WASHINGTON
Medical
Commission

Licensing. Accountability. Leadership.

Rules Workshop

New Profession: Certified Anesthesiologist Assistants

November 18, 2024 – 1:30 pm to 3:30 pm

Virtual via Teams Webinar

Rules Workshop Agenda

WASHINGTON **Medical Commission**
Licensing. Accountability. Leadership.

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Virtual via Teams Webinar

Commissioners and staff will attend this workshop virtually.

In-person at Department of Health, TC2 Room 166, 111 Israel Rd. SE, Tumwater, Washington

Monday, November 18, 2024 – 1:30 pm

New Profession: Anesthesiologist Assistants

Register for this meeting at: Rules Workshop

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Senate Bill 5184: 5184.SL.pdf (wa.gov)

Anesthesiologist Assistants: RCW 18.71D

CR-101, Preproposal statement of inquiry: WSR #24-18-057

SB 5184 Implementation Draft

WAC Chapter 246-921 ANESTHESIOLOGIST ASSISTANTS—WASHINGTON MEDICAL COMMISSION

246-921-005 Definitions.

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

(1) "Anesthesiologist" or "Qualified physician anesthesiologist" means an actively practicing, board-eligible physician licensed under chapter 18.71, 18.71B, or 18.57 RCW who has completed a residency or equivalent training in anesthesiology.

(2) "Anesthesiologist assistant" or "Certified Anesthesiologist Assistant" means a person who has successfully completed an accredited anesthesiologist assistant program approved by the commission and has successfully passed the certification exam offered by the National Commission for Certification of Anesthesiologist Assistants (NCCAA), or other exam approved by the commission. These individuals, who may be known as "AA" or "CAA", ~~is~~ are licensed by the commission to assist in developing and implementing anesthesia care plans for patients under the supervision of an anesthesiologist or group of anesthesiologists approved by the commission to supervise such assistant.

(3) "Assist" means the anesthesiologist assistant personally performs those duties and responsibilities delegated by the anesthesiologist. Delegated services must be consistent with the delegating anesthesiologist's education, training, experience, and active practice. Delegated services must be of the type that a reasonable and prudent anesthesiologist would find within the scope of sound medical judgment to delegate.

(4) American Academy of Anesthesiologist Assistants (AAAA) is the national professional associations for Certified Anesthesiologist Assistants.

(5) "Commission" means the Washington medical commission.

(6) "Commission approved program" means a Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredited education program specifically designed for training anesthesiologist assistants or other substantially equivalent organization(s) approved by the commission.

~~(7) "Certified Anesthesiologist Assistant" means an individual who has successfully completed an accredited anesthesiologist assistant program approved by the commission and has successfully passed the certification exam offered by the National Commission for Certification of Anesthesiologist Assistants (NCCAA), or other exam approved by the commission. These individuals may be referred to as a "CAA" or "AA".~~

(~~8~~7) "Practice medicine" has the same meaning defined in RCW 18.71.011.

~~(9)~~

(8) "Secretary" means the secretary of health or the secretary's designee.

(~~10~~9) "Supervise" means the immediate availability of the medically directing anesthesiologist for consultation and direction of the activities of the anesthesiologist assistant. A medically directing anesthesiologist is immediately available if they are in physical proximity that allows the anesthesiologist to reestablish direct contact with the patient to meet medical needs and any urgent or emergent clinical problems, and personally participating in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence. These responsibilities may also be met through coordination among anesthesiologists of the same group or department. Supervision through remote or telecommunications methods are not permitted under this definition and rule.

246-921-100 Application withdrawals.

An application for a license may not be withdrawn after the commission determines that grounds exist for denial of the license or for the issuance of a conditional license under RCW

18.130. Applications that are subject to investigation of unprofessional conduct or impaired practice may not be withdrawn.

246-921-105 Anesthesiologist assistant—Requirements for licensure.

(1) An applicant for licensure as an anesthesiologist assistant must submit to the commission:

(a) A completed application on forms provided by the commission;

(b) Proof the applicant has completed a CAAHEP accredited commission approved anesthesiologist assistant program and successfully passed the NCCAA examination;

(c) All applicable fees as specified in WAC 246-921-990; and

(d) Other information required by the commission.

(2) The commission will only consider complete applications with all supporting documents for licensure.

(3) Internationally trained individuals do not currently have a pathway to licensure as an anesthesiologist assistant due to ineligibility for the certifying exam offered by NCCAA.

246-921-110 Background check—Temporary practice permit.

The commission may issue a temporary practice permit when the applicant has met all other licensure requirements, except the national criminal background check requirement. The applicant must not be subject to denial of a license or issuance of a conditional license under this chapter.

(1) If there are no violations identified in the Washington criminal background check and the applicant meets all other licensure conditions, including receipt by the department of health of a completed Federal Bureau of Investigation (FBI) fingerprint card, the commission may issue a temporary practice permit allowing time to complete the national criminal background check requirements.

A temporary practice permit that is issued by the commission is valid for six months. A one-time extension of six months may be granted if the national background check report has not been received by the commission.

(2) The temporary practice permit allows the applicant to work in the state of Washington as an anesthesiologist assistant during the time period specified on the permit. The temporary practice permit is a license to practice medicine as an anesthesiologist assistant provided that a supervision arrangement exists with a physician anesthesiologist as defined in this rule.

(3) The commission issues a license once it receives the national background check report, as long as the report is not negative, and the applicant meets all other licensing requirements.

(4) The temporary practice permit is no longer valid after the license is issued or the application for a full license is denied.

246-921-115 How to obtain an expedited temporary license—Military spouse.

A military spouse may receive a temporary license while completing any specific additional requirements that are not related to training or practice standards for anesthesiologist assistants under the following conditions.

(1) An expedited temporary license may be issued to an applicant who is a military spouse and:

(a) Is moving to Washington as a result of the military person's transfer to the state of Washington;

(b) Holds an unrestricted, active license in another state or United States territory that the commission currently deems to have substantially equivalent licensing standards for an anesthesiologist assistant to those in the state of Washington; and

(c) Is not subject to any pending investigation, charges, or disciplinary action by the regulatory body in any other state United States territory in which the applicant holds a license.

(2) An expedited temporary license grants the applicant the full scope of practice for the anesthesiologist assistant.

(3) An expedited temporary license expires when any one of the following occurs:

(a) A full or limited license is issued to the applicant;

(b) A notice of decision on the application is mailed to the applicant, unless the notice of decision on the application specifically extends the duration of the expedited temporary license; or

(c) One hundred eighty days after the expedited temporary license is issued.

(4) To receive an expedited temporary license, the applicant must:

(a) Meet all requirements and qualifications for the license that are specific to the training, education, and practice standards for anesthesiologist assistants;

(b) Submit a written request for an expedited temporary license; and

(c) Submit a copy of the military service member's orders and a copy of one of the following:

(i) The military-issued identification card showing the military service member's information and the applicant's relationship to the military service member;

(ii) A marriage license; or

(iii) A state registered domestic partnership.

(5) For the purposes of this section the following definitions shall apply:

(a) "Military spouse" is someone married to or in a registered domestic partnership with a military person who is serving in the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States; and

(b) "Military person" means a person serving in the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States.

246-921-120 Exemption from licensure—Qualified physician assistant pathway.

(1) A physician assistant may practice medicine within the full scope of an anesthesiologist assistant without requiring a separate license under RCW 18.71D if the physician assistant:

(a) Fulfills of the practice, education, training, and licensure requirements specified in WAC 246-918-080;

(b) Graduation from an approved program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP)that is specifically designed to train anesthesiologist assistants;

(c) Has successfully passed and maintains certification through the National Council on Certification of Anesthesiologist Assistants; and

(d) Is supervised according to the requirements in this section and RCW 18.71D by a physician anesthesiologist licensed under RCW 18.71, 18.71B, or RCW 18.57.

246-921-125 Renewal, continuing medical education cycle, and maintenance of licensure.

(1) Under WAC **246-12-020**, an initial credential issued within ninety days of the anesthesiologist assistant's birthday does not expire until the anesthesiologist assistant's next birthday.

(2) An anesthesiologist assistant must renew their license every two years on their birthday. Renewal fees are accepted no sooner than ninety days prior to the expiration date.

(3) Each anesthesiologist assistant shall have four years to meet the continuing medical education requirements as defined

by this rule. The review period begins at the second renewal after initial licensure or second renewal after reactivation of an expired license.

(4) An anesthesiologist assistant must complete two hundred hours of continuing education every four years as required in chapter **246-12** WAC, Part 7, which may be audited for compliance at the discretion of the commission.

(5) In lieu of two hundred hours of continuing medical education the commission will accept:

(a) Current certification with the NCCAA; or

(b) Compliance with a continuing maintenance of competency program through NCCAA; or

(c) Other programs approved by the commission.

(6) The commission approves the following categories of creditable continuing medical education as accredited by the Accreditation Council for Continuing Medical Education (ACCME) or affiliated education providers. A minimum of eighty credit hours must be earned in Category I.

Category I	Continuing medical education activities with accredited sponsorship through ACCME or recognized affiliated education providers.

Category II Continuing medical education activities with nonaccredited sponsorship and other meritorious learning experience.

(7) The commission adopts the standards approved by the ACCME for the evaluation of continuing medical education requirements in determining the acceptance and category of any continuing medical education experience.

