trustee after there are more people nominated for trustee than can be elected; or

g. The approval of any self-dealing transaction as such transactions are defined in Section 5233(a) of the California Nonprofit Public Benefit Corporation Law, except as permitted under Section 25 of this Article.

Any such committee must be created, and the members thereof appointed, by resolution adopted by a majority of the number of trustees then in office, and any such committee may be designated as an executive committee or by such other name as the Board shall specify. The Board will make every reasonable attempt to place a representative from the hospital, health plan, purchaser and consumer stakeholder group, unless the Board waives this requirement by resolution. The Board may appoint, in the same manner, alternate members to a committee who may replace any absent member at any meeting of the committee. The Board shall have the power to prescribe the manner in which proceedings of any such committee shall be conducted. In the absence of any such prescription, such committee shall have the power to prescribe the manner in which its proceedings shall be conducted. Unless the Board, such committee, or these Bylaws shall otherwise provide, the regular and special meetings and other actions of any such committee shall be governed by the provisions of this Article IV applicable to meetings and actions of the Board. Minutes shall be kept of each meeting of each committee.

(ii) Executive Committee. If an executive committee is approved by the Board, it shall consist of one trustee representing health plans, one representing hospitals, one representing consumers and one representing purchasers. The trustee representing CHCF shall also be on the committee. The executive director shall staff the committee. The purpose of the Executive Committee is to act when the full Board is unavailable. It shall also act as a nominating committee for the Board and make its recommendation at least two weeks prior to the meeting of the Board for the election of officers and trustees. The Executive Committee shall have all the authority of the Board in the management of the business and affairs of the corporation, except those powers that under these Bylaws or by law cannot be delegated by the Board. Every action properly taken by the Executive Committee shall be reported to the Board at the next regular or special meeting of the Board occurring after the action was taken by the Executive Committee.

Section 19. Audit Committee.

a. Appointment. An audit committee shall be appointed for any fiscal year in which the corporation is required to file an Audited Financial Report (as such term is defined in Section 31 of this Article).

b. Members. The Board shall appoint one (1) or more individuals to serve as the corporation's audit committee. The corporation's audit committee may include persons who are not trustees, but may not include any member of the staff of the corporation, including, without limitation, its president or its chief financial officer. If the corporation has a finance committee, it must be separate from the audit committee. Members of the finance committee may serve on the audit committee; however, the chairperson of the audit committee may not be a member of the finance committee and members of the finance committee shall constitute less than one-half of the membership of the audit committee.

c. Compensation. Members of the audit committee shall not receive any compensation from the corporation and shall not have a material financial interest in any entity doing business with the corporation.

d. Responsibilities. Subject to the supervision of the Board, the audit committee shall be responsible for recommending to the Board the retention and termination of the corporation's independent auditor, to prepare the Audited Financial Report, and may negotiate the independent auditor's compensation on behalf of the Board. The audit committee shall confer with the auditor to satisfy its members that the financial affairs of the corporation are in order, shall review and determine whether to accept the Audited Financial Report, shall assure that any nonaudit services performed by the auditing firm conform with standards for auditor independence referred to in Section 12586(e)(1) of the California Government Code, and shall approve the performance of nonaudit services by the auditing firm.

Section 20. Other Committees.

a. The president, subject to the limitations imposed by the Board, or the Board, may create other committees, either standing or special, to serve the Board which do not have the powers of the Board. The president, with the approval of the Board, shall appoint members to serve on such committees, and shall designate the committee chair. If a trustee is on a committee, he or she shall be the chair. Each member of a committee shall continue as such until the next annual election of officers and until his or her successor is appointed, unless the member sooner resigns or is removed from the committee.

b. Meetings of a committee may be called by the president, the chair of the committee or a majority of the committee's voting members. Each committee shall meet as often as is necessary to perform its duties. Notice of a meeting of a committee may be given at any time and in any manner reasonably designed to inform the committee members of the time and place of the meeting. A majority of the voting members of a committee shall constitute a quorum for the transaction of business at any meeting of the committee. Each committee may keep minutes of its proceedings and shall report periodically to the Board. A committee may take action by majority vote.

c. Any member of a committee may resign at any time by giving written notice to the president. Such resignation, which may or may not be made contingent upon formal acceptance, shall take effect upon the date of receipt or at any later time specified in the notice. The president may, with prior approval of the Board, remove any appointed member of a committee. The president, with the Board's approval, shall appoint a member to fill a vacancy in any committee or any position created by an increase in the membership for the unexpired portion of the term.

Section 21. Fees and Compensation.

Trustees and members of committees shall not receive any compensation for their services; however, the Board may approve reimbursement of a trustee's actual and necessary expenses incurred in the conduct of the corporation's business.

Section 22. Nonliability of Trustees.

No trustee shall be personally liable for the debts, liabilities or other obligations of this corporation.

Section 23. Interested Persons.

Not more than forty-nine percent (49%) of the trustees serving on the Board may be "interested persons." An "interested person" is (i) any person compensated by the corporation for services rendered to it within the previous twelve (12) months whether as a full- or part-time employee, independent contractor, or otherwise, excluding any reasonable compensation paid to a trustee as trustee, and (ii) any brother, sister, ancestor, descendant, spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law or father-in-law of any such person. However, any violation of the provisions of this Section shall not affect the validity or enforceability of any transaction entered into by the corporation.

Section 24. Standard of Care.

A trustee shall perform the duties of a trustee, including duties as a member of any committee of the Board upon which the trustee may serve, in good faith, in a manner such trustee believes to be in the best interests of the corporation and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under similar circumstances. In performing the duties of a trustee, a trustee shall be entitled to rely on information, opinions, reports or statements, including financial statements and other financial data, in each case prepared or presented by:

One or more officers or employees of the corporation whom the trustee believes to be reliable and competent in the matters presented;

Counsel, independent accountants or other persons as to matters which the trustee believes to be within such person's professional or expert competence; or

A committee of the Board upon which the trustee does not serve as to matters within its designated authority, provided the trustee believes merits confidence and the trustee acts in good faith, after reasonable inquiry when the need therefore is indicated by the circumstances and without knowledge that would cause such reliance to be unwarranted.

