WASHINGTON
Medical
Commission

Licensing. Accountability. Leadership.

Rules Workshop

Physician Assistants

May 10, 2021 – 1:30 pm to 3:30 pm

GoToWebinar

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

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Rule Workshop Notice

WASHINGTON Medical Commission
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Rulemaking
The Washington Medical Commission (Commission) has officially filed a CR-101 with the Office of the Code Reviser on November 19, 2020. The WSR# is 20-24-015.

The Commission is considering updating the physician assistant (PA) chapter to more closely align with current industry standards, modernize regulations to align with current national industry standards and best practices, and provide clearer rules language for licensed PAs.

Included in this rulemaking proposal is incorporating the requirements of Substitute House Bill 2378 (SHB 2378) Concerning physician assistants. The Commission is considering adding new sections in accordance with SHB 2378. This bill combines the physician assistant (PA) licensing under the Washington Medical Commission effective July 1, 2021 and eliminates the profession of Osteopathic Physician Assistant. The bill instructs the Commission to consult with the Board of Osteopathic Medicine and Surgery when investigating allegations of unprofessional conduct by a licensee under the supervision of an osteopathic physician. The bill also reduces administrative and regulatory burdens on PA practice by moving practice agreements from an agency-level approval process to employment level process. Employers are required to keep agreements on file. The bill requires the Commission to collect and file the agreements. Changes nomenclature from "delegation" to "practice" agreement and from "supervising physician" to "participating physician" agreement.

Proposed Physician Assistant Rules Workshop Meeting
In response to the filing, the Commission will conduct an open public rules workshop on Monday, May 10, 2021, from 1:30 pm to 3:30 pm via GoToWebinar.

Please register for this workshop at:
https://attendee.gotowebinar.com/register/5686337003549137165
After registering, you will receive a confirmation email containing information about joining the webinar.

This meeting will be open to the public.

In response to the COVID-19 public health emergency, and to promote social distancing, the Medical Commission will not provide a physical location for this

meeting. A virtual public meeting, without a physical meeting space, will be held instead.

The purpose of the rules workshop will be to:

- Invite committee members and members of the public to present draft rule language; and
- Discuss next steps

Interested parties and the general public are invited to participate in the rules workshops or provide comments on draft rules. For continued updates on rule development, interested parties are encouraged to join the Commission's rules GovDelivery.

For more information, please contact Amelia Boyd, Program Manager, Washington Medical Commission at (360) 236-2727 or by email at amelia.boyd@wmc.wa.gov.

*CR means Code Reviser

Rules Workshop Agenda

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In response to the COVID-19 public health emergency, and to promote social distancing, the Medical Commission will not provide a physical location for this meeting. A virtual public meeting, without a physical meeting space, will be held instead. The registration link can be found below.

Monday, May 10, 2021 – 1:30 pm to 3:30 pm

Physician Assistants Pre-Proposal Rules

- Housekeeping
- Open workshop
- Discuss draft language
  - WAC 246-918-055 Practice agreements
- Written comments from interested parties
- Other comments
- Next steps
- Close workshop

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

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CR-101

PREPROPOSAL STATEMENT OF INQUIRY

CR-101 (October 2017)
(Implements RCW 34.05.310)
Do **NOT** use for expedited rule making

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: November 19, 2020
TIME: 2:34 PM

WSR 20-24-015

Agency: Department of Health- Washington Medical Commission

Subject of possible rule making: Chapter 246-918 WAC Physician Assistants--Washington Medical Commission (commission). Revising physician assistant (PA) rules pursuant to Substitute House Bill (SHB) 2378 (Chapter 80, Laws of 2020) and updating PA rules to incorporate current, national standards and best practices.

Statutes authorizing the agency to adopt rules on this subject: RCW 18.71A.150, RCW 18.130.050, chapter 18.71A RCW, and SHB 2378.

Reasons why rules on this subject may be needed and what they might accomplish: The commission is considering updating the PA chapter to more closely align with current industry standards, modernize regulations to align with current national industry standards and best practices, and provide clearer rules language for licensed PAs.

Included in this rulemaking proposal is incorporating the requirements of SHB 2378 Concerning physician assistants. The commission is considering adding new sections in accordance with SHB 2378. This bill combines the physician assistant (PA) licensing under the Washington Medical Commission effective July 1, 2021 and eliminates the profession of Osteopathic Physician Assistant. The bill instructs the commission to consult with the Board of Osteopathic Medicine and Surgery (BOMS) when investigating allegations of unprofessional conduct by a licensee under the supervision of an osteopathic physician. The bill also reduces administrative and regulatory burdens on PA practice by moving practice agreements from an agency-level approval process to employment level process. Employers are required to keep agreements on file. The bill requires the commission to collect and file the agreements. Changes nomenclature from "delegation" to "practice" agreement and from "supervising physician" to "participating physician" agreement.

Identify other federal and state agencies that regulate this subject and the process coordinating the rule with these agencies: None

Process for developing new rule (check all that apply):

- ☐ Negotiated rule making
- ☐ Pilot rule making
- ☐ Agency study
- ☒ Other (describe) Collaborative rulemaking

Interested parties can participate in the decision to adopt the new rule and formulation of the proposed rule before publication by contacting:

	(If necessary)
Name: Amelia Boyd, Program Manager	Name:
Address: PO Box 47866, Olympia, WA 98504-7866	Address:
Phone: (360) 236-2727	Phone:
Fax: N/A	Fax:
TTY: 711	TTY:
Email: amelia.boyd@wmc.wa.gov	Email:
Web site: wmc.wa.gov	Web site:
Other:	Other:

Additional comments: To join the interested parties email list, please visit:
https://public.govdelivery.com/accounts/WADOH/subscriber/new?topic_id=WADOH_153

Date: November 19, 2020	**Signature:** Signature on file
Name: Melanie de Leon	
Title: Executive Director	

WASHINGTON Medical Commission
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Draft Language

Chapter 246-918 WAC

PHYSICIAN ASSISTANTS—WASHINGTON MEDICAL COMMISSION

Commented [AB1]: For those changes that take effect July 1, 2022 we will request an expedited rulemaking for both this chapter and the physician's chapter 246-919 WAC to make the necessary updates to the opioid prescribing sections.

Last Update: 3/26/20

WAC 246-918-005 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

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

(2) "Commission approved program" means a physician assistant program accredited by the committee on allied health education and accreditation (CAHEA); the commission on accreditation of allied health education programs (CAAHEP); the accreditation review committee on education for the physician assistant (ARC-PA); or other substantially equivalent organization(s) approved by the commission.

~~(3) "Delegation agreement" means a mutually agreed upon plan, as detailed in WAC 246-918-055, between a sponsoring physician and physician assistant, which describes the manner and extent to which the physician assistant will practice and be supervised.~~

(~~4~~3) "NCCPA" means National Commission on Certification of Physician Assistants.

(~~5~~4) "Osteopathic physician" means an individual licensed under chapter 18.57 RCW.

(~~6~~5) "Physician" means an individual licensed under chapter 18.71 RCW.

(~~7~~6) "Physician assistant" means a person who is licensed under chapter 18.71A RCW by the commission to practice medicine to a limited extent only under the supervision of a physician or osteopathic physician ~~as defined in chapter 18.71 RCW~~.

(a) "Certified physician assistant" means an individual who has successfully completed an accredited and commission approved physician assistant program and has passed the initial national boards examination administered by the National Commission on Certification of Physician Assistants (NCCPA).

(b) "Noncertified physician assistant" means an individual who:

(i) Successfully completed an accredited and commission approved physician assistant program, is eligible for the NCCPA

examination, and was licensed in Washington state prior to July 1, 1999;

(ii) Is qualified based on work experience and education and was licensed prior to July 1, 1989;

(iii) Graduated from an international medical school and was licensed prior to July 1, 1989; or

(iv) Holds an interim permit issued pursuant to RCW 18.71A.020(1).

(c) "Physician assistant-surgical assistant" means an individual who was licensed under chapter 18.71A RCW as a physician assistant between September 30, 1989, and December 31, 1989, to function in a limited extent as authorized in WAC 246-918-250 and 246-918-260.

~~(8) "Remote site" means a setting physically separate from the sponsoring or supervising physician's primary place for meeting patients or a setting where the physician is present less than twenty-five percent of the practice time of the licensee.~~

(7) "Practice agreement" means a mutually agreed upon plan, as detailed in WAC 246-918-055, between a supervising physician

and physician assistant, which describes the manner and extent to which the physician assistant will practice and be supervised.

(8~~9~~) "Supervising physician" means ~~a sponsoring or alternate physician providing clinical oversight for a physician assistant.~~

~~(a) "Sponsoring physician" means~~ any physician ~~licensed under chapter 18.71 RCW~~or osteopathic physician ~~and~~ identified in a ~~delegation~~ practice agreement as providing primary clinical and administrative oversight for a physician assistant.

(b) "Alternate physician" means any physician ~~licensed under chapter 18.71 or 18.57 RCW~~or osteopathic physician who provides clinical oversight of a physician assistant in place of or in addition to the ~~sponsoring~~ supervising physician.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2019 c 55. WSR 20-08-069, § 246-918-005, filed 3/26/20, effective 4/26/20. Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-005, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-085, § 246-918-005, filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-

073, § 246-918-005, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71A.020 and 18.71.060. WSR 93-21-016, § 246-918-005, filed 10/11/93, effective 11/11/93. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-005, filed 6/3/92, effective 7/4/92.]

WAC 246-918-007 Application withdrawals. An applicant for a license or interim permit may not withdraw his or her application if grounds for denial exist.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-007, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-085, § 246-918-007, filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-007, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-007, filed 6/3/92, effective 7/4/92.]

WAC 246-918-035 Prescriptions. (1) A physician assistant may prescribe, order, administer, and dispense legend drugs and Schedule II, III, IV, or V controlled substances consistent with the scope of practice in an approved ~~delegation~~ practice agreement filed with the commission provided:

(a) The physician assistant has an active DEA registration; and

(b) All prescriptions comply with state and federal prescription regulations.

(2) If a supervising physician's prescribing privileges have been limited by state or federal actions, the physician assistant will be similarly limited in his or her prescribing privileges, unless otherwise authorized in writing by the commission.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-035, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-035, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-035, filed 6/3/92, effective 7/4/92. Statutory Authority: RCW 18.71A.020. WSR 91-08-007 (Order 153B), § 246-918-035, filed 3/26/91, effective 4/26/91.]

WAC 246-918-050 Physician assistant qualifications for interim permits. An interim permit is a limited license. The permit allows an individual who has graduated from a commission approved program within the previous twelve months to practice

prior to successfully passing the commission approved licensing examination.

(1) An individual applying to the commission for an interim permit under RCW 18.71A.020(1) must have graduated from an accredited commission approved physician assistant program.

(2) An interim permit is valid for one year from completion of a commission approved physician assistant training program. The interim permit may not be renewed.

(3) An applicant for a physician assistant interim permit must submit to the commission:

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

(b) Applicable fees as specified in WAC 246-918-990; and

(c) Requirements as specified in WAC 246-918-080.

~~(4) An interim permit holder may not work in a remote site.~~

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-050, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-085, § 246-918-050, filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 18.71.017

and 18.71A.020. WSR 96-03-073, § 246-918-050, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-050, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 89-20-023, § 308-52-165, filed 9/27/89, effective 10/28/89.]

WAC 246-918-055 ~~Delegation~~ Practice agreements.

(1) A practice agreement must meet the requirements in RCW 18.71A.xxx. A model practice agreement~~, which conforms to the requirements of RCW 18.71A.--- (section 6, chapter 80, Laws of 2020)~~ is available on the commission's web site.

(2) A physician assistant may have more than one supervising physician if the practice agreement is entered into with a group of physicians and the language of the practice agreement designates the supervising physicians.

(3) It must be noted in the practice agreement that a physician assistant delivering general anesthesia or intrathecal anesthesia has completed an accredited anesthesiologist assistant program and received certification as an anesthesiologist assistant.

~~(1) The physician assistant and sponsoring physician must submit a joint delegation agreement on forms provided by the~~

Commented [AB2]: Suggested language from WANA:
A physician assistant delivering general anesthesia or intrathecal anesthesia pursuant to a practice agreement with a physician shall show evidence of adequate education and training in the delivery of the type of anesthesia being delivered on his or her practice agreement. Adequate education and training will meet, at minimum, the education and training required for anesthesia providers licensed to perform anesthesia in the state, which are certified registered nurse anesthetists and physician anesthesiologists.

~~commission. A physician assistant may not begin practicing without written commission approval of a delegation agreement.~~

~~(2) The delegation agreement must specify:~~

~~(a) The names and Washington state license numbers of the sponsoring physician and alternate physician, if any. In the case of a group practice, the alternate physicians do not need to be individually identified;~~

~~(b) A detailed description of the scope of practice of the physician assistant;~~

~~(c) A description of the supervision process for the practice; and~~

~~(d) The location of the primary practice and all remote sites and the amount of time spent by the physician assistant at each site.~~

~~(3) The sponsoring physician and the physician assistant shall determine which services may be performed and the degree of supervision under which the physician assistant performs the services.~~

~~(4) The physician assistant's scope of practice may not exceed the scope of practice of the supervising physician.~~

~~(5) A physician assistant practicing in a multispecialty group or organization may need more than one delegation agreement depending on the physician assistant's training and the scope of practice of the physician(s) the physician assistant will be working with.~~

~~(6) It is the joint responsibility of the physician assistant and the supervising physician(s) to notify the commission in writing of any significant changes in the scope of practice of the physician assistant. The commission or its designee will evaluate the changes and determine whether a new delegation agreement is required.~~

~~(7) A physician may enter into delegation agreements with up to five physician assistants, but may petition the commission for a waiver of this limit. However, no physician may have under his or her supervision:~~

~~(a) More than three physician assistants who are working in remote sites as provided in WAC 246-918-120; or~~

~~(b) More physician assistants than the physician can adequately supervise.~~

~~(8) Within thirty days of termination of the working relationship, the sponsoring physician or the physician assistant shall submit a letter to the commission indicating the relationship has been terminated.~~

~~(9) Whenever a physician assistant is practicing in a manner inconsistent with the approved delegation agreement, the commission may take disciplinary action under chapter 18.130 RCW.~~

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-055, filed 2/3/15, effective 3/6/15.]