(8) An anesthesiologist assistant does not need prior approval of any continuing medical education. The commission will accept any continuing medical education that reasonably falls within the requirements of this section and relies upon each anesthesiologist assistant's integrity to comply with these requirements.

(9) A continuing medical education sponsor does not need to apply for or expect to receive prior commission approval for a formal continuing medical education program. The continuing medical education category will depend solely upon the accredited status of the organization or institution. The number of hours may be determined by counting the contact hours of instruction and rounding to the nearest quarter hour. The commission relies upon the integrity of the program sponsors to

present continuing medical education for the anesthesiologist assistant that constitutes a meritorious learning experience.

246-921-130 Training in suicide assessment, treatment, and management.

(1) A licensed anesthesiologist assistant must complete a one-time training in suicide assessment, treatment, and management. The training must be at least six hours in length and may be completed in one or more sessions.

(2) The training must be completed by the end of the first full continuing education reporting period after initial licensure.

(3) The training must be on the model list developed by the department of health under RCW **43.70.442**.

(4) The hours spent completing training in suicide assessment, treatment, and management count toward meeting applicable continuing education requirements in the same category specified in WAC 246-921-125.

(5) The commission exempts any licensed anesthesiologist assistant from the training requirements of this section if the anesthesiologist assistant has only brief, limited, or no patient contact.

246-921-135 Health equity continuing education training requirements.

(1) An anesthesiologist assistant must complete two hours of health equity continuing education training every four years as described in WAC **246-12-800** through **246-12-830**.

(2) The two hours of health equity continuing education an anesthesiologist assistant completes count toward meeting applicable continuing education requirements in the same category specified in WAC 246-921-125.

246-921-140 Retired license.

(1) To obtain a retired license, an anesthesiologist assistant must comply with chapter **246-12** WAC.

(2) An anesthesiologist assistant with a retired license must have a supervision arrangement with a physician anesthesiologist in order to practice except when serving as a "covered volunteer emergency worker" as defined in RCW **38.52.180** (5)(a) and engaged in authorized emergency management activities or serving under chapter **70.15** RCW.

(3) An anesthesiologist assistant with a retired license may not receive compensation for health care services.

(4) An anesthesiologist assistant with a retired license may practice under the following conditions:

(a) In emergent circumstances calling for immediate action; or

(b) Intermittent circumstances on a part-time or full-time nonpermanent basis.

(5) A retired license expires every two years on the license holder's birthday. Retired credential renewal fees are accepted no sooner than ninety days prior to the expiration date.

(6) An anesthesiologist assistant with a retired license shall report one hundred hours of continuing education at every renewal.

246-921-145 Returning to active status when a license has expired.

(1) To return to active status the anesthesiologist assistant must meet the requirements of chapter **246-12** WAC, Part 2, which includes paying the applicable fees under WAC 246-921-990 and meeting the continuing medical education requirements under WAC 246-921-125.

(2) If the license has expired over three years, the anesthesiologist assistant must:

(a) Meet requirements in subsection (1) of this section;

(b) Meet the current licensure requirements under WAC 246-921-105; and

(c) Satisfy any demonstration of competence requirements deemed necessary by the commission. Demonstration of competence may take the form of clinical knowledge examinations or fitness for duty evaluations conducted by commission approved entities.

246-921-150 Anesthesiologist assistant identification.

(1) An anesthesiologist assistant must clearly identify themselves as an ~~Anesthesiologist~~ anesthesiologist assistant and must appropriately display on their person identification as an ~~Anesthesiologist~~ anesthesiologist assistant.

(2) An anesthesiologist assistant must not present themselves in any manner which would tend to mislead the public as to their title.

246-921-155 Mandatory reporting.

The commission adopts the rules for mandatory reporting in chapter **246-16** WAC.

246-921-160 Practice limitations and scope of practice.

(1) An anesthesiologist assistant is required to have a supervision arrangement with a qualified physician anesthesiologist consistent with and as defined by this rule. The supervision arrangements are not required to be filed with the commission.

(2) Duties which an anesthesiologist may delegate to an anesthesiologist assistant include but are not limited to:

(a) Assisting with preoperative anesthetic evaluations, postoperative anesthetic evaluations, and patient progress notes, all to be cosigned by the supervising anesthesiologist within 24 hours;

(b) Administering and assisting with preoperative consultations;

(c) Under the supervising anesthesiologist's consultation and direction, order perioperative pharmaceutical agents, medications, and fluids, to be used only at the facility where ordered, including but not limited to controlled substances, which may be administered prior to the co-signature of the supervising anesthesiologist. The supervising anesthesiologist may review and if required by the facility or institutional policy must cosign these orders in a timely manner;

(i) For the purposes of this section, an anesthesiologist assistant under the supervising anesthesiologist consultation and direction is permitted to order the items specified in, but not limited to item (c), so long as the items are used within the facility where ordered.

(ii) For the purposes of this chapter, ordering pharmaceuticals, agents, medications, and fluids is not considered prescribing as noted in (3) of this section.

(d) Changing or discontinuing a medical treatment plan, after consultation with the supervising anesthesiologist;

(e) Calibrating anesthesia delivery systems and obtaining and interpreting information from the systems and monitors, in consultation with an anesthesiologist;

(f) Assisting the supervising anesthesiologist with the implementation of medically accepted monitoring techniques;

(g) Assisting with basic and advanced airway interventions, including but not limited to endotracheal intubation, laryngeal mask insertion, and other advanced airways techniques;

(h) Establishing peripheral intravenous lines, including subcutaneous lidocaine use;

(i) Establishing radial and dorsalis pedis arterial lines;

(j) Assisting with general anesthesia, including induction, maintenance, and emergence;

(k) Assisting with procedures associated with general anesthesia, such as but not limited to gastric intubation;

(l) Administering intermittent vasoactive drugs and starting and titrating vasoactive infusions for the treatment of patient responses to anesthesia;

(m) Assisting with spinal and intravenous regional anesthesia;

(n) Maintaining and managing established neuraxial epidurals and regional anesthesia;

(o) Assisting with monitored anesthesia care;

(p) Evaluating and managing patient-controlled analgesia, epidural catheters, and peripheral nerve catheters;

(q) Obtaining venous and arterial blood samples;

(r) Assisting with, ordering, and interpreting appropriate preoperative, point of care, intraoperative, or postoperative diagnostic tests or procedures as authorized by the supervising anesthesiologist;

(s) Obtaining and administering perioperative anesthesia and related pharmaceutical agents including intravenous fluids and blood products;

(t) Participating in management of the patient while in the preoperative suite and recovery area;

(u) Providing assistance to a cardiopulmonary resuscitation team in response to a life-threatening situation;

(v) Participating in administrative, research, and clinical teaching activities as authorized by the supervising anesthesiologist; and

(w) Assisting with such other tasks not prohibited by law under the supervision of a licensed anesthesiologist that an anesthesiologist assistant has been trained and is proficient to assist with.

(3) Nothing in this section shall be construed to prevent an anesthesiologist assistant from having access to and being able to obtain drugs as directed by the supervising anesthesiologist. An anesthesiologist assistant may not prescribe, order, compound, or dispense drugs, medications, or devices of any kind except as authorized in (2) of this section.

(4) Signing Authority: An anesthesiologist assistant may sign and attest to any certificates, cards, forms, or other required documentation that the anesthesiologist assistant's supervising anesthesiologist may sign, provided that it is within the anesthesiologist assistant's scope of practice.

246-921-165 Supervision ratios and group supervision

(1) Physician anesthesiologists may themselves supervise no more than four anesthesiologist assistants. If a supervision ratio above 4:1 is needed, the physician anesthesiologist may

submit a request for an exception to the commission using a form provided by the commission.

(2) In the exception request, the physician anesthesiologist must provide:

(a) A descriptive justification of need;

(b) What quality review and improvement mechanisms are in place to maintain the patient safety and the standard of care; and

(c) What escalation and physician backup procedures are in place should multiple anesthesiologist assistants require the presence or assistance of the physician anesthesiologist.

(3) Those submitting exception requests may, at the sole discretion of the commission, be denied. In the event of a request denial, requestors are entitled to appeal the decision utilizing the brief adjudication process as defined in WAC 246-11-425.

(4) The commission permits a group supervision model for anesthesiologist assistants in settings where the physician led Anesthesia Care Team:

(a) Operates in a single physical location such as a hospital or clinic;

(b) Does not operate above the 4:1 ratio without a commission granted exemption as required in these rules; and

(c) Has protocols and staffing available to designate backup and on-call physician anesthesiologists.

246-921-170 Notification of investigation or disciplinary action.

The anesthesiologist assistant shall notify their supervising physician whenever the anesthesiologist assistant is the subject of an investigation or disciplinary action by the commission. The commission may notify the supervising physician or other supervising physicians of such matters as appropriate.

~~**WAC 246-921-300 Safe and effective analgesia and anesthesia administration in office-based surgical settings. (MD Rule: WAC 246-919-601:)**~~

~~(1) Purpose. The purpose of this rule is to promote and establish consistent standards, continuing competency, and to promote patient safety. The commission establishes the following rule for anesthesiologist assistants licensed under this chapter who assist in anesthesia administration, analgesia or sedation in office-based settings.~~

~~(2) Definitions. The following terms used in this subsection apply throughout this section unless the context clearly indicates otherwise:~~

Commented [DB1]: Remove references to performing procedures and surgeries.

Commented [MM2R1]: Based on legal advice from OBS original author, we are deleting this because the rules in the MD chapter specify the requirements to be enforced by the MD in these settings.