Section 25. Self-Dealing Transactions.

Except as provided in subsection a. below, a self-dealing transactions means transactions to which the corporation is a party and in which one or more of the trustees ("interested trustee(s)") has a material financial interest and which does ***not*** meet the requirements of subsection b.(A), (B), or (C) below.

a. A self-dealing transaction does not include:

An action by the Board fixing the compensation of a trustee as a trustee or officer of the corporation.

A transaction which is part of a public or charitable program of the corporation if the transaction is (A) approved or authorized by the corporation in good faith and without unjustified favoritism, and (B) results in a benefit to one or more trustees or their families because they are in a class of persons intended to be benefited by the public or charitable program.

A transaction of which the interested trustees have no actual knowledge, and which does not exceed the lesser of one percent (1%) of the corporation's gross receipts for the preceding fiscal year or One Hundred Thousand Dollars ($100,000).

b. None of the remedies available under Section 5233(h) of the California Nonprofit Public Benefit Corporation Law will be granted to a party permitted to bring an action under Section 5233(c) of the California Nonprofit Public Benefit Corporation Law (with respect to a self-dealing transaction), if:

The Attorney General, or the court in an action in which the Attorney General is an indispensable party, has approved the transaction before or after it was consummated; *or*

The following facts are established:

(A) The corporation entered into the transaction for its own benefit;

(B) The transaction was fair and reasonable as to the corporation at the time the corporation entered into the transaction;

(C) Prior to consummating the transaction or any part thereof, the Board authorized or approved the transaction in good faith by vote of a majority of the trustees then in office without counting the vote of the interested trustee(s), and with knowledge of the material facts concerning the transaction and the interested trustee's interest in the transaction. Except as provided in subsection b.iii. below, action by a committee of the Board will not satisfy this requirement; and

(D) (I) Prior to authorizing or approving the transaction, the Board considered and in good faith determined after reasonable investigation under the circumstances that the corporation could not have obtained a more advantageous arrangement with reasonable effort under the circumstances, or (II) the corporation in fact could not have obtained a more advantageous arrangement with reasonable effort under the circumstances; *or*

The following facts are established:

(E) A committee or person authorized by the Board approved the transaction in a manner consistent with the standards prescribed for approval by the Board under subsection b.(B) above;

(F) It was not reasonably practical to obtain approval of the Board prior to entering into the transaction; and

(G) The Board, after determining in good faith that the conditions set forth in subparagraphs (A) and (B) of this subsection b. were satisfied, ratified the transaction at its next meeting by a vote of a majority of the trustees then in office without counting the vote of the interested trustee(s).

Section 26. Interested Trustee's Vote.

In determining whether the Board validly met to authorize or approve a self-dealing transaction, interested trustees may be counted to determine the presence of a quorum, but an interested trustee's vote may not be counted toward the required majority for such authorization, approval or ratification.

Section 27. Persons Liable and Extent of Liability.

If a self-dealing transaction has not been approved as provided in Section 25 of this Article, the interested trustee(s) may be required to do such things and pay such damages as a court may provide as an equitable and fair remedy to the corporation, considering any benefit received by it and whether or not the interested trustee(s) acted in good faith and with the intent to further the best interests of the corporation.

Section 28. Contracts or Transactions With Mutual Trustees.

No contract or other transaction between the corporation and any domestic or foreign corporation, firm or association of which one or more of the corporation's trustees are trustees is either void or voidable because such trustee(s) are present at the meeting of the Board or committee thereof which authorizes, approves or ratifies the contract or transaction if:

The material facts as to the transaction and as to such trustee's other directorship are fully disclosed or known to the Board or committee, and the Board or committee authorizes, approves or ratifies the contract or transaction in good faith by a vote sufficient without counting the vote of the common trustee(s); or

As to contracts or transactions not approved as provided in subsection i. of this Section, the contract or transaction is just and reasonable as to the corporation at the time it is authorized, approved or ratified.

Notwithstanding the foregoing, this Section shall not apply to self-dealing transactions described in Section 25 of this Article above.

Section 29. Corporate Loans and Advances.

The corporation shall not make any loan of money or property to or guarantee the obligation of any trustee or officer, unless approved by the Attorney General; provided, however, that the corporation may advance money to a trustee or officer of the corporation or any subsidiary for expenses reasonably anticipated to be incurred in the performance of the duties of such officer or trustee, if, in the absence of such advance, such trustee or officer would be entitled to be reimbursed for such expenses by the corporation, its parent or any subsidiary.

Section 30. Annual Report.

Pursuant to Section 6321 of the California Nonprofit Public Benefit Corporation Law, the chief financial officer shall cause an annual report to be prepared and sent to each trustee not later than 120 days after the close of the fiscal year. Such annual report shall be prepared in conformity with the requirements of the California Nonprofit Public Benefit Corporation Law as it may be in effect from time to time.

Section 31. Reports to the Attorney General.

(i) Registration and Renewal. The corporation shall file a registration fee, a copy of its Articles of Incorporation and a copy of these Bylaws and such other materials as may be required with the California Attorney General's Registry of Charitable Trusts within 30 days after receipt of any assets. Thereafter, the corporation shall annually file with the Attorney General, Form RRF-1, a written report, setting forth information as to its assets held for charitable purposes and the administration thereof, within four months and fifteen days after the close of the corporation's fiscal year. Form RRF-1 shall be accompanied by the applicable renewal fee and, if the corporation's total gross revenue or assets in the preceding fiscal year equaled $25,000 or more, a copy of IRS Form 990, 990-EZ, or 990PF and attachments.

(ii) Audited Financial Report.

a. Preparation of Report. For any fiscal year that the corporation receives or accrues gross revenue of two million dollars ($2,000,000) or more, (exclusive of grants from, and contracts for services with governmental entities for which the governmental entity requires an accounting of the funds received), the corporation shall prepare annual financial statements using generally accepted accounting principles that are audited by an independent certified public accountant in conformity with generally accepted auditing standards ("Audited Financial Report").

b. Inspection. For any year the corporation prepares an Audited Financial Report (whether or not required), it shall be available for inspection by the Attorney General and by members of the public no later than nine months after the close of the fiscal year to which it relates. The corporation shall make its Audited Financial Report available to the public in the same manner that is prescribed for IRS Form 990 by

the latest revision of Section 6104(d) of the Internal Revenue Code and associated regulations.

