

Minutes for Public Workshops:

September 28, 17 individuals attended

September 30, 12 individuals attended

September 28, 2009

Outpatient Settings

Section 16 - the Institute for Medical Quality wants to be added to the list of approved accrediting organizations within the outpatient settings regulations.

A representative of the Nevada Health Care Association indicated there's concern for small practices using only conscious levels of sedation. There needs to be some additional explanation in the regulations for the exception discussed in Section 8 of AB 123.

An outpatient setting physician indicated there's a big difference in the settings that administer deep sedation and general anesthesia vs. those settings where conscious sedation is used for pain control in terms of risk and infection rates. These regulations will force certain physicians to switch to using oral pain medications and topical or local anesthetics. These regulations are prohibitive for offices using light conscious sedation and pain control and will force these practices to fail. The drafters should consider conscious sedation separately from deep sedation and general anesthesia. The accreditation organizations also bundle conscious sedation with general anesthesia, so this is also a problem with regulations that require accreditation as well as state licensure. It is cost prohibitive to have to meet accreditation requirements.

An outpatient setting physician indicated infection control is independent of the type of anesthesia being used. Trying to regulate infection control and anesthesia in the same regulations is counterproductive. The problem is not in complying with the intent of the regulations, because we are in compliance with all of these rules already, but documenting everything and meeting the criteria for the accreditation agencies, such as a backup power supply, is not going to prevent infection.

An outpatient setting physician indicated, based on the definition of surgery in ASC's, many physicians would be performing surgery and would either need to become licensed as outpatient settings or in his case, he will cease performing surgeries in his office and will perform them in licensed ambulatory surgery centers. This will drive up the costs to patients receiving surgical services. He agrees with other comments indicating that we are regulating anesthesia and the building, yet the problem is with infections. Improving the building will not prevent people from doing stupid things inside it.

A representative from an accredited outpatient setting indicated that she didn't understand how these regulations would make things any safer, since they are already in full compliance with these regulations.

A representative from the ASC association indicated that although some have attempted to re-characterize the sedation they are using as light conscious sedation, conscious sedation is conscious sedation, and this is what is described in the law.

September 28, 2009

Modifications for Surgical Centers for Ambulatory Patients

Section 10 - the Institute for Medical Quality wants to be added to the list of approved accrediting organizations within the outpatient settings regulations.

A podiatric surgeon was in support of the changes to recognize podiatric surgeons as physicians.

A representative from the ASC association indicated, there should be some kind of review prior to approving additional accrediting organizations to the list of approved organizations.

Section 25 – there should be language similar to the x-ray technologist for qualifying the first assistant, because there are very few “certified” first assistants, yet there are many who should be grandfathered into meeting this requirement based on experience, etc.

Section 14(2) – there should be no requirement for a medical history during the pre-surgical evaluation.

Section 14(3) – there should be a change to what “immediately available” means, from “sufficiently free from other duties,” to “in the building.”

September 28, 2009

Fees

A representative from the ASC association indicated, there should be no difference in the fees between a surgical center for ambulatory patients and the outpatient settings. Both need to be inspected annually by the State staff and both need to be accredited, so there should not be a difference in the fees.

An outpatient setting physician indicated the ambulatory surgery centers are generally larger and the operations are more complex than in the outpatient setting, so it stands to reason that the inspections are more complex and should cost more in the surgery center. There is justification for the fees to be set at different levels.

September 30, 2009

Outpatient Settings

Section 33(10)(d) – the pre-procedure history and physical should be allowed 30 days prior to the surgery (this is the requirement in the CMS regulations).

A representative from an outpatient setting indicated that there should be clarification in the definition of outpatient setting, because there are a lot of procedures (some that could be classified as surgery – some that are not surgery) that are performed without sedation, but where topical or local anesthetic is used or, in some cases, the procedure is conducted without the use of any anesthetic.

An outpatient setting physician expressed concerns with ambiguity in AB 123 section 8, wherein certain vascular surgeons using high doses of Lidocain, would not be required to become permitted, yet these surgeons are doing vascular surgery. He believes that rather than merely allowing these surgeons to opt out of the requirements, there should be a process that requires all physicians performing surgery to become permitted or apply for an exemption. Anxiolytics even given to reduce anxiety can produce sedation, depending on the amount of medication. (May need the definition of surgery in both ASC and outpatient settings). Liposuction would not require a permit, yet there's the same potential for infection as more invasive procedures.

September 30, 2009

Modifications for Surgical Centers for Ambulatory Patients

Section 14 – the pre-procedure history and physical should be allowed 30 days prior to the surgery (this is the requirement in the CMS regulations). Language should be changed back to the way it was.

Section 25(8)(b)(1)and(2) – these requirements should meet the ASPEN (American Society of Post Anesthesia Nursing) requirements. If there's only one patient present, only one nurse should be required in phase 1 recovery, then as numbers of patients increase, there should be additional nurses. Some patients come directly out of the procedure room at a level 2 recovery. There needs to be some allowance for flexibility depending on the level of sedation used.

Section 14(3) - there should be a change to what “immediately available” means, from “sufficiently free from other duties,” to “in the building.”

A representative from the Board of Podiatry indicated that they are happy with the change to define Podiatrists as physicians, but Section (9) under the definition of surgery was eliminated. The representative indicated that the definition should include any authorized activity for a licensed podiatric physician.

Section 15(2) – should change to the ASC must develop pharmacy policies; that are then approved by the pharmacist.

Section 15(7) – this should not require “all” drugs, but rather controlled substances only. The existing language should remain the same.

Section 15(9) – the language should be changed to allow an event report to be filled out within 24 hours and then those event reports should be reviewed by the consulting pharmacist during the consulting visit, but not require immediate notification or by the next working day.

Section 27(4) – questioned the value of a procedure log for endoscopic centers.

An outpatient setting physician expressed concerns that liposuction would not require a licensure, yet there’s the same potential for infection as more invasive procedures. (The definition of surgery should include liposuction.)

Section 12(2) – a definition for a single physician operator needs to be established.

Section 27(3) – the report should not be required immediately after surgery, but there should be an allowance for dictation within 24 hours of surgery and transcription within 7 days following surgery.