~~(a) "Deep sedation" or "analgesia" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.~~

~~(b) "General anesthesia" means a state of unconsciousness intentionally produced by anesthetic agents, with absence of pain sensation over the entire body, in which the patient is without protective reflexes and is unable to maintain an airway, and cardiovascular function may be impaired. Sedation that unintentionally progresses to the point at which the patient is without protective reflexes and is unable to maintain an airway is not considered general anesthesia.~~

~~(c) "Local infiltration" means the process of infusing a local anesthetic agent into the skin and other tissues to allow painless wound irrigation, exploration and repair, and other procedures, including procedures such as retrobulbar or periorbital ocular blocks only when performed by a board eligible or board-certified ophthalmologist. It does not include procedures in which local anesthesia is injected into areas of~~

~~the body other than skin or muscle where significant cardiovascular or respiratory complications may result.~~

~~(d) "Major conduction anesthesia" means the administration of a drug or combination of drugs to interrupt nerve impulses without loss of consciousness, such as epidural, caudal, or spinal anesthesia, lumbar or brachial plexus blocks, and intravenous regional anesthesia. Major conduction anesthesia does not include isolated blockade of small peripheral nerves, such as digital nerves.~~

~~(e) "Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Minimal sedation is limited to oral, intranasal, or intramuscular medications.~~

~~(f) "Moderate sedation" or "analgesia" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.~~

~~(g) "Office-based surgery" means any surgery or invasive medical procedure requiring analgesia or sedation, including, but not limited to, local infiltration for tumescent liposuction, performed in a location other than a hospital or~~

~~hospital-associated surgical center licensed under chapter **70.41** RCW, or an ambulatory surgical facility licensed under chapter **70.230** RCW.~~

~~(3) Exemptions. This rule does not apply to anesthesiologist assistants working within their defined scope and supervised by a qualified physician anesthesiologist as defined under WAC 246-921-005 when:~~

~~(a) Performing surgery and medical procedures that require only minimal sedation (anxiolysis), or infiltration of local anesthetic around peripheral nerves. Infiltration around peripheral nerves does not include infiltration of local anesthetic agents in an amount that exceeds the manufacturer's published recommendations.~~

~~(b) Performing surgery in a hospital or hospital-associated surgical center licensed under chapter **70.41** RCW, or an ambulatory surgical facility licensed under chapter **70.230** RCW.~~

~~(c) Performing surgery utilizing or administering general anesthesia. Facilities in which physicians administer general anesthesia or perform procedures in which general anesthesia is a planned event are regulated by rules related to hospital or hospital-associated surgical center licensed under chapter **70.41** RCW, an ambulatory surgical facility licensed under chapter **70.230** RCW, or a dental office under WAC **246-919-602**.~~

~~(d) Administering deep sedation or general anesthesia to a patient in a dental office under WAC~~ **246-919-602**~~.~~

~~(e) Performing oral and maxillofacial surgery, and the physician:~~

~~(i) Is licensed both as a physician under chapter~~ **18.71** ~~RCW and as a dentist under chapter~~ **18.32** ~~RCW;~~

~~(ii) Complies with dental quality assurance commission regulations;~~

~~(iii) Holds a valid:~~

~~(A) Moderate sedation permit;~~

~~(B) Moderate sedation with parenteral agents permit; or~~

~~(C) General anesthesia and deep sedation permit; and~~

~~(iv) Practices within the scope of their specialty.~~

~~(4) Application of rule.~~

~~This rule applies to anesthesiologist assistants practicing with a single qualified physician anesthesiologist or in a group setting who perform office-based surgery employing one or more of the following levels of sedation or anesthesia:~~

~~(a) Moderate sedation or analgesia; or~~

~~(b) Deep sedation or analgesia; or~~

~~(c) Major conduction anesthesia.~~

~~(5) Accreditation or certification.~~

~~(a) A physician who performs a procedure under this rule must ensure that the procedure is performed in a facility that~~

~~is appropriately equipped and maintained to ensure patient safety through accreditation or certification and in good standing from an accrediting entity approved by the commission.~~

~~(b) The commission may approve an accrediting entity that demonstrates to the satisfaction of the commission that it has all the following:~~

~~(i) Standards pertaining to patient care, recordkeeping, equipment, personnel, facilities and other related matters that are in accordance with acceptable and prevailing standards of care as determined by the commission;~~

~~(ii) Processes that assure a fair and timely review and decision on any applications for accreditation or renewals thereof;~~

~~(iii) Processes that assure a fair and timely review and resolution of any complaints received concerning accredited or certified facilities; and~~

~~(iv) Resources sufficient to allow the accrediting entity to fulfill its duties in a timely manner.~~

~~(c) An anesthesiologist assistant working within their scope and supervised by a qualified physician anesthesiologist may perform procedures under this rule in a facility that is not accredited or certified, provided that the facility has submitted an application for accreditation by a commission-approved accrediting entity, and that the facility is~~

~~appropriately equipped and maintained to ensure patient safety such that the facility meets the accreditation standards. If the facility is not accredited or certified within one year of the physician and anesthesiologist assistants' performance of the first procedure under this rule, the physician and anesthesiologist assistant must cease performing procedures under this rule until the facility is accredited or certified.~~

~~(d) If a facility loses its accreditation or certification and is no longer accredited or certified by at least one commission-approved entity, the physician and anesthesiologist assistant shall immediately cease performing procedures under this rule in that facility.~~

~~(6) Competency. When a physician anesthesiologist or Anesthesiologist assistants is not present, the physician performing office-based surgery and using a form of sedation defined in subsection (4) of this section must be competent and qualified both to perform the operative procedure and to oversee the administration of intravenous sedation and analgesia.~~

~~(7) Qualifications for administration of sedation and analgesia may shall include:~~

~~(a) Completion of a commission approved anesthesiologist assistant training program;~~

~~(b) Supervision by a physician anesthesiologist according to the requirements of this chapter; andor~~

~~(c) Credentialed for providing anesthesia.~~ ~~Having privileges for conscious sedation granted by a hospital medical staff.~~

~~(8) At least one licensed health care practitioner currently certified in advanced resuscitative techniques appropriate for the patient age group must be present or immediately available with age-size-appropriate resuscitative equipment throughout the procedure and until the patient has met the criteria for discharge from the facility. Certification in advanced resuscitative techniques includes, but is not limited to, advanced cardiac life support (ACLS), pediatric advanced life support (PALS), or advanced pediatric life support (APLS).~~

~~(9) Sedation assessment and management.~~

~~Sedation is a continuum. Depending on the patient's response to drugs, the drugs administered, and the dose and timing of drug administration, it is possible that a deeper level of sedation will be produced than initially intended.~~

~~(a) If an anesthesiologist or anesthesiologist assistants is not present, a physician intending to produce a given level of sedation should be able to "rescue" a patient who enters a deeper level of sedation than intended.~~

~~(b) If a patient enters into a deeper level of sedation than planned, the physician or anesthesiologist assistant must return the patient to the lighter level of sedation as quickly~~

~~as possible, while closely monitoring the patient to ensure the airway is patent, the patient is breathing, and that oxygenation, heart rate and blood pressure are within acceptable values. A physician or anesthesiologist assistant who returns a patient to a lighter level of sedation in accordance with this subsection (c) does not violate subsection (10) of this section.~~

~~(10) Separation of surgical and monitoring functions.~~

~~(a) The physician performing the surgical procedure must not administer the intravenous sedation or monitor the patient.~~

~~(b) The licensed health care practitioner, designated by the physician to administer intravenous medications and monitor the patient who is under moderate sedation, may assist the operating physician with minor, interruptible tasks of short duration once the patient's level of sedation and vital signs have been stabilized, provided that adequate monitoring of the patient's condition is maintained. The licensed health care practitioner who administers intravenous medications and monitors a patient under deep sedation or analgesia must not perform or assist in the surgical procedure.~~

~~(11) Emergency care and transfer protocols. A physician performing office-based surgery must ensure that in the event of a complication or emergency:~~

~~(a) All office personnel are familiar with a written and documented plan to timely and safely transfer patients to an appropriate hospital.~~

~~(b) The plan must include arrangements for emergency medical services and appropriate escort of the patient to the hospital.~~

~~(12) Medical record. The physician performing office-based surgery must maintain a legible, complete, comprehensive, and accurate medical record for each patient.~~

~~(a) The medical record must include all the following:~~

~~(i) Identity of the patient;~~

~~(ii) History and physical, diagnosis and plan;~~

~~(iii) Appropriate lab, X-ray or other diagnostic reports;~~

~~(iv) Appropriate preanesthesia evaluation;~~

~~(v) Narrative description of procedure;~~

~~(vi) Pathology reports, if relevant;~~

~~(vii) Documentation of which, if any, tissues and other specimens have been submitted for histopathologic diagnosis;~~

~~(viii) Provision for continuity of postoperative care; and~~

~~(ix) Documentation of the outcome and the follow-up plan.~~

~~(b) When moderate or deep sedation, or major conduction anesthesia is used, the patient medical record must include a separate anesthesia record that documents:~~

~~(i) The type of sedation or anesthesia used;~~

~~(ii) Name, dose, and time of administration of drugs;~~

~~(iii) Documentation at regular intervals of information obtained from the intraoperative and postoperative monitoring;~~

~~(iv) Fluids administered during the procedure;~~

~~(v) Patient weight;~~

~~(vi) Level of consciousness;~~

~~(vii) Estimated blood loss;~~

~~(viii) Duration of procedure; and~~

~~(ix) Any complication or unusual events related to the procedure or sedation/anesthesia.~~

246-921-305 Sexual misconduct.