Section 32. Annual Statement of Certain Transactions and Indemnifications.

Pursuant to Section 6322 of the California Nonprofit Public Benefit Corporation Law, the corporation shall furnish an annual statement of certain transactions and indemnifications to each of the trustees no later than 120 days after the close of the fiscal year. If the corporation issues an annual report as set forth in Section 30 of this Article above, this requirement shall be satisfied by including the required information, as set forth below, in such report. Such annual statement shall describe:

Any "covered transaction" (defined below) during the previous fiscal year of the corporation involving (a) more than Fifty Thousand Dollars ($50,000) or, (b) which was one of a number of "covered transactions" in which the same "interested person" (defined below) had a direct or indirect material financial interest, and which transactions in the aggregate involved more than Fifty Thousand Dollars ($50,000). The statement shall describe the names of any "interested persons" involved in such covered transactions, including such "interested persons" relationship to the transaction, and, where practicable, the amount of such interest; provided, that in the case of a transaction with a partnership of which the "interested person" is only a partner, only the interest of the partnership need be stated.

For the purposes of this Section, a "covered transaction" is a transaction in which the corporation, its parent or its subsidiary, was a party, and in which either of the following had a direct or indirect material financial interest:

(a) Any trustee or officer of the corporation, or its parent or subsidiary; or

(b) Any holder of more than ten percent (10%) of the voting power of the corporation, its parent or its subsidiary.

The amount and circumstances of any indemnifications or advances aggregating more than Ten Thousand Dollars ($10,000) paid during the fiscal year of the corporation to any officer or trustee of the corporation.

For purposes of this Section, any person described in either paragraph (a) or (b) of subsection ii. above is an "interested person."

Section 33. Property Rights.

No trustee shall have any right or interest in any of the corporation's property or assets.

ARTICLE V
Officers

Section 1. Officers.

The officers of this corporation shall be a president, one or more vice presidents, a secretary, and a chief financial officer. The corporation may also have an executive director. The corporation may also have, at the discretion of the Board, one or more assistant secretaries, one or more assistant treasurers, and such other officers as may be elected or appointed by the Board. Any number of offices may be held by the same person, except that neither the secretary nor the treasurer may serve concurrently as the president.

Section 2. Appointment of Officers.

Except as otherwise specified in Sections 3 and 9 of this Article, the officers of the corporation shall be chosen annually by the Board and each shall hold office until he or she shall resign or shall be removed or otherwise disqualified to serve, or his or her successor shall be elected and qualified.

Section 3. Subordinate Officers.

The Board may appoint and may empower the president to appoint such other officers as the business of the corporation may require, each of whom shall hold office for such period, have such authority, and perform such duties as are provided in the Bylaws or as the Board may from time to time determine.

Section 4. President.

The president is the chief executive officer of the corporation and has general supervision, direction and control of the business and affairs of the corporation. The president has the general management powers and duties usually vested in the office of president of a corporation, as well as such other powers and duties as may be prescribed from time to time by the Board. The president shall be an ex officio voting member of each Board committee.

Section 5. Vice President.

In the absence or disability of the president, vice president (or if more than one (1) vice president is appointed, in order of their rank as fixed by the Board or if not ranked, the vice president designated by the Board) shall perform all the duties of the president and when so acting shall have all the powers of, and be subject to all of the restrictions upon, the president. The vice presidents shall have such other powers and perform such other duties as the Board may prescribe from time to time.

Section 6. Secretary.

The secretary shall keep or cause to be kept, at the principal office of the corporation the State of California, the original or a copy of the corporation's Articles of Incorporation and Bylaws, as amended to date, and a register showing the names of all trustees

and their respective addresses. The secretary shall keep the seal of the corporation and shall affix the same on such papers and instruments as may be required in the regular course of business, but failure to affix it shall not affect the validity of any instrument. The secretary also shall keep or cause to be kept at the principal office, or at such other place as the Board may order, a book of minutes of all meetings of the Board and its committees, with the time and place of holding; whether regular or special; if special how authorized; the notice thereof given; the names of those present and absent; and the proceedings thereof. The secretary shall give or cause to be given notice of all the meetings of the Board required by these Bylaws or by law to be given; shall keep the seal of the corporation in safe custody; shall see that all reports, statements and other documents required by law are properly kept or filed, except to the extent the same are to be kept or filed by the treasurer; and shall have such other powers and perform such other duties as may be prescribed from time to time by the Board.

Section 7. Chief Financial Officer.

The chief financial officer shall keep and maintain or cause to be kept and maintained adequate and correct accounts of the properties and business transactions of the corporation, including accounts of its assets, liabilities, receipts, disbursements, gains and losses. The books of account shall at all times be open to inspection by any trustee. The chief financial officer shall deposit or cause to be deposited all monies and other valuables in the name and to the credit of the corporation in such depositories as may be designated by the Board. The chief financial officer shall disburse the funds of the corporation as shall be ordered by the Board, shall render to the president and the trustees, upon request, an account of all transactions as chief financial officer. The chief financial officer shall present an operating statement and report, since the last preceding Board meeting, to the Board at all regular meetings. The chief financial officer shall have such other powers and perform such other duties as may be prescribed from time to time by the Board.

Section 8. Executive Director.

Subject to the authority of the president and the control of the Board, the executive director of the corporation shall have general supervision, direction and control of the administrative business and the administrative officers of the corporation, if any, and exercise the general powers and perform the duties of administration and management of the day-to-day operations of the business of the corporation and shall have such other powers and duties as may be prescribed by the Board or these Bylaws.

Section 9. Removal and Resignation.

