CALIFORNIA ASSOCIATION OF NURSE ANESTHESIOLOGY (CANA)
CANA advances patient safety, fosters access to the highest quality anesthesia and supports the nurse anesthesia profession in California.

December 8, 2023

Via Personal Delivery

Tomás Aragón, M.D., Dr.P.H.
Director and Public Health Officer
California Department of Public Health (CDPH)
1615 Capitol Avenue, MS 0503
Sacramento, CA 95899-7377

Re: CDPH Should Modernize Its Title 22 Medical Staff Regulations To Conform With New Nurse Practitioner Laws, To Provide Flexibility To California Hospitals, and To Promote Advanced Practice Nursing Leadership

Dear Dr. Aragón:

CANA hereby renews its petition to amend portions of Title 22 of the California Code of Regulations to include in the hospital medical staff regulations all California licensed providers having independent practice in California, including Nurse Practitioners (NPs), Certified Nurse Midwives (CNMs), and Certified Registered Nurse Anesthetists (CRNAs). The provisions of Title 22 governing medical staff membership are outdated, do not reflect current state statutes or related federal guidance, and impermissibly limit medical staff membership.

Who are we?

California Association of Nurse Anesthesiology (CANA) is a statewide organization of over 2,000 members who are licensed is the state to perform nurse anesthesia services. CANA's mission is to advance patient safety, foster access to the highest quality anesthesia, and support the nurse anesthesia profession. CANA implements the core principles of its mission by monitoring the practice of nurse anesthesia, consulting with institutions of higher education on standards for quality programming and clinical experience and promoting quality of care through community-provider partnerships.

Why is our Petition important?

Hospital and outpatient medical staffs sit on the front lines of patient care. They are responsible for overseeing critical self-governance concerns like clinical policies, peer review, credentialing,

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privileging, availability of providers for emergencies, professional education programs, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics.[1] Nearly all, if not all, hospitals in California have at least one NP or CRNA who are or – pursuant to AB 890 – will be performing services independently within the scope of their license.

Not all hospitals are alike, though. Some are urban, some are rural. Some have access to physician anesthesiologists, and some rely entirely on Certified Registered Nurse Anesthetists (CRNAs) for anesthesia services. At present, the medical staff of a rural hospital may have no anesthesia providers involved, if one or CRNAs are performing the anesthesia in that hospital. As a result, hospital medical staffs have been deprived of the authority to comprehensively assess the quality of care as it relates to the practice of anesthesia, or, on the flip side, to take into account the clinical experience and expertise of the anesthesia providers at their own hospital when designing policies and procedures that directly relate to anesthesia. Similarly, when a peer review need arises, necessitating the input of the anesthesia providers on staff, those providers may not be able to provide any insight under the peer review and quality assurance privilege, which protects the proceedings and records of an organized committees of medical staffs.[2] As such, the exclusion of APNs from the medical staff does risk chilling of speech essential to quality assurance and performance improvement.

Recognizing the need for a diversity of providers on the medical staff, California statutes give hospitals ***flexibility*** to determine the composition of their medical staffs. The law authorizes medical staffs to include "physicians and surgeons and ***other licensed practitioners***," including non-physicians.[3]

Yet, California regulations continue to inhibit this flexibility by forcing hospitals to limit medical staff membership to ***physicians, dentists, podiatrists and clinical psychologists***.[4] These

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[1] California Code of Regulations, Title 22, § 70703(b)-(h).
[2] California Evidence Code §1157(a).
[3] California Business & Professions Code §§ 2282(b) and 2283(a).
[4] California Code of Regulations, Title 22, §§ 70529(b), 70701(a)(1)(e), and 70703(a)(1).

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outdated regulations directly conflict with AB890 and fail to recognize that NPs, CNMs, and CRNAs are essential members of hospital and surgery center leadership.