WAC 246-918-075 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 a physician assistant during the time period specified on the permit. The temporary practice permit is a license to practice medicine as a physician assistant provided that the temporary practice permit holder has a ~~delegation~~ practice agreement ~~approved by~~on file with the commission.

(3) The commission issues a license after it receives the national background check report if the report is negative and the applicant otherwise meets the requirements for a license.

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

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-075, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.130.064 and 18.130.075. WSR 10-05-029, § 246-918-075, filed 2/9/10, effective 2/11/10.]

WAC 246-918-076 How to obtain a temporary practice permit—Military spouse. A military spouse or state registered domestic partner of a military person may receive a temporary practice permit while completing any specific additional requirements that are not related to training or practice standards for physician assistants.

(1) A temporary practice permit may be issued to an applicant who is a military spouse or state registered domestic partner of a military person and:

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

(b) Left employment in another state to accompany the military person to Washington;

(c) Holds an unrestricted, active license in another state that has substantially equivalent licensing standards for –a physician assistant to those in Washington; and

(d) Is not subject to any pending investigation, charges, or disciplinary action by the regulatory body of the other state or states.

(2) A temporary practice permit grants the individual the full scope of practice for the physician assistant.

(3) A temporary practice permit expires when any one of the following occurs:

(a) The license is granted;

(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 temporary practice permit; or

(c) One hundred eighty days after the temporary practice permit is issued.

(4) To receive a temporary practice permit, the applicant must:

(a) Submit to the commission the necessary application, fee(s), fingerprint card if required, and documentation for the license;

(b) Attest on the application that the applicant left employment in another state to accompany the military person;

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

(d) Provide verification of having an active unrestricted license in the same profession from another state that has substantially equivalent licensing standards as a physician assistant in Washington;

(e) Submit a copy of the military person's orders and a copy of:

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

(ii) A marriage license; or

(iii) A state registered domestic partnership; and

(f) Submit a written request for a temporary practice permit.

(5) For the purposes of this section:

(a) "Military spouse" means the husband, wife, or registered domestic partner of a military person.

(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. [Statutory Authority: RCW 18.71A.020 and 18.340.020. WSR 17-18-097, § 246-918-076, filed 9/6/17, effective 10/7/17.]

WAC 246-918-080 Physician assistant—Requirements for licensure. (1) Except for a physician assistant licensed prior to July 1, 1999, individuals applying to the commission for licensure as a physician assistant must have graduated from an accredited commission approved physician assistant program and successfully passed the NCCPA examination.

(2) An applicant for licensure as a physician assistant must submit to the commission:

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

(b) Proof the applicant has completed an accredited commission approved physician assistant program and successfully passed the NCCPA examination;

(c) All applicable fees as specified in WAC 246-918-990;

~~(d) Proof of completion of four clock hours of AIDS education as required in chapter 246-12 WAC, Part 8;~~ and

(d~~e~~) Other information required by the commission.

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

(4) A physician assistant may not begin practicing without ~~written commission approval of a delegation~~ filing a practice agreement with the commission.

(5) A physician assistant licensed under 18.57A RCW prior to July 1, 2021 renewing their license on or after July 1, 2021, must do so with the commission if they choose to renew their physician assistant license in this state. Individuals licensed under chapter 18.57A RCW and renewing their license after July 1, 2021 will follow the renewal schedule set forth in WAC 246-918-071. The commission shall issue a physician assistant license to the individuals described in this subsection without requiring full application or reapplication, but may require additional information from the renewing physician assistant.

Commented [AB3]: Deleted under WSR #21-07-055 filed 3/12/2021.

Commented [AB4]: This may not be needed as these rules are for Washington.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-080, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017, 18.71.050 and chapter 18.71 RCW. WSR 01-18-085, § 246-918-080, filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-918-080, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-080, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 91-06-030 (Order 147B), recodified as § 246-918-080, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 89-06-077 (Order PM 822), § 308-52-139, filed 3/1/89. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 88-21-047 (Order PM 782), § 308-52-139, filed 10/13/88. Statutory Authority: RCW 18.71A.020. WSR 88-06-008 (Order PM 706), § 308-52-139, filed 2/23/88; WSR 86-12-031 (Order PM 599), § 308-52-139, filed 5/29/86; WSR 82-24-013 (Order PL 412), § 308-52-139, filed 11/19/82; WSR 81-03-078 (Order PL 368), § 308-52-139, filed 1/21/81; WSR 80-15-031 (Order PL-353), § 308-52-139, filed 10/8/80; WSR 78-04-029 (Order PL 285, Resolution No. 78-140), § 308-52-139, filed 3/14/78.]

WAC 246-918-081 How to return to active status when a license has expired. (1) To return to active status the physician assistant must meet the requirements of chapter 246-12 WAC, Part 2, which includes paying the applicable fees under WAC

246-918-990 and meeting the continuing medical education requirements under WAC 246-918-180.

(2) If the license has expired for over three years, the physician assistant must meet requirements in subsection (1) of this section and the current licensure requirements under WAC 246-918-080.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-081, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-918-081, filed 2/13/98, effective 3/16/98.]

~~**WAC 246-918-082 Requirements for obtaining an allopathic physician assistant license for those who hold an active osteopathic physician assistant license.** A person who holds a full, active, unrestricted osteopathic physician assistant license that is in good standing issued by the Washington state board of osteopathic medicine and surgery and meets current licensing requirements may apply for licensure as an allopathic physician assistant through an abbreviated application process.~~

~~(1) An applicant for an allopathic physician assistant license must:~~

~~(a) Hold an active, unrestricted license as an osteopathic physician assistant issued by the Washington state board of osteopathic medicine and surgery;~~

~~(b) Submit a completed application on forms provided by the commission; and~~

~~(c) Submit any fees required under WAC 246-918-990.~~

~~(2) An allopathic physician assistant may not begin practice without written commission approval of the delegation agreement.~~

~~[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-082, filed 2/3/15, effective 3/6/15.]~~

Commented [AB5]: Repeal effective July 1, 2021.

~~WAC 246-918-095 Scope of practice Osteopathic alternate physician.~~ ~~The physician assistant shall practice under the delegation agreement and prescriptive authority approved by the commission whether the alternate supervising physician is licensed as an osteopathic physician under chapter 18.57 RCW or an allopathic physician under chapter 18.71 RCW.~~

Commented [AB6]: Repeal effective July 1, 2021.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-095, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-095, filed 1/17/96,

effective 2/17/96. Statutory Authority: RCW 18.71A.020, 18.71A.040 and 18.130.186(2). WSR 94-15-065, § 246-918-095, filed 7/19/94, effective 8/19/94.]

WAC 246-918-105 Practice limitations due to disciplinary action. (1) To the extent a supervising physician's prescribing privileges have been limited by any state or federal authority, either involuntarily or by the physician's agreement to such limitation, the physician assistant will be similarly limited in his or her prescribing privileges, unless otherwise authorized in writing by the commission.

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

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-105, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71A.020, 18.71A.040 and 18.130.186(2). WSR 94-15-065, § 246-918-105, filed 7/19/94, effective 8/19/94.]

WAC 246-918-120 Remote site. (1) A physician assistant may not work in a remote site without approval of the commission or its designee. A physician may not supervise more than three physician assistants who are working in remote sites, or more physician assistants than the physician can adequately supervise.

(2) The commission or its designee may grant the use of a physician assistant in a remote site if:

(a) There is a demonstrated need for such use;

(b) Adequate provision for timely communication exists between the supervising physician and the physician assistant;

(c) The supervising physician spends at least ten percent of the practice time of the physician assistant in the remote site. In the case of part time or unique practice settings, the physician may petition the commission to modify the on-site requirement providing the supervising physician demonstrates that adequate supervision is being maintained by an alternate method including, but not limited to, telecommunication. The commission will consider each request on an individual basis.

~~(3) The names of the supervising physician and the physician assistant must be prominently displayed at the entrance to the clinic or in the reception area of the remote site.~~

~~(4) A physician assistant holding an interim permit may not work in a remote site.~~

~~[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-120, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71A.020 and chapter 18.71A RCW. WSR 04-11-100, § 246-918-120, filed 5/19/04, effective 6/30/04. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-120, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-120, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-120, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 88-06-008 (Order PM 706), § 308-52-147, filed 2/23/88.]~~

Commented [AB7]: Repeal effective July 1, 2021.

WAC 246-918-125 Use of laser, light, radiofrequency, and plasma devices as applied to the skin. (1) For the purposes of this rule, laser, light, radiofrequency, and plasma devices (hereafter LLRP devices) are medical devices that:

(a) Use a laser, noncoherent light, intense pulsed light, radiofrequency, or plasma to topically penetrate skin and alter human tissue; and

(b) Are classified by the federal Food and Drug Administration as prescription devices.

(2) Because an LLRP device penetrates and alters human tissue, the use of an LLRP device is the practice of medicine under RCW 18.71.011. The use of an LLRP device can result in complications such as visual impairment, blindness, inflammation, burns, scarring, hypopigmentation and hyperpigmentation.

(3) Use of medical devices using any form of energy to penetrate or alter human tissue for a purpose other than the purpose set forth in subsection (1) of this section constitutes surgery and is outside the scope of this section.

PHYSICIAN ASSISTANT RESPONSIBILITIES

(4) A physician assistant must be appropriately trained in the physics, safety and techniques of using LLRP devices prior

to using such a device, and must remain competent for as long as the device is used.

(5) A physician assistant may use an LLRP device so long as it is with the consent of the ~~sponsoring or~~ supervising physician, it is in compliance with the practice ~~arrangement plan approved by~~agreement on file with the commission, and it is in accordance with standard medical practice.

(6) Prior to authorizing treatment with an LLRP device, a physician assistant must take a history, perform an appropriate physical examination, make an appropriate diagnosis, recommend appropriate treatment, obtain the patient's informed consent (including informing the patient that a nonphysician may operate the device), provide instructions for emergency and follow-up care, and prepare an appropriate medical record.

PHYSICIAN ASSISTANT DELEGATION OF LLRP TREATMENT

(7) A physician assistant who meets the above requirements may delegate an LLRP device procedure to a properly trained and licensed professional, whose licensure and scope of practice

allow the use of an LLRP device provided all the following conditions are met:

(a) The treatment in no way involves surgery as that term is understood in the practice of medicine;

(b) Such delegated use falls within the supervised professional's lawful scope of practice;

(c) The LLRP device is not used on the globe of the eye; and

(d) The supervised professional has appropriate training in, at a minimum, application techniques of each LLRP device, cutaneous medicine, indications and contraindications for such procedures, preprocedural and postprocedural care, potential complications and infectious disease control involved with each treatment.

(e) The delegating physician assistant has written office protocol for the supervised professional to follow in using the LLRP device. A written office protocol must include at a minimum the following:

(i) The identity of the individual physician assistant authorized to use the device and responsible for the delegation of the procedure;

(ii) A statement of the activities, decision criteria, and plan the supervised professional must follow when performing procedures delegated pursuant to this rule;

(iii) Selection criteria to screen patients for the appropriateness of treatments;

(iv) Identification of devices and settings to be used for patients who meet selection criteria;

(v) Methods by which the specified device is to be operated and maintained;

(vi) A description of appropriate care and follow-up for common complications, serious injury, or emergencies; and

(vii) A statement of the activities, decision criteria, and plan the supervised professional shall follow when performing delegated procedures, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician assistant concerning specific decisions

made. Documentation shall be recorded after each procedure, and may be performed on the patient's record or medical chart.

(f) The physician assistant is responsible for ensuring that the supervised professional uses the LLRP device only in accordance with the written office protocol, and does not exercise independent medical judgment when using the device.

(g) The physician assistant shall be on the immediate premises during any use of an LLRP device and be able to treat complications, provide consultation, or resolve problems, if indicated.

[Statutory Authority: RCW 18.71.017, 18.71A.020 and 18.130.050(12). WSR 07-03-177, § 246-918-125, filed 1/24/07, effective 3/1/07.]

WAC 246-918-126 Nonsurgical medical cosmetic procedures. (1) The purpose of this rule is to establish the duties and responsibilities of a physician assistant who injects medication or substances for cosmetic purposes or uses prescription devices for cosmetic purposes. These procedures can result in complications such as visual impairment, blindness, inflammation, burns, scarring, disfiguration, hypopigmentation

and hyperpigmentation. The performance of these procedures is the practice of medicine under RCW 18.71.011.

(2) This section does not apply to:

(a) Surgery;

(b) The use of prescription lasers, noncoherent light, intense pulsed light, radiofrequency, or plasma as applied to the skin; this is covered in WAC 246-919-605 and 246-918-125;

(c) The practice of a profession by a licensed health care professional under methods or means within the scope of practice permitted by such license;

(d) The use of nonprescription devices; and

(e) Intravenous therapy.

(3) Definitions. These definitions apply throughout this section unless the context clearly requires otherwise.

(a) "Nonsurgical medical cosmetic procedure" means a procedure or treatment that involves the injection of a medication or substance for cosmetic purposes, or the use of a prescription device for cosmetic purposes. Laser, light, radiofrequency and plasma devices that are used to topically penetrate the skin are devices used for cosmetic purposes, but

are excluded under subsection (2)(b) of this section, and are covered by WAC 246-919-605 and 246-918-125.

~~(b) "Physician" means an individual licensed under chapter 18.71 RCW.~~

~~(c) "Physician assistant" means an individual licensed under chapter 18.71A RCW.~~

Commented [AB8]: These are defined elsewhere. They can be deleted from this section.

(d) "Prescription device" means a device that the federal Food and Drug Administration has designated as a prescription device, and can be sold only to persons with prescriptive authority in the state in which they reside.