Any officer may be removed, either with or without cause, by the Board at any time. In the case of an officer appointed by the president, the president shall also have the power of removal. Any such removal shall be without prejudice to the rights, if any, of the officer under any contract of employment. Any officer may resign at any time by giving written notice to the corporation, but without prejudice to the rights, if any, of the corporation under any contract to which the officer is a party. Any such resignation shall take effect at the date of the receipt of such notice or at any later time specified therein, and, unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

Section 10. Vacancies.

A vacancy in any office because of death, resignation, removal, disqualification, or any other cause, shall be filled in the manner prescribed in the Bylaws for regular election or appointment to such office, provided that such vacancies shall be filled as they occur and not on an annual basis.

ARTICLE VI
Indemnification

Section 1. Definitions.

For the purposes of this Article, "agent" means any person who is or was a trustee, director, officer, or employee of this corporation, or is or was serving at the request of the corporation as a trustee, director, officer, employee or agent of another foreign or domestic corporation, partnership, joint venture, trust or other enterprise, or was a trustee, director, officer, employee or agent of a foreign or domestic corporation which was a predecessor corporation of this corporation or of another enterprise at the request of such predecessor corporation; and "proceeding" means any threatened, pending completed action or proceeding, whether civil, criminal, administrative or investigative; and "expenses" includes, without limitation, attorneys' fees and any expenses of establishing a right to indemnification under Sections 4 or 5b. of this Article.

Section 2. Indemnification in Actions by Third Parties.

This corporation may indemnify any person who was or is a party or is threatened to be made a party to any proceeding (other than an action by or in the right of this corporation to procure a judgment in its favor, an action bought under Section 5233 of the California Nonprofit Public Benefit Corporation Law, or an action brought by the Attorney General or a person granted relator status by the Attorney General for any breach of duty relating to assets held in charitable trust) by reason of the fact that such person is or was an agent of this corporation, against expenses, judgments, fines, settlements and other amounts actually and reasonably incurred in connection with such proceeding if such person acted in good faith and in a manner such person reasonably believed to be in the best interests of this corporation, and, in the case of a criminal proceeding, had no reasonable cause to believe the conduct of such person was unlawful. The termination of any proceeding by judgment, order, settlement, conviction or upon a plea of *nolo contendere* or its equivalent shall not, of itself, create a presumption that the person did not act in good faith and in a manner which the person reasonably believed to be in the best interests of this corporation or that the person had reasonable cause to believe that the person's conduct was unlawful.

Section 3. Indemnification in Actions by or in the Right of the Corporation.

This corporation may indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action by or in the right of this corporation, or brought under Section 5233 of the California Nonprofit Public Benefit Corporation Law, or brought by the Attorney General or a person granted regulator status by the Attorney General for breach of duty relating to assets held in charitable trust, to procure a

judgment in its favor by reason of the fact that such person is or was an agent of the corporation, against expenses actually and reasonably incurred by such person in connection with the defense or settlement of such action if such person acted in good faith, in a manner such person believed to be in the best interests of the corporation and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under similar circumstances. No indemnification shall be made under this Section:

In respect of any claim, issue or matter as to which such person shall have been adjudged to be liable to this corporation in the performance of such person's duty to the corporation, unless and only to the extent that the court in which such proceeding is or was pending shall determine upon application that, in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for the expenses which such court shall determine;

Of amounts paid in settling or otherwise disposing of a threatened or pending action, with or without court approval; or

Of expenses incurred in defending a threatened or pending action which is settled or otherwise disposed of without court approval, unless it is settled with the approval of the Attorney General.

Section 4. Indemnification Against Expenses.

To the extent that an agent of this corporation has been successful on the merits in defense of any proceeding referred to in Sections 2 or 3 of this Article or in defense of any claim, issue or matter therein, the agent shall be indemnified against expenses actually and reasonably incurred by the agent in connection therewith.

Section 5. Required Determinations.

Except as provided in Section 4 of this Article, any indemnification under this Article shall be made by this corporation only if authorized in the specific case, upon a determination that indemnification of the agent is proper in the circumstances because the agent has met the applicable standard of conduct set forth in Sections 2 or 3 of this Article by:

a. A majority vote of a quorum consisting of trustees who are not parties to such proceeding; or

b. The court in which such proceeding is or was pending upon application made by this corporation or the agent or the attorney or other person rendering services in connection with the defense, whether or not such application by the agent, attorney or other person is opposed by this corporation.

Section 6. Advance of Expenses.

Expenses incurred in defending any proceeding may be advanced by this corporation prior to the final disposition of such proceeding upon receipt of an undertaking by or

on behalf of the agent to repay such amount unless it shall be determined ultimately that the agent is entitled to be indemnified as authorized in this Article.

Section 7. Other Indemnification.

No provision made by this corporation to indemnify its or its subsidiary's trustees, directors or officers for the defense of any proceeding, whether contained in the Articles of Incorporation, Bylaws, a resolution of members or trustees/directors, an agreement, or otherwise, shall be valid unless consistent with this Article. Nothing contained in this Article shall affect any right to indemnification to which persons other than such trustees/directors and officers may be entitled by contract or otherwise.

Section 8. Forms of Indemnification Not Permitted.

No indemnification or advance shall be made under this Article, except as provided in Sections 4 or 5b. of this Article, in any circumstances where it appears:

a. That it would be inconsistent with a provision of the Articles of Incorporation, these Bylaws, or an agreement in effect at the time of the accrual of the alleged cause of action asserted in the proceeding in which the expenses were incurred or other amounts were paid, which prohibits or otherwise limits indemnification; or

b. That it would be inconsistent with any condition expressly imposed by a court in approving a settlement.

Section 9. Insurance.

The corporation shall have the power to purchase and maintain insurance on behalf of any agent of this corporation against any liability asserted against or incurred by the agent in such capacity or arising out of the agent's status as such whether or not this corporation would have the power to indemnify the agent against such liability under the provisions of this Article; provided, however, that this corporation shall have no power to purchase and maintain such insurance to indemnify any agent of the corporation for a violation of Section 5233 of the California Nonprofit Public Benefit Corporation Law.

Section 10. Nonapplicability to Fiduciaries of Employee Benefit Plans.

