California Hospital Association Responses

Submitted 11/3/21

CHA submitted the following responses in response to the California Department of Public Health's (CDPH) All Facilities Letter 21-38, which requested stakeholder input on general acute care hospital (GACH) practices and procedures. This will inform amendments CDPH is developing pertaining to GACH regulations on coronary care service, dental service, intensive care service, distinct-part intermediate care service, and distinct-part skilled-nursing service.

1. Dental Service: How are the needs of patients that receive dental treatment in GACHs different from the needs of patients that receive dental treatment in a dental office?

For elective outpatient dental procedures, dental patients' needs are similar across both settings.

However, many dental patients who receive care in GACHs are inpatients or emergency department patients who are at the hospital for other medical reasons. These patients often need emergency care or surgery for non-dental needs (e.g., cardiac, cancer) and must have their dental needs addressed to make the surgery safe.

2. Dental Service: What type of supplemental staff are needed in a GACH dental service?

Supplemental staff required to support dental care are dental assistants and dental hygienists.

3. Dental Service: Is dental cone-beam imaging needed to provide GACH dental services?

No, cone-beam imaging is not necessary to provide dental services in a GACH. Some type of radiography is necessary to help establish a diagnosis.

4. Dental Service: Please describe your recommendations/suggestions for amending the existing GACH dental service regulations to meet current industry standards?

We do not have additional feedback on dental services in GACHs at this time.

5. Intensive Care Service and Coronary Care Service: Is it acceptable practice for an emergency care physician with experience in critical care medicine to serve as the physician responsible for the intensive care service? If so, what minimum amount of experience in critical care medicine that the physician should have?

Yes, it is acceptable practice for an emergency care physician with experience in critical care medicine to serve as the physician responsible for the intensive care service.

Minimum experience in critical care medicine requirements could be that the emergency care physician should have completed fellowship training in critical care and be board certified in critical care, or have equivalent training and experience as determined by the department chair, hospital credentials and privileges committee, or hospital medical executive committee.

6. Intensive Care Service and Coronary Care Service: Is it acceptable practice for an internist or an intensivist with training and experience in cardiovascular disease to serve as the physician responsible for the coronary care service if the physician consults with a cardiologist?

Yes, it is acceptable practice for an internist or an intensivist with training and experience in cardiovascular disease to serve as the physician responsible for the coronary care service, if the physician consults with a cardiologist.

7. Intensive Care Service and Coronary Care Service: Please describe the minimum amount and type of training and experience that the nurse responsible for intensive care nursing operations should have.

Title 22 does not currently prescribe the training and experience of the nurse responsible for intensive care nursing operations. This is important, as the training requirements may depend on the nurse's experience. No modification to the current requirements is recommended, besides codifying the standard practice for nurses in a critical care setting to be certified in Advanced Cardiovascular Life Support (ACLS).

8. Intensive Care Service and Coronary Care Service: Please describe the minimum amount and type of training and experience that the nurse responsible for coronary care nursing operations should have.

Title 22 does not currently prescribe the training and experience of the nurse responsible for coronary care nursing operations. This is important as the training requirements may depend on the nurse's experience. No modification to the current requirements is recommended, besides codifying the standard practice for nurses in a critical care setting to be certified in Advanced Cardiovascular Life Support (ACLS).

9. Intensive Care Service and Coronary Care Service: Is it standard practice for hospitals to require nurses in the intensive care service or the coronary care service to be certified in Advanced Cardiovascular Life Support (ACLS)? If not, please describe any certifications the nurses have and/or should have. Please be specific.

Yes, it is standard practice for nurses in a critical care setting to be certified in Advanced Cardiovascular Life Support (ACLS).

10. Intensive Care Service and Coronary Care Service: Please describe your recommendations/ suggestions for amending the existing intensive care service or coronary care service regulations.

CHA recommends that the intensive care service requirements for equipment and supplies (Section 70497) be amended to update terminology in accordance with current practice.

11. Distinct Part-Intermediate Care Service and Distinct-Part Skilled Nursing Service: Please describe your recommendations/suggestions for amending the existing GACH distinct-part intermediate care service and/or distinct part-skilled nursing service regulations.

CHA suggests that additional language be added to reflect that newly established requirements for the facility's contracted medical director differ between hospital-based distinct-part skilled-nursing facilities (SNFs) and free-standing SNFs.

CHA also suggests that Section 70267 be amended to reflect that the requirement for the SNF patient care, infection control, and pharmaceutical services committees may be met through

coordination with, and participation in, the corresponding GACH committees. Supporting integration of clinical oversight between hospital-based SNFs and GACHs will support maximum access to necessary resources and expertise, as well as consistency of practice and communication across the continuum of care.

These could both be accomplished with the addition of the language — underlined below — to section 70627, Skilled Nursing Service General Requirements:

(a) The regulations for Skilled Nursing Facilities, Chapter 3, Division 5, Title 22, California Administrative Code, shall be met with the following exceptions:
(1) The administrator of the hospital does not need to possess a license as a nursing home administrator and his services may be shared between the hospital and the skilled nursing service.
(2) The functions of the director of nurses may be shared between the hospital and the skilled nursing service. The registered nurse requirement, referred to as director of the nursing service, in Section 72323 of regulations for Skilled Nursing Facilities.
(3) The qualified physician contracted as the medical director may be:

i. certified, or pursuing certification, by the American Board of Post-Acute and Long-Term Care Medicine as a Certified Medical Director, or
ii. board certified in a medical specialty consistent with the type of care provided in the skilled nursing facility, whose role as the medical director of the skilled nursing facility has been reviewed and approved by the hospital's leadership.

(4) The SNF Patient Care, Infection Control, and Pharmaceutical Services Committees may be met through coordination with and participation in the corresponding general acute care hospital committees.
(b) There shall be written policies and procedures relating to the transfer of patients between the hospital and skilled nursing service that are approved by the medical staff.
(c) The skilled nursing service shall be provided in a distinct part.