PHYSICIAN ASSISTANT RESPONSIBILITIES

(4) A physician assistant may perform a nonsurgical medical cosmetic procedure only after the commission approves a practice plan permitting the physician assistant to perform such procedures. A physician assistant must ensure that the supervising ~~or sponsoring~~ physician is in full compliance with WAC 246-919-606.

(5) A physician assistant may not perform a nonsurgical cosmetic procedure unless his or her supervising ~~or sponsoring~~

physician is fully and appropriately trained to perform that same procedure.

(6) Prior to performing a nonsurgical medical cosmetic procedure, a physician assistant must have appropriate training in, at a minimum:

(a) Techniques for each procedure;

(b) Cutaneous medicine;

(c) Indications and contraindications for each procedure;

(d) Preprocedural and postprocedural care;

(e) Recognition and acute management of potential complications that may result from the procedure; and

(f) Infectious disease control involved with each treatment.

(7) The physician assistant must keep a record of his or her training in the office and available for review upon request by a patient or a representative of the commission.

(8) Prior to performing a nonsurgical medical cosmetic procedure, either the physician assistant or the delegating physician must:

(a) Take a history;

(b) Perform an appropriate physical examination;

(c) Make an appropriate diagnosis;

(d) Recommend appropriate treatment;

(e) Obtain the patient's informed consent including disclosing the credentials of the person who will perform the procedure;

(f) Provide instructions for emergency and follow-up care; and

(g) Prepare an appropriate medical record.

(9) The physician assistant must ensure that there is a written office protocol for performing the nonsurgical medical cosmetic procedure. A written office protocol must include, at a minimum, the following:

(a) A statement of the activities, decision criteria, and plan the physician assistant must follow when performing procedures under this rule;

(b) Selection criteria to screen patients for the appropriateness of treatment;

(c) A description of appropriate care and follow-up for common complications, serious injury, or emergencies; and

(d) A statement of the activities, decision criteria, and plan the physician assistant must follow if performing a procedure delegated by a physician pursuant to WAC 246-919-606, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made.

(10) A physician assistant may not delegate the performance of a nonsurgical medical cosmetic procedure to another individual.

(11) A physician assistant may perform a nonsurgical medical cosmetic procedure that uses a medication or substance that the federal Food and Drug Administration has not approved, or that the federal Food and Drug Administration has not approved for the particular purpose for which it is used, so long as the physician assistant's sponsoring or supervising physician is on-site during the entire procedure.

(12) ~~A physician assistant may perform a nonsurgical medical cosmetic procedure at a remote site. A physician assistant must comply with the established regulations governing physician assistants working in remote sites, including~~

~~obtaining commission approval to work in a remote site under WAC 246-918-120.~~

~~(13)~~ A physician assistant must ensure that each treatment is documented in the patient's medical record.

(14~~4~~3) A physician assistant may not sell or give a prescription device to an individual who does not possess prescriptive authority in the state in which the individual resides or practices.

(14~~5~~) A physician assistant must ensure that all equipment used for procedures covered by this section is inspected, calibrated, and certified as safe according to the manufacturer's specifications.

(15~~6~~) A physician assistant must participate in a quality assurance program required of the supervising or sponsoring physician under WAC 246-919-606.

[Statutory Authority: RCW 18.71.017, 18.71A.020 and 18.130.050(4). WSR 10-11-001, § 246-918-126, filed 5/5/10, effective 6/5/10.]

WAC 246-918-130 Physician assistant identification. (1) A physician assistant must clearly identify himself or herself as

a physician assistant and must appropriately display on his or her person identification as a physician assistant.

(2) A physician assistant must not present himself or herself in any manner which would tend to mislead the public as to his or her title.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-130, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-130, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-130, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-130, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 88-06-008 (Order PM 706), § 308-52-148, filed 2/23/88.]

WAC 246-918-171 Renewal and continuing medical education cycle. (1) Under WAC 246-12-020, an initial credential issued within ninety days of the physician assistant's birthday does not expire until the physician assistant's next birthday.

(2) A physician assistant must renew his or her license every two years on his or her birthday. Renewal fees are

accepted no sooner than ninety days prior to the expiration date.

(3) Each physician assistant will have two years to meet the continuing medical education requirements in WAC 246-918-180. The review period begins on the first birthday after receiving the initial license.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-171, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017, 18.130.050(1), 18.130.040(4), 18.130.050(12) and 18.130.340. WSR 99-23-090, § 246-918-171, filed 11/16/99, effective 1/1/00.]

WAC 246-918-175 Retired active license. (1) To obtain a retired active license a physician assistant must comply with chapter 246-12 WAC, Part 5, excluding WAC 246-12-120 (2)(c) and (d).

(2) A physician assistant with a retired active license must have a ~~delegation~~ practice agreement ~~approved by~~on file with the commission 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) A physician assistant with a retired active license may not receive compensation for health care services.

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

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

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-175, filed 2/3/15, effective 3/6/15.]

WAC 246-918-180 Continuing medical education requirements. (1) A physician assistant must complete one hundred hours of continuing education every two years as required in chapter 246-

12 WAC, Part 7, which may be audited for compliance at the discretion of the commission.

(2) In lieu of one hundred hours of continuing medical education the commission will accept:

(a) Current certification with the NCCPA; or

(b) Compliance with a continuing maintenance of competency program through the American Academy of Physician Assistants (AAPA) or the NCCPA; or

(c) Other programs approved by the commission.

(3) The commission approves the following categories of creditable continuing medical education. A minimum of forty credit hours must be earned in Category I.

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

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

(5) A physician 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 physician assistant's integrity to comply with these requirements.

(6) 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 physician assistant that constitutes a meritorious learning experience.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-180, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-918-180, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-180, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-180, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-180, filed 2/26/91, effective 3/29/91. Statutory

Authority: RCW 18.71A.020. WSR 82-03-022 (Order PL 390), § 308-52-201, filed 1/14/82; WSR 81-03-078 (Order PL 368), § 308-52-201, filed 1/21/81.]

WAC 246-918-185 Training in suicide assessment, treatment, and management. (1) A licensed physician 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 January 1, 2016, or during the first full continuing education period after initial licensure, whichever occurs later, or during the first full continuing education reporting period after the exemption in subsection (6) of this section no longer applies. The commission accepts training completed between June 12, 2014, and January 1, 2016, that meets the requirements of RCW 43.70.442 as meeting the one-time training requirement.

(3) Until July 1, 2017, the commission must approve the training. The commission will approve an empirically supported training in suicide assessment, suicide treatment, and suicide management that meets the requirements of RCW 43.70.442.

(4) Beginning July 1, 2017, the training must be on the model list developed by the department of health under RCW 43.70.442. The establishment of the model list does not affect the validity of training completed prior to July 1, 2017.

(5) 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 246-918-180.

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

[Statutory Authority: RCW 18.71.017 and 43.70.442. WSR 17-07-044, § 246-918-185, filed 3/8/17, effective 4/8/17.]

WAC 246-918-250 Basic physician assistant-surgical assistant (PASA) duties. The physician assistant-surgical assistant (PASA) who is not eligible to take the NCCPA certifying exam shall:

(1) Function only in the operating room as approved by the commission;

(2) Only be allowed to close skin and subcutaneous tissue, placing suture ligatures, clamping, tying and clipping of blood vessels, and cauterizing for hemostasis under direct supervision;

(3) Only be allowed to assist the operating surgeon. The PASA may not perform any independent surgical procedures, even under direct supervision;

(4) Have no prescriptive authority; and

(5) Only write operative notes. The PASA may not write any progress notes or order(s) on hospitalized patients.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-250, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-250, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.71A.020 and 18.71.060. WSR 93-21-016, § 246-918-250, filed 10/11/93, effective 11/11/93. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-250, filed 6/3/92, effective 7/4/92; WSR 91-06-030 (Order 147B), recodified as § 246-918-250, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 89-13-002 (Order PM 850), § 308-52-650, filed 6/8/89, effective 9/30/89.]

WAC 246-918-260 Physician assistant-surgical assistant (PASA)—Use and supervision. The following section applies to the physician assistant-surgical assistant (PASA) who is not eligible to take the NCCPA certification exam.

(1) Responsibility of PASA. The PASA is responsible for performing only those tasks authorized by the supervising physician(s) and within the scope of PASA practice described in WAC 246-918-250. The PASA is responsible for ensuring his or her compliance with the rules regulating PASA practice and failure to comply may constitute grounds for disciplinary action.

(2) Limitations, geographic. No PASA may be used in a place geographically separated from the institution in which the PASA and the supervising physician are authorized to practice.

(3) Responsibility of supervising physician(s). Each PASA shall perform those tasks he or she is authorized to perform only under the supervision and control of the supervising physician(s). Such supervision and control may not be construed to necessarily require the personal presence of the supervising physician at the place where the services are rendered. It is

the responsibility of the supervising physician(s) to ensure that:

(a) The operating surgeon in each case directly supervises and reviews the work of the PASA. Such supervision and review shall include remaining in the surgical suite until the surgical procedure is complete;

(b) The PASA shall wear identification as a "physician assistant-surgical assistant" or "PASA." In all written documents and other communication modalities pertaining to his or her professional activities as a PASA, the PASA shall clearly denominate his or her profession as a "physician assistant-surgical assistant" or "PASA";

(c) The PASA is not presented in any manner which would tend to mislead the public as to his or her title.

[Statutory Authority: RCW 18.71.017, 18.130.050, chapter 18.71A RCW, and 2013 c 203. WSR 15-04-122, § 246-918-260, filed 2/3/15, effective 3/6/15. Statutory Authority: RCW 18.71.017 and 18.71A.020. WSR 96-03-073, § 246-918-260, filed 1/17/96, effective 2/17/96. Statutory Authority: RCW 18.130.250. WSR 93-11-008 (Order 360B), § 246-918-260, filed 5/5/93, effective 6/5/93. Statutory Authority: RCW 18.71.017. WSR 92-12-089 (Order 278B), § 246-918-260, filed 6/3/92, effective 7/4/92; WSR 91-06-

030 (Order 147B), recodified as § 246-918-260, filed 2/26/91, effective 3/29/91. Statutory Authority: RCW 18.71A.020. WSR 89-13-002 (Order PM 850), § 308-52-660, filed 6/8/89, effective 9/30/89.]

WAC 246-918-410 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 physician 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 physician assistant and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.

(b) "Physician assistant" means a person licensed to practice as a physician assistant under chapter 18.71A RCW.

(c) "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) A physician assistant shall not engage in sexual misconduct with a current patient or a key third party. A physician assistant engages in sexual misconduct when he or she engages in the following behaviors with a patient or 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 physician assistant or masturbation by the physician 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 physician assistant.

(3) A physician 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 physician 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 physician 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 physician 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.

[Statutory Authority: RCW 18.71.017, 18.130.062, and Executive Order 06-03. WSR 16-06-009, § 246-918-410, filed 2/18/16, effective 3/20/16. Statutory Authority: RCW 18.130.180,

18.71.017, and 18.71A.020. WSR 06-03-028, § 246-918-410, filed 1/9/06, effective 2/9/06.]

WAC 246-918-420 Abuse. (1) A physician assistant commits unprofessional conduct if the physician assistant abuses a patient. A physician assistant abuses a patient when he or she:

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

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

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

(d) Engages 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.
[Statutory Authority: RCW 18.130.180, 18.71.017, and 18.71A.020. WSR 06-03-028, § 246-918-420, filed 1/9/06, effective 2/9/06.]

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Comments

From: Daniela Alexianu
To: Karen B Domino; Farrell, Michael (WMC); Boyd, Amelia (WMC)
Subject: PAs administering general anesthesia
Date: Thursday, April 8, 2021 1:25:07 PM

External Email

It came to our WSSA Board attention that yesterday, the Washington Medical Commission discussed the rules to implement the Physician Assistant legIslation from 2020 which allows PAs to administer general and intrathecal anesthesia.
We appreciate very much Dr. Karen Domino's testimony explaining why is so important for the rules to delineate clearly what type of education and training is required for Physician Anesthesiologists, Certified Registered Nurse Anesthetists and Anesthesiologist Assistants in order to provide the safest care to our patients.
As one of WSSA Board members and ASA Director for WA State, I urge you to consider all the following points in your decision making in this very important matter to our Physician Anesthesiologists practicing in WA State:

- The enabling legislation says PAs administering general and intrathecal anesthesia "shall show evidence of adequate education and training in the delivery of the type of anesthesia being delivered on his or her practice agreement," but does not define it. **Without defining adequate education and training in the rules, the Commission is leaving this up to the judgment of individual providers to determine what they think is adequate, and it may be subject to various interpretations.**
- ASA is not aware of any state that explicitly authorizes PAs to administer general anesthesia. The CMS Interpretive Guidelines for hospitals specifically exclude PAs from general and deep sedation in the Conditions of Participation (see below).
- Anesthesiologist Assistants are specifically trained to work with Physician Anesthesiologists and are licensed in multiple states. They are recognized by CMS. They are directly supervised by the Physician.
- The rules governing the practice of administering anesthesia should not be vague or undefined.
- It is a matter of public safety to ensure that individuals delivering anesthesia are adequately educated and trained.
-
-
- Respectfully,
- Daniela Alexianu, MD, FASA, ASA Director WA State

From: Condon, Erik
To: Karen B Domino; Farrell, Michael (WMC); Boyd, Amelia (WMC)
Subject: RE: [EXTERNAL] RE: Legislation Enabling PA"s to Deliver General and Intrathecal Anesthesia
Date: Thursday, April 8, 2021 12:29:23 PM

External Email

Karen –

Thank you very much for that clarification. The wording from the WSSA board was a little vague on that point. I would absolutely agree that the appropriate course of action would be to require AA training for any PA that would like to deliver general or intrathecal anesthesia. This seems to be the tidiest solution.

Thank you for your work in this regard,

Erik

From: Karen B Domino <kdomino@uw.edu>
Sent: Thursday, April 8, 2021 12:23 PM
To: Condon, Erik [redacted]; michael.farrell@wmc.wa.gov; amelia.boyd@wmc.wa.gov
Subject: [EXTERNAL] RE: Legislation Enabling PA's to Deliver General and Intrathecal Anesthesia

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Dear Dr. Condon-thanks for your email message.