This Article does not apply to any proceeding against any trustee, investment manager or other fiduciary of an employee benefit plan in such person's capacity as such, even though such person may also be an agent of the corporation as defined in Section 1 of this Article. The corporation shall have power to indemnify such trustee, investment manager or other fiduciary to the extent permitted by subdivision (f) of Section 207 of the California General Corporation Law.

ARTICLE VII
Miscellaneous

Section 1. Fiscal Year.

The fiscal year of the corporation shall be a fiscal year ending December 31.

Section 2. Inspection of Corporate Records.

The books of account and minutes of the proceedings of the Board, and of any executive committee or other committees of the trustees, shall be open to inspection at any reasonable time upon the written demand of any member of the Board. Such inspection may be made in person or by an agent or attorney, and shall include the right to make photocopies and extracts.

Section 3. Checks, Drafts, Etc.

All checks, drafts or other orders for payment of money, notes or other evidences of indebtedness issued in the name of or payable to the corporation and any and all securities owned by or held by the corporation requiring signature for transfer shall be signed or endorsed by such person or persons and in such manner as from time to time shall be determined by the Board or the executive committee, if any, or by the president.

Section 4. Endorsement or Execution of Documents and Contracts.

Subject to the provisions of applicable law, any note, mortgage, evidence of indebtedness, contract, conveyance or other instrument in writing and any assignment or endorsement thereof executed or entered into between the corporation and any other person, when signed by the president, certain designated vice-presidents, the secretary or the chief financial officer of the corporation, shall be valid and binding on the corporation in the absence of actual knowledge on the part of the other person that the signing officer(s) had no authority to execute the same. Additionally, by resolution of the Board, general signatory authority may be granted and delegated to other persons on behalf of the corporation. Any such instruments may be signed by any other person or persons and in such manner as from time to time shall be determined by the Board or the president. Unless so authorized, no officer, agent or employee shall have any power or authority to bind the corporation to any contract or engagement or to pledge its credit or to render it liable for any purpose or amount.

ARTICLE VIII
Effective Date and Amendments

Section 1. Effective Date.

These Bylaws shall become effective immediately upon their adoption by the vote of a majority of the Board. Amendments to these Bylaws shall become effective immediately upon their adoption, unless the Board directs otherwise.

Section 2. Amendments.

These Bylaws may be amended or repealed and new Bylaws adopted only by the vote of a majority of trustees/directors then in office.

CERTIFICATE OF ADOPTION

I, the undersigned, do hereby certify that I am the Secretary of California Hospital Assessment and Reporting Task Force (CHART), and that the foregoing Bylaws constitute the Bylaws of such corporation as duly adopted by the corporation's Board of Trustees on _____, 2007.

Date: _____, 2007

_____

_____, Secretary

Bylaws Amendment for Cal Hospital Compare
June 9, 2021

Section 1. Number and Qualifications of Trustees.

i. The authorized number of trustees shall be not less than three (3) or more than twenty-one (21), unless changed by a duly adopted amendment to this provision. The exact number of trustees shall be fixed within these limits by a resolution of the Board.

ii. The initial Board of Trustees shall be appointed by the incorporator. Of the nineteen (19) initial Board members, four (4) shall be representatives of health plans providing healthcare coverage to subscribers or enrollees, four (4) shall be representatives of acute care hospitals licensed under Section 1250(a) or (b) of the California Health and Safety Code, four (4) shall represent consumers of health care, four (4) shall represent purchasers of healthcare, i.e., employers or organizations representing employers, one (1) representative of the Association of California Nurse Leaders ("ACNL"), one (1) representative from the California Medical Association ("CMA"), and one representative from the California Healthcare Foundation ("CHCF"). The ratio of four health plans, four hospital, four consumers, four purchasers, one ACNL, one CMA and one CHCF member shall remain after appointment of the initial Board until changed by the Board.

iii. Effective March 17, 2015, the Board shall be eleven (11) members. The existing Board shall elect from its members or from new candidates, two (2) representatives of health plans providing healthcare coverage to subscribers or enrollees, two (2) representatives of acute care hospitals licensed under Section 1250(a) or (b) of the California Healthcare Safety Code, three (3)representatives of consumers of health care, one of which may be from the California Healthcare Foundation, two (2) representatives of purchasers of healthcare, i.e., employers or organizations representing employers which purchase healthcare coverage, one (1) representative of the an integrated health entity and the Executive Director of the corporation.

iv. Effective July 1, 2021, the Board shall be thirteen (13) members. Along with the members identified in Section 2 subsection iii above, the Board shall elect two (2) representatives involved in the Long-Term Services & Supports in California.

v. The Board at its discretion may invite representatives from state or federal agencies as ex officio members of the Board.

2023 OPIOID MANAGEMENT HOSPITAL SELF-ASSESSMENT

Background: For more than a decade, Cal Hospital Compare (CHC) has been providing Californians with objective hospital performance ratings. CHC is a non-profit organization that is governed by a multi-stakeholder board, with representatives from hospitals, purchasers, consumer groups, and health plans. CHC uses an open and collaborative process to aggregate multiple sources of public data, and to establish relevant measures and scoring.

To address California's opioid epidemic and accelerate hospital progress to reduce opioid related deaths, CHC publishes an annual Opioid Care Honor Roll to support continued quality improvement and recognize hospitals for their contributions fighting the epidemic. Since 2019, CHC has used the *Opioid Management Hospital Self-Assessment* to assess performance and progress across the following 4 domains of care:

1. Safe & effective opioid use
2. Identifying and treating patients with Opioid Use Disorder
3. Overdose prevention
4. Applying cross-cutting opioid management best practices

Instructions: **We invite all adult and pediatric acute care hospitals to apply.** For each measure, please read through the measure description then select the level that best describes your hospital's work in that area. Please note that the levels build on each other e.g., to achieve a Level 3 your hospital must have also implemented the strategies outlined in Levels 1 and 2. Similarly, if your hospital has addressed some of the components outlined in Level 4 but not Level 3 then your hospital may fall into the Level 3 or even the Level 2 category. CHC recommends each hospital convene a multi-stakeholder team to complete the *Opioid Management Hospital Self-Assessment* to ensure accuracy and completeness. To reduce variability in results year over year, CHC recommends hospitals follow a similar process each year.