At the federal level, the Centers for Medicare and Medicaid Services ("CMS") set forth the following policy statement:

> [CMS] encourage[s] physicians and hospitals to enlist qualified non- physician practitioners to fully assist them in taking on the work of overseeing and protecting the health and safety of patients. This applies not only to the 'work' of <u>the medical staff</u>. . . but also to the everyday duties of caring for patients. . . [CMS] believe[s] that an interdisciplinary team approach to patient care is the best model for patients.[5]

The Joint Commission – which accredits hospitals and surgery centers – recognizes that licensed independent practitioners may be members of the medical staff, but sometimes have clinical privileges without clinical oversight.[6]

As the supply of physicians declines, rural healthcare systems increasingly rely on NPs, CNMs, and CRNAs to deliver care.[7] Research shows that physicians leave the healthcare market when rural hospitals close, but NPs, CNMs, and CRNAs continue to

[5] Federal Register Vol. 77, No. 95, pgs. 29047-48 (emphasis added).
[6] The Joint Commission, "Medical Staff Essentials," pp. 2-3, available at Medical Staff Essentials Guide (https://store.jcrinc.com/assets/1/14/EBMSE17SamplePages.pdf) (last visited September 14, 2023).
[7] Germack, HD, Kandrack, R, and Martsolf, GR, Nurse Outlook, "Relationship Between Rural Hospital Closures and the Supply of Nurse Practitioners and Certified Registered Nurse Anesthetists," 2021 Nov-Dec; 69(6); 945-952, available at National Library of Medicine (https://pubmed.ncbi.nlm.nih.gov/34183190/) (last visited July 11, 2023). *See also* Kozhimannil, KB, Henning-Smith, C, and Hung, P, Journal of Midwifery and Women's Health, "The Practice of Midwifery in Rural US Hospitals," 2016 Apr; 61(4); 411-418, available at Wiley Online Library (https://onlinelibrary.wiley.com/doi/abs/10.1111/jmwh.12474)(last visited Nov 29, 2023).

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provide care in their local communities, regardless of hospital closures.[8] In addition, the growing workforce of NPs is more likely to practice in underserved areas.[9]

At present, Title 22 regulations prohibit California hospitals from appointing advanced practice nurses to their medical staffs regardless of a hospital's individual situation or needs. Many rural and underserved hospitals do not have physician anesthesiologists on staff; rather, they must rely on CRNAs with anesthesia privileges. As a result, Title 22 stands in the way of medical staffs including the expertise and experience of their only anesthesia providers when they adopt anesthesia safeguards and policies. Even in hospitals with physician anesthesiologists on staff, CRNAs need a seat at the governance table to foster mutual responsibility and patient-centered care.

<u>What is the current legal landscape?</u>

Medical staff membership is governed by California Business & Professions Code §§ 2282(b) and 2283(a), which both state:

> [M]embership on the medical staff shall be restricted to physicians and surgeons and <u>other licensed practitioners</u> competent in their respective fields and worthy in professional ethics. (emphasis added.)

Prior Legal Opinions from both the California Attorney General's Office and the *former* Department of Health Services (DHS)[10] have confirmed that California Business &

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[8] *Id.*; Germack, HD, Kandrack, R, and Martsolf, GR, "When Rural Hospitals Close, The Physician Workforce Goes," Health Aff (Millwood), 2019 Dec; 38(12): 2086-2094, available at National Library of Medicine (https://pubmed.ncbi.nlm.nih.gov/31794309/) (last visited July 11, 2023).

[9] Buerhaus, P, "Nurse Practitioners: A Solution to America's Primary Care Crisis," American Enterprise Institute, 2018 Sept, available at American Enterprise Institute (https://www.aei.org/wp- content/uploads/2018/09/Nurse-practitioners.pdf) (last visited July 11, 2023).

[10] DHS was split into the Department of Public Health (DPH) and Department of Health Care Services (DHCS). Pursuant to DPH's purview over the licensing of general acute care hospitals and other hospitals and ambulatory surgery centers, CANA addresses this letter to the present California agency.

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Professions Code §§ 2282(b) and 2283(a) support allowing individual hospitals to determine whether to enlarge the composition of medical staff membership beyond those specifically mandated by statute.[11]

Since 2012, the federal government (specifically, CMS) has authorized inclusion of non- physician practitioners in medical staff membership at hospitals. In fact, the Federal Register states that the 2012 CMS update was "written to allow a hospital's governing body the greatest flexibility in determining which categories of non-physician practitioners that it chooses to be eligible for appointment to the medical staff."[12] Furthermore, CMS has never restricted outpatient surgery center membership or critical access hospital membership to physicians.[13]

What types of regulatory changes have been considered, and what changes are sought now?