Please note that the PA legislation was already passed. The Washington Medical Commission has only been asked to define the educational requirements for PAs to administer GA/neuraxial anesthesia, which could be defined as requiring "anesthesiologist assistant training in an accredited AA program and certification as an anesthesiologist assistant" in the rule making process. This specific specification could avoid the important patient safety concerns you describe below. I hope that you continue to engage in this discussion with the WMC as the wording of the appropriate training is put together. Thanks so much for your helpful feedback! Karen

From: Condon, Erik <Erik.Condon@providence.org>
Sent: Thursday, April 8, 2021 11:13 AM
To: Karen B Domino <kdomino@uw.edu>; michael.farrell@wmc.wa.gov; amelia.boyd@wmc.wa.gov
Subject: Legislation Enabling PA's to Deliver General and Intrathecal Anesthesia

Dr. Domino:

It has come to my attention that there is legislation being considered that would explicitly authorize physician assistants to deliver general and intrathecal anesthesia in the state of Washington. I would strongly urge the Washington Medical Commission to advise the legislature to vote against this proposal.

This explicit authorization would be unprecedented in all 50 states. There is no formal pathway (other than through CMS recognized Anesthesiology Assistant (AA) educational programs) for PAs to be adequately trained to deliver anesthesia. The result would be inevitable harm to patients as ill-trained PAs feel empowered to delve into a realm of medicine for which they have no opportunity for adequate education. What takes physicians a minimum of 4 years after medical school cannot be easily learned in a weekend course or on-the-job training. If more anesthesia resources are needed other than the available pool of CRNAs and physician anesthesiologists, then the answer is to allow AAs to practice anesthesia in the state of Washington.

Please consider strongly opposing this legislation.

Respectfully,

Erik J Condon, MD
Division Lead Physician
Providence Anesthesia Services
Spokane Hospitals

[redacted]

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From: Jeffrey McLaren
To: Boyd, Amelia (WMC)
Subject: Concerns about possible changes to PA scope of practice
Date: Thursday, April 8, 2021 9:51:25 AM

External Email

Hi Amelia,

My name is Jeff McLaren and I am an anesthesiologist in Seattle and board member of the Washington State Society of Anesthesiologists. It has recently come to my attention that current legislation being considered has not clearly defined the training required for PA's to administer anesthesia, specifically general and intrathecal anesthesia:

- The enabling legislation says PAs administering general and intrathecal anesthesia "shall show evidence of adequate education and training in the delivery of the type of anesthesia being delivered on his or her practice agreement," but does not define it. **Without defining adequate education and training in the rules, the Commission is leaving this up to the judgment of individual providers or organizations to determine what they think is adequate, and it may be subject to various interpretations and also rely on supervising physicians that also may not have appropriate training.**

Currently our national society, the ASA, is not aware of any state that explicitly authorizes PAs to administer general anesthesia. The CMS Interpretive Guidelines for hospitals specifically exclude PAs from general and deep sedation in the Conditions of Participation (below):.
General anesthesia, regional anesthesia and monitored anesthesia, including deep sedation/analgesia, may only be administered by:
• A qualified anesthesiologist;
• An MD or DO (other than an anesthesiologist);
• A dentist, oral surgeon or podiatrist who is qualified to administer anesthesia under State law;
• A CRNA who is supervised by the operating practitioner or by an anesthesiologist who is immediately available if needed; or
• An anesthesiologist's assistant under the supervision of an anesthesiologist who is immediately available if needed.

There are specific training programs for PA's looking to provide anesthesia care (also known as Anesthesiologist Assistants or AA's) which are accredited and work with direct physician oversight. Anesthesiologist Assistants are specifically trained to work with Physician Anesthesiologists and are licensed in multiple states. They are recognized by CMS. They are directly supervised by the Physician. The rules governing the practice of administering anesthesia should not be vague or undefined as this is a matter of public safety to ensure individuals delivering anesthesia are adequately educated and trained.
While it is certainly challenging to gain consensus on these minute details, they are essential to keep Washingtonians safe. Preventable harm is something we as anesthesiologists work hard every day eliminating from the perioperative care patients receive and it is important to me

that our members in congress help us in that effort.

Sincerely,
Jeff McLaren MD
WSSA Board Member
Seattle, WA

From: katie podorean
To: [redacted]; Farrell, Michael (WMC); Boyd, Amelia (WMC)
Subject: PAs and anesthesia
Date: Friday, April 9, 2021 8:35:07 AM

External Email

Dear Dr. Karen Domino, Mike Farrell and Amelia Boyd,

I am very concerned about recent legislation that would allow physician assistants to administer general and intrathecal anesthesia. For the sake of patient safety this legislation should be very clear and define that PAs shall show evidence of adequate education and training in the delivery of anesthesia. Without defining adequate education and training in the rules, the Commission is leaving this up to the judgment of individual providers to determine what they think is adequate, and it may be subject to various interpretations. ASA is not aware of any state that explicitly authorizes PAs to administer general anesthesia. The CMS Interpretive Guidelines for hospitals specifically exclude PAs from general and deep sedation in the Conditions of Participation. Anesthesiologist Assistants are specifically trained to work with Physician Anesthesiologists and are licensed in multiple states. They are recognized by CMS. They are directly supervised by the Physician. The rules governing the practice of administering anesthesia should not be vague or undefined. Delivering anesthesia is life threatening if not done with the adequate training and supervision. Thank you for your time.

Sincerely,
Dr. Katherine Podorean

From: Hsiung, Robert
To: Karen B. Domino [redacted]; Farrell, Michael (WMC); Boyd, Amelia (WMC)
Subject: Rules on PAs administering anesthesia
Date: Thursday, April 8, 2021 8:08:20 AM

External Email

Dr. Domino, Mr. Farrell, and Mrs. Boyd,

My name is Robert Hsiung and I have served as the immediate past president of the Washington State Society of Anesthesiologists and am very involved at the national American Society of Anesthesiologists (ASA). It has just come to my attention that the rules of physician assistants (PAs) in administrating anesthesia has surfaced, and while you will hear from the ASA, I hope to serve as a resource in person, over phone, and any other discussion in your deliberations.

First, there are no physician assistants practicing anesthesia independently or under supervision anywhere. When the WSSA first heard that this was happening infrequently, eyebrows were raised because we have an entire anesthesia community made up of physician anesthesiologists, certified nurse anesthetists (CRNAs), and anesthesia assistants (AAs). Most states also allow oral surgeons, dentists (now there is dental anesthesia), and podiatrists to also administer limited aspects of anesthesia, with some carve out to allow doctors (MDs or Dos) other than anesthesiologists for emergency purposes e.g. strong sedatives to place back a dislocated shoulder. For other non-anesthesiologist physicians I believe the intent was mostly for those purposes and rarely do you see one specialty crossing over to the other – I for one will never do LASIK on anyone's eyes, and cardiologists generally do not give propofol unless they wish to risk another Michael Jackson incident, and they would never be providing general anesthesia for an eye operation. The understanding of risk, oversight, and education and training are not comparable.

The WSSA has been in the process of incorporating AAs to the state, and while PAs and AAs may look similar on paper, AAs are trained specifically for anesthesia, and work under the supervision of anesthesiologists. If PAs wishes to administer anesthesia, there is the AA route, the CRNA route, or back to medical school for a residency in anesthesiology. Furthermore, CMS recognizes AAs for billing reimbursement but not for PAs, and thus there are no financial incentive for PAs to practice anesthesia. I was trying to think of some emergent scenario where this could happen – on a very long flight over the pacific where someone broke their leg and require casting and sedation is needed, which then realized that the plane has none of those equipment anyway. Furthermore, in a truly emergent situation there are always exceptional circumstances but where this discussion is heading could lead to an interpretation for the routine administration of anesthesia. Another possibility would be that, perhaps being rural or inaccessible, the hospital or center just can't (or won't) hire an anesthesiologist or CRNAs. I would counter that there are traveling anesthesiologists and CRNAs covering that need, and doctors providing sedation in emergent circumstances. Never should a PA be performing general anesthesia for surgery or place an epidural or spinal anesthetic for pregnant laboring women. If those situations are happening, I hope those centers shoulder the liability; the lawyers will be salivating, and the press will have a field day.

Most states have pretty strict definition of who delivers anesthesia and your do words matter. Thank you for your time and consideration.

Sincerely,

Robert Hsiung
Staff Anesthesiologist/Intensivist
Virginia Mason Medical Center
[redacted]

From: Terri W. Blackburn
To: [redacted]; Farrell, Michael (WMC); Boyd, Amelia (WMC)
Subject: PA scope of practice
Date: Friday, April 9, 2021 9:24:22 AM

External Email

To Members of the Washington Medical Commission:

I have concerns regarding submitted legislation regarding PA scope of practice to include general anesthesia, and intrathecal anesthesia. The proposed legislation does not define adequate education and training in the rules, leaving this up to the judgement of individual providers and subject to various interpretations.

The CMS Interpretative Guidelines for hospitals specifically exclude PAs from general and deep sedation in the Conditions of Participation. The ASA is not aware of any states that explicitly authorize PAs to administer general anesthesia. However, Anesthesia Assistants (AA) are specifically trained to work with physician anesthesiologists and are licensed in multiple states. AA's are recognized by CMS and are directly supervised by physicians specifically trained in anesthesiology.

It is a matter of public safety the ensure that individuals delivering anesthesia are adequately educated and trained in Anesthesiology. The rules governing the practice of who may administer anesthesia should not be vague or undefined.

Thank you in advance for your careful consideration of this matter.

Terri W Blackburn, MD
WSSA District 2 Assistant Director
Providence Washington Anesthesia Services

From: Tim
To: Boyd, Amelia (WMC); [redacted]; Farrell, Michael (WMC)
Subject: Rules for PAs to administer anesthesia
Date: Thursday, April 8, 2021 12:26:01 PM

External Email

Hi Dr. Domino, Ms. Boyd, and Mr. Farrell,

I am a physician anesthesiologist is Wenatchee, Washington and am concerned about the rule making regarding PA licensure. As you have heard from several of my colleagues, we must define adequate education for a PA to perform anesthetics.

The enabling legislation says PAs administering general and intrathecal anesthesia "shall show evidence of adequate education and training in the delivery of the type of anesthesia being delivered on his or her practice agreement," but does not define it. **Without defining adequate education and training in the rules, the Commission is leaving this up to the judgment of individual providers to determine what they think is adequate, and it may be subject to various interpretations.**

ASA is not aware of any state that explicitly authorizes PAs to administer general anesthesia. The CMS Interpretive Guidelines for hospitals specifically exclude PAs from general and deep sedation in the Conditions of Participation (see below).

Anesthesiologist Assistants are specifically trained to work with Physician Anesthesiologists and are licensed in multiple states. They are recognized by CMS. They are directly supervised by the Physician.

The rules governing the practice of administering anesthesia should not be vague or undefined.

It is a matter of public safety to ensure individuals delivering anesthesia are adequately educated and trained.

Thank you for your work in this issue and for considering the safety of our patients.

Sincerely,
Tim Clement M.D.

From: James Stangl, M.D.
To: [redacted]; Farrell, Michael (WMC); Boyd, Amelia (WMC)
Subject: Rule making on PA practice related to administration of Anesthesia
Date: Thursday, April 8, 2021 5:58:37 PM

External Email

Dear Dr. Domino, Mr. Farrell, and Ms. Boyd,

As a practicing anesthesiologist, and past president of the Washington State Society of Anesthesiologists, I would like to add my comments on the rule making process related to the 2020 legislation expanding PA practice. By way of full disclosure, I am in full-time practice at Tacoma General, Mary Bridge Children's, and Allenmore Hospitals in the MultiCare health system. My practice includes not only "routine" inpatient and ambulatory cases in adults and children, but adult cardiac and complex neurosurgical, orthopedic, trauma, and pediatric cases, as well as a large number of cases performed under neuraxial (intrathecal and epidural) anesthesia.

I have several concerns with the rules proposed by WAPA, including:

- The enabling legislation says PAs administering general and intrathecal anesthesia "shall show evidence of adequate education and training in the delivery of the type of anesthesia being delivered on his or her practice agreement," but does not define it. **Without defining adequate education and training in the rules, the Commission is leaving this up to the judgment of individual providers to determine what they think is adequate, and it may be subject to various interpretations.**
- The rules governing the practice of administering anesthesia **should not be vague or undefined.**
- **It is a matter of public safety to ensure individuals delivering anesthesia are adequately educated and trained**.
- Anesthesiology Assistants (AAs) and nurse anesthetists (CRNAs) undergo extensive formal training, both didactic and clinical, in order to practice under the supervision of physician anesthesiologists. MD and DO anesthesiologists undergo substantially more education and training in order to safely administer or direct/supervise the administration of safe general and neuraxial anesthesia, not to mention moderate to deep sedation. **It would be a significant step backwards to permit the discretion of individual providers supervising PAs to trump the advanced training of anesthesiologists, CRNAs, and AAs, and would create real concerns as to patient safety.**
- My specialty society, the American Society of Anesthesiologists, is not aware of any state that explicitly authorizes PAs to administer general anesthesia. The CMS Interpretive Guidelines for hospitals specifically exclude PAs from general and deep sedation in the Conditions of Participation.

I respectfully submit that PAs wishing to include the practice of general and neuraxial anesthesia in their overall practice should be held to the level of training and certification that certified Anesthesiology Assistants currently are. Anything less is contrary to current regulations in every other state, and poses real patient safety risks for patients in Washington.

Thank you very much for the opportunity to comment.

Sincerely,

James Stangl, M.D.
Tacoma Anesthesia Associates, P.S.
[redacted]

From: Jennifer Van Atta
To: Boyd, Amelia (WMC)
Subject: Washington Telehealth Rules
Date: Thursday, April 15, 2021 9:03:32 AM
Attachments: Outlook-su3bl1ix.png

External Email

Good morning Amelia,

I am unable to attend the Rules Workshop but if it's not too late I would like to offer add a few comments to the discussion, unless you believe they have already been addressed elsewhere.