For more information on the Opioid Care Honor Roll Program and to access resources to support your quality improvement journey, including our measurement guide and resource library, check out the Cal Hospital Compare website here.

2023 Opioid Care Honor Roll Program

Performance period: April 2022 – March 2023

Assessment period: January 1, 2023 – March 31, 2023

Stay tuned for information on how to submit your 2023 Opioid Management Hospital Self-Assessment results!

Questions? Contact Alex Stack, Director, Programs & Strategic Initiatives via email at astack@cynosurehealth.org

Safe & Effective Opioid Use						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Level 5 (5 pts.)** *Sustainability*

Appropriate Opioid Discharge Prescribing Guidelines
 	
Develop and implement evidence-based discharge prescribing guidelines across multiple service lines to prevent new starts in opioid naïve patients and for patients on opioids to manage chronic pain. Possible exemptions: end of life, cancer care, sickle cell, and palliative care patients.
 	
Service line prescribing guidelines should address the following:
• Opioid use history (e.g., naïve versus tolerant)
• Pain history
• Behavioral health conditions
• Current medications; prescribed and illicit
• Provider, patients, and family set expectations regarding pain management
• Limit benzodiazepine and opioid co-prescribing
• For opioid naïve patients:
  ○ Limit initial prescription (e.g., <5 days)
  ○ Use immediate release vs. long acting
• For patients on opioids for chronic pain:
  ○ For acute pain, prescribe short acting opioids sparingly
  ○ Avoid providing opioid prescriptions for patients receiving medications from another provider
	Developed and implemented evidence-based opioid discharge prescribing guidelines in **1 service line**, the Emergency Department OR 1 Inpatient Unit (e.g., Burn Care, General Medicine, Behavioral Health, OB, Cardiology, etc.)	Developed and implemented evidence-based opioid discharge prescribing guidelines across **2 service lines**, the Emergency Department AND 1 Inpatient Unit (e.g., Burn Care, General Medicine, Behavioral Health, OB, Cardiology, etc.)	Developed and implemented **hospital wide** opioid discharge prescribing guidelines; these guidelines may be department specific	Developed and implemented evidence-based opioid discharge prescribing **guidelines for surgical patients in at least one surgical specialty** as part of an Enhanced Recovery After Surgery (ERAS) program	Your hospital is actively **measuring and developing strategies to improve** appropriate opioid prescribing at discharge	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period
						
						Hospital continues to **monitor performance but** implementing appropriate opioid discharge prescribing is no longer an active QI initiative
						
						Great job!

Safe & Effective Opioid Use						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Level 5 (5 pts.)** *Sustainability*
Alternatives to Opioids for Pain Management Use an evidence based, multi-modal, non-opioid approach to analgesia for patients with acute and chronic pain. Guidelines should address the following: • Utilize non-opioid approaches as first line therapy for pain while recognizing it is not the solution to all pain • Provide pharmacologic alternatives (e.g., NSAIDs, Tylenol, Toradol, Lidocaine patches, muscle relaxant medication, Ketamine, medications for neuropathic pain, nerve blocks, etc.) • Offer non-pharmacologic alternatives (e.g., TENS, comfort pack, heating pad, visit from spiritual care, physical therapy, virtual reality pain management, acupuncture, chiropractic medicine, guided relaxation, music therapy, aromatherapy, etc.) • Provide care guidelines for common acute diagnoses e.g., pain associated with headache, lumbar radiculopathy, musculoskeletal pain, renal colic, and fracture/dislocation (ALTO Protocol) • Opioid use history (e.g., naïve versus tolerant) • Patient and family engagement (e.g., discuss realistic pain management goals, addiction potential, and other evidence-based pain management strategies that could be used in the hospital or at home)	Your hospital **does not** have a standardized approach to providing alternatives to opioids for pain management	Developed and implemented a non-opioid analgesic multi-modal pain management guidelines in the **Emergency Department OR 1 Inpatient Unit** (e.g., Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.)	Developed and implemented a non-opioid analgesic multi-modal pain management guidelines in the **Emergency Department AND 1 Inpatient Unit** (e.g., Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.) Hospital offers at least at least **1 non-pharmacologic alternative** for pain management	Developed **supportive pathways** that promote a team-based approach to identifying opioid alternatives (e.g., integrated pharmacy, physical therapy, family medicine, psychiatry, pain management, shared decision making with patient and family, etc.) **Aligned standard order sets** with non-opioid analgesic, multi-modal pain management program (e.g., changes to EHR order sets, set order favorites by provider, etc.)	Your hospital is actively **measuring and developing strategies to improve** use of opioid alternatives for pain management	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period Hospital continues to **monitor performance but** implementing strategies to ensure alternatives to opioids for pain management are provided is no longer an active QI initiative **Great job!**

Identification and Treatment						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Level 5 (5 pts.)** *Sustainability*
Medication Assisted Treatment (MAT) Provide MAT for patients (adults and youth) identified as having OUD, or in withdrawal, and continue MAT for patients in active treatment. Components of a MAT program should include: • Identifying patients eligible for MAT, on MAT, and/or in opioid withdrawal • Treatment is accessible in the emergency department, and in all other hospital departments • Treatment is provided rapidly (same day) and efficiently in response to patient needs • Human interactions that build trust are integral to treatment *Suggested guidelines on how to universally offer MAT to all patients: • Do not screen patients for OUD • Do not ask patients if they are interested in MAT services; this may be time consuming for providers and stigmatizing for patients • Do promote MAT services using signage in waiting and exam rooms, badge flare, and patient forms • Do let patients know that their site offers MAT during the exam so that patients can choose to disclose whether and when they need support	Methadone and buprenorphine on hospital **formulary**	MAT is offered, initiated, and continued for those already on MAT in at least **1 service line** (ED, Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.) Hospital **provides support to care teams** in understanding **risk, benefits, and evidence of buprenorphine** in MAT for adults and youth	MAT is offered, initiated, and continued for those already on MAT in at least **2 service lines** (ED, Burn Care, General Medicine, General Surgery, Behavioral Health, OB, Cardiology, etc.) Hospital **provides support to care teams** in understanding **risk, benefits, and evidence of buprenorphine** in MAT for adults and youth	MAT is **universally offered*** to all patients (adults and youth) presenting to the hospital One or more **hospital staff** has the time and skills to **engage with patients** (adults and youth) on a human level, motivating them to engage in treatment (e.g., a hospital employee embedded within either an ED or an inpatient setting to help patients begin and remain in addiction treatment – commonly known as a Substance Use Navigator, Case Manager, Social Worker, Patient Liaison, Peer Mentor, Chaplain, etc.)	Your hospital is actively **measuring and developing strategies to improve** access to MAT	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period Hospital continues to **monitor performance** but MAT is no longer an active QI initiative **Great job!**