(1) The following definitions apply throughout this section unless the context clearly requires otherwise.

(a) "Patient" means a person who is receiving health care or treatment or has received health care or treatment without a termination of the anesthesiologist assistant-patient relationship. The determination of when a person is a patient is made on a case-by-case basis with consideration given to a number of factors, including the nature, extent and context of the professional relationship between the anesthesiologist assistant and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.

(b) "Key third party" means a person in a close personal relationship with the patient and includes, but is not limited to, spouses, partners, parents, siblings, children, guardians and proxies.

(2) An anesthesiologist assistant shall not engage in sexual misconduct with a current patient or a key third party. An anesthesiologist assistant engages in sexual misconduct when they engage in the following behaviors with a patient or a key third party:

(a) Sexual intercourse or genital to genital contact;

(b) Oral to genital contact;

(c) Genital to anal contact or oral to anal contact;

(d) Kissing in a romantic or sexual manner;

(e) Touching breasts, genitals or any sexualized body part for any purpose other than appropriate examination or treatment;

(f) Examination or touching of genitals without using gloves, except for examinations of an infant or prepubescent child when clinically appropriate;

(g) Not allowing a patient the privacy to dress or undress;

(h) Encouraging the patient to masturbate in the presence of the anesthesiologist assistant or masturbation by the anesthesiologist assistant while the patient is present;

(i) Offering to provide practice-related services, such as medications, in exchange for sexual favors;

(j) Soliciting a date;

(k) Engaging in a conversation regarding the sexual history, preferences or fantasies of the anesthesiologist assistant.

(3) An anesthesiologist assistant shall not engage in any of the conduct described in subsection (2) of this section with a former patient or key third party if the anesthesiologist assistant:

(a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or

(b) Uses or exploits privileged information or access to privileged information to meet the anesthesiologist assistant's personal or sexual needs.

(4) Sexual misconduct also includes sexual contact with any person involving force, intimidation, or lack of consent; or a conviction of a sex offense as defined in RCW **9.94A.030**.

(5) To determine whether a patient is a current patient or a former patient, the commission will analyze each case individually, and will consider a number of factors including, but not limited to, the following:

(a) Documentation of formal termination;

(b) Transfer of the patient's care to another health care provider;

(c) The length of time that has passed;

(d) The length of time of the professional relationship;

(e) The extent to which the patient has confided personal or private information to the anesthesiologist assistant;

(f) The nature of the patient's health problem;

(g) The degree of emotional dependence and vulnerability.

(6) This section does not prohibit conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment situation.

(7) It is not a defense that the patient, former patient, or key third party initiated or consented to the conduct, or that the conduct occurred outside the professional setting.

(8) A violation of any provision of this rule shall constitute grounds for disciplinary action.

246-921-310 Abuse.

(1) An anesthesiologist assistant commits unprofessional conduct if the anesthesiologist assistant abuses a patient. An anesthesiologist assistant abuses a patient when they:

(a) Make statements regarding the patient's body, appearance, sexual history, or sexual orientation that have no legitimate medical or therapeutic purpose;

(b) Remove a patient's clothing or gown without consent;

(c) Fail to treat an unconscious or deceased patient's body or property respectfully; or

(d) Engage in any conduct, whether verbal or physical, which unreasonably demeans, humiliates, embarrasses, threatens, or harms a patient.

(2) A violation of any provision of this rule shall constitute grounds for disciplinary action.

246-921-990 Anesthesiologist assistant fees and renewal cycle

The Secretary of the Department of Health has authority over the fees. This section will be addressed in an upcoming workshop.

SB 5184 Implementation Draft

WAC Chapter 246-921 ANESTHESIOLOGIST ASSISTANTS—WASHINGTON MEDICAL COMMISSION

246-921-005 Definitions.

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

(1) "Anesthesiologist" or "Qualified physician anesthesiologist" means an actively practicing, board-eligible physician licensed under chapter 18.71, 18.71B, or 18.57 RCW who has completed a residency or equivalent training in anesthesiology.

(2) "Anesthesiologist assistant" or "Certified Anesthesiologist Assistant" means a person who has successfully completed an accredited anesthesiologist assistant program approved by the commission and has successfully passed the certification exam offered by the National Commission for Certification of Anesthesiologist Assistants (NCCAA), or other exam approved by the commission. These individuals, who may be known as "AA" or "CAA", are licensed by the commission to assist in developing and implementing anesthesia care plans for patients under the supervision of an anesthesiologist or group of anesthesiologists approved by the commission to supervise such assistant.

(3) "Assist" means the anesthesiologist assistant personally performs those duties and responsibilities delegated by the anesthesiologist. Delegated services must be consistent with the delegating anesthesiologist's education, training, experience, and active practice. Delegated services must be of the type that a reasonable and prudent anesthesiologist would find within the scope of sound medical judgment to delegate.

(4) American Academy of Anesthesiologist Assistants (AAAA) is the national professional associations for Certified Anesthesiologist Assistants.

(5) "Commission" means the Washington medical commission.

(6) "Commission approved program" means a Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredited education program specifically designed for training anesthesiologist assistants or other substantially equivalent organization(s) approved by the commission.

(7) "Practice medicine" has the same meaning defined in RCW 18.71.011.

(8) "Secretary" means the secretary of health or the secretary's designee.

(9) "Supervise" means the immediate availability of the medically directing anesthesiologist for consultation and direction of the activities of the anesthesiologist assistant. A

medically directing anesthesiologist is immediately available if they are in physical proximity that allows the anesthesiologist to reestablish direct contact with the patient to meet medical needs and any urgent or emergent clinical problems, and personally participating in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence. These responsibilities may also be met through coordination among anesthesiologists of the same group or department. Supervision through remote or telecommunications methods are not permitted under this definition and rule.

246-921-100 Application withdrawals.

An application for a license may not be withdrawn after the commission determines that grounds exist for denial of the license or for the issuance of a conditional license under RCW 18.130. Applications that are subject to investigation of unprofessional conduct or impaired practice may not be withdrawn.

246-921-105 Anesthesiologist assistant—Requirements for licensure.

(1) An applicant for licensure as an anesthesiologist assistant must submit to the commission:

(a) A completed application on forms provided by the commission;

(b) Proof the applicant has completed a CAAHEP accredited commission approved anesthesiologist assistant program and successfully passed the NCCAA examination;

(c) All applicable fees as specified in WAC 246-921-990; and

(d) Other information required by the commission.

(2) The commission will only consider complete applications with all supporting documents for licensure.

(3) Internationally trained individuals do not currently have a pathway to licensure as an anesthesiologist assistant due to ineligibility for the certifying exam offered by NCCAA.

246-921-110 Background check—Temporary practice permit.

The commission may issue a temporary practice permit when the applicant has met all other licensure requirements, except the national criminal background check requirement. The applicant must not be subject to denial of a license or issuance of a conditional license under this chapter.

(1) If there are no violations identified in the Washington criminal background check and the applicant meets all other licensure conditions, including receipt by the department of health of a completed Federal Bureau of Investigation (FBI)

fingerprint card, the commission may issue a temporary practice permit allowing time to complete the national criminal background check requirements.

A temporary practice permit that is issued by the commission is valid for six months. A one-time extension of six months may be granted if the national background check report has not been received by the commission.

(2) The temporary practice permit allows the applicant to work in the state of Washington as an anesthesiologist assistant during the time period specified on the permit. The temporary practice permit is a license to practice medicine as an anesthesiologist assistant provided that a supervision arrangement exists with a physician anesthesiologist as defined in this rule.

(3) The commission issues a license once it receives the national background check report, as long as the report is not negative, and the applicant meets all other licensing requirements.

(4) The temporary practice permit is no longer valid after the license is issued or the application for a full license is denied.

246-921-115 How to obtain an expedited temporary license—Military spouse.

A military spouse may receive a temporary license while completing any specific additional requirements that are not related to training or practice standards for anesthesiologist assistants under the following conditions.

(1) An expedited temporary license may be issued to an applicant who is a military spouse and:

(a) Is moving to Washington as a result of the military person's transfer to the state of Washington;

(b) Holds an unrestricted, active license in another state or United States territory that the commission currently deems to have substantially equivalent licensing standards for an anesthesiologist assistant to those in the state of Washington; and

(c) Is not subject to any pending investigation, charges, or disciplinary action by the regulatory body in any other state United States territory in which the applicant holds a license.

(2) An expedited temporary license grants the applicant the full scope of practice for the anesthesiologist assistant.

(3) An expedited temporary license expires when any one of the following occurs:

(a) A full or limited license is issued to the applicant;

(b) A notice of decision on the application is mailed to the applicant, unless the notice of decision on the application specifically extends the duration of the expedited temporary license; or

(c) One hundred eighty days after the expedited temporary license is issued.

(4) To receive an expedited temporary license, the applicant must:

(a) Meet all requirements and qualifications for the license that are specific to the training, education, and practice standards for anesthesiologist assistants;

(b) Submit a written request for an expedited temporary license; and

(c) Submit a copy of the military service member's orders and a copy of one of the following:

(i) The military-issued identification card showing the military service member's information and the applicant's relationship to the military service member;

(ii) A marriage license; or

(iii) A state registered domestic partnership.