1) If a non-WA licensed provider obtains a telephone consult with a WA licensed provider, this appears to make the WA licensed provider responsible for the primary diagnosis and testing/treatment of the patient. Is that what was intended? I might imagine a scenario where the non-WA licensed provider may contact a WA orthopedist for review of an xray and recommendations. To make the WA orthopedist responsible for the primary diagnosis and treatment recommendations of the patient encounter seems unreasonable - the burden should remain with the non-WA licensed provider, who then should be obligated to thoroughly document the consult and any resulting action. The way this is currently written, there may be reluctance on the part of WA providers to offer consults.

2) I'd like to suggest that beyond referring to an Emergency Room, there is an indication for referring to Urgent Care. For example, if a provider is unable to fully evaluate a rash over Telemedicine video (which is quite common), the patient may be advised to present to Urgent Care for face-to-face evaluation but would be an inappropriate referral to the Emergency Room. A similar situation could occur with a presentation inconclusive for Strep Pharyngitis, but which would benefit from a point-of-care test.

3) Thought should be given to what constitutes a physical exam in Telehealth. For example, is it limited to observational findings (alert, oriented, no respiratory distress, no cyanosis) or physical exam findings performed by the patient and interpreted by the provider over video (for example, "Press on your face/sinuses in these specific locations - does that cause pain? Press on your skin and release your finger quickly. Does your skin turn white briefly?)

Thank you and best regards,

Jennifer Van Atta, MS, PA-C

[redacted]

WASHINGTON Medical Commission
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AA Training Information

www.anesthetist.org

Certified Anesthesiologist Assistants

Comparison: AA, CRNA Training/Practice

	Anesthesiologist Assistants	Nurse Anesthetists
Description of Practice	Medically directed by a physician Anesthesiologist	Supervision by physician of unspecified specialty (excluding Opt-Out states)
Model of Practice	Anesthesia Care Team	Anesthesia Care Team, supervision by any physician, or independent practice without supervision (Opt Out states)
Distribution of Providers	2000+ Certified AAs in 18 jurisdictions (Including District of Columbia and Guam) and Veteran's Administration	36,000 CRNAs in all 50 states and Veteran's Administration
Programs	12 (in 9 states, plus District of Columbia)	120 (in 37 states, plus DC and PR)
Program Length	24-28 months	24-36 months
Type of Program	Master's degree (specific degree title unique to each program)	Doctor of Nursing Practice degree-DNP (specific degree title unique to each program)
Certifying Body	National Commission for Certification of Anesthesiologist Assistants in collaboration with National Board of Medical Examiners	Council on Certification of Nurse Anesthetists
National Organization	American Academy of Anesthesiologist Assistants (AAAA) **www.anesthetist.org**	American Association of Nurse Anesthetists (AANA)
Admission Requirements	Bachelor degree with GPA > 3.0; Completion of Medical College Admissions Test (MCAT) or Graduate Record Exam (GRE), dependent on each program's individual requirements; Previous health care experience preferable; Personal interview	BN Degree Science curriculum for general practice nursing GPA 3.0 Licensure as a registered nurse Minimum one year of nursing experience in acute care setting Personal interview
Program Requirements	All AA programs must be affiliated with an LCGME accredited medical school; Medical Director is a board-certified physician Anesthesiologist; Programs located in academic facilities that meet anesthesia residency requirements for physicians	Faculty includes MDs, CRNAs, and graduate nurses; Program Director must possess a master's degree
Program Accreditation	Commission for Accreditation of Allied Health Education Programs (CAAHEP) Accreditation Review Committee for Anesthesiologist Assistants (ARC-AA)	Council on Accreditation of Nurse Anesthesia Programs
Didactic Education	56-132 didactic hours (depends on program)	34-80 didactic hours (depends on program)
Clinical Education	Minimum of 2000 clinical hours (average > 2500 hrs)	Minimum of 600 cases (average ~2000+ hours - including Master or DNP trained)
Clinical Rotations	All sub-specialties of anesthesia	All sub-specialties of anesthesia
Advanced Skills	Regional anesthesia and invasive line placement	Regional anesthesia and invasive line placement
Clinical Instructors	CAAs, CRNAs, Anesthesiologists, Anesthesiology Residents in training	CRNAs and Anesthesiologists
Recertification	40 CMEs submitted biennially + sit for Continued Demonstration of Qualifications Exam (CDQ) every 6 years	8 year-two-part recertification process began August 2016. • First Four Years – Submission of 40 CMEs • Second Four Years – Inclusion of recertification exam (*first exam to commence in 2024 with no pass/fail. First pass/fail exam to administered in 2032*).
Graduation Requirements	Good class standing; All course semester and clinical requirements completed	All course semester and clinical requirements completed

Sept. 2017

1818 Parmenter St, Ste 300 | Middleton, WI 53562 | info@anesthetist.org | 678.222.4233

Scope of Practice

Certified Anesthesiologist Assistants (CAAs) practice in the Anesthesia Care Team (ACT) with Physician Anesthesiologist oversight. The scope of clinical practice for CAAs is identical to that of nurse anesthetists working in the ACT.

The scope of practice of CAAs is determined by the following:

- The Physician Anesthesiologist
- The hospital credentialing body
- The state's board of medicine
- Any applicable state statute or regulation.

Job Description

The Anesthesiologist Assistant (AA) is qualified by academic and clinical education to provide anesthetic care under the direction of a qualified physician anesthesiologist. The physician anesthesiologist who is responsible for the Anesthesiologist Assistant is available to prescribe and direct particular therapeutic interventions.

By virtue of the basic medical science education and clinical practice experience, the Anesthesiologist Assistant is proficient in the use of contemporary patient monitoring and interpretation of data in all anesthesia care environments. The Anesthesiologist Assistant provides patient care that allows the supervising physician anesthesiologist to use his or her own medical education more efficiently and effectively.

The Anesthesiologist Assistant is prepared to gather patient data, perform patient evaluation, and to administer and document the therapeutic plan that has been formulated for the anesthetic care of the patient. The tasks performed by AAs reflect regional variations in anesthesia practice and state regulatory factors.

Under the direction of a physician anesthesiologist, in agreement with the ASA Statement on the Anesthesia Care Team (ACT) and in accordance with the AAAA Statement on the ACT, the Anesthesiologist Assistant’s functions include, but are not limited to, the following:

a. Obtain an appropriate and accurate preanesthetic health history, perform an appropriate physical examination, and record pertinent data in an organized and legible manner;

b. Obtain diagnostic laboratory and related studies as appropriate, such as drawing arterial and venous blood samples and any other necessary patient fluids;

c. Insert and interpret data from invasive monitoring modalities such as arterial lines, pulmonary artery catheterization, and central venous lines, as delegated by the supervising physician anesthesiologist;

d. Administer anesthetic agents and controlled substances under the direction of a supervising physician anesthesiologist. This includes, but not limited to, administration of induction agents, maintaining and altering anesthesia levels, administering adjunctive treatment and providing continuity of anesthetic care into and during the post-operative recovery period;

e. Establish and maintain appropriate airway management and provide appropriate ventilatory support;

f. Apply and interpret advanced monitoring techniques;

g. Make post-anesthesia patient rounds by recording patient progress notes, compiling and recording case summaries, and by transcribing standing and specific orders;

h. Evaluate and treat life-threatening situations, such as cardiopulmonary resuscitation, on the basis of established protocols (BLS, ACLS, and PALS);

i. Perform duties in intensive care units, pain clinics, and other settings, as appropriate;

j. Train and supervise personnel in the calibration, troubleshooting, and use of patient monitors;

k. Perform administrative duties in an anesthesiology practice or anesthesiology department, including management of personnel;

l. Participate in the clinical instruction of others; and

m. Perform and monitor regional anesthesia to include, but not limited to, spinal, epidural, IV regional, and other special techniques such as local infiltration and nerve blocks.

Educational Program Requirements

An accredited anesthesiologist assistant educational program must be supported by an anesthesiology department of a medical school that is accredited by the Liaison Committee on Medical Education or its equivalent. The Anesthesiology department must have the educational resources internally or through educational affiliates that would qualify it to meet the criteria of the Accreditation Council for Graduate Medical Education (ACGME), or its equivalent, for sponsorship of an anesthesiology residency program

Although the standards recognize the importance of a basic science education within a clinically oriented academic setting, it is also recognized that some of the supervised clinical practice components of the curriculum may be carried out in affiliated community hospitals that have the appropriate affiliation agreements specifying the requisite teaching faculty and staffing ratios for the clinical experience.

The AA curriculum is based on an advanced graduate degree model and requires at least two full academic years. The current programs are 24 to 28 months. Graduates from all AA educational programs earn a Master's Degree.

Prerequisites

Baccalaureate degree from a regionally accredited college or university in the US or Canada

- English
- General Biology with lab
- General Chemistry with lab
- Human Anatomy with lab
- Human Physiology with lab
- Organic Chemistry with lab
- Biochemistry
- General Physics (lab recommended)
- Calculus
- Advanced Statistics
- Medical College Admissions Test (MCAT) or the Graduate Records Admission Test Examination (GRE).

*Please review training program websites for specific information regarding prerequisites.

Master of Science in Anesthesia Average Matriculant GPA			U.S. Medical Schools Average Matriculant GPA		
	Overall	Science		Overall	Science
2014	3.48	3.56	2014	*	*
2013	3.42	3.51	2013	3.54	3.44
2012	3.50	3.57	2012	3.54	3.44
2011	3.52	3.63	2011	3.53	3.43
2010	3.48	3.56	2010	3.53	3.43
2009	3.49	3.65	2009	3.51	3.51

www.aamc.org/data/facts/applicantmatriculant/ (Table 17)
*AAMC's GPA totals from 2014 are not yet available

Training Programs

- Emory University (Atlanta, GA)
- Case Western Reserve University (Cleveland, OH; Houston, TX; Washington, DC)
- Indiana University (Indianapolis, IN)
- Quinnipiac University (North Haven, CT)
- Medical College of Wisconsin (Milwaukee, WI)
- Nova Southeastern University (Tampa, FL; Fort Lauderdale, FL)
- South University (Savannah, GA)
- University of Colorado (Denver, CO)
- University of Missouri-Kansas City (Kansas City, MO)

The Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredits AA training programs. The American Society of Anesthesiologists (ASA) is a CAAHEP member and participates in the accreditation processes for three health professions: Anesthesiologist Assistants, Respiratory Therapy and Emergency Medical Technician-Paramedic. CAAHEP is the largest accreditor in the health sciences field. In collaboration with its Committees on Accreditation, CAAHEP reviews and accredits over 2000 educational programs in 19 health science occupations and is recognized by the Council for Higher Education Accreditation.

Certification

The National Commission for Certification of Anesthesiologist Assistants (NCCAA) was founded in July 1989 to develop and administer the certification process for AAs in the United States. The NCCAA consists of commissioners representing the ASA and the American Academy of Anesthesiologist Assistants (AAAA) and includes physician and AA members (at-large). Graduates or senior students in the last semester of a CAAHEP-accredited AA educational program may apply for initial certification. Such a professional distinction is awarded to an AA who has successfully completed the Certifying Examination for Anesthesiologist Assistants administered by NCCAA in collaboration with the National Board of Medical Examiners (NBME). Certified AAs are permitted to use the designation CAA to indicate that they are currently certified.

The content for the Certifying Examination for Anesthesiologist Assistants is based on knowledge and skills required for anesthetist practice. NCCAA has contracted with NBME to serve as a consultant for the development and ongoing administration of the Certifying Examination. A Test Committee of Anesthesiologists and AAs is responsible for writing and evaluating test questions for the examinations. The first Certifying Examination was administered in 1992.

NCCAA maintains a database of Certified Anesthesiologist Assistants for verification of individual practitioners. Hospitals, practice groups, state boards and others may verify an individual AA's certification via a printed verification statement posted on the Verify Certification page of the NCCAA's web site, www.aa-nccaa.org. The web site also contains additional information about the National Commission and about the certification process.

Recertification

AAs are granted a time-limited certificate after passing the initial examination. The process for recertification requires that an AA submit documentation to NCCAA every two years that he/she has completed 40 hours of Continuing Medical Education (CME). In addition, every six years the practitioner must pass the examination for Continued Demonstration of Qualifications (CDQ).

The CDQ examination was first administered in 1998, making AAs the first anesthesia profession to require passage of a written examination as part of the recertification process. Failure to meet any of the above CME or examination requirements results in withdrawal of the AA's certification.

Professional Definition

Certified Anesthesiologist Assistants (CAAs) are highly skilled health professionals who work under the direction of licensed physician Anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the Anesthesia Care Team model, as described by the American Society of Anesthesiologists (ASA). The goal of AA education is to guide the transformation of qualified student applicants into competent health care practitioners who aspire to work in the Anesthesia Care Team for the benefit of patients.

All CAAs must complete a comprehensive didactic and clinical program at the **graduate school level**. To be admitted into an AA training program, students must have earned a baccalaureate degree with premedical coursework. AAs are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. AAs perform such tasks as administering drugs, obtaining vascular access, applying and interpreting monitors, establishing and maintaining a patient's airway, and assisting with preoperative assessment. AAs train and work under the supervision of physician Anesthesiologists who retain responsibility for the immediate care of the patient. The care team model expands the medical treatment provided by the physician Anesthesiologist and equips the medical facility to serve patients more effectively and efficiently.

History

In the early 1960s, leaders in the medical specialty of Anesthesiology recognized the existence of staffing shortages. To meet growing demands and to accommodate the increasing complexity of anesthesia and surgery, three Anesthesiologists (Drs. Gravenstein, Steinhaus, and Volpitto) proposed the concept of an "anesthesia technologist" who would be a member of the anesthesia team and would be considered an "applied physiologist." This was the precursor to what is now the Certified Anesthesiologist Assistant. The doctors designed an educational program whereby students would build on undergraduate premedical training then earn a master's degree in Anesthesiology. The concept became a reality in 1969 when the first AA training program began accepting students at Emory University in Atlanta, Georgia, followed shortly thereafter by a program at Case Western Reserve University in Cleveland, Ohio.