As of January 1, 2023, California Business & Professions Code § 2837.103(a)(3) created an independent pathway to hospital and outpatient nurse practitioner practice, and specifically authorized nurse practitioner inclusion as members of hospital medical staffs. In fact, the law requires NPs to adhere to all bylaws of the medical staff and governing body for the organization in which they work, to be eligible to serve on the medical staff and hospital committees, to be eligible to attend department meetings, and to vote on matters effecting NPs.

[11] State of California Department of Justice – Office of the Attorney General John K. Van De Kamp, June 11, 1990 Letter to Kenneth Kizer, MD, MPH, Director, Department of Health Services concerning "Regulatory Restrictions on Medical Staff Membership."
[12] Federal Register Vol. 77, No. 95, pg. 29047. *See* 42 CFR § 482.22(a).
[13] *See* 42 C.F.R. section 416.45 (ambulatory surgery centers); 42 C.F.R. section 468.618(d)(1) (critical access hospitals). *See also* CMS State Operations Manual Appendix L – Guidelines for Surveyors – Ambulatory Surgery Centers, Interpretative Guidelines for 42 C.F.R. section 416.45 ("Medical staff privileges may be granted both to physician and non-physician practitioners. . .").

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Because there is a recognized conflict between the Title 22 regulations and newly signed law, Government Code § 11342.2 render the Title 22 regulations void and unenforceable, until such time as they are brought into compliance with existing law. *See* § 11342.2:

> [N]o regulation adopted is valid or effective unless consistent and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute.

Additional statutory changes also compel updates to Title 22, including the inclusion of NPs in Business & Professions Code §§ 805 and 805.5, which govern mandatory reporting requirements for NPs whose privileges have been disciplined, terminated, or otherwise impacted, as well as the Board of Registered Nursing's reporting requirement for when NPs are considered for a grant or renewal of staff privileges. These changes necessitate updates to hospital polices on credentialing and privileging. In addition, NPs have been included in California's Physician Anti-Self-Referral Provisions set forth in Business & Professions Code § 650.01, prompting the need for updated hospital conflict of interest policies to ensure NPs and their immediate family members have complied with referral prohibitions or exceptions when referring patients for designated health services.

What are we proposing?

Title 22 of the California Code of Regulations should be amended as follows:

A. Section 70529(b)

All physicians, dentists, ~~and~~ podiatrists**, and licensed independent practitioners competent in their respective fields and worthy in professional ethics,** providing services in the outpatient unit shall be members of the organized medical staff. All other health care professionals providing services in outpatient settings shall meet the same qualifications as those professionals providing services in inpatient services.

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B. Section 70701(a)(1)(E)

> Membership on the medical staff which shall be restricted to physicians, dentists, podiatrists, ~~and~~ clinical psychologists**, and licensed independent practitioners** competent in their respective fields, worthy in character and in professional ethics. No hospital shall discriminate with respect to employment, staff privileges or the provision of professional services against a licensed clinical psychologist within the scope of his/her licensure, or against a licensed physician and surgeon or podiatrist on the basis of whether the physician and surgeon or podiatrist holds an M.D., D.O. or D.P.M. degree**, or against a non-physician practitioner on the basis of the category of license or certification held by such practitioner**. . .

C. Section 70703(a)(1)

> The medical staff shall be composed of physicians, **independent licensed practitioners**, and, where dental or podiatric services are provided, dentists or podiatrists.

It is of particular importance to hospitals and advanced practice nurses that medical staff bylaws be amended to address California's recent changes to the composition of the medical staff, and that they can ensure that the medical staff has the resources to assess the qualifications of NPs transitioning to independent practice. Although CDPH has authorized inclusion of non-physician practitioners on a **case-by-case basis**, this process risks wasting essential resources and time of both hospitals and CDPH. California hospitals don't need a one-size-fits-all mandate; they need the same ***flexibility*** to appoint medical staffs that reflect the realities and needs of their individual facilities.

Therefore, the undersigned respectfully request that CDPH renew its proposal to amend the Title 22 regulations to include any licensed practitioners in hospital and outpatient medical staffs.

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Respectfully submitted,

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President of CANA

cc: Maral Farsi, Deputy Director, CDPH Office of Legislative and Governmental Affairs

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