(5) For the purposes of this section the following definitions shall apply:

(a) "Military spouse" is someone married to or in a registered domestic partnership with a military person who is

serving in the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States; and

(b) "Military person" means a person serving in the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States.

246-921-120 Exemption from licensure—Qualified physician assistant pathway.

(1) A physician assistant may practice medicine within the full scope of an anesthesiologist assistant without requiring a separate license under RCW 18.71D if the physician assistant:

(a) Fulfills of the practice, education, training, and licensure requirements specified in WAC 246-918-080;

(b) Graduation from an approved program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP)that is specifically designed to train anesthesiologist assistants;

(c) Has successfully passed and maintains certification through the National Council on Certification of Anesthesiologist Assistants; and

(d) Is supervised according to the requirements in this section and RCW 18.71D by a physician anesthesiologist licensed under RCW 18.71, 18.71B, or RCW 18.57.

246-921-125 Renewal, continuing medical education cycle, and maintenance of licensure.

(1) Under WAC **246-12-020**, an initial credential issued within ninety days of the anesthesiologist assistant's birthday does not expire until the anesthesiologist assistant's next birthday.

(2) An anesthesiologist assistant must renew their license every two years on their birthday. Renewal fees are accepted no sooner than ninety days prior to the expiration date.

(3) Each anesthesiologist assistant shall have four years to meet the continuing medical education requirements as defined by this rule. The review period begins at the second renewal after initial licensure or second renewal after reactivation of an expired license.

(4) An anesthesiologist assistant must complete two hundred hours of continuing education every four years as required in chapter **246-12** WAC, Part 7, which may be audited for compliance at the discretion of the commission.

(5) In lieu of two hundred hours of continuing medical education the commission will accept:

(a) Current certification with the NCCAA; or

(b) Compliance with a continuing maintenance of competency program through NCCAA; or

(c) Other programs approved by the commission.

(6) The commission approves the following categories of creditable continuing medical education as accredited by the Accreditation Council for Continuing Medical Education (ACCME) or affiliated education providers. A minimum of eighty credit hours must be earned in Category I.

Category I Continuing medical education activities with accredited sponsorship through ACCME or recognized affiliated education providers.

Category II Continuing medical education activities with nonaccredited sponsorship and other meritorious learning experience.

(7) The commission adopts the standards approved by the ACCME for the evaluation of continuing medical education requirements in determining the acceptance and category of any continuing medical education experience.

(8) An anesthesiologist assistant does not need prior approval of any continuing medical education. The commission will accept any continuing medical education that reasonably falls within the requirements of this section and relies upon each anesthesiologist assistant's integrity to comply with these requirements.

(9) A continuing medical education sponsor does not need to apply for or expect to receive prior commission approval for a formal continuing medical education program. The continuing

medical education category will depend solely upon the accredited status of the organization or institution. The number of hours may be determined by counting the contact hours of instruction and rounding to the nearest quarter hour. The commission relies upon the integrity of the program sponsors to present continuing medical education for the anesthesiologist assistant that constitutes a meritorious learning experience.

246-921-130 Training in suicide assessment, treatment, and management.

(1) A licensed anesthesiologist assistant must complete a one-time training in suicide assessment, treatment, and management. The training must be at least six hours in length and may be completed in one or more sessions.

(2) The training must be completed by the end of the first full continuing education reporting period after initial licensure.

(3) The training must be on the model list developed by the department of health under RCW **43.70.442**.

(4) The hours spent completing training in suicide assessment, treatment, and management count toward meeting applicable continuing education requirements in the same category specified in WAC 246-921-125.

(5) The commission exempts any licensed anesthesiologist assistant from the training requirements of this section if the anesthesiologist assistant has only brief, limited, or no patient contact.

246-921-135 Health equity continuing education training requirements.

(1) An anesthesiologist assistant must complete two hours of health equity continuing education training every four years as described in WAC **246-12-800** through **246-12-830**.

(2) The two hours of health equity continuing education an anesthesiologist assistant completes count toward meeting applicable continuing education requirements in the same category specified in WAC 246-921-125.

246-921-140 Retired license.

(1) To obtain a retired license, an anesthesiologist assistant must comply with chapter **246-12** WAC.

(2) An anesthesiologist assistant with a retired license must have a supervision arrangement with a physician anesthesiologist in order to practice except when serving as a "covered volunteer emergency worker" as defined in RCW **38.52.180** (5)(a) and engaged in authorized emergency management activities or serving under chapter **70.15** RCW.

(3) An anesthesiologist assistant with a retired license may not receive compensation for health care services.

(4) An anesthesiologist assistant with a retired license may practice under the following conditions:

(a) In emergent circumstances calling for immediate action; or

(b) Intermittent circumstances on a part-time or full-time nonpermanent basis.

(5) A retired license expires every two years on the license holder's birthday. Retired credential renewal fees are accepted no sooner than ninety days prior to the expiration date.

(6) An anesthesiologist assistant with a retired license shall report one hundred hours of continuing education at every renewal.

246-921-145 Returning to active status when a license has expired.

(1) To return to active status the anesthesiologist assistant must meet the requirements of chapter **246-12** WAC, Part 2, which includes paying the applicable fees under WAC 246-921-990 and meeting the continuing medical education requirements under WAC 246-921-125.

(2) If the license has expired over three years, the anesthesiologist assistant must:

(a) Meet requirements in subsection (1) of this section;

(b) Meet the current licensure requirements under WAC 246-921-105; and

(c) Satisfy any demonstration of competence requirements deemed necessary by the commission. Demonstration of competence may take the form of clinical knowledge examinations or fitness for duty evaluations conducted by commission approved entities.

246-921-150 Anesthesiologist assistant identification.

(1) An anesthesiologist assistant must clearly identify themselves as an anesthesiologist assistant and must appropriately display on their person identification as an anesthesiologist assistant.

(2) An anesthesiologist assistant must not present themselves in any manner which would tend to mislead the public as to their title.

246-921-155 Mandatory reporting.

The commission adopts the rules for mandatory reporting in chapter **246-16** WAC.

246-921-160 Practice limitations and scope of practice.

(1) An anesthesiologist assistant is required to have a supervision arrangement with a qualified physician anesthesiologist consistent with and as defined by this rule. The supervision arrangements are not required to be filed with the commission.

(2) Duties which an anesthesiologist may delegate to an anesthesiologist assistant include but are not limited to:

(a) Assisting with preoperative anesthetic evaluations, postoperative anesthetic evaluations, and patient progress notes, all to be cosigned by the supervising anesthesiologist within 24 hours;

(b) Administering and assisting with preoperative consultations;

(c) Under the supervising anesthesiologist's consultation and direction, order perioperative pharmaceutical agents, medications, and fluids, to be used only at the facility where ordered, including but not limited to controlled substances, which may be administered prior to the co-signature of the supervising anesthesiologist. The supervising anesthesiologist may review and if required by the facility or institutional policy must cosign these orders in a timely manner;

(i) For the purposes of this section, an anesthesiologist assistant under the supervising anesthesiologist consultation

and direction is permitted to order the items specified in, but not limited to item (c), so long as the items are used within the facility where ordered.

(ii) For the purposes of this chapter, ordering pharmaceuticals, agents, medications, and fluids is not considered prescribing as noted in (3) of this section.

(d) Changing or discontinuing a medical treatment plan, after consultation with the supervising anesthesiologist;

(e) Calibrating anesthesia delivery systems and obtaining and interpreting information from the systems and monitors, in consultation with an anesthesiologist;

(f) Assisting the supervising anesthesiologist with the implementation of medically accepted monitoring techniques;

(g) Assisting with basic and advanced airway interventions, including but not limited to endotracheal intubation, laryngeal mask insertion, and other advanced airways techniques;

(h) Establishing peripheral intravenous lines, including subcutaneous lidocaine use;

(i) Establishing radial and dorsalis pedis arterial lines;

(j) Assisting with general anesthesia, including induction, maintenance, and emergence;

(k) Assisting with procedures associated with general anesthesia, such as but not limited to gastric intubation;

(l) Administering intermittent vasoactive drugs and starting and titrating vasoactive infusions for the treatment of patient responses to anesthesia;

(m) Assisting with spinal and intravenous regional anesthesia;

(n) Maintaining and managing established neuraxial epidurals and regional anesthesia;

(o) Assisting with monitored anesthesia care;

(p) Evaluating and managing patient-controlled analgesia, epidural catheters, and peripheral nerve catheters;

(q) Obtaining venous and arterial blood samples;

(r) Assisting with, ordering, and interpreting appropriate preoperative, point of care, intraoperative, or postoperative diagnostic tests or procedures as authorized by the supervising anesthesiologist;

(s) Obtaining and administering perioperative anesthesia and related pharmaceutical agents including intravenous fluids and blood products;

(t) Participating in management of the patient while in the preoperative suite and recovery area;

(u) Providing assistance to a cardiopulmonary resuscitation team in response to a life-threatening situation;

(v) Participating in administrative, research, and clinical teaching activities as authorized by the supervising anesthesiologist; and

(w) Assisting with such other tasks not prohibited by law under the supervision of a licensed anesthesiologist that an anesthesiologist assistant has been trained and is proficient to assist with.

(3) Nothing in this section shall be construed to prevent an anesthesiologist assistant from having access to and being able to obtain drugs as directed by the supervising anesthesiologist. An anesthesiologist assistant may not prescribe, order, compound, or dispense drugs, medications, or devices of any kind except as authorized in (2) of this section.