In 1989, the National Commission for Certification of Anesthesiologist Assistants (NCCAA) was established to create a national certification process. Since 2002, there has been a significant expansion of AA education programs in the US. Today, the ASA fully supports Anesthesiologist Assistants and the expansion of AA licensure and practice across the nation.

Scope of Practice

The scope of CAA clinical practice is generally the same as that of nurse anesthetists on the Anesthesia Care Team. The local scope of practice of CAAs is usually defined by the following:

- The medically directing Anesthesiologist
- The hospital credentialing body
- The state board of medicine
- Any applicable state statute or regulation.

Practice Locations

Certified Anesthesiologist Assistants enjoy career pathways in a dynamic profession that continues to realize exponential growth, as evidenced by the addition of new training sites and new states opening to AA practice. States, territories, and districts in which CAAs work by license, regulation, and/or certification:

- Alabama
- Colorado
- District of Columbia
- Florida
- Georgia
- Indiana
- Kentucky
- Missouri
- New Mexico
- North Carolina
- Ohio
- Oklahoma
- South Carolina
- Vermont
- Wisconsin
- US Territory Guam

States in which AAs are granted practice privilege through physician delegation:

- Michigan
- Texas

If a state does not presently provide the legislative or delegatory option of AA practice, consultation should take place with the state board of medicine or other governing body to explore the specific legal implications of AA practice in your state. General information on the steps to establish CAA practice is available from the AAAA Director of State Affairs office (info@anesthetist.org) Additional information can be found at https://www.anesthetist.org/info

Recognized by Federal Government

CAAs may practice at any Veterans Affairs facility in all 50 states.

The federal Centers for Medicare and Medicaid Services (CMS) recognizes both Certified AAs and Certified Registered Nurse Anesthetists (CRNAs) as non-physician anesthesia providers. Similarly, commercial insurance payers make no distinction between the two anesthetist types with regard to payments for services provided under medical direction by a physician Anesthesiologist.

Standard: Organization and Staffing

The organization of Anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by the following providers:

- A qualified physician Anesthesiologist;
- A doctor of medicine or osteopathy (other than an Anesthesiologist);
- A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under state law;
- A CRNA, as defined in § 410.69(b) of the Federal Register, "who is under the supervision of the operating practitioner or of an Anesthesiologist who is immediately available if needed"; or
- An AA, as defined in § 410.69(b) of the Federal Register, "who is under the supervision of an Anesthesiologist who is immediately available if needed."

Commission on Accreditation of Allied Health Education Programs

Standards and Guidelines
for the Accreditation of Educational Programs for the Anesthesiologist Assistant

Essentials/Standards initially adopted
June 1987; revised in 2000, 2001, 2004, 2009, 2016

Adopted by the
American Academy of Anesthesiologist Assistants
American Society of Anesthesiologists
Accreditation Review Committee for the Anesthesiologist Assistant
and
Commission on Accreditation of Allied Health Education Programs

The Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredits programs upon the recommendation of the Accreditation Review Committee for the Anesthesiologist Assistant.

These accreditation **Standards and Guidelines** are the minimum standards of quality used in accrediting programs that prepare individuals to enter the Anesthesiologist Assistant profession. Standards are the minimum requirements to which an accredited program is held accountable. Guidelines are descriptions, examples, or recommendations that elaborate on the Standards. Guidelines are not required, but can assist with interpretation of the Standards.

Standards are printed in regular typeface in outline form. *Guidelines* are printed in italic typeface in narrative form.

Preamble

The Commission on Accreditation of Allied Health Education Programs (CAAHEP), the Accreditation Review Committee for the Anesthesiologist Assistant (ARC-AA), the American Academy of Anesthesiologist Assistants (AAAA), and the American Society of Anesthesiologists (ASA) cooperate to establish, maintain, and promote appropriate standards of quality for educational programs for Anesthesiologist Assistants and to provide recognition of educational programs that meet or exceed the minimum standards outlined in these accreditation **Standards and Guidelines**. Lists of accredited programs are published for the information of students, employers, educational institutions and agencies, and the public.

These **Standards and Guidelines** are to be used for the development, evaluation, and self-analysis of Anesthesiologist Assistant programs. On-site review teams assist in the evaluation of the program's relative compliance with the accreditation Standards.

Description of the Profession

The Anesthesiologist Assistant (AA) is qualified by academic and clinical education to provide anesthetic care under the direction of a qualified physician anesthesiologist. The physician anesthesiologist who is responsible for the Anesthesiologist Assistant is available to prescribe and direct particular therapeutic interventions.

By virtue of the basic medical science education and clinical practice experience, the Anesthesiologist Assistant is proficient in the use of contemporary patient monitoring and interpretation of data in all anesthesia care environments. The Anesthesiologist Assistant provides patient care that allows the supervising physician anesthesiologist to use his or her own medical education more efficiently and effectively.

The Anesthesiologist Assistant is prepared to gather patient data, perform patient evaluation, and to administer and document the therapeutic plan that has been formulated for the anesthetic care of the patient. The tasks performed by AAs reflect regional variations in anesthesia practice and state regulatory factors.

Under the direction of a physician anesthesiologist, in agreement with the ASA Statement on the Anesthesia Care Team (ACT) and in accordance with the AAAA Statement on the ACT, the Anesthesiologist Assistant's functions include, but are not limited to, the following:

a. Obtain an appropriate and accurate preanesthetic health history, perform an appropriate physical examination, and record pertinent data in an organized and legible manner;

b. Obtain diagnostic laboratory and related studies as appropriate, such as drawing arterial and venous blood samples and any other necessary patient fluids;

c. Insert and interpret data from invasive monitoring modalities such as arterial lines, pulmonary artery catheterization, and central venous lines, as delegated by the supervising physician anesthesiologist;

d. Administer anesthetic agents and controlled substances under the direction of a supervising physician anesthesiologist. This includes, but not limited to, administration of induction agents, maintaining and altering anesthesia levels, administering adjunctive treatment and providing continuity of anesthetic care into and during the post-operative recovery period;

e. Establish and maintain appropriate airway management and provide appropriate ventilatory support;

f. Apply and interpret advanced monitoring techniques;

g. Make post-anesthesia patient rounds by recording patient progress notes, compiling and recording case summaries, and by transcribing standing and specific orders;

h. Evaluate and treat life-threatening situations, such as cardiopulmonary resuscitation, on the basis of established protocols (BLS, ACLS, and PALS);

i. Perform duties in intensive care units, pain clinics, and other settings, as appropriate;

j. Train and supervise personnel in the calibration, troubleshooting, and use of patient monitors;

k. Perform administrative duties in an anesthesiology practice or anesthesiology department, including management of personnel;

l. Participate in the clinical instruction of others; and

m. Perform and monitor regional anesthesia to include, but not limited to, spinal, epidural, IV regional, and other special techniques such as local infiltration and nerve blocks.

I. Sponsorship

A. Sponsoring Education Institution

A sponsoring institution must be at least one of the following:

1. a post-secondary academic institution accredited by an institutional accrediting agency that is recognized by the U.S. Department of Education, and must be authorized under applicable law or other acceptable authority to provide a post-secondary program, which awards a minimum of a master's degree at the completion of the program.

   The Anesthesiologist Assistant program must be supported by a Liaison Committee on Medical Education (LCME) accredited school of medicine, or its successor, or supported by an American Osteopathic Association's Commission on Osteopathic College accredited school of medicine, or its successor. The anesthesiology

department jointly with the Anesthesiologist Assistant program must have the educational resources internally or through educational affiliates that would qualify it to meet the criteria of the Accreditation Council for Graduate Medical Education (ACGME), or its successor, for sponsorship of an anesthesiology residency program.

2. a foreign post-secondary academic institution acceptable to CAAHEP that is authorized under applicable law or other acceptable authority to provide a post-secondary program, which awards a minimum of a master's degree or equivalent upon completion of the program.

B. Consortium Sponsor

1. A consortium sponsor is an entity consisting of two or more members that exists for the purpose of operating an educational program. In such instances, at least one of the members of the consortium must meet the requirements of a sponsoring educational institution as described in I.A.

2. The responsibilities of each member of the consortium must be clearly documented in a formal affiliation agreement or memorandum of understanding, which includes governance and lines of authority.

C. Responsibilities of Sponsor

The Sponsor must ensure that the provisions of these **Standards and Guidelines** are met.

II. Program Goals

A. Program Goals and Outcomes

There must be a written statement of the program's goals and learning domains consistent with and responsive to the demonstrated needs and expectations of the various communities of interest served by the educational program. The communities of interest that are served by the program must include, but are not limited to, students, graduates, faculty, sponsor administration, hospital administration, employers, physicians, and the public.

Program-specific statements of goals and learning domains provide the basis for program planning, implementation, and evaluation. Such goals and learning domains must be compatible with the mission of the sponsoring institution(s), the expectations of the communities of interest, and nationally accepted standards of roles and functions. Goals and learning domains are based upon the substantiated needs of health care providers and employers, and the educational needs of the students served by the educational program.

B. Appropriateness of Goals and Learning Domains

The program must regularly assess its goals and learning domains. Program personnel must identify and respond to changes in the needs and/or expectations of its communities of interest.

An advisory committee, which is representative of these communities of interest named in these **Standards**, must be designated and charged with the responsibility of meeting at least annually, to assist program and sponsor personnel in formulating and periodically revising appropriate goals and learning domains, monitoring needs and expectations, and ensuring program responsiveness to change.

Advisory committee meetings may include participation by synchronous electronic means.

C. Minimum Expectations

The program must have the following goal defining minimum expectations: "To prepare competent entry-level Anesthesiologist Assistants in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains."

Programs adopting educational goals beyond entry-level competence must clearly delineate this intent and provide evidence that all students have achieved the basic competencies prior to entry into the field.

Nothing in this standard restricts programs from formulating goals beyond entry-level competence.

III. Resources

A. Type and Amount

Program resources must be sufficient to ensure the achievement of the program's goals and outcomes. Resources must include, but are not limited to: faculty; clerical and support staff; curriculum; finances; offices; classroom, laboratory, and, ancillary student facilities; clinical affiliates; equipment; supplies; computer resources; instructional reference materials; and faculty/staff continuing education.

B. Personnel

The sponsor must appoint sufficient faculty and staff with the necessary qualifications to perform the functions identified in documented job descriptions and to achieve the program's stated goals and outcomes.

The program director must hold an academic appointment with the sponsoring institution. The medical director must hold either an administrative appointment or an academic appointment with the sponsoring institution.

1. Program Director

a. Responsibilities

The program director must assume or delegate the following responsibilities:

1) supervise those activities of the faculty and administrative staff that are in direct support of the Anesthesiologist Assistant program;
2) organize, administer, continuously review, plan, and develop processes that ensure general effectiveness of didactic education in the program;
3) ensure that continuous and competent educational guidance is provided through contact with all entities that participate in the education of the students;
4) ensure that continuous and competent medical guidance for the clinically related program components is provided, so that:
    a) supervised clinical instruction meets current standards of acceptable practice; and
    b) Anesthesiologist Assistant students learn, develop, and practice the knowledge and skills essential to successful professional interactions with physicians in the medical workplace;
5) ensure that continuous and competent educational guidance is provided, so that the didactic demands placed by the clinical educational environment are adequately addressed by classroom curriculum design.

b. Qualifications

The program director must:

1) be a certified Anesthesiologist Assistant;
2) hold a graduate degree in education, administration, medicine, or the medical basic sciences;
3) have the requisite knowledge and skills to administer the classroom/academic aspects of the program; and,
4) have the requisite knowledge and skills to administer the operation of the overall program.

The title of program director should not prevent a delegated division of duties or the involvement of educational or operational professionals. Delegated areas of responsibility, as defined by the program director, should exist in a clear organizational structure that facilitates timely review of problems, refinement of processes, and overall advancement of the educational mission of the program.

2. Medical Director

a. Responsibilities

The medical director must:

1) organize, administer, continuously review, plan, and develop processes that ensure general effectiveness of clinical education component of the program; and
2) Participate in teaching anesthesia practice and/or coursework focusing on principles of medicine.

b. Qualifications

The medical director must:

1) be a physician anesthesiologist currently licensed and board certified in anesthesiology; and
2) have the requisite knowledge and skills to administer the clinical/academic aspects of the program.

3. Faculty and Instructional Staff

a. Responsibilities

The instructional staff must be responsible for providing instruction, for evaluating students and reporting progress as required by the institution, and for periodically reviewing and updating course materials.

In each location where a student is assigned for didactic or supervised practice instruction, there must be a qualified individual designated to provide that supervision and related frequent assessments of the student's progress in achieving acceptable program requirements.

b. Qualifications

Faculty must be individually qualified by education and experience and must be effective in teaching the subjects assigned. Faculty for the supervised clinical practice portion of the educational program must include a physician alone or a physician with an Anesthesiologist Assistant or a physician with another non-physician anesthesia provider.

Resident physicians may contribute to clinical or didactic instruction. However, the physician faculty roster should be composed predominantly of board certified physician anesthesiologists.

C. Curriculum

1. The curriculum must ensure the achievement of program goals and learning domains. Instruction must be an appropriate sequence of classroom, laboratory, and clinical activities. Instruction must be based on clearly written course syllabi that include course description, course objectives, methods of evaluation, topic outline, and competencies required for graduation.