Identification & Treatment						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Level 5 (5 pts.)** *Sustainability*
Timely follow up care Hospital coordinates follow up care for patients initiating MAT within 72 hours either in the hospital or outpatient setting. Hospital based providers and practitioners must have a X-waiver to prescribe buprenorphine at discharge under the Drug Addiction Treatment Act of 2000 (DATA 2000). As of 2021 for providers treating ≤30 patients the X-waiver education requirement is waived. If hospital does not have X-waivered providers: • Providers may provide a loading dose for long effect, provide follow up care in the ED that is in alignment with the DEA Three Day Rule or connect patient to X-waivered community provider for immediate follow care If hospital has X-waivered providers: • Prescribe sufficient buprenorphine until patient's follow up appointment with community provider *Practitioners= MDs, physician extenders, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives (see SUPPORT Act for details)	Hospital **identifies X-waivered providers** within the hospital and/or within the community Provides list of **community-based resources** for follow up care to patients, family, caregivers, and friends (e.g., primary care, outpatient clinics, outpatient treatment programs, telehealth treatment providers, mental health providers, etc.)	Hospital provides support to **practitioners* in the ED and IP units to obtain X-waiver** (e.g., provides education on changes to x-waiver education requirement, supports application process, education on how to use buprenorphine, hospital's process for providing MAT, etc.) Hospital is actively **building relationships and coordinating with post-acute services to support care transitions**	Hospital has an agreement in place with **at least one community provider to provide timely follow up care**	**Actively refer and/or schedule** MAT and OUD patients with a community provider for ongoing treatment (e.g., primary care, outpatient clinic, outpatient treatment program, telehealth treatment provider, mental health provider, etc.)	Your hospital is actively **measuring and developing strategies to improve** patient access to timely follow up care	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period Hospital continues to **monitor performance** but implementing strategies to ensure timely follow up care is no longer an active QI initiative **Great job!**

Overdose prevention						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Level 5 (5 pts.)** *Sustainability*
Naloxone education and distribution program Provide naloxone prescriptions and education to all patients, families, caregivers, and friends discharged with an opioid prescription and/or at risk of overdose. *Staff include MD, PA, NP, Pharmacist, RN, LVN, Health Coach, Substance Use Navigator, Clinical Social Worker, Research Staff, Emergency Department Technician, Clerk, Medical Assistant, Security Guard, etc. trained to distribute naloxone and provide education on how to use it	Hospital **does not engage in overdose prevention** strategies	**Identify overdose prevention & other harm reduction resources within hospital, health system, and community** (e.g., community access points, low/no-cost options, community pharmacies with naloxone on hand, community coalitions, safe injection sites, safe opioid disposal sites, community access points for fentanyl test strips, etc.)	**Standard workflow** for MDs and physician extenders in place for providing naloxone prescription at discharge for patients with a long-term opioid prescription and/or at risk of overdose; discharge prescriptions sent to patient's pharmacy of choice (e.g., naloxone incorporated into a standard order set for appropriate opioid prescriptions, and/or referral to low or no cost distribution centers, etc.)	**Standing order** in place allowing approved staff* to educate and distribute naloxone in hand to all patients, caregivers, at no cost while in the hospital setting under the California Naloxone Distribution Project; this should be an ED led process in collaboration with pharmacy (see CA BRIDGE Guide to Naloxone Distribution for details)	Your hospital is actively **measuring and developing strategies to improve** access to naloxone & other harm reduction services	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period Hospital continues to **monitor performance** but providing free naloxone kits to patients and families is no longer an active QI initiative **Great job!**
	Extra credit (1 pt.) Your hospital provides patients and families one or more of the following harm reduction services: access to low cost or no cost fentanyl test strips and safe injection kits, and information on how to properly store and dispose of opioid medications					

Cross Cutting Opioid Management Best Practices						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Level 5 (5 pts.)** *Sustainability*
Organizational Infrastructure Opioid stewardship is a strategic priority with multi-stakeholder buy in and programmatic support to drive continued/sustained improvements in appropriate opioid use and treatment (e.g., executive leadership, Pharmacy, Emergency Department, Inpatient Units, General Surgery, Information Technology, etc.)	Opioid stewardship is **not a quality improvement priority**	**Multi-stakeholder team** identified opioid stewardship as a strategic priority and set improvement goals in one or more of the following areas: safe and effective opioid use, identifying and treating patients with OUD, overdose prevention, applying cross-cutting opioid management best practices (e.g., opioid stewardship committee, medication safety committee, a dedicated quality improvement team, subcommittee of the Board, etc.) **Executive sponsor/project champion identified**	**Communicated program, purpose, goal, key performance indicators, and progress to goal to appropriate staff** (e.g., a dashboard, all staff meeting, annual competencies, etc.) Opioid stewardship is included in **strategic plan** **Hospital/health system leadership plays an active role** in reviewing data, advising and/or designing initiatives to address gaps	Hospital participates in **local opioid coalition or learning collaborative** Hospital has an accurate and automated process to collect data on **appropriate PDMP utilization and safe use of opioids (eCQM)**	Hospital is actively **measuring and developing strategies** that support opioid stewardship as an organizational priority Hospital **benchmarks performance** against publicly available data such as the California Overdose Surveillance Dashboard, Healthy Places Index, Opioid Care Honor Roll results, Bridge Navigator Program metrics, etc.	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period Hospital continues to **monitor performance** but enhancing organizational infrastructure is no longer an active QI initiative **Great job!**