(4) Signing Authority: An anesthesiologist assistant may sign and attest to any certificates, cards, forms, or other required documentation that the anesthesiologist assistant's supervising anesthesiologist may sign, provided that it is within the anesthesiologist assistant's scope of practice.

246-921-165 Supervision ratios and group supervision

(1) Physician anesthesiologists may themselves supervise no more than four anesthesiologist assistants. If a supervision ratio above 4:1 is needed, the physician anesthesiologist may

submit a request for an exception to the commission using a form provided by the commission.

(2) In the exception request, the physician anesthesiologist must provide:

(a) A descriptive justification of need;

(b) What quality review and improvement mechanisms are in place to maintain the patient safety and the standard of care; and

(c) What escalation and physician backup procedures are in place should multiple anesthesiologist assistants require the presence or assistance of the physician anesthesiologist.

(3) Those submitting exception requests may, at the sole discretion of the commission, be denied. In the event of a request denial, requestors are entitled to appeal the decision utilizing the brief adjudication process as defined in WAC 246-11-425.

(4) The commission permits a group supervision model for anesthesiologist assistants in settings where the physician led Anesthesia Care Team:

(a) Operates in a single physical location such as a hospital or clinic;

(b) Does not operate above the 4:1 ratio without a commission granted exemption as required in these rules; and

(c) Has protocols and staffing available to designate backup and on-call physician anesthesiologists.

246-921-170 Notification of investigation or disciplinary action.

The anesthesiologist assistant shall notify their supervising physician whenever the anesthesiologist assistant is the subject of an investigation or disciplinary action by the commission. The commission may notify the supervising physician or other supervising physicians of such matters as appropriate.

246-921-305 Sexual misconduct.

(1) The following definitions apply throughout this section unless the context clearly requires otherwise.

(a) "Patient" means a person who is receiving health care or treatment or has received health care or treatment without a termination of the anesthesiologist assistant-patient relationship. The determination of when a person is a patient is made on a case-by-case basis with consideration given to a number of factors, including the nature, extent and context of the professional relationship between the anesthesiologist assistant and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.

(b) "Key third party" means a person in a close personal relationship with the patient and includes, but is not limited to, spouses, partners, parents, siblings, children, guardians and proxies.

(2) An anesthesiologist assistant shall not engage in sexual misconduct with a current patient or a key third party. An anesthesiologist assistant engages in sexual misconduct when they engage in the following behaviors with a patient or a key third party:

(a) Sexual intercourse or genital to genital contact;

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(c) Genital to anal contact or oral to anal contact;

(d) Kissing in a romantic or sexual manner;

(e) Touching breasts, genitals or any sexualized body part for any purpose other than appropriate examination or treatment;

(f) Examination or touching of genitals without using gloves, except for examinations of an infant or prepubescent child when clinically appropriate;

(g) Not allowing a patient the privacy to dress or undress;

(h) Encouraging the patient to masturbate in the presence of the anesthesiologist assistant or masturbation by the anesthesiologist assistant while the patient is present;

(i) Offering to provide practice-related services, such as medications, in exchange for sexual favors;

(j) Soliciting a date;

(k) Engaging in a conversation regarding the sexual history, preferences or fantasies of the anesthesiologist assistant.

(3) An anesthesiologist assistant shall not engage in any of the conduct described in subsection (2) of this section with a former patient or key third party if the anesthesiologist assistant:

(a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or

(b) Uses or exploits privileged information or access to privileged information to meet the anesthesiologist assistant's personal or sexual needs.

(4) Sexual misconduct also includes sexual contact with any person involving force, intimidation, or lack of consent; or a conviction of a sex offense as defined in RCW **9.94A.030**.

(5) To determine whether a patient is a current patient or a former patient, the commission will analyze each case individually, and will consider a number of factors including, but not limited to, the following:

(a) Documentation of formal termination;

(b) Transfer of the patient's care to another health care provider;

(c) The length of time that has passed;

(d) The length of time of the professional relationship;

(e) The extent to which the patient has confided personal or private information to the anesthesiologist assistant;

(f) The nature of the patient's health problem;

(g) The degree of emotional dependence and vulnerability.

(6) This section does not prohibit conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment situation.

(7) It is not a defense that the patient, former patient, or key third party initiated or consented to the conduct, or that the conduct occurred outside the professional setting.

(8) A violation of any provision of this rule shall constitute grounds for disciplinary action.

246-921-310 Abuse.

(1) An anesthesiologist assistant commits unprofessional conduct if the anesthesiologist assistant abuses a patient. An anesthesiologist assistant abuses a patient when they:

(a) Make statements regarding the patient's body, appearance, sexual history, or sexual orientation that have no legitimate medical or therapeutic purpose;

(b) Remove a patient's clothing or gown without consent;

(c) Fail to treat an unconscious or deceased patient's body or property respectfully; or

(d) Engage in any conduct, whether verbal or physical, which unreasonably demeans, humiliates, embarrasses, threatens, or harms a patient.

(2) A violation of any provision of this rule shall constitute grounds for disciplinary action.

246-921-990 Anesthesiologist assistant fees and renewal cycle

The Secretary of the Department of Health has authority over the fees. This section will be addressed in an upcoming workshop.

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Anesthesiologist Assistants

Rule Description:
New Profession- Anesthesiologist Assistants

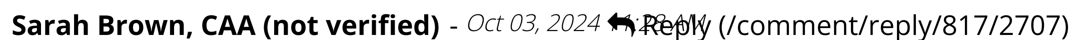
Code Reviser (CR) Document:

- CR-101 (https://wmc.wa.gov/sites/default/files/rules/24-18-057%20CR%20101%20AA%20NS.pdf)
- Nov. 4 Workshop Packet (https://wmc.wa.gov/sites/default/files/rules/WMC11.4.2024AAWorkshopPkt._0.pdf)

RCW-WAC:

- Chapter 18.71D RCW (https://app.leg.wa.gov/rcw/default.aspx?cite=18.71D&full=true)

Public Comments

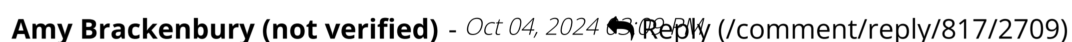

Sarah Brown, CAA (not verified) - *Oct 03, 2024 4:28 AM* Reply (/comment/reply/817/2707)

✕ **Ask Doc!**

October 4, 2024 Washington Medical Commission P.O. Box 47866 Olympia, WA 98504-7866 ATTN: Amelia Boyd, Program Manager RE: INITIAL COMMENTS FOR WSR 24-18-157 – RULES IMPLEMENTING SB 5184 (ANESTHESIOLOGIST ASSISTANTS) Dear Members of the Washington Medical Commission, I am writing on behalf of

the Certified Anesthesiologist Assistant (CAA) community to express our strong and urgent support for the implementation of Senate Bill 5184, which was passed by the Washington State Legislature in March of 2024. We believe this legislation represents an important step forward in improving patient care in Washington State by formally recognizing CAAs as licensed medical professionals within the anesthesia care team. As you develop the rules and regulations to implement this bill, I would like to offer the following recommendations to ensure an effective and timely rollout: 1. Licensing Timeline With Washington facing an anesthesia workforce shortage, we urge the Commission to establish a clear timeline for the initial licensing of CAAs in the state with the goal of CAA licensing beginning by the end of 2024 or in the first quarter of 2025. With an estimated initial cohort between 20 and 30, the agency will have sufficient time to efficiently manage the volume, ensuring a smooth and effective rollout for the new licensing process. The faster timeline is important to have CAAs providing clinical care as early in 2025 as possible. Many trained CAAs are already in Washington or are prepared to move here, growing as the profession gains recognition in the state. Additionally, with numerous students expected to graduate from CAA programs across the country in the next two years, Washington has a unique opportunity to attract these highly trained professionals. Starting the licensing process soon will encourage newly graduated CAAs to consider relocating to Washington, helping to address the state's growing anesthesia workforce needs. 2. Flexibility for Hospitals and Anesthesia Groups Senate Bill 5184 provides a detailed and prescriptive framework for CAA practice in Washington, more so than in most other states. Given this, we believe there is little need to add further prescriptive elements in the rulemaking process. It is critical that anesthesia groups and hospitals retain flexibility in how CAAs are integrated into their specific care team models. Each hospital and anesthesia group may have its own unique structure, and we encourage the Commission to maintain a broad approach that supports effective integration without unnecessary restrictions. The language in Section 4 (1) very clearly ensures the supervising anesthesiologist has delegatory authority and the ability to assess competence based on education, training and experience – which is appropriate for a position like the CAA who operates as a physician extender. In conclusion, we believe the framework established by SB 5184 strikes the right balance between safety, supervision, and flexibility. We encourage the Washington Medical Commission to implement the legislation in a way that supports timely licensing, allows flexibility for hospitals and anesthesia groups, and ensures that CAAs can contribute fully to the anesthesia care team. We are confident that CAAs will be a valuable addition to the healthcare workforce in Washington, and we look forward to working with the Commission as this new profession is integrated into our state's healthcare system. Thank you for considering these recommendations. We are happy to provide further information or clarification to support the process, ensuring CAAs can begin serving patients in Washington as soon as possible. Sincerely, Sarah Brown, President WA Academy of Anesthesiologist Assistants Spokane, WA

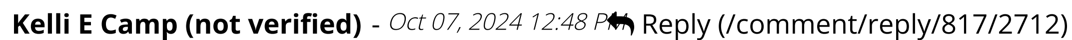
Ask Doc!