General content areas must include:

a. Those basic medical sciences that are needed as a foundation for the clinical role of the Anesthesiologist Assistant. In particular, the basic science curriculum must include appropriate content in anatomy, biochemistry, physiology, and pharmacology, with particular emphasis on the cardiovascular, respiratory, renal, nervous, and neuromuscular systems.

b. Medical biophysics appropriate to anesthesia practice, including and emphasizing the principles underlying the function of the devices used in anesthesia delivery systems, in life support systems such as ventilators, and in basic and advanced patient monitors.

c. The principles of patient monitoring emphasizing the design, function, and recognition of artifacts and interpretation of data relevant to anesthesia care.

d. The function of lab instruments and interpretation of data obtained from clinical laboratories, cardiac and pulmonary laboratories.

e. The concepts of data analysis as related to the collection, processing, and presentation of basic science and clinical data in medical literature emphasizing methods that support an understanding of clinical decision-making.

f. Patient assessment, including techniques of interviewing to elicit a health history and performing a physical examination at the level appropriate for preoperative, intraoperative, and postoperative anesthetic evaluations.

g. Extensive instruction in the clinical practice of anesthesia and patient monitoring, principally in an operating room setting, but also in preoperative areas, postoperative recovery areas, intensive care units, pain clinics, affiliated clinical laboratories and other supporting services.

h. Clinical quality assurance conferences and literature reviews.

i. Competencies in emergency preparedness consistent with professional standards.

2. For first year students, the program must set and require minimum number of clinical hours, and at least annually evaluate and document that the established program minimum is adequate to continue promotion to the second year of the program.

   For second and third year students, the program must set and require minimum number of cases by patient population (including pediatrics, adults, geriatrics, acuity, and subspecialties cases - neuro, obstetrics, cardiac, trauma, out-patient) for each of the required patients and conditions listed in these **Standards**, and at least annually evaluate and document that the established program minimums are adequate to achieve entry-level competency.

   The curriculum should include the content in Appendix B. The suggested curriculum content is based on the AA Practice Analysis conducted in 2014.

D. Resource Assessment

The program must, at least annually, assess the appropriateness and effectiveness of the resources described in these **Standards**. The results of resource assessment must be the basis for ongoing planning and appropriate change. An action plan must be developed when deficiencies are identified in the program resources. Implementation of the action plan must be documented and results measured by ongoing resource assessment.

IV. Student and Graduate Evaluation/Assessment

A. Student Evaluation

1. Frequency and purpose

Evaluation of students must be conducted on a recurrent basis and with sufficient frequency to provide both the students and program faculty with valid and timely indications of the students' progress toward and achievement of the competencies and learning domains stated in the curriculum.

2. Documentation

Records of student evaluations must be maintained in sufficient detail to document learning progress and achievements.

B. Outcomes

1. Outcomes Assessment

The program must periodically assess its effectiveness in achieving its stated goals and learning domains. The results of this evaluation must be reflected in the review and timely revision of the program.

Outcomes assessments must include, but are not limited to: national credentialing examination(s) performance, programmatic retention/attrition, graduate satisfaction, employer satisfaction, job (positive) placement, and programmatic summative measures. The program must meet the outcomes assessment thresholds.

"Positive placement" means that the graduate is employed full or part-time in the profession or in a related field; or continuing his/her education; or serving in the military. A related field is one in which the individual is using cognitive, psychomotor, and affective competencies in the educational program.

2. Outcomes Reporting

The program must periodically submit to the ARC-AA the: program goal(s), learning domains, evaluation systems (including type, cut score, and appropriateness), outcomes, its analysis of the outcomes, and an appropriate action plan based on the analysis.

Programs not meeting the established thresholds must begin a dialogue with the ARC-AA to develop an appropriate plan of action to respond to the identified shortcomings.

V. Fair Practices

A. Publications and Disclosure

1. Announcements, catalogs, publications, and advertising must accurately reflect the program offered.

2. At least the following must be made known to all applicants and students: the sponsor's institutional and programmatic accreditation status as well as the name, mailing address, web site address, and phone number of the accrediting agencies; admissions policies and practices, including technical standards (when used); policies on advanced placement, transfer of credits, and credits for experiential learning; number of credits required for completion of the program; tuition/fees and other costs required to complete the program; policies and processes for withdrawal and for refunds of tuition/fees.

3. At least the following must be made known to all students: academic calendar, student grievance procedure, criteria for successful completion of each segment of the curriculum and graduation, and policies and processes by which students may perform clinical work while enrolled in the program.

4. The sponsor must maintain, and make available to the public, current and consistent summary information about student/graduate achievement that includes the results of one or more of the outcomes assessments required in these **Standards**.

The sponsor should develop a suitable means of communicating to the communities of interest the achievement of student/graduates (e.g. through a website or electronic or printed documents).

B. Lawful and Non-discriminatory Practices

All activities associated with the program, including student and faculty recruitment, student admission, and faculty employment practices, must be non-discriminatory and in accord with federal and state statutes, rules and regulations. There must be a faculty grievance procedure made known to all paid faculty.

C. Safeguards

The health and safety of patients, students, faculty, and other participants associated with the educational activities of the students must be adequately safeguarded.

All activities required in the program must be educational and students must not be substituted for staff.

Anesthesiologist Assistant students must be readily identifiable to patients and clinical co-workers as Anesthesiologist Assistant students.

The intent of the students' patient management experience must always be focused on patient safety while maximizing the educational experience. Students must undertake patient care duties commensurate with their level of competency. The students must at no time be considered the anesthesia provider of record. When students are assigned to any patient care duty, a physician anesthesiologist must be immediately available to provide hands-on care that can affect the patient outcome.

As students approach graduation, the supervising physician anesthesiologist may assign to them an increased level of responsibility for the delivery of anesthesia care to patients commensurate with their demonstrated knowledge, skills, and clinical judgment.

D. Student Records

Satisfactory records must be maintained for student admission, advisement, counseling, and evaluation. Grades and credits for courses must be recorded on the student transcript and permanently maintained by the sponsor in a safe and accessible location.

E. Substantive Change

The sponsor must report substantive change(s) as described in Appendix A to CAAHEP/ARC-AA in a timely manner. Additional substantive changes to be reported to ARC-AA within the time limits prescribed include:

1. Change in relationship with the school of medicine; and
2. Change in relationship with the Department of Anesthesiology affiliations.

F. Agreements

There must be a formal affiliation agreement or memorandum of understanding between the sponsor(s) and all other entities that participate in the education of the students describing the relationship, role, and responsibilities between the sponsor and that entity.

Appendix A

Application, Maintenance and Administration of Accreditation

A. Program and Sponsor Responsibilities

1. Applying for Initial Accreditation

a. The chief executive officer or an officially designated representative of the sponsor completes a "Request for Accreditation Services" form and returns it electronically or by mail to:

ARC-AA
N84W33137 Becker Ln
Oconomowoc, WI 53066

The "Request for Accreditation Services" form can be obtained from the CAAHEP website at https://www.cognitoforms.com/CAAHEP2/RequestForAccreditationServices.

Note: There is **no** CAAHEP fee when applying for accreditation services; however, individual committees on accreditation may have an application fee.

b. The program undergoes a comprehensive review, which includes a written self-study report and an on-site review.

The self-study instructions and report form are available from the ARC-AA. The on-site review will be scheduled in cooperation with the program and ARC-AA once the self-study report has been completed, submitted, and accepted by the ARC-AA.

2. Applying for Continuing Accreditation

a. Upon written notice from the ARC-AA, the chief executive officer or an officially designated representative of the sponsor completes a "Request for Accreditation Services" form, and returns it electronically or by mail to:

ARC-AA
N84W33137 Becker Ln
Oconomowoc, WI 53066

The "Request for Accreditation Services" form can be obtained from the CAAHEP website at https://www.cognitoforms.com/CAAHEP2/RequestForAccreditationServices.

b. The program may undergo a comprehensive review in accordance with the policies and procedures of the ARC-AA.

If it is determined that there were significant concerns with the conduct of the on-site review, the sponsor may request a second site visit with a different team.

After the on-site review team submits a report of its findings, the sponsor is provided the opportunity to comment in writing and to correct factual errors prior to the ARC-AA forwarding a recommendation to CAAHEP.

3. Administrative Requirements for Maintaining Accreditation

a. The program must inform the ARC-AA and CAAHEP within a reasonable period of time (as defined by the ARC-AA and CAAHEP policies) of changes in chief executive officer, dean of health professions or equivalent position, and required program personnel (Refer to Standard III.B.).

b. The sponsor must inform CAAHEP and the ARC-AA of its intent to transfer program sponsorship. To begin the process for a Transfer of Sponsorship, the current sponsor must submit a letter (signed by the CEO or

designated individual) to CAAHEP and the ARC-AA that it is relinquishing its sponsorship of the program. Additionally, the new sponsor must submit a "Request for Transfer of Sponsorship Services" form. The ARC-AA has the discretion of requesting a new self-study report with or without an on-site review. Applying for a transfer of sponsorship does not guarantee that the transfer will be granted.

c. The sponsor must promptly inform CAAHEP and the ARC-AA of any adverse decision affecting its accreditation by recognized institutional accrediting agencies and/or state agencies (or their equivalent).

d. Comprehensive reviews are scheduled by the ARC-AA in accordance with its policies and procedures. The time between comprehensive reviews is determined by the ARC-AA and based on the program's on-going compliance with the Standards, however, all programs must undergo a comprehensive review at least once every ten years.

e. The program and the sponsor must pay ARC-AA and CAAHEP fees within a reasonable period of time, as determined by the ARC-AA and CAAHEP respectively.

f. The sponsor must file all reports in a timely manner (self-study report, progress reports, probation reports, annual reports, etc.) in accordance with ARC-AA policy.

g. The sponsor must agree to a reasonable on-site review date that provides sufficient time for CAAHEP to act on a ARC-AA accreditation recommendation prior to the "next comprehensive review" period, which was designated by CAAHEP at the time of its last accreditation action, or a reasonable date otherwise designated by the ARC-AA.

Failure to meet any of the aforementioned administrative requirements may lead to administrative probation and ultimately to the withdrawal of accreditation. CAAHEP will immediately rescind administrative probation once all administrative deficiencies have been rectified.

4. Voluntary Withdrawal of a CAAHEP- Accredited Program

Notification of voluntary withdrawal of accreditation from CAAHEP must be made by the Chief Executive Officer or an officially designated representative of the sponsor by writing to CAAHEP indicating: the desired effective date of the voluntary withdrawal, and the location where all records will be kept for students who have completed the program.

5. **Requesting Inactive Status of a CAAHEP- Accredited Program**

Inactive status for any accredited program may be requested from CAAHEP at any time by the Chief Executive Officer or an officially designated representative of the sponsor writing to CAAHEP indicating the desired date to become inactive. No students can be enrolled or matriculated in the program at any time during the time period in which the program is on inactive status. The maximum period for inactive status is two years. The sponsor must continue to pay all required fees to the ARC-AA and CAAHEP to maintain its accreditation status.

To reactivate the program, the Chief Executive Officer or an officially designated representative of the sponsor must provide notice of its intent to do so in writing to both CAAHEP and the ARC-AA. The sponsor will be notified by the ARC-AA of additional requirements, if any, that must be met to restore active status.

If the sponsor has not notified CAAHEP of its intent to re-activate a program by the end of the two-year period, CAAHEP will consider this a "Voluntary Withdrawal of Accreditation."

B. CAAHEP and Committee on Accreditation Responsibilities – Accreditation Recommendation Process

1. After a program has had the opportunity to comment in writing and to correct factual errors on the on-site review report, the ARC-AA forwards a status of public recognition recommendation to the CAAHEP Board of Directors. The recommendation may be for any of the following statuses: initial accreditation, continuing accreditation, transfer of sponsorship, probationary accreditation, withhold of accreditation, or withdrawal of accreditation.

The decision of the CAAHEP Board of Directors is provided in writing to the sponsor immediately following the CAAHEP meeting at which the program was reviewed and voted upon.

2. Before the ARC-AA forwards a recommendation to CAAHEP that a program be placed on probationary accreditation, the sponsor must have the opportunity to request reconsideration of that recommendation or to request voluntary withdrawal of accreditation. The ARC-AA reconsideration of a recommendation for probationary accreditation must be based on conditions existing both when the committee arrived at its recommendation as well as on subsequent documented evidence of corrected deficiencies provided by the sponsor.

   The CAAHEP Board of Directors' decision to confer probationary accreditation is not subject to appeal.

3. Before the ARC-AA forwards a recommendation to CAAHEP that a program's accreditation be withdrawn or that accreditation be withheld, the sponsor must have the opportunity to request reconsideration of the recommendation, or to request voluntary withdrawal of accreditation or withdrawal of the accreditation application, whichever is applicable. The ARC-AA reconsideration of a recommendation of withdraw or withhold accreditation must be based on conditions existing both when the ARC-AA arrived at its recommendation as well as on subsequent documented evidence of corrected deficiencies provided by the sponsor.

   The CAAHEP Board of Directors' decision to withdraw or withhold accreditation may be appealed. A copy of the CAAHEP "Appeal of Adverse Accreditation Actions" is enclosed with the CAAHEP letter notifying the sponsor of either of these actions.

   At the completion of due process, when accreditation is withheld or withdrawn, the sponsor's Chief Executive Officer is provided with a statement of each deficiency. Programs are eligible to re-apply for accreditation once the sponsor believes that the program is in compliance with the accreditation Standards.

Note: Any student who completes a program that was accredited by CAAHEP at any time during his/her matriculation is deemed by CAAHEP to be a graduate of a CAAHEP-accredited program.