Cross Cutting Opioid Management Best Practices						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Level 5 (5 pts.)** *Sustainability*
Address stigma with physicians and staff Hospital culture is welcoming and does not stigmatize substance misuse. Hospital actively addresses stigma, including but not limited to, through the education and promotion of the medical model of addiction, trauma informed care, motivational interviewing, and by offering harm reduction services across all departments to facilitate disease recognition, greater access to patient partnerships, and the use of non-stigmatizing language/behaviors (e.g., words matter).	Hospital **does not address stigma with** physicians and staff	Provides passive, **general education** on hospital opioid prescribing guidelines in **at least 2 service lines**, identification, and treatment, and overdose prevention to appropriate providers and staff (e.g., M&M, lunch and learns, flyers/brochures, CME requirements, RN annual competencies, etc.)	Provides **point of care decision making support** (e.g., MME flag for providers, automatic pharmacy review for long-term opioid prescription, auto prescribe naloxone with any opioid prescription, reminder to check CURES, flag concurrent opioid and benzo prescribing, etc.)	Trains appropriate providers and staff on, some combination of, the **medical model of addiction, harm reduction principles, motivational interviewing and trauma informed care** to normalize OUD and treatment (e.g., stigma reduction training, M&M, lunch and learns, CME requirements, RN annual competencies, etc.) **Regularly assesses stigma** among providers and staff (e.g., audit of existing materials for stigmatizing language including medical records and patient forms, annual survey, focus groups, focused leader rounding, etc.)	Your hospital is actively **measuring and developing strategies** to addresses physician and staff stigma towards OUD patients	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period Hospital continues to **monitor performance** but addressing stigma is no longer an active QI initiative **Great job!**

Cross Cutting Opioid Management Best Practices						
Measure	**Level 0 (0 pt.)** *Getting started*	**Level 1 (1 pt.)** *Basic management*	**Level 2 (2 pts.)** *Hospital wide standards*	**Level 3 (3 pts.)** *Integration & innovation*	**Level 4 (4 pts.)** *Practice Improvement*	**Level 5 (5 pts.)** *Sustainability*
Patient and family engagement **Actively engage** patients, families, and friends in appropriately using opioids for pain management (opioid prescribing, treatment, and overdose prevention via naloxone, harm reduction services provided by the hospital and within the community, risk associated with illicit fentanyl use, hospital quality improvement initiatives, etc.)	**Patients and families are not actively** engaged in OUD prevention/ treatment, and/or quality improvement initiatives	Provides general education to **all patients, families, and friends in at least 2 service lines** (e.g., ED, Burn Care, General Medicine, Behavioral Health, OB, Cardiology, Surgery, etc.) regarding opioid risk including risk associated with illicit fentanyl, alternatives, and overdose prevention strategies (e.g., posters about preventing or responding to an overdose, brochures/fact sheets on opioid risk and alternative pain management strategies, general information on hospital pain management strategies on website or portal, etc.)	Provides **focused education** to opioid naïve and opioid tolerant patients via conversations with care providers (e.g., MAT options, opioid risk and alternatives, naloxone use, etc.) Patients are part of a **shared decision-making process** for acute and/or chronic pain management (e.g., establish realistic pain trajectory and pain management plan with a special focus on managing pain associated with common procedures such as c-sections and hip/knee, risk and side effects associated with opioid use, etc.)	Provides opportunities for **patients and families to engage** in hospital wide opioid management activities (Patient Family Advisory Council, Youth Advisory Council, volunteer or paid peer navigator positions, program design, etc.)	Your hospital is actively **measuring and developing strategies** to improve patient and family engagement Measurement includes **patient experience and/or patient reported outcomes** (e.g., patient states that they were given education on the risk/benefits associated with long term opioid use, treatment options, etc.)	Hospital has **achieved its performance target** on related key performance indicators, with sustained performance over a 12-month period Hospital continues to **monitor performance** but addressing stigma is no longer an active QI initiative **Great job!**

Additional hospital information:

Open ended responses:

1. Briefly describe the steps your hospital has taken to improve opioid stewardship across the 4 domains assessed in the 2023 Opioid Management Hospital Self-Assessment.
2. What would you like to learn more about in 2024 that would help you to close a gap in your work?
3. What else do you want us to know?

Optional responses: This data will help us to understand and align future iterations of the *Opioid Management Hospital Self-Assessment* and program resources with the work that you are doing. For the most recent 12 months we invite you to share the following metrics:

1. Number of OUD related ED visits / total ED volume
2. Number of OUD related inpatient admissions / total inpatient admissions
3. Number of naloxone doses prescribed, dispensed, and/or distributed

Other:

1. Is your hospital part of a hospital system? If yes, what is the name of the hospital system?
2. Select YES to opt IN sharing your assessment results and open-ended responses with others in the program for the purposes of spreading bright spots and lessons learned. If yes, please let us know if you would like us to include your contact information so that others in the program can reach out to learn more. Your responses and contact information will be visible only to others in the program.
3. Select YES to opt IN data sharing with our improvement partners, CA Bridge, and the Health Services Advisory Group.

2023 Opioid Management Hospital Self-Assessment Results:

Measures	Score
Safe & effective opioid use	
Appropriate opioid discharge prescribing guidelines	
Alternatives to opioids for pain management	
Identification & treatment	
Medication Assisted Treatment (MAT)	
Timely follow-up care	
Overdose prevention	
Naloxone education and distribution program	
Cross cutting opioid management best practices	
Organizational infrastructure	
Address stigma with physicians and staff	
Patient and family engagement	
"Hon-rolled" a friend *Share the Opioid Care Honor Roll opportunity with another hospital that has not yet participated in our program. If they apply for the 2023 Opioid Care Honor Roll you both get 1 additional point.*	Provide hospital name(s)
Total score *(out of 42 points)*	

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