Amy Brackenbury (not verified) - *Oct 04, 2024 03:09 PM* Reply (/comment/reply/817/2709)

Ms. Boyd, Thank you for the opportunity to comment on proposed regulations for the licensure of Certified Anesthesiologist Assistants (CAAs) in our state. On behalf of the members of the Washington State Society of Anesthesiologists, we urge the Commission to take swift action on rules for licensure, so we can increase our health care workforce and expand access to trained, skilled and professional anesthesia care for patients. The scope of practice outlined in RCW 18.71D provides a comprehensive and detailed framework for CAA licensure that is consistent with their education and training, and reflects the work they perform in the 20 other states where they currently practice. The proposed rules adhere closely to the legislation adopted by lawmakers earlier this year and we support their adoption. This is a challenging time in health care. Hospital bed shortages have resulted in unprecedented wait times for patients who often need critical care. And operating rooms aren't functioning at full capacity because we don't have enough people to staff them. We hope the Commission will act expeditiously to implement rules for CAA licensure, and that our members will be working alongside their CAA colleagues in 2025. Thank you for your consideration.

Kelli E Camp (not verified) - *Oct 07, 2024 12:48 PM* Reply (/comment/reply/817/2712)



Submitted on behalf of the Washington Association of Nurse Anesthesiology (WANA). In 2024, SB 5184 passed the legislature allowing a new anesthesia provider into the state of WA. WA state is the first state on the west coast to license anesthesiologist assistants (AAs). WANA recommends that rules for this profession include education of the public, proper signage in facilities and on consent paperwork, and notice to prospective patients of who is providing their anesthesia care. Because an AA is a new profession in WA, WANA strongly recommends the Commission mandate all practicing AAs use only their official title "Certified Anesthesiologist Assistant" or "Anesthesiologist Assistant" on all facility identification and upon introduction to prospective patients. Proper use of titles is crucial for patient safety because it clearly informs patients about their provider's qualifications and prevents confusion with other healthcare professionals, promoting transparency and informed decision-making. During the 2024 session, WANA raised concerns about the proposed scope of practice for AAs. In other states where AAs are licensed, there has been failure to meet regulatory medical direction criteria, raising concerns about patient safety and the quality of care when the criteria are not followed. Given the critical nature of anesthesia, it is essential to ensure stringent oversight and accountability when introducing AAs in Washington to avoid potential risks to patient outcomes. Therefore, amendments were offered and accepted to alter the scope of practice for AAs in WA to more closely align with the depth of their training as an assistant. Included in these amendments was the removal of any temporary licensure for an AA who has not yet passed their certification exam. The language that remains in RCW Chapter 18.71D could be misconstrued to allow licensure for an AA who is only certification-eligible rather than fully certified. WANA raised this concern with the committee chair and staff to define the intent of the language that remained after amendments in RCW 18.71D.020 2(a) "That the applicant has completed an accredited anesthesiologist assistant program approved by the commission and is

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eligible to take the examination approved by the commission.” WANA received communication from Representative Riccelli via email on February 18, 2024, stating his striker amendment (that was accepted) “eliminates the issuance of a … license for persons who have completed an anesthesiologist assistance program, but not passed a certification examination.” Bill language was further clarified with House committee staff on February 19, 2024, in communication to WANA stating “the anesthesiologist assistant will have to wait for a license and to practice until they have passed the exam” (communication available upon request). WANA recommends that the Commission explicitly align rules with the intent of the legislature and ensure verification of certification exam passage is provided to the Commission prior to granting licensure. Consistent with most other professions, health care providers must demonstrate a novice level of professional competency by passing a certification exam prior to receiving a license to care for patients. Further amendments during the 2024 session removed the following activities from AA scope of practice that were written in the original bill: “1) Removes an anesthesiologist assistant's authority to order oxygen therapy and respiratory therapy, 2) Removes an anesthesiologist assistant's authority to obtain informed consent for anesthesia and related procedures, 3) Removes an anesthesiologist assistant's authority to establish central lines.” WANA recommends that the Commission establish rulemaking that would include these details as beyond the scope of practice for an AA (may not be delegated), to align with the intent of the legislature. According to Centers for Medicare and Medicaid (CMS), Health and Human Services (HHS) 42 CFR Ch. IV §415.110, for each patient, the physician must: (i) perform a pre-anesthetic examination and evaluation; (ii) prescribes the anesthesia plan; (iii) personally participates in the most demanding aspects of the anesthesia plan including, if applicable, induction and emergence; (iv) ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in operating instructions; (v) monitors the course of anesthesia administration at frequent intervals; (vi) remains physically present and available for immediate diagnosis and treatment of emergencies; (vii) provides indicated post-anesthesia care. https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-sec415-110.pdf In RCW Chapter 18.71D, section 010 (3) states “’Assists’ means the anesthesiology assistant personally performs…” which clearly is not interpreted as “assist” by a usual definition which is “to give support or aid” or “to be present as a spectator” according to Merriam-Webster. RCW Chapter 18.71D.040 1(a) and 1(b) allows an AA to personally perform (stated as assist) the preoperative and postoperative consultation or evaluation. This is in direct violation of CMS § 415.110 (a)1(i) physician anesthesiologist MUST “perform the pre-anesthetic examination and evaluation” and CMS § 415.110 (a)1(vii) requiring the physician anesthesiologist “provides indicated post-anesthesia care”. Additionally, the language of RCW Chapter 18.71D.040 1(c) is in direct conflict with CMS § 415.110 (a)1(ii) stating physician anesthesiologist “prescribes the anesthesia plan”. RCW Chapter 18.71D.040 1(j) allows an AA to personally perform (stated as assists with) “general anesthesia, including induction, maintenance, and emergence.” This is not aligned with RCW 18.71D.010 (7) requiring the physician anesthesiologist be “… personally participating in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence” which is also a requirement of CMS § 415.110 (a)1(iii) REQUIRING that physician anesthesiologist “personally participate in the most demanding aspects of the anesthesia plan.” The AA may not

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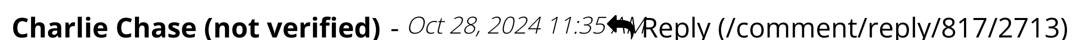
perform these demanding aspects without a physician anesthesiologist physically present in the room. RCW Chapter 18.71D.040 (r) allows: “Assisting with, ordering, and interpreting appropriate preoperative, point of care, intraoperative, or postoperative diagnostic tests or procedures…” CMS § 415.110 (a)1(vi) requires the physician anesthesiologist to remain “physically present and available for immediate diagnosis and treatment.” These outlined standards of care provide for the PHYSICIAN, and not the AA, to diagnose and order treatments. CMS and HHS play a significant role in protecting the public by overseeing the health and safety of millions of Americans by: 1. Setting and Enforcing Standards: CMS establishes guidelines for healthcare providers that ensure high standards of care. These standards help guarantee that care is delivered safely and effectively, protecting patients from harm and ensuring they receive quality care. 2. Regulating Access to Care: CMS ensures access to essential healthcare services (including for vulnerable populations) by setting rules for reimbursement and care delivery under … the Affordable Care Act. 3. Monitoring Quality and Safety: Both HHS and CMS are involved in monitoring healthcare facilities, ensuring compliance with federal regulations and enforcing standards related to patient safety. 4. Promoting Evidence-Based Practices: CMS and HHS develop and promote evidence-based guidelines and policies aimed at improving patient outcomes and reducing risks. WANA urges the Commission to ensure the scope of AA practice in WA state aligns with federal regulations established by CMS and HHS and not stray from these outlined standards. These federal regulatory bodies enforce healthcare standards, ensure access to quality care, and protect patients by promoting safe, evidence-based medical practices. RCW Chapter 18.71D has components in direct violation of the established federal rules, as referenced above in CMS/HHS 42 CFR Ch. IV §415.110. When making rules for this new profession, it is critical that the Commission ensure consistency with federal standards and regulations to protect the health and well-being of the public. Numerous studies evaluating the ability of physician anesthesiologists to meet the seven requirements of medical direction detailed in CMS/HHS 42 CFR Ch. IV §415.110 have shown that a ratio of more than 1:1 (i.e. 1:2, 1:3 or 1:4) results in failure of the physician anesthesiologist to meet these medical direction requirements. WANA strongly urges the Commission to limit the supervision ratio to 1:2 for AAs in Washington State to prevent gaps in patient care. A higher supervision ratio increases the risk of physician anesthesiologists being unable to meet critical medical direction requirements, potentially leaving patients vulnerable and without the proper care during high-risk procedures. Without strict limits, patient care could be severely compromised, leading to devastating consequences in anesthesia care.



I am a C-AA in St. Louis Missouri and am avidly awaiting the opportunity to be back near my family and work in WA asap. I support the current rules draft, as it aligns with the statute. This addition of more anaesthetists to Washington state will greatly enhance the workforce, as C-AAs and CRNAs are seemlessly interchangeable within the anaesthesia care team model, which works in a 1 physician to 4 anaesthetist ratio. I personally, and we in the Washington Academy

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of Anaesthesiologist Assistants, are looking forward to a smooth rules making process with clear timelines. Thank you, Charlie Chase secretary and treasure of the Washington Academy of Anaesthesiologist Assistants.