APPENDIX B
Guidelines for Curriculum Didactic and Clinical Content

A. PHYSIOLOGY *(Applied and General)*

1. *Neuromuscular physiology*
    a. *Physiology of the neuron*
    b. *Anatomy of the neuromuscular junction*
    c. *Membrane and action potentials*
    d. *Excitation and contraction of the smooth muscle*
    e. *Neuromuscular blockade and transmission*
    f. *Malignant hyperthermia*

2. *Nervous system*
    a. *Organization of the nervous system*
    b. *Peripheral and central nervous system*
    c. *Physiology of neurons and synapses*
    d. *Characteristics of synaptic transmission*
    e. *Sensory receptors*
    f. *Nerve fibers that transmit different types of signals and their physiologic classification*
    g. *Spatial and temporal summation*

3. *Autonomic nervous system*
    a. *Sympathetic nervous system*
        i. *Anatomy of the sympathetic nervous system*
        ii. *Sympathetic neurotransmission and catecholamine physiology*
        iii. *Adrenergic receptors*
    b. *Parasympathetic nervous system*
        i. *Anatomy of the parasympathetic nervous system*
        ii. *Parasympathetic neurotransmission*
        iii. *Cholinergic receptors*

4. *Central nervous system*
    a. *Neuroanatomy of spine and spinal cord*
        i. *Cranial nerves*
        ii. *Motor functions of the spinal cord and cord reflexes*
        iii. *Cerebrospinal fluid*
            a. *Cerebral blood flow and metabolism*
        iv. *Intracranial pressure*
            a. *Head trauma, psychiatric illness, and cerebrovascular disorders*

5. *Cardiac physiology*
    a. *Electrophysiology and conduction pathways*
        i. *Mechanisms of heart rate control and ventricular action potentials*
        ii. *Specialized excitatory and conductive systems*
        iii. *Control of excitation and conduction*
        iv. *Electrocardiographic interpretation*
    b. *Determinants of cardiac output and systemic arterial blood pressure*
        i. *Preload, afterload, and contractility*
        ii. *Cardiac output, venous return and their regulation*
        iii. *Frank – Starling Mechanism*
    c. *Left ventricular pressure-volume relationships*
    d. *Ventricular function curves*
    e. *Treatment of intra-operative ischemia and coronary artery disease*
    f. *Subvalvular aortic stenosis*
    g. *Cardiac arrhythmias*

6. *Circulatory physiology*
    a. *Microcirculation, lymphatics, capillary fluid exchange, interstitial fluid*

b. *Local and humoral control of blood flow by the tissues*

7. *Blood and Hemostasis*
    a. *Platelet aggregation and coagulation cascade*
    b. *Fibrinolysis, plasmin, and coagulation tests*
    c. *Disorders of coagulation*
    d. *Transfusion therapy*

8. *Respiratory physiology*
    a. *Anatomy of the larynx*
    b. *Gas diffusion and partial pressures*
    c. *Oxygen and carbon dioxide carriage by blood*
        i. *Oxygen dissociation curves and abnormalities*
    d. *Control of ventilation*
        i. *Respiratory centers and sensory pathways*
    e. *Pulmonary mechanics*
        i. *Ventilation: perfusion relationships*
        ii. *Hypoxic pulmonary vasoconstriction and one-lung ventilation*
    f. *Pulmonary function tests*
        i. *Flow volume loops*
        ii. *Airway closure and closing capacity*
        iii. *Blood gas physiology*
    g. *Chronic and acute respiratory pathophysiology*
        i. *Restrictive and obstructive diseases*
        ii. *OSA*

9. *Body fluid, electrolytes and the kidney*
    a. *Fluid compartments*
    b. *Fluid management*
    c. *Anatomy of the nephron and vascular supply*
    d. *Physiology of urine formation*
    e. *Regulation of fluid volume and osmolality*
    f. *Intra- and extra-cellular fluids*
    g. *Renal tubular control of electrolyte balance*
    h. *Renal failure and fluid-electrolyte disturbances*
    i. *Acid-base balance and disturbances*

10. *Endocrine physiology*
    a. *Thyroid and adrenal physiology*
    b. *Insulin, glucagon and somatostatin*
    c. *Parathyroid hormone and calcitonin*
    d. *Endocrine disorders*

11. *Hepatic physiology*
    a. *Hepatic anatomy and vascular physiology*
    b. *Hepatic disease*

12. *Physiology of pregnancy*
    a. *Pathophysiology of the uterus and the placenta*
    b. *Parturition*
    c. *Pharmacological alterations*

13. *Fetal and neonatal physiology*
    a. *Cardiopulmonary system*
    b. *Fluid balance*
    c. *Renal and hepatic function*

B. PHARMACOLOGY

1. *Pharmacokinetics and pharmacodynamics*
    a. *Absorption, distribution, metabolism, and excretion*
    b. *Drug-receptor interactions*
    c. *Weak acids and weak bases*

2. *Inhalational anesthetics*

3. *Intravenous anesthetics*

4. *Opioids*
    a. *Pharmacology of opioid agonists and antagonists*
    b. *Central and peripheral administration of opioids*
    c. *Pain pathways*
        i. *Peripheral afferents and pain conduction*
        ii. *Classification of pain*
        iii. *Mechanism of analgesia*
        iv. *Modulation of pain*
        v. *Spinal and supraspinal analgesia*

5. *Neuromuscular blocking agents*
    a. *Depolarizing and non-depolarizing agents*
    b. *Interactions with neuromuscular blockers*
    c. *Reversal of neuromuscular blockade*

6. *Drugs acting on the autonomic nervous system*
    a. *Sympathetic nervous system*
        i. *Clinical use of catecholamines and synthetic non-catecholamines*
        ii. *Effects of adrenergic agonists and antagonists*
        iii. *Centrally and peripherally acting sympathetic nervous system agents*
    b. *Parasympathetic nervous system*
        i. *Cholinergic agonists and antagonists*

7. *Local anesthetics*
    a. *Structure activity relationships*
    b. *Metabolism*
    c. *Management of toxicity syndrome*

8. *Calcium channel blockers*

9. *Cardiac antidysrhythmic drugs*

10. *Cardiac glycosides and related drugs*

11. *Antihypertensives and vasoactive agents*

12. *Antihistaminergic drugs and autacoids*

13. *Antimicrobial pharmacology*

14. *Steroids*

15. *NSAIDs*

16. *Hormones*

17. *Hemostatic agents*
    a. *Anticoagulants, antifibrinolytics, and thrombin inhibitors*

18. *Diuretics*
    a. *Mechanisms of action and side effects*

19. *Gastroinestinal pharmacology*
    a. *Antacids and prokinetics*

20. *Antiemetics*

21. *Insulin and oral hypoglycemic agents*

22. *Antiseizure drugs*

23. *Math for calculating concentrations*

24. *Drug-drug interactions and toxicities*

25. *Drug allergies*

C. ANESTHESIA EQUIPMENT

1. *Anesthesia delivery systems*

2. *Gases, gas containers, and piping systems*

3. *Anatomy of the anesthesia machine*

4. *Vaporizing liquid anesthetic agents*

5. *Breathing circuits*
    a. *Open, semi-open, closed, semi-closed breathing systems*
    b. *Time constants*

6. *Anesthesia ventilators*

7. *Scavenging waste gases and controlling pollution*

8. *Oxygen delivery and ventilation during MAC, transport, and MRI*

9. *Ultrasound*

D. INSTRUMENTATION & MONITORING

1. *Assess, interpret, and respond to changes in patient monitoring*
    a. *ECG*
        i. *ECG in relation to mechanical and electrical events of the heart*
        ii. *Intervals and QRS nomenclature*
        iii. *Atrial and ventricular arrhythmias and conduction abnormalities*
    b. *Non-invasive monitoring*
        i. *Blood pressure*
        ii. *Transesophageal echocardiography (e.g., PFT, ECHO)*
        iii. *Doppler and ultrasonic imaging*
        iv. *Cardiac output*
    c. *Oxygen monitoring, oximetry and plethysmography*
    d. *Capnography & respiratory gas analysis*
    e. *Monitoring the neuromuscular junction*
    f. *Invasive monitoring principles and techniques*
        i. *Peripheral arterial pressure waveforms and monitoring*
        ii. *Pulmonary artery pressure and monitoring*
        iii. *Central venous pressure and monitoring*

iv. *Intracranial pressure monitoring*
v. *Cardiac output measurement*

g. *Temperature control and monitoring*
i. *Body and fluid warming devices*

h. *Fetal Monitoring*
i. *Arterial blood gas analysis*
j. *EEG, processed EEGs, and evoked potentials*
k. *Point of care devices*

2. *Cardiovascular support devices*
a. *Pacemakers and AICDs*
b. *Ventricular assist devices and cardiopulmonary bypass*

3. *Blood salvage and rapid infusion devices*

E. PHYSICS

1. *Units of measurement, dimensional analysis review of special functions, physical concepts and mathematical tools*

2. *Pressure, tension, and vacuum*

3. *Flow, resistance, power and work*

4. *Partial pressures and solubility*

5. *Diffusion and osmosis*

6. *Gas laws, cylinders, and transport processes*

7. *Vaporization and humidification*

8. *Physiologic signals and electrical analogs*

9. *Electrical circuits and physiologic analogs*
a. *Pressure/voltage, flow/current, resistance*
b. *Direct and alternating current sources*
c. *Series, parallel and series-parallel circuits*
d. *Capacitors and inductors – time constants*
e. *Impedance*
f. *Transformers*

10. *Principles of lasers, fires, explosions and radiation*
a. *Electrocautery and laser technology*

F. AIRWAY MANAGEMENT

1. *Airway anatomy and physiology*

2. *Airway management equipment (e.g., fiberoptic and glide scopes, LMA, DLT)*

3. *Evaluation of the airway*

4. *Techniques for intubation & extubation*

5. *The difficult airway*

6. *Pediatric and advanced airway management*

7. *Ventilation assist devices (e.g., BiPAP, CPAP)*

G. METHODS OF ANESTHESIA *(e.g., general, regional, MAC, TIVA)*

1. *Regional anesthesia*
    a. *Neuraxial blockade*
    b. *Peripheral nerve blockade*
    c. *Intravenous regional anesthesia*
    d. *Complications and techniques*
    e. *Drug regimens for epidural and spinal anesthetics*

2. *Monitored anesthesia care*
    a. *Unique challenges of diverse sedation management techniques and locations*

3. *Positioning*
    a. *Considerations related to safe positioning in regard to surgical and anesthesia implications (e.g., lithotomy, sitting craniotomy, beach chair, brachial plexus, extremity neuropathy, prone facial/ocular, ventilation perfusion mis-match)*

4. *Obstetric anesthesia*
    a. *Physiologic changes of the parturient*
    b. *Fetal and placental physiology*
    c. *General and regional anesthesia during pregnancy*
    d. *Stages of labor and pain pathways*
    e. *Management of the complicated pregnancy*

5. *Pediatric anesthesia*
    a. *Pediatric physiology and anatomy*
    b. *Pediatric congenital anomalies (cardiovascular and developmental)*
    c. *Pharmacodynamics and kinetics of the pediatric patient*
    d. *Airway management of the pediatric patient*

6. *Geriatric anesthesia*
    a. *Physiologic and pharmacologic changes of aging*

7. *Neurosurgical anesthesia*

8. *Cardiac anesthesia*

9. *Trauma anesthesia*

H. ANESTHESIA MANAGEMENT

1. *Preoperative Assessment*
    a. *preoperative evaluation and assessment techniques*
        i. *Lab value assessment*
        ii. *Physical exam*
        iii. *Patient interview*
        iv. *NPO guidelines*
        v. *Anesthesia plan formulation*
        vi. *Special tests (e.g., PFT, ECHO)*
    b. *Imaging*

2. *Intraoperative Management*
    a. *Communication with perioperative team*
        i. *Timeout*
        ii. *Care transitions or handoffs*
    b. *Intraoperative complications/critical events*
        i. *Hazards (e.g., airway fires, burns, electrical)*
    c. *Changes in patient physiology*
    d. *Documentation/charting*

e. *Perioperative pain management*

3. *Postoperative management*
    a. *Patient care transfer to PACU, ICU, etc.*
    b. *Acute pain management strategies*
    c. *Post-operative complications*

I. INFECTION CONTROL

1. *Universal precautions*
    a. *PPEs*
    b. *Hand hygiene*
    c. *Scrubbing and gowning*

2. *Surgical site infection prevention protocols (e.g., prophylactic antibiotic treatment, sterile technique)*

J. CLINICAL PRACTICE MANAGEMENT AND DEVELOPMENT

1. *ASA Practice Guidelines*

2. *ASA Standards of Care*

3. *Professional organizations in the field (e.g., ARC-AA, AAAA, NCCAA, ASA)*

4. *QA/QI process*

5. *Evidence-based case study analysis*

6. *Provision of high quality cost-effective care*

7. *Professional practice standards*

8. *Role of the Anesthesia Care Team*

9. *Cardiopulmonary Resuscitation*

10. *Situational awareness*

11. *Patient safety guidelines*

12. *Non-operating room anesthesia*

K. PROFESSIONALISM

1. *Truthfulness and transparency*

2. *Patient sensitivity, empathy, accountability, respect*

3. *Ethics in anesthesia*

4. *Advocacy*

L. PROVIDER WELLNESS

1. *Occupational health*
    a. *Infection from patients*
    b. *Exposure to anesthetic agents*

2. *Practitioner personal wellness*

a. *Stress management*
b. *Managing challenging outcomes*
c. *Dependency*

M. CLINICAL CONTENT OUTLINE

Total Anesthesia Cases	*600*
Total Hours Clinical Anesthesia	*2000*
Patient ASA Class III & IV	*150*
Emergent (ASA Class E)	*30*
Trauma Cases	*5*
Ambulatory	*100*
Patient Population	
Geriatric (65 + years)	*100*
*Pediatric (0 - 18)**	*50*
Anatomical Location Surgery	
Intra-abdominal	*75*
Intracranial	*5*
Head & Neck	*20*
Intrathoracic	*20*
Heart	*10*
Lung	*10*
Obstetrical Cases (including Deliveries, C-Sect & Procedures)	*35*
Vascular	*15*
Methods of Anesthesia	
General Anesthesia	*400*
Induction, Maintenance & Emergence	
Mask Induction	*35*
Mask Management	*30*
Supraglottic Airway Device	*35*
Tracheal Intubation	*255*
Oral	*250*
Nasal	*5*
Total Intravenous Anesthesia	*10*
Emergence from Anesthesia	*250*
Regional Techniques	
Management/Administration	*40*
Monitored Anesthesia Care	*30*

Other Anesthetic Management	
Alternative Airway Management	
Fiberoptic Intubation, Light Wand, etc. (all airway techniques other than direct laryngoscopy and supraglottic airway device)	10
Arterial Technique	
Arterial Puncture/Catheter Insertion	25
Intra-arterial BP monitoring	30
Central Venous Pressure Catheter	
Placement	5
Monitoring	15
Other	
Intravenous Catheter Placement	125
Gastric Tube Placement	5
Placement of One Lung Isolation Device	5