Christy Kohlsaat (not verified) - *Oct 28, 2024 11:50 AM* Reply (/comment/reply/817/2714)

I am a CAA from Miami, FL and am eager to work in WA as soon as possible. I want to be near my family and be able to deliver the same care in Washington, as I do in a Florida. My boys are 4 years old and 2 years old, and I'd like them to be near their grandpa and aunt and uncle. I look forward to moving closer to family and performing the same job I currently do as CAA in Florida. Thank you for your efforts to license CAAs in Washington. Christine Kohlsaat, Vice President of the Washington Academy of Anesthesiologist Assistants

Rep. Marcus Riccelli (not verified) - *Oct 28, 2024 03:30 PM* Reply (/comment/reply/817/2715)

The AA bill was agreed upon in the legislature to: Not allow AAs to do central lines. Not allow AAs to do epidurals. That AAs need to be supervised during induction and emergence. That there will not be a temporary license for AAs. This agreement allowed the legislation to get enough votes to be signed into law. Introducing these concepts in rulemaking will likely create more legislation in the future and could mean changes to newly established rules in the near future.

Kevin Van De Wege (not verified) - *Oct 28, 2024 04:52 PM* Reply (/comment/reply/817/2716)

Ms. Boyd: SB 5184 passed the legislature only after a strategic agreement was reached between interested parties and legislators, ensuring it garnered the necessary votes to become law. We believe that if the commission does not address the intent of the legislature in the rulemaking process, it may lead to ongoing challenges and necessitate further legislative efforts to find a resolution. We hope to work collaboratively to avoid such conflicts and ensure a smooth path forward. Washington Association of Nurse Anesthesiology wants to highlight three areas of concern for this next rulemaking meeting and appreciates the opportunity to do so. First, Anesthesiologist Assistants should not be given temporary (interim) licensure. This provision was intentionally removed from the bill as part of an agreement among interested parties and legislators, who acknowledged that the unique environment in which AAs function requires full board certification before granting any licensure. Second, in proposed Rule 246-921-200 2 c AAs are given the authority to order medications. Under the same rule, 2 w (4) AAs are specifically not allowed to order medications. The agreement during the 2024 session, among interested parties and legislators, was that AAs are not allowed to order or prescribe medications. Naturally, AAs may pick up and administer medications only

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after they have been ordered and prescribed by a physician anesthesiologist. Third, the section of rules WAC 246-921-300 is directly copied from WAC 246-919-601 which pertains to physicians and physician assistants. AAs are neither of these occupations and WANA urges great caution in applying the same rules across the board to very different professions. Indeed, the following direct quotation is found on the American Academy of Anesthesiologist Assistants (AAAA®) webpage (CAA being interchangeable with AA in this quote): “Although CAAs and physician assistants (PAs) both function as physician extenders, they do not perform the same functions. Each has its own separate educational curriculum, standards for accreditation, and its own agency for certification. PAs receive a generalist education and may practice in many different fields under the supervision of a physician who is qualified and credentialed in that field. An AA may not practice outside of the field of anesthesia or apart from the supervision of an anesthesiologist. A CAA may not practice as a physician's assistant unless the CAA has also completed a PA training program and passed the National Commission for the Certification of Physician Assistants (NCCPA) exam. Likewise, a PA may not identify him- or herself as a CAA unless he or she has completed an accredited AA program and passed the National Commission for the Certification of Anesthesiologist Assistants (NCCAA) exam. If also certified as a CAA, such a dual-credentialed PA would be required to practice as an anesthetist only as an extender for an anesthesiologist and could not provide anesthesia care at the direction of a physician of any other specialty.” https://aaaa.memberclicks.net/faqs#:~:text=An%20AA%20may%20not%20practice,Physician%20Assistants%

Senator Annette... (not verified) - *Nov 01, 2024 01:42 PM* Reply (/comment/reply/817/2717)

To the Honorable Members of the Washington Medical Commission, We understand that in the rule-making process for the rules on the Anesthesiologist Assistants bill (SB 5184), there have been some questions about legislative intent during the negotiations and the version of the bill that passed. As the sponsors of SB 5184, we believe the bill is very clear regarding intent when it comes to scope of practice for Anesthesiologists Assistants (AAs). The listed elements of scope for AAs in the law is intended to be where there is explicit authority for AAs to do this work. However, this is not an exhaustive list as the language in the statute stipulates per the following: • Sec 4 (1) very clearly states that “An anesthesiologist assistant may not exceed the scope of their supervising anesthesiologist’s practice and may assist with those duties and responsibilities delegated to them by the supervising anesthesiologist, and for which they are competent to assist with based on their education, training and experience.” This gives the supervising anesthesiologist the ability in the law to determine the duties for the Anesthesiologist Assistant based on the needs of their practice. • Sec 4 (1) also states, “Duties which an anesthesiologist may delegate to an anesthesiologist assistant include but are not limited to:” and then lists the explicit authorized duties. However, the “include but are not limited to” language in this bill, combined with the first sentence clearly states that the supervising anesthesiologist is the ultimate arbiter of the delegation of duties. The language of the law clearly indicates that the statute itself is not a limiting document. • In addition, in Sec 4 (1) (w) the law states within the explicit

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delegation of duties “Assisting with other tasks not prohibited by law under the supervision of a licensed anesthesiologist that an anesthesiologist assistant has been trained and is proficient to assist with.” Once again, this is clearly ensuring the only duties that are prohibited are those specifically prohibited within the statute. In the negotiations on the bill as it moved toward passage, none of this language regarding the authority of the supervising anesthesiologist was altered, changed, or removed. Although some language regarding explicit authority for certain procedures was removed, the language that allows the supervising anesthesiologist to continue to allow an AA to assist with these procedures based on their training, experience and competency remained. It is for this reason that we, as sponsors of the bill, agreed to these changes. The effect statement for the bill clearly outlined this as well, using the language “removes authority” rather than “prohibits.” We urge the Medical Commission to minimize changes to this statutory section in the rule and leave the language intact to retain the effect in policy that we intended as sponsors. Sincerely, Senator Annette Cleveland Senator Ann Rivers 49th Legislative District 18th Legislative District

Submit public comment on this rule (/comment/reply/817#comment-form)

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Chief Executive Officer

October 11, 2024

Amelia Boyd
Program Manager
Washington Medical Commission

Dear Ms. Boyd,

On behalf of the Washington State Medical Association (WSMA) and our over 12,000 physician and physician assistant members, thank you for the opportunity to comment on the Washington Medical Commission (WMC) rulemaking implementing SB 5184 concerning certified anesthesiologist assistants (CAA). To help our state meet the anesthesia workforce needs, the WSMA supported this concept when it was under sunrise review at the Department of Health and when SB 5184 was under legislative consideration. As such, **we support the WMC implementing SB 5184 to the full extent authorized by the legislature in an expeditious manner.**

A growing number of states have helped address anesthesia workforce needs by licensing anesthesiologist assistants, who provide high quality patient care working in physician-led teams. RCW 18.71D clearly outlines the CAA scope of practice and provides a comprehensive and detailed framework for licensure. **The proposed rules adhere closely to the legislation adopted by lawmakers earlier this year and we support their adoption.**

Thank you for the opportunity to provide comment. Should you have any follow-up questions, please contact WSMA Associate Policy Director Billie Dickinson.

Sincerely,

Billie Dickinson

Billie Dickinson
Associate Policy Director
Washington State Medical Association

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Washington State Senate

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November 1, 2024

To the Honorable Members of the Washington Medical Commission,

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- Sec 4 (1) also states, "Duties which an anesthesiologist may delegate to an anesthesiologist assistant include but are not limited to:" and then lists the explicit authorized duties. However, the "include but are not limited to" language in this bill, combined with the first sentence clearly states that the supervising anesthesiologist is the ultimate arbiter of the delegation of duties. The language of the law clearly indicates that the statute itself is not a limiting document.

- In addition, in Sec 4 (1) (w) the law states within the explicit delegation of duties "Assisting with other tasks not prohibited by law under the supervision of a licensed anesthesiologist that an anesthesiologist assistant has been trained and is proficient to assist with." Once again, this is clearly ensuring the only duties that are prohibited are those specifically <u>prohibited</u> within the statute.

In the negotiations on the bill as it moved toward passage, none of this language regarding the authority of the supervising anesthesiologist was altered, changed, or removed. Although some

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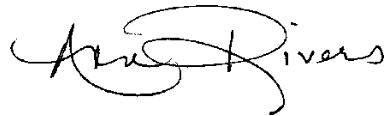
Sincerely,



Senator Annette Cleveland
49th Legislative District

Senator Ann Rivers
18th Legislative District

Cc:

Kyle Karinen, Washington Medical Commission
Amelia Boyd, Washington Medical Commission
Micah Matthews, Washington Medical Commission
Stephanie Mason, Washington Medical Commission

New Profession – Anesthesiologist Assistants

Rules Workshop

November 18, 2024

Agenda

- Housekeeping
- Open workshop
- Draft language discussion
- Written comments discussion
- Next steps
- Close workshop

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Keep in mind...

Important Information

- Senate Bill 5184 codified as chapter 18.71D RCW
- WMC is the authority for:
  - Allopathic physicians (MD)
  - Physician Assistants (PA)
  - Certified Anesthesiologist Assistants (CAA)
- For other professions, visit doh.wa.gov.

Attendance Verification

Draft language

Revisions

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Proposed Rule Development Timeline

Next Steps

- Workshop
- Initiate CR-102

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Thank you!

Send your written comments to:
medical.rules@wmc.wa.gov